STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	165390	A. BUILDING _____ B. WING _____	07/19/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
STATE CENTER SPECIALTY CARE	702 THIRD STREET NW STATE CENTER, IA 50247

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 000 OK/TAG ✓	INITIAL COMMENTS Correction Date: 8/11/22 The following deficiencies resulted from the facility's Annual Recertification Survey and investigation of Complaints #98851-C, #101483-C, #102865-C, #104608-C, #105358-C, #105367-C, #105477-C, conducted July 05, 2022 to July 19, 2022. Complaints #98851-C, #101483-C, #102865-C, #104608-C, #105358-C, #105367-C and #105477-C were substantiated. See Code of Federal Regulations (42CFR) Part 483, Subpart B-C.	F 000	"This Plan of Correction is prepared and submitted as required by law. By submitting this Plan of Correction, State Center Specialty Care does not admit that the deficiency listed on this form exist, nor does the facility admit to any statements, findings, facts, or conclusions that form the basis for the alleged deficiency. The facility reserves the right to challenge in legal and/or regulatory or administrative proceedings the deficiency, statements, facts, and conclusions that form the basis for the deficiency."	
F 550 SS=E	Resident Rights/Exercise of Rights CFR(s): 483.10(a)(1)(2)(b)(1)(2) §483.10(a) Resident Rights. The resident has a right to a dignified existence, self-determination, and communication with and access to persons and services inside and outside the facility, including those specified in this section. §483.10(a)(1) A facility must treat each resident with respect and dignity and care for each resident in a manner and in an environment that promotes maintenance or enhancement of his or her quality of life, recognizing each resident's individuality. The facility must protect and promote the rights of the resident. §483.10(a)(2) The facility must provide equal access to quality care regardless of diagnosis, severity of condition, or payment source. A facility must establish and maintain identical policies and	F 550	F550 Resident Rights/Exercise of Rights Residents at State Center Specialty Care will have the right to a dignified existence, self-determination inside and outside the facility. Each resident will be treated with respect and dignity and care for each resident in a manner and in an environment that promotes maintenance and enhancement of their quality of life. The facility will provide equal access to quality care regardless of diagnosis, severity of condition, or payment source. The facility will maintain practices regarding transfer, discharge, and the provision of services. Each resident has the right to exercises his or her rights and exercise those rights in a manner without interference, coercion, discrimination, or reprisal.	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Chris Cohen	ADMN 8/11/22	08/02/2022

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

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F 550	Continued From page 1 practices regarding transfer, discharge, and the provision of services under the State plan for all residents regardless of payment source. §483.10(b) Exercise of Rights. The resident has the right to exercise his or her rights as a resident of the facility and as a citizen or resident of the United States. §483.10(b)(1) The facility must ensure that the resident can exercise his or her rights without interference, coercion, discrimination, or reprisal from the facility. §483.10(b)(2) The resident has the right to be free of interference, coercion, discrimination, and reprisal from the facility in exercising his or her rights and to be supported by the facility in the exercise of his or her rights as required under this subpart. This REQUIREMENT is not met as evidenced by: Based on clinical record review, resident and staff interviews, the facility failed to speak to residents with dignity and respect for 4 of 4 residents (Residents #7, #21, #31 and #39). The facility reported a census of 38. Findings Include: 1. Resident #7's Minimum Data Set (MDS) Assessment Tool, dated 4/14/22, revealed resident diagnoses: stroke, coronary artery disease (heart disease), hypertension (high blood pressure) and diabetes. The MDS identified the resident's cognition intact with a Brief Interview for Mental Status (BIMS) score of 15 out of 15.	F 550	Resident #7 was provided dignity and respect. Resident #21 was provided dignity and respect. Resident #31 was provided dignity and respect. Resident #39 was treated with dignity and respect. Current residents have the potential to be affected Staff have been educated on treating residents with respect, dignity, and following resident rights. Administrator will monitor that staff are treating each resident with respect and dignity. Administrator of designee will conduct three dignity and respect audits x4 weeks. Random audits their after. Concerns identified will be reported and addressed in the facility QAPI committee meetings for additional interventions as indicated.	

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F 550	Continued From page 2 Resident #7's Care Plan dated 4/20/22 revealed resident's Advanced Directive request as being full code, and to provide opportunities for expression of feelings to maintain psychosocial well-being but did not address how the resident preferred to be called by his name. In an interview on 7/8/22 at 12:05 PM, resident #7 stated that Staff A, CNA (Certified Nursing Assistant) was rude to him, used foul language and was forceful when talking to him. In an interview on 7/7/22 at 2:20 PM, Staff A CNA revealed that she called resident #7 "Bud" and stated that "he does not like that". In an interview on 7/9/22 at 2:00 PM, the Director of Nursing (DON) stated that resident #7 had not spoken to her about staff who had been rude. 2. The Annual MDS dated 5/19/22 for Resident #21 included a BIMS score of 9 that indicated moderately impaired cognition for daily decision making. The MDS reported he required extensive assistance of 1 staff for bed mobility and personal hygiene and extensive assistance of 2 staff for transfers and toilet use. The MDS documented diagnoses of atrial fibrillation, cerebrovascular accident (CVA), depression and acute respiratory failure. Resident #21's Care Plan dated 6/27/22 included a focus area for being dependent for meeting emotional, intellectual, physical and social needs. The Care Plan directed staff to provide 1:1 bedside or in room visits and activities if unable to attend out of room events, and to introduce him	F 550		

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F 550	Continued From page 3 to residents with similar background and interests and encourage and facilitate interaction. During an interview on 7/7/22 at 11:50 AM, Resident #21's close friend stated Staff D, Temporary Nurse Aide (TNA) is rough and rude. The friend stated he was going to talk to Administrator about Staff D today. When talking with Resident #21, asked if anyone was mean to him and he replied "yes", and when asked if anyone yelled at him he replied "yes". Resident #21 then asked if any one hurt him replied "yes" and when asked how he stated "he is mean". The resident asked who he was referring to and he replied "Staff D". 3. The Quarterly MDS dated 6/9/22 for Resident #31 included a BIMS score of 15 that indicated intact cognition for daily decision making. The MDS reported diagnoses of anxiety disorder, depression and chronic obstructive pulmonary disease. Resident #31's Care Plan updated 6/8/22 included a focus area for use of antianxiety medications and directed staff to monitor him for any signs of anxiety, agitation or restlessness. During an interview on 7/12/22 at 2:56 PM, Resident #31 explained one day he asked Staff D, TNA to get fresh water. Resident #31 stated Staff D told him they were passing water down the other hallway and can you not wait 45 minutes for fresh water. Resident #31 explained Staff D gets mad and his tone of voice is bad, you can tell he is mad.	F 550		

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F 550	Continued From page 4 4. The 5-Day Scheduled MDS dated 7/5/22 for Resident #39 reported she had a BIMS score of 15 that indicated intact cognition for daily decision making and required extensive assistance of 2 staff for bed mobility, transfers and toilet use and extensive assistance of 1 for dressing and personal hygiene. The MDS documented diagnoses of coronary artery disease, renal insufficiency, hyponatremia, other fracture, seizure disorder, anorexia and obsessive-compulsive disorder. Resident #39's Care Plan dated 6/28/22 included a focus area being unable to transfer independently and directed staff to assist with dressing, toileting, bathing and repositioning as needed and required assistance of 2 staff for all transfers. During an interview on 7/12/22 at 2:18 PM, Resident #39 acknowledged she thinks Staff A, CNA and Staff S, CNA are rough when turning her over instead of letting me turn myself and they come in yelling in a load voice "what do you need". When the resident said something to them about her brief being twisted they say it looks okay to me, they don't have me turn over to straighten it out. They are not very good about the tabs on the brief they stick to my skin. During an interview on 7/14/22 at 1:03 PM, the Administrator stated it is his expectation that every staff treat residents with the utmost respect and to be free of abuse.	F 550		
F 584 SS=D	Safe/Clean/Comfortable/Homelike Environment CFR(s): 483.10(i)(1)-(7) §483.10(i) Safe Environment.	F 584	F584 Safe/Clean/Comfortable/Homelike Environment Residents at State Center Specialty Care	

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F 584	Continued From page 5 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.	F 584	Will be provided a safe, clean, comfortable, and homelike environment, including but not limited to receiving treatment and supports to daily living safely. Resident #19 was provided a safe, clean, comfortable and homelike environment. Current residents have the potential to be affected. Staffed have been educated on providing a safe, clean, comfortable environment. Administrator or designee will monitor audits on safe, clean, comfortable environment. Administrator of designee will conduct three environmental audits per week x4 weeks. Random audits their after. Concerns identified will be reported and addressed in the facility QAPI committee meetings for additional interventions as indicated.	

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F 584	Continued From page 6	F 584		

This REQUIREMENT is not met as evidenced by:
Based on observations, interviews, Housekeeping Staff Schedule review and Policy review, the facility failed to ensure that a resident's room was clean with noted dust on the vents and visible dirt/debris/grime on the floor and under the bed (Resident #19). The facility reported a census of 38.

Findings include:

A Minimum Data Set (MDS) Assessment Tool, dated 4/28/22, documented diagnoses for Resident #19 included Chronic Obstructive Pulmonary Disease (COPD) and the resident's Brief Interview for Mental Status (BIMS) score was 15 out of 15, which indicated intact cognition.

On 7/11/22 at 12:34 PM, Resident #19 stated her room was sort of clean. She stated it has gotten less and less that the Housekeeping Staff clean her room. She stated she didn't think they ever dusted. She added that they are nice girls and she did not want to be upsetting them, but my floor is dirty and I don't think they clean beside the chair. Resident #19 stated that when the Environmental Supervisor cleans the room he will get under the chair and added they don't even clean under the bed anymore. She said they just push the broom in the open areas and say see you tomorrow. Resident #19 said the Housekeeper on this day could not have been in this resident's room for more than a minute. She stated they do not mop in the room.

Observations during this time revealed there was an ant trap on the floor, a coat of dust on the vent, debris under the bed and dirt and grime on

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F 584	Continued From page 7	F 584		

the floor beside the head of the bed. Noted an inhaler was on her bedside table. Pictures were taken.

On 7/11/22 at 2:32 PM, the Environmental Supervisor stated he put down the ant bait himself. He usually puts the ant bait in rooms that have crumbs and stuff in them. He stated it was hard to get under the bed cleaned when a resident is in the bed. He stated Resident #19 is one of them that will refuse to get up. He acknowledged there was dust on the vent. Stated he does have a little red vacuum that can clean some of that up but doesn't have enough staff. He stated that he currently had 4 staff and 2 of them he has talked to regarding their quality of work. He normally has 6 staff. He stated his staff do laundry and housekeeping and he did have someone scheduled to deep clean on this day, but the staff called in though. He stated understanding that the dust in the vent may cause issues for someone with respiratory problems, but stated he cannot do much about it. He works many hours and just can't get good people hired. He keeps trying. A picture was shown to the Environmental Supervisor of dirt and grime by Resident #19's head of bed on the floor He said his staff can move the tray table to sweep and mop. The cords can cause an issue too. He stated that Resident #19's room is one of the hardest to clean. When told a resident reported some of the girls just come in and sweep the middle in general and do not get in between things, he stated he believed it.

An Environmental Guidelines and Protocols book with Policies and Protocols dated 3/2013, directed that the facility will provide Housekeeping and Maintenance Services to maintain a sanitary,

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F 584	Continued From page 8 orderly, and comfortable interior. The facility will maintain a sanitary environment reasonably free of dust, fingerprints, stains, scuffs, soil, and objectionable odors. Sanitation includes, but is not limited to, proper storage, and cleaning of resident care equipment. Refuse will be properly disposed of and pest control measures will be maintained.	F 584		
F 600 SS=D	Free from Abuse and Neglect CFR(s): 483.12(a)(1) §483.12 Freedom from Abuse, Neglect, and Exploitation The resident has the right to be free from abuse, neglect, misappropriation of resident property, and exploitation as defined in this subpart. This includes but is not limited to freedom from corporal punishment, involuntary seclusion and any physical or chemical restraint not required to treat the resident's medical symptoms. §483.12(a) The facility must- §483.12(a)(1) Not use verbal, mental, sexual, or physical abuse, corporal punishment, or involuntary seclusion; This REQUIREMENT is not met as evidenced by: Based on clinical record review, policy review, staff, Resident Representative and resident interviews the facility failed to provide resident safety and well-being for 1 of 1 Residents (Resident #21). The facility reported a census of 38. Findings Include: The Annual Minimum Data Set (MDS) dated	F 600	F600 Free from Abuse and Neglect Residents at State Center Specialty Care have the right to be free from abuse, neglect, misappropriation of resident property, and exploitation. Each resident has the right to be free of corporal punishment, involuntary seclusion and any physical or chemical restraint not required to treat the resident's medical symptoms. Resident #21 was free of abuse, neglect, and exploitation. Current residents have the potential to be affected. Staffed have been educated on abuse, neglect, misappropriation, and exploitation. Administrator will monitor to ensure residents are free of abuse, neglect, and exploitation. Administrator or designee will conduct three resident interview audits per week x4 weeks. Random audits their after.	

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F 600	Continued From page 9 5/19/22 for Resident #21 included Brief Interview for Mental Status (BIMS) score of 9 out of 15, indicating moderately impaired cognition for daily decision making. The MDS identified the resident required extensive assistance of 1 staff for bed mobility and personal hygiene and extensive assistance of 2 staff for transfers and toilet use and documented diagnoses of atrial fibrillation, cerebrovascular accident (CVA), depression and acute respiratory failure. Resident #21's Care Plan dated 6/27/22 included a focus area for being dependent for meeting emotional, intellectual, physical and social needs. The Care Plan directed staff to provide 1:1 bedside or in room visits and activities if unable to attend out of room events, and to introduce him to residents with similar background and interests and encourage and facilitate interaction. The document titled Dependent Adult Abuse Protocols dated 11/21 included the following for Timely Abuse Reporting: a. All allegations of resident abuse, neglect, exploitation, mistreatment, injuries of unknown origin and misappropriation should be reported immediately to the Charge Nurse. The Charge Nurse is responsible for immediately reporting the allegation of abuse to the Administrator, or designate representative. b. All allegations of resident abuse shall be reported to the Iowa Department of Inspections and Appeals no later than 2 hours after the allegation is made. During an interview on 7/7/22 at 11:50 AM, Resident #21's close friend stated Staff D, Temporary Nursing Assistant (TNA) is rough and rude. The friend stated he was going to talk to	F 600	Concerns identified will be reported and addressed in the facility QAPI committee Meetings for additional interventions as indicated.	

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F 600	Continued From page 10 Administrator about Staff D today. When talking with Resident #21 ask if anyone mean he replied "yes", and when asked if anyone yelled at him he replied "yes", and when asked if any one hurt him replied "yes, he is mean" and stated it was Staff D. During an interview on 7/13/22 at 1:00 PM, Resident #21's close friend stated he did call and report to the Administrator on Friday 7/8/22 to report Staff D since he waited at his office on Thursday afternoon and unable to the Administrator then. He stated he reported the rough and rude care being provided by Staff D. The Administrator stated already working on it. The resident's friend also explained he was going to the facility on Thursday 7/14/22 and would be talking to Administrator to find out what is going on with his complaint. During an interview on 7/14/22 at 1:03 PM, the Administrator stated regarding Staff D a complaint had been reported to him back a while ago on a Saturday afternoon about a disgruntled employee in the hallway. It had been reported about Staff D before and they had just treated it as a disgruntled employee and no disciplinary actions taken. He thought it was only in the hallway and not around residents. During an interview on 7/14/22 at 1:35 PM, Resident #21 close friend reported he did talk to Administrator about Staff D and being rough and mean. The Administrator told him he suspended Staff D for a prior incident.	F 600		
F 607 SS=D	Develop/Implement Abuse/Neglect Policies CFR(s): 483.12(b)(1)-(3)	F 607	F607 Develop/Implement Abuse/Neglect Policies	

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F 607	Continued From page 11 §483.12(b) The facility must develop and implement written policies and procedures that: §483.12(b)(1) Prohibit and prevent abuse, neglect, and exploitation of residents and misappropriation of resident property, §483.12(b)(2) Establish policies and procedures to investigate any such allegations, and §483.12(b)(3) Include training as required at paragraph §483.95, This REQUIREMENT is not met as evidenced by: Based on personnel file reviews, facility policy review and staff interview, the facility failed to provide Mandatory Dependent Adult Abuse Training within the required 6 months after hired for 4 of 5 current employees sampled (Staff C, D, P and R). The facility reported a census of 38 residents. Findings Include: Review of Personnel Files revealed the following: a. Staff C, Licensed Practical Nurse (LPN) revealed a hire date of 12/10/21. The personnel record contained a Dependent Adult Abuse Training Certificate dated 7/11/22. b. Staff D, Temporary Certified Nursing Assistant (TNA) revealed a hire date of 7/12/21. The personnel record lacked Mandatory Dependent Adult Abuse Training. c. Staff P, TNA revealed a hire date of 9/14/21. The personnel record contained a dependent adult abuse training certificate dated 7/11/22. d. Staff R, Certified Dietary Manager (CDM) revealed a hire date of 11/1/21. The personnel	F 607	Residents at State Center Specialty Care have the right to be free of abuse, neglect, exploitation, and misappropriation. State Center Specialty Care employees will complete Dependent Adult Abuse training within the required 6 months after hire date. Staff C dependent adult abuse training was completed Staff D dependent adult abuse training was completed Staff P dependent adult abuse training was completed Staff R dependent adult abuse training was completed Current residents have the potential to be affected. Staffed have been educated on completing Dependent Adult timely. Administrator will monitor dependent adult training to ensure completed timely. Administrator or designee will conduct monthly dependent adult training x 3 months. Random audits their after. Concerns identified will be reported and addressed in the facility QAPI committee Meetings for additional interventions as indicated.	

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STATE CENTER SPECIALTY CARE	702 THIRD STREET NW STATE CENTER, IA 50247

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F 607	Continued From page 12 record contained a dependent adult abuse training certificate dated 7/8/22. Review of facility policy titled Dependent Adult Abuse November 2019 Edition under abuse training of employees documented within six months of hire each employee shall be required to complete an initial 2-hour training course provided by the Iowa Department of Human Services relating to the identification and reporting of dependent adult abuse. During an interview 07/12/22 at 10:20 AM, the Administrator acknowledged Staff C, Staff D, Staff P and Staff R had not completed Mandatory Dependent Adult Abuse Training within 6 months of employment.	F 607		
F 609 SS=D	Reporting of Alleged Violations CFR(s): 483.12(c)(1)(4) §483.12(c) In response to allegations of abuse, neglect, exploitation, or mistreatment, the facility must: §483.12(c)(1) Ensure that all alleged violations involving abuse, neglect, exploitation or mistreatment, including injuries of unknown source and misappropriation of resident property, are reported immediately, but not later than 2 hours after the allegation is made, if the events that cause the allegation involve abuse or result in serious bodily injury, or not later than 24 hours if the events that cause the allegation do not involve abuse and do not result in serious bodily injury, to the administrator of the facility and to other officials (including to the State Survey Agency and adult protective services where state law provides for jurisdiction in long-term care facilities) in	F 609	F609 Reporting of Alleged Violations Residents at State Center Specialty Care have the right to be free of abuse, neglect, exploitation, and mistreatment. Alleged Violations will be reported timely. Resident #3 allegation was reported. Current residents have the potential to be affected. Staff educated on reporting alleged violations. Administrator will monitor allegations to ensure reported timely.	

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F 609	Continued From page 13 accordance with State law through established procedures. §483.12(c)(4) Report the results of all investigations to the administrator or his or her designated representative and to other officials in accordance with State law, including to the State Survey Agency, within 5 working days of the incident, and if the alleged violation is verified appropriate corrective action must be taken. This REQUIREMENT is not met as evidenced by: Based on clinical record review, policy review and staff interviews the facility failed to report an allegation of abuse within a timely manner for 1 of 1 residents (Resident #3). The facility reported a census of 38. Findings included: The Quarterly Minimum Date Set (MDS) dated 6/23/22 for Resident #3 reported he had a Brief Interview for Mental Status (BIMS) score of 15 that indicated intact cognition. The MDS documented he required extensive assistance of 1 staff for locomotion of and off the unit and had diagnoses of heart failure, renal insufficiency, diabetes Mellitus and cerebrovascular accident (CVA). Resident #3's Care Plan dated 3/25/22 included a focus area that he is unable to transfer independently and directed staff to assist with transfer, toileting, repositioning, dressing and eating. An Incident Report dated 7/7/22 at 2:30 PM, reported a Certified Nurse Aide (CNA) yelling at the resident in the dining room and aggressively	F 609	Administrator or designee will perform three resident interview audits per week x4 weeks. Random audits to occur their after. Concerns identified will be reported and addressed in the facility QAPI committee Meetings for additional interventions as indicated.	

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F 609	Continued From page 14	F 609		

pushing Resident #3 down the hallway and cursing.

Review of the document titled Dependent Adult Abuse Protocols dated 11/21 included the following on Timely Abuse Reporting:
a. All allegations of resident abuse, neglect, exploitation, mistreatment, injuries of unknown origin and misappropriation should be reported immediately to the Charge Nurse. The Charge Nurse is responsible for immediately reporting the allegation of abuse to the Administrator, or designate representative.
b. All allegations of resident abuse shall be reported to the Iowa Department of Inspections and Appeals no later than 2 hours after the allegation is made.

During an interview on 7/12/22 at 1:03 PM, Staff G, CNA stated to other Surveyor last week and verified she had reported she heard Staff D, Temporary Nurse Aide (TNA) swear at Resident #3 so she reported the incident to the Weekend Manager, Staff J, Social Services/Activities Staff. Staff G explained that Staff J was the only one available at the time and Staff G thought it was back in May, but could not be positive with the date.

During an interview on 7/13/22 at 1:10 PM, Staff J Social Services/Activities Staff reported she had been the Weekend Manager when it was reported to her about Staff D, TNA yelling at a resident and cussing at Resident #3. Staff J explained she was sitting in her office down the B Hallway when Staff D, TNA went by her office and she over heard the commotion the closer he got. Staff D stated to the resident "you're a brat and no one wants to help you just because you

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F 609	Continued From page 15 worked in a Nursing Home before, you don't know anything". Resident #3 explained he was in pain and needed help, that he did not need to yell at him. Staff J acknowledged she wrote up a Grievance Form that Saturday 5/21/22 and called or texted the Director of Nursing (DON) and Administrator and they stated they would talk about it on Monday. Review of Resident #3's Progress Notes lacked documentation of the incident on 5/21/22 or the incident reported on 7/7/22. During an interview on 7/14/22 at 1:03 PM, the Administrator stated it is his expectation that staff treat residents with the utmost respect and to be free of abuse. He stated regarding Staff D it was reported to him back a while ago on a Saturday afternoon about a disgruntled employee in the hallway. It also had been reported about Staff D before and they had just treated as a disgruntled employee, no disciplinary actions taken. He thought it was only in the hallway and not around residents. The Administrator explained when he talked to Resident #3, he did not state Staff D was in his room and understood Staff D yelled at Resident #3 in the hallway. The Administrator explained Staff D left his shift on 7/7/22 and was notified via phone of his suspension pending investigation. The Administrator stated Staff D had no other previous disciplinary actions and his Dependent Adult Abuse Mandatory Reporter Training document unavailable.	F 609		
F 622 SS=D	Transfer and Discharge Requirements CFR(s): 483.15(c)(1)(i)(ii)(2)(i)-(iii) §483.15(c) Transfer and discharge- §483.15(c)(1) Facility requirements-	F 622	F622 Transfer and Discharge Requirements Residents at State Center Specialty Care will discharge from the facility if needs cannot be met in the facility.	

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F 622	Continued From page 16 (i) The facility must permit each resident to remain in the facility, and not transfer or discharge the resident from the facility unless- (A) The transfer or discharge is necessary for the resident's welfare and the resident's needs cannot be met in the facility; (B) The transfer or discharge is appropriate because the resident's health has improved sufficiently so the resident no longer needs the services provided by the facility; (C) The safety of individuals in the facility is endangered due to the clinical or behavioral status of the resident; (D) The health of individuals in the facility would otherwise be endangered; (E) The resident has failed, after reasonable and appropriate notice, to pay for (or to have paid under Medicare or Medicaid) a stay at the facility. Nonpayment applies if the resident does not submit the necessary paperwork for third party payment or after the third party, including Medicare or Medicaid, denies the claim and the resident refuses to pay for his or her stay. For a resident who becomes eligible for Medicaid after admission to a facility, the facility may charge a resident only allowable charges under Medicaid; or (F) The facility ceases to operate. (ii) The facility may not transfer or discharge the resident while the appeal is pending, pursuant to § 431.230 of this chapter, when a resident exercises his or her right to appeal a transfer or discharge notice from the facility pursuant to § 431.220(a)(3) of this chapter, unless the failure to discharge or transfer would endanger the health or safety of the resident or other individuals in the facility. The facility must document the danger that failure to transfer or discharge would pose.	F 622	Resident #34 was discharged to the hospital safely. Current residents at State Center have the potential to be affected. Staff have been educated on discharge transfer process. Director of Nursing or designee will monitor discharges and transfers to ensure documentation completed. Director of Nursing or designee will perform two audits per week on transfers and/or discharges x 4 weeks. Random audits their after. Concerns identified will be reported and addressed in the facility QAPI committee Meetings for additional interventions as indicated.	

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F 622	Continued From page 17 §483.15(c)(2) Documentation. When the facility transfers or discharges a resident under any of the circumstances specified in paragraphs (c)(1)(i)(A) through (F) of this section, the facility must ensure that the transfer or discharge is documented in the resident's medical record and appropriate information is communicated to the receiving health care institution or provider. (i) Documentation in the resident's medical record must include: (A) The basis for the transfer per paragraph (c)(1)(i) of this section. (B) In the case of paragraph (c)(1)(i)(A) of this section, the specific resident need(s) that cannot be met, facility attempts to meet the resident needs, and the service available at the receiving facility to meet the need(s). (ii) The documentation required by paragraph (c)(2)(i) of this section must be made by- (A) The resident's physician when transfer or discharge is necessary under paragraph (c)(1)(A) or (B) of this section; and (B) A physician when transfer or discharge is necessary under paragraph (c)(1)(i)(C) or (D) of this section. (iii) Information provided to the receiving provider must include a minimum of the following: (A) Contact information of the practitioner responsible for the care of the resident. (B) Resident representative information including contact information (C) Advance Directive information (D) All special instructions or precautions for ongoing care, as appropriate. (E) Comprehensive care plan goals; (F) All other necessary information, including a	F 622		

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F 622	Continued From page 18 copy of the resident's discharge summary, consistent with §483.21(c)(2) as applicable, and any other documentation, as applicable, to ensure a safe and effective transition of care. This REQUIREMENT is not met as evidenced by: Based on clinical record review, staff, family and resident interviews and policy review, the facility failed to transfer and discharge a resident to an acute care setting at the resident's request for the resident's welfare and to meet their physical needs (Resident #34). The facility reported a census of 38. Finding Include: 1. Review of the Minimum Data Set (MDS) Assessment dated 5/4/22 revealed Resident #34 entered the facility from the hospital on 4/27/22. The MDS Assessment did not address Resident #34's Brief Interview for Mental Status (BIMS) score. The MDS revealed the resident had diagnosis that included diabetes mellitus, atrial fibrillation, and multiple left rib fractures from a motor vehicle accident and needed extensive assist of one for bed mobility, and limited assist of 1 for transferring and toileting. Resident #34 used a walker and wheelchair for mobility, took a diuretic medication (water pill), used oxygen and received Physical and Occupational Therapy. A Discharge BIMS was completed on 5/6/22 which revealed a score of 13 indicating resident was cognitively intact. The Care Plan dated 4/27/22 revealed a focus area for transitional care planning to home with a goal to transfer to the community and an intervention that included transitioning to home	F 622		

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with goals met.

Review of Resident #34's Progress Notes revealed the following:
a. On 5/4/22 at 11:19 AM, Resident #34 oxygen saturation was 96% on room air. No shortness of breath noted. Lungs sound diminished and respirations easy and non-labored. Resident complained of feeling weak. Fluids were encouraged.
b. On 5/5/22 at 3:03 AM, Resident #34 oxygen saturation was 98% on room air. No shortness of breath noted. Edema was noted to bilateral lower extremities. Resident denied shortness of breath. No cough noted. Lungs sounds diminished.
c. On 5/6/22 at 10:25 AM, Resident #34 oxygen saturation was 94% on room air. No shortness of breath noted. Lung sound were diminished in bilateral lower bases. Respirations were easy and non-labored.
d. On 5/6/22 at 8:00 PM, Resident #34 oxygen saturation was 95% with oxygen on via nasal cannula. Resident noted to have shortness of breath when lying flat. Resident was sitting up in his chair and reported intermittent shortness of breath with activity and it took more time for him to recover after activity. Oxygen saturation was within normal limits. No visible distress was noted.
e. On 5/7/22 at 10:45 AM, Resident #34 oxygen saturation was 91% with oxygen on via nasal cannula. No shortness of breath was noted. Lung sounds were diminished. Resident was in bed and appeared to be resting comfortably.
f. On 5/7/22 at 1:02 PM, an order was received to discontinue from skilled services on 5/7/22 at 11:59 PM and admit to Intermediate Care Facility (ICF) on 5/8/22.
g. On 5/7/22 at 5:40 PM, an order was received

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to discharge resident home on 5/8/22.
h. On 5/7/22 at 7:38 PM, Resident #4 noted to be alert and friendly. Hearing and vision with glasses was adequate. Resident's speech was clear and resident was able to make his needs known. Resident #34 transferred with staff assistance. Resident denied any shortness of breath or issues breathing. Resident was continent of bowel and bladder. Bruises were noted related to motor vehicle accident with multiple fractures. Had been at the facility for Physical and Occupational Therapy Skilled Services.
i. On 5/7/22 at 9:00 PM, Resident #34 oxygen saturation was 97% on oxygen via nasal cannula. Resident noted to have shortness of breath while lying flat. Resident #34 was sitting up in his chair and reported some shortness of breath after activity. Oxygen saturation was within normal limits. Lungs sounds clear to auscultation.
j. On 5/8/22 at 4:56 AM, Resident #34 reported to a Certified Nursing Assistant (CNA) that after he was discharged he was going to the Emergency Room (ER) due to shortness of breath. No acute distress was noted. The resident was asked if he wanted to be transferred to the ER and the resident declined at that time.
k. On 5/8/22 at 6:20 AM, Resident #34's wife arrived to the facility. She reported at that time they would like to have an ambulance called and have the resident sent to the ER for his reports of shortness of breath. The nurse explained to the wife that they could do that but would need him to return to the facility before he could be discharged home. Resident #34 wife was upset with the response and returned to the resident's room. Staff I, Director of Nursing (DON) returned to the resident's room and explained the situation to the resident and his wife. They decided they would discharge home. Instructions reviewed and

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signed by resident, his wife and Staff I. All belongings were taken out to the car by the resident's wife. Resident #34 was being assisted down the hall to go to the car and when staff were switching oxygen tanks the resident's wife called 911 and told them she needed an ambulance to the facility because the resident was short of breath and they had been discharged from the facility already. Resident and his wife waited in the front lobby for the ambulance to arrive. The ambulance arrived at 7:10 AM and as they were backing in the resident and his wife ambulated out to the ambulance and met the Emergency Medical Technician (EMT) at the door with the stretcher. The EMT's assisted the resident into the ambulance. The nurse thought the EMT's would return to get report but the ambulance drove out of the facility followed by the wife in her personal vehicle. The hospital called at 0810 asking for the facilities side of the story and the situation was explained to the nurse calling. Administration was notified of the situation.
I. On 5/8/22 at 1:00 PM, Resident #34's wife called and reported the resident was admitted to the hospital for fluid around his heart and lungs.

A recapitulation of Stay was completed on 5/8/22 indicating the resident was discharging to home.

In a phone interview on 7/11/22 at 11:04 AM, Resident #34 and his wife reported the resident had been complaining of shortness of breath in their phone conversations for the 4 days prior to discharge. The wife reported Resident #34 called her at 5:00 AM on Sunday 5/8/22 asking her to take him to the ER related to his continued shortness of breath. The resident's wife reported when she got to the facility at around 6:00 AM that morning she found the resident to be very

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short of breath. He told his wife at that time that he wanted the ambulance called. She reported the staff told her they were not going to do that because if they did, he would have to return to the facility for 1 day before discharging. The wife stated she then called the ambulance and while waiting for the ambulance to come they signed all the Discharge Paperwork. He was then transported to the ER where he was determined to have congestive heart failure and was admitted to the hospital. Resident #34 reported he had been complaining about being short of breath and was told the shortness of breath was related to his injuries including fractured ribs and clavicle.

In an interview on 7/11/22 at 1:05 PM, Staff J, Social Services/Activities Staff reported she had never heard that if a resident requested to be sent out via ambulance to the ER in lieu of being discharged to home, they would need to return to the facility for discharge. She reported if that was a rule, she had never heard of it.

In an interview on 7/11/22 at 1:10 PM, the Administrator was unsure if it was a requirement for a resident that was planning a discharge to home but was sent to the ER instead needed to return to the facility for discharge to home. He stated he would have to check with Staff K, Nurse Consultant.

In an interview on 7/11/22 at 1:25 PM, Staff I, DON stated it was her understanding that if a resident was in the process of discharging and requested to be sent to the ER, they would need to return to the facility after hospitalization to complete paperwork before discharge. She was unsure how long they would need to remain in the facility upon return from the hospital.

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F 622	Continued From page 23 In an interview on 7/11/22 at 1:40 PM, Staff K stated it was not a requirement that a resident return to a facility post hospitalization and prior to discharge. She stated the facility is absolutely able to call the ambulance if needed and at a resident's request. They do not have to return to the facility, instead the resident can be discharged to the hospital. They would need to complete a Discharge Recapitulation and make note in the Discharge Notes. She further stated it would not be an expectation that the family or resident make the call to get an ambulance if needed and they would not have to sign Discharge Papers prior to the ambulance taking them away. She reported she does not believe staff have been trained on this but the education could easily be done. The facility provided Discharge Summary and Plan policy last revised December 2016 stated the Discharge Plan would be re-evaluated based on changes in the resident's condition or needs prior to discharge.	F 622		
F 657 SS=D	Care Plan Timing and Revision CFR(s): 483.21(b)(2)(i)-(iii) §483.21(b) Comprehensive Care Plans §483.21(b)(2) A comprehensive care plan must be- (i) Developed within 7 days after completion of the comprehensive assessment. (ii) Prepared by an interdisciplinary team, that includes but is not limited to-- (A) The attending physician. (B) A registered nurse with responsibility for the resident. (C) A nurse aide with responsibility for the	F 657	F657 Care Plan Timing and Revision Residents at State Center Specialty Care will have a comprehensive care plan completed timely by the interdisciplinary team. Resident #31 comprehensive care plan was completed timely. Current residents have the potential to be affected.	

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F 657	Continued From page 24 resident. (D) A member of food and nutrition services staff. (E) To the extent practicable, the participation of the resident and the resident's representative(s). An explanation must be included in a resident's medical record if the participation of the resident and their resident representative is determined not practicable for the development of the resident's care plan. (F) Other appropriate staff or professionals in disciplines as determined by the resident's needs or as requested by the resident. (iii)Reviewed and revised by the interdisciplinary team after each assessment, including both the comprehensive and quarterly review assessments. This REQUIREMENT is not met as evidenced by: Based on clinical record review, resident and staff interviews the facility failed to hold and invite residents to the Quarterly Care Plan Meetings for 1 of 15 Residents (#Resident 31). The facility reported a census of 38. Findings Include: The Quarterly Minimum Data Set (MDS) dated 6/9/22 for Resident #31 included a Brief Interview for mental Status (BIMS) score of 15 that indicated intact cognition for daily decision making. The MDS reported diagnoses of anxiety disorder, depression and chronic obstructive pulmonary disease. Resident #31's Care Plan updated 6/8/22 included a focus area for use of antianxiety medications and directed staff to monitor him for any signs of anxiety, agitation or restlessness.	F 657	Staff education was completed on comprehensive care plans. Director of Nursing or designee will monitor comprehensive cares for timely completion. Director of Nursing or designee will perform three care plan audits per week x 4 weeks. Random audits their after. Concerns identified will be reported and addressed in the facility QAPI committee Meetings for additional interventions as indicated.	

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F 657	Continued From page 25 The Care Plan Conference Signature Page dated 11/16/21 included resident and staff signature. The form lacked any signatures after that date. During an interview on 7/7/22 at 10:43 AM, Resident #31 stated he had not been invited to a Care Plan meeting for quite a while. During an interview on 7/12/22 at 12:18 PM, the Director of Nursing (DON) acknowledged she only could find paper work for the 11/16/21 Care Plan Meeting. The DON explained she knows she is behind doing Care Plans.	F 657		
F 676 SS=D	Activities Daily Living (ADLs)/Mntn Abilities CFR(s): 483.24(a)(1)(b)(1)-(5)(i)-(iii) §483.24(a) Based on the comprehensive assessment of a resident and consistent with the resident's needs and choices, the facility must provide the necessary care and services to ensure that a resident's abilities in activities of daily living do not diminish unless circumstances of the individual's clinical condition demonstrate that such diminution was unavoidable. This includes the facility ensuring that: §483.24(a)(1) A resident is given the appropriate treatment and services to maintain or improve his or her ability to carry out the activities of daily living, including those specified in paragraph (b) of this section ... §483.24(b) Activities of daily living. The facility must provide care and services in accordance with paragraph (a) for the following activities of daily living: §483.24(b)(1) Hygiene -bathing, dressing,	F 676	F676 Activities of Daily Living(ADL's)/Mntn abilities Residents at State Center Specialty Care will have comprehensive assessment of a resident consistent with the residents needs and choices. The facility will provide the necessary care and services to ensure that a residents abilities in activities of daily living do not diminish unless circumstances of the individuals clinical condition demonstrate that such diminution was unavoidable. Resident #19 was provided a restorative program Current residents have the potential to be affected. Staff education has been completed on providing restorative programs.	

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F 676	Continued From page 26 grooming, and oral care, §483.24(b)(2) Mobility-transfer and ambulation, including walking, §483.24(b)(3) Elimination-toileting, §483.24(b)(4) Dining-eating, including meals and snacks, §483.24(b)(5) Communication, including (i) Speech, (ii) Language, (iii) Other functional communication systems. This REQUIREMENT is not met as evidenced by: Based on interviews and record review, the facility failed to provide Restorative Care as recommended by Physical Therapy (PT) for 1 out of 1 residents (Resident #19) reviewed. This resident did not receive routine Restorative Therapy. The facility reported a census of 38. Findings Include: A Minimum Data Set (MDS) Assessment dated 4/28/22, documented diagnoses for Resident #19 included Chronic Obstructive Pulmonary Disease (COPD), osteoarthritis of knee, and unspecified morbid obesity. Resident #19's Brief Interview for Mental Status (BIMS) score was 15 out of 15, indicating intact cognition. The MDS identified the resident required extensive assist of 2 for bed mobility, transfers, personal hygiene and dressing. On 7/11/22 at 9:54 AM, Resident #19's niece stated she would like to see some consistency with providing PT or getting her aunt to	F 676	Director of Nursing or designee will perform three restorative audits per week X4weeks. Random audits their after. Concerns identified will be reported and addressed in the facility QAPI committee Meetings for additional interventions as indicated.	

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appointments to be evaluated.

On 7/11/22 at 10:54 AM, Resident #19 stated they do not provide Restorative Programming for her. She stated they do nothing with her.

In an email on 7/13/22 at 4:46 PM, a request was made to the Nursing Home Administrator (NHA), asking for recommendations of a Restorative Program from Therapy that ended in November of 2021.

In an email on 7/14/22 at 11:59, the NHA stated the facility could find any record of a Restorative Program within that time period.

On 7/14/22 at 1:44 PM, the Regional Director of Operations (RDO), stated discharge notes from 11/15/21 recommended Restorative Active Range of Motion (ROM) X 20 reps at 2-3 sets, 3-5 X's per week. The RDO stated she could not say if the facility did this or not. She stated she would provide the Discharge Summary for the Discharge on 11/15/21. She stated there was also a Discharge from Therapy Services in February of 2022. She stated she would provide the Discharge Summary for this session of Therapy as well.

As of 7/15/22, a PT Discharge Summary was not provided for Therapy ending in February 2022.

A PT Discharge Summary dated 11/15/2021 at 7:10 AM, documented that this resident's Discharge Recommendations were:
a. Air mattress, FMP/RNP(functional maintenance program/restorative nursing program), gel cushion and 24 hour care.
b. Restorative Range of Motion (ROM) Program

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bilateral lower extremities (BLE) active range of motion to all available planes x 20 repetitions, X(times) 2-3 sets, x 3-5 days week.

An undated and untitled Restorative Program with Resident #19's initials and restorative written on top was provided by the facility. It included the following:
a. Active ROM lower extremities: 20 reps x 1-2 sets in all planes and supine exercises 20 reps x 1-2 sets in all planes.
b. Omnicycle: lower extremities level 2 X 15 minutes.
c. Pulleys X 5 minutes.
d. BLE seated exercises with 2 pound ankle weights and green theraband.

An undated, untitled, sheet with dates and times for Restorative was provided by the facility for this resident. The resident's name is not on the sheet. The sheet shows that Restorative Care was done 13 days with this resident, between dates ranging from 4/18 to 6/29 (22). The sheet contained 2 Restorative Aides names and initials handwritten on top.

No further documentation of Restorative Therapy was provided by the facility.

A Restorative Nursing Services policy dated July 2017, directed that residents will receive Restorative Nursing Care as needed to help promote optimal safety and independence as follows:
a. Restorative Nursing Care consists of nursing interventions that may or may not be accompanied by
formalized rehabilitative services (e.g., Physical, Occupational or Speech Therapies).

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F 676	Continued From page 29 b. Residents may be started on a Restorative Nursing Program upon admission, during the course of stay or when discharged from Rehabilitative Care. c. Restorative goals and objectives are individualized and resident-centered, and are outlined in the resident's Plan of Care. d. The resident or representative will be included in determining goals and the Plan of Care. e. Restorative goals may include, but are not limited to supporting and assisting the resident in: a. Adjusting or adapting to changing abilities; b. Developing, maintaining or strengthening his/her physiological and psychological resources; c. Maintaining his/her dignity, independence and self-esteem; and d. Participating in the development and implementation of his/her Plan of Care.	F 676		
F 684 SS=G	Quality of Care CFR(s): 483.25 § 483.25 Quality of care Quality of care is a fundamental principle that applies to all treatment and care provided to facility residents. Based on the comprehensive assessment of a resident, the facility must ensure that residents receive treatment and care in accordance with professional standards of practice, the comprehensive person-centered care plan, and the residents' choices. This REQUIREMENT is not met as evidenced by: Based on clinical record review, resident and staff interviews, the facility failed to provide assessment and interventions for the necessary care and services, to maintain the residents'	F 684	F684 Quality of Care Residents at State Center Specialty Care will receive treatment and care in accordance with professional standards of practice, the comprehensive person-centered care plan, and choices. Resident #7 had a thorough assessment and was provided treatment per physician orders. Resident #23 bruising was assessed. Current residents have the potential to be affected.	

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F 684	Continued From page 30 highest practical physical well- being. Clinical record review revealed the Nursing Staff did not complete a thorough assessment and provide treatment according to the Physician's Orders for 1 of 1 residents reviewed (Resident #7) also the facility failed to ensure that a resident received treatment and care in accordance with professional standards of practice, for 1 of 1 resident reviewed for bruising (Resident #23). Resident #23 noted with multiple bruises which had not been assessed, documented nor were additional interventions put in to place by/at the time of the Survey. Resident #23 had bruises in different stages of healing. The facility reported a census of 38. Finding Include: 1. Resident #7's Minimum Data Set (MDS) Assessment, dated 4/14/22, revealed diagnoses: stroke, coronary artery disease (heart disease), hypertension (high blood pressure) and diabetes. The MDS documented the resident's cognition intact with a Brief Interview for Mental Status (BIMS) score of 15 out of 15. Care Plan dated 4/20/22 revealed directive for staff to give anti-hypertensive medication as ordered. There was no directive for treating of chest pain with Nitroglycerin, and no direction for staff to follow for when to monitor blood pressure or when to call physician. During an interview on 7/5/22 at 2:30 PM, resident #7 stated they facility ran out of the evening blood pressure medication and he experienced chest pain and a headache at the base of his skull. Resident #7 stated it felt like when he had his stroke and described the feeling	F 684	Director of Nursing or designee will monitor new skin areas as they arise to provide documentation of investigation and treatment. Staff education has been completed on providing a thorough skin investigation when a new area arises. Staff education has been completed on blood pressure reporting parameters. Director of Nursing or designee will monitor blood pressures of residents receiving anti-hypertensive medications to ensure notification to physician occurred if outside reporting parameters. Director of Nursing or designee will perform daily audits of blood pressures x4 weeks to ensure notification to physician occurred. Random audits their after. Director of Nursing or designee will perform three audits per week of skin observations x 4 weeks. Random audits their after. Concerns identified will be reported and addressed in the facility QAPI committee Meetings for additional interventions as indicated.	

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as "the blood pressure was frightening, my head was throbbing and I could hear the whooshing sound". Resident #7 stated the nurse brought the evening medication and the resident noticed the blood pressure pill was not there. Resident #7 stated when he inquired about the medication, the nurse stated they ran out and "you're not the only one this happens to". Resident #7 stated his blood pressure was over 200 and he called 911.

Physician's Orders revealed Toprol XL 75 milligrams (mg) to be given once a day started on 4/28/22 and Nitroglycerin (Nitro) tablet 0.4 mg ordered on 6/16/22 for chest pain.

Progress Notes revealed on 6/9/22, resident #7 experienced stabbing chest pain, Tylenol given, physician not notified. Resident #7 experienced chest pain again on 6/13/22 and 6/15/22 when the physician was sent a fax. The fax was answered on 6/16/22 with the new order for Nitro for chest pain. Resident was monitored on 6/17/22 through 6/20/22 with no reoccurring chest pain.

Review of the Medication Administration Record (MAR) dated 6/1/22 - 6/30/22 revealed Toprol was not given on 6/24/22, code 9 indicates medication not available.

Progress Notes dated 6/24/22 revealed at 6:58 PM, the medication Toprol for high blood pressure was not available. At 11:00 PM, staff was called to resident #7's room, resident was agitated, reported a headache, "feels exactly like when I had my stroke", blood pressure 220/143, heart rate 87. Resident #7 calling police. At 11:10 PM nurse called the Physician Assistant (PA) and received an order to send resident #7 to the

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hospital. At 11:15 PM the nurse called the Emergency Medical Service (EMS) and they were on the way already. At 11:35 PM EMS arrived to the facility.

Progress Notes dated 6/25/22 at 4:05 AM, revealed resident #7 returned to the facility, blood pressure 164/111, resident #7 complained of headache. There are no further cardiac assessments nor follow up completed. On 6/30/22 at 2:27 PM the physician seen resident #7.

Review of a document from the local hospital - Ambulance Service Transport Record dated 6/24/22, contained a paragraph titled History of Present Event revealed that resident #7 developed chest pain and headache after 7:30 PM described chest pain as stabbing and reported the facility had trouble adjusting resident's blood pressure medications over the last two months, resident had not received his blood pressure medication that evening resulting in a blood pressure of 230/120. The document listed resident #7's past history of two heart attacks and stroke. The document revealed an electrocardiograph (EKG) results of sinus rhythm and blood pressure at 11:36 PM at 186/96, at 11:42 PM 181/100 and at 11:50 PM 167/102. Resident taken to a local hospital..

A document from the local hospital's Emergency Department dated 6/24/22 revealed resident #7 was seen for elevated blood pressure. Resident #7 reported his chest pain stopped and was given a pain medication for headache in the Emergency Department (ED). An EKG, Chest X-ray and labs were performed and reviewed. The elevated blood pressure was stabilized and resident #7

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was returned to the facility.

During phone interview on 7/8/22 at 12:45 PM, Staff B, Licensed Practical Nurse (LPN) stated they have been having problems receiving medications from the pharmacy, "not arriving". Staff B stated she worked on 6/25/22 and remembered the situation with resident #7's medication, "it was labeled wrong". She stated she found it with that mornings medication, relabeled it and put it with the evening medications.

During an interview on 7/9/22 at 2:00 PM, the Director of Nursing (DON) stated the Evening Staff Nurse, Staff C, LPN, called and notified her of Resident #7 transfer and return to the facility. The DON revealed she knew about the missing medication and that it was found in the morning, incorrectly labeled. She stated her expectations of her nurses for chest pain, "I would expect them to do a cardiac assessment for symptoms and take blood pressure and pulse then call the doctor to report, probably get a onetime order for blood pressure medication or transfer him to the hospital".

2. A MDS Assessment dated 5/19/22, documented diagnoses for Resident #23 included Cerebrovascular Accident (CVA) and schizophrenia. The Brief Interview for Mental Status revealed a score of 6 out of 15, indicating severely impaired cognition. The resident required assist of 1 with transfers and ambulation.

A Care Plan with a focus area initiated on 7/2/22, directed staff that Resident #23 was at risk for

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falls. Her goal was that she would not experience any injuries related to falls. The Care Plan directed staff on the following:
a. To encourage this resident to use her call light for assistance.
b. This resident needed a safe environment without clutter.
c. To make sure she was wearing appropriate footwear.
d. To monitor her for unsteady gait.

Nursing Skin Observation forms documented the following weekly assessments:
a. On 6/23/22 this resident had no new skin issues
b. On 6/29/22 this resident refused a skin assessment.
c. On 7/6/22 this resident had no new skin issues.
d. On 7/13/22 this resident had no new skin issues.

A Hospital Emergency Department Provider Notes document dated 7/6/22, documented that there was a number of bruises mainly on extremities. Pictures revealed that there was more than 20 bruises on this resident's lower extremities and left wrist.

Progress Notes included documentation of the following:
a. On 6/24/22 at 4:50 AM, Certified Nurse Assistant (CNA) called this nurse that the resident is on the floor. Upon arriving in resident's room, the resident was on the floor and laying on her right side. Resident was in front of the door, behind her wheelchair and next to foot of her bed. Resident laid on her back and head supported with a pillow. Resident was assessed and vitals were taken. No injuries noted, res denied having

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pain or discomfort. Resident was wearing gripper socks at the time of fall, resident did not utilize call light.
b. On 6/24/22 at 11:10 PM, Resident denies pain or injury from recent fall.
c. On 6/25/2022 at 9:45 AM, Resident has no injuries noted related to fall.
d. On 6/25/2022 at 8:35 PM, Resident denies pain or injury from recent fall. Full Range of Motion (ROM) to all extremities. Resident is alert but forgetful.
e. On 6/26/2022 at 9:15 AM, Resident has no injuries noted related to the fall. Resident is alert and oriented x 3 (person, place and time) with noted forgetfulness at times.
f. On 6/26/22 at 8:25 PM, Resident forgetful at times but alert. Denies changes pain or injury related to recent fall.
g. On 6/27/22 at 12:50 PM, Follow up related to unwitnessed fall. Resident is alert, resting in bed with no complaints of pain or discomfort. No new skin issues or injuries observed.
h. On 6/29/2022 at 1:45 AM, fall follow up, denies injury.
i. On 7/1/2022 at 4:10 PM, Resident being monitored for unwitnessed fall on 6/30. No injuries noted. Resident Alert and Oriented x 3 with noted forgetfulness.
j. On 7/7/2022 at 1:26 AM, CNA reports to his nurse that resident was on the floor. Found resident sitting on the floor by bed side, no injuries noted, vitals and neuros stable.
k. On 7/9/2022 at 1:50, Resident complained of chest pain. At 2:30 AM, resident was transported to the hospital.
l. On 7/12/2022 at 5:35 PM, Resident noted to have scattered bruising in multiple healing stages. A fax (was sent) to the doctor related this resident was on plavix and aspirin and will have

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various bruises.
m. On 7/13/22 from 3:17 to 3:21 PM, 6 entries were documented each entry had an identified bruise.
n. On 7/13/2022 at 3:56 PM, Nurse notified of resident having multiple bruises to extremities. Resident assessed head to toe and bruises noted in various stages to all extremities. Skin evaluations completed. Resident states she bumps them (arms and legs) a lot. Medications reviewed and resident taking plavix and aspirin. Resident has fragile skin and bruises easily. Doctor notified. Call placed to brother and made aware. Thanked nurse for the update.

On 7/12/22 at 12:56 PM, Skin Assessments and Evaluations were requested regarding bruises on this resident. The Director of Nursing (DON) was not aware of bruises and stated she would look into it.

On 7/14/22 at 10:59 AM, the Director of Nursing (DON) stated she had went down and did a head to toe on Resident #23. She stated this resident did have extremity bruises in various stages and some were faded out yellow. There were one or two that were a darker purple. The DON stated this resident had a couple of falls lately and is also on Plavix and aspirin. The DON stated this resident said she bumped into things. The DON stated this resident is hit or miss on reliability. The DON felt like when she talked to the resident about stuff the resident is reliable. She was not sure why none of the bruises were charted. She stated they should have been charted on the weekly skin checks. When told the weekly skin checks on the 7th and the 13th stated there were no new skin issues, she stated it should have been charted there. When asked if the CNAs

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F 684	Continued From page 37	F 684		

report bruises, she said the bruises should have been reported and documented on. She stated that directly after the 3 falls the bruises may not have shown up yet. She stated she called the Nurse Consultant about the bruises after being asked about documentation on them on 7/12/22. The DON stated that she was directed to call the physician, do assessments on the bruises and document it all in the chart. The DON stated she did not start any type of investigation into this. She stated she will need to ask some questions of her staff as to why this was not documented. She repeated it should have been documented on the weekly skin assessments.

On 7/14/22 at 12:25 PM, Staff A, CNA, stated Resident #23 is technically an assist of 1, but she is non-compliant and transfers all the time by herself. She stated this resident takes herself to the bathroom and is incontinent and doesn't' always change her brief when it is wet. Staff A stated they check and change this resident. Staff A stated this resident puts her knees on the bed instead of sitting then crawls on to the bed and gets the bruises on her shins a lot. Staff A, reported that she didn't see the bruising so much when working as a Medication Aide, as this resident would have pants on but Staff A saw it a lot more as a CNA. Bruises are pretty typical for this resident. Staff A stated this resident uses her call light when she needs something as well, but has had a couple of falls lately.

On 7/14/22 12:36 PM, Staff E, CNA, stated that sometimes Resident #23 has bruises on her legs. Staff E stated that when she first started, she reported the bruising, but she was told it happens and they knew about the bruising. She repeated that they just tell me they know about it.

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F 684	Continued From page 38 On 7/14/22 at 12:57 PM, Staff F, Licensed Practical Nurse (LPN), stated she just started working again in the last 2 weeks as she was in Nursing School. She stated she had done the weekly skin assessment on 7/13/22 for Resident #23. She stated that none of those bruises were new and that is why she marked no, to the question if there are any new skin areas. When asked if records were kept of bruises, she stated she would assume they would keep those on a record until they were healed or gone. She stated there is an I-Pad thing that they use to take a picture of the new skin areas and measure them. She did not know the paper work piece of it yet. She hadn't heard anything about the bruises through report so she guessed those bruises were from Resident #23 transferring herself and recent falls. Staff F stated that she was still in orientation so not sure how the records are kept. An Accidents and Incidents-Investigating and Reporting Policy revised on 7/2017, directed that all accidents or incidents involving residents, employees, visitors, vendors, etc., occurring on our premises shall be investigated and reported to the Administrator. Policy Interpretation and Implementation 1. The Nurse Supervisor/Charge Nurse and/or the Department Director or Supervisor shall promptly initiate and document an investigation of the accident or incident. 2. The following data, as applicable, shall be included on the Report of Incident/Accident form: a. The date and time the accident or incident took place; b. The nature of the injury/illness (e.g., bruise, fall, nausea, etc.);	F 684		

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F 684	Continued From page 39 c. The circumstances surrounding the accident or incident; d. Where the accident or incident took place; e. The name(s) of witnesses and their accounts of the accident or incident; f. The injured person's account of the accident or incident; g. The time the injured person's Attending Physician was notified, as well as the time the physician responded and his or her instructions; h. The date/time the injured person's family was notified and by whom; i. The condition of the injured person, including his/her vital signs; j. The disposition of the injured (i.e., transferred to hospital, put to bed, sent home, returned to work, etc.); k. Any corrective action taken; l. Follow-up information; m. Other pertinent data as necessary or required; and n. The signature and title of the person completing the report. 3. This facility is in compliance with current rules and regulations governing accidents and/or incidents involving a medical device. 4. This facility will adhere to the definitions in the Medical Device Reporting Act when filing the Food and Drug Administration MED-WATCH Forms (3500). 5. The Nurse Supervisor/Charge Nurse and/or the department director or supervisor shall complete a Report of Incident/Accident form and submit the original to the Director of Nursing Services within 24 hours of the incident or accident.	F 684		

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F 684	Continued From page 40 6. The Director of Nursing shall ensure that the Administrator receives a copy of the Report of Incident/ Accident form for each occurrence. 7. Incident/Accident reports will be reviewed by the Safety Committee for trends related to accident or safety hazards in the facility and to analyze any individual resident vulnerabilities.	F 684		
F 689 SS=D	Free of Accident Hazards/Supervision/Devices CFR(s): 483.25(d)(1)(2) §483.25(d) Accidents. The facility must ensure that - §483.25(d)(1) The resident environment remains as free of accident hazards as is possible; and §483.25(d)(2)Each resident receives adequate supervision and assistance devices to prevent accidents. This REQUIREMENT is not met as evidenced by: Based on observations, clinical record review and staff interview the facility failed to properly transport a resident in a wheelchair down the hallway for 1 of 1 Residents (Resident #32). The facility reported a census of 38 Residents. Findings Include: The Annual Minimum Data Set (MDS) Assessment dated 6/16/22 for Resident #32 reported a Brief Interview for Mental Status (BIMS) score of 8 which indicated moderately impaired cognition for daily decision making. The MDS included he required extensive assistance of 2 staff for transfers and extensive assistance of 1 staff for mobility on and off unit and diagnoses of cancer, atrial fibrillation, diabetes	F 689	F689 Free of Accident Hazards/Supervision/ Devices Residents at State Center Specialty Care will remain free of accident hazards as is possible and receives adequate supervision and assistance devices to prevent accidents. Resident #32 was propelled in wheelchair with pedals. Current residents have the potential to be affected. Staff educated on wheelchair pedal use. Director of Nursing or designee will monitor residents who utilize wheelchairs to ensure pedals on while propelling resident. Director of Nursing or designee will perform three wheelchair pedal audits per week x 4 weeks. Random audits their after. Concerns identified will be reported and addressed in the facility QAPI committee	

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F 689	Continued From page 41 mellitus, muscle weakness and neoplasm of the bone, soft tissue and skin. Resident #32's Care Plan dated 6/25/21 identified a focus area for requiring staff assistance for Activities of Daily Living and the resident required a wheelchair propelled for mobility. During an observation on 7/7/22 at 8:26 AM, Staff D, Temporary Nursing Aide (TNA) pushed Resident #32 down the hallway with no foot peddles and his feet very close to the floor approximately 58 feet (counting 29 tile (the 2 ft x 4 ft ceiling tile)). During an interview on 7/14/22 at 1:03 PM, the Administrator acknowledged they did not have a policy for using foot pedals on wheelchairs. He did explain the expectation is to have wheelchair pedals on while pushing a resident.	F 689	Meetings for additional interventions as indicated.	
F 695 SS=D	Respiratory/Tracheostomy Care and Suctioning CFR(s): 483.25(i) § 483.25(i) Respiratory care, including tracheostomy care and tracheal suctioning. The facility must ensure that a resident who needs respiratory care, including tracheostomy care and tracheal suctioning, is provided such care, consistent with professional standards of practice, the comprehensive person-centered care plan, the residents' goals and preferences, and 483.65 of this subpart. This REQUIREMENT is not met as evidenced by: Based on observations, clinical record review, resident and staff interviews the facility failed to properly handle oxygen tubing for 1 of 1 resident (Resident #31). The facility reported a census of	F 695	F695 Respiratory/Tracheostomy Care and Suctioning Residents at State Center Specialty Care will ensure that a resident who needs respiratory care, including tracheostomy care and suctioning, is provided such care, consistent with professional standards of practice, the comprehensive person-centered care plan and the residents goals and preferences. Resident #31 oxygen was properly handled. Current residents have the potential to be affected.	

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F 695	Continued From page 42 38. Findings Included: The Quarterly Minimum Data Set (MDS) Assessment dated 6/9/22 for Resident #31 included a Brief Interview for Mental Status (BIMS) score of 15 indicated intact cognition for daily decision making. The MDS reported diagnoses of anxiety disorder, depression and chronic obstructive pulmonary disease and used oxygen while a resident. Resident #31's Care Plan identified a focus area for chronic obstructive pulmonary disease (COPD) and directed staff to monitor of signs and symptoms for acute respiratory insufficiency , anxiety, confusion, restlessness, and shortness of breath at rest. The Care Plan directed staff to set the oxygen at 4 liters per nasal cannula continuously and humidified and may increase to 6 liters if oxygen saturation under 92%. Resident #31's Treatment Administration Record (TAR) included an order to change oxygen tubing Saturdays and as needed for maintenance. The TAR shown the tubing charted as changed 7/2/22 and 7/9/22. Observation on 7/7/22 at 11:07 AM, the oxygen tubing on the concentrator dated 7/3/22. Observation on 7/12/22 at 2:09 PM, the oxygen tubing on the concentrator dated 7/3/22. An interview on 7/12/22 at 2:09 PM, Resident # 31 stated they do not change the tubing often. During an interview on 7/13/22 at 11:18 AM, Staff	F 695	Staff education completed on oxygen use. Director of Nursing will monitor residents with oxygen to ensure tubing is being changed routinely. Director of Nursing or designee will perform three oxygen audits per week x 4 weeks. Random Audits their after. Concerns identified will be reported and addressed in the facility QAPI committee Meetings for additional interventions as indicated.	

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F 695	Continued From page 43 C License Practical Nurse (LPN) stated she worked Saturday 7/9/22 and explained it was a crazy night she most likely signed off she changed oxygen tubing but did not actually get it done. During an interview on 7/14/22 at 1:03 PM, the Administrator acknowledged his expectation would be that when the oxygen tubing was signed off as changed the Nursing Staff would have changed the tubing.	F 695		
F 726 SS=D	Competent Nursing Staff CFR(s): 483.35(a)(3)(4)(c) §483.35 Nursing Services 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)(3) The facility must ensure that licensed nurses have the specific competencies and skill sets necessary to care for residents' needs, as identified through resident assessments, and described in the plan of care. §483.35(a)(4) Providing care includes but is not limited to assessing, evaluating, planning and implementing resident care plans and responding to resident's needs.	F 726	F726 Competent Nursing Staff Residents at State Center Specialty Care will provide sufficient nursing staff with appropriate competencies and skill 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. Staff Q completed CPR certification. Current residents have the potential to be affected. Staff education completed completing CPR certification. Administrator or designee will monitor CPR certifications to ensure completed timely.	

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F 726	Continued From page 44 §483.35(c) Proficiency of nurse aides. The facility must ensure that nurse aides are able to demonstrate competency in skills and techniques necessary to care for residents' needs, as identified through resident assessments, and described in the plan of care. This REQUIREMENT is not met as evidenced by: Based on record review and staff interview, the facility failed to ensure properly trained personnel certified in Cardiopulmonary Resuscitation (CPR) was available the required 24 hours a day. Review of CPR certified staff along with review of Nursing Staff Schedules revealed the facility went without a CPR certified staff member during 7 twelve hour shifts from 6/19/22-7/11/22. The facility reported a census of 38 residents. Findings Include: Review of facility Nursing Schedules dated 6/19/22-7/11/22 documented Staff Q, Licensed Practical Nurse (LPN) as the covering nurse for the following dates and times: a. On 6/20/22- 6:00 PM-6:00 AM. b. On 6/21/22- 6:00 PM-6:00 AM. c. On 6/29/22- 6:00 PM-6:00 AM. d. On 6/30/22- 6:00 PM-6:00 AM. e. On 7/4/22- 6:00 PM-6:00 AM. f. On 7/5/22- 6:00 PM-6:00 AM. g. On 7/11/22- 6:00 PM-6:00 AM. The facility was unable to provide a current CPR certificate for Staff Q when requested on 7/12/22. No other CPR qualified staff were working during the documented time periods. Facility policy titled Emergency Procedure-	F 726	Administrator or designee will perform CPR certification audits monthly x three monthly. Random audits their after. Concerns identified will be reported and addressed in the facility QAPI committee Meetings for additional interventions as indicated.	

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F 726	Continued From page 45 Cardiopulmonary Resuscitation directed staff to obtain and/or maintain American Red Cross or American Heart Association certification in Basic Life Support (BLS)/Cardiopulmonary Resuscitation (CPR) for key clinical staff members who will direct resuscitative efforts. If an individual is found unresponsive and not breathing normally, a licensed staff member who is certified in CPR/BLS shall initiate CPR unless it is known that a Do Not Resuscitate (DNR) order that specifically prohibits CPR and/or an external defibrillation exits for that individual. During an interview 07/12/22 at 12:38 PM, the Administrator acknowledged there was not CPR coverage on 6/20, 6/21, 6/29, 6/30, 7/4, 7/5 and 7/11/22 from 6:00 p.m.- 6:00 a.m.	F 726		
F 755 SS=D	Pharmacy Srvcs/Procedures/Pharmacist/Records CFR(s): 483.45(a)(b)(1)-(3) §483.45 Pharmacy Services The facility must provide routine and emergency drugs and biologicals to its residents, or obtain them under an agreement described in §483.70(g). The facility may permit unlicensed personnel to administer drugs if State law permits, but only under the general supervision of a licensed nurse. §483.45(a) Procedures. A facility must provide pharmaceutical services (including procedures that assure the accurate acquiring, receiving, dispensing, and administering of all drugs and biologicals) to meet the needs of each resident. §483.45(b) Service Consultation. The facility must employ or obtain the services of a licensed pharmacist who-	F 755	F755 Pharmacy Srvcs/Procedures/Pharmacist/Records Residents at State Center Specialty Care will be provide routine and emergency drugs and biologicals. All drugs and biologicals will each residents needs. Resident#39 was provided medications as ordered. Current residents have the potential to be affected. Staff education completed on pharmacy services. Director of Nursing or designee will monitor pharmacy services and medications to ensure resident receive medications as	

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F 755	Continued From page 46 §483.45(b)(1) Provides consultation on all aspects of the provision of pharmacy services in the facility. §483.45(b)(2) Establishes a system of records of receipt and disposition of all controlled drugs in sufficient detail to enable an accurate reconciliation; and §483.45(b)(3) Determines that drug records are in order and that an account of all controlled drugs is maintained and periodically reconciled. This REQUIREMENT is not met as evidenced by: Based on clinical record review, facility policies, resident and staff interviews the facility failed to provide medications as ordered on admission for 1 of 1 Residents (Resident #39). The facility reported a census of 38. Findings Include: The 5-day scheduled Minimum Data Set (MDS) dated 7/5/22 for Resident #39 reported she had a Brief Interview for Mental Status (BIMS) score of 15 that indicated intact cognition for daily decision making. The MDS documented she had diagnoses of coronary artery disease, renal insufficiency, hyponatremia, other fracture, seizure disorder, anorexia and obsessive-compulsive disorder (OCD). Resident #39's Care Plan dated 6/28/22 identified a focus area for the medication promethazine for headaches, Xanax for anxiety, and a diuretic therapy for hypertension. The Care Plan directed staff to administer the medication and monitor for any adverse effects and report to the physician as	F 755	ordered. Director of Nursing or designee will perform three pharmacy audits per week x4 weeks. Random audits their after. Concerns identified will be reported and addressed in the facility QAPI committee Meetings for additional interventions as indicated.	

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F 755	Continued From page 47 needed. The discharge orders from the hospital for Resident #39 dated 6/28/22 included the following medications: a. Ranitidine 150 milligrams (mg) 1 tablet by mouth daily. b. Biotin 5 mg 2 tablets by mouth 2 times a day. c. Tecfidera 240 mg by mouth 2 times a day for multiple sclerosis. d. Modafinil 100 mg (stimulant) 1 tablet 3 times a daily for OCD. e. QVAR inhaler 40 micro grams (mcg/activate) inhale 1 puff 2 times a day. f. Magnesium chloride-calcium delayed release 64-108 mg give 2 tablets by mouth 2 times a day. Resident #39's Medication Administration Record (MAR) for June 2022 contained the following: a. QVAR inhaler 40 mcg/act inhale 1 puff 2 times a day. On June 28th, 29th, and 30th documented other/ see progress note. b. Biotin 5 mg tablet 1 by mouth 2 times a day. On June 29th 2 times and once on the 30th documented other/see progress note. c. Tecfidera 240 mg by mouth 2 times a day for multiple sclerosis. On the 29th and 30th documented other/see progress note. e. Modafinil 100 mg (stimulant) 1 tablet 3 times a daily for OCD. On the 29th and 30th all 3 times documented other/see progress note. Resident #39's MAR for July 2022 contained the following: a. Ranitidine 150 mg 1 tablet by mouth daily. On the 2nd and 4th documented other/see progress note. b. Biotin 5 mg 2 tablets by mouth daily. On the 5th, 6th , 11th and 12th documented other/see	F 755		

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F 755	Continued From page 48 progress note. c. Magnesium chloride-calcium delayed release 64-108 mg give 2 tablets by mouth 2 times a day. Once on the 1st, 2 times on the 4th, 5th, 6th, 7th, 8th, 10th, 11th and 1 time on the 12th documented other/see progress notes. Resident #39's Progress Notes lacked documentation about any of the medications noted on the June and July MAR's with the notation of other/see progress note and what the reference meant. The document tilted Medication and Treatment Orders updated 7/16 included the following for Policy Statement: a. Orders for medications and treatment will be consistent with principles of safe and effective order writing. For Policy interpretation and Implementation: a. Drugs and biologicals that are required to be reordered from the issuing pharmacy not less then 3 days prior to the last dosage being administered to ensure that refills are readily available. The document titled Documentation of Medication Administration updated 4/07 included the Documentation must include as a minimum: a. Reason(s) why a medication was withheld, not administered, or refused (as applicable). During an interview on 7/12/22 at 2:18 PM, Resident #39 explained many of her medications were wrong. Modafinil 100 mg AM 100 mg should be get 200 mg in the am and get 100 mg at noon. Not sure how they have a an as needed (PRN) medication on the weekend and today they	F 755		

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
STATE CENTER SPECIALTY CARE	702 THIRD STREET NW STATE CENTER, IA 50247

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F 755	Continued From page 49 don't have it, they had to check on it. Bumex is wrong I should get 1 mg in the a.m. and 1 mg at noon and they just have it as 1 mg at noon. Resident #39 mentioned she had talked to the doctor and he was not comfortable changing the dose and amount she had. An interview on 7/14/22 at 1:03 PM, the Administrator stated they were having Pharmacy issues and the staff fax often when a medication did not come in.	F 755		
F 759 SS=D	Free of Medication Error Rts 5 Prcnt or More CFR(s): 483.45(f)(1) §483.45(f) Medication Errors. The facility must ensure that its- §483.45(f)(1) Medication error rates are not 5 percent or greater; This REQUIREMENT is not met as evidenced by: Based on observations, interviews, and record review, the facility failed to keep their Medication Error Rate less than 5 percent for 2 of 2 residents observed during Medication Pass (Resident #21 and #39). Observed 9 out of 11 medications administered to Resident #21 and 10 out of 14 medications administered to Resident #39 were administered outside of the timeframe/parameters without doctor notification. The facility reported a census of 38 residents. Findings Include: 1. On 7/12/22 at 10:26 A.M., Staff G, Certified Medication Aide (CMA), stated she did not notify the doctor that the pills were being given late since she was a CMA. Staff G stated she was	F 759	F7959 Free of Medication Error Rts 5 Prcnt or More Residents at State Center Specialty Care will have their medications administered per physician order. Resident #21 medications were administered per physician order Resident #39 medications were administered per physician order Current residents have the potential to be affected. Staff education completed on administration of medications. Director of Nursing or designee will monitor medication pass time to ensure medications administered timely. Director of Nursing or designee will perform three medication pass audits x4	

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F 759	Continued From page 50 told to start passing the medications after they were able to get paper copies of the MAR (Medication Administration Record). Staff G proceeded to administer 11 medications to Resident #21. Review of Resident #21's MAR revealed 9 of these medications were to be given earlier in the AM. At 7/12/22 at 10:41 A.M., Staff G asked Staff H, Licensed Practical Nurse (LPN), what to do with a 6 A.M. medication (med/s) for a different resident as the other resident had a 10 A.M. medication Staff H replied to hold his 6 A.M. medication and give his 10 A.M. medication, then to make a note. Staff H would then need to notify the doctor. Staff H stated she was not sure what medications had been given and what ones hadn't. Staff H stated she failed to notify the doctor/provider that the medications were being administered late. Staff H stated she was uncertain at that point what the providers are being notified about. Staff H stated that she was the Charge Nurse on that day and usually they have one nurse for the whole facility and then the MDS (Minimum Data Set) nurse , if the MDS Nurse (who also was the acting Director of Nursing (DON)) was there to help. Usually a nurse does the A hall and then a CMA will do the B and C halls. Staff H stated their phones were not working and they would have to use their personal phones to call the doctor. She stated she had never had this happen before. Staff H stated it took until almost 7:45 A.M. before they could get paper copies of the MAR's due to the Internet not working. 2. On 7/12/22 at 10:59 A.M., Staff F, LPN,	F 759	weeks. Random audits their after. Concerns identified will be reported and addressed in the facility QAPI committee Meetings for additional interventions as indicated.	

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F 759	Continued From page 51 administered Resident #39 her 14 morning medications. Review of Resident #39's MAR revealed 10 of these medications were to be given in the AM. On 7/14/22 at 11:09 AM, the DON acknowledged understanding that because the Medication Administration Pass observation for A.M. medications was after 10 A.M., the medications were out of the parameters and were medication errors. She stated she called the doctor regarding one resident's insulin. She stated she was hoping someone called about the other residents who had insulin. She added that no medications should have been given outside of the parameters without notifying the doctor and getting permission to give. The DON stated that their A.M. med pass times are 7 A.M. to 9 A.M. and then we have an hour before or after so 6 A.M.-10 A.M. is the parameters to give morning medications. On 7/14/22 at 3:15 P.M., a review of Resident #21 and Resident #39's Doctor's Orders revealed that no new orders were obtained to give these 2 residents their A.M. medications outside of the 6 A.M. to 10 A.M. parameter. An Administering Medications policy revised on 4/2019, directed that medications are administered in accordance with prescriber's orders, including any required timeframe. It directed that medications are administered within 1 hour of their prescribed time, unless otherwise specified.	F 759		
F 803 SS=D	Menus Meet Resident Nds/Prep in Adv/Followed CFR(s): 483.60(c)(1)-(7)	F 803	F803 Menus Meet Residents Nds/Prep in Adv/Followed	

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F 803	Continued From page 52 §483.60(c) Menus and nutritional adequacy. Menus must- §483.60(c)(1) Meet the nutritional needs of residents in accordance with established national guidelines.; §483.60(c)(2) Be prepared in advance; §483.60(c)(3) Be followed; §483.60(c)(4) Reflect, based on a facility's reasonable efforts, the religious, cultural and ethnic needs of the resident population, as well as input received from residents and resident groups; §483.60(c)(5) Be updated periodically; §483.60(c)(6) Be reviewed by the facility's dietitian or other clinically qualified nutrition professional for nutritional adequacy; and §483.60(c)(7) Nothing in this paragraph should be construed to limit the resident's right to make personal dietary choices. This REQUIREMENT is not met as evidenced by: Based on observations, clinical record review, resident and staff interviews the facility failed to meet the nutritional needs of residents by not making reasonable efforts for input from the resident about dietary choices for 1 of 1 Resident (Resident #31). The facility reported a census of 38. Findings Include: The Quarterly Minimum Data Set (MDS)	F 803	Residents at State Center Specialty Care will have their nutritional needs met in accordance to national guidelines. Resident #31 nutritional needs were met. Staff education completed on resident nutritional needs. Current residents have the potential to be affected. Dietary Manager or designee will monitor resident menus and alternative menus to ensure residents nutritional needs are met. Dietary Manager or designee will audit three menus weekly x 4 weeks. Random audits their after. Concerns identified will be reported and addressed in the facility QAPI committee Meetings for additional interventions as indicated.	

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F 803	Continued From page 53 Assessment dated 6/9/22 for Resident #31 included a Brief Interview for mental Status (BIMS) score of 15, indicating intact cognition for daily decision making. The MDS reported diagnoses of anxiety disorder, depression and chronic obstructive pulmonary disease. Resident #31's Care Plan dated 7/14/21 identified a focus area for potential for altered nutritional status related to history of chronic obstructive pulmonary disease, depression, anxiety and poor dentition (no lower teeth). The Care Plan directed staff to honor his food preferences of special request as able, offer alternates at meals if requested and to notify his physician if exhibits signs or symptoms of chewing difficulty or intolerance to current diet texture. Resident #31's Progress Notes contained the following Dietary Notes: a. On 7/21/2021 9:00 AM - Dietary Note: Registered Dietician (RD) notified yesterday evening of resident's prealbumin (PAB) result of 12.7 mg/dl, which is low. Recommend initiation of Nutrition intervention Program (NIP) at meals and re-checking PAB level in one month. If PAB remains low, may need to consider alternative supplementation. Director on Nursing (DON) notified of recommendation. Care plan updated. b. On 8/30/2021 2:00 PM - Dietary Note: RD notified of request from physician to evaluate resident's current prealbumin (PAB) level. Prealbumin drawn 8/24 was 14.6 mg/dl, which is low but has improved from last PAB of 12.7 mg/dl. At this time, recommend continuing Nutritional Improvement Program (NIP) program. Meal intakes 75-100% at most meals. It is likely with adequate intakes that PAB may continue to trend upward. Will continue to monitor closely	F 803		

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F 803	Continued From page 54 and follow up as needed. c. On 11/24/2021 8:25 AM - Dietary Note: Reweigh requested yesterday for 11/20 weight of 214 lb. Uncertain of accuracy of 19.8 lb gain for resident - meal intakes and fluid status have not appeared to change significantly in order to lead to this gain. Will follow up with reweigh once available. During an observation and interview in Resident #31's room on 7/7/22 at 10:58 AM, he stated they do not always give him what he ordered for meals. He explained he orders food off amazon and had food stored in his room. During a follow up interview on 7/12/22 at 2:56 PM, Resident #31 stated the Dietician has not met with him to make sure of his diet. He explained he had no problem with getting a hamburger. He stated he has difficulty eating their food and can only eat somethings. During an interview on 7/14/22 at 1:03 PM, the Administrator when asked if he knew Resident #31 had ordered food off amazon, stated he was not aware of it. During an interview on 7/14/22 at 2:40 PM, Staff O, Registered Dietician (RD stated she had talked with Resident #31 when doing Quarterly Reviews. The facility tried to buy other foods when he first came in and the resident still not satisfied with the food and acknowledged Resident #31 had been able to maintain his weight.	F 803		
F 880 SS=E	Infection Prevention & Control CFR(s): 483.80(a)(1)(2)(4)(e)(f)	F 880	F880 Infection Prevention & Control	

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F 880	Continued From page 55 §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: §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,	F 880	Residents at State Center Specialty Care will be provided a safe, sanitary, and comfortable environment. Resident #11 catheter remained below the bladder and tubing off the floor. Staff, vendors, and visitors screened in on covid kiosk screener. Current residents have the potential to be affected. Staff education completed on infection control practices. Administrator and or designee will monitor accushield screening on the covid kiosks to ensure staff, visitors, and vendors are screening in prior to entering building. Director of Nursing or designee will monitor residents with catheters. Administrator or designee will perform daily accushield audit reports x 4 weeks. Random audits their after. Director of Nursing or designee will perform two audits per week x4 weeks on catheter care. Random audits their after. Concerns identified will be reported and addressed in the facility QAPI committee Meetings for additional interventions as indicated.	

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F 880	Continued From page 56 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. §483.80(a)(4) A system for recording incidents identified under the facility's IPCP and the corrective actions taken by the facility. §483.80(e) Linens. Personnel must handle, store, process, and transport linens so as to prevent the spread of infection. §483.80(f) Annual review. The facility will conduct an annual review of its IPCP and update their program, as necessary. This REQUIREMENT is not met as evidenced by: Based on observations, record review, staff interviews and policy review the facility failed to ensure staff, visitors, and vendors were screened when entering the facility to aid in the prevention and transmission of COVID-19. The facility also failed to provide appropriate infection control techniques to protect against cross contamination and potential infection with managing indwelling urinary catheters for 1 of 1 residents reviewed (Resident #11). The facility reported a census of 38 residents.	F 880		

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F 880	Continued From page 57 Findings Include: 1. In an observation on 7/12/22 at 7:15 AM, a Surveyor with the Department of Inspections and Appeals entered the facility and attempted to screen in using the facility Kiosk. After trying to get the kiosk to work with no success, the Surveyor asked Staff H, Licensed Practical Nurse (LPN) sitting at the Nurse's Station, about the kiosk. Staff H stated the Internet was down and had been for hours and the kiosk wasn't working. They were waiting for Information Technology (IT) Support to respond and assist with getting the Internet up and running again. The Surveyor asked Staff H what the Surveyor was to do about screening in. Staff H stated she didn't know and to just go ahead and go in. No screening was completed. In an observation on 7/12/22 at 8:30 AM, it was noted that 3 other Surveyors with the Department of Inspections and Appeals had not been able to utilize the kiosk to screen in related to the Internet still being down. All three were not screened in when entering the facility. In an observation on 7/12/22 at 1:29 PM, 2 employees with a local furniture store were seen entering the facility to deliver a new recliner to a resident in Room #5 in the A Hall. The furniture store employees did not screen prior to entering the facility and did not wear a surgical mask. The furniture store employees entered the resident's room to talk to the resident and then left the recliner in the hall outside the room before exiting the facility. In an interview on 7/13/22 at 12:11 PM, Staff M, Temporary Nursing Aide (TNA) reported she had	F 880		

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F 880	Continued From page 58	F 880		

only been employed at the facility for a couple of weeks. Staff M stated she checked her temperature when entering the facility but did not use the kiosk to screen herself in. She stated she kept track of her temperature on her phone but did not write it down or document it anywhere the facility could access it. She also stated she did not answer any questions related to COVID-19 when entering the facility.

In an interview on 7/13/22 at 1:23 PM, Staff N, LPN reported she screened in at the Main Entrance kiosk when entering the facility and answered several COVID-19 related questions and then took and documented her temperature in the kiosk as prompted. Staff N reported she screened herself in and took her own temperature each time. She reported she was unsure of the procedure if the kiosk was not working or not available.

In a phone interview on 7/13/22 at 2:21 PM, Staff I, Director of Nursing (DON) reported it was the expectation visitors' screen in using the kiosk provided at the Main Entrance to the facility but it was not required or monitored closely. The facility provided surgical masks but visitors were not required to wear one if they did not have any symptoms of COVID-19. Staff I also stated that it was a goal for staff to screen the visitors and take their temperatures when entering the facility but it did not always happen and the visitors could their own screening and take their own temperature. Staff I stated staff were expected to screen for COVID-19 symptoms upon entering the facility at the main entrance on the kiosk provided. She stated all staff had been trained on the expectation and how to use the kiosk. Staff I reported it was on the honor system but there had

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F 880	Continued From page 59	F 880		

been verbal education provided by herself or the Administrator to staff members found not in compliance in the area. Staff I stated she did not track the information put in the kiosk or who had used it but stated if the information put into the kiosk was flagged an email was sent to the Administrator and he was to follow up with the individual involved. Staff I reported she was unsure of the expectations for outside vendors entering the facility and the need for them to be screened prior to entering. Staff I stated there had not been a plan in place for screening if the kiosk was down. She further stated the facility had implemented a plan for this after the incident of the kiosk being down on the previous day. They had placed a binder out by the kiosk with forms for manual screening should the kiosk not be working for some reason again in the future.

In a phone interview on 7/14/22 at 2:32 PM, the Administrator stated it was the expectation staff screen for COVID-19 signs and symptoms using the kiosk prior to the start of their shift. He stated the only monitoring that was done was via a log on the computer which he stated he periodically checked to ensure staff were screening prior to entering the facility. He stated if staff or a visitor flagged on a question, an email was sent to notify him of the issue and the facility would require the person to test prior to entering the facility. The Administrator admitted he may not see the email initially when it was sent but staff have been instructed to share with the nurse on duty any signs or symptoms they were experiencing so testing could be completed. He reported the facility had moved the screening kiosk into the Main Entryway between the doors today to make it more visible to all staff and visitors and hoped this would help with compliance. They had moved

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F 880	Continued From page 60 it during the winter months related to the kiosk not working properly due to cold temperatures. The Administrator reported there was not a plan in place on 7/12/22 when the kiosk for screening was down. He stated he was pretty sure staff who entered the facility on 7/12/22 when the kiosk was down did not get screened during that period of time. He reported visitors were expected to screen in when entering the facility as well. He stated if staff were available they were to assist them with the screening but if they were not available visitors were to independently screen in and log their temperature in the kiosk. The Administrator also reported it was the expectation that outside vendors screen in when entering the facility and should wear a mask. The facility policy titled COVID-19 Visitation Policy dated 9/17/20 stated part of the Core Principles of COVID-19 Infection Prevention is screening of all who enter the facility for signs and symptoms of COVID-19 (e.g. temperature checks, questions about and observations of signs and symptoms), and denial of entry of those with signs and symptoms or those who have had close contact with someone with COVID-19 infection in the prior 14 days. 2. The Minimum Date Set (MDS) Assessment dated 4/21/22 documented resident #11 with a Brief Interview for Mental Status (BIMS) score of 15 indicating the resident was cognitively intact. The MDS revealed the resident's diagnoses included heart failure, renal insufficiency, diabetes mellitus, depression, pressure ulcer of sacral region, Stage 4. The MDS documented that the resident required extensive assistance of two staff for bed mobility, transfers, dressing and toileting, limited assistance of one staff for	F 880		

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F 880	Continued From page 61 personal hygiene and total assistance of two staff for bathing. The MDS identified the resident with an indwelling catheter. The Care Plan dated 7/23/21 on admission and most recently updated on 5/3/22 noted the same focus, goal and intervention initiated on 7/23/21 . The focus area revealed the resident had a urinary catheter and the goal was that the resident would remain free from catheter related trauma. The interventions indicated Resident #11 would receive catheter care every shift, use a 16 french Foley catheter, and the catheter bag and tubing was to be positioned below the level of the bladder. Review of Resident #11's Progress Notes revealed the following orders associated with urinary tract infections: a. On 1/24/22 Augmentin, 875 milligram (mg) by mouth, twice a day for 10 days. b. On 2/16/22 Bactrim DS, 800/160 mg by mouth, twice a day for 3 days. c. On 3/03/22 Cefdinir, 300 mg by mouth, 1 capsule, two times a day for 10 days. d. On 5/05/22 Augmentin, 875 mg by mouth, one tab twice a day for 10 days. e. On 7/06/22 Cephalexin, 500 mg by mouth, four times a day for 10 days. On the following observations concerns noted in regards to Resident 11's catheter: a. On 7/06/22 at 2:04 PM, Resident #11 was sitting in her recliner and clear urine noted in the catheter bag. The catheter bag was hanging on the trash container with no cover and the bag was touching the floor. b. On 7/07/22 at 8:30 AM, Resident #11 sitting in her recliner eating her breakfast and the catheter	F 880		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	165390	A. BUILDING _____ B. WING _____	07/19/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
STATE CENTER SPECIALTY CARE	702 THIRD STREET NW STATE CENTER, IA 50247

(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 880	Continued From page 62 bag was hanging on the trash can with no cover and the catheter bag was touching the floor. c. On 7/07/22 at 11:36 AM, Resident #11 in the dining room for lunch, sitting in a wheelchair and the catheter bag was sitting on the linoleum floor under the wheelchair. d. On 7/07/22 at 1:19 PM, Resident #11 in her wheelchair using her feet to propel down the hall and the catheter bag was dragging on the carpeted floor under the wheelchair. e. On 7/07/22 at 2:30 PM, Resident #11 in her room recliner and the catheter bag was hanging on her closed walker above the resident's waist. In an interview on 07/07/22 at 2:35 PM, the Interim Director of Nursing (DON) acknowledged the catheter bag that had been placed on the closed walker above the resident's waist and should have been placed lower than the bladder. She moved the catheter bag to the resident's recliner foot rest and acknowledged the catheter bag should not be on the floor. The facility provided policy for Catheter Care dated September 2014 revealed the purpose was to prevent catheter associated urinary tract infections. Under the Infection Control section it indicated staff were to be sure the catheter tubing and drainage bag were kept off the floor. Under the Maintaining Unobstructed Urine Flow section it was noted the urinary drainage bag was to be held or positioned lower than the bladder at all times to prevent the urine in the tubing and drainage bag from flowing back into the urinary bladder.	F 880		

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Fishbone Diagram Worksheet

Introduction

The fishbone diagram is a tool to help the RCA team identify the causes and effects of an event and get to the root cause. The problem or effect is identified at the head or mouth of the fish. Contributing causes are listed on the smaller "bones" under various cause categories. A fishbone diagram can be helpful in identifying all causes for a problem. The team looks at the categories and thinks of all the factors affecting the problem or event. Use the fishbone diagram to keep the team focused on the causes of the problem, rather than the symptoms or the solutions.

How to Use

Use this worksheet to identify possible causes of a problem and to sort ideas into useful categories. The team should include members who have personal knowledge of the processes and systems involved in the problem or event being investigated and follow these steps:

1. Agree on the problem statement, also referred to as the effect. This is written at the mouth of the "fish". Be as clear and specific as you can about defining the problem. Be aware of the tendency to define the problem in terms of a solution, e.g., We need more of something. The problem is what happened.
2. Agree on the major categories of causes of the problem, written as branches or "bones" from the main arrow. Major categories in health care settings often include: equipment/supply factors, environmental factors, rules/ policy/procedure factors, and people/staff factors.
3. Brainstorm all the possible causes of the problem. Ask "Why does this happen?" As each idea is given, the facilitator writes on the fishbone diagram under the appropriate category. These are contributing or causal factors leading to the problem. Causes can be written in more than one place if they relate to several categories.
4. The team again asks "Why does this happen?" about each cause. Write sub-causes branching off the cause bones as they are identified.
5. The team continues to ask "Why?" and generate deeper levels of causes and organizes them under the related categories. This will help identify and then address root causes to prevent future problems.

Tips

- Consider drawing your fishbone diagram on a flip chart or large dry erase board.
- Make sure to leave enough space between the major categories on the diagram so that you can add minor detailed causes later.
- When you are brainstorming causes, consider having team members write each cause they can identify on a sticky note and place it on the diagram. Continue going through the group, identifying more factors, until all ideas are exhausted. This encourages each team member to participate in the brainstorming activity and voice their opinions.
- Note that the "five-whys" technique is often used in conjunction with the fishbone diagram – keep asking "why?" until you get to the root cause.
- Another way to help identify the root causes from all the ideas generated is to consider a multi-voting technique. Have each team member identify the top three causes of the problem or event. Ask each team member to place three tally marks or colored sticky dots on the fishbone next to what they believe are the root causes that could be addressed.

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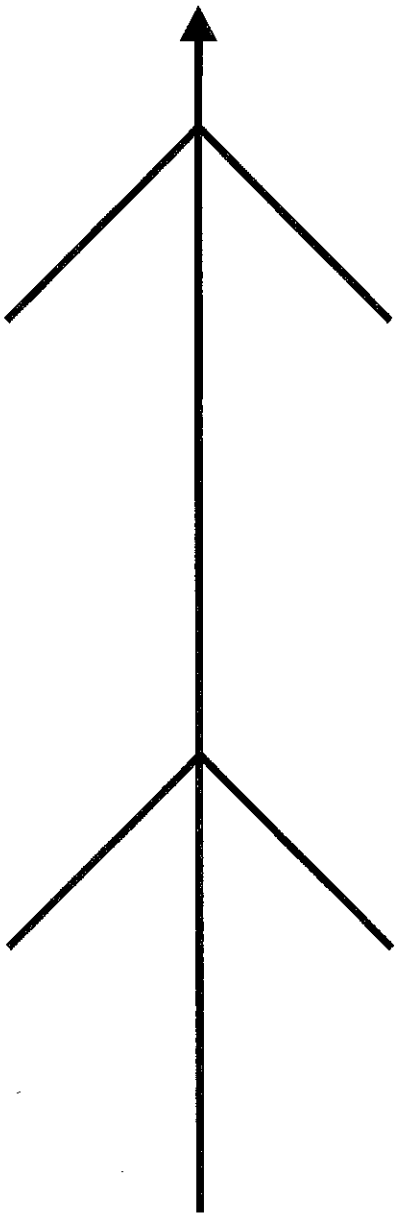
(Problem statement:) Infection Control



Covid Kiosk Screener

Staff failed to screen in appropriatly

Staff failed to recognize covid symptoms

Lack of education

Failed to screen in visitors and family me

Catheter Use

Tubing on the floor

catheter bag above the bladder

increased UTIs

privacy bag not in place

catheter bag hanging on trash can.

Nursing home name: State Center Specialty Care

CMS Certification Number (CCN):

For additional information completing the RCA:
http://www.ihi.org/education/IHIOpenSchool/resources/Pages/AudioandVideo/Whiteboard16.aspx

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Five Whys Worksheet

Accurately state the problem (Five Whys is used in trouble shooting, quality improvement and problem solving. It is best suited for simple or moderately complex problems).

PROBLEM:

Employee, Vendor, and visitors not screening in on Covid Kiosk prior to entering the facility.

Why is this happening? Enter all the reasons why. You may need more boxes. For each reason, begin asking **WHY.**

WHY? REASON #1	**WHY? REASON #2**	**WHY? REASON #3**
Lack of education	Front door unlocked allowing visitors, vendors, and staff to freely enter the facility.	Staff not understanding the symptoms of covid
WHY? Frequently changing guidance.	**WHY?** Facility door was left unlocked to create a homelike environment.	**WHY?** Lack of education
WHY? Changing country transmission rates	**WHY?** Safety hazard for residents who tend to respond to the sound of a doorbell.	**WHY?**
WHY? Testing guidelines per vaccine status.	**WHY?** Cognitively impaired.	**WHY?**
WHY?	**WHY?**	**WHY?**

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