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F 000	INITIAL COMMENTS Correction Date:_________ A re-certification survey and investigation of Complaints #94356-C and #94791-C completed 2/22-3/4/21 resulted in the following deficiencies. Complaint #94356-C was substantiated. Complaint #94791-C was substantiated. See the Code of Federal Regulations (42CFR) Part 483, Subpart B-C. AMENDED 5-13-21 following IDR	F 000		
F 578 SS=D	Request/Refuse/Dscntnue Trmnt;Formlte Adv Dir CFR(s): 483.10(c)(6)(8)(g)(12)(i)-(v) §483.10(c)(6) The right to request, refuse, and/or discontinue treatment, to participate in or refuse to participate in experimental research, and to formulate an advance directive. §483.10(c)(8) Nothing in this paragraph should be construed as the right of the resident to receive the provision of medical treatment or medical services deemed medically unnecessary or inappropriate. §483.10(g)(12) The facility must comply with the requirements specified in 42 CFR part 489, subpart I (Advance Directives). (i) These requirements include provisions to inform and provide written information to all adult residents concerning the right to accept or refuse medical or surgical treatment and, at the resident's option, formulate an advance directive. (ii) This includes a written description of the facility's policies to implement advance directives	F 578		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE 03/22/2021

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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and applicable State law.
(iii) Facilities are permitted to contract with other entities to furnish this information but are still legally responsible for ensuring that the requirements of this section are met.
(iv) If an adult individual is incapacitated at the time of admission and is unable to receive information or articulate whether or not he or she has executed an advance directive, the facility may give advance directive information to the individual's resident representative in accordance with State Law.
(v) The facility is not relieved of its obligation to provide this information to the individual once he or she is able to receive such information. Follow-up procedures must be in place to provide the information to the individual directly at the appropriate time.
This REQUIREMENT is not met as evidenced by:
Based on record review and staff interview, the facility failed to ensure 1 of 13 active resident's advanced directive for cardiopulmonary resuscitation and Living Will were available (Resident #21). The facility reported a census of 51 residents.

Findings include:

The Admission Record revealed Resident #21 with a do not resuscitate (DNR) and a Living Will, and indicated to see the chart for instructions.

A Medication Review Report dated 5/29/18 documented the resident had a DNR and a Living Will, and indicated see the chart for instructions.

Progress Notes dated 6/1/18 at 4:30 p.m. documented staff spoke with the resident's family

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F 578	Continued From page 2 member on the phone, and verified the DNR status consistent with the resident's wishes. The Client Uploaded Files in the electronic health record lacked the resident's written DNR directive and Living Will. During an interview on 2/24/21 at 3:31 p.m. the Nurse Consultant stated they were unable to locate the advanced directive signed by the resident. On 2/25/21 at 9:16 a.m. the Nurse Consultant stated she did not find the resident's DNR form or Living Will in the hard chart.	F 578		
F 580 SS=D	Notify of Changes (Injury/Decline/Room, etc.) CFR(s): 483.10(g)(14)(i)-(iv)(15) §483.10(g)(14) Notification of Changes. (i) A facility must immediately inform the resident; consult with the resident's physician; and notify, consistent with his or her authority, the resident representative(s) when there is- (A) An accident involving the resident which results in injury and has the potential for requiring physician intervention; (B) A significant change in the resident's physical, mental, or psychosocial status (that is, a deterioration in health, mental, or psychosocial status in either life-threatening conditions or clinical complications); (C) A need to alter treatment significantly (that is, a need to discontinue an existing form of treatment due to adverse consequences, or to commence a new form of treatment); or (D) A decision to transfer or discharge the resident from the facility as specified in §483.15(c)(1)(ii). (ii) When making notification under paragraph (g)(14)(i) of this section, the facility must ensure that	F 580		

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F 580	Continued From page 3 all pertinent information specified in §483.15(c)(2) is available and provided upon request to the physician. (iii) The facility must also promptly notify the resident and the resident representative, if any, when there is- (A) A change in room or roommate assignment as specified in §483.10(e)(6); or (B) A change in resident rights under Federal or State law or regulations as specified in paragraph (e)(10) of this section. (iv) The facility must record and periodically update the address (mailing and email) and phone number of the resident representative(s). §483.10(g)(15) Admission to a composite distinct part. A facility that is a composite distinct part (as defined in §483.5) must disclose in its admission agreement its physical configuration, including the various locations that comprise the composite distinct part, and must specify the policies that apply to room changes between its different locations under §483.15(c)(9). This REQUIREMENT is not met as evidenced by: Based on record review, staff interview, and policy/procedure review, the facility failed to notify the the representative of a significant change in condition for 1 of 15 residents reviewed (Resident #44). The facility reported a census of 51 residents. Findings included: A Minimum Data Set (MDS) identified Resident #44 with a Brief Interview for Mental Status (BIMS) score of 5 indicating severely impaired	F 580		

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F 580	Continued From page 4 cognition. The resident's diagnoses included: debility for a cardiorespiratory condition and diabetes. The resident's care plan revealed an undated Focus for potential for social isolation and compromised psychosocial functioning related to visitor restrictions related to the pandemic (target date 4/14/21). An intervention, dated 3/21/20, documented facility staff planned to keep the resident's emergency contact information up to date for notification of the resident's needs. A nursing Progress Notes entry, dated 11/23/20 at 7:00 p.m., documented the medical provider saw the resident via telehealth and ordered a rapid Covid test ordered. Record review lacked documentation of the test results. A document with no title and no print date identified the resident diagnosed with Covid 19 on 11/23/20. A nursing Progress Notes entry, dated 11/24/20 at 7:33 p.m. documented the resident unresponsive, hard to arouse, and vital signs included a temperature of 100.2 degrees, respirations 20 to 25 per minute, pulse 96 to 100 per minute. The resident received oxygen at 5 liters per nasal cannula and had an oxygen saturation level of 93 to 94%. The resident had a cough, responded to his name, the family aware, and an order obtained to send the resident to the emergency room to evaluate and treat. On 2/22/21 at 7:53 p.m., the resident's representative denied receiving notification of the resident's positive Covid 19 status until the resident went to the emergency room (ER) the	F 580		

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F 580	Continued From page 5 evening of 11/24/20 due to a change in condition. On 2/24/21 at 11:31 a.m., the DON (Director of Nursing) verified the resident diagnosed with Covid 19 late in the day on 11/23/20 and she expected staff to notify the resident's representative right away. On 2/24/21 at 11:53 a.m., the MDS Coordinator verified the record lacked notification of family until the resident transferred to the ER on 11/24/20. The Family and Physician Notification Relating to Accident or Change in Medical Condition Policy, with a revision date of April 2012, directed staff to notify the resident's responsible party immediately of a change in condition. The Procedure directed the charge nurse to notify the resident and responsible party, document the date and time in the medical record, and the staff may use the attached guidelines to determine urgency of notification. The Signs & Symptoms sheet directed staff to notify immediately when a lab report reveals a potentially communicable pathogen.	F 580		
F 684 SS=D	Quality of Care CFR(s): 483.25 § 483.25 Quality of care Quality of care is a fundamental principle that applies to all treatment and care provided to facility residents. Based on the comprehensive assessment of a resident, the facility must ensure that residents receive treatment and care in accordance with professional standards of practice, the comprehensive person-centered care plan, and the residents' choices.	F 684		

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This REQUIREMENT is not met as evidenced by:
Based on record review, provider and staff interview, the facility failed to provide assessment per the Centers for Disease Control (CDC) guidelines for ill residents with Covid-19 for 2 of 2 residents reviewed (Resident #104 and #105). The facility reported a census of 51 residents.

Findings include:

1. A Minimum Data Set (MDS) assessment dated 10/9/20 assessed Resident #104 with a Brief Interview for Mental Status (BIMS) score of 14 (no cognitive impairment). The MDS identified the resident as independent with activities of daily living (ADL's) including bed mobility, transfer, and dressing. The resident's diagnoses included: atrial-fibrillation, diabetes, and chronic obstructive pulmonary disease.

Progress Notes dated 11/20/20 at 7:57 a.m. documented assessment of the resident due to lab confirmation of Covid-19, on droplet and contact isolation precautions. Vital Signs registered: Temperature (T) 98.0, Pulse (P) 69, Respirations (R) 24, Blood Pressure (BP) 164/72, Blood Sugar (BS) 172, Oxygen (O2) saturation (sat) 97 % on room air. The resident's cough productive, with medium amount of white sputum. The resident experienced shortness of breath at rest and while talking or eating, with worsening of shortness of breath. The resident's respiratory effort labored and pattern tachypneic (rapid breathing), and lung sounds with inspiratory and expiratory wheezes. The resident also reported poor appetite and nothing tasted good.

Progress Notes dated 11/20/20 at 3:16 p.m.

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documented a fax received from x-ray with chest x-ray results including no acute osseous abnormalities, mild calcification and tortuosity of the aorta compatible with atherosclerotic disease. The lungs appeared well expanded, with no airspace consolidation. or significant abnormal interstitial opacity, no no pulmonary vascular congestion, and no evidence of pneumothorax effusion or pneumothorax. The results were reported to the Advanced Registered Nurse Practitioner (ARNP), with new orders received for Decadron (steroid) 6 mg daily for 7 days and Mucinex (expectorant) 600 mg daily for 7 days.

The Clinical Assessment page documented a Covid-19 suspected/actual assessment completed 11/20/20, with no additional assessments documented.

The Weights and Vitals record revealed the last documented vital signs:
a. Respirations 24 on 11/20/20 at 7:58 a.m.
b. Pulse 69 on 11/20/20 at 7 a.m.
c. Temperature 98 degrees on 11/20/20 at 7:58 a.m.
d. Blood pressure 164/72 on 11/20/20 at 7:57 a.m.
e. Oxygen saturation 97% on 11/20/20 at 7:01 a.m.

The Progress Notes lacked additional assessments.

Progress Notes dated 11/23/20 at 11:10 a.m. revealed when the nurse checked the resident's blood sugar at noon, she observed the resident lethargic and unable to stay alert for questioning. The resident's O2 sat registered 45% on room air. The nurse called 911 and the resident

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transferred to the emergency room (ER). Staff notified the ARNP on rounds of the resident's health status.

A hospital History and Physical dated 11/23/20 identified the resident as a known positive Covid. Emergency Medical Services (EMS) called due to lethargy and low oximetry in the 40's. Earlier in day she complained to nursing staff of shortness of breath and pulse oximetry in the 40's to 50's confirmed by EMS on arrival. Upon arrival to Emergency Department (ED) they placed her on 6 liters of oxygen with an oximetry of 70%. The problem constant, moderate in severity, exacerbated by Covid-19.

On 2/24/21 at 12:48 p.m. the Director of Nursing (DON) stated the facility assessed residents with Covid 1 time a day. She said she did not work during the time the resident transferred to the hospital.

On 2/24/21 at 3:21 p.m. the Resident Care Coordinator (RCC) stated when residents had Covid the facility tried to assess them 1-2 times a day, and stated the surveyor could find assessments in Point Click Care (PCC/electronic health record).

On 2/24/21 at 5:03 p.m. the MDS Coordinator stated facility staff were told the residents needed assessment 1 time a day. She looked for a folder to try and find additional (hand written) assessments and could not locate any.

On 2/25/21 at 9:16 the Nurse Consultant stated the facility followed CDC (Centers for Disease Control), CMS (Centers for Medicare & Medicaid Services), and IDPH (Iowa Department of Public

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Health) guidelines.

On 2/25/21 12:53 p.m. Staff F Registered Nurse (RN) stated she believed the resident had been ill, but not necessarily in distress prior to sending her out. She said she administered a nebulizer treatment or inhaler the day of the ER transfer or the day before. She didn't remember if she checked the resident's O2 sats, or the effectiveness of the treatment- she may not have, She stated the morning of or days leading up to the day the resident transferred, they did Covid sheets/physician round assessments, and they tried to do those daily.

On 2/25/21 at 2:41 p.m. the Gerontological ARNP stated she discussed procedure with the medical director and the facility to assess residents positive for Covid daily until recovered. The resident tested positive on 11/18/20. She said she would expect assessment every shift if a change in condition. She last saw the resident 11/20/20 and she had onset of a cough and poor fluid intake. She felt the facility took excellent care of the residents. She said they would assess the residents daily and fax results. She stated they did not have the faxes, they were shredded. She said if they assessed the resident 3 times a day, they may not have noted a change until the time they noted her O2 sat at 45%.

On 3/1/21 at 9:37 a.m. the Medical Director stated when they had discussions they talked about 2 assessments a day, questioning if the guidelines were mandates and what they could actually do with the staffing situation/shortage.

On 3/1/21 at 3:20 p.m. Staff G RN stated she started at the facility November 2020. She said

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they only did Covid assessments on the night shift if the day shift did not get the daily assessments done. She said they recorded the assessments on paper and handed them in. She thought the administrative nurses picked them up.

2. A MDS dated 11/26/20 revealed Resident #105 scored 15 on the BIMS indicating no cognitive impairment. The resident required extensive assistance with ADL's including bed mobility, transfer, and dressing. The resident's diagnoses included: asthma, heart failure, and a stroke.

The facility report of Covid-19 testing included the resident testing positive on 11/19/20.

Progress Notes dated 11/23/20 at 7:20 p.m. documented the resident had a harder time breathing, and saw the ARNP via tele-health with new orders for Dexamethasone 6 mg BID for 7 days and Mucinex 600 mg BID for 7 days.

The Clinical Assessment page showed the resident lacked Covid-19 Suspected/actual assessments 11/22, 29/20 and 12/1/20. She had assessments only 1 time a day documented 11/19, 20, 21, 23, 24, 25, 26, 27, 28, and 30/20.

Progress Notes dated 11/30/20 at 7:11 a.m. documented lab confirmation that the resident tested positive for Covid-19, and droplet and contact isolation precautions in place. Vital Signs were T 98.2, P 68, R 18, BP 128/68, O2 sat 96.0 % with O2 via nasal cannula. The resident's cough productive sounding with a small amount of yellow sputum. The resident's shortness of breath improving, with O2 at 2 liters per nasal cannula. Her respiratory effort relaxed and

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F 684	Continued From page 11 regular. The resident stated she coughed up yellow sputum and lung sounds with rhonchi. The Weights and Vitals record lacked respirations, O2 sat, blood pressure, and temperature between 11/30/20 between 7 and 8 a.m. and 12/1/20 at 5:15 p.m. At 5:15 p.m. the vitals registered T not recorded, pulse 110, R 30, BP 192/110 and O2 sat 90% per mask. Progress Notes dated 12/1/20 at 5:15 p.m. documented staff summoned to the resident's room to answer the call light. The resident sat up in the recliner and her entire body shook and her lips were cyanotic. She said to call her family member. She had O2 in place with O2 sat 81%, O2 increased to 5 liters and mask applied. The Licensed Practical Nurse (LPN) stayed in the room with the resident. At 5:17 p.m. a call placed to 911 to have the resident transferred to the emergency department (ED) per ambulance to evaluate and treat. At 5:20 p.m. a call placed to the resident's family and informed them of the resident's condition, and agreed with the plan to send the resident to the ED. At 5:25 p.m. the ambulance arrived and the resident transferred to the ED. The ED called and informed the resident on the way to be seen. At 8:15 p.m. the facility received a call from the ARNP reporting the resident would admit to the hospital (observation status) with diagnoses of atrial-fibrillation, respiratory distress, elevated white blood count (WBC), and elevated d-dimer (likely due to Covid +). On 2/25/21 at 2:41 p.m. the ARNP identified the resident as chronically ill a considerable length of time, and conservative with what she would do for her health. They previously considered hospice.	F 684		

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F 684	Continued From page 12 The resident did not wish to go through treatment when hospitalized with Covid, so additional assessment would not have made a difference. On 3/2/21 at 9:18 a.m. the DON stated they did not find additional assessments for the residents during their illness with Covid. On 3/3/21 at 6:03 p.m. Staff J RN stated she thought they were doing assessments 2 times a day, or 1 time each shift, and thought they would be in PCC, but may not have transferred from paper. The Centers for Medicare and Medicaid Services (CMS) Covid-19 Long-Term Care Facility Guidance dated April 2, 2020 directed Nursing Homes should immediately ensure they were complying with all CMS and CDC guidance related to infection control. The CDC memo Preparing for Covid-19 in Nursing Homes updated Nov. 20, 2020 included increased monitoring of ill residents, including assessment of symptoms, vital signs, oxygen saturation via pulse oximetry, and respiratory exam, to at least 3 times daily to identify and quickly manage serious infection.	F 684		
F 690 SS=D	Bowel/Bladder Incontinence, Catheter, UTI CFR(s): 483.25(e)(1)-(3) §483.25(e) Incontinence. §483.25(e)(1) The facility must ensure that resident who is continent of bladder and bowel on admission receives services and assistance to maintain continence unless his or her clinical condition is or becomes such that continence is not possible to maintain.	F 690		

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§483.25(e)(2)For a resident with urinary incontinence, based on the resident's comprehensive assessment, the facility must ensure that-
(i) A resident who enters the facility without an indwelling catheter is not catheterized unless the resident's clinical condition demonstrates that catheterization was necessary;
(ii) A resident who enters the facility with an indwelling catheter or subsequently receives one is assessed for removal of the catheter as soon as possible unless the resident's clinical condition demonstrates that catheterization is necessary; and
(iii) A resident who is incontinent of bladder receives appropriate treatment and services to prevent urinary tract infections and to restore continence to the extent possible.

§483.25(e)(3) For a resident with fecal incontinence, based on the resident's comprehensive assessment, the facility must ensure that a resident who is incontinent of bowel receives appropriate treatment and services to restore as much normal bowel function as possible.
This REQUIREMENT is not met as evidenced by:
Based on observation, record review, and staff interview, the facility failed to assure residents with indwelling urinary catheters maintained the tubing off the floor for 1 of 2 residents reviewed (Resident #23). The facility reported a census of 51 residents.

Findings include:

A Minimum Data Set (MDS) assessment dated

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12/9/20 revealed Resident #23 had long and short term memory problems and severely impaired skills for daily decisions regarding tasks of daily life. The resident required extensive assist with with activities of daily living (ADL's) including bed mobility, transfer, dressing and toilet use. The resident had an indwelling urinary catheter. The resident's diagnoses included Parkinson's disease.

The current Care Plan revised 12/13/19 identified the resident with mixed bladder incontinence. The interventions included: resident had a catheter for urinary retention, changed monthly. To watch and report if the resident showed signs and symptoms of urinary tract infection (UTI) including pain, burning, blood tinged urine, cloudiness, no output, deepening of urine color, increased temp, urinary frequency, foul smelling urine, fever, chills, altered mental status, change in behavior, or change in eating patterns.

Observation showed on 2/23/21 at 7:34 a.m. the resident sat in the dining room, with the catheter tubing on the floor.

Observation showed on 2/23/21 at 9:45 a.m. Staff D Certified Nursing Assistant (CNA) wheel the resident down hall, with the tubing touching the floor.

Observation showed on 2/23/21 on 11:41 a.m. the resident sat in the dining room, the catheter tubing touching the floor.

Observation showed on 02/24/21 at 12:11 p.m. the resident sat in the front lobby area in the wheelchair. The catheter tubing rested on the floor.

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F 690	Continued From page 15 On 02/25/21 at 8:33 a.m. the Resident Care Coordinator stated the catheter probably should not lay on or touch the floor. She agreed it would be an infection control concern. On 2/25/21 at 9:16 a.m. the Nurse Consultant stated they had no specific policy on keeping the catheter tubing off the floor, but that would be the expectation, for infection control.	F 690		
F 725 SS=E	Sufficient Nursing Staff CFR(s): 483.35(a)(1)(2) §483.35(a) Sufficient Staff. The facility must have sufficient nursing staff with the appropriate competencies and skills sets to provide nursing and related services to assure resident safety and attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident, as determined by resident assessments and individual plans of care and considering the number, acuity and diagnoses of the facility's resident population in accordance with the facility assessment required at §483.70(e). §483.35(a)(1) The facility must provide services by sufficient numbers of each of the following types of personnel on a 24-hour basis to provide nursing care to all residents in accordance with resident care plans: (i) Except when waived under paragraph (e) of this section, licensed nurses; and (ii) Other nursing personnel, including but not limited to nurse aides. §483.35(a)(2) Except when waived under paragraph (e) of this section, the facility must	F 725		

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designate a licensed nurse to serve as a charge nurse on each tour of duty.
This REQUIREMENT is not met as evidenced by:
Based on resident, staff and confidential group interviews and record review, the facility failed to assure sufficient numbers of qualified nursing staff available at all times to provide nursing and related services to meet the residents' needs by answering residents calls lights in a timely manner for four (Resident # 20, #34, #22 and #48) out of eight residents reviewed. The facility reported a census of 51 residents.

Findings Include:

1. A Minimum Data Set (MDS) dated 1/26/21 for Resident # 48 revealed a Brief Interview for Mental Status (BIMS) score of 9 indicating moderate impairment of cognition. The MDS revealed the resident received hospice care while a resident. The resident had diagnoses that included: cerebral infarction, heart disease, Covid-19, pulmonary embolism, and hypertension.

On 2/22/21 at 12:42 p.m. the resident identified waiting as long as 45 minutes for the staff to answer her call light. The Resident stated she knew the time she waited by the clock located above her TV. The resident states the afternoon shift seemed the worst.

An electronic call light system report showed on 2/20/21 the resident activated the call light at 1:37 a.m. and remained on for 17:26 minutes. On 2/20/20 resident activated the call light at 5:20 a.m. and remained on for 29:47 minutes. On 2/21/21 the call light activated at 11:48 a.m. and

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remained on for 17:19 minutes. On 2/23/21 the call light activated at 1:38 a.m. and remained on for 17:35 minutes.

2. A Minimum Data Set (MDS) completed for Resident #20 with an Assessment Reference Date (ARD) of 12/4/21 showed a BIMS score of 15, indicating intact cognition. The resident had diagnoses of Multiple sclerosis, vitamin D deficiency, hypokalemia, and anemia.

On 2/22/21 at 12:31 p.m. Resident #20 identified waiting for staff to answer the call light sometimes takes 20 to 30 minutes.

An electronic call light system report showed on 2/20/21 the call light activated at 7:44 p.m. and remained on for 24:01 minutes. On 2/22/21 the call light activated at 3:09 p.m. and remained on for 23:36 minutes. On 2/22/21 the call light activated at 9:04 p.m. and remained on for 19:51 minutes.

The Administrator stated on 2/24/21 at 9:38 a.m. the call light system works by the resident pulls the call light and the signal is sent to the CNA's pager. If the call light is not answered after 7 minutes, the nurse is alerted through their pager. If the call light is still not answered after 10 minutes, the Administrator and Director of Nursing receive alerts. The Administrator revealed the call light response times as on their Quality Assurance process to improve. The Administrator expected staff to respond to call lights within 5 to 15 minutes.
3. The MDS, dated 1/6/21, documented Resident #34 with a BIMS score of 15 indicating intact cognition. The resident required extensive staff assistance with dressing and toilet use and had

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total dependence with transfers. The resident had frequent urine incontinence and occasional bowel incontinence.

On 2/23/21 at 9:42 a.m., the resident stated she waited 30 to 45 minutes during the night for the staff to answer her call light. The resident stated staff turned her call light off without offering assistance when the resident had her eyes closed and then she had to turn the call light back on to get help to change her wet brief. The resident stated she often waited longer than 15 minutes for staff to answer her call light and used a clock on the wall to keep track of time.

On 2/24/21 at 9:40 a.m., the Administrator reviewed the electronic call light records and verified the following call light response times:

a. 2/19/21 at 7:04 p.m., the call light activated and the resident waited 20 min. (minutes).
b. 2/19/21 at 7:27 p.m., the call light activated and the resident waited 21 min. and 24 sec (seconds).
c. 2/19/21 at 8:16 p.m., the call light activated and the resident waited 21 min and 13 sec.
d. 2/21/21 at 12:13 a.m., the call light activated and the resident waited 23 min. and 7 sec.
e. 2/22/21 at 9:30 p.m., the call light activated and the resident waited 17 min. and 30 sec.
f. 2/23/21 at 9:55 a.m., the call light activated and the resident waited 19 min. and 14 sec.

4. The MDS, dated 12/21/20, documented Resident #22 with a BIMS score of 15 indicating intact cognition. The resident required extensive staff assistance with bed mobility, transfers, dressing, toilet use, and personal hygiene.

On 2/23/21 at 10:05 a.m., the resident stated he

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waited 1.5 hours twice since admission to the facility (12/14/20). Once the computer had been down and someone had a heart attack the other time. The resident stated staff needed to walk the halls to find out if the residents required assistance when the computer down. The resident stated he watched the clock on the wall to keep track of time.

On 2/24/21 at 2:35 p.m., the resident identified 20 minutes as too long to wait for staff assistance depending on what he needed.

On 2/24/21 at 9:40 a.m., the Administrator reviewed the electronic call light records and verified the following call light response times and stated the computer had been down no longer than 1 hour:

a. 2/19/21 at 8:09 p.m., the call light activated and the resident waited 21 min. and 13 sec.
b. 2/19/21 at 9:05 p.m., the call light activated and the resident waited 27 min. and 7 sec.
c. 2/20/21 at 9:49 p.m., the call light activated and the resident waited 27 min. and 1 sec.
d. 2/21/21 at 6:21 a.m., the call light activated and the resident waited 47 min. and 57 sec.
e. 2/21/21 at 10:59 a.m., the call light activated and the resident waited 25 min. and 14 sec.
f. 2/22/21 at 6:16 a.m., the call light activated and the resident waited 25 min. and 29 sec.
g. 2/23/21 at 6:25 a.m., the call light activated and the resident waited 30 min. and 12 sec.
h. 2/23/21 at 4:37 p.m. the call light activated and the resident waited 22 min. and 47 sec.
i. 2/24/21 at 8:27 a.m., the call light activated and the resident waited 52 min. and 28 sec.

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F 725	Continued From page 20 5. During confidential group interview on 2/24/21 at 1:54 p.m. 2 of 4 residents voiced concerns with call light response time. One resident stated she sat on the toilet for 35 minutes the previous week and the manager came in and didn't know she had been sitting there that long. Another resident said it could take 20 minutes for staff to answer the call light, if they gave it to her.	F 725		
F 804 SS=E	Nutritive Value/Appear, Palatable/Prefer Temp CFR(s): 483.60(d)(1)(2) §483.60(d) Food and drink Each resident receives and the facility provides- §483.60(d)(1) Food prepared by methods that conserve nutritive value, flavor, and appearance; §483.60(d)(2) Food and drink that is palatable, attractive, and at a safe and appetizing temperature. This REQUIREMENT is not met as evidenced by: Based on observation, record review and staff and confidential group interview, the facility failed to hold hot food at proper temperatures to ensure prevention of bacterial pathogen growth for three residents trays sampled, and four residents reviewed (Resident #48, #20,#34, and #35). The facility reported a census of 51 residents. Findings include: 1. On 1/23/20 at 11:40 a.m., observation showed covered trays on a mobile open rack in the dining room for delivery to residents rooms. Staff plated and placed the first tray on the top rack at 11:48 a.m. The full rack contained covered plated food trays for staff to deliver to hall A, hall, B and hall	F 804		

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F 804	Continued From page 21 C. Staff A, Dietary Aid tested the temperature of the food in the first plated covered tray placed on the rack which revealed the pork chop with an internal temperature of 126.5, the sweet potatoes with an internal temperature of 144.5, and the peas with an internal temperature of 138.0. A second randomly chosen tray contained a pork chop with an internal temperature of 125.6. Staff delivered the trays to resident rooms and the rack returned to the dining room. The open mobile rack was prepared with trays for delivery to hall D and E. At 12:29 p.m. the first plate was plated and placed on the open rack in the top slot. Staff continued to fill the rack with plated trays for delivery to residents. Staff A Dietary Aid tested the temperature of the first plated tray of food located in the top slot. The pork chop had an internal temperature of 129.9, the sweet potatoes were 149.0, and the peas measured 139.0. The facility failed to ensure food was held at a high enough temperature. The FDA 2013 Food Code, deemed that a standard practice in the foodservice industry is all potentially hazardous hot food must be held for service at a minimum of 135 degrees Fahrenheit on a steam table. 2. A Minimum Data Set (MDS) completed for Resident #48 with an Assessment Reference Date (ARD) of 1/20/21 showed a Brief Interview for Mental Status (BIMS) score of 15, indicating intact cognition. The resident had diagnoses of chronic obstructive pulmonary disease, heart Failure, vitamin B12 deficiency anemia, and lymphedema. During an interview on 2/23/21 at 12:54 p.m., the resident stated that the food was cold when	F 804		

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F 804	Continued From page 22 delivered to her room for lunch on 2/23/21. 3. A MDS completed for Resident #20 with an ARD of 12/4/21 showed a BIMS score of 15, indicating intact cognition. The resident had diagnoses of Multiple sclerosis, vitamin D deficiency, hypokalemia, and anemia. On 2/23/21 at 12:54 p.m., the resident stated the food delivered to her room for lunch on 2/23/21 tasted cold as usual. Review of Resident Council meeting minutes dated January 21, 2021 revealed the residents expressed concerns stating "most meals are cold", "that the certified nursing assistants (CNA) need to help pass trays so the meals are served hot". Review of the Resident Council meeting minutes dated October 3, 2020 revealed resident concerns "the food is always cold (this was mentioned by a lot of resident)". On 2/24/21 at 8:29 AM the Dietary Manager (DM) stated she knew of the cold food served and the pork and fish served to the residents on room trays under the required temperature. The DM stated the facility switched the room tray procedures and started preparing 3 to 4 trays at a time and then delivering them so all the trays do not sit on the mobile rack getting cold. The new process started today. The DM stated the facility did not have a food policy but have a temperature book for staff to refer to. She expected the food served to be held at the correct temperature and expected it to remain at 140 degrees or higher as stated in the Temperature Book.	F 804		

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The Temperature Book directed staff to maintain the hot holding temperature at 140 degrees or above.
4. Observation showed on 2/23/21 at 12:05 p.m., Staff A (cook) and Staff B (dietary aide) entered Hall C with a cart with noon meal trays for 3 residents remaining after delivering meal trays on the same cart to residents on Halls A and B.

Observation showed on 2/23/21 at 12:08 p.m., Staff A checked food temperatures for Resident #29's noon tray just prior to staff serving the tray. With the Nurse Consultant and the DM observing, Staff A verified the following food temperatures: fish 125.6 degrees F. (Fahrenheit), sweet potatoes 132 degrees F, pork chop 118 degrees F., and peas 123.2 degrees F. The DM instructed Staff A to reheat the food before serving Resident #29.

5. The MDS, dated 1/13/21, documented Resident #38 with intact cognition. On 2/23/21 at 12:15 p.m., the resident stated her noon meal tasted warm enough but identified the pork chop as alittle tough and dry. Observation revealed the resident received her noon meal just prior to food temperatures checked at 12:08 p.m.

6. The MDS with ARD of 2/19/21 documented Resident #153 with intact cognition. On 2/23/21 at 12:19 p.m., the resident (Hall B) identified his noon meal as hot enough and the pork a little tough.

7. The MDS, dated 1/6/21, documented Resident #34 with intact cognition.

The MDS, dated 1/6/21, documented Resident #35 with intact cognition.

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F 804	Continued From page 24 Observation showed on 2/23/21 at 12:04 p.m., Staff A (cook) and Staff B (dietary aide) set 2 foam carry out type containers (isolation resident meals) on a table outside of Room 8 for Residents #34 and #35 and notified staff via walkie talkie to take the meals to the residents. On 2/23/21 at 12:21 p.m., Resident #34 identified eating a cold hamburger without a bun and the hamburger tasted cold before putting salad dressing on the hamburger. The resident stated she ate cold food for so long that she was used to it. Resident #35 stated she had a cold easy over egg for lunch and agreed the facility served cold food. 8. During a confidential group interview on 2/24/21 at 1:54 p.m. 3 of 4 residents stated the facility served cold food to them.	F 804		
F 842 SS=D	Resident Records - Identifiable Information CFR(s): 483.20(f)(5), 483.70(i)(1)-(5) §483.20(f)(5) Resident-identifiable information. (i) A facility may not release information that is resident-identifiable to the public. (ii) The facility may release information that is resident-identifiable to an agent only in accordance with a contract under which the agent agrees not to use or disclose the information except to the extent the facility itself is permitted to do so. §483.70(i) Medical records. §483.70(i)(1) In accordance with accepted professional standards and practices, the facility must maintain medical records on each resident	F 842		

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	165411	A. BUILDING ______ B. WING ______	03/04/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SOUTHFIELD WELLNESS COMMUNITY	2416 SOUTH DES MOINES STREET WEBSTER CITY, IA 50595

(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 842	Continued From page 25 that are- (i) Complete; (ii) Accurately documented; (iii) Readily accessible; and (iv) Systematically organized §483.70(i)(2) The facility must keep confidential all information contained in the resident's records, regardless of the form or storage method of the records, except when release is- (i) To the individual, or their resident representative where permitted by applicable law; (ii) Required by Law; (iii) For treatment, payment, or health care operations, as permitted by and in compliance with 45 CFR 164.506; (iv) For public health activities, reporting of abuse, neglect, or domestic violence, health oversight activities, judicial and administrative proceedings, law enforcement purposes, organ donation purposes, research purposes, or to coroners, medical examiners, funeral directors, and to avert a serious threat to health or safety as permitted by and in compliance with 45 CFR 164.512. §483.70(i)(3) The facility must safeguard medical record information against loss, destruction, or unauthorized use. §483.70(i)(4) Medical records must be retained for- (i) The period of time required by State law; or (ii) Five years from the date of discharge when there is no requirement in State law; or (iii) For a minor, 3 years after a resident reaches legal age under State law. §483.70(i)(5) The medical record must contain-	F 842		

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(i) Sufficient information to identify the resident;
(ii) A record of the resident's assessments;
(iii) The comprehensive plan of care and services provided;
(iv) The results of any preadmission screening and resident review evaluations and determinations conducted by the State;
(v) Physician's, nurse's, and other licensed professional's progress notes; and
(vi) Laboratory, radiology and other diagnostic services reports as required under §483.50.
This REQUIREMENT is not met as evidenced by:
Based on record review, staff interview, and policy review, the facility failed to document blood sugar results at the time staff completed the blood sugar check, resulting in an inaccurate record for 4 of 6 residents with fasting blood sugars.(Residents #4, #5, #10, and #37). The facility reported a census of 51 residents.

Findings included:

Upon entrance to the back area of the facility 2/23/21 at 6:07 a.m., Staff E, LPN (Licensed Practical Nurse) stated she completed blood sugar testing for Residents #4, #5, #10, and #37. Staff E stated her assignment included the residents on Halls D and E.

Electronic record review with the (RCC) Resident Care Coordinator and with the DON (Director of Nursing) and Consultant Nurse present reviewed the following:

a. The Medication Administration (Admin) Audit Report and the RCC verified that Staff E documented she performed and completed Resident #10's blood sugar check at 6:25 a.m. on

F 842 | F 842

Continued From page 27
2/23/21.

b. The Medication Admin Audit Report and the RCC verified that Staff E documented she performed and completed Resident #4's blood check at 6:19 a.m. on 2/23/21.

c. The Medication Admin Audit Record and the RCC verified that Staff E documented she performed and completed Resident #5's blood sugar check at 6:20 a.m. on 2/23/21.

d. The Medication Admin Audit Record and the RCC verified that Staff E documented she performed and completed Resident #37's blood sugar check at 6:22 a.m. on 2/23/21.

On 2/24/21 at 12:10 p.m.,the Nurse Consultant stated when staff documented a procedure in Point Click Care the staff clicks the Administration tab to start the procedure and if the nurse gets called away from the task, she can go back later and document the actual time a procedure completed.

On 2/25/21 at 9:19 a.m., the Nurse Consultant stated she did not find a specific policy for nursing staff to document actual times they completed a medication, treatment, or other procedure. The Nurse Consultant stated general nursing guidelines include documentation of the time completed and if a nurse gets called away she/he can document the actual time later.

On 2/25/21 at 9:20 a.m., Staff E verified she performed the blood sugar checks on the residents before 6:07 a.m. (when the surveyor arrived at the back area of the facility.) Staff E stated she had the ability to take a lap top along

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F 842	Continued From page 28 with her to perform the blood sugar checks and document the time and results right away. Staff E stated she did not write down the actual time she completed the blood sugar checks and verified the times documented in the electronic record as not the actual time she completed the blood sugar checks. According to wikipedia medication administration record: https://en.wikipedia.org/wiki/Medication_Administration_Record A Medication Administration Record[1] (MAR, or eMAR for electronic versions), commonly referred to as a drug chart, is the report that serves as a legal record of the drugs administered to a patient at a facility by a health care professional. The MAR is a part of a patient's permanent record on their medical chart. The health care professional signs off on the record at the time that the drug or device is administered.	F 842		
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 and control program (IPCP) that must include, at a minimum, the following elements:	F 880		

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F 880	Continued From page 29 §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 by staff involved in direct resident contact.	F 880		

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§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 record review, observation, and policy, the facility failed to utilize infection control techniques for a resident between wound treatment and medication administration for 1 of 13 residents observed (Resident #37). The facility reported a census of 51 residents.

Findings included:

The Minimum Date Set (MDS) dated 1/11/21 assessed Resident # 37 with intact cognition. The resident's diagnoses included: amputation, coronary artery disease, peripheral vascular disease, renal insufficiency, and diabetes.

The resident's Treatment Administration Record (TAR) for February 2021 directed staff to apply Betadine to the open areas on the resident's left heel and the 3rd digit of the left foot twice daily until healed for an alteration in skin integrity, order date 2/11/21.

The resident's TAR for February 2021 directed staff to administer Ipratropium-Albuterol 0.5/2.5 milligrams in 3 milliters inhaled three times daily

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F 880	Continued From page 31 for chronic obstructive pulmonary disease (start date 10/7/20). Observation showed on 2/24/21 at 3:50 p.m., Staff C, R.N. (Registered Nurse), with the DON (Director of Nursing) observing, completed the resident's wound care and a nebulizer treatment. Staff C washed her hands and applied gloves, cleaned the resident's left heel and 3rd toe wound with wound wash and clean gauze pads. Staff C used a new Povidone Iodine stick for the left heel and toe skin impairments. Staff C changed gloves without washing or sanitizing her hands in between and proceeded to administer the resident's nebulizer treatment. Staff C removed her gloves and washed her hands. On 2/24/21 at 3:59 a.m., the DON verified Staff C failed to wash or sanitize her hands in between glove changes. The policy, Infection Prevention and Control Program (ICP) Guidelines, revised 11/17, pages 8 to 9 for Hand Hygiene, directed staff to complete hand hygiene after removing gloves. CDC Hand Hygiene Recommendations for Healthcare Providers dated 1/8/21 revealed multiple opportunities for hand hygiene may occur during a single care episode. Staff should perform hand hygiene with an alcohol based sanitizer immediately following glove removal.	F 880		

Southfield Wellness Community

2416 Des Moines Street • Webster City, Iowa 50595 • Ph: (515) 832-3881

Plan of Correction for Survey ending 3/4/2021

Preparation and implementation of this plan of correction should not be construed as an admission of the deficiencies cited. This plan of correction is prepared solely because it is required under federal or state law.

The facility is disputing these deficiencies and is submitting a response with additional information in a separate document. However, for the required Plan of Correction, the facility submits the following:

F000 – Correction Date: April 13th, 2021

F578 -- 483.10(c)(6)(8)(g)(i)-(v) All residents are afforded the right to request, refuse and/or discontinue treatment, and formulate advance directives.

1. Upon admission a facility representative reviews Resident's Rights with each resident and/or their legal representative. During this meeting, the resident and/or their representative is informed of their right to formulate advance directives. In this case, Resident #21 did formulate an advance directive that was confirmed with the family and documented in the electronic health record via a progress note.
2. When we are notified that an advance directive has been executed, we ask the resident or their representative to provide a copy for the resident's records, and when that is provided to us, it is stored within the medical record system. If it is not provided to us, however, then we do not have a copy. If that occurs, we will continue to ask the resident or their representative to please provide us a copy or execute another [duplicate] directive until the issue is resolved.
3. An audit was performed by the Social Services Director on 3/30/2021 to ensure the presence of advance directive documents for residents who have chosen to execute them. Going forward, when applicable the social services director will verify the presence of executed advance directives in conjunction with the residents' quarterly comprehensive assessments.
4. The Administrator or his designee will conduct random audits to ensure the presence of advance directive documents for a minimum of 10 residents. These audits will be two times monthly for 3 months. The results will be reviewed as part of our on-going quality improvement process and the frequency of audits thereafter will be based on the outcomes of the initial audits and recommendations of the CQI Committee.

F580 – 483.10(g)(14)(i)-(iv)(15) Notification of Changes

1. The charge nurse on duty will provide notification to the resident and/or the authorized representative of changes in resident's condition per the policy for family and physician notification. Staff receives education and training

regarding notification requirements upon hire and via periodic in-services. Nursing staff received re-education via nursing in-service meeting on 3/5/2021.

2. The Administrator or his designee will conduct audits of required notifications 2 times per month for 3 months. The results will be reviewed as part of our on-going quality improvement process and the frequency of audits thereafter will be based on the outcomes of the initial audits and recommendations of the CQI Committee.

F684 -- 483.25 Quality of Care, Based on the comprehensive assessment of a resident, the facility ensures that residents receive treatment and care in accordance with professional standards of practice, the comprehensive person-centered care plan, and the residents' choices.

1. The pandemic was peaking in Hamilton county in mid- November with a positivity rate as high as 34%. In late November and early December there were times where approximately 40% of front line staff were unavailable and off work while 100% of our residents were infected with COVID-19.
2. The facility was able to secure staffing agency nurses in an extremely competitive environment and never-before seen incentivized crisis pay rates in conjunction with agency staff's choice of ABCM facility assignments over other facilities based on ABCM's outstanding organizational reputation. During this time, a medical provider was rounding with the nursing staff on ill residents daily and all treatment orders were implemented timely.
3. The Preparing for COVID-19 Long Term Care Facilities document referenced in the Findings was updated by the CDC nearly every month from April 2020 on. The guide, in November, 2020, advised to *increase monitoring of ill residents including assessment of symptoms, vital signs, oxygen saturation via pulse oximetry, and respiratory exam.*
4. Nursing staff was educated on above CDC guidance via 1:1 education and during an in-service conducted on 3/5/21.
5. The Director of Nursing or their designee will perform random audits of nursing assessments of residents who are ill with COVID-19 monthly for 3 months. Nurses will continue to follow guidelines based on the standard of care as well as their nursing judgement in each individual situation.

F690 – 483.25(e)(1)-(3) Incontinence/Catheter

1. Nursing staff receives education and training upon hire on how to properly care for catheters and their relative equipment.
2. Nursing staff was re-educated on how to properly care for catheter tubing on 3/5/2021 at a nursing staff in-service.
3. The Director of Nursing or her designee will perform an audit to ensure all regulations regarding catheter care are met. These audits will be performed 3 times a month for 3 months. The audits will be reviewed as part of our on-going quality improvement process, and the frequency of reviews thereafter will be based on outcomes and subsequent recommendations.

F725 -- 483.35(a)(1)(2) Sufficient Nursing Staff

1. The Administrator, Director of Nursing, Nursing Scheduler, and Human Resource Director audited the allocation of all nursing hours on 3/31/2021. This audit was performed to ensure there is sufficient staff in each resident occupied area throughout each shift.
2. Nursing staff was re-educated on the importance of answering call lights in a timely manner on 3/5/2021. Non-nursing staff was re-educated on 3/10/2021 regarding the fact that ALL employees are expected to respond to emergency call lights to determine what assistance the resident needs and then to notify a nursing staff member if the assistance is nursing related.
3. Starting 4/5/2021, charge nurses will be responsible for reviewing call light logs prior to leaving their shift. The charge nurse will involve the Certified Nurse Aides and identify trends and to determine the reason for any extended response times. Reports of these reviews will be reviewed by the QA team at least monthly.
4. Call light response time will continue to be monitored as part of our on-going quality improvement process. The frequency of audits thereafter will be based on the outcomes of the initial audits and recommendations of the CQI Committee.

F804 -- 483.60(d)(1)(2) Palatable Food and Drink of Safe and Appetizing Temperature

1. All dietary staff re-educated on 3/10/2021 and 3/30/2021 about the required temperatures for potentially hazardous hot food. The staff was reminded of the Temperature Book that is present and directed to ensure a temperature of at least 140 degrees.
2. Only 3-4 room trays will be put onto the rack and passed at one time. This will prevent the trays from sitting and getting cold.
3. The Administrator or his designee will conduct audits of the food temperatures 2 times per month for 3 months. The results will be reviewed as part of our on-going quality improvement process and the frequency of audits thereafter will be based on the outcomes of the initial audits and recommendations of the CQI Committee.

F842 -- 483.20(f)(5), 480.70(i)(1)-(5) Resident Records – Identifiable information

1. Staff E performed blood sugar checks and documented the occurrence in the Medication Administration Record at a later time following general nursing guidelines. Nurses often get pulled away from what they are doing and come back to chart in the health record at a later time.
2. The charge nurse on duty will be responsible for following nursing guidelines. They will also be responsible for charting any treatment or medication administration in the health record as soon as they are able to following the administration or treatment.
3. The Administrator or his designee will conduct audits to ensure an accurate record of no less than 3 residents chosen at random. These audits will take place twice a month for 3 months. The results will be reviewed as part of our on-going quality improvement process and the frequency of audits thereafter

will be based on the outcomes of the initial audits and recommendations of the CQI Committee.

F880 – 483.80(a)(1)(2)(4)(e)(f) Infection Prevention and Control

1. The facility has a robust infection control and exposure control program. Surveillance testing of all staff that is eligible takes place at least once a week, depending on the County positivity rate. The facility has not had a single resident or employee COVID-19 case in 2021.
2. Education is provided to staff via stand-up meetings nearly every day throughout the week. All staff has been assigned two educational videos, PPE Lessons and Clean Hands, as instructed. Nursing staff was re-educated on the importance of infection control in an in-service on 3/5/2021. All staff received re-education on the importance of infection control on 3/10/2021.
3. Facility staff will view the Clean Hands and PPE Lessons by 4/13/2021.
4. Evidence of a Root Cause Analysis involving the Infection Preventionist, Quality Assurance and Performance improvement (QAPI) and Governing Body will be provided by 4/13/2021.
5. The Administrator or his designee will conduct audits 3 times a month for 3 months to ensure all infection control guidelines are followed. The results will be reviewed as part of our on-going quality improvement process and the frequency of audits thereafter will be based on the outcomes of the initial audits and recommendations of the CQI Committee.