STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	165358	A. BUILDING _____ B. WING _____	04/06/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THOMAS REST HAVEN	217 MAIN STREET COON RAPIDS, IA 50058

(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: 4/29/22 The following deficiencies resulted from the facility's annual recertification survey and investigation of #94493-C, #99996-C, #94762-I, #97391-I, #101442-I, and #1013604-I conducted March 29, 2022 to April 6, 2022. Complaint #94493-C was substantiated Complaint #99996-C was substantiated. Facility reported incident #94762-I was substantiated. Facility reported incident #97391-I was substantiated. Facility reported incident #101442-I was substantiated. Facility reported incident #1013604-I was substantiated. See Code of Federal Regulations (42CFR) Part 483, Subpart B-C.	F 000		
F 550 SS=D	Resident Rights/Exercise of Rights CFR(s): 483.10(a)(1)(2)(b)(1)(2) §483.10(a) Resident Rights. The resident has a right to a dignified existence, self-determination, and communication with and access to persons and services inside and outside the facility, including those specified in this section. §483.10(a)(1) A facility must treat each resident with respect and dignity and care for each resident in a manner and in an environment that promotes maintenance or enhancement of his or her quality of life, recognizing each resident's individuality. The facility must protect and	F 550		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE: Administrator | (X6) DATE: 4/19/2022

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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F 550	Continued From page 1 promote the rights of the resident. §483.10(a)(2) The facility must provide equal access to quality care regardless of diagnosis, severity of condition, or payment source. A facility must establish and maintain identical policies and practices regarding transfer, discharge, and the provision of services under the State plan for all residents regardless of payment source. §483.10(b) Exercise of Rights. The resident has the right to exercise his or her rights as a resident of the facility and as a citizen or resident of the United States. §483.10(b)(1) The facility must ensure that the resident can exercise his or her rights without interference, coercion, discrimination, or reprisal from the facility. §483.10(b)(2) The resident has the right to be free of interference, coercion, discrimination, and reprisal from the facility in exercising his or her rights and to be supported by the facility in the exercise of his or her rights as required under this subpart. This REQUIREMENT is not met as evidenced by: Based on observation, record review, policy review, and staff interview the facility failed to treat each resident with respect and dignity for 3 of 15 (Residents #22, #191, and #192) residents reviewed. The facility reported a census of 42 residents. Findings include: 1. The Minimum Data Set (MDS) assessment for Resident #22 dated 2/17/22, included diagnoses	F 550		

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F 550	Continued From page 2 of heart failure, morbid obesity, left, and right foot drop. The MDS documented the resident needed extensive assist of 1 staff for locomotion, personal hygiene, bathing and extensive assist of 2 staff for bed mobility and transfers. A Brief Interview for Mental Status (BIMS) score of 13, indicating mild cognitive impairment for decision-making. During an observation on 3/31/22 at 10:17 AM, Staff B, Certified Nursing Assistant (CNA),was in the hallway with Resident #22 as the Director of Nursing (DON) was in the same hallway. Resident #22 was in a shower chair with a blanket wrapped around him, his lower legs and feet were exposed. As Staff B moved the shower chair, Resident #22's feet slid across the carpeted floor. Staff B proceeded to pull Resident #22, in the shower chair, backwards down Hall 300 and into the 200 Hall shower room, approximately 60 feet. During an interview on 3/31/22 at 10:22 AM, the DON confirmed she witnessed the observation and stated expectation for residents completely covered when transported to the shower room, not pulled backwards in the shower chair, and feet not rubbing against the floor. The facility policy labeled "Resident's Bill of Rights" revised 3/21, documented that the resident has the right to a dignified existence. The facility must treat each resident with respect, dignity, and care for each resident in a manner and in an environment that promotes maintenance or enhancement of his or her quality of life. 2) According to the MDS dated 10/6/21, Resident #192 had a BIMS score of 8, indicating moderate	F 550		

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F 550	Continued From page 3	F 550		

cognitive impairment. Resident #192 exhibited physical and verbal behavioral symptoms toward others for one to three days in the lookback period. Resident #192 rejected care for one to three times in the lookback period. Resident #192 required extensive assistance of two people for bed mobility and dressing. Resident #192 was totally dependent with help of two people for transfers and toilet use.

The Care Plan Focus dated 1/19/21 documented Resident #192 had self-care deficits as evidenced by her need for assistance activities of daily living (ADLs), mobility, and incontinence.

The Care Plan Focus dated 1/20/21 indicated that Resident #192 had episodes of behaviors as evidenced by combativeness, negative verbalizations, name calling, and resisting cares. The Focus included an intervention dated 1/20/21 directed staff to intervene as necessary to protect the rights and safety of others. The intervention indicated to approach the resident in a calm manner, divert her attention, and observe for early warning signs of agitation.

The Care Plan Focus dated 1/20/21 recorded that Resident #192 had impaired cognitive function and/or impaired thought processes as evidenced by short and long-term memory deficits, impaired decision making, and/or impaired ability to understand others. The Focus included the intervention dated 1/20/21 explaining that Resident #192 understood simple directives. The staff were to provide her with cues, stop, and return if or when she was agitated.

According to a self-report to the Department of Inspections and Appeals (DIA) dated 12/23/21 at

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F 550	Continued From page 4 4:27 PM, on 12/17/21 at 7:00 AM Staff C, CNA, was assisting Resident #192 with morning cares, Staff D, CNA, overheard Resident #192 call out "get this fat bitch away from me." Staff D reported that she heard Staff C respond to Resident #192 saying that "if you want to see what a bitch looks like I'll get you a fucking mirror." Staff D approach Staff C and told her to calm down and slow down while providing cares. On 4/4/22 at 11:28 AM, Staff D said that she remembered the incident when Staff C swore at Resident #192. Staff D said that she had worked with Staff C many times and she often swore at other staff in passing. On 4/5/22 at 7:57 AM Staff G, CNA, said that she worked with Staff C many times and she did swear often. On 4/4/22 at 3:11 PM Staff A, Licensed Practicing Nurse (LPN), said that she worked with Staff C many times and she had a "short fuse" and it didn't take much to get her upset. On 4/5/22 at 2:24 Staff C said she remembered the incident with Resident #192 and said that the resident was calling her names. She said that her response to Resident #192 was that she wasn't fat, but pregnant. Staff C said that the resident would call the staff names every day and every name in the book. Staff C explained that this was the only time that she had been disciplined for swearing and there weren't any other warnings related to disrespectful interactions with residents. The Performance Development Plan written by the DON on 3/3/20 for Staff C documented the	F 550		

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F 550	Continued From page 5	F 550		

date of performance issue for 2/12 and 2/19. On 2/12 documents that Staff C had reports of swearing, neglect, or lack of care to residents. On 2/19 documentation indicated that numerous staff complained of Staff C having inability to work with all staff and continued to have a lack of care to residents. The expectations/consequences explained that complaints continued to happen. The expectation was for employees to work as scheduled. The staff should perform duties as assigned without harm to residents and/or interruption in their daily lives. The plan indicated as the a written one was signed by Staff C on 3/9/20.

On 3/3/20, the DON notified Staff C in writing that the facility received numerous complaints by staff, families, and even resident involving inappropriate dress, inappropriate language, inappropriate use of time, and inability to complete all tasks as assigned. Multiple conversations occurred regarding the complaints. The DON documented her main concern was for the safety and care for the residents. The letter continued to direct that as of 3/3/20, Staff C remained in a probation like status until noted improvement in her work abilities and attendance was noted. The notification continued to inform that if continued issues occurred it could result in immediate termination.

On 6/12/20, a written notice completed by the DON notified Staff C of notice to terminate her employment due to frequency of absences.

On 6/12/20, written notice by the DON and Administrator indicated that Staff C reported a lifting restriction on 6/10/20. Staff C received notification to report her progress on her condition

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F 550	Continued From page 6 before 7/8/20. The Performance Development Plan dated 2021 marked as the Final Written indicated performance issues on 12/17/21 and 12/19/21. As Staff C helped a resident, the resident got upset as she felt Staff C rushed her. Resident #192 called Staff C a foul word "FB". Staff C's response to Resident #192 by telling her that she would get a mirror so she could see what a foul word "FB" looked like. The form indicated that was Dependent Adult Abuse and was unacceptable behavior. The Expectation was immediate and sustaining improvement in the following areas of resident safety a. Not rush the client b. Be gentle and caring c. Staff C must step away if the client pushed her beyond being able to control her words. The Exit Interview form dated 2/3/22 indicated that Staff C's last date worked was 12/19/21. The type of action indicated as discharged and termed on 2/3/22. The interviewer's comments and evaluation of reasons for departure recorded that Staff C was suspended on 11/21 for elder abuse. 3) According to the MDS dated 11/20/20, Resident #191 had a BIMS score of 3, indicating severe cognitive deficit. Resident #191's Mood indicated they felt short-tempered, easily annoyed nearly every day. Resident #191 exhibited physical and verbal behavioral symptoms daily in the lookback period. Resident #191 rejected care for four to six days in the lookback period. Resident #191 required extensive assistance of two people for transfers, walking, dressing and toilet use.	F 550		

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F 550	Continued From page 7 Resident #191's Care Plan Focus dated 10/16/20, documented they had physical behaviors towards others such as hitting, kicking, pushing, scratching and grabbing firmly. The Focus included the following interventions dated 10/16/20 a. Allow Resident #191 to have control over situations, if possible. Allow Resident #191 to make decisions, set schedules, set realistic goals, meet challenges, and participate in self-care. b. Convey an attitude of acceptance towards Resident #191. c. Maintain a calm environment and approach when interacting or providing care to Resident #191. d.. When Resident #191 became physically abusive, STOP, and try task later. Do not force him to do the task. The undated New Employee Record Checklist indicated that Staff F did their Dependent Adult Abuse Training on 2/20/20. The Employee Disciplinary Action dated 11/17/20 for Staff F, CNA, documented a suspension warning due to violation of company policies. The Description of Infraction indicated that Staff F was suspended pending the results of the DIA investigation. If the DIA determined no abuse occured to Resident #191, then Staff F would be allowed to return to work and would be compensated for her missed scheduled days. If Staff F was found guilty of abuse, she would then be terminated. Staff F's Letter of Suspension dated 11/17/20 signed by the Administrator documented that on 11/16/20 at 4:30 AM Staff E was assisting CNA	F 550		

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F 550	Continued From page 8 Staff F to change the bedding and clothing of Resident #191. While providing care, the resident became agitated and struck Staff F in the face. According to Staff E, Staff F became angry and retaliated against the resident by prying his clenched hand open, grabbing his pinky finger, and bending it back toward his wrist until he screamed. Staff E reported that Staff F then said that she wanted to beat the s**t out of him. Staff F was suspended pending investigation. Staff F continued to stand next to Resident #191 and tell him that he was an a**hole and a pain the a**. Once Staff E reported the incident they told the Administrator they never saw such evil. Staff E received notice that they would be suspended without pay until the completion of investigation from the DIA. The Exit Interview dated 2/3/22 for Staff F indiated not applicable for the last date worked. The type of action indicated discharged. The Interviewer's comments and evaluation for reasons for departure indicated suspended for elder abuse with a case open. Not willing to bring Staff F back as an employee due to the severity of the abuse case. The form recorded in termed 2/3/22. On 4/4/22 at 1:09 Staff E said that she worked with Staff F and remembered that one of the first nights that she had worked at the facility she was working with Staff F on an overnight shift. When Staff E asked about doing rounds to check and change residents, Staff F told her that they didn't do the changes until 4:00 AM. At around 4:30 AM they then went in to change Resident #191. He became agitated and was swinging his arms around. As he swung his arms he hit Staff F in the face. She got very upset and grabbed the	F 550		

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F 550	Continued From page 9 resident's hand. While holding Resident #191's hand, she pulled back his pinky finger so far that Resident #191 started to scream. Staff E said that it had been just the two of them in the hallway at that time and the nurse on duty did not hear or see the incident. On 4/5/22 at 11:37 AM, Staff H, Registered Nurse (RN), reported that she was the interim DON for a couple of months during the time of the incident with Resident #191. She had assessed the resident on 11/17/20 and didn't find any injury to his fingers. Staff H explained that she worked with Staff F on other occasions, and that she saw Staff F get verbally harsh and impatient with Resident #191. According to the facility policy titled: Nursing Facility Abuse Prevention, Identification, Investigation and Reporting Policy dated January 2022, all residents have the right to be free from abuse. The policy documented that verbal abuse could be considered to be a type of mental abuse and verbal abuse. Verbal abuse included the use of communication to a resident such as mocking, insulting, and ridiculing.	F 550		
F 644 SS=D	Coordination of PASARR and Assessments CFR(s): 483.20(e)(1)(2) §483.20(e) Coordination. A facility must coordinate assessments with the pre-admission screening and resident review (PASARR) program under Medicaid in subpart C of this part to the maximum extent practicable to avoid duplicative testing and effort. Coordination includes: §483.20(e)(1)Incorporating the recommendations	F 644		

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F 644	Continued From page 10 from the PASARR level II determination and the PASARR evaluation report into a resident's assessment, care planning, and transitions of care. §483.20(e)(2) Referring all level II residents and all residents with newly evident or possible serious mental disorder, intellectual disability, or a related condition for level II resident review upon a significant change in status assessment. This REQUIREMENT is not met as evidenced by: Based on observations, clinical record reviews, and staff interviews the facility failed to refer 1 of 1 residents (Resident #5) with a negative Level 1 result for the Preadmission Screening and Resident Review (PASRR), who later identified with a newly evident or possible serious mental disorder, intellectual disability, or other related condition to the appropriate state-designated authority for Level II PASRR evaluation and determination to ensure the resident received proper placement and services needed. The facility reported a census of 42 residents. Findings Include: The Minimum Data Set (MDS) assessment dated 1/21/22, for Resident #5, identified a Brief Interview for Mental Status (BIMS) score of 3, indicating severe cognitive impairment. The MDS identified verbal behavioral symptoms directed towards others for one to three days in the last 7 days. The behaviors significantly intruded on the privacy or activity of others. The MDS documented diagnoses that included: non-Alzheimer's dementia, depression, psychotic disorder, and unspecified dementia with behavioral disturbance. The MDS coded the	F 644		

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F 644	Continued From page 11 resident received antipsychotic and antidepressant medications for seven of seven days in the lookback period. The Care Plan revised 10/21/21, identified Resident #5 at risk for adverse effects due to use of psychotropic medication to aide with the treatment of dementia, depression, psychotic disorder, and major depression. The care plan interventions included: a. Alert the resident's physician of abnormal findings with medication use as indicated revised 8/16/21. b. Monitor, document, and report as needed any adverse reaction of the antipsychotic medication: unsteady gait, tardive dyskinesia, shuffling gait, rigid muscles, shaking, frequent falls, refusal to eat, difficulty swallowing, dry mouth, depression, suicidal ideations, social isolation, blurred vision, diarrhea, fatigue, insomnia, loss of appetite, weight loss, muscle cramps, nausea, vomiting, behavior symptoms not usual to the person dated 6/25/21. c. Observe for side effects of antidepressant medications: anorexia, anxiety, constipation, diarrhea, dizziness, dry mouth, headache, insomnia, nausea, pay special attention to increased risk of suicidal thinking, and behavior revised 8/16/21. d. Pharmacy review monthly and as indicated revised 8/16/21. The Care Plan revised 3/14/22, identified Resident #5 had episodes of behaviors or potential for behaviors as evidenced by negative verbalization, name calling, crying episodes, and attention seeking behavior such as throwing items. The care plan interventions revised 3/14/22 included:	F 644		

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F 644	Continued From page 12 a. Administer medications as ordered and monitor/document side effects and effectiveness b. Intervene as necessary to protect the rights and safety of others c. Approach/speak in a calm manner, divert attention, and remove from the situation d. Minimize potential for disruptive behaviors by offering tasks which divert attention e. Observe & chart behaviors, and report to the physician as indicated f. Observe for early warning signs of behavior: approach in a calm manner, call the resident by name, and remove unwanted stimuli g. Refer for psychological/psychiatric consult as indicated initiated on 6/24/21. Progress notes On 6/20/21 at 8:15 AM, the Behavior note (BN) recorded that the resident continued to be hyperfixated with hate and anger towards a Staff M, CNA (Certified Nurse's Assistant). Resident #5 reported that the Staff M took the resident out of the facility on days that Staff M didn't come to the facility and the resident was accounted for on all shifts. The facility staff encouraged the resident that she was safe and to decrease behaviors. Staff M did not provide cares to Resident #5. On 6/21/21 at 11:45 AM, the Health Status Note (HSN) documented that Resident #5 continued to fixate anger against Staff M. Staff M didn't provide cares to the resident and the resident continued to insist that Staff M took the resident out of the facility during the night. The resident was comforted and informed that she was safe. The Facility document titled Fax dated 6/24/21, documented by the MDS Coordinator that	F 644		

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F 644	Continued From page 13 Resident #5 had increased agitation and verbal aggression towards certain staff and resident in the last 2 weeks. Resident #5 fixated on things that didn't occur. The MDS Coordinator asked the primary care provider (PCP) if any medication changes would help with the behavior. The PCP responded with a diagnosis of dementia with delusions and ordered Seroquel 25 milligrams (mg) two times a day. On 6/24/21 at 7:37 PM, the HSN revealed Resident #5's PCP was in the facility for rounds. The PCP addressed the fax related to the resident's increased agitation and anger with delusions. Resident #5 received a diagnosis of dementia with delusions and new order for Seroquel 25 mg two times a day, then monitor her for tiredness and effectiveness. The Medication Administration Record (MAR) dated April 2022, revealed an order dated 6/25/21 for Seroquel (antipsychotic) 25 mg two times a day for psychotic disorder with delusions. The document titled Notice of Negative Level I Screen Outcome dated 6/3/15, recorded that no Level II Condition-Level I Negative. The rationale provided that Resident #5 had diagnoses of dementia, neurocognitive disorder, and mild situational depression. The resident didn't exhibit any signs or symptoms related to mental illness in the past six months. Resident #5 didn't have an inpatient psychiatric hospitalization, no recent psychiatric behavioral evaluation, or significant life disruptions due to mental health symptoms in the last 2 years. No intellectual disabilities or related conditions reported for Resident #5. Based on the information received, no Level 2 condition/Level 1 Negative approval given.	F 644		

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F 644	Continued From page 14 Should an exacerbation related to mental illness or a discrepancy in the reported information occur, a status change should be submitted for further evaluation. On 3/30/22 at 12:30 PM, the Director of Nursing (DON) verified Resident #5's PASRR dated 6/3/15 didn't contain a psychotic disorder. During a joint review with the DON related to Resident #5's order dated 6/24/21 for seroquel, the diagnosis of dementia with delusions, and the diagnosis dated 6/25/21 of psychotic disorder with delusions, the DON stated they were unaware of the need for a new PASRR as they were still learning. On 3/30/22 at 4:42 PM, the Social Service Designee (SSD) stated they were unaware of new and/or change in Resident #5's medications and/or any new diagnoses. The SSD stated they were involved with the new admission PASRR's but not with the change in status PASRR's. The SSD stated the facility needed to communicate with the team when changes occurred with the residents. The SSD added that the MDS Coordinator and the DON were also involved with PASRR's. During a follow up interview on 4/5/22 at 9:15 AM the DON remarked that they believed that the facility should complete a PASRR change in status for Resident #5, however, added they were still learning. The DON reported that they should have completed an updated PASRR with the new diagnosis. The DON remarked that it was one of those things that slipped through the cracks like many things.	F 644		
F 686 SS=D	Treatment/Svcs to Prevent/Heal Pressure Ulcer	F 686		

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F 686	Continued From page 15 CFR(s): 483.25(b)(1)(i)(ii) §483.25(b) Skin Integrity §483.25(b)(1) Pressure ulcers. Based on the comprehensive assessment of a resident, the facility must ensure that- (i) A resident receives care, consistent with professional standards of practice, to prevent pressure ulcers and does not develop pressure ulcers unless the individual's clinical condition demonstrates that they were unavoidable; and (ii) A resident with pressure ulcers receives necessary treatment and services, consistent with professional standards of practice, to promote healing, prevent infection and prevent new ulcers from developing. This REQUIREMENT is not met as evidenced by: Based on observations, clinical record review, and staff interview the facility failed to complete a thorough assessment of a pressure ulcer for 1 of 1 residents reviewed (Resident #29). Resident #29 admitted to the facility on 10/29/21 with a Stage 1 Pressure ulcer. The facility failed to notify the dietary department of a pressure ulcer at the time of Resident #29'a admission, failed to thoroughly complete a weekly assessment of the pressure ulcer that resulted in deterioration of the wound, and the facility failed to accurately complete a comprehensive care plan to include the identified pressure ulcer. The facility reported a census of 42 residents. Findings include: The Minimum Data Set (MDS) assessment for Resident #29, dated 11/9/21, identified a Brief Interview for Mental Status (BIMS) score of 15, indicating intact cognition (memory). The MDS	F 686		

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F 686	Continued From page 16 documented the resident required extensive physical assistance of 1 to 2 people for bed mobility, transfers, dressing, toilet use, and personal hygiene. The MDS coded that the resident was occasionally incontinent of urine. The MDS documented diagnoses of hypertension and arthritis. The MDS revealed that the resident had a 5% weight loss in the last 6 months. The MDS identified the resident had a pressure ulcer and was at risk of developing pressure ulcers. The MDS coded the resident admitted to the facility with a Stage 1 pressure ulcer. The MDS identified the resident had a pressure device for bed and chair, pressure ulcer care, and application of ointment/medications. The MDS assessment for Resident #29 dated 1/12/22, identified a BIMS score of 15, indicating intact cognition. The MDS documented that the resident required extensive physical assistance of 2 people for bed mobility, transfers, toilet use, personal hygiene, and dependent on one person for dressing. The MDS coded that the resident was occasionally incontinent of urine. The MDS documented diagnoses of hypertension, rheumatoid arthritis with rheumatoid factor multiple site, osteoarthritis, and arthritis. The MDS identified the resident had a pressure ulcer and at risk of developing pressure ulcers. The MDS coded the resident with a Stage 2 pressure ulcer. The MDS identified the resident had a pressure device for their bed, pressure device for their chair, received pressure ulcer care, nutritional interventions, hydration interventions to manage skin problems, application of non-surgical dressing, medications, and ointments. The MDS identified the following descriptions of	F 686		

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F 686	Continued From page 17 pressure ulcers: Stage I intact skin with non-blanchable redness of a localized area usually over a bony prominence. Darkly pigmented skin may not have a visible blanching; in dark skin tones only it may appear with persistent blue or purple hues. Stage II partial thickness loss of dermis presenting as a shallow open ulcer with a red or pink wound bed, without slough (moist dead tissue). May also present as an intact or open/ruptured blister. Stage III Full thickness tissue loss. Subcutaneous fat may be visible but bone, tendon or muscle is not exposed. Slough may be present but does not obscure the depth of tissue loss. May include undermining and tunneling. Stage IV full thickness tissue loss with exposed bone, tendon or muscle. Slough or eschar (black, dead tissue) may be present on some parts of the wound bed. Often includes undermining and tunneling. Unstageable ulcer, due to the inability to see the wound bed due to the coverage of slough and/or eschar. Deep Tissue Pressure Injury (DTPI): intact skin with localized persistent non-blanchable deep red, maroon, or purple discoloration due to the damage of underlying tissue. The area may be preceded by tissue that was painful, firm, mushy, boggy, warmer or cooler as compared to adjacent tissue. These changes often precede skin color changes and discoloration may appear differently in dark pigmented skin. This injury results from	F 686		

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F 686	Continued From page 18 intense and/or prolonged pressure and shear forces at the bone-muscle interface. Resident interview On 3/29/22 at 4:24 PM, during the initial tour, Resident #29 explained that she had an area on her bottom that required a daily dressing change. Resident #29 remarked that she believed the area healed and that the nursing staff checked it every day. Resident #29 confirmed that she had a cushion in her recliner. Resident's Representative interview On 3/29/22 at 4:59 PM, Resident #29's daughter confirmed the area to the resident's coccyx improved. Resident #29 stated that she was upset by the pressure area because she never had open areas when she lived at home. Observations On 3/30/22 at 9:45 AM, observation of Resident #29 with Staff I Registered Nurse (RN) revealed an increased red area to the right inner buttock with small chaffed (dry peeling skin) area without open areas. The red area size appeared approximately 2 cm x 1 cm. On 3/31/22 at 8:00 AM, an observation of Resident #29 showed her up in her recliner with the cushion in place, eating breakfast independently. Care Plan reviews Resident #29's Baseline Care Plan completed oon 10/31/21 revealed:	F 686		

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F 686	Continued From page 19 a. Cognition - alert/cognitively intact b. Dietary - regular diet and ensure (dietary supplement) daily c. ADL's (activities of daily living) - assist of 2+ (plus) people for bed mobility, transfer, and toilet use d. Bowel and Bladder - continent of bowel and incontinent/continent of bladder use of briefs or pads e. Skin concerns - current Stage 1 pressure ulcer to coccyx. Turn and reposition every 2 hours, cushion or wedge in their wheelchair, cushion or wedge in their recliner, treatment of soothe and cool (moisture barrier) to coccyx (very bottom portion of the spine). Resident #29's Care Plan initiated 2/28/22 revealed self-care deficits as evidenced by, they required assistance with ADL's and incontinence. The care plan interventions included: a. Bed mobility, assist of 1 b. Mobility, assist of 1 c. Positioning device: ½ side rail x 2 to assist with bed mobility, repositioning and promote independence. Resident #29 usually slept in their recliner and rarely slept in their bed. d. Transfer, assist of 2 people with a gait belt Resident #29's Care Plan initiated 2/28/22 revealed a potential risk for impaired skin integrity related to fragile, thin skin, urinary incontinence, friction and shearing potential. The care plan goal dated 12/7/21, documented no impaired skin integrity through next review date. The care plan interventions included: a. Encourage good nutrition and hydration to promote healthier skin b. Caution during transfers and bed mobility to prevent striking arms, legs, and hands against	F 686		

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F 686	Continued From page 20 sharp or hard surfaces c. Utilize pressure reduction equipment and procedures as indicated for preventative measures. Cushion to wheelchair, specialty mattress to bed as needed for skin integrity, turn and reposition. d. Weekly skin assessment by licensed nurse and report any negative findings to physician. Obtain orders for treatment as needed. Resident #29's Care Plan initiated 12/9/21 identified a nutritional risk due to limited use of arm, assistance with eating, tracheostomy, small stature, and body mass index (BMI, indicate healthy body weight) 19.2 (typically healthy weight 18.5-24.9). The care plan interventions included: a. Resident #29's family or the facility staff assisted them with eating until they could eat independently. b. Personal supplements per order c. Provide and serve diet as ordered. d. Monitor intake and record every meal e. Supplements per order Progress Notes reviews On 11/4/21 at 11:01 AM, the Admission Summary revealed the resident admitted to the facility for skilled care following gall bladder surgery and placement of a drainage system. The resident was alert and orientated to all three spheres (person, place, and time), dependent on one person for mobility, assist of two people for transfers, and required the assistance of one to two for ADL's. The resident was continent of bowel and bladder, however, wore incontinent products. Noted breakdown/fragile skin to coccyx area upon assessment.	F 686		

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F 686	Continued From page 21 On 11/4/21 at 8:46 PM, the Dietician's progress note recorded a weight of 90# (pounds) with a significant weight loss from their admission weight of 97#. Resident #29's weight at time of the Progress Note was similar to the previous February weight of 88#. Resident #29 was unable to reach her mouth due to arthritis. Ensure was appropriate for additional calories, protein, and fluids. No pressure related skin issues noted. On 11/29/21 at 1:01 PM, the Order Note indicated a new order received to discontinue soothe and cool then start to apply mepilex (foam dressing) on bath days and as needed. On 12/6/21 at 12:36 PM, the Skin Note revealed a Stage 1 pressure area to Resident #29's coccyx opened and measured 1 centimeter (cm) by (x) 0.5 cm. Resident #29's PCP (primary care provider) faxed to continue mepilex and dycem (non-slip product) applied to the recliner to prevent worsening of pressure wound due to the resident frequently sliding in the recliner. On 12/7/21 at 10:05 AM, the Order Note revealed a new order received to continue mepilex to their coccyx and dycem to recliner to prevent further shearing. On 12/9/21 at 11:33 AM, the Skin/Wound Note by the Dietician identified staff reported the resident had a stage 1 area on admission and progressed to a Stage 2 due to her small stature and sitting in her chair. The resident's family offered to bring in the resident's recliner from home, but the resident refused. Discussed if an Occupational Therapy consult would benefit. Resident #29 had a caloric supplement, no multivitamin. Multivitamin offered due to skin and Resident #29 considered the	F 686		

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F 686	Continued From page 22 order. On 12/15/21 at 3:00 PM, late entry the Health Status Note (HSN) revealed Resident #29's family would bring the resident's recliner from home. On 12/16/21 at 7:17 AM, the Psychosocial Note indicated the facility had a care conference on 12/15/21 with the family. Resident #29's daughter expressed concerned regarding an open area on Resident #29's coccyx. Resident #29 and her family believed that the cushion she used caused her to slide. The skin nurse would offer a different style of cushion and Resident #29's family would bring in her recliner from home. The staff would continue to monitor the area to Resident #29's coccyx closely. On 1/14/22 at 10:54 AM, the Skin/Wound Note by the Dietician revealed Resident #29 continued to have a pressure area. Resident #29 accepted 4 ounces (oz) of house supplement at 100 percent (%) daily and took various multivitamins. Resident #29 weighed 81# at the end of December and was eating independently per the documentation. Resident #29 ate in her room with her spouse. On 1/26/22 at 8:10 AM, the Order Note indicated Resident #29 had a Wound Consultant visit on 1/25/22. The Wound Consultant gave new orders to: cleanse wound with wound cleanser, mix one packet of collagen powder with 5 milliliters (ml) of anasept (wound gel to keep the wound moist to help with healing) gel, apply to Resident #29's wound bed, cover the area with a border foam dressing, and change daily. On 2/3/22 at 2:58 PM, the Skin/Wound Note	F 686		

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F 686	Continued From page 23	F 686		

documented by the Dietician identified Resident #29 continued to have a pressure area to her coccyx. The Dietician faxed Resident #29's PCP to request to increase her house supplement to twice daily. The Dietician indicated that Resident #29 didn't take a multivitamin and included in the fax to add an multivitamin daily.

On 2/24/22 at 8:21 AM, the Skin/Wound note indicated the Wound Consultant visited on 2/22/22 and gave no new orders.

On 3/3/22 at 3:42 PM, the Dietician Progress Note indicated the resident accepted the supplement twice per day and continued to take the multivitamin. Resident #29's pressure area noted to be improving.

On 3/10/22 at 9:55 AM, the Skin/Wound Note identified a complete body assessment to Resident #29. Resident #29's area to her coccyx showed improvement; the area observed to be light pink with no open areas.

On 3/24/22 at 3:40 PM, the Dietician Progress Note documented that Resident #29 recently returned from the hospital. Resident #29 reported that she was going to sleep in the bed which would help her skin and prevent swelling from returning in her legs.

On 3/25/22 at 7:24 AM, the Order Note revealed a new order for a dressing to Resident #29's coccyx

On 4/3/22 at 8:15 PM, the Admission Summary Note revealed an area to Resident #29's sacrum/coccyx area healed. Resident #29 continued to receive prophylactic treatment to the

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F 686	Continued From page 24 area. Clinical record review The Braden Scale for Predicting Pressure Ulcer Risk for Resident #29 dated 10/29/21 revealed: Score 16, at risk due to: slightly limited sensory perception, occasionally moist, chair fast, slightly limited mobility, friction and shear potential problem. Clinical Suggestions: wheelchair cushion, elevate heels off bed, pillows to position and off load pressure, position change at least every hour in wheelchair, turn and reposition every 2 hours in bed, encourage small frequent position changes, and educate resident/family regarding importance of position changes. The documents titled Wound/Skin Record, Pressure Injury for Resident #29 revealed: a. Date of onset 10/29/21, admission 1. Site A/Location: Coccyx, Stage 1 2. 3 cm x 4 cm 3. PCP faxed 4. Family aware b. On 11/3/21 1. Site A, Stage 1 2. 3 cm x 3.8 cm 3. No exudate (drainage) 4. No odor 5. Wound bed: epithelial 6. Surrounding skin color: normal 7. Surrounding tissue/wound edges: normal 8. Response to treatment: no change 9. Pain: no c. On 11/10/21 1. Site A, Stage 1 2. 3 cm x 3.6 cm	F 686		

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F 686	Continued From page 25 3. No exudate 4. No odor 5. Wound Bed: epithelial 6. Surrounding skin color: normal 7. Surrounding tissue/wound edges: normal 8. Response to treatment: improved 9. Pain: no d. On 11/30/21 1. Site A, Stage 1 2. 5 cm x 8 cm 3. Exudate: blank 4. Odor: blank 5. Wound bed: epithelial 6. Surrounding skin color: normal 7. Surrounding tissue/wound edges: normal 8. Response to treatment: deteriorated 9. Pain: no 10. Comments: new treatment, increased redness, physician and family notified e. On 12/6/21 1. Site A, Stage 2 2. 1 cm x 0.5 cm 3. Exudate: blank 4. Odor: blank 5. Wound bed: granulation 6. Surrounding skin color: pink 7. Surrounding tissue/wound edges: normal 8. Response to treatment: deterioration 9. Pain: no 10. Comments: faxed the PCP, dycem applied to recliner, physician, family, and dietary notified f. On 12/8/21 1. Site blank, Stage blank 2. 0.8 cm x 0.5 cm 3. Exudate: none 4. Odor: none	F 686		

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F 686	Continued From page 26 5. Wound bed: granulation 6. Surrounding skin color: pink 7. Surrounding tissue/wound edges: normal 8. Response to treatment: no change 9. Pain: yes, see flow sheet 10. Comments: painful to touch g. On 12/15/21 1. Site blank, Stage blank 2. 0.5 x 0.5 cm 3. Exudate: light 4. Odor: none 5. Wound bed: granulation 6. Surrounding skin color: pink 7. Surrounding tissue/wound edges: normal 8. Response to treatment: deteriorated 9. Pain: blank h. On 12/22/21 1. Site blank, Stage blank 2. 0.5 x 0.5 cm 3. Exudate: light 4. Odor: none 5. Wound bed: blank 6. Surrounding skin color: normal 7. Surrounding tissue/wound edges: normal 8. Response to treatment: improved 9. Pain: blank i. On 1/5/22 1. Site blank, Stage blank 2. 1 x 1 cm 3. Exudate: blank 4. Odor: blank 5. Wound bed: blank 6. Surrounding skin color: blank 7. Surrounding tissue/wound edges: blank 8. Response to treatment: blank 9. Pain: blank	F 686		

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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F 686	Continued From page 27 j. On 1/12/22 1. Site blank, Stage blank 2. 1 x 1 cm 3. Exudate: blank 4. Odor: blank 5. Wound bed: blank 6. Surrounding skin color: blank 7. Surrounding tissue/wound edges: blank 8. Response to treatment: blank 9. Pain: blank 10. Comments: smaller dressing k. On 1/25/22 1. Site blank, Stage: unstageable 2. 1.2 x 0.7 cm 3. Exudate: blank 4. Odor: blank 5. Wound bed: blank 6. Surrounding skin color: blank 7. Surrounding tissue/wound edges: blank 8. Response to treatment: blank 9. Pain: blank 10. Comments: wound consult l. On 2/2/22 1. Site blank, Stage blank 2. 1 x 1 cm 3. Exudate: blank 4. Odor: blank 5. Wound bed: blank 6. Surrounding skin color: blank 7. Surrounding tissue/wound edges: blank 8. Response to treatment: no change 9. Pain: blank m. On 2/9/22 1. Site blank, Stage blank 2. 1 x 0.5 cm	F 686		

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F 686	Continued From page 28 3. Exudate: blank 4. Odor: blank 5. Wound bed: blank 6. Surrounding skin color: blank 7. Surrounding tissue/wound edges: blank 8. Response to treatment: blank 9. Pain: blank n. On 2/22/22 1. Site blank, Stage blank 2. 0.4 x 0.3 x depth <0.2 cm 3. Exudate: blank 4. Odor: blank 5. Wound bed: blank 6. Surrounding skin color: blank 7. Surrounding tissue/wound edges: blank 8. Response to treatment: blank 9. Pain: blank 10. Comments: wound consult visit, no treatment change. Physician notified 2/24/22 and family 2/22/22 o. On 2/28/22 re-admit from the local hospital 1. Site blank, Stage blank 2. Exudate: blank 3. Odor: blank 4. Wound bed: blank 5. Surrounding skin color: blank 6. Surrounding tissue/wound edges: blank 7. Response to treatment: blank 8. Pain: blank 9. Comments: 1 x 0.3 cm p. On 3/2/23 1. Site blank, Stage blank 2. 1 x 0.3 cm 3. Exudate: blank 4. Odor: blank 5. Wound bed: blank	F 686		

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F 686	Continued From page 29 6. Surrounding skin color: blank 7. Surrounding tissue/wound edges: blank 8. Response to treatment: blank 9. Pain: blank 10. Comments: pink q. On 3/10/22 1. Site blank, Stage blank 2. 3 x 2 cm 3. Exudate: blank 4. Odor: blank 5. Wound bed: blank 6. Surrounding skin color: blank 7. Surrounding tissue/wound edges: blank 8. Response to treatment: blank 9. Pain: blank 10. Comments: pink, not open r. On 3/16/22 - no documentation, all blank s. On 3/22/22 1. Site blank, Stage blank 2. 2.5 x 1.5 cm 3. Exudate: blank 4. Odor: blank 5. Wound bed: blank 6. Surrounding skin color: blank 7. Surrounding tissue/wound edges: blank 8. Response to treatment: blank 9. Pain: blank 10. Comments: pink, not closed The facility documents titled Wound Care-Skin Integrity-Evaluation for Resident #29 revealed: a. On 1/25/22 1. Wound: Coccyx 2. Date of onset: 11/3/21 3. Exudate: moderate 4. Thickness: full thickness	F 686		

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F 686	Continued From page 30 5. Etiology: Pressure, unstageable 6. Size: 1.2 x 0.7 cm and depth unable to determine 7. Tunneling: none 8. Undermining: none 9. Drainage: serous 10. Wound bed: red 20%, pink/red; healthy granulation; yellow 80%, slough 11. Peri-wound/wound edges: intact/uninvolved tissues flush with wound base; edge epithelializing flush with wound base 12. Wound pain: rating 3 (1-10 scale); coccyx; acute wound pain 13. Treatment intervention: cleanse wound with cleanser of choice, mix 1 packet of collagen powder with 5 ml anasept gel, apply to wound bed, and cover with border foam dressing daily and as needed b. On 2/22/22 1. Wound: Coccyx 2. Date of onset: 11/3/21 3. Exudate: moderate 4. Thickness: full thickness 5. Etiology: Pressure, Stage 3 6. Size: 0.4 x 0.3 cm and depth <0.2 cm 7. Tunneling: none 8. Undermining: none 9. Drainage: serous 10. Wound bed: red 100%, pink/red; healthy granulation 11. Peri-wound/wound edges: intact/uninvolved tissues flush with wound base; edge epithelializing flush with wound base 12. Wound pain: rating 3 (1-10 scale); coccyx; acute wound pain 13. Treatment intervention: cleanse wound with cleanser of choice, mix 1 packet of collagen powder with 5 ml anasept gel, apply to wound	F 686		

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F 686	Continued From page 31 bed, and cover with border foam dressing daily and as needed Review of the clinical record revealed the facility failed notify the dietary department of the pressure upon the resident's admission to the facility on 10/29/21, until deterioration occurred on 12/6/21. The facility failed to complete a thorough assessment of the pressure ulcer weekly, which resulted in deterioration of the wound. The facility failed to accurately complete a comprehensive care plan to include the identified pressure ulcer. Director of Nursing (DON) Interviews On 3/31/22 at 1:25 PM, the DON stated the facility didn't have a policy or procedure related to pressure ulcers. During a follow-up interview on 4/5/22 at 9:19 AM, the DON stated the facility's guidance for pressure ulcers included; weekly assessment and if the wound didn't improve in two to three weeks to notify the physician. The DON added the facility didn't have a policy related to pressure ulcers. The DON explained that the facility implemented wound care visits for Resident #29 when the wound didn't healing. The DON said that the wound care visits occurred monthly to assist her with ensuring the correct treatment. The DON added that she expected the weekly assessment of the pressure ulcer to include: measurement and a full assessment. The DON stated she could not answer if dietary received notification of Resident #29's pressure ulcer at her admission to the facility. The DON reported that facility lacked a set defined guidelines on what the facility should do with a pressure ulcer. The DON commented that the facility would	F 686		

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F 686	Continued From page 32 implement a multivitamin. The DON stated that the facility conducted clinical meetings weekly on Thursdays and was unaware if they missed Resident #29's pressure ulcer. The DON remarked that she expected a thorough weekly skin assessment to be completed for all residents with pressure ulcers. During an additional follow-up interview on 4/5/22 at 11:47 AM, the DON reported not being able to locate the comprehensive care plan for Resident #29 between the Baseline Care Plan dated 10/31/21 and the Care Plan initiated on 12/7/21. The DON confirmed the Comprehensive Care Plan didn't include Resident #29's pressure ulcer. The DON explained the Care Plan only included the risk for pressure ulcers. The DON expected the Care Plan to include Resident #29's pressure ulcer. The DON confirmed the initiation of the Care Plan Focus Area on 2/28/22 related to the risk for pressure ulcers.	F 686		
F 689 SS=G	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 observations, clinical record reviews, and staff interviews, the facility failed to adequately supervise residents at risk for falls for 2 of 3 residents reviewed (Resident #190 and	F 689		

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F 689	Continued From page 33 #32). Resident #190 had a history of trying to get up by himself and not waiting for the staff to help him. Resident #190 required staff assistance of one with transfers. On 9/19/21, as a different resident walked by Resident #190's room, they noticed him on the floor. The other resident called for staff assistance. Once staff arrived they discovered Resident #190 lying on his left side complaining of pain to his left hip. Despite observing Resident #190 on his left side and complaining of pain to his left hip, three staff members assisted him off the floor and into his bed. After Resident #190 got into bed, the nurse noticed his hip appeared fractured. The nurse transferred Resident #190 to the hospital, where he received a diagnosis of a displaced mildly comminuted intertrochanteric fracture of his left femur (broken left hip). On the day of the fall, the staff witness reports documented that the last time the staff observed Resident #190 was while he ate at supper. One staff member reported they thought Resident #190 was independent with toileting. In interviews with the staff, a few staff members reported the resident showed increased confusion the week before his fall. Some of the staff reported that Resident #190 should be the first one helped after supper to prevent him from self-transferring. Resident #32 admitted to the facility on 4/21/21 following a fall at home resulting in a pelvic fracture. Resident #32's Baseline Care Plan indicated he had behavior concerns of getting up alone and safety concerns of a history of falls with a broken pelvis. Resident #32 required an assistance of one staff member with ambulation (walking). On 4/23/22, a Therapist discovered Resident #32 lying on his right side at 7:30 AM. At the time of assessment, Resident #32 complained of his right hip and groin hurting. Despite staff observing Resident	F 689		

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F 689	Continued From page 34 #32 laying on his right side and complaining of hip pain, the nurse and Certified Nurse Aide (C.N.A.) assisted him into his wheelchair. Resident #32 transferred to the hospital and had an X-Ray that revealed a right femoral neck fracture (right broken hip) with some displacement of the fracture fragments. The facility reported a census of 42 residents. Findings include: 1. Resident #190's Minimum Data Set (MDS) assessment dated 9/2/21, identified a Brief Interview for Mental Status (BIMS) score of 10, indicating moderate cognitive impairment. The MDS revealed that Resident #190 required limited physical assistance of one staff member for bed mobility and transfers. Resident #190 required physical assistance of one staff member for ambulation, dressing, toilet use, and personal hygiene. The MDS identified the resident's balance during transitions and walking, was not steady and he was only able to stabilize with staff assistance. The MDS indicated Resident #190 used a walker and wheelchair for mobility. The MDS documented diagnoses of orthostatic hypotension and non-Alzheimer's dementia. The MDS identified Resident #190 had a history of falls without injury. The Care Plan revised 9/10/21 identified Resident #190, as a risk for falls related to his impaired balance, poor safety awareness, neuromuscular, functional impairment, and/or his use of medication that could increase the risk of falls. The Care Plan interventions included: a. Date Initiated 9/21/21: Reminder signs posted in the resident's room to use a pendent and/or call light then wait for assistance.	F 689		

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F 689	Continued From page 35 b. Revision date 8/12/21: Call pendent used to ask for assistance whenever or wherever Resident #190 was located throughout the facility c. Revision date 8/12/21: Encourage the resident to ask for assistance from the staff d. Revision date 8/12/21: Encourage the resident to participate in activities that promote exercise, physical activity for strengthening, and improved mobility e. Revision date 8/12/21: Ensure the resident wore appropriate footwear when ambulating or using his wheelchair f. Initiated 1/23/29: Follow facility fall protocol g. Revised 8/12/21: Keep the resident's personal items; wheelchair, walker and call light within his reach h. Initiated 1/23/20: Monitor, document, report for 72-hours to the physician any signs or symptoms of pain, bruises, change in mental status, new onset of confusion, sleepiness, inability to maintain posture, or agitation. The Care Plan revised 9/10/21, identified Resident #190 had self-care deficit as evidenced by Resident #190 required assistance with his activities of daily living (ADL's), impaired balance during transitions, incontinence, and the need for assistance with walking. The Care Plan interventions included: a. Revision date 6/3/21: Ambulation: assist of 1 staff with use of forward wheeled walker (FWW) b. Revision date 8/12/21: Mobility: assist of 1. Staff to push Resident #190's wheelchair for long distances. Resident #190 could propel himself at times c. Revision date 6/3/21: Toilet use: assist of 1. Provide incontinence cares with each incontinent episode as the resident allowed d. Revision date 8/19/21: Transfer: assist of 1	F 689		

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F 689	Continued From page 36 with an FWW Resident #190's Care Plan revised 9/10/21 identified the resident had impaired cognitive function and/or impaired thought processes as evidenced by short-term memory deficit, long-term memory deficit, impaired decision making, and/or impaired ability to understand others. The Care Plan interventions included: a. Revision date 8/12/21: Communication: Face the resident when speaking, make eye contact, and reduce any distractions. The resident could understand consistent, simple, and direct sentences. Provide the resident with necessary cues, stop, and return if he becomes agitated. b. Revision date 8/12/21: Use task segmentation to support short-term memory deficits and break down tasks to one step at a time. The Progress Notes for Resident #190 revealed: On 9/9/21 at 10:24 AM, the Health Status Note (HSN) documented that the staff observed the resident wheeling himself in his wheelchair in the wrong direction, going towards his room. The staff noticed a change in the resident's cognition and the resident reported his memory felt worse. The resident required increased assistance from the staff. On 9/16/21 at 5:02 PM, the HSN recorded that the resident transferred himself to the bathroom independently and sustained a skin tear. On 9/20/21 at 12:32 AM, the Incident Note documented that at approximately 7:00 PM another resident found Resident #190 on the floor. Resident #190 laid at the foot of the bed with his back to the wall, with his legs crossed,	F 689		

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F 689	Continued From page 37 and he complained of left hip pain. Resident #190 said he attempted to go to bed and he observed a piece of paper on the floor. Resident #190 continued reporting that when he attempted to pick up the paper, his right foot slid, and he fell on his left hip. Resident #190 reported increased pain to his left hip. Three staff manually lifted Resident #190 and placed him in bed. Upon inspection, the left hip appeared fractured. Resident #190 was transported to the local Emergency Room (ER), at 8:30 PM the ER reported to the facility that Resident #190 went to surgery. The Fall Scale dated 9/1/21, identified Resident #190 at a high risk for falls with a score of 90. The score calculated from Resident #190's history of falls, more than one diagnosis, use of a walker, impaired gait (walk), and mental status. The Fall Investigation - Quality Improvement Document dated 9/19/21 at 7:00 PM recorded that Resident #190 attempted to self-transfer from his bed to his chair and his foot slipped. As Resident #190 fell, he landed on his left hip. The document questioned the following interventions a. Did the resident have an alarm - No alarm b. Was the resident's call light on - No c. Was the resident's call light within reach - yes d. Was the Care Plan followed - yes e. Was an assistive device being used - no f. Were there any environmental hazards present - Resident #190 had a box at the foot of his bed and he was trying to walk to his bed without assistance. The hospital Imaging Report dated 9/19/21 indicated Resident #190 had a displaced and mildly comminuted intertrochanteric fractured left	F 689		

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F 689	Continued From page 38 femur (bony areas on the femur where the thighbone attaches to the hip broke into multiple pieces). Written Statements The Written Statement dated 9/19/21 completed by Staff O, RN, documented that Resident #190 became more confused the week before and attempted to transfer by himself to bed. The documentation indicated that the floor wasn't wet, the resident had on clothes, and shoes. Staff O documented that the resident needed an alarm. The Written Statement dated 9/19/21 completed by Staff P, CMA (certified medication aide), documented Resident #190 was really confused lately. Staff P documented that the resident was confused lately, he did not and had not used his call light that was attached to his chair. Staff P documented that Resident #190 stood behind his wheelchair independently at 2:30 PM on 9/19/21. Staff P informed Resident #190 to use their call light. The Written Statement dated 9/19/21 completed by Staff Q, CNA, documented Resident #190 seemed more confused. Staff Q documented that the last time she saw the resident was at supper. Staff Q reported the last time Resident #190 used the toilet was before supper. The Written Statement dated 9/19/21 completed by Staff R, CNA, documented that Resident #190 seemed more confused throughout the day. Staff R documented last seeing Resident #190 at supper and he went to the toilet before supper. Staff interviews	F 689		

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F 689	Continued From page 39 On 4/4/22 at 9:36 AM, Staff J confirmed Resident #190 transferred himself to the bathroom on 9/16/21. Staff J denied knowing of any interventions put into place at that time to prevent falls. Staff J reported that at one time Resident #190 had an alarm. Staff J said she didn't know if the fall occurred during that time frame. Staff J stated eventually the facility did implement alarms for Resident #190. On 4/4/22 at 9:57 AM, Staff K reported that she was unsure if Resident #190 was independent at the time of his fall on 9/19/21. Staff K stated Resident #190 required assistance with staff for care, but she believed he ambulated himself to the bathroom. Staff K explained that the nursing staff checked on the resident regularly and the resident used his call light. Staff K said that Resident #190 would turn on his call light in the morning when he was ready to get up. Staff K reported if there were any changes with Resident #190, it would be communicated in the CNA binder at the nurse's station. Staff K stated they did not know if any additional interventions were implemented related to the resident's increased confusion. Staff K stated Resident #190 was intelligent and would outwit the staff. Staff K reported that she felt all the staff checked on the resident frequently to see if he needed assistance. Staff K remarked that they didn't work at the time of the fall on 9/19/21. On 4/4/22 at 11:15 AM, the MDS Coordinator explained that communication with the CNA's and nurses occurred between shifts if a resident had a change in condition. The MDS Coordinator added that an intervention was implemented for Resident #190. They put a sign on Resident	F 689		

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THOMAS REST HAVEN	217 MAIN STREET COON RAPIDS, IA 50058

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F 689	Continued From page 40 #190's wall and a sign on his walker. The MDS Coordinator denied knowing of additional interventions put in place to prevent falls. The MDS Coordinator stated after supper, Resident #190 would propel himself to his room. If the staff saw the resident, they were to encourage him to stay in the main lobby. The MDS Coordinator reported that the resident required assistance with toilet use, transfers, and personal hygiene at time of the fall. On 4/4/22 at 11:35 AM, Staff J commented that she reviewed Resident #190's Care Plan from 9/16-9/19/21. During that time frame no additional interventions were added related to the resident getting up without assistance and/or related to his increased confusion. Staff J remarked that August 2021 was the last time Resident #190's fall interventions were revised. On 4/4/22 at 12:59 PM Staff L stated Resident #190 preferred to stay up late. Staff L stated Resident #190's routine after supper was to go to the recliner. Staff L said Resident #190 was one of the last residents to go to bed, at around 10:00 PM. Staff L reported that Resident #190 had a history of getting up without assistance. The facility put signs in his room to use his call light and to ask for help. One sign was placed on his walker and another on the wall beside his bed. Staff L explained they didn't recall when the signs were placed. Staff L remarked that the current DON and Administrator investigated Resident #190's fall on 9/19/21. Staff L stated the resident had been hallucinating and had an alarm placed, but didn't know when it was placed. Staff L added that the resident had incontinent issues and saw a mental health provider with numerous medication changes all at once due to his	F 689		

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F 689	Continued From page 41 cognitive issues. Staff L commented notifying a change in resident's condition to the CNA's by report and/or the communication binder. On 4/4/22 at 2:51 PM Staff B, CNA, stated Resident #190 had increased difficulty with transfers and required increased assistance from staff. Staff B didn't remember if Resident #190 ever got up without waiting for assistance. On 4/4/22 at 3:15 PM, Staff S, CNA, reported that at times Resident #190 transferred himself without using his call light or without waiting for assistance from the staff. Staff S said that Resident #190 got a personal alarm after he fell and broke his hip. Staff S added that right after supper Resident #190 was transferred right away to the recliner in his room. Staff S wasn't sure what happened the night of his fall, as she didn't work that night. If the facility was short staffed, they would leave Resident #190 in the living room. If Resident #190 was left in the living room he would take himself to his room and attempt to self-transfer. Staff S said that the resident would stay in the recliner and then turn the light on when he was ready for bed. Staff S commented that the resident became more confused before his fall on 9/19/21, she didn't know if additional interventions were put into place. Staff S remarked that before his fall on 9/19/21, Resident #190 couldn't alert staff of the need to use the bathroom, because he wasn't aware of the need to go. On 4/4/22 at 4:19 PM Staff M reported that Resident #190 was very forgetful and didn't use the call light or wait for assistance from the staff. Staff M stated that Resident #190 had alarms in place, a note by his bed, and a note on his walker to remind him to ask for help.	F 689		

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F 689	Continued From page 42 On 4/5/22 at 7:37 AM Staff T, CNA, reported that Resident #190 had alarms in place before his fall on 9/19/21, but they weren't enforced. Staff T explained that the resident didn't always have the alarms in place, and they weren't used consistently. Staff T added that after supper Resident #190 was the first one done and he would take himself in his wheelchair half-way to his room. Staff T added that the staff would assist Resident #190 to his room, help him to the bathroom, and assist him into the recliner. Staff T commented that the resident used a call pendant or the staff would stop in his room between 6:45 PM and 7:00 PM to see what time Resident #190 wanted to go to bed. Staff T explained that Resident #190 went to bed later, as he was one of the last ones. Staff T said that Resident #190 would not tell the staff when he needed to use the bathroom, as he didn't know. Staff T stated she would check on Resident #190 every 2 hours and offer him the bathroom, but he was incontinent. Staff T said Resident #190 always attempted to self-transfer and didn't wait for assistance from the staff. On 4/5/22 at 7:44 AM, Staff U, CNA, recalled Resident #190's fall and hip fracture, but said she wasn't working at the time. Staff U stated the resident became more unsteady and had a long history of not waiting for staff's help. Staff U reported that if Resident #190 had a wheelchair or walker in reach he would attempt to self-transfer. Staff U reported that it wasn't uncommon for Resident #190 to get up with his walker and go. Staff U stated that once staff took Resident #190 to his room, they knew he needed assistance with the bathroom. After he used the bathroom, the staff assisted Resident #190 to the	F 689		

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F 689	Continued From page 43 recliner so he wouldn't transfer himself. Staff U remarked that she knew the resident would transfer himself if he went to his room without staff. On 4/5/22 at 7:56 AM Staff V, CNA, said Resident #190 self-transferred all the time. Staff V reported that she found the resident taking himself to the bathroom at night. Staff V explained that at times the resident used the call light, but he usually got up by himself and went to the bathroom. On 4/5/22 at 9:33 AM, the DON reported that the Resident #190 started to use an alarm after his fall on 9/19/21. The DON stated that she discussed with the staff the need to take the resident back to his room and transfer him right away after meals to his recliner. The DON denied documentation of that, but reported that she did have a discussion to take Resident #190 to his room after meals and transfer him to his recliner. The DON stated Resident #190 propelled himself independently in his wheelchair to his room after meals. The DON denied knowing what Resident #190 did after supper on the night of his fall. The DON stated Resident #190 was incontinent of urine, but didn't know if he had a toileting program, the staff did go in more frequently to assist and encourage Resident #190 to use the toilet. The DON added that the resident would deny the need of assistance from the staff. After his fracture, he required total assistance from the staff. The DON discussed the resident's changes and reminded the CNA's to assist the resident, but denied documentation of the education. The DON reported that the CNA's didn't always read the communication book and a lot of the communication occurred by word of mouth.	F 689		

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F 689	Continued From page 44 On 4/5/22 at 10:28 AM Staff W, CNA, stated that the resident had a history of not waiting for staff to assist him with transfers. Staff W added that the resident got up a ton without staff assistance. Staff W reported that the resident did not use his call light and would just get up without help. Staff W declared that Resident #190 was incontinent of urine. Staff W explained that when Resident #190 became incontinent he knew and attempted to take himself to the bathroom. Staff W reported that she usually helped him after meals. Staff W explained that she would assist the resident to his room and transfer him to the recliner after helping him in the bathroom if needed, but didn't think she worked the night of his fall. Staff W remarked that Resident #190 was a fall risk, so she checked him a couple of times. Staff W stated that the resident preferred to go to bed later, and liked to stay up in his recliner. 2. Resident #32's MDS assessment dated 5/19/21, identified a BIMS score of 12, indicating moderately impaired cognition. The MDS revealed the resident required limited physical assistance of one to two staff for bed mobility, transfers, ambulation, toilet use, and personal hygiene. The MDS coded the resident's balance during transitions and walking as not steady and only able to stabilize with staff assistance. The MDS documented diagnoses of hypertension, vertigo (dizziness), and ataxia (impaired balance). The MDS identified that the resident had a fall in the last month prior to his admission to the facility and one fall with a major injury since admission to the facility. Resident interview On 3/29/22 at 12:45 PM, during the initial tour,	F 689		

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F 689	Continued From page 45 observed Resident #32, well-groomed, in his recliner. Resident #32 explained that he attempted to go home the week before on his birthday, just a few weeks ago. Resident #32 explained that it didn't work out because he fell and broke his ribs. After that he came back to the facility. Resident #32 stated that he required assistance from the staff to get up with his walker. An observation showed a urinal in a bucket beside the recliner. Resident #32 explained that he previously fell and got a fracture while at the nursing home, however, he wasn't able to recall the specifics due the length of time that passed. The Baseline Care Plan with an admission date of 4/21/21, identified Resident #32: a. Cognition - alert/cognitively intact b. History of falls - history of a fall resulting in a broken pelvis c. Behavior concern - Resident #32 does get up alone d. Assist of one with bed mobility, transfer, walking, toilet use, and locomotion e. History of falls with injury Progress Notes review On 4/21/21 at 3:41 PM, the Admission Summary identified Resident #32 admitted to the facility from the local hospital. At the time of admission Resident #32 noted to be alert and oriented x 3 (person, place, and time), in good spirits, and accepting of his placement for skilled services. The resident identified with a history of falls and a bed alarm while in the hospital during the night. The resident had vertigo at times and required assistance of 1 with a forward wheeled walker. Resident #32 received orientation to the facility,	F 689		

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F 689	Continued From page 46 room, call light, and meal time. On 4/22/21 at 3:06 PM, the Skilled Evaluation identified that Resident #32 obeyed commands and alert and oriented x 3. Resident #32 displayed a pleasant mood without behaviors. On 4/23/21 at 1:20 PM, the Health Status Note (HSN) documented that the aide heard Resident #32, then found him on the floor in the bathroom. Resident #32 denied hitting his head but did complain of pain to his right hip. The head-to-toe assessment revealed no shortening or rotation of his right leg. The staff assisted Resident #32 to his wheelchair with an assistance of three. Resident #32 did not apply pressure to his right leg. The staff notified the son and sent Resident #32 to the local emergency room. On 4/24/21 at 4:12 PM, the HSN revealed that the resident had surgery for a right hip repair. Clinical record review The Fall Investigation - Quality Improvement Document dated 4/23/21, no time, completed by Staff Y, Licensed Practical Nurse (LPN) identified Resident #32 fell in the bathroom. Resident #32 reported that he just fell. The following interventions were reviewed and answered by Staff Y a. Did Resident #32 have a personal alarm, chair alarm, or bed alarm? If Resident #32 used any type of alarm, was it on and functioning? - not applicable b. Was Resident #32's call light on - no c. Was Resident #32's call light in reach of resident - no d. Was Resident #32's Care Plan followed - yes	F 689		

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F 689	Continued From page 47 e. Was an assistive device in use - yes f. Was there any environmental hazards present - no The undated Facility Investigation identified a Therapist found Resident #32 on the floor in the bathroom on 4/23/21 at 7:30 AM. The Therapist observed the call light on and notified the nursing personnel immediately of Resident #32's fall. The Rehab Communications dated 4/23/21 indicaed Resident #32 requires staff assistance of one staff with transfers and gait with FWW to patient's tolerance or two to three times daily. The Occupational Therapy Plan of Care dated 4/21/22 documented precautions of a fall risk. Resident #32 required supervision or touching assistance, helper provides verbal cues and/or touching/steadying for mobility toilet transfer. Assistance may be provided throughout the activity or intemittently. The Emergency Room's X-Ray report dated 4/23/21 at 11:36 AM revealed Resident #32 had a right femoral neck (a hip fracture involving the thigh bone just below the ball-and-socket hip joint) fracture. Staff Interviews On 4/4/22 at 9:23 AM Staff J, Registered Nurse (RN), confirmed the Baseline Care Plan contained only an admission date of 4/21/21 with undated interventions. Staff J reported the facility implemented a checklist for Baseline Care Plans completed in the resident's electronic health record (EHR). The facility started to use a Baseline Care Plan on the computer, which made	F 689		

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F 689	Continued From page 48 it consistent for all staff and dated. Staff J stated that when the Baseline Care Plan was completed on paper, it was a hot mess. Staff J reported the facility nurses were instructed on how to implement fall interventions in the resident's EHR. Staff J remarked that the nurses however, documented the intervention in the resident's progress notes and the MDS nurse added the intervention to the resident's Care Plan in the EHR. Staff J said that when the nurse admits a resident to the facility, they complete the Admit Screener and initiate a Baseline Care Plan, then the Certified Nurse's Aides (CNA) were able to access the Care Plan interventions through the Kardex in the EHR. Staff J explained that with new admissions to the facility, a document titled Admission Care Plan was placed in the CNA's communication book to make the CNA's aware of the new resident needs. Staff J reported being unaware of the fall interventions in place for Resident #32 at the time of his admission on 4/21/21. Staff J reported being unaware of the length of time Resident #32's call light was on before therapy found him on the floor on 4/23/21. Staff J remarked they were unaware if Resident #32 preferred to get up early. Staff J commented that Resident #32 wasn't much of a breakfast person, however, it was possible he was at the time of the fall. On 4/4/22 at 11:10 AM, the MDS Coordinator confirmed that she couldn't determine the dates of interventions on Resident #32's Baseline Care Plan. The MDS Coordinator stated with each new resident's admission a document that provided the information for care was placed in the CNA's binder at the nurse's station. The MDS Coordinator denied knowing how long Resident #32's call light was on before therapy found him	F 689		

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F 689	Continued From page 49 on the floor on 4/23/21. The MDS coordinator remarked that due to Resident #32's admission on 4/21/21, the facility staff didn't know the resident's routine, and if he preferred to get up early. The MDS Coordinator added that when Resident #32 returned to the facility on 4/26/21, the Baseline Care Plan received updated interventions for the admission date of 4/21/21. The MDS Coordinator confirmed that the facility should have dated the new interventions. On 4/4/22 at 11:30 AM, Staff J stated the CNA received the undated document titled Admission Care plan, at the time of Resident #32's admission on 4/21/21. On 4/4/22 at 12:54 PM, Staff L, RN (the former Director of Nursing, DON), stated at the time of Resident #32's admission to the facility on 4/21/21, he was alert and oriented x 3. Staff L stated Resident #32 turned on his call light, but didn't wait for staff to assist him to the bathroom. Staff L remarked that Resident #32 told the MDS Coordinator that he thought he could make it to the bathroom by himself and that he should have waited for assistance. Staff L explained that the call light record checked at the time of the fall, showed the call light wasn't on even five minutes. Staff L denied knowing when the report had been printed out. Staff L stated that the CNA's headed to Resident #32's room first thing due to the call light being on. Resident #32 was one of the first residents to get up in the mornings per his preference. Staff L stated Resident #32 used his call light; but he just didn't wait for staff assistance. Staff L denied knowing that Resident #32 got up without assistance before the fall. Staff L denied knowing if Resident #32 was incontinent at the time of the fall.	F 689		

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F 689	Continued From page 50 On 4/4/22 at 4:19 PM, Staff M, CNA, said that when Resident #32 first admitted to the facility on 4/21/21, he was confused and required staff assistance from one person. Staff M stated that the nursing staff reminded the resident to use his call light. Staff M stated she believed Resident #32 had an alarm in place due to a band on his wrist from the hospital, indicating a fall risk. Staff M stated Resident #32 used a urinal beside his recliner and he was continent of urine. On 4/5/22 at 9:27 AM, the DON didn't know how long Resident #32's call light was on at the time of the fall on 4/23/21. The DON denied knowing when therapy completed the screening evaluation for Resident #32. The DON reported that the nurse who completed the Admission Assessment, completed the Admission Care Plan sheet provided to the CNAs. The staff attempted to do a small huddle to review the new admission, however, it didn't always happen. The DON added she implemented starting the Baseline Care Plan in the resident's EHR, connecting it to the CNA's tasks for the new resident.	F 689		
F 761 SS=E	Label/Store Drugs and Biologicals CFR(s): 483.45(g)(h)(1)(2) §483.45(g) Labeling of Drugs and Biologicals Drugs and biologicals used in the facility must be labeled in accordance with currently accepted professional principles, and include the appropriate accessory and cautionary instructions, and the expiration date when applicable. §483.45(h) Storage of Drugs and Biologicals	F 761		

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F 761	Continued From page 51 §483.45(h)(1) In accordance with State and Federal laws, the facility must store all drugs and biologicals in locked compartments under proper temperature controls, and permit only authorized personnel to have access to the keys. §483.45(h)(2) The facility must provide separately locked, permanently affixed compartments for storage of controlled drugs listed in Schedule II of the Comprehensive Drug Abuse Prevention and Control Act of 1976 and other drugs subject to abuse, except when the facility uses single unit package drug distribution systems in which the quantity stored is minimal and a missing dose can be readily detected. This REQUIREMENT is not met as evidenced by: Based on clinical record review, observations, facility policy review, and staff interviews the facility failed to ensure drugs used in the facility were stored in accordance with the currently accepted professional principles. The facility failed to keep the medication cart locked while not in the direct line of site by the licensed nurse. The facility reported a census of 42 residents. Findings include: During an observation on 3/29/22 at 12:11 PM, observed the North Medication Cart unlocked without nursing staff in the direct line of site. Staff A, Licensed Practical Nurse (LPN), left the medication cart and proceeded into the dining room. At 12:12 PM, Staff A returned to the medication cart. During an observation on 3/31/22 at 7:39 AM, observed the North Medication Cart located at the top of the 300 hall by room 302 unlocked. At time	F 761		

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THOMAS REST HAVEN	217 MAIN STREET COON RAPIDS, IA 50058

(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 761	Continued From page 52 of observation, no nursing staff were present at the medication cart. Staff A found in room 301 without a direct line of site to the medication cart. The Housekeeper came in and out of room 300. Resident #17 with a BIMS (Brief Interview for Mental Status) score of 6, indicating severe cognitive impairment; ambulated independently past the cart to the end of the hallway. At 7:42 AM the Director of Nursing approached and confirmed that the medication cart was unlocked without nursing staff present. The facility document titled Resident Daily Living Vital Info dated 3/29/22, identified 6 current residents with a wanderguard in place and a high risk for elopement. On 4/5/22 at 9:11 AM, the Director of Nursing stated she expected the medication carts to be locked when the nurse wasn't present and the computer screen to be locked. The DON reported that the facility did not have a policy in place related to the medication cart being locked when unattended.	F 761		
F 880 SS=D	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 development and transmission of communicable diseases and infections. §483.80(a) Infection prevention and control program. The facility must establish an infection prevention	F 880		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	165358	A. BUILDING _____ B. WING _____	04/06/2022

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F 880	Continued From page 53 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. (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	F 880		

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F 880	Continued From page 54 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 observations, clinical record reviews, staff interview, and facility policy review, the facility failed to use appropriate infection control standards of practice by not changing oxygen tubing and a nebulizer mask for 2 of 3 residents (Residents #23 and #27) reviewed. The facility reported a census of 42 residents. Findings include: 1. Resident #23's Minimum Data Set (MDS) assessment dated 2/21/22 included a diagnosis of Alzheimer's disease. The MDS included a Brief Interview for Mental Status (BIMS) score of 4, indicating severe cognitive (memory) impairment. The MDS documented that the resident received oxygen therapy while a resident in the fourteen day lookback period. During an observation on 3/29/22 at 2:48 P.M., observed Resident #23 in bed with oxygen (O2) administered per nasal cannula (NC), with no date on the O2 tubing. A bag hanged from the O2	F 880		

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F 880	Continued From page 55 concentrator with the date of 3/11/22. Resident #23's Order Summary Report indicating active orders as of 3/30/22 included the following orders dated 2/10/22 for a. O2 at two liters (L) two times a day. b. Change and date the O2 tubing and nasal cannula weekly and as needed (PRN). Clean the filter every Wednesday night shift and label with date and initials. Resident #23's Treatment Administration Records (TAR) dated 3/1/22 - 3/31/22, lacked documentation of the O2 tubing change completed on the scheduled days of 3/2, 3/9, 3/16, and 3/23/22. 2. Resident #27's MDS assessment dated 2/28/22 included diagnoses of pneumonia and Pulmonary Fibrosis (damaged and scarred lung tissue). The MDS included a Brief Interview for Mental Status score of 15, indicating intact cognition. The MDS documented the resident received oxygen therapy while a resident during the fourteen day lookback period. During an observation on 3/29/22 at 12:41 PM, Resident #27 sat in his recliner with O2 administered per NC. The O2 tubing lacked a date and the date on the nebulizer mask was 3/19/22. Resident #27's Order Summary Report indicated the active orders as of 3/30/22 included the following orders dated 2/16/22 for a. O2 at 1 L by NC continuously. b. Levalbuterol HCl Nebulization Solution 1.25 milligrams (MG) by (/) 3 milliliters (ML). Resident #27 to inhale medication by nebulizer three times	F 880		

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F 880	Continued From page 56 a day related to pulmonary fibrosis. The Order Summary Report lacked documentation of an order to change the oxygen tubing and/or the nebulizer mask. Resident #27's TAR dated 3/1/202- 3/31/22, lacked documentation of an order to change the oxygen tubing and/or the nebulizer mask. The Respiratory Equipment Cleaning Procedure revised 3/17/20, documented that O2 tubing, nasal cannula/mask would be changed weekly. During an interview on 3/30/22 at 3:15 PM, the Director of Nursing stated her expectation for the changing of the O2 tubing and nebulizer mask should be done weekly. Once changed it should be labeled with a date, initials, and documented on the TAR.	F 880		

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This plan of correction constitutes Thomas Rest Haven's commitment to compliance. Preparation and implementation of the plan of correction should not be construed as an admission of the deficiencies cited. The plan of correction is prepared solely because it is required under federal or state law. Thomas Rest Haven continues to meet the applicable provisions of the State and Federal regulations.

F550 Dignity POC Date 04/29/22

1. Resident #22 New shower chair ordered with footrest.
2. Resident #191 No longer resident at the facility
3. Resident #192 No longer resident at the facility
4. New privacy drape was ordered on 04/22/22and en route to ensure dignity is provided during transfers to the shower.
5. Staff # B Educated on 4/26/22 regarding dignity while taking residents to the shower room.
6. Nursing staff was re-educated on: 4/12/22, 04/22/22, 04/25/22, 04/26/22 on the importance of maintaining dignity and respect for residents during care and encounters. Educated staff to transfer residents in the shower room. If unable to transfer to the shower room, residents should be covered to provide dignity while traveling through the halls.
7. Audits will be completed weekly x3 weeks and then PRN to ensure privacy drape is used during transfers to shower. Any areas of concern to be addressed through the quality assurance process improvement process. Staff education forms will be provided, and disciplinary action will be taken if warranted.

F644 PASRR POC Date 04/29/22

1. Resident #5 PASRR was completed and submitted on 04/07/2022 to include mental health diagnosis and antipsychotic medication.
2. Education was provided to the social service designee on 4/19/22 by Lisa Roederer, Nursing Consultant related to PASRR requirements.
3. Staff in-service for correction educated all staff on 4/12/22, 4/22, 4/25,4/26, and ensure all staff communicate antipsychotic medication and new diagnosis.
4. All resident's current PASRRs were audited on 04/25/22 to ensure residents with mental health diagnoses and/or those taking psychotropic medications have current PASRRs. Those that required a status review change were submitted to PASRR on 4/27/22 and 4/28/22.
5. To ensure further compliance the management team will add to the morning stand-up agenda to include mental health diagnoses and psychoactive medication changes to ensure PASRRs are updated timely.
6. Audits will be completed weekly x3, any noted concerns will be addressed through Quality Assurance Process Improvement.

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F686 Treatment/Services to Prevent / Heal Pressure Ulcers POC Date 4/29/22

1. Resident #29 wound/skin record updated on 4/06/22. Weekly assessments are current.
2. DON assessed and audited all residents' skin. All residents with current skin issues have weekly skin assessment sheets in place.
3. Weekly skin assessment audits will be completed weekly x3 weeks and then PRN to ensure compliance with weekly skin assessments.
4. DON is responsible to ensure weekly skin assessments are completed when the skin nurse is off duty.
5. Nursing Staff were re-educated on 4/12/22, 04/22/22, 04/25/22, and 04/26/22. Pressure ulcer guidelines include notification to the dietary department/dietician with any ulcers noted upon admission and/or during the resident's stay. Emphasized the importance of weekly skin assessments, and implementation of individualized care plan interventions.
6. DON reached out to Gina Anderson with Telligen on 4/20/22 for guidance on pressure ulcer prevention.
7. Dietitian updated on all pressure areas on 4/28/22.
8. Any areas of concern will be addressed through the Quality Assurance Process Improvement.

F689 POC Date 04/19/22

1. Resident #190 is no longer resident in the facility
2. Resident #32 resident has had no falls.
3. For continued compliance, additional fall assessment education was provided on 4/12/22, 4/17/22, 4/22/22, 4/25/22, 4/26/22
4. For continued compliance education provided to DON on 4/24/22, reduction of falls, and placing interventions on care plans.
5. Incident Report audits will be completed weekly x3 and PRN to ensure compliance with fall assessments and care plan interventions to reduce the risk of falls. Any areas of concern will be addressed through the Quality Assurance Process Improvement.

F761 POC Date 04/29/22

1. Staff # A was educated on 3/31 while surveyors were present in the facility and reeducated on 4/22/22.
2. Nursing staff was re-educated on 4/12/22, 4/22/22, 4/25/22, and 4/26/22 regarding the importance and expectation of keeping medication carts locked when unattended.
3. Random audit weekly x 3 weeks any noted concerns will be addressed through Quality Assurance Process Improvement.

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F880 Infection Control: POC Date 4/29/22

1. Resident #23 Oxygen tubing was changed during the survey and continues to be changed weekly.
2. Resident #27 is no longer a resident of the facility.
3. All other residents on oxygen and/or nebulizer tubing were audited on 4/14 and 4/21. TAR reviewed to ensure tubing changes were added to support documentation of tubing changes.
4. Nursing staff was re-educated on the importance of changing oxygen and nebulizer tubing to aid in maintaining good infection control practices on 4/12/22, 4/22, 4/25, and 4/26.
5. Audits will be completed weekly x 3 and then PRN to ensure oxygen and nebulizer tubings are changed each week. Any areas of concern will be addressed through the Quality Assurance Process Improvement.
6. Gina Anderson was contacted on 4/20/22 to schedule root cause analysis of infection control practice. Telligen Root Cause Webinar viewed and completed on 04/26/2022.
7. Telligen Root Cause Fishbone worksheet completed by TRH QAPI committee and governing body on 04/29/22.
8. Staff were educated on PPE Lessons, Sparkling Surfaces, Clean Hands, and COVID Out via you-tube as directed by our DIA letter. These trainings were completed on 04/22/22, 04/25/22, and 4/25/22.