STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	165197	A. BUILDING _____ B. WING _____	C 10/05/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CEDAR FALLS HEALTH CARE CENTER	1728 WEST EIGHTH STREET CEDAR FALLS, IA 50613

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 000	INITIAL COMMENTS Correction Date 12/11/2020 and 12/26/2020 The following deficiencies were identified during the investigation of complaints 93136-C, 93167-C, 92857-C, 90813-C, 93356-C, 92586-C, 93458-C, 92685-C, 93149-C, 93574-C, 93152-C. 90296-C, 91782-C, 90332-C, and facility reported incident 93589-I completed from September 14 - October 5, 2020. All of the complaints and were substantiated. The facility reported incident was substantiated. See code of Federal Regulations (45 CFR) Part 483, Subpart B-C. In addition to the above investigation, a COVID-19 Focused Infection Control survey was conducted by the Department of Inspection and Appeals, It was found the facility was not in substantial compliance with CMS and Centers for Disease Control and Prevention (CDC) recommended practices to prepare for COVID-19. Total residents: 47	F 000	This plan of correction does not constitute an admission or agreement by Cedar Falls Health Care Center of the truth of the facts alleged or the conclusions set forth in the statement of deficiencies. This plan of correction is prepared solely because it is required by State and Federal law. This plan of correction shall serve as Cedar Falls Health Care Center's credible allegation of compliance.	
F 584 SS=E	Safe/Clean/Comfortable/Homelike Environment CFR(s): 483.10(i)(1)-(7) §483.10(i) Safe Environment. The resident has a right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely. The facility must provide- §483.10(i)(1) A safe, clean, comfortable, and	F 584	F 584 1. The floors in rooms 2, 3, 4, 5, 6, 7, 8, 13, 15, 16, 17, 19, 20, 21, 23, 24, 27, 30, "D" wing hallway floor and the front dining room floor will be cleaned by housekeeping staff on or before 12/25/2020. The back-dining room cabinets will be cleaned, and the sheet rock will be installed by Maintenance Director or designee on or before 12/25/2020. "A" wing shower room floor, wall tile and toilet bowl will be cleaned by housekeeping staff on or before 12/25/2020. Room 4's air conditioner unit will have the towel removed by the Maintenance Director or designee on or before 12/25/2020. The clothes on the floor in room 8 will be removed by housekeeping staff on 9/14/20. Room 17's missing floor tile and rubber base board will be replaced by Maintenance Director or designee on or before 12/25/2020. Room 22 and Resident #1's broken dressers have will be replaced by Maintenance Director or designee on or before 12/25/2020. Room 8 has will be deep cleaned by housekeeping staff on 12/25/2020.	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Leslie Walsh — TITLE: Administrator — (X6) DATE: 12/09/2020

12/22/2020

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F 584	Continued From page 1 homelike environment, allowing the resident to use his or her personal belongings to the extent possible. (i) This includes ensuring that the resident can receive care and services safely and that the physical layout of the facility maximizes resident independence and does not pose a safety risk. (ii) The facility shall exercise reasonable care for the protection of the resident's property from loss or theft. §483.10(i)(2) Housekeeping and maintenance services necessary to maintain a sanitary, orderly, and comfortable interior; §483.10(i)(3) Clean bed and bath linens that are in good condition; §483.10(i)(4) Private closet space in each resident room, as specified in §483.90 (e)(2)(iv); §483.10(i)(5) Adequate and comfortable lighting levels in all areas; §483.10(i)(6) Comfortable and safe temperature levels. Facilities initially certified after October 1, 1990 must maintain a temperature range of 71 to 81°F; and §483.10(i)(7) For the maintenance of comfortable sound levels. This REQUIREMENT is not met as evidenced by: Based on observation, staff interview, and record review the facility failed to maintain the environment in a clean, sanitary and homelike environment. The facility reported a census of 61 residents.	F 584	2. An environmental audit will be conducted by Administrator or Designee on or before 12/25/2020 to identify other areas that require cleaning or repairs needed. 3. Administrator will re-educate Housekeeping staff on or before 12/25/20 regarding cleaning schedule and processes to maintain clean, comfortable and homelike environment. Administrator will re-educate maintenance staff regarding the requirements of completing repairs to keep the facility equipment in good working order. 4. Administrator/Designee will complete environmental rounds weekly for 4 weeks then monthly for 2 months to ensure cleanliness continues to be completed to maintain a clean, comfortable homelike environment and repairs continue to be completed as required. Results of these audits will be presented to the QAPI meeting monthly for 3 months for review and recommendations as needed. The administrator is responsible for monitoring and follow-up as needed. Compliance date: 12/26/2020	12/26/2020

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F 584	Continued From page 2 Findings include: 1. During an initial tour of the facility on 9/14/2020 from 9:05 A.M. 0 9:45 A.M., observations included: The back dining room lower cabinets contained a large amount of grime, food debris, and drips. The dining room floor had heavy dirt and grime buildup. The walls had multiple areas of missing sheet rock. Observation through the D wing door window revealed the hall floor had heavy buildup of dirt and grime. The front dining room floor had heavy buildup of dirt and grime. A Hall: Room 2 - Floor had heavy buildup of dirt and grime. Room 3 - Floor had heavy buildup of dirt, grime and linens on the floor. Room 4 - Floor had heavy buildup of dirt and grime. The air conditioner had a towel wedged underneath it in the window. The toilet area had a large dark buildup around the base of the toilet. Room 5 - Floor had heavy buildup of dirt and grime. Room 6 - Floor had heavy buildup of dirt and grime. Room 7 - Floor had heavy buildup of dirt and grime. The toilet area had a large amount of dark stains around the toilet. Room 8 - Floor had heavy buildup of dirt and grime. The toilet area had a large amount of dark stains around the toilet, and clothes lay on the floor.	F 584		

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F 584	Continued From page 3 The shower room in A hall had several pieces of resident equipment present, a dark buildup around the base of the floor and wall tile, and dark buildup inside of the toilet. B Hall: Room 13 - Floor had heavy buildup of dirt and debris. The toilet area had a large amount of dirt and staining around the toilet base. Room 15 - Floor had heavy buildup of dirt and debris. The toilet area had a large amount of dirt and staining around the toilet base. Room 16 - Floor had heavy buildup of dirt and debris. The toilet area had a large amount of dirt and staining around the toilet base. Room 17 - Floor had heavy dirt buildup. The toilet area had floor tile and rubber base board missing. Room 19 - Floor had heavy buildup of dirt and debris. The toilet area had a large amount of dirt and staining around the toilet base. Room 20 - Floor had heavy buildup of dirt and debris. The toilet area had a large amount of dirt and staining around the toilet base. Room 21 - Floor had heavy buildup of dirt and debris. The toilet area had a large amount of dirt and staining around the toilet base. Room 23 - Carpeted floor and tile floor had heavy buildup of dirt and debris. The toilet area had a large amount of dirt and staining around the toilet base. Room 24 - Floor had heavy buildup of dirt and debris. The toilet area had a large amount of dirt and staining around the toilet base. D Hall observation on 9/15 at approximately 1:20: Room 30 - Floor had heavy buildup of dirt and debris.	F 584		

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F 584	Continued From page 4 Room 27 - Floor had heavy buildup of dirt and debris. At approximately 9:10 A.M. Staff B, Housekeeping, reported working full time at the facility and resident rooms get cleaned every day. Staff B reported on the weekends, including 9/13/2020, they work in laundry. At approximately 9:25 A.M. Staff A, Housekeeping reported working in laundry on the weekends. At 1:20 P.M. Staff A reported using a lemon disinfectant on the floors. The maintenance staff tries to clean floors with a floor scrubber every week. Staffing is lacking and Staff A had often worked alone and can't get to every room. Staff A said they had not been able to clean the floors on B hall for greater than one week, they failed to have enough help and cannot get to every room. At approximately 2:30 P.M. Staff D, Maintenance Director indicated the facility had no cleaning schedule but is working on a Housekeeping Deep Cleaning Checklist that they plan on implementing. One or two days a week the facility had one housekeeping staff, they have to also cover laundry Friday, Saturday and Sunday. Observation on 9/16/2020 at 9:30 A.M. revealed a long, six drawer dresser in Room 22-1 used as a television stand with two drawers that had the fronts broken.. One drawer front hung loosely and the other, completely off, sat next to the drawer. During an interview on 9/16/2020 from 8:50 - 9:30 A.M., Resident #1 revealed staff reclined the chair on the other side of the curtain used to separate the room and it pushed the dresser with	F 584		

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F 584	Continued From page 5 the television over, breaking the dresser and the television a couple of weeks prior. The facility replaced the television, but failed to fix the dresser. During an interview on 9/22/2020 at 3:50 P.M., revealed Resident #1's dresser continued to have three drawers broken with drawer fronts not connected and propped against the dresser. The resident revealed they would like it if the facility would fix the dresser. Observation on 9/14/20 at 9:29 a.m. revealed the bathroom in room 4 had a large brownish colored area surround the toilet. There are paper towels noted on the floor with brown substance on them. The resident in Room 4 stated his room mate cannot hit the mark and commented the bathroom is disgusting. The bathroom has a strong odor of urine upon entering. Observation on 9/14/20 at 9:22 a.m. revealed the floor in Room 8 cluttered with debris, the bed had balls of dust and debris under it, the recliner contained brown debris around the base of the chair. The floor had areas of brown discoloration which appeared to be dirt. Observation on 9/14/20 at 9:15 a.m. revealed a mud scattered on the floor in Room 17. On A hall, outside Room 17, the floor had mud and dirt scattered the length of the hall. Observation on 9/14/20 at 12:00 p.m. revealed the floor heater in Room 3 was without a cover, which exposed heating coils.	F 584		
F 604 SS=D	Right to be Free from Physical Restraints CFR(s): 483.10(e)(1), 483.12(a)(2)	F 604	F 604 1. Resident # 15 was assessed by DON/ Designee and the seat belt was removed on or before 12/22/20. 2. An audit was completed by DON/Designee on or before 12/25/20 related to any other restraints in use that needed to be assessed. No other restraints were identified. 3. DON/Designee provided education to Licensed Nurses on 10/20/20 regarding use of seatbelts/restraints and the requirements to complete restraint assessments. 4. DON/Designee will complete audits weekly for 4 weeks then monthly for 2 months, to ensure restraint assessment continue to be completed as required. Results of these audits will be taken to the facility QAPI meeting monthly for 3 months for review and recommendation as needed. The Director of Nursing is responsible for monitoring and follow-up. Compliance date: 12/26/2020	12/26/2020

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F 604	Continued From page 6 §483.10(e) Respect and Dignity. The resident has a right to be treated with respect and dignity, including: §483.10(e)(1) The right to be free from any physical or chemical restraints imposed for purposes of discipline or convenience, and not required to treat the resident's medical symptoms, consistent with §483.12(a)(2). §483.12 The resident has the right to be free from abuse, neglect, misappropriation of resident property, and exploitation as defined in this subpart. This includes but is not limited to freedom from corporal punishment, involuntary seclusion and any physical or chemical restraint not required to treat the resident's medical symptoms. §483.12(a) The facility must- §483.12(a)(2) Ensure that the resident is free from physical or chemical restraints imposed for purposes of discipline or convenience and that are not required to treat the resident's medical symptoms. When the use of restraints is indicated, the facility must use the least restrictive alternative for the least amount of time and document ongoing re-evaluation of the need for restraints. This REQUIREMENT is not met as evidenced by: Based on clinical record review, staff and resident interviews and observations the facility failed to properly assess a wheelchair restraint before use for 1 of 1 residents sampled. Resident #15. The facility reported a census of 61 residents.	F 604		

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F 604	Continued From page 7 Findings include: According to the Minimum Data Set (MDS) dated 8/8/29, Resident #15 had diagnoses which included seizure disorder, celiac disease, unspecified intellectual disabilities and Down syndrome. The MDS revealed the resident required extensive assistance of 1 staff for bed mobility, personal hygiene and extensive assistance of 2 staff for transfers and toilet use. The resident utilized a wheelchair for mobility. Review of the care plan dated 9/23/20 directed the staff to allow the resident time to make decision about her cares and provide her opportunities for choices during cares. The resident is dependent upon staff for activities of daily living. The care plan indicated the resident requires 1 staff with toilet use and 1 staff for transfers and dressing. The care plan directed staff to take the resident to the toilet before and after meals as well as before bed and as needed. Review of a Fall Risk Assessment form dated 8/18/20 revealed Resident #15 had a high risk for falls due to inability to independently come to a standing position. Review of a progress note dated 7/26/20 at 12:00 p.m. revealed Staff Q-RN summoned to the residents room, upon entering the room Resident #15 found sitting on the floor in front of her wheelchair having seizure like activity with a wheelchair seat belt across the upper part of her chest, holding her in that position. Staff Q released the seat belt to remove the resident from the situation.	F 604		

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F 604	Continued From page 8 During an interview with Staff Q-RN on 9/28/20 at 10:40 am., she revealed she was the nurse who found the resident hanging from the wheelchair by the wheelchair seat belt. The seat belt noted around the upper chest area, the resident was having a seizure. Staff Q stated the staff did not assess her for the seat belt usage prior to its use and the resident could not independently remove the seat belt. During an interview with Staff R-Corporate Nurse on 9/28/20 at 12:00 p.m. revealed the resident's clinical record does not include a restraint assessment completed for the use a wheelchair seat belt. She stated that wheelchair should never have been given to the resident to use with a seat belt restraint on it upon admission. During an interview with the Director of Nurses on 9/28/20 at 11:55 a.m., the DON stated Resident #15 admitted with the seatbelt on her wheelchair and reported she asked maintenance to remove seat belt. The DON stated she told the staff not to use the wheelchair with the seat belt on it. The DON stated Resident #15 cannot independently remove the seat belt. During an interview with Staff BB-Agency CNA on 9/28/20 at 2:07 p.m. she stated Resident #15 used her wheelchair with the seat belt attached for the first week after her admission. Staff BB stated she assumed it was alright because she came with it and no one told her she could not use it. Staff BB stated she was later told that they cannot use the wheelchair seat belt because it is a restraint. During an interview with Staff U-CNA on 9/29/20 at 10:31 a.m., Staff U stated Resident #15 had	F 604		

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F 604	Continued From page 9 the seat belt on her wheelchair upon admission and the staff used it for several days to a week after the resident admitted. Staff U stated the resident could not independently unfasten the seat belt. Review of a Restraint Prevention Policy dated 4/2013, the policy indicated the facility is preventing restraint usage by completing an effective evaluation, implementation and on going monitoring of interventions to promote freedom of movement, safety and improved functional status.	F 604	F 677 1. Resident #9, 18, 2,4, 5, no longer reside at the facility. Resident #1, 3, 8, 20, and 10 received showers per schedule by the clinical staff during week of 10/26/2020 to 10/31/2020. Resident #17's facial hair was removed by clinical staff on 9/28/2020. Resident #1's nails were cleaned and trimmed by clinical staff on 10/20/2020. Resident #1's call light is positioned under resident's chin per request as of 9/22/2020. Resident # 3 and #10's preferences for rising each day were reviewed, and care plan updated by MDSC on 12/7/2020	
F 677 SS=E	ADL Care Provided for Dependent Residents CFR(s): 483.24(a)(2) §483.24(a)(2) A resident who is unable to carry out activities of daily living receives the necessary services to maintain good nutrition, grooming, and personal and oral hygiene; This REQUIREMENT is not met as evidenced by: Based on observation, staff, and resident interviews and clinical record review the facility failed to provide activities of daily living to maintain grooming and personal hygiene for 11 of 11 residents reviewed. The facility reported a census of 61 residents. Findings include: 1. During facility tour on 9/14/2020 from 9:05 A.M. - 9:40 A.M. observation included Resident #9 had heavy dark facial hair present and Resident #18 had long and dirty fingernails. 2. According to the MDS dated 7/16/2020, Resident #1 had no cognitive impairment and required total assistance of two staff for bed	F 677	Resident 15 incontinent care needs are provided by clinical staff and verified by DON/Designee on or before 9/15/20. 2. An audit was completed to ensure residents are receiving showers per shower scheduled with Charge Nurses verifying documentation completed. An audit was completed related to resident grooming to include facial hair, fingernails and toenails care to identify any resident in need of shaving or nail care, with care provided at the time of the audit as needed. An audit was completed of residents' call light placement to ensure call lights are withing resident's reach, adjustments made at the time of the audit as needed. An audit was completed, to ensure resident assistance with rising and timely incontinence care is being completed. These audits were completed by the DON/ Designee on or before 12/24/20. 3. DON/Designee will educate Licensed Nurses and CNA's 9/23/20 and 10/20/20 regarding the requirements of assisting resident with grooming including showers, shaving unwanted facial hair and nail care; call light placement within resident's reach, assistance with rising out of bed and timely incontinent care.	

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F 677	Continued From page 10 mobility, personal hygiene, eating, and dressing. The resident had diagnosis of quadriplegia. The Care Plan directed staff to provide transfer assistance with a Hoyer mechanical lift, extensive assistance of one staff with eating meals, and encourage resident to follow restorative program. The resident had a risk for skin breakdown related to decreased mobility and directed staff to provide daily skin checks and incontinence cares. On 9/16/2020 observation at 9:30 A.M. revealed Resident Resident #1 had long toenails with jagged edges. Resident #1's documentation of August and September bathing revealed the resident received two baths during the month of August and one bath from September 1 - 17th. During an interview on 9/16/2020 at 1:20 A.M., Resident #1 expressed a concern regarding baths, and said staff usually, but not always, offered two baths per week. Observation on 9/22/2020 at 3:50 P.M. revealed the resident lay on their back with the soft touch call light hanging on the head of the bed, out of the resident's reach. The resident stated staff failed to place the call light underneath their chin. The surveyor notified the Administrator. 3. According to the MDS dated 6/11/2020, Resident #2 required extensive assistance of two staff to transfer from one surface to another, extensive assistance of one staff for personal hygiene, did not ambulate (walk), and did not have a bath during the seven day look back period. The resident had diagnoses including	F 677	4. DON/ADON/Designee will complete audits 4 times a week for 4 weeks and 2 days a week for 8 weeks to ensure assistance with ADLs/ grooming and documentations continues to be completed as required including showers, shaving unwanted facial hair and nail care; call light placement within resident's reach, assistance with rising out of bed and timely incontinent care. Results of these audits will be taken to the facility QAPI meeting for review and recommendation as needed. The Director of Nursing is responsible for monitoring and follow-up. Compliance date: 12/26/2020	12/26/2020

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F 677	Continued From page 11	F 677		

dementia and depression.
The Care Plan revealed the resident had a risk for falls and directed staff to encourage frequent exercise, restorative nursing, low bed with fall mat, scoop mattress on bed, attempt to toilet before and after meals and provide incontinence cares. Staff could use an EZ stand lift for transfers, wheel chair for mobility, Dycem in recliner to prevent resident from sliding out and total assist with intake.

On 9/15/2020 at 12:10 P.M., observation revealed Resident #2 had heavy growth of facial hair. A sign on the wall above the bed reminded staff to shave the resident daily. Staff F, CNA (Certified Nurse's Aide) indicated the resident's spouse used to spend each day with the resident before Covid. The resident had an electric razor but they were unsure of it's location because the resident had a room change.

The resident's bath record revealed they received two baths during the month of August and one from September 1 - 17, 2020.

4. According to the MDS dated 8/20/2020 and 5/21/2020, Resident #3 had no cognitive impairment, transferred with extensive assistance, and had range of motion limits of upper extremities and lower extremities. The MDS had no documentation of range of motion. The resident had diagnoses including hemiplegia depression, dysphagia, paraplegia, and epilepsy.

CNA documentation in Point Click Care (PCC) revealed Resident #3 had a bath on 8/31/2020 and was totally dependent on staff. The September documentation revealed the resident had no baths documented.

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F 677	Continued From page 12 A sign on the resident's door instructed staff to get the resident up for breakfast. During an interview on 9/17/2020 at 10.45, Resident #3 reported staff did not always offer a bath two times a week. The resident acknowledged there were times they did refuse, however, there were when they were not given the option. The resident also reported staff failed to get assist them up for breakfast in a timely manner. Staff deliver the breakfast tray, leave the room, and fail to assist him/her out of bed. The resident reported eating cold breakfast food by the time staff assist them. 5. According to the MDS dated 3/9/2020, Resident #4 had diagnoses including anxiety and post traumatic stress disorder. The MDS revealed the resident did not have a bath during the seven day look back period. The CNA task charting revealed the resident did not receive a bath in the month of September. 6. According to the MDS dated 8/10/2020, Resident #5 had diagnoses including dementia, heart disease and diabetes no cognitive impairment. The MDS revealed the resident did not have a bath during the seven day look back period. The 30 day look back documentation revealed the resident received no bath on 8/26/2020 and no baths in the 30 days prior. During an interview on 9/15/20 Resident #5 reported staff occasionally fail to offer two baths a week.	F 677		

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F 677	Continued From page 13 7. According to the MDS dated 7/22/2020, Resident #8 had no cognitive impairment and had diagnoses including coronary artery disease and heart failure. The MDS documented the resident did not have a bath during the seven day look back period. The CNA task documentation revealed Resident #8 had one bath in September and no baths documented in August. 8. According to the MDS dated 8/15/2020, Resident #20 had no cognitive impairment and required extensive assistance of staff for hygiene. The MDS documented diagnoses that included diabetes, arthritis and anxiety. The resident's bath records revealed they received four baths from 8/27 - 9/21/2020. During an interview on 9/21/2020 at 10:50 A.M., the resident reported staff were staff busy and failed to provide baths as scheduled routinely. The resident expressed a willingness to give up their bath if staff is too busy. During an interview on 9/28/2020 at 10:35 A.M., Staff Q, RN and Staff Z, RN reported they developed a new shower schedule with skin assessment sheets to be completed by CNA's and turned into them. They are to notify nurses if residents refuse. Staff Q and Staff Z will be auditing charts for skin assessments. 9. According to the Minimum Data Set (MDS) dated 7/16/20, Resident #17 had diagnoses which included heart failure, diabetes, rheumatoid arthritis, osteoporosis and low back pain. The resident demonstrated moderate cognitive ability. The resident required limited assistance of 1 staff	F 677		

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for bed mobility and transfers, the resident did not walk but utilized a wheelchair for mobility, required extensive assistance of 1 staff for toilet use and personal hygiene.

According to the care plan updated on 9/8/20, the resident had a potential risk for self care deficit related to contractures to hands. The care plan directed the staff to provide supervision with cares and to encourage the resident to participate to the fullest extent possible with each interaction. The care plan directs the staff to keep items needed within reach and to anticipate the resident's needs. The care plan stated the resident is able to call for assistance if needed.

Observation on 9/14/20 at 9:22 a.m. Resident #17 in bed, noted to have facial hair on her chin about 1/4 inches long.

Observation on 9/20/20 at 9:25 a.m. revealed the resident sat in her recliner with facial hair on her chin about 1/4 inches long. The resident stated the staff has not shaved her in awhile but will do it with her baths sometimes.

Observation on 9/28/20 at 10:10 a.m. revealed the resident sat in her recliner with 1/4 inch facial hair on her chin.

Observation on 9/29/20 at 9:00 a.m. revealed resident was free of facial hair. She stated she had a shower and they shaved her face. Resident #17 reported she is happy with this and feels feels better now.

10. According to the Minimum Data Set (MDS) dated 8/8/20, Resident #15 had diagnoses which included seizure disorder, celiac disease,

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unspecified intellectual disabilities, and Down syndrome. The MDS revealed the resident required extensive assistance of 1 staff for bed mobility and personal hygiene and extensive assistance of 2 staff for transfers and toilet use.

Review of the care plan dated 9/23/20 directed the staff to allow the resident time to make decision about her cares and provide her opportunities for choices during cares. The resident is dependent upon staff for activities of daily living and requires 1 staff with toileting and 1 staff for transfers and dressing. The care plan directed staff to toilet the resident before and after meals as well as before bed and as needed.

Observation on 9/15/20 at 1:45 p.m., revealed the resident sat in her wheelchair in her room. Two staff entered the room to provide cares. Resident stood up from wheelchair with assist of 2 staff; her slacks were wet. The staff transferred the resident to her bed and removed her slacks and brief. The brief was completely soaked with urine and liquid feces. Staff provided incontinence cares and dressed the resident in fresh, clean clothes.

During an interview with Staff J-CNA at 2:00 p.m. revealed the last time Staff J performed personal cares on the resident was shortly after the resident ate breakfast this morning. Staff J admitted she had not changed the resident since just after breakfast. She added they had been very busy today and she didn't get around to it.

11. According to the MDS dated 8/14/20 Resident #10 had diagnoses which included heart failure, chronic obstructive pulmonary disease and diabetes. The resident had a BIMS score of

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15 which indicated he had intact cognitive ability. The resident required supervision for bed mobility of 1 staff, did not transfer, dressed only twice in one week with assistance of 1 staff, had total dependence on 1 staff for toilet use. The resident had occasional bladder incontinence and was always continent with bowels.

According to the Care Plan dated 12/18/2019 the resident required assistance with self care related to weakness and respiratory issues and needed a mechanical lift for transfers. The plan directed staff to provide cares with 2 staff, encourage the resident's participation, encourage the use of call light for assistance, complete routine weekly skin assessments, and check the length and trim nails with baths.

Observation on 9/22/20 at 9:30 a.m. revealed Resident #10 in bed. The resident stated he needed assistance to use the bathroom. The resident stated he is still waiting for staff to help him to get cleaned up and dressed for the day. He remarked they don't have enough staff to take care of the people in the facility and he has been waiting to get up since 6:30 a.m. The resident reported he only gets a bed bath once weekly.

Review of the CNA documentation of bathing for the month of September 2020 revealed no baths documented for the month of September 2020.

During an interview with the D.O.N. on 9/22/20 at 9:50 a.m., the D.O.N. was informed the resident had been waiting for cares and assistance to get up this morning The D.O.N. stated both of the aides are currently on morning break but she will go get them to provide cares for the resident.

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F 677	Continued From page 17 During an interview with Staff Z-CNA on 9/22/20 at 10:00 a.m. stated she had not yet completed any cares for Resident #10 this am.	F 677	F 684 1. Resident #9 was assessed by the licensed nurse; physician was notified, and resident was discharged to the hospital on 9/17/20.	
F 684 SS=K	Quality of Care CFR(s): 483.25 § 483.25 Quality of care Quality of care is a fundamental principle that applies to all treatment and care provided to facility residents. Based on the comprehensive assessment of a resident, the facility must ensure that residents receive treatment and care in accordance with professional standards of practice, the comprehensive person-centered care plan, and the residents' choices. This REQUIREMENT is not met as evidenced by: Based on clinical record review, staff and resident interviews and observations, the facility failed to notify the resident's physician of a change in condition, failed to complete timely and appropriate skin assessments, failed to assess a resident with complaints of hip pain post fall for 6 of 6 sampled residents (Residents #7, #9, #11, #16, #19, & #21). These findings constituted an Immediate Jeopardy to resident health and safety. The facility reported a census of 61 residents. Findings include: 1. According to the Minimum Data Set (MDS) dated 8/21/2020 Resident #9 had diagnoses which included heart failure, neurogenic bladder, depression, bipolar disease, psychotic disorder, schizophrenia, chronic lung disease, and pain/stiffness in left shoulder. The MDS indicated the resident had a Brief Interview for Mental	F 684	2. DON/ADON/Designee will audit documentation of head to toe skin assessments on all residents on or before 12/14/2020 to ensure skin break down has been identified, provider was notified, and treatment orders are in place. DON/ADON/Designee will audit documentation of wound assessments on all residents with wounds on or before 12/14/20 to ensure wounds have been assessed, documentation completed, and physician notified of any new or worsening wounds. DON/ADON/Designee will review 24-hour report and progress notes for the past 7 days (10/6/20-12/21/20) to ensure providers are notified of any changes in the resident's condition. 3. DON/ADON/Designee will educate licensed nurses on 9/23/2020 and10/20/2020 related to the requirements of completing weekly head to toe skin assessments, weekly wound assessments and notification of the provider when there is a change in the residents condition, including documentation requirements. Any licensed nurses that has not completed this training will be educated prior to the beginning of their next shift. The DON/ADON/Designee reviewed residents shower schedule on 9/22/20 and 11/24/2020, to ensure weekly skin assessment schedule to be completed on shower days. A shower sheet was implemented on 9/24/20 and validate again on 12/21/2020 for CNAs to complete as a communication tool to the nurses related to skin observations during care.	

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F 684	Continued From page 18 Status (BIMS) score of 15 which indicated the resident showed intact cognitive ability and did not exhibit behaviors. The MDS identified Resident #9 required total assistance of 2 or more staff for bed mobility, toilet use, and personal hygiene. The MDS revealed the resident did not transfer, walk, or dress, experienced bowel incontinence, and utilized an indwelling catheter for urinary elimination. The MDS documented the resident weighed 571 pounds at the time of the assessment. The assessment revealed the resident had a risk for pressure sores, but did not identify any problems with impaired skin. Review of the care plan revised on 9/8/20 failed to identify Resident #9 had potential for or actual skin impairments and failed to identify the resident exhibited behaviors such as refusing cares, failed to identify the resident had pain related to her left shoulder from an unknown injury, and failed to indicate the resident utilized oxygen. The care plan failed to provide direction to staff on assisting the resident with Activities of Daily Living and did not identify resident needed 4-6 staff for bed mobility or transfers. Review of a re-entry Braden Skin assessment completed on 8/21/20 documented the resident as unresponsive to painful stimuli with constantly moist skin. The form revealed the resident was bedfast, had very limited mobility, and had a problem with friction/shearing because they required moderate to maximum assistance with moving. The assessment identified the resident as at a very high risk for skin impairments. Review of a Weekly Skin Assessment dated 8/23/20 revealed staff had documented the	F 684	Nurse to review shower sheet, sign/date. Shower sheets will be collected by DON for review. DON/ADON/Designee will educate CNAs on or before 9/24/20 and again on 10/20/2020 related to the new shower sheets and the requirements of documentation of bathing completed and of notifying resident's nurse when they observe a change in the resident skin or condition. Any CNA that has not completed this training will be educated prior to the beginning of their shift. 4. DON/ADON/Designee will observe documentation of 10 weekly skin assessments per week for 12 weeks to ensure licensed nurses continue to complete skin assessments and provider notification, including CNAs shower sheet documentation as required. DON/ADON/Designee will review 24-hour report and progress notes 5 days per week for 12 weeks to ensure nurses continue to assess and notify physician of any change in resident's condition. Results of these audits will be taken to the facility QAPI meeting monthly for 3 months for review and recommendation as needed. The Director of Nursing is responsible for monitoring and follow-up. Compliance date: 12/11/2020	12/11/2020

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resident had intact skin with edema (swelling) noted to her left forearm related to a dislocation.

Review of a Physician Order Summary Report for the period of 6/1/2020 thru 9/30/2020 revealed the resident had the following treatment orders:

a. X-ray to upper left arm to rule out acute/past injury, ordered on 7/10/20.
b. Ice pack/heat pack every 20 minutes as needed for swelling/pain 4 times daily to upper left arm, ordered on 7/1 and stopped 7/10/2020.
c. Nystatin powder to affected areas topically to excoriation twice daily, ordered on 8/20/20.

Review of a local hospital emergency department record dated 8/19/20 revealed Resident #9 transferred to a local emergency room with complaint of shortness of breath, left arm swelling and pain, and left shoulder pain. The resident arrived via ambulance. The patient described her pain as sharp in the left arm and constant for the past 2 months. The physical exam in the emergency room revealed the resident exhibited decreased range of motion of the left shoulder and hand. The physician noted the resident's left arm is visibly distended and dusky looking. Her capillary refill is diminished and she reported tenderness with light palpations. X-rays completed on 8/19 revealed no fracture but did show edema. The resident had diagnosis of cellulitis of the left hand and probable left shoulder dislocation.

Review of the Progress Notes dated 8/19/20 at 5:16 p.m. Staff S, RN contacted the resident's Primary Care Provider (PCP) to report a low blood pressure of 87/37 and low oxygen saturation level of 85% on 2 liters of oxygen. The

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staff received orders to send the resident to a local hospital and increase the oxygen to 5 liters.

Review of a local hospital history and physical records dated 8/20/20 revealed the resident transferred to the emergency room on 8/20/20 for shortness of breath, left arm swelling and pain and pain to the left shoulder. The resident indicated the pain worsened when working with the therapist and she subsequently experienced shortness of breath. Upon further discussion with the patient, the patient states that her left arm might have been pulled in the nursing home during position change about 2 months ago. The physician noted the resident had diminished breath sounds due to body habitus, non-pitting edema in bilateral lower extremities, left hand swelling and skin changes noted on the left hand secondary to dependent edema. The resident is alert and oriented x 3. The resident admitted to the hospital for a 23 hour observation period.

Review of an Order Requisition (discharge orders) from a local hospital dated 8/20/20 Resident #9 had a new diagnosis of left shoulder dislocation. The resident discharged from the hospital with new orders for nystatin powder topically twice daily as needed and a referral for physical and occupational therapy to evaluate and treat. The resident requested full code status.

Review of a Progress Note dated 8/20/20 at 5:59 p.m., revealed Resident #9 returned to the facility via cot and transferred to her bed with the assistance of 6 staff. The staff positioned the resident with pillows under her left arm for comfort.

Review of a telehealth visit progress note dated

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9/2/20, revealed Resident #9 appeared groggy with a blank stare on her face.

Review of a progress note dated 9/3/20 at 5:06 a.m. showed Staff T, LPN noted an increase in the resident's left hand edema, the aide reported the hand was in a dependent position, the aide propped up the resident's hand for comfort and Staff T indicated they will monitor the swelling. A note dated 9/3/20 at 5:58 a.m. documented the resident noted with more edema to the left hand and complaints of pain. The staff attempted to prop up her left hand but resident reported the arm kept falling down. Staff T stated they will monitor the edema. The staff failed to contact the PCP regarding the increase in edema and pain.

A progress note dated 9/7/20 at 9:31 p.m. revealed the resident complaining of right arm pain, they repositioned the right arm and will continue to monitor.

A progress note dated 9/11/20 revealed the staff evaluated the resident's skin and found blisters on the resident's back. The facility failed to notify the PCP of the areas.

Observation on 9/16/20 at 11:20 a.m. revealed 4 staff washed and put on gloves to prepare to provide cares for Resident #9. The resident lay on her back with oxygen on. The resident reported pain to the left arm and yelled out in pain with attempts to reposition. Staff U-C.N.A. cleansed the catheter, and the resident had redness to the left side of the abdomen with edema noted to the area. The resident moaned loudly in pain, made gurgling sounds with respirations, and had a large amount of edema to her left forearm and hand. Staff G-CNA/AD stood

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F 684	Continued From page 22 at the resident's left shoulder area. Staff G pulled a soiled bath towel out from under the resident. Observation revealed the towel contained a large amount of brownish brownish colored fluid and when asked where the towel came from, Staff G replied from under the resident's left arm pit. The staff rolled the resident onto her right side as she continued to moan loudly with pain. Observation showed the resident's bottom was a dark red color with BM present and contained an open area to the left buttock. Staff V-RN was present in the room to assist and when asked about the bath towel with drainage and the open areas, Staff V stated she had no idea where the drainage came from and did not know of any open areas. Observation on 9/16/20 at 1:15 p.m. revealed Staff V and the Director of Nurses (DON) in Resident #9's room completing a skin assessment. They reported they will contact the PCP when they complete the assessment. Review of a progress note dated 9/16/20 at 2:08 p.m. revealed the resident as very groggy, refusing all meals, lung sounds diminished, and mouth breathing with gurgling noises. The resident spoke incoherently and speech inaudible with shortness of breath with repositioning. The resident noted today with 2 open areas and excoriation to folds to abdomen, back, sides, and arms. Staff notified the PCP notified and gave orders for x-rays and medication to excoriated areas and treatment dressing orders for open areas noted during the assessment. A note on 9/16 at 2:45 p.m. revealed the social worker contacted the family to have the resident's code status changed to do not resuscitate after receiving an order from the PCP.	F 684		

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Review of the resident's skin sheets revealed the staff failed to complete a weekly skin assessment due every Wednesday for the following months:

a. The July 2020 Weekly Skin Assessment forms revealed the staff completed 1 skin assessment on 7/8/20.
b. The August 2020 Weekly Skin Assessment form revealed the staff completed 3 skin assessments during the month on 8/5, 8/12 and 8/23.
c. The September 2020 Weekly Skin Assessment form revealed the staff completed 2 assessments during the month, on 9/2 and 9/11/20.

Review of an Activities of Daily Living sign in sheet obtained 9/15/20 revealed staff provided Resident #9's last documented on 8/11/20. Another sheet that accompanied the sign off sheet directed the staff to provide cares for the resident every shift. The sheet directed the facility now had suitable lift for the resident and "we" needed to start getting her up each day; perineal cares are not optional. There is a sign in sheet in her room for all to time, date and sign when they completed cares and D.O.N. to follow up.

Observation on 9/17/20 at 10:30 a.m. revealed 6 staff in the resident's room preparing to provide care. The resident had a sling under her as staff prepared to weigh her with the Hoyer lift. The staff lifted the resident slightly off the bed, and the resident moaned loudly in pain. Observation revealed the edema to the resident's left hand markedly increased from the observation on 9/16/20 and the resident non-responsive to staff. The resident made gurgling noises with respirations.

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During an interview with the PCP on 9/17/20 at 11:00 a.m., the PCP stated the resident had a dislocated left shoulder and edema to her left hand, and neither the facility nor the resident had any idea how the injury occurred. The PCP reviewed her notes and stated the last time she saw the resident was on 9/2/20 via a telehealth visit and had not had any other communication with the facility until yesterday afternoon. At that time, staff reported blisters to the resident's back and also excoriated skin folds. The PCP stated the facility did not contact her with condition changes in her residents and when she gave an order they did not follow the orders given. The PCP stated the facility did not have enough staff to get Resident #9 out of bed for showers or to sit in her chair. The PCP stated she did not know the resident was non responsive with gurgling respirations or that she had an increase in left hand edema. The PCP said she would contact the facility immediately and give an order for the facility to send the resident to a local emergency room for evaluation.

Review of a progress note dated 9/17/20 at 12:30 revealed the PCP called the facility and ordered staff to transfer the resident to a local emergency room due to critical labs and changes in medical status.

Review of a local hospital emergency room report dated 9/17/20 revealed Resident #9 arrived to the emergency room at 12:57 p.m. and expired in the emergency room 4:10 p.m.. The emergency room physician noted the cause of death respiratory arrest. The notes indicated the facility transferred the resident to the emergency room as she had been less responsive since about 1:00 pm on

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9/16/20. The notes indicated the PCP reports the facility last called them on 9/1/20 that she was groggy after narcotic pain medications. The staff document upon arrival to the ED, the resident arrived in poor condition and unable to follow any commands, moaning loudly, with shallow respirations.
Review of the physician exam revealed the resident's perineal areas is unclean, very malodorous and discharge noted throughout the area. The indwelling catheter present but without urine in the tubing. The resident is noted to have dried vomit throughout her back scalp and hair.

During an interview with the Director of Nurse on 9/17/20 at 8:30 a.m. the DON stated the resident required assistance of multiple staff to complete her cares. She stated the nurses were responsible for the weekly skin checks, but obviously they were not getting the checks completed on a weekly basis.

During an interview with Staff V-RN on 9/21/20 at 10:30 a.m., Staff V stated she did complete a skin assessment for the resident on 9/16 after everyone left the room. She stated she did not know the resident had open areas until then, she reported she noted 2 open areas on each of her breasts and all skin folds were reddened and excoriated. She placed a call to the PCP to receive orders for the excoriation. Staff V stated each nurse working on the unit is responsible for the skin assessments if it comes up on the treatment record, the days vary for each resident as the facility did not have a designated skin nurse. Staff V stated any nurse that measured wounds only completed the computer skin assessment form and did communicate the findings with other nurses. Staff V reported it took

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F 684	Continued From page 26 a minimum of 4 staff to roll Resident #9 for cares. During an interview with the Administrator on 9/21/20 at 12:45 pm., the Administrator verified staff had voiced concerns to her regarding the amount of assistance Resident #9 required to complete cares, that they need to find help when doing he cares. The Administrator reported being made aware of the skin issues noted on 9/16 and stated it concerned her greatly and added she would look into the situation. She stated the resident should have been getting a bed bath daily. During an interview with Staff R/RN/Corporate Nurse on 9/21/20 at 12:17 p.m., she stated she could not find physician notification for the increase in swelling noted on 9/3, the pain in right arm on 9/7, skin blisters noted to the resident's back on 9/11, the low oxygen saturation level of 87% on 9/12, or the low oxygen saturation level of 84% on 9/13/20. Staff R stated they had no a physician notification policy but they had a policy regarding clinical change of conditions. During an interview on 9/17/20 at 12:30 p.m., Staff G-CNA/AD stated Resident #9 had a recent decline, although she had complained of pain to her left arm for a long time. Staff G identified that she was the person that had pulled the soiled bath towel out from under the resident during cares on 9/16. She stated the drainage could have possibly been from the open area under her left breast and her yeasty folds. Staff G stated it required about 6 staff to provide cares for the resident. During an interview with Staff U-CNA on 9/16/20 at 2:00 p.m., Staff U stated they do not have the	F 684		

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staff or the man power to provide care for Resident #9. She stated she had not seen the resident's skin condition for a time but reported it is much worse than before. She added the staff used to apply Nystatin powder to the folds and give her a daily bed bath, but stopped in June due to the lack of staff. Staff U stated she and others had asked for help with this resident but nothing was ever done to help. Staff U stated they could not get the Hoyer lift into the resident's room due to the extreme clutter.

During an interview with Staff E-LPN on 9/16/20 at 11:22 a.m., Staff E stated it takes 6-7 people to provide care for Resident #9 and to turn her. She stated the Agency Nurses/CNAs do not provide the resident her cares as they should. She stated they have repeatedly asked the Administration and DON for assistance with this issue, but nothing was done. Staff E had been in the room for observation of cares on 9/16 and verified the resident had open areas, multiple reddened areas, and her left arm had a marked increase in edema. Staff E also verified the resident was non responsive and that was a change of condition.

Review of the change of Clinical Change in Condition Management Policy dated 6/2015 directed staff to observe each resident's condition daily and communicate the changes that require further investigation which included:

a. participation in daily routines
b. physical assessment (i.e. cardiovascular, respiratory, mental status and neurological)
c. behavior
d. mobility
e. comfort level
f. response to medications.

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F 684	Continued From page 28 If abnormalities/changes noted, staff should contact the PCP and provide clinical data and information regarding the resident's condition and then document notification and physician response in the medical record. The policy directed staff are to initiate any new physician orders. The facility was notified of the IJ on 9/23/20. On 9/24/20, the facility abated the Immediate Jeopardy and the Scope and Severity was lowered to an E level. The facility provided education to the nursing staff on Clinical Change in Condition Management Policy dated June 2015. The policy instructed the Nursing Staff on notification and documentation requirements for all changes of residents condition to the PCP, family and facility staff. The facility formulated a new Shower Skin Check List and provided education to the Certified Nurse's Aides on the proper use of the form and expectations on reporting skin abnormalities. The ADON and MDS Coordinator performed skin checks on every resident in the facility and completed a Weekly Skin Assessment Form. 2. According to the MDS dated 8/21/20 Resident #11 had diagnoses which included heart failure, bowel disease, pneumonia, Alzheimer's disease, seizure disorder, and Downs Syndrome. The MDS documented the resident had severely impaired cognitive ability and memory issues, and was totally dependent on 2 or more staff for transfers, dressing, toilet use, and eating. The resident had skin issues which included one Stage 1 pressure sore and two Stage 2 pressure ulcers.	F 684		

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The facility failed to formulate a care plan to direct resident care with regard to wound care and Activities of Daily Living.

Review of a Braden Score dated 8/31/20 revealed the resident had a high risk of pressure ulcer development.

Review of a Weekly Skin Record dated 8/17/20 revealed the resident had wounds to his scrotum, left buttock, and right buttocks.

Review of a Weekly Skin Record dated 8/20/20 revealed the resident had bruising to arms, an groin excoriated area, and also excoriation noted to left gluteal and right gluteal areas.

Review of a Weekly Skin Record dated 9/8/20 revealed the resident had a ruptured blister to the upper back, left ear, and posterior of the neck.

Review of a Weekly Skin Record dated 9/18/20 revealed the resident had open wounds to the right buttock, left ear, right knee, upper back, neck, scrotum, and inner left thigh.

Review of the Treatment Record for September 2020 directed the staff to apply the following skin treatments:

a. Mupirocin Ointment 2% topically three times daily to wounds, which started on 8/17 and was discontinued on
9/14/20. The Treatment record showed staff failed to apply ointment 19 times out of 39 opportunities.
b. Bacitracin Zinc Ointment 500 unit/gram to the left ear and upper back blisters twice daily for 7

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F 684	Continued From page 30 days beginning on 9/9/20. The facility failed to apply the ointment on 3 occasions out of 14 opportunities. c. The physician ordered stoma adhesive powder followed by z-guard and then adhesive stoma powder again to the coccyx, perineal area, and scrotum on 9/15/20. Staff failed to apply the treatment twice out of 10 opportunities. 3. According to the MDS dated 8/13/20, Resident #7 had diagnoses which included heart disease, heart failure, renal insufficiency, diabetes, and blindness in 1 eye. The MDS revealed the resident had a Brief Interview for Mental Status (BIMS) score of 15 which indicated the resident demonstrated intact cognitive abilities. The MDS documented the resident required limited assistance of 1 staff for transfers and extensive assistance of 1 staff for dressing, toilet use and personal hygiene. The MDS also documented Resident #7 had a risk for developing pressure sores and had diabetic foot ulcers. The care plan dated 2/17/17 documented Resident #7 as at risk for skin impairments, tears, and/or bruises. The care plan directed the staff to monitor skin with cares and inform the nurse of any concerns, to complete treatments as ordered, and to complete weekly skin and wound assessments by the licensed nurse and daily skin checks by the certified nursing staff for early identification of concerns. Review of a Weekly Pressure Injury Weekly Assessment forms revealed the following data: a. An assessment form dated 6/9/20 revealed the	F 684		

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resident had a pressure sore on the left outer ankle which
measured 0.5 centimeters by 1.0 centimeters (cm). The form documented the area was red with exudate noted,
and identified the area as facility acquired, but did not identify when the area first appeared.
b. The assessment form dated 7/8/20 revealed the left ankle pressure ulcer measured 0.5 cm by 0.5 cm, did
not contain exudate, and the wound appeared black.
c. An assessment form dated 7/24/20 revealed the pressure sore to the left outer ankle measured 1.6 cm x 0.4 cm
and contained a scant amount of drainage. The form revealed staff last notified the physician on 6/24/20.
d. An assessment form dated 8/12/20 revealed the resident had a skin tear on the left outer ankle which measured
0.8 cm x 0.4 cm with a scant amount of drainage. Staff had last notified the physician on 6/24/20.
e. An assessment form dated 8/26/20 revealed the resident had a left ankle pressure ulcer which measured 2.2 cm x
2.5 cm, had wound drainage, and was identified as a Stage 2 pressure sore.
f. An assessment form dated 9/10/20 revealed the resident had a left ankle pressure area which measured 1.5 cm x
2.2 cm and had drainage.

Review of a Physician's Order sheet dated 6/1-9/30/2020 directed the staff to complete a skin assessment every Wednesday and document on the Weekly Skin form. Review of the Pressure Injury Weekly Reports revealed the

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F 684	Continued From page 32 staff failed to assess the resident's pressure sore from 6/9 through 9/23/20/20 (10 weeks). Observation on 9/16/20 at 9:35 p.m. revealed Staff O-RN providing Resident #7's wound treatment. Staff O cleansed the pressure area with wound cleaner and replaced the tubi grip socks to the left lower leg. The resident is had a black colored area to the left ankle. Review of the August and September 2020 Treatment Record failed to include a treatment for Resident #7's left ankle. 4. According to the MDS dated 6/18/20, Resident #16 had diagnoses which included diabetes, peripheral vascular disease and bipolar disorder. The resident had a BIMS score of 15 which meant the resident demonstrated intact cognitive abilities. The resident required limited assistance of 1 staff for transfers and ambulation and extensive assistance of 1 staff for dressing, toilet use, and personal hygiene. The resident utilized a walker and wheelchair for mobility, was at risk for pressure sores, and had one Stage 2 pressure ulcer and one venous ulcer. Review of the care plan updated on 5/27/20 revealed the resident had impaired skin related to post amputation of toes to right foot, edema, and fragile skin. The care plan directed staff to monitor/document location, size and treatment of skin injury (initiated 3/3/2017). The care plan directed the staff to complete weekly skin assessment by a licensed nurse (initiated 7/8/2017). Review of a Braden Scale form last completed on 2/19/19 revealed the resident remained at low risk for pressure ulcers with a score of 17.	F 684		

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Review of the Pressure Injury Weekly Assessment forms from 5/17 through 9/21/20 revealed the staff failed to complete weekly skin assessments for the pressure ulcer on Resident #16's right foot for 8 weeks throughout that time frame.

Review of the August and September 2020 Treatment Administration Record directed the staff to apply 1/4 strength Dakins solution to the left foot wound topically twice daily, beginning 5/23/20.

Observation on 9/16/20 at 9:55 a.m. revealed Staff E-LPN removed the tubigrip from the resident's left lower leg, the dressing and packing from the left great toe area, and cleansed the wound with wound cleaner. Staff E re-applied a Dakins' dressing to the area and covered it with a 4 x 4 bandage.

A facility Skin Care and Wound Management Policy dated 6/2015 documented the staff strives to prevent resident skin impairments and to promote the healing of existing wounds. They are to complete the Braden Scale assessments on admission and then every 4 weeks, complete weekly skin assessments, communicate risk factors and interventions, and evaluate consistent implementation of interventions and evaluate effectiveness.

5. Review of the clinical record revealed Resident #19 admitted to the facility on 7/1/2020.

According to the MDS dated 7/6/2020, Resident #19 had diagnoses that included heart failure,

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diabetes, thyroid disorder, and non-pressure chronic ulcer of lower leg, unspecified. The MDS documented the resident displayed intact cognitive abilities. The MDS also documented Resident #19 transferred with assistance of one staff, did not walk, and experienced incontinence of both bowel and bladder. The MDS revealed the resident had skin tear(s), moisture associated skin damage, and remained at risk for developing pressure ulcers. The MDS documented the resident did not have a pressure ulcer during the look back period, utilized a pressure reducing device for bed and chair, and received application of ointment/medications and nonsurgical dressings.

The Care Plan documented the resident had impaired skin integrity due to admission to facility with an area on the right knee, initiated 9/14/2020. The Care Plan directed staff to administer treatments as ordered, measure area weekly and fill out appropriate skin sheet, and notify provider if area worsens. Monitor for signs of infection, refer to qualified professional as needed and provide pressure relief mattress on bed and cushion in wheel chair.

The Physician's Orders included:

a. 8/25/2020 - Dress open right knee wound with silver alginate, cover with gauze, and secure with netting daily
b. 8/25/2020 - Venous cream (1/2 lotrisone, 1/2 Silvadene) one time daily for area around right knee wound.
c. 9/24/2020 - Mepilex Border dressing daily.

The September 2020 TAR (Treatment Administration Record) instructed staff to

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administer skin treatments as ordered, provide a skin assessment every Tuesday, and document weekly on the skin assessment form, dated 9/27/2020.

The August 2020 TAR instructed staff to administer skin treatments to the right knees as ordered; silver alginate and venous cream.

The July 2020 TAR instructed staff to administer Bactroban ointment to the right proximal upper leg wound, cover with gauze, and secure with band netting or paper tape.

Weekly Skin Assessments included:

a. 7/4/2020 - skin intact
b. 7/22/2020 - skin intact
c. 8/31/2020 - skin intact
d. 9/17/2020 - skin intact

Non Pressure Weekly Skin Record:

a. 8/20/2020 - Right knee surgical wound: 1.2 cm x 1.0 cm with serosanguineous exudate and surrounding skin excoriated. Improving.
b. 8/25/2020 - Open area right knee: First observed 8/25/2020. 1.5 cm x 1.5 cm x 0.1 cm depth with scant serosanguineous exudate and granulation. Stable progress.

Resident #19's admission assessment on 7/1/2020 included a right knee open area that measured 2.1 cm x 2.8 cm x 0.1 cm.

Wound Clinic 9/24/2020 - Impact virtual wound nurse visit:

1. Wound Assessment - right knee chronic

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F 684	Continued From page 36 Infection 4.2 X 4.0 X 0.1 cm (centimeters) 2. Wound Bed - pink, small slough 3. Exudate - scant serosanguineous. No odor, peri wound is intact. 4. Assessment and Plan - Open wound right knee with complication. Dry wound base, discontinue alginate. Mepilex border dressing, change twice weekly on bath days. Not expected to heal due to MRSA chronic, post total knee replacement. 5. Goal - maintain wounds and prevent systemic infection. Impact visits dated 9/9, 8/31, 8/25, 7/22, 7/14 and 7/8/2020 contained no wound measurements. Observation on 9/23/2020 at 11:00 a.m. revealed Staff O, RN provided wound treatment to the right knee. Staff O measured the right knee wound at 4 cm X 4 cm. and administered alginate and venous cream to the surrounding area. During an interview on 9/28/2020 at 10:30 a.m., Staff Z, RN reported they knew about the resident's skin issues and added the resident had skin issues upon admission in July. Staff is to provide weekly skin assessments and notify the physician if the condition worsens. Staff Z stated the nurse assigned to the resident on the day the TAR instructed staff to provide the assessment responsible for making sure it gets completed. During an interview on 9/28/2020 at 10:35 A.M., Staff Q, RN and Staff Z, RN reported they developed a new shower schedule with skin assessment sheets to be completed by CNA's and turned into them. They are to notify nurses if residents refuse. Staff Q and Staff Z will be	F 684		

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auditing charts for skin assessments. Staff Z and Staff Q, RN reported they were aware of the lack of appropriate skin assessments and knew they needed to fix it.

6. According to the clinical record, Resident #21 admitted to the facility March, 2020.

The MDS dated 9/10/2020 documented the resident did not display cognitive impairment, transferred with extensive assistance of two staff, did not walk in the hall, and only walked once or twice in the room with two staff present. The MDS also revealed the resident required extensive assistance of two staff for dressing, toilet use, and personal hygiene. The resident had diagnoses that included morbid obesity, reflux, heart failure, stroke, renal insufficiency, and diabetes. The MDS reported the resident had occasional pain, and no falls since admission/entry or re-entry, had a surgical wound and no other skin conditions.

The MDS dated 8/29/2020 revealed the resident transferred and ambulated independently.

The Care Plan initiated 6/29/2020 revealed the resident received dialysis Monday, Wednesday, and Friday due to renal failure. The resident had a potential for falls related to end stage kidney disease and was on dialysis. The Care Plan instructed staff to keep the walker within reach of resident at all times, refer to qualified professional as needed. The Care Plan revealed the resident had chronic pain related to end stage kidney disease with dialysis, depression and coronary artery disease. It instructed staff resident could request pain medication when needed, to administer analgesics as ordered, anticipate need

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for pain relief and respond appropriately to any complaint of pain, monitor for signs of non-verbal pain, and refer to professional as needed. The Care Plan identified the resident had a risk for impaired skin integrity and directed staff to administer treatments as ordered, and apply pressure reduction mattress to bed and cushion in wheel chair. The Care Plan documented the resident as independent with bed mobility (no side rails), transfers, ambulation with a walker, and propelling their wheel chair. The resident required assistance of one staff for perineal care.

The Physician's Orders included:

a. Assess pain on a scale of 1-10 every shift two times a day for monitoring health - 9/21/2020
b. Hydrocodone - Acetaminophen 5/325 mg (milligrams), one tablet every six hours as needed for pain. 8/20 - 8/27/2020, 9/23/2020.
c. Skin assessment to be completed on weekly skin assessment every Tuesday - 6/30/2020
d. Acetaminophen 1000 mg, every eight hours as needed for pain relief - 9/6/2020
e. Acetaminophen 1000 mg, three times a day - 4/8 - 8/27/2020

The MAR (Medication Administration Record) revealed from 9/12 - 9/22/2020 Resident #21 received Hydrocodone-Acetaminophen 5-325 mg 28 times out of 33 opportunities. The MAR revealed the resident had an order for Hydrocodone-Acetaminophen on 9/4/2020, however the resident did not receive the medication from 9/4 - 9/12/2020.

Progress Notes included:

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F 684	Continued From page 39 - 8/11/2020 at 7:08 P.M., Resident complained of nausea and right mid abdomen pain and reported being light headed. Temp 96.5 degrees, BP 118/57, pulse 60, respirations 20. Administered PRN (as needed) Narco (Hydrocodone-acetaminophen). Resident reported no relief and requesting to go to the ER. Call placed to the physician. - At 8:03 P.M., follow up pain scale revealed 9 out of 10. Resident reported no relief from med. - At 11:41 P.M. resident continued to complain of abdominal pain and not feeling well. Abdomen soft, round and nondistended, hyperactive right upper quadrant/ right lower quadrant and hypoactive left upper and lower quadrant. Resident given all PRN's ordered for resident with reports of little relief. DON (Director of Nursing) updated on complaints and concerns at this time. -8/12/2020 at 8:32 a.m. resident nauseated and complained of stomach pain and vomited green-tinged watery liquid. An assessment revealed bowel sounds present in all four quadrants. Dialysis notified and directed resident to keep scheduled treatment if no further vomiting this a.m. Call placed to physician - received order for Zofran 4 mg as needed (for nausea and vomiting). -At 12:29 Staff E, LPN administered Zofran to the resident, and the resident went to dialysis. - At 8:26 p.m., Staff S, RN received a report that the resident went to ER from dialysis due to complaints of discomfort. -8/13/2020 at 5:06 a.m., Staff T, LPN received word the resident had admitted to the hospital	F 684		

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with a small bowel obstruction, had a NG (nasogastric) tube in place, received morphine for pain, with a general surgery consult scheduled later that day.

-8/19/2020 at 4 p.m. resident returned to the facility. Staff S performed a head to toe assessment with all systems within normal limits.

-8/20/2020 at 5:40 a.m., resident rested throughout night without any complaints of pain, staples intact.
-At 8:44 p.m. the resident complained of severe abdominal pain, 10/10. Hydrocodone given at 7:07 p.m. with no relief. Resident had loose stools throughout day with hyperactive bowel sounds in upper quadrants and hypoactive sounds in lower quadrants. Resident requested to go to the ER, physician notified, order received and resident transferred via ambulance. Daughter notified.

-8/21/2020 at 3:58 a.m. and 11:27 a.m. - the resident admitted with diarrhea, abdominal pain and end stage renal disease. The resident received a clear liquid diet, and x-rays showed no obstruction.

-8/23/2020 at 6:47 p.m., resident returned to facility, up with a walker and eating a regular textured diet.

-8/25/2020 at 7 o'clock p.m. resident complained of pain in the abdomen, 10/10. Pain medication given at 5:51 p.m. without relief. Resident reports feeling nauseated and refused 7 up. Resident stated "I feel like I am dying". Physician called with no return call at 7:30 p.m. Assessment revealed faint bowel sounds in right upper quadrant and absent bowel sounds in left upper,

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right lower and left lower quadrant. Vitals assessed, BP 80/46, temperature 97.4 degrees. Abdomen very tender to touch. Call placed to 911 to send the resident out with nurse's discretion at 9 o'clock p.m. The resident admitted, received surgery for a perforated bowel and then to ICU (Intensive Care Unit).

-9/4/2020 at 4:24 p.m. the resident returned from the hospital. At 4:34 p.m., Vitals were stable at arrival of patient. Staff S was told about the surgical incision and wound on sacrum. Surgical incision is packed wet to dry with 0.9% Normal Saline and surgical gauze. Wound on bottom is covered with Mepilex.
-At 10:00 p.m., Staff T, LPN went to get report from Staff S when the resident fell in another resident's room. Vitals were stable, resident noted to be very agitated with increased confusion. Staff T sent the resident to the ER due to increased need for care beyond staff ability at this time. DON (Director of Nursing) aware of behaviors and recent fall. Physician on call service called with message to return call.
-At 2:04 a.m. the resident returned with diagnosis of delirium, all labs within normal limits. Daughter aware of all tests and results done in ER. At 2:20 a.m. the resident returned from hospital stay via care ambulance and staff transferred the resident to the wheel chair with assist of 2, tolerated transfer without difficulties. Staff T, LPN assessed the resident's vitals and two staff transferred the resident to the bed.

In an Incident Report dated 9/5/2020 at 9:30 p.m. Staff O, RN documented a CNA summoned them to the resident's room and observed the resident on the floor, on their back and their head toward bed. The resident wore shoes and clothes and

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F 684	Continued From page 42 stated they were trying to go to Parkersburg to see their daughter. Passive Range of Motion with no limitations. Resident reported general achiness (due to had fallen two times previously). Vital signs were stable, oriented to self and place but hallucinating about situations that happened past week. Progress Notes: -9/5/2020 at 10:30 p.m. - Staff O notified the physician of the resident's fall. The physician reported Zyprexa had been ordered for discharge from hospital. Pharmacy sent medication but no order in point click care. -At 10:30 p.m. Staff O documented resident in wheel chair refusing to go to bed and stated "I was hit by a semi and I think I broke my hip." At 10:53 p.m. Staff S documented the resident had asked for assistance to transfer to the recliner. Staff S explained they were currently with another resident and would assist Resident #21 next. Two minutes later, Staff S heard the resident call out for help and found the resident on the floor. -9/9/2020 at 1:00 a.m., Staff T, LPN documented, resident resting in bed at this time, treatment to abdomen completed without difficulties, assessment done on left ankle related to recent complaints of pain and discomfort. Resident had trace edema from knee to toes and was resistant to range of motion to knee and leg. Staff administered APAP (Acetaminophen) due to Hydrocodone being on order from pharmacy. -9/12/2020 at 12:35 p.m. Staff V, RN administered Hydrocodone/Acetaminophen 5-325 mg. for pain. Resting, distraction, repositioning all ineffective given left hip pain.	F 684		

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F 684	Continued From page 43 -9/13/2020 at 1:05 p.m., Staff administered Hydrocodone/Acetaminophen 5-325 mg. for pain. Resident complained of increased pain. At 8:10 a.m. Staff V administered Hydrocodone/Acetaminophen 5-325 mg. for left hip pain. Progress Notes revealed the resident received Hydrocodone/Acetaminophen 5-325 mg. for pain daily with relief provided. -9/15/2020, the resident went to a follow up post-surgery appointment. The physician noted the wound not healing well along superior aspect, needs abdominal binder and follow up in one week. -9/16/2020, Staff O ordered the abdominal binder. -9/18/2020 - binder on order, not available. -9/21/2020, Resident's wounds and staples lifted and loose with pus oozing. The resident had an appointment to see the physician on 9/22/2020. -9/22/2020, Physician noted wound draining incision with fibrin exudate and serous drainage, skin/staples macerated, needs abdominal binder. Refer to wound clinic for possible wound vac, and wet to dry dressing two times a day for wound healing. Dressing on sacrum will be changed daily with Mepilex. Wound clinic appointment 10/8/2020. -9/23/2020 at 7:29 p.m., Staff V documented resident was transferred from dialysis to Unity Point Hospital. Per floor nurse, resident hospitalized for left hip fracture with surgery scheduled 9/25/2020.	F 684		

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-9/25/2020 at 8:58 a.m., Staff V documented a late entry for 9/12/2020 at 12:15 p.m.: Notified physician of increased generalized pain as reported by resident during repositioning. Per physician, continue to utilize pain medication.

Occupational Therapy notes included:

a. 9/11/2020 - 9/20/2020 certification period.
b. 9/11/2020 - Pain Assessment: Pain with movement 8/10; Frequency - constant; Location - both hips when rolling; Pain description - hurts a lot. Pain limits functions of sitting, standing, ambulating, reaching down to feet. What relieves pain? - remaining still. What exacerbates pain? - sitting, standing, prolonged activity. Pain at rest - 0/10.
Assessment: Resident uses Hoyer for all transfers, does not push wheel chair very far.
c. 9/14/2020 - Used E-Z stand to obtain an upright position. Resident complained loudly that his/her left hip was painful and wanted to stop. Resident in wheel chair and complained of left hip/knee pain and did not want to continue with task.
d. 9/17/2020 - resident complained loudly of left hip pain when returning back to bed. Also addressed weight bearing on left hip with moderate resistance from resident.
e. 9/18/2020 - Resident yelled about left hip pain initially but had no pain through tasks. Resident did take a step toward wheel chair and sat down with moderate/maximum assist of two.
f. 9/22/2020 - resident with much resistance to performing all tasks, needed maximum assist of two to get resident to participate, worked on bed mobility, dressing, standing up and transferred to wheel chair with much difficulty. Maximum assist

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F 684	Continued From page 45 times two, did not complain of pain in left hip. g. 9/23/2020 - moderate assist with putting left foot into pair of shorts, resident able to pull foot through moderate independence. Did not want to pull right foot through due to feeling like he/she needed to vomit. No pain present. Physical Therapy notes included: h. 9/9/2020 - Pain assessment: Pain at rest =0. Pain with movement = 6/10, left leg specifically left thigh and knee. Pain limits the following functional activities: any movement to the left lower extremity. What relieves pain? = Sitting down, remaining still. What exacerbates pain? = Bending. Clinical Impression: Patient presents with impairments including balance deficits, pain lower left extremity. h. 9/10/2020 - Pain present left hip. i. 9/14/2020 - training in wheel chair propulsion/maneuvering - left lower extremity drags patient uses right lower extremity to assist with mobility forward. Pain limits lower left extremity mobility with wheel chair propulsion. What relieves pain? = remaining still. j. 9/16/2020 - Seated exercises in wheel chair: Left side, patient tolerating only limited motion of approximately 20 degrees extension to 80 degrees flexion with pain limiting tolerance. Patient stated "can't do it, it hurts", but exhibits no grimacing or pulling back from pain, by the end of 20 reps, patient tolerated the motion better with less reports of pain. k. 9/22/2020 - Wheel chair propulsion: minimal left lower extremity usage, patient increased left usage by using right lower extremity behind left lower extremity for advancement and propulsion. Hospital Records included:	F 684		

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F 684	Continued From page 46 8/12/2020 - Emergency Department records included: Onset - several days Timing/severity: constant Location: Lower abdomen, worse with palpation. Nausea, vomiting, diarrhea, cough. Presented to the emergency department for evaluation of constant lower abdominal pain over the past few days with associated nausea, vomiting, diarrhea. The lower abdominal area is tender to palpitation. Reports some black stools and denies any hematemesis (vomiting of blood). Did not receive dialysis treatment this morning due to symptoms. Clinical Impression: Small Bowel Obstruction (SBO), End Stage Renal Disease (ESRD). Imaging demonstrates SBO with concern for bowel ischemia. CT abdomen: Fluid dilated loops of proximal and mid small bowel with abrupt transition zone to empty/collapsed distal small bowel consistent with a small bowel obstruction. Some of the subtending small bowel mesentery has a hazy appearance worrisome for edema and possible impending bowel ischemia. Resident had a small bowel resection on 8/13/2020 and discharged to the facility on 8/19/2020. 8/20/2020 - Emergency Department Note. Impression: Diarrhea, abdominal pain, ESRD. Presents with history of physical exam consistent with diarrhea and abdominal pain and loose BM after lysis of adhesions and small bowel resection for SBO. Patient is nontoxic appearing and initial vital signs are not concerning, Abdomen is diffusely tender, Labs are not concerning. Imaging does demonstrate likely post-op ileus	F 684		

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F 684	Continued From page 47 versus developing obstruction. Resident returned to the facility on 8/23/2020 8/24/2020 - Hospital records included: Emergency Department: 10 p.m. Exam - well healing surgical would site at the upper abdomen, abdomen is soft with diffuse tenderness and moderate guarding. Absent bowel sounds. History - Patient describes pain as sharp diffuse pain all over abdomen, pain started all of a sudden this afternoon and pain is worse tonight. Patient stated they had a normal bowel movement this morning. CT Abdomen: There is new pneumoperitoneum since 8/21/2020 indicating bowel perforation. The exact location of the perforation is not clearly seen. Surgical consult recommended. Resident returned to the facility on 9/4/2020. Emergency Department (ED) notes dated 9/4/202 included: At 11:08 p.m. - presented to ED after resident found lying on the floor and acting confused. Unsure if he/she fell. Patient reports not in any current pain, had a recent small bowel obstruction that recently had surgery for a perforation. Musculoskeletal: Right and Left lower leg, no edema. General: No swelling, tenderness, deformity or signs of injury. CT head or brain, Chest X-ray, CBC (Complete Blood Count), BMP (Metabolic Panel), EKG performed. Negative for acute findings. Clinical Impression: Delirium. Abdominal surgery, follow-up exam. Discharge back to the facility	F 684		

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F 684	Continued From page 48 At 1:10 a.m., 9/5/2020, ED nurse spoke to Staff T, RN with updates regarding the resident's condition. 9/23/2020 Hospital Records included: Arrival time - 9/23/2020 at 11:43 a.m. Abdominal Pain, sent from dialysis center, patient having abdominal pain and reported no bowel sounds, he has had a history of bowel obstruction, there is a concern for that and is oozing small amounts of stool. Presented to the ED for hip and knee pain but sent by dialysis with concern for bowel obstruction. Patient reports they fell two weeks ago and has had consistent knee and hip pain since. The resident had been told it was not broken, but it continues to hurt. The resident denied abdominal pain and denied re-injury to the hip and knee. The dialysis nurse stated resident doubled over in pain due to abdominal pain. Daughter reports patient has been unable to walk for the past two weeks. Musculoskeletal: Left Hip exhibits decreased range of motion, tenderness, bony tenderness and swelling. Left knee exhibits decreased range of motion and effusion. Tenderness found. Imaging: CT scan and x-ray shows an intertrochanteric left hip fracture. Surgical procedure: Left hip intramedullary nailing, left hip. Dialysis communication, facility to dialysis 9/23/2020 at 10:13 a.m. Resident alert and oriented to self, resident pleasant, assist of two with peri cares and dressing, transfers with assist of 2 and a Hoyer, able to propel self in wheel chair short distances using upper extremities. Resident seen in clinic for abdominal incision, referred to wound clinic.	F 684		

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Fall Risk Assessment dated 9/4/2020: Score 23 (High risk for falls). Multiple falls within last six months.

Resident documentation regarding amount eaten revealed the resident ate 0% on 9/22 for breakfast, lunch and supper and 0% on 9/23 for breakfast.

Physician Progress Notes dated 6/23/2020 - telehealth - chronic back pain, recently changed to a different long term care facility, continues with dialysis three days a week.

During an interview on 9/28/2020 at 1:20 p.m., Staff R, RN, Corporate, reported with Resident #21's history of bowel obstruction, staff would be expected to assess bowel sounds daily, meal intakes and check for edema.

During an interview on 9/28/2020 at 2 p.m., Staff I, Administrator reported the resident had a couple of falls. In a morning meeting Staff EE, RN, (DON) Director of Nursing said the resident complained of hip pain. Staff T, LPN said the resident had a full body scan and was fine. The resident's daughter reported the resident did not have a full body scan. From 9/5 - 9/23/2020 Staff I indicated the resident appeared fine and even wanted to go out and smoke. Staff I did not know until today, 9/28 that the resident had an impacted bowel. Staff I knew the resident's dentures were missing and they planned to replace them if they could not be found.

During an interview on 9/29/2020 at 11:50 a.m., Staff EE, DON reported the resident returned from the hospital on Friday and had confusion,

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difficult behaviors and hollered out. The resident fell on 9/4 and staff sent them to the emergency room due to increased confusion. The resident received Zyprexa in the ER and returned to the facility around 2 o'clock a.m. The resident fell again on 9/5/2020 when Staff O, RN and Staff S, RN were present. Staff O completed the incident report. On Friday, 9/11/2020 Staff U, CNA reported the resident complained of pain all over and hip pain, and had informed Staff V, RN. Staff EE went to the resident's room and the resident complained of pain all over and the left abdomen. Staff O called the doctor and reported increased generalized pain and the physician said to treat with pain medication. When the confusion improved, the resident started to pivot transfer and take a few steps with therapy. On 9/4/2020 Staff T reported the ER nurse reported the resident received a full body scan with negative results. But now they knew the resident only received a head CT scan and a chest x-ray. Nobody reported any pain to Staff EE after 9/11/2020 and the resident had no further falls.

During an interview on 9/28/2020 at 10:30 a.m., Staff Z, RN, ADON (Assistant t Director of Nursing) and Staff Q, RN reported they conducted a skin assessment on Resident #21 on 9/23/2020. The resident directed them to not touch their foot and not assist with turning. Staff Z and Staff Q notified Staff FF, RN who reported it had been hurting.

During an interview on 9/29/2020 at 12:01 p.m., Staff S, RN reported working 9/4 and 9/5/2020 when Resident #21 had falls. On 9/4 when the resident returned from the hospital, they had two falls. One when Staff S attempted to transfer the resident to the recliner and ended up lowering

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him to the floor, not necessarily a fall. The resident yelled out, not normal behavior for them and appeared short tempered. Prior to the surgery the resident ambulated with a walker, after the surgery the resident had more unsteadiness with ambulation. The resident had another fall in another resident's room across the hall. Staff found him naked except for a brief. They ended up sending the resident to the emergency room for evaluation. The next day, 9/5 Staff S went into a room across the hall, Resident #21 wanted to transfer to the recliner, attempted to transfer themselves and fell. Staff O, RN assessed the resident and completed the incident report. It occurred near the end of the shift. Staff S assisted with transferring the resident with a gait belt and could not recall the resident complained of pain. Staff S last worked at the facility on 9/16/2020. Staff S reported to administration, the resident required closer monitoring and with staff call-ins, they could not meet the needs of the resident.

During an interview on 9/28/2020 at 12:01 p.m., Staff O, RN reported working at the facility on 9/5/2020. After the fall the resident stated feeling as though they were hit by a semi and broke their hip. The physician instructed staff to administer Zyprexa for confusion. The resident mainly complained of abdominal pain. Staff O indicated the resident had no range of motion concern during the fall assessment. Nobody reported any hip pain to Staff O. Staff O assisted the resident transfer numerous times and the resident complained of abdominal pain.

During an interview on 9/29/2020 at 9:05 a.m., Staff T, LPN reported the resident complained of abdominal pain in mid-August, so Staff T called

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the doctor and had no return call. The resident asked to go the ER. Staff T monitored the resident, the next day went to dialysis and they sent the resident to the ER with a small bowel obstruction. The day after the resident returned from that hospital stay, they complained of pain again. Staff T sent the resident to the ER and they returned after a few days. A couple of days after returning from that hospital stay, the resident again complained of increased pain so Staff T sent the resident to the ER. The resident admitted with a perforated bowel. When the resident re-admitted after that surgery, they did not seem like the same person and had mean and aggressive behaviors. Staff O reported the resident fell and landed on their knees and they were sending the resident to the ER. An ER nurse called the facility and informed Staff T the resident had delirium and could not be admitted and all labs and x-rays were okay. The resident returned around 2:30 a.m. A couple of days later the resident complained of ankle pain. Staff T noted swelling from the left knee to ankle. Staff V had notified the physician and received orders to administer pain medication. During the night shift the resident rarely asked for anything, slept well and did not get out of bed. When Staff T arrived the resident had already been in bed and remained there throughout the shift. CNA's reported the resident complained of knee and ankle pain; nobody said they complained of hip pain.

During an interview on 9/29/2020 at 11:15 a.m., Staff V, RN reported Staff T sent the resident to the ER after a fall. The resident reported pain everywhere and screamed, but it seemed primarily about abdominal pain. The physician said to administer pain medication. The Aides did

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report the resident complained of pain, but Staff T did not recall them mentioning leg pain specifically.

During an interview on 9/29/2020 at 1:12 p.m., Staff AA, LPN reported prior to the surgeries, the resident ambulated independently. The resident re-admitted with confusion. Staff AA and Staff S transferred the resident to the recliner and the resident wanted to get to their truck and smoke. The resident tried to transfer themselves and fell in another resident's room. Prior to that, the resident slid from the recliner when Staff S attempted to transfer them. One day Staff AA observed the resident's foot was off the wheelchair pedal and went to assist with placing it back on the pedal. The resident said "oww" and reported back pain. Another day the resident refused to get up due to back pain.

During an interview on 9/29/2020, Staff U, CNA reported working on D wing for two weeks after Resident #21 fell. Staff U reported they only got the resident out of bed on dialysis and shower days. The resident complained of a lot of abdominal pain. Anytime they rolled the resident, anytime they attempted to do anything that involved moving that leg, even a little, they complained of pain. When staff attempted to put socks on, pull their pants up or roll the resident side to side, they complained of leg pain. Staff U reported it to nurses. Staff V reported the resident had x-rays and had no concerns. Staff U reported they lifted the resident's leg and the resident screamed with pain. The new pain pills seemed to help.

During an interview on 9/30/2020 at 10:45 a.m., Staff J, CNA reported Resident #21 transferred

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with a Hoyer, mechanical lift. Every time the resident moved, they yelled out due to hip pain after the falls. The hip did not feel right, it protruded and seemed swollen. The resident screamed and stated it hurt. Staff J reported it to the nurse and Staff EE, DON. They indicated the resident had an x-ray and it was fine.

During an interview on 9/28/2020 at 12:10 p.m., Staff K, PTA (Physical Therapy Assistant) and Staff L, OT (Occupational Therapist) reported Resident #21 returned from the hospital on 9/4/2020 with therapy orders, however they did not receive the orders immediately and began treatment on 9/9/2020. The resident progressed slowly with bed mobility and sitting at the edge of the bed, and then progressed to transfers with assist of two. The resident had difficulty moving the left leg from seating, to put leg up, and sitting at edge of bed. The resident used the right leg to propel the wheel chair. Therapy staff told nursing the pain interfered with therapy. OT saw the resident on 9/23/2020, early before dialysis and they had no complaints of pain. They worked on bed mobility because the resident refused to get out of bed that day. The resident complained of hip pain at times but they were told the resident had no fracture because the tests were negative. On 9/11/2020 Staff I, Administrator called Staff L wanting to know how the resident did in therapy. Staff L told Staff I the resident's biggest barrier was the left hip pain.

The facility failed to appropriately document each of the three falls the resident sustained 9/4-9/5/2020. The facility failed to provide timely assessment and intervention when the resident complained of abdominal pain on 8/11/20. The facility failed to appropriately assess and provide

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F 684	Continued From page 55 intervention when the resident complained of left leg pain after the falls on 9/4- 9/5/2020. The facility failed to appropriately assess pain and administer appropriate pain medication from 9/4 - 9/12/2020.	F 684	F 688 1. Residents # 3, 1, 20, 13 will be evaluated by the Registered Nurse and the interdisciplinary team to identify measurable restorative goals and practical interventions that can be implemented and achieved with nursing support. Evaluations were verified by the DON on/or before 12/22/20.	
F 688 SS=E	Increase/Prevent Decrease in ROM/Mobility CFR(s): 483.25(c)(1)-(3) §483.25(c) Mobility. §483.25(c)(1) The facility must ensure that a resident who enters the facility without limited range of motion does not experience reduction in range of motion unless the resident's clinical condition demonstrates that a reduction in range of motion is unavoidable; and §483.25(c)(2) A resident with limited range of motion receives appropriate treatment and services to increase range of motion and/or to prevent further decrease in range of motion. §483.25(c)(3) A resident with limited mobility receives appropriate services, equipment, and assistance to maintain or improve mobility with the maximum practicable independence unless a reduction in mobility is demonstrably unavoidable. This REQUIREMENT is not met as evidenced by: Based on observation, clinical record review and staff and resident interviews the facility failed to provide restorative therapy according to the resident's plan restorative program plan for 4 of 5 residents reviewed. The facility reported a census of 61 residents. Findings include: 1. According to the MDS (Minimum Data Set)	F 688	2. An Audit will be completed by the DON/ Designee on or before 12/22/20 to identify those who qualify for the Restorative Nursing Program. Those residents will be evaluated by the interdisciplinary team to identify measurable restorative goals and practical interventions that can be implemented and achieved with nursing support and on or before 12/22/20 3. IDT Team and Nursing staff will be re-educated by the DON/designee on 10/30/2020 related to the requirements of Restorative Nursing Program that met the needs of the residents. CNA's will be re-educated by the DON/ Designee on or before 10/20 regarding the requirements of providing restorative nursing care per the residents' plan of care. 4. DON/Designee will audit 3 residents weekly for 4 weeks then monthly for 2 months to ensure individual Restorative Program continues to be completed to meet the needs of the resident and per residents' plan of care. Results of these audits will be taken to the facility QAPI meeting monthly for 3 months for review and recommendation as needed. The Director of Nursing is responsible for monitoring and follow-up. Compliance date: 12/26/2020	12/26/2020

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dated 8/20/2020 and 5/21/2020, Resident #3 had no cognitive impairment, transferred with extensive assistance, and had range of motion limits of upper extremities and lower extremities. The MDS had no documentation of range of motion and documented diagnoses that included hemiplegia depression, dysphagia, paraplegia, and epilepsy.

The Therapy to Restorative Nursing Communication from PT (Physical Therapy) to the facility dated 4/15/2020 directed staff to have the resident use a motorized bike 15 - 20 minutes two to three times a day and ambulate (walk) in the hallway with two person assist 20 - 30 feet, and follow with wheelchair daily.

The facility failed to provide charting that verified the resident had restorative exercises provided.

During an interview on 9/17/2020 at 10:45 A.M., Resident #3 reported admitting to the facility approximately 7 months prior with therapy services after suffering a stroke. After therapy discontinued they switched to restorative care. The resident reported Staff G, CNA, Restorative Aide told the resident staff should walk the resident three times a week. The resident reported they failed to offer assistance with walking consistently, often times not more than one time per week. The resident added Staff G had a busy schedule and wore many hats.

During an interview on 9/17/2020 at 12:20 P.M., Staff G reported they tried to assist Resident #3 with ambulation, though there is no documentation.

Observation on 9/15/2020 revealed Staff G and

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Staff J, both CNAs ambulate (walk) the resident with a gait belt and wheel chair following. The resident ambulated short distances with frequent stops to rest.

2. According to the MDS dated 8/15/2020, Resident #20 had no memory impairment, did not transfer or ambulate, required extensive assistance for hygiene, and did not have no restorative care.

The Therapy to Restorative Nursing Communication dated 5/18/2020 instructed staff to have patient complete seated bilateral upper extremity strengthening and encourage resident to use commode with an EZ stand lift for toilet use as tolerated.

During an interview on 9/21/2020 at 11:05 A.M., Resident #20 reported they had received therapy and discharged in May with a restorative plan. The resident said they were supposed to be doing exercises with a CNA, but was busy with activities.

3. According to the MDS dated 7/16/2020, Resident #1 demonstrated no cognitive impairments and required total assistance of two staff for bed mobility, personal hygiene, eating, and dressing. The MDS revealed the resident had a diagnosis of quadriplegia.

The Care Plan directed staff to provide transfer assistance with a Hoyer mechanical lift, extensive assistance of one staff with eating, and encourage the resident to follow their restorative program. The resident had a risk for skin breakdown related to decreased mobility and directed staff to provide daily skin checks and

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incontinence cares.

The Restorative Plan of Care initiated 1/22/2020 included: Passive Range of Motion to decrease contracture for optimized positioning in bed and wheel chair for skin integrity and comfort. It directed staff to provide range of motion one time a day, five to seven days a week.

The September 2020 Nursing Rehab. Range of Motion to all extremities 3 - 6 times a week contained no documentation of task completion.

During an interview on 9/17/2020 at 1:20 P.M., Staff I, Administrator reported Staff G, CNA often got pulled to the floor, but they hope to expand the restorative program. Staff G switched to activities recently so Staff J, CNA trained in restorative and they plan to have them work as a restorative aide a couple of days a week. Staff G has been working with Staff J with training. The facility has implemented a Quality Assessment and Performance Improvement Plan to improve the program.

On 9/22/2020 at 9:50 A.M., Staff I, Administrator reported they planned to have Staff J, CNA start working as the Restorative Aide on 9/23/2020.

On 10/5/2020, at approximately 1 o'clock P.M., Staff I indicated they were able to schedule Staff J in restorative on 10/5/2020.

During an interview on 9/17/2020 at noon, Staff K, Physical Therapy Assistant revealed Staff G had been in charge of the restorative program and also did activities. It is difficult when therapy builds a resident up and then there is a lack of

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follow through with restorative, and they decline. When a resident is released from therapy, they place restorative recommendations in a restorative binder and communicate it to staff.

At 1:50 P.M. Staff K presented copies of restorative care programs for current residents. Staff K indicated facility staff makes them aware when a resident has had a decline, therapy evaluates, builds the resident back up, and then releases them to restorative.

During an interview on 9/17/2020 at 12:20 P.M., Staff G, CNA reported they worked as the restorative aide until April when they switched to activities. Currently, Staff J had completed restorative training but had not been able to start doing restorative duties because they have to work the floor. When Staff G worked in restorative, they also had to work as a CNA on the floor on the weekends. Staff G has expressed concerns to management and no documentation is available for restorative care for more than thirty days.

Staff G reported they used to complete range of motion, clipped nails and massaged Resident #1's legs.
Resident #18 and Resident #2 used to ride the bike and they enjoyed it.

During an interview on 9/17/2020 at 2:15 P.M., Staff J, CNA reported they received certification restorative in July and had not been scheduled to work in restorative. The plan is for Staff J to work as restorative aide and administration has expressed a desire to implement the restorative program again. No staff has been scheduled in restorative since Staff G changed jobs to

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activities. On 9/30/2020 Staff J reported working in restorative for one shift thus far.
4. Review of the MDS dated 8/29/20 revealed Resident # 13 had diagnoses which included cancer, anxiety, depression, acquired deformity of the right foot and Celiac Disease. The MDS indicated the resident had a Brief Mental Status Interview (BIMS) of 15 which indicated intact cognitive ability. The resident ate independently and required limited assistance of 1 staff for transfers. The MDS documented the resident did not walk but utilized a wheelchair for mobility and had a restorative nursing program but only completed the program 1 day.

The Care Plan revised on 9/8/20 indicated the resident required 1 staff for walking with a walker. The care plan failed to indicate the resident had a Restorative Nursing Program.

Review of a Consultation Clinic Referral dated 1/15/20 directed the staff to work with the resident in restorative on ambulation.

Review of a Therapy to Restorative Nursing Communication form dated 5/29/20 revealed Physical Therapy directed staff to ambulate the resident 200 feet, wheelchair to follow, to complete restorative 5-6 times a week with the use of a gait belt and a front wheeled walker.

Review of a Nursing Restorative Care Program dated 11/30/2018 revealed the resident to work with restorative to strengthen, improve balance, and range of motion to prevent falls. 3-5 times weekly. The resident should utilize a front wheeled walker and assist of 1 staff.

During an interview on 9/29/20 at 1:00 p.m. the

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F 688	Continued From page 61 resident stated she does not participate in restorative, no one walks her and she just moves about the facility in her wheelchair. Review of a Restorative Nursing Policy dated 4/2014 stated the facility strives to enable residents to attain and maintain their highest practical level of functioning. A licensed nurse manages the restorative program with assistance of nursing assistants trained in proving restorative care.	F 688		
F 689 SS=D	Free of Accident Hazards/Supervision/Devices CFR(s): 483.25(d)(1)(2) §483.25(d) Accidents. The facility must ensure that - §483.25(d)(1) The resident environment remains as free of accident hazards as is possible; and §483.25(d)(2)Each resident receives adequate supervision and assistance devices to prevent accidents. This REQUIREMENT is not met as evidenced by: Based on observation, clinical record review and staff interviews the facility failed to provide adequate nursing supervision and assistance devices top prevent accidents for 1 of 3 residents reviewed (Resident # 2). The facility reported a census of 61 residents. Findings include: 1. According to the Minimum Data Set (MDS) assessment tool dated 6/11/2020, Resident #2 had diagnoses that included dementia and depression. The MDS documented Resident #2 demonstrated severely impaired cognitive skills,	F 689	F 689 1. Resident # 2 no longer resides at the facility 2. An audit will be completed by DON/Designee on or before 12/25/20 related to residents who are Care Planned to have dycem in their chairs for fall prevention to ensure interventions are implemented per plan of care. 3. Licensed Nurses and CNA's will be educated by DON/designee on or before 12/25/20 related to the requirements of providing fall intervention per resident's plan of care. 4. DON/Designee will complete audits weekly for 12 weeks to ensure residents that require dycem for fall interventions continue to be provided per resident's plan of care. Results of these audits will be taken to the facility QAPI meeting monthly for 3 months for review and recommendation as needed. The Director of Nursing is responsible for monitoring and follow-up. Compliance date: 12/26/2020	12/26/2020

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CEDAR FALLS HEALTH CARE CENTER	1728 WEST EIGHTH STREET CEDAR FALLS, IA 50613

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did not walk, required extensive assistance of two staff to transfer from one surface to another, and extensive assistance of one staff for personal hygiene.

The Care Plan revealed the resident had a risk for falls and directed staff to encourage frequent exercise, restorative nursing, low bed with fall mat, scoop mattress on bed, and attempt to toilet before and after meals and provide incontinence cares. The care plan also directed staff to use an EZ stand lift for transfers, a wheel chair for mobility, and dycem (non-skid aid) in recliner to prevent resident from sliding to the floor. The care plan revealed Resident #2 required total assistance with intake.

The Incident Report dated 9/6/2020 at 10:17 P.M. revealed Staff S, RN documented they walked into the resident's room and observed the resident on the floor with their head slightly hidden under the bed and legs stretched out and crossed. The mechanical lift sat at the foot of the bed. Staff S completed a head to toe assessment and observed restricted movement of the right upper extremity. All other extremities had normal range of motion. Staff S assessed the resident's pain level at a "7" on a 0-10 scale, (10 being the worst pain ever felt) based on body language, facial expression, and breathing. There were no witnesses to the incident.

The Progress Notes included:

On 9/6/2020 at 10:31 P.M., Staff S documented they observed the resident on the floor at 3 o'clock P.M., and performed a head to toe assessment. The resident had elevated blood pressure for the initial assessment. Staff

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contacted the resident's physician and received an order to send the resident to the emergency room.

The Emergency Department record revealed the resident transferred to the emergency room on 9/6/2020 at 6:51 P.M. after an unwitnessed fall and a sodium level of 157. The resident received intravenous fluids and a recommendation to increase daily fluids.

Observation on 9/15/2020 at 12:10 P.M. revealed the resident on D wing, quarantined unit after a transfer to the emergency room. Staff transferred the resident with the use of the E-Z stand up lift.

Observation on 10/5/2020 at 8:00 A.M. revealed the resident at the main dining room table with staff providing total assist with eating. Observation of the resident's room on B wing revealed a recliner with no dycem present.

During an interview on 9/23/2020 at 12:45 P.M., Staff H, CNA reported working the day Resident #2 had a fall. Staff H began passing snacks and water at the beginning of the shift at 2 o'clock P.M. Staff H entered Resident #2's room and observed the resident on the floor. The wheel chair sat near the sink, the lift sat by the window, the recliner had no dycem on the seat, and the resident had a mechanical lift sling underneath them on the floor, wrapped up in the resident's arm. Staff H reported they summoned a nurse for assistance and added the resident transferred to the emergency room two hours later.

During an interview on 9/22/2020 at 10:10 A.M., Staff W, CNA reported working the day shift on 9/6/2020. Staff W assisted Staff X, CNA to

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transfer Resident #2 from the bed to the recliner. As Staff X pushed the resident's recliner back, it knocked over Resident #1's television and dresser on the other side of the curtain used to divide the room. Staff W and Staff X picked up the dresser and television. When they left the room, Resident #2 rested in the recliner.

During an interview on 9/22/2020 at 11:50 A.M. and 9/23/2020 at 9:37 A.M., Staff X, CNA reported working on 9/6/2020 during the day shift. After lunch, Staff X and Staff W transferred Resident #2 from the bed to recliner using a mechanical lift. When they reclined the chair, they knocked over Resident #1's dresser and television, not realizing how close it was. They picked it up and left the room. Staff X denied leaving the lift sling underneath the resident and verified the recliner had no dycem in the chair, only a chux (incontinence) pad.

During an interview on 9/22/2020 at 9:50 A.M. and 3:42 P.M., Staff Y, CNA reported working the evening shift on 9/6/2020, the day Resident #2 sustained a fall. Staff H started passing snacks and came to the nurse's station and reported a resident needed help. Staff Y entered the room and observed Resident #2 on the floor between the bed and recliner wearing a shirt and brief with the mechanical lift sling under him/her. The resident's arm was tangled in the sling and their head lay partially under the bed. The resident' roommate, Resident #1 reported two aides, Staff W and Staff X were feeding them lunch and knocked over the dresser and television. The lift sat near the window. Staff Y could not recall whether or not the recliner had dycem present.

During an interview on 9/30/2020 at 11:45 A.M.,

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F 689	Continued From page 65 Staff S, RN (Registered Nurse) reported working the evening staff found Resident #2 on the floor. Staff H, CNA requested assistance in the resident's room. The resident lay on the floor with their head partially under the bed. The mechanical lift sat in the corner of the room, the recliner, partially reclined, did not contain dycem. The resident attempted to move their head and staff used the sling that was already under the resident to transfer them. Staff S assessed the non-verbal resident and they transferred the resident to the bed. Staff S transferred the resident to the Emergency room for evaluation due to the mechanical lift being in the room and the television and dresser had been knocked over. The Fall Risk Reduction and Management policy included: Components of the falls risk program include but are not limited to : Identification of risk factors for falls and injuries Implementation of individualized interventions to minimize risk factors for falls and injuries. Address underlying medical issues that may contribute to a fall risk Identification of resident/patient with a recent fall Review of each resident fall Post fall care and management	F 689		
F 725 SS=E	Sufficient Nursing Staff CFR(s): 483.35(a)(1)(2) §483.35(a) Sufficient Staff. The facility must have sufficient nursing staff with the appropriate competencies and skills sets to provide nursing and related services to assure resident safety and attain or maintain the highest practicable physical, mental, and psychosocial	F 725	F 725 1. Resident # 17's call light was placed within reach by clinical staff on 9/14/2020 by the administrator. Resident #3 and #20 call lights were repaired by maintenance on 10/5/2020. DON/Designee assured resident needs were met for: resident # 3 on 9/17/2020, resident # 20 on 9/14/2020, resident #17 on 9/14/2020, and resident #16 on 9/21/2020. 2. An Audit of call light function and placement was completed by the DON/Designee on 11/23/2020 to ensure call lights are functioning and within residents reach as required. 3. DON/Designee provided education to nursing staff on 10/20/20 related to the requirements of maintaining Call Lights within resident's reach and ensuring call lights are functioning. 4. DON/Designee will complete audit weekly for 4 weeks, then monthly for 2 months, to ensure call light continue to be functioning and within resident's reach at as required. Results of these audits will be taken to the facility QAPI meeting monthly for 3 months for review and recommendation as needed. The Director of Nursing is responsible for monitoring and follow-up. Compliance date: 12/26/2020	12/26/2020

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F 725	Continued From page 66 well-being of each resident, as determined by resident assessments and individual plans of care and considering the number, acuity and diagnoses of the facility's resident population in accordance with the facility assessment required at §483.70(e). §483.35(a)(1) The facility must provide services by sufficient numbers of each of the following types of personnel on a 24-hour basis to provide nursing care to all residents in accordance with resident care plans: (i) Except when waived under paragraph (e) of this section, licensed nurses; and (ii) Other nursing personnel, including but not limited to nurse aides. §483.35(a)(2) Except when waived under paragraph (e) of this section, the facility must designate a licensed nurse to serve as a charge nurse on each tour of duty. This REQUIREMENT is not met as evidenced by: Based on observation and resident and staff interviews the facility failed to have sufficient staffing to ensure call lights were answered in a timely manner. The facility reported a census of 61 residents. Findings include: 1. Observation on 9/14/2020 revealed: Room A-2 call light observed on at 9:20 A.M., staff responded at 9:46 A.M. Room A-8 call light observed on at 9:20 A.M., staff responded at 9:46 A.M. 2. On 9/17/2020 observation of Room A-1	F 725		

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revealed Resident #3 had no working call light but did have a bell near the bed and in the bathroom.

Resident #3 reported the call light had not worked for about a month and they had repeatedly asked to have it fixed. Staff tell the resident to put the call light on, however it did not work. The resident received the bell to use in its place about a month prior as well. At times the resident had to go to the nurse's station to summon assistance. Resident #3 reported staff failed to respond to the call bell within 15 - 20 minutes at times, depending on how busy they were.

3. During observation on 9/14/2020 at 9:20 - 9:46 A.M. staff failed to respond to Resident #20's call light. During an interview on 9/21/2020 at 11:05 A.M., the resident reported staff failed to frequently respond to his/her call light for greater than 30 minutes. The resident watched the clock and timed the response time. The resident also had a bell used to summon staff.

4.. According to the Minimum Data Set (MDS) dated 7/16/20, Resident #17 had diagnoses which included heart failure, diabetes, rheumatoid arthritis, osteoporosis and low back pain. The resident had a Brief Interview for Mental Status score of 10 which indicated moderate cognitive ability. The resident required limited assistance of 1 staff for bed mobility and transfers, the resident did not walk but utilized a wheelchair for mobility, required extensive assistance of 1 staff for toilet use and personal hygiene. The resident had bowel and bladder continence and shortness of breath with exertion.

According to the care plan updated on 4/20/20 indicated the resident had gait and balance problems and had falls. The care plan directs the

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staff to keep items needed within reach and to anticipate the resident's needs. The care plan stated the resident is able to call for assistance if needed.

Observation on 9/14/20 at 9:22 a.m. Resident #17 in bed, her call light is on and she is yelling out "I need to get up, I have to get up and go to the bathroom and eat breakfast". Upon observation of her room, her breakfast is sitting on her bedside stand covered up. The resident stated she frequently has problems getting the staff to answer her call light timely.

Observation on 9/14/20 at 9:46 a.m., staff entered the resident's room and turned off the resident's call light.

Observation on 9/22/20 at 9:25 a.m. the resident sat in her chair in her room and she stated she has to use the bathroom but cannot find her call light. The call light was observed under the resident's mattress in between the bed springs. Call light given to the resident and she readily activated the call light to get assistance.

During an interview with Staff R-Corporate RN on 9/17/20 at 10:30 a.m., Staff R states the facility administrative staff do call light audits in person, they do not have an electronic monitoring system.

5. Review of the MDS dated 6/18/20 revealed Resident #16 had diagnoses which included Diabetes, Peripheral Vascular Disease and bipolar disorder. The resident had a BIMS score of 15 which indicated he had intact cognitive ability. The resident required limited assistance of 1 staff for transfers and ambulation and extensive assistance of 1 staff for dressing, toilet use and

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F 725	Continued From page 69 hygiene. The resident utilized a walker and wheelchair for mobility. The MDS revealed the resident had a risk for pressure sores, had 1 Stage 2 pressure ulcer and 1 venous ulcer. Review of the care plan dated 3/3/2017 informed the staff the resident had a self care deficit related to amputation of toes on right foot, imbalance, weakness and decreased motivation. The staff are directed to complete cares in pairs, to assist the resident with toileting and hygiene. The resident uses a urinal at the bedside and staff need to assist the resident in emptying the urinal as needed During an interview with Resident #16 on 9/21/20 at 3:00 p.m. the resident reported the staff do not come when he puts on his call light and reports its especially if there are a lot of agency or contract staff working. During an interview with Social Service Designee on 10/5/20 at 9:50 a.m., the staff stated her office is on the wing that Resident #16 resides and she reports the call lights are not answered timely and are left on for an extended period of time. She stated if she has noticed the call lights are on for an extended prior of time she will go and get an aide to answer the call lights.	F 725		
F 803 SS=D	Menus Meet Resident Nds/Prep In Adv/Followed CFR(s): 483.60(c)(1)-(7) §483.60(c) Menus and nutritional adequacy. Menus must- §483.60(c)(1) Meet the nutritional needs of residents in accordance with established national guidelines.;	F 803	F 803 1. Resident #13 and #15 were served a gluten free diet per order on 9/30/20 and validated by the dietary manager. 2. An audit will be completed by the Food Service Supervisor/Designee on or before 10/6/20 to ensure residents with gluten free are receiving meals per physician's orders. 3. Food Service Supervisor/Designee completed education for Dietary staff on 1020/20 to ensure related to the requirements of providing Gluten free diets per resident's orders. Director Nursing educated nursing staff on 10/20/20 related to the requirements of monitoring meal intake including documentation requirements. Dietary Manager educated dietary staff on 10/20/2020 related to the requirements of monitoring meal intake including documentation requirements. 4. Food Service Supervisor/Designee will complete audits weekly for 4 weeks then monthly for 2 months, to ensure Gluten free diets continue to be served and residents meal intake are being monitored as required. Results of these audits will be taken to the facility QAPI meeting monthly for 3 months for review and recommendation as needed. The Food Service Supervisor is responsible for monitoring and follow-up. Date of Compliance: 12/26/2020	12/26/2020

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F 803	Continued From page 70 §483.60(c)(2) Be prepared in advance; §483.60(c)(3) Be followed; §483.60(c)(4) Reflect, based on a facility's reasonable efforts, the religious, cultural and ethnic needs of the resident population, as well as input received from residents and resident groups; §483.60(c)(5) Be updated periodically; §483.60(c)(6) Be reviewed by the facility's dietitian or other clinically qualified nutrition professional for nutritional adequacy; and §483.60(c)(7) Nothing in this paragraph should be construed to limit the resident's right to make personal dietary choices. This REQUIREMENT is not met as evidenced by: Based on clinical record review, staff and resident interview, and observations the facility failed to provide a noon meal according to the menu for 4 of 4 observed. The facility reported a census of 61. Findings included: 1. Review of the Minimum Data Set (MDS) dated 8/29/20 revealed Resident # 13 had diagnoses which included cancer, anxiety, depression and Celiac Disease. The MDS indicated the resident had a Brief Mental Status Interview (BIMS) of 15 which indicated intact cognitive ability. The resident ate independently. The Care Plan revised on 9/8/20 directed the staff	F 803		

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F 803	Continued From page 71 to provide and serve a gluten free diet as ordered. Review of an Order Summary Report (Physician's Order Sheet) directed staff to serve the resident a gluten free diet, regular textured food, and regular fluid, thin consistency for Celiac's Disease. During an interview on 9/14/20 at 9:40 a.m., Resident #13 reported she did not get any toast for breakfast today, stated she is gluten free and they didn't have any bread. She commented she would have really liked some bread to eat with her eggs. Observations on 9/14/20 at 12:20 a.m. noted Resident #13 received her noon meal which consisted of meatloaf, mashed potatoes, and beverages, but no bread. Review of the 9/14/20 noon meal menu revealed gluten free diets are to receive gluten free hamburger steak, gluten free mashed potatoes with margarine, peas, gluten free bread with margarine, and peaches and milk. Review of the recipe used for the meatloaf on 9/14/20 noon meal indicated for a recipe of meatloaf for 48 residents, the cook is to add 2 pounds of Ritz crackers into the meatloaf mix. During an interview with the Food Service Supervisor on 9/14/20 at 12:22 p.m., the FSS stated they do not have a substitute for the gluten free bread, they are out and they won't have any until tomorrow. Observation on 9/29/20 at 12:20 p.m. revealed the staff served the resident mashed potatoes	F 803		

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F 803	Continued From page 72 with light brown gravy on the top, turkey, beets and fruit. During an interview with the FSS on 9/29/20 at 12:30 p.m., they stated Resident #13 is not wanting to follow her gluten free diet all the time, they faxed the physician but the physician returned a fax that the resident needs to remain on the gluten free diet as she takes several medications for diarrhea. During an interview with Staff DD-Dietary Aide on 9/29/20 at 12:30 p.m. the dietary aide stated they do not have gluten free gravy at facility, everyone today at noon meal got regular gravy mix on mashed potatoes. 2. According to the Minimum Data Set (MDS) dated 8/8/29 revealed Resident #15 had diagnoses which included seizure disorder, celiac disease, unspecified intellectual disabilities and Downs syndrome. The MDS revealed the resident required extensive assistance of 1 staff for bed mobility and personal hygiene and extensive assistance of 2 staff for transfers and toilet use. Review of the care plan dated 9/22/20 the resident has a potential for nutritional problems and directed the staff to serve the resident a gluten free diet as order, to monitor intake at every meal and requires staff assistance with eating. Observation on 9/14/20 at 11:45 a.m., the Cook plated the food for Resident #15, she placed one scoop of mash potatoes with one ladle of brown gravy on it, a scoop of peas. and a white container of fruit. The Cook did not put bread on	F 803		

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F 803	Continued From page 73	F 803		

the residents lunch tray.

Review of the Diet Type Report dated 9/14/20 indicated Resident #15 had an order for a regular consistency, gluten free diet with thin liquids.

Review of the 9/14/20 noon meal menu revealed gluten free diets are to receive gluten free hamburger steak, gluten free mashed potatoes with margarine, peas, gluten free bread with margarine, peaches, and milk.

During an interview with Staff CC-Dietary Aide on 9/14/20 at 12:26 p.m. stated they ran out of gluten free bread yesterday.

Observation on 9/15/20 at 11:50 a.m. the staff served the noon meal which consisted of tuna noodle casserole, that had cheese and crackers on the top. Staff J-CNA stated she got the same tuna noodle casserole as all other residents on A wing. Staff J assisted the resident with her lunch and reported the resident ate all of the offered tuna noodle casserole.

Review of the dietary menu spread sheet for 9/15/20 noon meal directed the staff to serve the gluten free diet residents, gluten free herb baked fish, broccoli, gluten free garlic toast, gluten free cake or fruit and 4 ounces of garlic butter noodles.

Observation on 9/15/20 at 1:45 p.m. Resident #15 had a large, incontinent liquid stool.

Observation on 9/29/20 at 12:28 p.m. revealed Staff M-CNA served Resident #15 her noon meal with consisted of a regular slice of white bread (not gluten free bread) and spinach casserole.

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CEDAR FALLS HEALTH CARE CENTER	1728 WEST EIGHTH STREET CEDAR FALLS, IA 50613

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F 803	Continued From page 74 The staff who assisted her to eat her noon meal stated she didn't give her the bread because it wasn't gluten free bread but she did eat all of the casserole served. Review of the recipe for the Spinach Au Gratin directs the cook for 48 servings to put in 1 pound of crushed crackers in the recipe along with spinach, cheese and margarine. During an interview with the FSS on 9/29/20 at 12:30 p.m. revealed the staff did serve the spinach casserole to Resident #15 for lunch.	F 803		
F 842 SS=D	Resident Records - Identifiable Information CFR(s): 483.20(f)(5), 483.70(i)(1)-(5) §483.20(f)(5) Resident-identifiable information. (i) A facility may not release information that is resident-identifiable to the public. (ii) The facility may release information that is resident-identifiable to an agent only in accordance with a contract under which the agent agrees not to use or disclose the information except to the extent the facility itself is permitted to do so. §483.70(i) Medical records. §483.70(i)(1) In accordance with accepted professional standards and practices, the facility must maintain medical records on each resident that are- (i) Complete; (ii) Accurately documented; (iii) Readily accessible; and (iv) Systematically organized §483.70(i)(2) The facility must keep confidential all information contained in the resident's records,	F 842	1. Resident #6 no longer resides at the facility. 2. An observational audit was completed on or before 12/20/2020 by DON or Designee to ensure meal intakes are monitored and documented. 3. The DON/Designee provided re-education to nursing staff on or before 10/20/2020 related to the requirements of recording meal intakes and completing documentation in the resident's medical record. The Dietary Manager provided re-education to dietary staff on 10/20/20 regarding calculating meal intakes and documentation requirements. 4. The DON, Dietary Manager or designee will complete audits weekly for 12 weeks to ensure meal intake documentation continues to be completed on paper and/or in PCC as required. Results of these audits will be taken to the QAPI meeting monthly for 3 months for review and recommendations as needed. The Director of Nursing and Dietary Manager is responsible for monitoring and follow up. Date of Compliance: 12/26/2020	12/26/2020

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F 842	Continued From page 75	F 842		

regardless of the form or storage method of the records, except when release is-
(i) To the individual, or their resident representative where permitted by applicable law;
(ii) Required by Law;
(iii) For treatment, payment, or health care operations, as permitted by and in compliance with 45 CFR 164.506;
(iv) For public health activities, reporting of abuse, neglect, or domestic violence, health oversight activities, judicial and administrative proceedings, law enforcement purposes, organ donation purposes, research purposes, or to coroners, medical examiners, funeral directors, and to avert a serious threat to health or safety as permitted by and in compliance with 45 CFR 164.512.

§483.70(i)(3) The facility must safeguard medical record information against loss, destruction, or unauthorized use.

§483.70(i)(4) Medical records must be retained for-
(i) The period of time required by State law; or
(ii) Five years from the date of discharge when there is no requirement in State law; or
(iii) For a minor, 3 years after a resident reaches legal age under State law.

§483.70(i)(5) The medical record must contain-
(i) Sufficient information to identify the resident;
(ii) A record of the resident's assessments;
(iii) The comprehensive plan of care and services provided;
(iv) The results of any preadmission screening and resident review evaluations and determinations conducted by the State;
(v) Physician's, nurse's, and other licensed

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F 842	Continued From page 76 professional's progress notes; and (vi) Laboratory, radiology and other diagnostic services reports as required under §483.50. This REQUIREMENT is not met as evidenced by: Based on clinical record review and staff interviews, the facility failed to ensure the resident record was complete and accurately documented for one of 1 of 4 residents reviewed (Resident #6). The facility reported a census of 61 residents. Findings include: 1. According to the MDS dated 2/27/2020, Resident #6 had severe cognitive impairment, failed to ambulate, transferred with extensive assistance of two staff and required extensive assistance of one staff for eating. The MDS revealed the resident had diagnoses including nutritional deficiency and dysphagia. The Care Plan identified the resident had a self feeding difficulty related to stroke and was totally dependent on others at meals. The Care Plan directed staff to provide a general diet and supervise and assist with eating. The Care Plan noted the resident's spouse spends most meals with resident, but if not available, staff to supervise and assist. The Care Plan also directed staff to monitor nutritional status quarterly and as needed, notify MD with change in condition, and staff to offer milk and juice at all meals when resident will accept. The March, 2020 Progress Notes included: 3/3/2020: Dietary Progress Note. Resident's weight is stable at 180 pounds.	F 842		

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F 842	Continued From page 77	F 842		

3/5/2020 - Seen by physician, new order for TSH (thyroid) next lab day.
3/9/2020 - Elevated value for TSH, 13.690, faxed physician, waiting response.
3/25/2020 - Staff V, RN documented at 4:28 p.m., resident noted to be lethargic, leaning to right side, unable to hold fluid in his/her mouth. Staff called a condition report to physician and received an order to send the resident to the ER for evaluation if family wishes.
3/25/2020 at 6:04 p.m., Resident #2 sent to emergency room for observation at 5:00 p.m..

The Emergency Department Notes dated 3/25/2020 included:

Resident presented with new right sided weakness and did not open their eyes. A report from the nursing home revealed the resident had been vomiting. The resident had a history of stroke and being non-verbal.

Labs results revealed the resident had hypernatremia (high sodium level), dehydration, and a urinary tract infection.

Documentation for Survey Report documented Amount Eaten: From 3/17 - 3/25/2020, meal intakes recorded 5 of 26 meals.

During an interview on 9/28/2020 at 2 o'clock p.m., Staff I, Administrator reported the resident's spouse came to the facility every day to assist the resident with eating until the facility put visitation restrictions in place due to Covid-19 on or about March 15th. The resident failed to drink as well for staff as they did for the spouse.

During an interview on 9/29/2020 at 10:20 a.m.,

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F 842	Continued From page 78 Staff U, CNA reported the resident's spouse came for three meals, almost every day. If they could not come, they would call to let them know and call to check on the resident. The resident took a lot of encouragement to drink, but did okay. During an interview on 9/29/2020 at 11:30 a.m., Staff V, RN verified working on March 25 and reported after the resident received a shower, Staff V attempted to give the resident their medications but the resident refused to open their mouth. The resident's spouse came every day to assist the resident until Covid-19 restrictions were put in place. Staff V could not recall any staff reporting the resident was not eating well. Staff V felt the resident missed their spouse. During an interview on 9/30/2020 at 10:50 a.m., Staff J, CNA reported the resident declined quickly after Covid restrictions were put in place. The resident had been refusing to eat or only taking small bites, although staff had encouraged the resident. Staff J recalled the resident never ate well when their spouse could not assist them and felt the resident had missed their spouse. She added staff were aware of the resident's refusal to eat. Staff J reported CNA's were responsible for documenting meal intakes in the electronic health record (Point Click Care).	F 842		
F 880 SS=E	Infection Prevention & Control CFR(s): 483.80(a)(1)(2)(4)(e)(f) §483.80 Infection Control The facility must establish and maintain an infection prevention and control program designed to provide a safe, sanitary and comfortable environment and to help prevent the	F 880	F 880 1. Staff # N, F, M have been re-educated on the requirements of wearing of PPE, staff #M has also been re-educated on how to discard soiled linen and hand washing by the DON/ Designee on or before 10/20/20. The soiled linens were removed from the floor and the floor was cleaned on 9/14/2020 by housekeeping staff. 2. An observational audit was completed by the DON/ADON on or before 10/23/2020 to evaluate any residents for signs of infection with physician updated as needed. 3. DON/Designee completed re-education for facility staff on or before 12/22/2020 regarding the requirements of infection control with focus on PPE, hand washing and linen handling. Facility staff viewed the following infection control videos on or before 12/22/2020; PPE lessons, Sparkling Surfaces, Clean Hands, and Keep COVID out. A root cause analysis was completed with the QIO on 12/21/2020. 4. DON/Designee will complete audits weekly for 4 weeks then monthly for 2 months to ensure staff continue to donning and doffing PPE as required to maintain infection control, removed of linen to maintain infection control and hand washing to decrease the risk of infection. Results of these audits will be taken to the facility QAPI meeting monthly for 3 months for review and recommendation as needed. The Director of Nursing is responsible for monitoring and follow-up. Compliance Date: 12/26/2020	12/26/2020

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F 880	Continued From page 79 development and transmission of communicable diseases and infections. §483.80(a) Infection prevention and control program. The facility must establish an infection prevention and control program (IPCP) that must include, at a minimum, the following elements: §483.80(a)(1) A system for preventing, identifying, reporting, investigating, and controlling infections and communicable diseases for all residents, staff, volunteers, visitors, and other individuals providing services under a contractual arrangement based upon the facility assessment conducted according to §483.70(e) and following accepted national standards; §483.80(a)(2) Written standards, policies, and procedures for the program, which must include, but are not limited to: (i) A system of surveillance designed to identify possible communicable diseases or infections before they can spread to other persons in the facility; (ii) When and to whom possible incidents of communicable disease or infections should be reported; (iii) Standard and transmission-based precautions to be followed to prevent spread of infections; (iv)When and how isolation should be used for a resident; including but not limited to: (A) The type and duration of the isolation, depending upon the infectious agent or organism involved, and (B) A requirement that the isolation should be the least restrictive possible for the resident under the circumstances.	F 880		

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F 880	Continued From page 80 (v) The circumstances under which the facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease; and (vi)The hand hygiene procedures to be followed by staff involved in direct resident contact. §483.80(a)(4) A system for recording incidents identified under the facility's IPCP and the corrective actions taken by the facility. §483.80(e) Linens. Personnel must handle, store, process, and transport linens so as to prevent the spread of infection. §483.80(f) Annual review. The facility will conduct an annual review of its IPCP and update their program, as necessary. This REQUIREMENT is not met as evidenced by: Based on clinical record review, staff and resident interviews, and observations the facility failed to follow recommended infection control practices to prevent the spread of COVID 19 for observations throughout the survey. The facility reported a census of 61 residents. Findings include: 1. Observation on 9/15/20 at 10:05 a.m., revealed Staff N, LPN on the COVID Isolation wing entered room 28 twice without wearing a gown or gloves as directed on the outside of the room. Observation of the signs on the outside of the door revealed the staff are required to wear a gown, gloves, mask and eye shield due to the	F 880		

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F 880	Continued From page 81 resident being in droplet isolation. During an interview on 9/16/20 at 8:55 a.m. Staff N confirmed she did enter room 28 twice yesterday without a gown on. She stated she didn't really know what the expectation for PPE was and acknowledged she didn't look at the signs on the room door. Staff N stated the aides wear full PPE when they go into a resident room on the isolation wing but the nurses do not when they are passing medications. Review of a written statement from the Regional Director of Operations dated 10/5/20 revealed the residents who live in Room 38 were to be in isolation until 9/16/20 due to exposure to a positive staff member. 2. Observation on 9/16/20 at 9:12 a.m. revealed Staff F, CNA accompanied a resident who resides in Room 34, on the Isolation Wing across the hall and into the shower room without a gown or gloves on. The resident who resides in room 34 had a sign on outside of her door that informed staff the residents inside the room are on droplet isolation and staff are required to wear gown, gloves, mask and shield. 3. Observation on 9/14/2020 at 11:50 A.M. revealed Resident #20 in bed with call light on and asked Staff O, RN (Registered Nurse) to send a CNA (Certified Nurse's Aide) to the room as they needed incontinence cares. Observation at 12:45 P.M. with the curtain partially closed and the room door open revealed Staff M, CNA with a gown, gloves, mask and shield in the resident's room providing cares. Staff M discarded the used and soiled linens on the floor without a barrier.	F 880		

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F 880	Continued From page 82 The facility reported Resident #20 resided in isolation. 4. Observation on 9/14/2020 at 12:08 P.M. revealed staff passing lunch trays on the A Wing. Staff M, CNA passed a tray to Room A-5 with gloves on, returned to the cart and passed another tray to Room A-6 without changing gloves. Staff M set up the tray and cut the meat for resident in room A-6 bed one. Staff M returned to the dietary cart and sanitized their hands and changed gloves. Staff M then passed a try to Room A-7 with gloves on and removed a dirty breakfast plate from the room. Without changing gloves, Staff M passed two plates to Room A-10 and removed the plastic wrap from Resident #18's plate prior to leaving the room. During an interview on 9/21/2020 at 11:46 a.m., Staff Q, RN, Infection Preventionist reported when staff pass lunch trays to residents in their room, staff should use hand sanitizer in between resident rooms and wash their hands with soap and water if they are visibly soiled. If they wear gloves, staff need to remove gloves in between passing each tray. During incontinence cares, staff should place used linens in a trash bag and remove the bag when finished. Staff Q indicated they planned to educate staff related to infection control and implement a process to watch CNA skills. On the isolation wing, all staff need to be in full PPE (Personal Protective Equipment) when providing cares. The facility infection control policy included: The facility strives to prevent transmission of infections and communicable disease, development of nosocomial infection, and effectively treat and manage nosocomial and	F 880		

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F 880	Continued From page 83 community acquired infections. The goal of the programs to identify and reduce the risks of acquiring and transmitting among residents/patients, employees, volunteers, and visitors. The program includes a system to monitor and investigate infection trends. The infection prevention program and control process is directed at lowering risk and improving trends and rates of significant infections. Prevention: standard and transmission based precautions including contact, droplet, and airborne. Personnel health, engineering and work practice controls and exposure control plans including tuberculosis and bloodstone pathogens.	F 880		
F 919 SS=E	Resident Call System CFR(s): 483.90(g)(2) §483.90(g) Resident Call System The facility must be adequately equipped to allow residents to call for staff assistance through a communication system which relays the call directly to a staff member or to a centralized staff work area. §483.90(g)(2) Toilet and bathing facilities. This REQUIREMENT is not met as evidenced by: Based on observation, record review and staff and resident interviews the facility failed to maintain a call system with all call lights functioning appropriately. Findings include: In an observation on 9/17/2020, Resident #3 in Room A-1 did not have a working call light but did have a bell near the bed and in the bathroom. The resident reported the call light had not	F 919	F 919 1. Resident #3 call light was repaired on 10/5/2020 by RDO and call light remains functional. 2. An Audit of call light function was completed by Administrator/Designee on 10/19/20 any identified lights were repaired at the time of the audit. 3. DON/Designee re-educated clinical staff on or before 10/20/2020 related to call lights requirements that include placement, function, and answering timely. Maintenance Manager was re-educated by the Administrator on 12/21/2020 related to the requirements of repairing of non-functioning call lights. 4. Administrator/Designee will complete audits weekly for 4 weeks then monthly for 2 months to ensure call light continue to function as required to meet resident's needs. Results of these audits will be taken to the facility QAPI meeting monthly for 3 months for review and recommendation as needed. The Administrator and Maintenance Director is responsible for monitoring and follow-up. Compliance date: 12/26/2020	12/26/2020

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F 919	Continued From page 84 worked for about a month and they had repeatedly asked to have it fixed. Staff tell the resident to put the call light on but it did not work. The resident received the bell to use in its place about a month prior. At times the resident had to go to the nurse's station to summon assistance. Resident #3 reported staff failed to respond to the call bell within 15 - 20 minutes at times, depending on how busy they were. On 9/17/2020 at 10:50 A.M., Staff R, Corporate Nurse performed an audit of the facility call lights and found four call lights that needed repair: Room A 1, A 6, B 21 and B 24. At 11:10 A.M., Staff H indicated the call lights were repaired by Staff D, Maintenance. During an interview on 9/17/2020 at 1:10 P.M., Staff D, Maintenance reported they found out today, 9/17/2020 that four call lights failed to function. Staff D reported all call lights had been repaired, and verified they did not perform call light audits.	F 919		