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F 000	INITIAL COMMENTS Correction date: 6/28/22 ✓ JB A COVID-19 Focused Infection Control Survey was conducted by the Department of Inspection and Appeals on 05-11, 2022 to 06-08, 2022. The facility was found to be in compliance with CMS and Centers for Disease Control and Prevention (CDC) recommended practices to prepare for COVID-19. Total Residents: 48 The following deficiencies resulted from investigation of complaints #102429-C, #102759-C, # 102825-C, #102829-C, #102916-C, 103698-C, #104451-C, #104562-C, #104626-C, #104729-C, and 104753-C conducted 5/11/2022 - 6/8/2022. Complaint #102429-C was substantiated. Complaint #102759-C was substantiated. Complaint #102825-C was substantiated. Complaint #102829-C was not substantiated. Complaint #102916-C was substantiated. Complaint #103698-C was substantiated. Complaint #104451-C was substantiated. Complaint #104562-C was substantiated. Complaint #104626-C was substantiated. Complaint #104753-C was not substantiated. Complaint #104729-C was substantiated. See code of Federal Regulations (42 CFR), Part 483, Subpart B-C.	F 000		
F 584 SS=D	Safe/Clean/Comfortable/Homelike Environment CFR(s): 483.10(i)(1)-(7) §483.10(i) Safe Environment.	F 584		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Miriam Brown — TITLE: Interim Administrator — (X6) DATE: 6/24/22

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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The resident has a right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely.

The facility must provide-
§483.10(i)(1) A safe, clean, comfortable, and homelike environment, allowing the resident to use his or her personal belongings to the extent possible.
(i) This includes ensuring that the resident can receive care and services safely and that the physical layout of the facility maximizes resident independence and does not pose a safety risk.
(ii) The facility shall exercise reasonable care for the protection of the resident's property from loss or theft.

§483.10(i)(2) Housekeeping and maintenance services necessary to maintain a sanitary, orderly, and comfortable interior;

§483.10(i)(3) Clean bed and bath linens that are in good condition;

§483.10(i)(4) Private closet space in each resident room, as specified in §483.90 (e)(2)(iv);

§483.10(i)(5) Adequate and comfortable lighting levels in all areas;

§483.10(i)(6) Comfortable and safe temperature levels. Facilities initially certified after October 1, 1990 must maintain a temperature range of 71 to 81°F; and

§483.10(i)(7) For the maintenance of comfortable sound levels.

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This REQUIREMENT is not met as evidenced by:
Based on observations, maintenance record review and staff interviews, the facility failed to ensure a sanitary, orderly and comfortable interior by failing to have a system in place to assure resident equipment got repaired promptly for 1 of 3 residents reviewed (Resident #3). The facility reported a census of 48 residents.

Findings include:

On 5/19/22 at 8:15 a.m. an observation revealed the bed in low position while staff completed cares on Resident #3. The bed noted to be in the low position when staff entered the room, and remained in the low position as the staff provided care to Resident #3.

On 5/19/22 at 9:04 a.m. Staff F, Certified Nurse Aide (CNA), stated that Resident #3's bed has been stuck in the low position for the past week and a half. Staff F reported telling the Maintenance Director at least a week before that they couldn't adjust the bed. The Maintenance Director told her the staff were supposed to use a maintenance sheet. As Staff F couldn't find the required sheets, she just put the request on a plain piece of paper.

On 5/19/22 at 9:45 a.m., Staff F, CNA demonstrated that the bed was in the low position and the staff couldn't raise the bed out of the low positon when the controller was activated.

On 6/1/22 at 12:45 p.m. the Maintenance Director explained that in the past, they used TELS (The Equipment Lifecycle System, a digital platform used to notify of maintenance needs in the

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F 584	Continued From page 3 nursing home), which he reviewed and found no documentation of notice that Resident #3's bed required repair. The Maintenance Director provided a calendar book that listed days of the week but no actual dates. The joint review of the book with the Maintenance Director revealed no notation that Resident #3's bed required repair. The Maintenance Director stated there should be a consistent way to communicate maintenance needs. The Maintenance Director further stated that the bed did get repaired. On 6/1/22 at 12:45 p.m., observed Resident #3's bed repaired.	F 584		
F 658 SS=D	Services Provided Meet Professional Standards CFR(s): 483.21(b)(3)(i) §483.21(b)(3) Comprehensive Care Plans The services provided or arranged by the facility, as outlined by the comprehensive care plan, must- (i) Meet professional standards of quality. This REQUIREMENT is not met as evidenced by: Based on clinical record reviews, staff interviews, and facility policy review the facility failed to follow professional standards for: 1. Following physician orders by failing to administer Permethrin (Elimite) cream as ordered for the treatment of scabies. 2. Failing to notify the provider of the omission of the first dose of a two dose treatment for 1 of 3 residents reviewed (Resident #7). The facility reported a census of 48 residents. Findings include:	F 658		

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1. Resident #7's Minimum Data (MDS) dated 3/30/22 documented a Brief Interview for Mental Status (BIMS) score of 6, indicating severely impaired cognition (memory). Resident #7 required extensive assistance of 2 persons for transfers and toilet use. Resident #7 required total dependence for bed mobility and personal hygiene. The MDS coded Resident #7 as always incontinent of bowel and bladder. The MDS included diagnoses of dementia without behavioral disturbance, depression, and falls.

The Physician Office Visit form dated 3/2/22 at 1:45 p.m. documented a new order for Elimite 5 percent (%) cream, apply head to toe for 10 hours, then rinse, repeat in seven days.

According to Drugs.com reviewed on 3/14/22, Elimite (Permethrin) 5% cream is an anti-parasite prescription medication used topically to treat an infestation of scabies.

The Nurses Note dated 3/2/22 at 3:34 p.m. recorded that Resident #7 went to the doctor's office due to a rash. The doctor explained that he believed the rash came from mites or bed bugs. The facility notified a Pest Control extermination who arrived at 3:30 p.m. The staff removed the resident's clothing, bedding, and linens from their room. The staff bagged them up and took them to the laundry. After the exterminator examined Resident #7's room and surrounding rooms, they reported no evidence of mites or bedbugs observed. They treated the rooms anyway out of precaution.

Resident #7's Medication Administration Record (MAR) documented the following orders.

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F 658	Continued From page 5 1. Permethrin Cream 5 percent (%) start date 3/2/22: apply to head to toe topically at bedtime for rash for one day leave in place for 10 hours then shower off. a. MAR lacked documentation of completion. 2. Permethrin Cream 5 percent (%) start date 3/9/22: apply to head to toe topically at bedtime for rash for one day leave in place for 10 hours then shower off. a. Medication documented as completed. In an interview on 5/25/22 at 4:51 p.m. the Director of Nursing #2 (DON #2) stated that she had contacted the pharmacy who confirmed they had received the order after 5:00 p.m. on 3/2/22 for the Permethrin cream. The local pharmacy filled the prescription at 6:00 p.m. and confirmed delivery that evening to the facility by a local emergent delivery system. The DON #2 confirmed the MAR lacked a signature indicating administration of the order. The DON #2 explained that she expected an order to be signed if it got administered as ordered. The DON #1 worked that night as the covering nurse and had no recollection of administering the medicated cream for Resident #7. The DON #2 further added that she would have expected the Primary Care Provider (PCP) to be notified of the omission of the first dose of a two dose order for further direction on how to proceed with treatment. In an interview on 6/1/22 at 2:45 p.m. DON #1 confirmed that worked that night as the nurse on the evening shift. The DON #1 reported that she remembered stripping the linens and everything from the room so they could be laundered or bagged, however she was not sure that she had received the medicated cream. The DON #1	F 658		

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F 658	Continued From page 6 couldn't recall if it popped up on her screen that she was supposed to administer. The DON #1 confirmed that she was aware that the medicated cream didn't get signed as administered, which would be a medication omission, an error. The DON #1 stated she got very behind that night and didn't followed up to assure that Resident #7 received the order. The DON #1 further stated the PCP should have been notified of the omission, so that they could get further direction. The DON #1 confirmed that she failed to notify the PCP of the omission. A nursing policy and procedure titled Adverse Consequences and Medication Error identified a medication error is defined as the preparation or administration of drugs or biological which is not in accordance with physician's orders, manufacturer specifications, or accepted professional standards and principles of the professional providing services. Examples of medications errors included: an omission - a drug ordered but not administered.	F 658		
F 684 SS=J	Quality of Care CFR(s): 483.25 § 483.25 Quality of care Quality of care is a fundamental principle that applies to all treatment and care provided to facility residents. Based on the comprehensive assessment of a resident, the facility must ensure that residents receive treatment and care in accordance with professional standards of practice, the comprehensive person-centered care plan, and the residents' choices. This REQUIREMENT is not met as evidenced by: Based on observations, clinical record reviews,	F 684		

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family, staff, and provider interviews, the facility failed to
1. Assess Resident #1 after reported changes in condition and urgently notify the physician which resulted in a delay of transfer for Resident #1. On May 9, 2022 staff got alerted of Resident #1 not acting like himself, he sat slumped in his chair, he exhibited signs and symptoms of a stroke which included: drooling, slurred speech, and weakness. The facility failed to assess the reported changes and sent a non-emergent fax to the physician. The reported changes didn't get documented or passed on (relayed) to the next shift that Resident #1 needed additional follow up. On May 10, 2022 Resident #1 had further decline resulting in a transfer to the local emergency room (ER) where the hospital determined he suffered a stroke. This failure posed an Immediate Jeopardy to Resident #1's health and safety.
2. Assess, document, provide relief of the symptoms (which included intense itching), and determine the cause of a skin rash on Resident #7. Resident #7 received an order for a medicated cream, used for the treatment of scabies, on 3/2/22. The facility reported identifying 16 residents with a rash. On May 11, 2022 the facility received an order to treat all residents with a cream for scabies. The facility reported a census of 48 residents.

Findings include:

1. Resident #1's Minimum Data Set (MDS) assessment dated 4/8/22 indicated a Brief Interview for Mental Status (BIMS) score of 4, indicating severely impaired cognition. Resident #1 required extensive assistance of two persons for bed mobility, transfers and toilet use. The

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MDS included medical diagnoses of hypertension, Parkinson's disease, dementia, and a urinary tract infection (UTI) in the last 30 days.

The Care Plan Problem dated 4/29/22 identified Resident #1 with hypertension. The Problem included the following interventions dated 4/29/22
a. Administer anti-hypertensive medications as ordered, monitor for effectiveness, side effects, such as orthostatic hypotension (a drop-in blood pressure based on a change in position) and increased heart rate.
b. Report any signs and symptoms of hypertension which included: headache, visual problems, confusion, disorientation, lethargy, nausea, vomiting, irritability, seizure activity, and difficulty breathing.

Resident #1's History and Physical dated 5/10/22 at 6:36 p.m., indicated the admitting provider documented Resident #1 admitted to the hospital for a CVA (Cerebrovascular Accident, a medical term for a stroke), confirmed by an MRI (Magnetic Resonance Imaging, a medical imaging test of the brain often used to diagnose a stroke). Resident #1's wife reported that two days before, on 5/7/22, Resident #1 slumped over in his wheelchair, and he had difficulty with weakness. Resident #1 presented to the ER with left-sided weakness, slurred speech, and drooling. The ER called a stroke alert and consulted neurology. An assessment of Resident #1 determined him as oriented only to self, confused, and difficult to understand with left-sided weakness. The neurologist concluded, per his clinical opinion, the MRI showed an evident stroke. The provider admitted Resident #1 to the hospital.

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On 5/16/22 at 12:50 p.m. Resident #1's wife reported that she visited Resident #1 on Sunday, 5/8/22, when she noticed her husband not acting as his usual self. Resident #1's wife explained that she reported his change to the staff. When she again visited on Monday, 5/9/22, she continued to notice changes, which she described as: slumped over in chair, weakness, drooling, and slurred speech. Resident #1's wife reported that she informed staff of his changes, and that she thought he was having a stroke. She further reported that no staff completed an assessment on him and the staff didn't communicate that they were going to notify the physician. On Tuesday, 5/10/22, she received a call from the facility informing her that hospital planned to transfer Resident #1 to the local hospital ER. Resident #1's wife confirmed that she wanted him transferred and treated for a stroke. Resident #1's wife said she got informed by the local hospital staff that her husband had a, as they described it, a bad stroke. She explained that her husband returned to the facility on 5/16/22 for end of life, comfort care.

The electronic Progress Notes dated 5/7/22 - 5/9/22 revealed a lack of documentation related to an assessment or changes in Resident #1's condition as reported by his wife.

A non-emergent facility fax, dated 5/9/22 at 3:30 p.m., signed as sent by Staff A, Licensed Practical Nurse (LPN), communicated that Resident #1's wife reported Resident #1 as not acting like himself that day. Staff A documented Resident #1 as slumped in his wheel chair, drooling, and having slurred speech. Staff A documented the following vital signs as blood pressure (bp) 131/84, pulse (p) 58, and oxygen

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saturation (PO2) 93% on room air. The fax failed to identify an assessment of Resident #1's condition by the nurse.

Review of a facility communication reporting tool titled, Hot Charting Sheets, dated 5/9/22 and 5/10/22 failed to identify that Resident #1 needed additional monitoring, and failed to communicate any reported or observed changes in his condition.

The Progress Note written by Staff B, Registered Nurse (RN), on 5/10/22 at 9:40 a.m., documented an assessment of Resident #1. Staff B recorded that she found Resident #1 slumped over in his wheelchair. Staff B listed his vital signs as BP 110/60 and PO2 90% on room air. Staff B noted left upper extremity weakness, Resident #1 failed to follow commands to assess for lower extremity weakness and drift. Staff B documented that she couldn't assess his pupil response. Staff B noted a fax on the clipboard dated 5/9/22 at 3:30 p.m. documented Resident #1 slumped in wheelchair, facial drooping, and drooling. Staff B called the provider and received an order to send Resident #1 to the local emergency room for evaluation and treatment.

Review of skilled therapy screening form dated 4/7/22 revealed no muscle weakness or reduced functioning of left or right upper or lower extremities documented.

On 5/16/22 at 2:33 p.m., Staff A reported that Staff C, Certified Nurse Aide (CNA), notified her on 5/9/22 that Resident #1 didn't act right all day and had been like that since the day before. Staff C reported that he had been slumped over in his wheelchair. Staff A approached Resident #1 and

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his wife at an activity. Staff A responded that she noted Resident #1 drooling, and his wife reported the slurred speech to her. Staff A verified that Resident #1 had slurred speech, which was a change. Staff A stated she failed to complete a full assessment, a neurological assessment, and she denied checking him for upper or lower extremity weakness. Staff A added that she missed that Resident #1 showed symptoms of a stroke, and she felt bad about it. Staff A confirmed that she sent a non-emergent fax to the provider, but added that if she thought he was having a stroke she would have phoned the provider due to it being an emergent health concern that required immediate intervention. Staff A further stated that she thought she charted when she sent the fax, but agreed the chart had no documentation present. Staff A also said she verbally informed the following shift, but reported that she hadn't added anything to the hot charting which would communicate the need for additional monitoring.

On 5/16/22 at 4:35 p.m., Staff C explained that on 5/9/22 Resident #1's wife reported that she felt helpless. Staff C commented that Resident #1 had slurred speech, increased confusion, and sat slumped over in his wheelchair. Staff C informed Staff A. Staff C said she observed Resident #1 so slumped over in his wheelchair, drooling, talking gibberish, and could hardly open his mouth to take his medications. Staff C reported that as a definite a change of condition for Resident #1. Staff C denied that she heard communication of the changes to the next shift.

On 5/12/22 at 11:45 a.m., Staff B reported that the staff summoned her around 8:00 a.m. on 5/10/22 after they couldn't transfer Resident #1.

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Staff B, stated that after she assessed Resident #1 she looked for charting on him and found none. She reviewed the therapy notes which documented no previous left sided weakness, and found the fax on the clipboard from 5/9/22. Staff B confirmed she didn't receive any communication of changes for Resident #1 in the shift report. Staff B reported that she called the provider as signs and symptoms of a stroke required immediate intervention. Staff B confirmed that she felt the nurse should have notified the provider the day before when Resident #1's wife reported the changes in him.

During an interview on 5/16/22 at 1:13 p.m. the local ER Admitting Provider confirmed she had assessed Resident #1 and visited with his wife as part of the assessment. She explained that when Resident #1 presented with signs and symptoms of a stroke on 5/8/22 and 5/9/22, she would have expected prompt assessment and transfer for the best outcome. The ER Admitting Provider explained that medications to break up a clot for treatment of a stroke must be administered within four hours. The ER Admitting Provider listed the signs of a stroke included: facial droop, arm weakness, and slurred speech. The ER Admitting Provider declared that time lost is brain lost. The ER Admitting Provider added that Resident #1 experience a hemorrhagic stroke, and most probably related to high blood pressure, not related to a clot. However, at the time Resident #1's symptoms presented there would have been no way for staff to determine the cause of the stroke. The ER Admitting Provider explained she would have expected the facility to transfer him for evaluation and treatment promptly.

During an interview on 5/12 22 at 11:20 a.m., the

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Director of Nursing #1, (DON #1) confirmed the chart lacked an assessment documented on 5/9/22 by Staff A. The DON #1 stated she would expect the nurse to do a full assessment due to the reported changes, then document in the electronic chart, and would have expected staff to call the provider with signs and symptoms of a stroke, not send a non-emergent fax notification.

The facility failed to provide a policy or protocol related to physician notification, assessment, and intervention.

The facility was notified of the Immediate Jeopardy (IJ) on 5/16/22. The facility removed the IJ on 5/13/22 after providing education to licensed nursing staff regarding communication of a change in resident's condition, assessment, and intervention of a resident's change in condition, and follow up documentation requirements related to a change in condition. The facility provided education to the licensed nursing staff regarding calling the physician when a resident experienced a change of condition and not sending a fax for urgent care needs. The facility planned to complete random daily audits of the 24-hour summary with ongoing education. The facility intended to use the Quality Assurance (QA) and Quality Assurance and Performance (QAPI) processes to review quarterly for further improvement of implementation needs.

2. Resident #7's Minimum Data (MDS) dated 3/30/22 documented a Brief Interview for Mental Status (BIMS) score of 6, indicating severely impaired cognition (memory). Resident #7 required extensive assistance of 2 persons for transfers and toilet use. Resident #7 required total dependence for bed mobility and personal

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hygiene. The MDS coded Resident #7 as always incontinent of bowel and bladder. The MDS included diagnoses of dementia without behavioral disturbance, depression, and falls.

Resident #7's Care Plan initiated on 1/24/20 lacked documentation related to her rashes.

On 5/19/22 at 7:55 a.m. observed Resident #7 in her room with no rash noted on her hands or visible skin.

The Nurses Note dated 1/25/22 at 12:47 p.m. documented a message left for the doctor regarding Resident #7's pink scattered rash to her abdomen. Resident #7 reported itching to areas and to her back.

A progress note dated 1/26/22 at 11:19 a.m. documented a new order for Benadryl for Resident #7's abdominal rash to be administer BID (twice daily) PRN (as needed).

Resident #7's electronic and paper record lacked documentation of an assessment or interventions for her abdominal rash and itching until 3/2/22.

The Physician Office Visit form dated 3/2/22 at 1:45 p.m. documented a new order for Elimite 5 percent (%) cream, apply head to toe for 10 hours, then rinse, and repeat in seven days.

The Family Medicine form dated 3/2/22 at 1:50 p.m. listed Resident #7's history of present illness as a skin problem. Resident #7's daughter reported that Resident #7 kept itching for months on her entire body. Resident #7 had no visible rash but the doctor did note sores on both of her hands that were there for a month. Resident #7

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complained that her hands were painful and she didn't receive improvement with Benadryl or other creams.

According to Drugs.com reviewed on 3/14/22, Elimite (Permethrin) 5% cream is an anti-parasite prescription medication used topically to treat an infestation of scabies.

The Nurses Note dated 3/2/22 at 3:34 p.m. recorded that Resident #7 went to the doctor's office due to a rash. The doctor explained that he believed the rash came from mites or bed bugs. The facility notified a Pest Control extermination who arrived at 3:30 p.m. The staff removed the resident's clothing, bedding, and linens from their room. The staff bagged them up and took them to the laundry. After the exterminator examined Resident #7's room and surrounding rooms, they reported no evidence of mites or bedbugs observed. They treated the rooms anyway out of precaution.

On 5/25/22 at 1:58 p.m. the local Clinic Nurse reported being present for Resident #7's 3/2/22 office visit. The Primary Care Provider (PCP) assessed a rash in Resident #7's perineal area and areas covered by her incontinence brief that were consistent with a mite, which she clarified to mean scabies. The Clinic Nurse explained that the PCP ordered Elimite, to apply the cream and repeat in seven days for the treatment of scabies. The Clinic Nurse responded that the facility got notified of the new order by a written paper order that went with the resident. The Clinic Nurse added that she also called the facility DON (DON #1) as a courtesy as she felt the facility would need to determine if other residents had been infested with scabies due to it being very

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contagious. The Clinic Nurse stated that the PCP hadn't ruled out bed bugs also, but clarified treatment was ordered for scabies.

The Nurses Note dated 3/5/22 at 10:17 a.m. documented that Resident #7's family visited and reported that Resident #7 complained of itching. The nurse assessed Resident #7 but found no areas of redness but she did state that she itched. The nurse applied lotion and Resident #7 reported that helped.

Resident #7's electronic and paper record lacked documentation of an assessment or interventions for her abdominal rash and itching until 5/11/22. On 5/11/22 the facility received an order to treat all residents at the facility with Permethrin 5% cream due to multiple residents reporting a rash.

Resident #7's Medication Administration Records (MAR) for January, February, March, April, and May 2022 documented an order for a Benadryl allergy tablet (diphenhydramine hcl) 25 milligrams (mg). The order started on 1/26/22 directed to give one table by mouth every 12 hours PRN for abdominal rash. The review of the MARS revealed no documentation of administration of the Benadryl to Resident #7 for relief of abdominal rash itching.

On 5/25/22 at 5:00 p.m. the Director of Clinical Services and the Corporate Infection Control Nurse reviewed the 3/2/22 order for Elimite. The Corporate Infection Control Nurse stated Elimite got prescribed for the treatment of scabies. The Corporate Infection Control Nurse explained that she would expect skin assessments for Resident #7 and other residents at the facility to contain the spread. She also expected ongoing assessments

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to determine the effectiveness of the treatment. The Corporate Infection Control Nurse confirmed no assessments got documented as completed. The Corporate Infection Control Nurse responded that she didn't know of Elimite being used anything for anything other than scabies. The Infection Control Nurse clarified that in a different form permethrin could be used for head lice in humans. The Director of Clinical Services responded that she would have expected the Benadryl to be administered as ordered for relief of symptoms that included intense itching and scratching by Resident #7.

On 6/1/22 at 3:15 p.m., DON #2 confirmed that 16 current residents at the facility had rashes. DON #2 stated she didn't know that Resident #7 had an order for the treatment of scabies on 3/2/22. DON #2 reported that she expected the nurses to do at least weekly skin assessments for residents who identified with rashes as well as do an assessment of their skin following the treatment to assess response. DON #2 would have expected the Benadryl to be administered as ordered for Resident #7 for the relief of intense itching and scratching associated with scabies. DON #2 confirmed that the Benadryl never been administered to Resident #7.

The Scabies Identification, Treatment, and Environmental Cleaning Procedure included the following:
a. Scabies is an itching skin irritation caused by the microscopic human itch mite, which burrows in the skin's upper layers and eventually causes itching, tiny irregular red lines and an allergic rash.
b. Secondary bacterial skin infections could result from untreated scabies.

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F 684	Continued From page 18 c. Symptoms sometimes include severe itching, which worsens at night. d. Common locations include: anterior axillary region or under breasts, around the waist, between the fingers, palm of the hand, inner thigh-groin-buttock, upper backs of nursing home residents, and hands of employees. e. Scabies is spread by skin to skin contact. f. Diagnosis may be established by recovering the mite from its burrow. Failure to identify scrapings as positive does not necessarily exclude diagnosis. Often diagnosis is made from signs and symptoms.	F 684		
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.	F 725		

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§483.35(a)(2) Except when waived under paragraph (e) of this section, the facility must designate a licensed nurse to serve as a charge nurse on each tour of duty.
This REQUIREMENT is not met as evidenced by:
Based on observations, clinical record reviews, resident, family, and staff interviews, the facility failed to ensure resident call lights and needs were met in a timely manner (Iowa Code 481-58.18(4) defines a timely manner as 15 minutes) for 4 of 8 active residents reviewed. (Resident #7, #9, #10, and #11). The facility reported a census of 48.

Findings include:

1. Resident #7's Minimum Data (MDS) dated 3/30/22 documented a Brief Interview for Mental Status (BIMS) score of 6, indicating severely impaired cognition (memory). Resident #7 required extensive assistance of 2 persons for transfers and toilet use. Resident #7 required total dependence for bed mobility and personal hygiene. The MDS coded Resident #7 as always incontinent of bowel and bladder. The MDS included diagnoses of dementia without behavioral disturbance, depression, and falls.

On 5/18/22 at 1:21 p.m., Resident #7's Family Member reported they visited Resident #7 and found them in bed, saturated in urine. Resident #7's Family Member further reported Resident #7 remained in the saturated brief even though they asked for assistance.

2. Resident #9's MDS assessment dated 5/18/22 identified a BIMS score of 4, indicating severely

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impaired cognition. The MDS indicated Resident #9 required extensive assistance of one person with bed mobility, dressing and toilet use. The MDS further coded Resident #9 required limited assistance of one person with ambulation and transfers. The MDS documented Resident #9 as occasionally incontinent of bowel, and always incontinent of bladder. Resident #7's diagnoses included Parkinson's disease, anxiety disorder, Schizophrenia, and traumatic brain injury. The MDS documented showed Resident #9 received hospice care.

Resident #9's Care Plan initiated on 5/17/21 included a Focus area indicating Resident #9 as incontinent of bowel and required assistance with toilet use. The Care Plan directed staff to provide pericare immediately after incontinent episodes.

On 5/31/22 at 12:16 p.m., the Hospice Nurse stated that she found Resident #9 in his room, soaked through his brief and pants, with a puddle of urine on the floor in January of 2022. On 2/23/22 she found Resident #9 wandering at the nurse's station. She took Resident #9 to his room, where he showed her his urine saturated brief no longer around his waist but down to his knees from the weight of the urine. The Hospice Nurse added that she found a puddle of urine in the room, she explained that Resident #9 cried the entire hour she visited with him from being so upset about not being cared for and embarrassment. The Hospice Nurse added that she had concerns with the frequency of incontinence care provided to Resident #9.

On 5/31/22 at 12:31 p.m. Staff D, Certified Nursing Assistant (CNA), stated that he routinely cared for Resident #9. Staff D reported that he

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had concerns with the care provided to Resident #9. Staff D explained that he found Resident #9 with his clothes and brief saturated with a puddle of urine on the floor. Staff D, added that even though Resident #9 could be forgetful and confused at times, he felt he was embarrassed and knew that he didn't get proper cared. Staff D reported that Resident #9 would act out in response to not being cared for.

On 5/31/22 at 1:00 p.m. observed Resident #9 up in a wheelchair, smiling, and able to self-propel with feet. Resident #9 appeared well groomed, clean shaven, wearing clean and dry clothes, while the hospice nurse provided one-on-one (1:1) time.

3. Resident #10's MDS assessment dated 4/27/22 identified a BIMS score of 15, indicating intact cognition. The MDS indicated Resident #10 required extensive assistance of two persons with bed mobility, transfers. The MDS additionally coded Resident #10 as totally dependent on two persons for dressing and toilet use. The MDS further documented Resident #10 as occasionally incontinent of bowel and bladder. Resident #10's diagnoses included Chronic Obstructive Pulmonary Disease (COPD), legal blindness, cellulitis, and morbid obesity.

On 5/18/22 at 4:00 p.m. Resident #10 reported that the staff were slow to respond to call lights. Resident #10 explained that she had an occasion the past week where Staff E, CNA, assisted her onto the toilet at 1:55 p.m. Resident #10 stated that she put her call light on a few minutes later when she got done. Resident #10 reported she stayed on the toilet until 2:48 p.m. when Staff F, CNA, heard her hollering and came into the room.

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Resident #10 confirmed that her call light was on the entire time. Resident #10 denied getting any marks or injuries, but reported that she got uncomfortable. Resident #10 stated that she felt like the facility didn't have enough staff to meet the needs of the residents.

On 5/19/22 at 9:04 a.m. Staff F confirmed that on Tuesday, 5/10/22, at 2:48 p.m. she and Staff G, CNA, heard Resident #10 yelling and crying in her bathroom, and that she helped Resident #10 off the toilet. Resident #10 reported that she received assistance to the toilet by Staff E at around 2:00 p.m. Staff F responded that she found no mark or injury, but noted Resident #10 as upset and crying.

On 5/19/22 at 9:20 a.m. Staff G explained that when they left work on Tuesday, 5/10/22, they heard Resident #10 hollering on the toilet. Staff G confirmed that her bathroom call light was activated. Staff G denied observing a mark or injury on Resident #10, but felt that she sat on the toilet too long. Staff G acknowledged that the residents didn't get changed as frequently as they should and felt it was because they were short staffed.

4. Resident #11's MDS assessment dated 4/20/22 documented a BIMS score of 6, indicating severely impaired cognition. The MDS coded Resident #11 as totally dependent on two persons for bed mobility, transfers, toilet use, dressing, and personal hygiene. The MDS included Resident #11 as incontinent of bowel and bladder. The MDS included diagnoses of dementia, bipolar disorder, anxiety and depression.

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On 5/25/22 at 4:00 p.m. Staff H, CNA, reported that he found Resident #11 in the same nightgown that he had put him two days before. Staff H confirmed it as the same gown, by the way the gown snapped. Staff H declared that it was definitely the same gown.

On 5/25/22 at 4:35 p.m. Staff I, CNA, reported she primarily worked the second shift and would find residents soaked with urine, trash bins full, debris on the floor, supplies out and not put away. Staff I explained that she reported that to the nurse. The residents would report that they hadn't been changed all day, were soaked, and uncomfortable. Staff I added that the facility completed shared rounds between shifts for the past couple of weeks, which had helped.

On 3/23/22 at 8:55 a.m. the Director of Nursing #2 (DON #2) the call light system couldn't provide a report of call light response times. The DON #2 explained that she expected call lights to be answered in 10 minutes, but no more than 15 minutes. The DON #2 responded that she would expect a resident's clothing to be changed daily and as needed due to incontience. The DON further reported that she would expect incontinence care to be provided every 2 to 3 hours depending on the resident.

Countryside Health Care Center

Provider Number 165540

Plan of Correction May 11th- June 8th 2022

The preparation of the following plan of correction for this deficiency does not constitute and should not be interpreted as an admission nor an agreement by the facility of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction prepared for these deficiencies was executed solely because provisions of state and federal law require it.

F 584 Safe/Clean/Comfortable/Homelike Environment

A. The bed for Resident #3 was repaired during the survey.

B. All residents have the potential to be affected by failure to provide a clean, comfortable and home like environment. All resident beds in the center were audited to ensure that all residents had working beds.

C. A generic login to the TELS system was established and facility staff were educated on how to use the system to enter any necessary work order for repairs in the center. Maintenance staff were educated on using the TELS system to ensure that all residents have a clean, homelike environment.

D. Maintenance/Administrator or designee will perform random daily audits of maintenance work orders and timely repair of resident/facility equipment to ensure residents are provided with a clean, comfortable and home like environment.

E. Responsible Party: Administrator/Designee

F. Date Certain: June 28th, 2022

F 658 Services Provided Meet Professional Standards

The facility will continue to meet Professional Standards by administering all medications and treatments as ordered by the Physician, facility will continue to notify Physicians of any omissions of medications and treatments, pharmacy fill or delivery concerns and refusal of medications.

A. Resident #7 has been provided with all medications and treatment orders provided by the physician.
B. All residents have the potential to be affected by improper Professional standards.
C. All Nurses have been educated on proper medication and treatment administration and all medication errors including omissions of medications are to be reported to Physicians in a timely manner.

D. Nursing will conduct random daily audits times one-week, Biweekly times two weeks, Weekly times 4, and random PRN with results forwarded to QA and QAPI committee for review.
E. Responsible Party: DON/Designee
F. Date Certain: June 28th, 2022

F 684 Quality of Care

The facility does and will continue to notify physicians of change in conditions and urgent health concerns so there is not a delay in care or transfers, facility continues to document, and report change conditions to oncoming nurses, facility does continue to assess residents, document findings, and provide relief from signs and symptoms residents may exhibit.

A. Resident #1 has expired. Resident #7 skin has been assessed, documented, and treated per physician's orders.
B. All residents have the potential to be affected from lack of assessment, documentation, and physician notification.
C. All licensed nursing staff were educated regarding communication of resident change of status, assessment, and intervention of resident change in condition, and follow up documentation requirements of change in condition. All residents had a head-to-toe assessment completed with concerns documented and treated accordingly, facility continues weekly skin sweeps for abnormal skin issues. All CNA staff were educated on reporting skin concerns to charge nurse, All Nurses were educated on assessing, documenting, and notifying physicians of skin concerns.
D. Nursing will perform random Daily audits of the 24/hr summary with ongoing education to licensed nursing staff regarding system improvement implementation regarding resident change in condition and appropriate follow up Assessment and intervention. The nursing manager will continue with weekly skin checks.
E. Responsible Party: DON/Designee
F. Date Certain: June 9th, 2022

F 725 Sufficient Nursing Staff

The facility continues to ensure that call lights and resident care needs are being met in a timely manner and accordance to state and federal regulations.

A. Staff educated on answering call lights in a timely manner, Incontinence care and frequency, and grooming which affected residents # 7, 9, 10, 11.
B. All residents have the potential to be affected by insufficient nursing staff.
C. All staff were educated on facility policy and procedure on answering call lights in a timely manner, assist with ADL's, resident cares, and treatments.

D. Nursing will conduct random weekly audits times one-week, Biweekly times two weeks, Weekly times 4, and random PRN with results forwarded to QA and QAPI committee for review.
E. Responsible Party: DON/Designee
F. Date Certain: June 28th, 2022