

**Iowa Department of Inspections and Appeals
Health Facilities Division
Citation**

Citation Number: #6108		Date: June 14, 2023		
Facility Name: Ivy at Davenport		Survey Dates: April 11, 2023 – June 5, 2023		
Facility Address/City/State/Zip: 800 East Rusholme Street Davenport, IA 52803		TAG		
		AMENDED 6/14/2023 - TAG		
Rule or Code Section	Nature of Violation	Class	Fine Amount	Correction date

58.19(2)b	<p>481—58.19(135C) Required nursing services for residents. The resident shall receive and the facility shall provide, as appropriate, the following required nursing services under the 24-hour direction of qualified nurses with ancillary coverage as set forth in these rules:</p> <p>58.19(2) Medication and treatment.</p> <p><i>b.</i> Provision of the appropriate care and treatment of wounds, including pressure sores, to promote healing, prevent infection, and prevent new sores from developing; (I, II)</p> <p>DESCRIPTION:</p> <p>Based on observation, staff interviews and clinical record review, the facility failed to provide wound care in a manner to reduce the risk of wound infections and failed to implement offloading devices to decrease pressure for 2 of 4 residents observed with pressure ulcers (Residents #4, and #49). This failure led to harm when Resident #4 developed a facility acquired Stage 3 pressure ulcer. The facility reported a census of 69 residents.</p>	CLASS I	\$8,750.00 (HELD IN SUSPENSION)	UPON RECEIPT
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	<p>Findings include:</p> <p><u>Minimum Data Set (MDS) Definitions of Pressure Ulcers</u></p> <p>Stage 1 Pressure Injury: Non-blanchable erythema of intact skin Intact skin with a localized area of non-blanchable erythema, which may appear differently in darkly pigmented skin. Presence of blanchable erythema or changes in sensation, temperature, or firmness may precede visual changes. Color changes do not include purple or maroon discoloration; these may indicate deep tissue pressure injury.</p> <p>Stage 2 Pressure Injury: Partial-thickness skin loss with exposed dermis Partial-thickness loss of skin with exposed dermis. The wound bed is viable, pink or red, moist, and may also present as an intact or ruptured serum-filled blister. Adipose (fat) is not visible and deeper tissues are not visible. Granulation tissue, slough and eschar are not present. These injuries commonly result from adverse microclimate and shear in the skin over the pelvis and shear in the heel. This stage should not be used to describe moisture associated skin damage (MASD) including incontinence associated dermatitis (IAD), intertriginous dermatitis (ITD), medical adhesive</p>			
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	<p>related skin injury (MARSI), or traumatic wounds (skin tears, burns, abrasions).</p> <p>Stage 3 Pressure Injury: Full-thickness skin loss Full-thickness loss of skin, in which adipose (fat) is visible in the ulcer and granulation tissue and epibole (rolled wound edges) are often present. Slough and/or eschar may be visible. The depth of tissue damage varies by anatomical location; areas of significant adiposity can develop deep wounds. Undermining and tunneling may occur. Fascia, muscle, tendon, ligament, cartilage and/or bone are not exposed. If slough or eschar obscures the extent of tissue loss this is an Unstageable Pressure Injury.</p> <p>Stage 4 Pressure Injury: Full-thickness skin and tissue loss Full-thickness skin and tissue loss with exposed or directly palpable fascia, muscle, tendon, ligament, cartilage or bone in the ulcer. Slough and/or eschar may be visible. Epibole (rolled edges), undermining and/or tunneling often occur. Depth varies by anatomical location. If slough or eschar obscures the extent of tissue loss this is an Unstageable Pressure Injury.</p> <p>Unstageable Pressure Injury: Obscured full-thickness skin and tissue loss Full-thickness skin and tissue loss in which the extent of tissue damage within the ulcer</p>			
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	<p>cannot be confirmed because it is obscured by slough or eschar. If slough or eschar is removed, a Stage 3 or Stage 4 pressure injury will be revealed. Stable eschar (i.e. dry, adherent, intact without erythema or fluctuance) on the heel or ischemic limb should not be softened or removed.</p> <p>1. The MDS assessment dated 11/4/22 for Resident #4 identified an original admission date of 10/28/22. The MDS documented no pressure ulcers present upon assessment.</p> <p>The wound physician Initial Wound Evaluation & Management Summary notes dated 1/16/23 documented under History of Present Illness that the resident had a Stage 3 pressure wound of the left, posterior heel for at least 2 days duration. The summary included the following:</p> <p>a. <u>Focused Wound Exam (Site 1) - Stage 3 pressure wound of the left, posterior heel full thickness</u> Wound Size: 6.0 cm (centimeters) by 4.0 cm by 0.2 cm with surface area 24.00 cm² (square centimeters) Duration: greater than 2 days Recommendations: float heels in bed, offload wound, reposition per facility protocol, turn side to side and front to back in bed every 1 to 2 hours if able, sponge boot.</p>			
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	<p>Coordination of Care: offloading is the resident's main issue and her compliance would be difficult due to her behavioral issues, severe schizophrenia/bipolar issues, and having her comply had been difficult. they would get her a sponge boot but unsure if she would be able to keep it on but discussed with RN (Registered Nurse) staff and resident and they would try.</p> <p>The MDS assessment dated 1/17/23 documented the resident discharged to the hospital with return not anticipated.</p> <p>The MDS assessment dated 1/23/23 documented an entry tracking when the resident returned from the hospital.</p> <p>The MDS assessment dated 1/31/23 identified a Brief Interview for Mental Status (BIMS) score of 12 which indicated moderate cognitive impairment. The MDS revealed the resident used a manual wheelchair and with partial assistance could wheel approximately 50 feet and make two turns. The MDS recorded the resident dependent on staff for toileting, picking up dropped objects from the floor, needed substantial assistance rolling side to side while lying in bed, and dependent on staff for taking off and putting on footwear. The MDS documented diagnoses that</p>			
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	<p>included sleep apnea, chronic obstructive pulmonary disease (COPD), congestive heart failure (CHF) and type two diabetes. The MDS recorded the presence of an unstageable pressure ulcer upon admit to the facility.</p> <p>The Care Plan focus area initiated 1/30/23 identified on 1/16/23 the resident had an in-house (facility) acquired Stage 3 pressure ulcer develop on her left heel. The care plan interventions directed staff to avoid positioning the resident with heels touching bed or chair. The care plan lacked documentation regarding a sponge boot or directions to raise wheelchair legs to offload pressure to the heel.</p> <p>The Progress Notes dated 3/21/23 at 12:20 PM documented a late entry physician progress note. The entry recorded on 3/8/23 the wound MD (doctor) continued to follow the resident and the resident to continue to try to offload the heel with the help of NS (nursing staff). The entry documented the wound continued to improve and the resident did have the PRAFO boots as well.</p> <p>The wound physician Wound Evaluation & Management Summary notes dated 4/3/23 documented the following:</p> <p>a. <u>Focused Wound Exam (Site 1) - Stage 3 pressure</u></p>			
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	<p><u>wound of the left, posterior heel full thickness</u> Wound Size: 1.5 cm by 3.0 cm by 0.1 cm with surface area 4.50 cm² (square centimeters) Duration: greater than 75 days Wound Progress: improved Recommendations: offload wound, turn side to side and front to back in bed every 1 to 2 hours if able, float heels in bed, sponge boot, reposition per facility protocol, antibiotic choice Bactrim DS 1 tab orally twice a day for 14 days.</p> <p>Observation on 4/11/23 at 11:30 AM revealed the resident used her left heel to propel her wheelchair in Hallway B.</p> <p>Observation on 4/12/23 at 1:00 PM revealed the resident used her left heel to propel her wheelchair in the North Dining Room.</p> <p>Observation on 4/13/23 at 2:00 PM revealed the resident used her left foot to propel her wheelchair in the South entry of the facility.</p> <p>The wound physician Wound Evaluation & Management Summary notes dated 4/14/23 documented the following: a. <u>Focused Wound Exam (Site 1) - Stage 3 pressure wound of the left, posterior heel full thickness</u></p>			
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	<p>Wound Size: 1.7 cm by 3.0 cm by 0.1 cm with surface area 5.10 cm² (square centimeters) Duration: greater than 86 days Wound Progress: no change Recommendations: offload wound, turn side to side and front to back in bed every 1 to 2 hours if able, float heels in bed, sponge boot, reposition per facility protocol, antibiotic choice Bactrim DS 1 tab orally twice a day for 14 days.</p> <p>Observation on 4/17/23 at 9:00 AM revealed the resident used her left foot to propel her wheelchair in the South hallway outside of conference room area.</p> <p>In an interview on 4/19/23 at 7:55 AM, Staff LL, LPN, stated the resident had a PRAFO (sponge) boot however the resident used her left foot to propel her wheelchair throughout the day. At 8:04 AM, Staff LL commented the resident's sponge boot had not been on all night due to the boot being on the floor.</p> <p>Observation on 4/19/23 at 8:04 AM revealed Staff LL, LPN, completed the daily wound care as provider ordered for the left heel Stage 3 pressure ulcer. Staff LL elevated the lower left leg and left foot on a pillow. Staff LL washed hands, donned gloves, removed the old dressing. Staff LL proceeded to cleanse wounds and apply the ordered treatment. Staff LL used</p>			
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	<p>scissors to cut a new medicated dressing then applied another dressing as ordered. Staff LL never washed hands or changed gloves during the wound care when removing dirty dressings, cleaning the wound, and then applying new dressings.</p> <p>In an interview on 4/19/23 at 8:40 AM, Staff LL responded she should have changed her gloves when going from a dirty field to a clean field.</p> <p>In an interview on 4/19/23 at 10:02 AM, the Advanced Registered Nurse Practitioner (ARNP) responded when asked about the resident's wounds and expectations that the resident was to have a PRAFO boot on her left foot for offloading. The ARNP stated the resident had a blister that opened and the resident to offload when sitting in the wheelchair with leg rest in the up position. After being informed that observations from 4/11/23 through 4/19/23 revealed the resident's wheelchair not observed in the up position, the ARNP responded the leg rest was to be in the up position whenever the resident was up.</p> <p>In an interview on 4/19/23 at 4:05 P.M. the Director of Nursing (DON) and Assistant Director of Nursing (ADON) stated they expected nursing staff to follow the policy to wash hands and change gloves when going from a dirty to a clean wound field.</p>			
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	<p>The facility policy revised March 2023 titled Clean Dressing Change included the following documentation:</p> <ul style="list-style-type: none"> 7. Wash hands and put on clean gloves. 9. Loosen the tape and remove the existing dressing (old dressing). 10. Remove gloves, pulling inside out over the dressing. Discard into appropriate receptacle. 11. Wash hands and put on clean gloves. 12. Cleanse wound. 13. Remove gloves. 14. Wash hands and put on clean gloves 17. Discard disposable items and gloves into appropriate trash receptacle and wash hands. <p>2. The MDS assessment dated 2/23/23 for Resident #49 identified the resident admitted from the hospital originally on 2/16/23. The MDS recorded a BIMS score of 14 which indicated intact cognition. The MDS documented diagnoses included Multiple Sclerosis (MS), paraplegia (paralysis of the legs and lower body), osteomyelitis (inflammation of the bone) of sacral region, bacterial infection unspecified, neurogenic bladder, pressure ulcer of sacral region Stage 4, and pressure ulcer of right buttock Stage 4. The MDS coded the presence of an indwelling</p>			
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	<p>catheter as well as 1 Stage 3 pressure ulcer and 2 Stage 4 pressure ulcers present upon admit to the facility. The MDS revealed the resident required extensive physical assistance of 1 person for bed mobility, extensive physical assistance of 2 persons for transfers, and totally dependent upon staff for bathing.</p> <p>The hospital discharge summary dated 2/16/23 documented discharge diagnoses that included osteomyelitis, Stage 4 decubitus ulcer, wound infection, chronic kidney disease stage 2, multiple sclerosis, paraplegia, and neurogenic bladder. The summary recorded the resident wheelchair-bound with chronic sacral decubitus ulcers with ulcer present on the coccyx, right ischial buttock, and left lateral ankle.</p> <p>The Care Plan focus area initiated 2/17/23 identified the resident had infection of the wounds of the coccyx and directed staff to administer antibiotics as per doctor orders and to maintain universal precautions when providing resident care.</p> <p>The Care Plan focus area initiated 2/20/23 identified the presence of a Stage 3 pressure ulcer on the left ankle and Stage 4 on the sacrum and right ischium related to a history of ulcers and immobility. The care</p>			
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	<p>plan interventions included notification to staff the resident needed to turn/reposition at least every 2 hours, more often as needed or requested.</p> <p>The Progress Notes dated 2/20/23 at 1:39 pm recorded a nutrition/dietary note which documented the resident seen by the wound MD (doctor) that day. The skin measurements recorded as:</p> <ul style="list-style-type: none"> a. Stage 3 to left lateral ankle 7.0 cm (centimeters) by 3.0 cm by 0.2 cm surface area 21.00 cm² (square centimeters) b. Stage 4 to right ischium 8.0 cm by 5.0 cm by 2.5 cm surface area 40.00 cm² c. Stage 4 to sacrum 8.0 cm by 8.0 cm by 20 cm surface area 64.00 cm². <p>The Progress Notes dated 2/22/23 at 2:44 pm recorded a Physician Note. The assessment portion documented the resident had a Stage 4 decubitus ulcer complicated with osteomyelitis and treated with IV (intravenous) antibiotics for 2 weeks after wound debridement performed 1/31/23 prior to admission to the facility.</p> <p>The Progress Notes dated 3/27/23 at 1:19 pm documented a change in condition summary that recorded the resident seen by the wound care provider due to increased drainage and foul odor and</p>			
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	<p>exposed necrotic bone exposed. The resident sent to the ER (Emergency Department) for evaluation.</p> <p>The Progress Notes dated 4/4/23 at 3:00 pm recorded the resident readmitted to the facility.</p> <p>The wound physician Wound Evaluation & Management Summary notes dated 3/6/23 documented the following:</p> <p>a. <u>Focused Wound Exam (Site 1) - Stage 3 pressure wound of the left, lateral ankle full thickness</u> Wound Size: 5.0 cm (centimeters) by 3.0 cm by 0.2 cm with surface area 15.00 cm² (square centimeters) Duration: greater than 44 days Wound Progress: Improved Recommendations: offload wound, reposition per facility protocol, turn side to side in bed every 1 to 2 hours if able</p> <p>b. <u>Focused Wound Exam (Site 2) - Stage 4 pressure wound of the right ischium full thickness</u> Wound Size - 8.0 cm by 5.0 cm by 2.5 cm, surface area 40.00 cm² Duration: greater than 164 days Wound Progress: no change Recommendations: Limit sitting to 60 minutes, offload wound, reposition per facility protocol, turn side to side in bed every 1 to 2 hours if able, upgrade offloading chair cushion, low air loss mattress</p>			
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	<p>c. <u>Focused Wound Exam (Site 3) - Stage 4 pressure wound sacrum full thickness</u> Wound Size - 8.0 cm by 8.0 cm by 20 cm, surface area 64.00 cm² Duration: greater than 164 days Wound Progress: no change Recommendations: Limit sitting to 60 minutes, offload wound, reposition per facility protocol, turn side to side in bed every 1 to 2 hours if able, Group 2 mattress, upgrade offloading chair cushion</p> <p>The Care Plan focus area lacked documentation to reflect the recommendations made by the wound physician to offload the wound, limit sitting to 60 minutes, upgrade the offloading chair cushion, low air loss mattress, and Group 2 mattress.</p> <p>The wound physician Wound Evaluation & Management Summary notes dated 4/3/23 documented the resident was not seen due to a wound-related hospitalization since the previous visit.</p> <p>The wound physician Wound Evaluation & Management Summary notes dated 4/14/23 documented the following:</p> <p>a. <u>Focused Wound Exam (Site 2) - Stage 4 pressure wound of the right ischium full thickness</u> Wound Size - 3.1 cm by 4.4 cm by 0.3 cm, surface</p>			
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	<p>area 13.64 cm 2 Duration: greater than 202 days Wound Progress: improved Primary Dressing: negative pressure wound therapy (wound vac) apply three times per week for 30 days Recommendations: upgrade offloading chair cushion, offload wound, limit sitting to 60 minutes, low air loss mattress, reposition per facility protocol, turn side to side in bed every 1 to 2 hours if able, low air loss mattress</p> <p>b. <u>Focused Wound Exam (Site 3) - Stage 4 pressure wound sacrum full thickness</u> Wound Size - 3.0 cm by 2.2 cm by 1.0 cm, surface area 6.60 cm 2 Duration: greater than 202 days Wound Progress: improved Primary Dressing: negative pressure wound therapy (wound vac) apply three times per week for 30 days Recommendations: Group 2 mattress, upgrade offloading chair cushion, reposition per facility protocol, turn side to side in bed every 1 to 2 hours if able, limit sitting to 60 minutes, offload wound, low air loss mattress</p> <p>Observations of wound care on 4/12/23 revealed the following: a. At 3:33 PM, Staff D, Licensed Practical Nurse (LPN), and Staff E, LPN, both entered room, washed their</p>			
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	<p>hands and donned gloves.</p> <p>b. At 3:53 PM, after Staff D had placed new foam into the wounds for the wound vac, she picked up the Foley (indwelling catheter) bag, handed it to Staff HH, LPN, and proceeded to finish the dressing change to the pressure ulcers without changing her gloves after she handled the Foley bag.</p> <p>In an interview on 4/25/23 at 9:43 AM, Staff D, LPN, reported during wound care nurses should change gloves after picking up dirty dressings and before putting on new dressings. She also admitted she should have changed her gloves after picking up the resident's Foley bag during wound care.</p> <p>In an interview on 4/25/23 at 9:53 AM, Staff K, Registered Nurse (RN), reported during wound care nurses should change gloves after touching anything soiled, wash hands, and put on new gloves.</p> <p>In an interview on 4/25/23 3:12 PM, the Director of Nursing (DON) reported during wound care she would expect nurses to change gloves before and after removing soiled dressings or if the gloves become visibly soiled. She would also expect nurses to change gloves after picking up a Foley bag before resuming the wound care.</p>			
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**Iowa Department of Inspections and Appeals
Health Facilities Division
Citation**

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	<p>A review of the facility policy titled: Clean Dressing Change dated as last reviewed March 2023 had documentation of the following:</p> <ol style="list-style-type: none"> 1. When multiple wounds are being dressed, the dressings will be changed in order of least contaminated to most contaminated (i.e. change extremity wounds before wounds contaminated with stool). Dressings of infected wounds should be changed last. 2. Set up clean field on the overbed table with needed supplies for wound cleansing and dressing application: <ol style="list-style-type: none"> a. If the table is soiled, wipe clean. b. Place a disposable cloth or linen saver on the overbed table. c. Place only the supplies to be used per wound on the clean field at one time (include wound cleanser, gauze for cleansing, disposable measuring guide and pen/pencil, skin protectant products as indicated, dressings, tape). d. If performing photo documentation, label measuring guide with patient identifier and date. e. Use no-touch techniques to remove ointments and creams from their containers (i.e. use tongue blade or applicator). Liquid solutions should be poured directly onto gauze sponges. 3. Establish area for soiled products to be placed (Chux or plastic bag). 			
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	<p>4. Wash hands and put on clean gloves.</p> <p>5. Place a barrier cloth or pad next to the resident, under the wound to protect the bed linen and other body sites.</p> <p>6. Loosen the tape and remove the existing dressing. If needed to minimize skin stripping or pain, moisten with prescribed cleansing solution or use adhesive remover to remove tape.</p> <p>7. Remove gloves, pulling inside out over the dressing. Discard into appropriate receptacle.</p> <p>8. Wash hands and put on clean gloves.</p> <p>9. Cleanse the wound as ordered, taking care to not contaminate other skin surfaces or other surfaces of the wound (i.e. clean outward from the center of the wound). Pat dry with gauze.</p> <p>10. Measure wound using disposable measuring guide. (Note: If performing photo documentation, remove gloves and wash hands. Photograph wound being careful to avoid any contamination of the camera equipment).</p> <p>11. Wash hands and put on clean gloves.</p> <p>12. Apply topical ointments or creams and dress the wound as ordered. Protect surrounding skin as indicated with skin protectant.</p> <p>13. Secure dressing. Mark with initials and date. (Add time if dressing is more than once daily.)</p>			
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58.28(3)e	<p>14. Discard disposable items and gloves into appropriate trash receptacle and wash hands.</p> <p>481—58.28(135C) Safety. The licensee of a nursing facility shall be responsible for the provision and maintenance of a safe environment for residents and personnel. (III)</p> <p>58.28(3) Resident safety. e. Each resident shall receive adequate supervision to protect against hazards from self, others, or elements in the environment. (I, II, III)</p> <p>DESCRIPTION:</p> <p>Based on observation, clinical record review, resident interviews, staff interviews, and facility policy review, the facility failed to ensure the functioning of a door alarm in order to prevent an elopement for 1 of 1 cognitively impaired residents reviewed for an elopement (Resident #71), failed to ensure residents could safely store and administer medications for 2 of 2 residents reviewed for self-administration of</p>	CLASS I	\$7,750.00 (HELD IN SUSPENSION)	UPON RECEIPT
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	<p>medications (Resident #36 and #24), failed to ensure 2 of 2 treatment carts and 1 of 2 medication carts locked or secured when staff not present, and failed to secure the kitchen steam table in a manner to prevent unsafe access by cognitively impaired residents with 5 residents nearby during 1 of 1 observations. The facility identified 26 residents as cognitively impaired and self-mobile. These failures resulted in possible endangerment for the residents, therefore causing an Immediate Jeopardy (IJ) to the health, safety, and security of the residents. The facility reported a census of 69 residents.</p> <p>Findings Include:</p> <p>1. The Minimum Data Set (MDS) Assessment Tool, dated 8/29/22, listed diagnoses for Resident #71 which included non-Alzheimer's dementia, unspecified dementia with behavioral disturbance, and anxiety disorder. The MDS documented the resident independent with transfers, and required supervision for walking and eating, extensive assistance of 1 staff for dressing, extensive assistance of 2 staff for toilet use and personal hygiene, and depended completely on 2 staff for bathing. The MDS listed the resident's Brief Interview for Mental Status</p>			
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	<p>(BIMS) score as 1 out of 15, indicating severely impaired cognition and identified he had wandering behaviors 4-6 days out of the 7-day review period and stated his behaviors placed the resident at significant risk of getting to a potentially dangerous place.</p> <p>An 8/23/22 Elopement Risk Evaluation stated the resident was currently actively exit seeking and was a high risk to elope.</p> <p>A 9/6/22 Social Service Note documented facility staff called the resident's sister to discuss possibly having to find a different placement for the resident due to exit seeking behaviors.</p> <p>A 9/12/22 Physician Note established the Nursing Staff reported on 8/23/22 that the resident stated he wanted to leave and be with his brother and that the resident tried to go out the doors twice "last night". The note stated staff discussed the possible risk for elopement and they would keep an eye on him.</p> <p>A 9/19/22 1:45 p.m., a General Note indicated the resident sat quietly eating lunch and denied pain or the need for analgesia (pain medication) at this time.</p> <p>A 9/19/22 4:44 p.m., a General Note reported the resident got out of the facility and the Police were</p>			
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	<p>contacted. The note revealed the resident was found shortly after by a Certified Nursing Assistant (CNA) outside of the facility.</p> <p>A 9/21/22 Physician Note documented the resident had an elopement on 9/19/22 and was found a few blocks away from the facility.</p> <p>Care Plan entries, dated 9/19/22, stated the resident was an elopement risk and wanderer related to disorientation to place. The resident had a history of attempts to leave the facility unattended and had impaired safety awareness and wandered aimlessly. Further 9/19/22 entries stated the resident's safety would be maintained through the review date and directed staff to:</p> <ul style="list-style-type: none"> a. Distract the resident from wandering by offering pleasant diversions, structured activities, food, conversation, television, and books. b. Monitor for fatigue and weight loss. c. Provide structured activities such as toileting, walking inside and outside, and reorientation strategies including signs, pictures and memory boxes. d. Identify a pattern of wandering. <p>The Care Plan lacked documentation of the resident's risk/history of eloping or interventions directed at the prevention of elopement prior to the 9/19/22</p>			
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	<p>incident.</p> <p>The National Weather Service Climatological Data retrieved from https://www.weather.gov/wrh/Climate?wfo=dvn on 4/19/23 listed the high and low temperatures on 9/19/22 as 83 degrees Fahrenheit and 63 degrees Fahrenheit.</p> <p>During a phone interview on 4/18/23 at 4:11 p.m., Staff I, CNA stated she remembered the resident leaving the facility. She stated while staff were in a meeting, the resident got out and they looked for him. Staff I stated she found him on Garfield and Davenport streets near the facility. She stated the resident was walking on the sidewalk and it was about an hour from the time they realized he was missing to the time they located him. Staff I stated they found him about a 5-minute walk away.</p> <p>During a phone interview on 4/18/23 at 4:33 p.m., Staff J, former Director of Nursing (DON) stated when the resident eloped the door alarm was not engaged. She stated staff observed the door opened and immediately did a head count and noticed the resident was not there. She stated the B Hall door alarm was broken and had been intermittently problematic when she worked there. She stated</p>			
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	<p>because of Resident #71's past history, when the door was open, they immediately thought of him. The former DON stated the resident had exit seeking behaviors was constantly walking and he eloped from the Group Home he was at previously. She stated it was 30 minutes by the time they found him. She explained some interventions they utilized to address his wandering were redirection and maintaining a visual on the resident. The former DON reported the resident was in the "Elopement Book" which had his picture and basic information. She stated the Elopement Book was a tool used if someone eloped but would not prevent an elopement. She stated the doors were supposed to be locked and reported the facility staff requested a Wanderguard (a device which alerted when residents were near exits) multiple times because the resident should "absolutely" have one.</p> <p>During an observation on 4/19/23 at 9:49 a.m., the Administrator demonstrated the door alarm mechanisms on the left hall door, right hall door, front dining room door, back dining room door, B Hall door, and A Hall door. The Administrator pushed on the door for 15 seconds and the door alarmed and the light turned red. In order to rearm the doors, the Administrator utilized a key. A receptionist sat next to the front door so the door was unarmed. She stated</p>			
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	<p>the door was armed when the receptionist was not present and required a code to be silenced.</p> <p>During an interview on 4/19/23 at 7:45 a.m., Staff F Certified Medication Aide (CMA) stated prior to the resident's elopement he kept getting out and they brought him back in. She stated on the day of the elopement, she did not hear the alarm.</p> <p>During an interview on 4/19/23 at 8:22 a.m., the Assistant Director of Nursing (ADON) stated if one pushed on the B hall door, the light would turn red and the alarm would be disabled. She stated staff did not rearm the door after the resident touched the door. The ADON reported prior to the elopement, the resident touched the door and they removed him and disabled the door but did not re-arm the door. She stated if the door was green, that indicated the door alarm was armed. She stated it was her practice to look at the doors and after the elopement, the facility completed education related to the door locks.</p> <p>During an interview 4/19/23 at 10:05 a.m., the Administrator stated prior to the elopement, the resident was agitated and staff had disarmed the door but not rearmed it. She remarked it was staff error.</p> <p>During an observation on 4/20/23 at 7:20 a.m., when</p>			
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	<p>the facility front door was pushed, it was locked and would not open.</p> <p>During an interview on 4/20/23 at 9:13 a.m., Staff N, CNA stated she did not know how the resident got out of the facility but she heard a Code Silver. She stated staff were trying to figure out who eloped but she knew it was him because of his history of wandering.</p> <p>During a phone interview on 4/20/23 at 9:44 a.m., Staff O, former Administrator stated the biggest concern he had with the resident was that he would pace. He explained the day before the elopement, the facility shut off the door annunciator due to complaints but stated the doors also had local alarms staff could still hear. He stated the resident left the facility and they completed a search and found the resident within the hour near a park sitting on some bleachers. The former Administrator stated if the door opened, the light at the top would turn red to indicate the door was not engaged. He stated a key was needed in order to re-arm the door and stated more than likely, the door opened prior to the elopement and staff failed to re-arm the door. After the elopement, he stated the facility turned the annunciators back on and completed staff education regarding elopement and door locks.</p>			
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	<p>The undated facility document "Cognitively Impaired and Independently Mobile", provided on 4/25/23 listed 26 cognitively impaired and independently mobile residents.</p> <p>During an interview on 4/26/23 at 2:04 p.m., the Director of Nursing (DON) stated a resident's history of elopement and related interventions should be included on the Care Plan.</p> <p>The facility policy "Elopements and Wandering Residents" reviewed 1/2023, stated the facility ensured that residents who exhibited wandering behavior and were at risk for elopement received adequate supervision to prevent accidents, and received care in accordance with their person-centered plan of care addressing the unique factors contributing to wandering or elopement risk.</p> <p>2. The MDS assessment dated 2/22/23 listed diagnoses for Resident #36 which included psychotic disorder, schizophrenia, and paranoid schizophrenia. The MDS listed the resident's Brief Interview for Mental Status (BIMS) score as 15 out of 15, indicating intact cognition.</p> <p>A 10/6/21 Care Plan entry stated the resident had</p>			
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	<p>delusions and hallucinations.</p> <p>During an observation on 4/13/23 at 10:39 a.m., Resident #36 sat in her wheelchair next to a small dresser. In the top dresser drawer, the resident had 2 medication cups containing approximately 5 pills each. The resident reached into one of the cups and consumed a blue pill. The resident stated that pill was for blood pressure and stated the other pills were mostly vitamins but pointed to other pills in the cups and stated one was for gout (a type of arthritis) and the others included metformin (used to treat diabetes), magnesium, and potassium. She stated one of the cups was from yesterday.</p> <p>On 4/13/23 at 10:50 a.m., the Administrator was aware that the resident had 2 pill cups in her drawer.</p> <p>A 4/13/23 3:48 p.m., a General Note stated the resident requested for her vitamins to be left at bedside and stated the resident was alert and oriented and able to make her own decisions.</p> <p>A 4/13/23 Medication Self-Administration Evaluation stated the resident was deemed able to safely self-administer medications. The resident's clinical record lacked an evaluation completed prior to 4/13/23.</p>			
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	<p>A Care Plan entry, dated 4/14/23, directed staff to complete a self-administration of medication assessment. The Care Plan lacked prior documentation regarding the self-administration of medications.</p> <p>The facility policy "Resident Self-Administration of Medication", reviewed January 2023, stated the facility would evaluate residents to determine if they could self-administer safety.</p> <p>During an interview on 4/25/23 at 1:00 p.m., the Director of Nursing (DON) stated the resident could only have her vitamins at bedside and stated she observed the resident's 2 cups containing other medications.</p> <p>3. The MDS Assessment dated 2/5/23 revealed Resident #24 scored 15 out of 15 on a BIMS exam, which indicated cognitively intact.</p> <p>During an observation on 4/18/23 at 1:01 PM, medications found in a pill cup on Resident #24's bedside table. The medication cup had 1 brown capsule, 1 oval tablet and 3 small round tablets in it. Resident #24 stated he was getting ready to take them. Resident #24 queried if staff left medications</p>			
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	<p>on his table often and he stated 99% of the time they brought them and left them on the table. Resident #24 asked if he knew what the medications in the cup were and he stated he knew one pill was gabapentin (nerve pain med) and wasn't sure about the other pills. Resident #24 stated he waited for his milk to take the pills. Resident #24 proceeded to open his milk carton and took the pills in the medication cup.</p> <p>Resident #24 had a Self-Administration of Medications Assessment completed on 9/16/21 and 2/4/22 and both assessments indicated Resident #24 not capable of storing medications in a secured area and not capable of opening or closing medication containers.</p> <p>The Care Plan dated 3/24/23 failed to reveal any documentation on Self-Administration of medications.</p> <p>The April MAR (Medication Administration Record) included the following medications:</p> <ul style="list-style-type: none"> a. Acetaminophen (Tylenol) 325 mg tablet b. Buspirone (antianxiety med) 7.5 mg tablet c. Furosemide (diuretic med) 20 mg tablet d. Gabapentin 400 mg tablet e. Magnesium oxide tablet 400 mg tablet f. Spironolactone (diuretic med) 25 mg tablet g. Tamsulosin (treats urinary symptoms) 0.4 mg capsule 			
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	<p>During an interview on 4/18/23 at 1:26 PM, Staff AA, Certified Medication Aide (CMA) queried if the facility had any residents who Self-Administered their medications and she stated no, that is why the facility had Medication Aides and Nurses. Staff AA asked if she watched the residents take their medications and she stated yes, we watch them. Informed Staff AA medications were found on Resident #24 bedside table and Staff AA stated he supposed to take them with milk and she put them on the table to get him milk and planned on coming back and forgot because she doing something for another resident. Staff AA informed Resident #24 had milk and she queried if she watched Resident #24 take his pills and Staff AA stated no, she didn't watch him, she forgot to and she knew they were supposed to watch the residents take their medications.</p> <p>During an interview on 4/24/23 at 4:01 PM, the DON queried if anyone in the facility self-administered medications and she stated Resident #15 could self-administer her lactase and Resident #36 issued a locked box for her vitamins and Self-Administered her vitamins. The DON asked what the expectations of medication administration for the nurses and CMA's and she stated don't pre-pop the medications, watch the residents take their medications, take vitals when</p>				
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	<p>indicated, and medications not be left at the bedside.</p> <p>The Facility Policy titled Medication Administration dated 3/2023 indicated the following:</p> <p>a. Observe resident consumption of medication.</p> <p>4. During an observation on 4/12/23 at 2:48 PM, a Medication Cart left unlocked in the dining hall when staff delivered medication to resident in the dining hall. Observed a resident pass in a wheelchair by the unlocked cart.</p> <p>During an observation on 4/13/23 at 7:51 AM, Staff BB, Registered Nurse (RN) walked down Hall B with the Treatment Cart unlocked and stated he needed to get a computer and walked away from the Treatment Cart and left it unlocked.</p> <p>During an observation on 4/13/23 at 7:53 AM, Staff BB returned to the cart and looked for blood glucose paperwork and stated he grabbed the wrong paper and walked away from the unlocked cart and walked into the dining room and retrieved the papers and returned to the cart. Staff BB prepared the insulin for the resident and went into the resident's room and left the insulin vial and insulin pen on top of the treatment cart and left the cart unlocked in the</p>			
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**Iowa Department of Inspections and Appeals
Health Facilities Division
Citation**

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Facility Address/City/State/Zip: 800 East Rusholme Street Davenport, IA 52803		TAG		
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	<p>hallway. Staff CC, Licensed Practical Nurse (LPN) observed in the hallway with her back turned to the Treatment Cart and residents in the hallway in their wheelchairs.</p> <p>During an observation on 4/13/23 at 8:09 AM, Staff BB prepped insulin for another resident and left the insulin vial and insulin pen on top of the Treatment Cart and left the cart unlocked when he went into the resident's room to ask the resident if he wanted his fast-acting insulin. The cart observed sitting in the hallway 2 doors down from the resident's room.</p> <p>During an interview on 4/13/23 at 8:13 AM, Staff BB queried if the Treatment Carts expected to be locked and he stated yes, the carts are supposed to be locked. Staff BB stated he guessed he had left it unlocked. He stated they had a lack of keys. Staff BB asked if medications were supposed to be secured in the carts and he stated yes, and he walked back to the cart to check. Staff BB informed he had left the insulin vials and pens on top of the cart when he administered the medications and Staff BB did not respond.</p> <p>During an observation on 4/13/23 at 8:16 AM in Hall B, Staff BB drew up insulin and went into a resident's room and left the insulin vial on top of the cart and</p>			
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	<p>left the cart unlocked.</p> <p>During an interview on 4/13/23 at 8:25 AM, Staff CC, LPN queried if medication carts are supposed to be locked and she stated yes, unless you are pulling or popping pills. Staff CC asked if the facility was short on keys and she stated she didn't know, she just started, maybe so.</p> <p>During an observation on 4/13/23 at 9:52 AM in Hall A, Treatment Cart #1 left unlocked between rooms A5 and A7. Observed Staff DD, Certified Medication Aide (CMA), down the hall two doors looking at the computer on her Medication Cart. The following observations made with the unlocked Treatment Cart:</p> <ul style="list-style-type: none"> a. At 9:55 AM, staff walked by the cart and didn't lock the cart. A resident in an electric wheelchair circled around the cart. b. At 10:04 AM, staff walked by the cart and asked Staff DD where to locate Staff BB and looked at the treatment cart and walked away. c. At 10:16 AM, resident wheeled by the unlocked treatment cart. d. At 10:17 AM, Staff DD wheeled her Medication Cart past the treatment cart and didn't lock it. e. At 10:21 AM, resident wheeled by the treatment cart in their wheelchair. f. At 10:22 AM, surveyor opened the cart and 			
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	<p>observed insulin and syringes found in the drawers. g. At 10:46 AM, Staff BB, approached the Treatment Cart and moved it next to the Medication Cart by room A3 and opened the drawers and pulled up medication into a syringe. h. At 10:48 AM, Staff BB went into a resident's room with syringe and left the cart unlocked and the 3rd drawer slightly opened on the cart.</p> <p>During an observation on 4/13/23 10:50 AM, found a set of keys left on the Treatment Cart in B Hall. At 10:51 AM. Staff DD, CMA picked up the keys off the cart.</p> <p>During an interview on 4/13/23 at 10:52 AM, Staff DD queried who the keys belonged to that she picked up and she stated she believed the keys belonged to one of the nurses and not supposed to be left on the cart so she snatched them up. Staff DD asked what the keys unlocked and she stated she didn't know, but thought the Treatment Carts and something else.</p> <p>During an interview on 4/13/23 at 2:11 PM, Staff BB queried if he had keys in his pocket and he stated yeah. Staff BB informed a pair of keys found on the Treatment Cart and he pulled out the keys from his pocket and stated his keys went to the utility room. Staff BB asked if the keys unlocked the Medication or</p>			
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	<p>Treatment Carts and he stated no, he didn't even know what most of the keys on the chain went to. He stated he was the A and B Hall Nurse and when he needed to do treatments he went to someone else to get the keys for the carts because they were short on keys. Staff BB queried why they were short on keys and he stated the Medication and Treatment keys are on the same key chain and if he needed something he would need to go to the Nurse or the Medication Aide for their keys.</p> <p>During an observation on 4/18/23 at 2:51 PM, the Medication Cart left unlocked in the dining hall. Staff EE, Activity Director with her back to the cart sat at a table with 9 residents and another staff member. Three other residents observed at tables in the dining area.</p> <p>During an observation on 4/18/23 at 2:53 PM, Resident #70 wheeled by the Medication Cart and spoke to a staff member right next to the cart.</p> <p>During an observation on 4/18/23 at 2:55 PM, Staff EE walked out of the dining area, another staff member walked into the dining area and sat behind the Nurse's Station with a computer monitor and counter between the staff member and unlocked Medication Cart.</p>			
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	<p>During an observation on 4/18/23 at 2:56 PM, the DON walked by the cart and then turned around and stood in front of the cart and locked the Medication Cart.</p> <p>During an interview on 4/24/23 at 4:01 PM, the DON queried about the expectations of medication and treatment carts being locked and she stated they should be locked at all times. The DON asked about the expectations of key control and she stated the Medication Aides had their own set of keys and the nurses had their own keys. The DON queried if the facility was short on keys and she stated she knew that one set of keys for A Hall had the Medication Cart and Treatment Cart keys and at one time the Assistant Director of Nursing (ADON) requested more keys for the carts. The DON stated she had the master keys for the carts.</p> <p>The undated document named "Cognitively impaired and independently mobile" provided by the Administrator revealed 26 residents cognitively impaired and independently mobile.</p> <p>The Facility Policy titled Medication Storage dated March 2022 revealed the following:</p> <p>a. All drugs and biologicals will be stored in locked</p>			
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58.19(1)n(7)	<p>compartments (i.e., medication carts, cabinets, drawers, refrigerators, medication rooms) under proper temperature controls.</p> <p>b. Only authorized personnel accessed to the keys to locked compartments.</p> <p>c. During a medication pass, medications must be under the direct observation of the person administering medications or locked in the medication storage area/cart.</p> <p>5. Observation on 4/12/23 at 11:50 AM, revealed the North kitchenette keypad door had been open. The door was noted to be left open 4-6 inches and the commercial steam table was left on. No facility Dietary or Nursing Staff observed in the North Dining room area. Noted approximately five residents, both ambulatory and able to propel a wheelchair within five to ten feet of the open door.</p> <p>481—58.19(135C) Required nursing services for residents. The resident shall receive and the facility shall provide, as appropriate, the following required nursing services under the 24-hour direction of qualified nurses with ancillary coverage as set forth in these rules:</p>	CLASS I	\$8,250.00 (HELD IN SUSPENSION)	UPON RECEIPT
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	<p>58.19(1) Activities of daily living. <i>n.</i> Nutrition and meal service. (7) Enteral nutrition (to be performed by a registered nurse or licensed practical nurse only); (I, II, III)</p> <p>DESCRIPTION:</p> <p>Based on observations, staff interviews, clinical record review, and policy review, the facility failed to address a resident's significant weight loss of 41 pounds or a 13.59% weight loss in 35 days (Resident #61). Resident #61 received 51% or more of his calories and 501 cc (cubic centimeters) per day or more of fluid intake via tube feeding. The facility also failed to notify the physician of residents' significant weight loss, seek orders to address the weight loss, and follow physician ordered interventions that addressed the weight loss for 2 residents (Resident #25, and #45). The failure resulted in 3 of 7 residents reviewed having a significant weight change and these failures caused a possible endangerment for the residents, therefore causing in an immediate jeopardy to health and safety of the residents. The facility reported a census of 69 residents.</p>			
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	<p>Findings Include:</p> <p>1. The Minimum Data Set (MDS) Assessment Tool, dated 3/15/23, listed diagnoses for Resident #61 which included malnutrition, morbid obesity, and weakness. The MDS documented the resident required supervision assistance with eating and listed the resident's cognition as moderately impaired. The MDS listed the resident's weigh as 312 pounds (lbs.).</p> <p>A 3/2/23 Hospital History and Physical listed the resident's weight as 142 kilograms (kg) or 313 lbs.</p> <p>A 3/28/23 Hospital Discharge Summary listed the resident's weight as 156.2 kg or 344 lbs.</p> <p>The resident's Weights Summary listed the following weights:</p> <ul style="list-style-type: none"> a. On 3/1/23: 303.2 lbs. b. On 3/10/23: 312.4 lbs. c. On 4/5/23: 262.0 lbs. (crossed out on 4/19/23 and reweighed). d. On 4/19/23: 287.2 lbs. <p>The resident's weight loss during the period of 3/1/23-4/5/23 calculated as a 13.59% loss.</p>			
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	<p>The facility lacked documentation of Physician Notification or additional interventions related to the resident's significant weight loss from the resident's weight on 4/5/23 and 4/19/23.</p> <p>Care Plan entries, dated 3/30/23, documented the resident was at risk for malnutrition related to recent critical illness and stated the resident would maintain adequate nutritional status as evidenced by maintaining weight within 5% current body weight. The entries documented the resident received nothing by mouth (NPO) and directed staff to provide the ordered enteral (referring to via the stomach/intestinal tract) feeding of Jevity 1.5 cal (a nutritional feeding) 360 milliliters (ml) with 50 ml water before and after three times daily.</p> <p>A 3/30/23 Nutrition Evaluation listed the most recent weight as 312.4 lbs. on 3/10/23 and stated the resident was at risk for malnutrition with the goal to maintain current body weight. The Evaluation recommended increasing the tube feeding order to better meet estimated needs: Jevity 1.5 cal, 360 ml 5 times per day.</p> <p>A 4/3/23 order directed staff to weigh the resident weekly every Thursday. The facility lacked documentation of a weight obtained between 4/5/23-</p>			
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	<p>4/19/23.</p> <p>During an observation on 4/18/23 at 10:36 a.m., Staff BB Registered Nurse (RN) administered a bolus (single dose) of Jevity 1.5 360 ml per the resident's G-tube (gastrostomy tube-a type of feeding tube).</p> <p>During an interview on 4/18/23 at 10:01 a.m., Staff G, Nurse Practitioner (NP) stated she was not aware of the resident's weight loss. She stated he needed a re-weight and would like to know about such losses. She stated in the past, the facility did not complete weights in a timely manner.</p> <p>During an interview on 4/25/23 at 1:00 p.m., the Director of Nursing (DON) stated from now on staff should provide her the list of weights for review. She stated if someone had a weight loss, the facility would speak to the Registered Dietician and possibly talk to psychiatric services. She stated they would reweigh the resident. She stated she would review Resident #61's weight and look at adjusting his caloric intake.</p> <p>In an interview on 4/26/23 at 2:04 p.m. the DON stated she thought the resident's weight was an error so they completed a reweigh.</p> <p>The facility policy "Weight Monitoring" revised March</p>			
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	<p>2023, documented the facility would ensure all residents maintained acceptable parameters of nutritional status such as usual body weight. The policy defined a significant change in weight as 5% in 30 days, 7.5 % in 90 days, or 10% in 180 days.</p> <p>2. The 5/24/23 Minimum Data Set (MDS) Assessment revealed Resident #25 had diagnoses that included congestive heart failure, hypertension (high blood pressure), cerebrovascular accident (a stroke) with hemiplegia (paralysis on 1 side of the body) and malnutrition, required extensive assistance from at least 1 staff for transfers to and from bed or chair, dressing and toileting, non-ambulatory and set-up assistance required for eating. The assessment reported the weight 181 pounds and not identified as a significant change in the last month, described as a change of 5 percent body weight, or a 10 percent change of body weight in the last 6 months.</p> <p>The resident's weights, recorded in pounds, revealed:</p> <table style="margin-left: 20px;"> <tr><td>9/3/22</td><td>193.7</td></tr> <tr><td>10/1/22</td><td>194.9</td></tr> <tr><td>11/4/22</td><td>192.6</td></tr> <tr><td>12/2/22</td><td>198.8</td></tr> <tr><td>1/2/23</td><td>199.5</td></tr> <tr><td>2/14/23</td><td>197.2</td></tr> </table>	9/3/22	193.7	10/1/22	194.9	11/4/22	192.6	12/2/22	198.8	1/2/23	199.5	2/14/23	197.2			
9/3/22	193.7															
10/1/22	194.9															
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12/2/22	198.8															
1/2/23	199.5															
2/14/23	197.2															

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	<p>3/7/23 193.1 4/3/23 187.5 5/4/23 180.5 6/1/23 175.9 The 6/1/23 weight indicated a 11.52 percent weight loss for 6 months and a significant weight loss.</p> <p>Physician orders directed staff: 2/21/23 Provide Ensure Plus twice daily for risk of malnutrition. 3/9/23 Provide a regular diet, soft and bite sized texture, add gravy/sauce on meats. Needs assist with all meals.</p> <p>A Swallowing Deficit related to Dysphagia (difficulty or inability to swallow) problem initiated 10/29/22 on the nursing care plan directed staff: Follow prescribed diet, initiated 10/29/22. Monitor for shortness of breath choking, labored respirations or lung congestion, initiated 10/29/22. Monitor/document/report any signs or symptoms of dysphagia that included pocketing food, choking, coughing, drooling, several attempts at swallowing, refusing to eat or appears concerned during meals, initiated 10/29/22.</p> <p>A Progress Note transcribed by the facility's Registered and Licensed Dietician (RDL) on 4/13/22</p>			
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	<p>at 2:35 p.m. stated significant weight change note, Albumin 2.7, a low value, on 2/23/23 (a measurement of serum protein level), resident received regular diet, soft and bite sized texture (consistent with mechanical soft texture), Ensure Plus (liquid supplement) provided twice daily, extra nourishments provided through snacks and activity attendance. Meal intake variable from 25 to 100 percent, feeding ability ranged from independent to limited assistance. Significant weight loss for 30 days, unplanned/undesired with etiology likely related to possible need for feeding assistance at meals. Observed at lunch and half of meal was eaten with food found on his shirt. When asked if he needed help with eating he said "yes". Spoke with nursing about administration of supplement. Education provided to offer and encourage this drink twice daily and not to be given at meals. It is my belief that either this has not been given as ordered or was refused by the resident. Will trial this and see if albumin improves.</p> <p>The RDLD's recommendations described in the Progress Note included continue the current diet order, please elaborate to have gravy/sauce on meats and starch, request order for assistance at meals, request order for protein snacks, request Speech Therapy (ST) to evaluate and treat, request vitamin D, folate and vitamin B12 lab levels, request multiple</p>			
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	<p>vitamin with mineral supplement administered oral daily.</p> <p>The RDLD summarized the information transcribed in the Progress Note in an email transcribed at 7:24 p.m. on 4/13/23 and send to the Administrator, Director of Nursing (DON) and Certified Dietary Manager (CDM). Progress Notes transcribed by the Advanced Practice Registered Nurse Practitioner (ARNP) on 4/14/23, 4/19/23, 4/21/23, all that describe a physical assessment of the resident, made no mention of the resident's significant weight loss or notification of such.</p> <p>The planned Soft & Bite Sized menu for the 5/31/23 evening meal included: 6 ounces Vegetable Soup 3 ounces Barbequed Chicken 4 ounces Baked Beans 4 ounces Mashed Potatoes</p> <p>Observations on 5/31/23 between 6:18 p.m. and 6:37 p.m. revealed Staff R, Cook, plated the evening meal from the steam table in the North Kitchenette, and did not utilize resident tray tickets or resident information diet cards for reference to plate the meals</p> <p>Observations 5/31/23 at 6:29 p.m. revealed the resident received 4 breaded Chicken Nuggets (not</p>			
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	<p>Barbequed), French Fries, Baked Beans, ketchup used for the French Fries, no other gravy or sauces observed and feeding assistance not provided. During an interview 6/1/23 at 12:42 p.m., the facility's RDL D stated she observed the resident during a meal without feeding assistance, the resident had spilled food on his chest area, she asked him if he needed assistance with eating and he stated that he did. The RDL D stated she communicated her findings and recommendations to key facility staff via email for documentation purposes, and dietary staff should follow physician orders and directives for resident diet and nutrition orders.</p> <p>On 6/5/23 at 9:09 a.m., the facility was asked to provide documentation that the physician was notified of the identified weight loss and the RDL D's recommendations, and could not provide the documentation as of the survey exit on 6/5/23.</p> <p>Other staff interviews related to weight loss: On 6/2/23, administrative staff at the Iowa Department of Inspections & Appeals notified the facility Administrator that she had to provide an updated list of resident weights, completed between 6/1/23 and 6/4/23, to the Nurse Surveyor assigned on the morning of 6/5/23.</p> <p>During an interview 6/5/23 at 9:58 a.m., the facility</p>			
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	<p>RDL D provided a list of June, 2023 weights for 49 residents, and stated she thought there were 15 residents without an updated weight at that time. During an interview 6/5/23 at 2:53 p.m., the facility Administrator and interim Director of Nursing provided an updated June, 2023 weight list for 63 residents and stated they had just obtained the last resident weight.</p> <p>3. The 3/15/23 MDS Assessment revealed Resident #45 had diagnoses that included hypertension (high blood pressure), a cerebrovascular accident (a stroke), Parkinson ' s disease, diabetes and dysphagia (difficulty or inability to swallow), required extensive assistance of at least 1 staff for transfers to and from bed and chair, dressing and toileting, non-ambulatory, and supervision with 1 staff assist required for eating. The MDS Assessment revealed the resident ' s weight 178 pounds and a significant weight loss of 10 percent or more in 6 months.</p> <p>The resident's weights, recorded in pounds, revealed:</p> <table style="margin-left: 20px; border: none;"> <tr><td>9/3/22</td><td>209.8</td></tr> <tr><td>10/1/22</td><td>181.8</td></tr> <tr><td>11/4/22</td><td>186.4</td></tr> <tr><td>12/6/22</td><td>184.4</td></tr> <tr><td>1/9/23</td><td>181.9</td></tr> </table>	9/3/22	209.8	10/1/22	181.8	11/4/22	186.4	12/6/22	184.4	1/9/23	181.9			
9/3/22	209.8													
10/1/22	181.8													
11/4/22	186.4													
12/6/22	184.4													
1/9/23	181.9													

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	<p>2/14/23 179.4 3/3/23 177.7 4/13/23 178.4 5/3/23 179.4 6/5/23 179.8</p> <p>The 3/3/23 weight represented a 15.3 percent loss in 6 months and a significant weight loss.</p> <p>Physician orders directed staff: 3/9/23 Serve a Controlled Carbohydrate Diet (CCD), No Added Salt (NAS), regular texture, large portion diet. 11/15/22 Serve 4 ounces of House Supplement (Mighty Shakes) 3 times daily with meals.</p> <p>Resident #45's record revealed the last assessment and note transcribed by the facility's RDLD was on 1/19/23, the former RDLD prior to 4/1/23. Resident #45's record lacked documentation the physician was notified of the significant weight loss in March, 2023, or any additional interventions implemented as a result of the documented weight loss.</p> <p>A Nutritional Problem related to Diabetes, Parkinson's disease and need for therapeutic diet and supplementation problem initiated 8/18/21 on the Nursing Care Plan directed staff: Weigh per physician orders, initiated 3/20/23.</p>			
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	<p>Monitor/document/report any signs or symptoms of dysphagia that included pocketing food, choking, coughing, drooling, several attempts at swallowing, refusing to eat or appears concerned during meals initiated, initiated 8/18/21.</p> <p>Provide and serve diet as ordered, initiated 8/18/21.</p> <p>Provide and serve supplements as ordered: Sugar Free Might Shakes times a day, initiated 11/14/22.</p> <p>RDL D to evaluate and make diet change recommendations as needed, initiated 11/14/22.</p> <p>Report to physician signs or symptoms of malnutrition that include muscle wasting, significant weight loss of 5 percent or more in 1 month, or 10 percent or more in 6 months, initiated 8/18/21.</p> <p>The facility's planned CCD menu for the 5/31/23 evening meal included: 6 ounces Vegetable Soup 3 ounces Barbequed Chicken 4 ounces Baked Beans 4 ounces French Fries</p> <p>Observation on 5/31/23 at 6:10 p.m. revealed Resident #45 seated in the Dining Room, received 4 ounces of Baked Beans, plate approximately ½ covered with French Fries and 3 pieced of Barbequed Chicken, each approximately 3 inches in length, 1 inch in width, with heavy breading/coating and bone inside</p>			
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58.19(2)a	<p>each piece.</p> <p>Observation in the kitchen on 5/31/23 at 6:50 p.m. with the facility's Chief Clinical Officer revealed 2 pieces of Barbequed Chicken, that included the breading and bone, weighed 2.5 ounces.</p> <p>During an interview 5/31/23 at 6:31 p.m., Staff R, Cook, stated 4 pieces was the regular serving size of Barbequed Chicken.</p>	CLASS I	\$5,000.00 (HELD IN SUSPENSION)	UPON RECEIPT
<p>481—58.19(135C) Required nursing services for residents. The resident shall receive and the facility shall provide, as appropriate, the following required nursing services under the 24-hour direction of qualified nurses with ancillary coverage as set forth in these rules:</p> <p>58.19(2) Medication and treatment. a. Administration of all medications as ordered by the physician including oral, instillations, topical, injectable (to be injected by a registered nurse or licensed practical nurse only); (I, II)</p>				

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	<p>DESCRIPTION:</p> <p>Based on clinical record review, resident and staff interviews, and facility policy review, the facility failed to provide medications as ordered to 1 out of 15 residents reviewed by giving the wrong medications to a resident causing the resident to be transported to the Emergency Room for medication overdose (Resident #19). The facility reported a census of 69 residents.</p> <p>Findings Include:</p> <p>The Minimum Data Set Assessment (MDS) for Resident #19 dated 5/18/22, revealed the diagnosis of Coronary artery disease (CAD), and hypertension (HTN). Resident #19's Brief Interview for Mental Status (BIMS) score reflected 14 out of 15 indicating intact cognition. The medications utilized in the past 7 days reflect antidepressant daily. The MDS medication utilized over the 7-day lookback failed to include antipsychotic medication, and opioids.</p>			
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	<p>The Care Plan for Resident # 19 dated 1/13/2022, directed Nursing Staff to administer medications as ordered and monitor/document for side effects and effectiveness.</p> <p>The Situation, Background, Assessment and Recommendation (SBAR) on 7/10/22 reflected Resident #19 lethargic, decreased consciousness, slurred speech. Transferred to the hospital.</p> <p>The General Note 7/10/2022 at 7:15 PM, included Resident #19 sat at table in Min Dining Room asleep. Resident easily aroused but returned to sleep quickly. Staff FF, Certified Medication Aide (CMA) reported she made a medication error. Staff FF stated she gave Resident #19 another resident's medications. The note continued Resident #19 sat at the Main Dining Room table unresponsive. Vitals assessed. B/P. 69/52. Respirations 12 and shallow. Multiple attempts to arouse Resident #19 ineffective. Call placed on call provider and order received to send to Emergency Room (ER).</p> <p>The facility provided a document titled #931 Medication dated 7/10/22, the report revealed the CMA reported to the Nurse she gave another residents medication to Resident #19. Resident #19</p>			
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	<p>unresponsive at the time. Vital signs included blood pressure 69/52, respiration 12 and shallow. Staff attempted multiple times to arouse resident unsuccessfully. Called Staff H, Nurse Practitioner and ordered to send Resident #19 to the ER for evaluation and treatment. The report reflected potential medication side effect.</p> <p>The Physician Progress Note dated 7/11/2022 at 4:01 PM, reflected the chief complaint medication overdose. The note identified a medication overdose on 7/10/22 per Nursing Service, when an accident on medication administration occurred. Resident # 19 sent to ER and received intravenous (IV) fluids. Resident #19 evaluated at the bedside. Nursing Services reported yesterday Resident #19 received the wrong resident's medications. Resident #19 took 2 milligrams (mg) Risperidone (anti-psychotic), 300 mg trazodone (antidepressant), 0,4 mg tamsulosin (alpha blockers), Docusate Senna (stimulant laxatives), 10 mg buspirone (anxiolytics), 500 mg Keppra and 300 mg gabapentin (anticonvulsants).</p> <p>On 4/11/23 at 1:28 PM, Resident #19 denied concerns or problems with the facility administering his medications.</p> <p>On 4/17/23 at 1:40 PM, Staff DD, CMA, stated the</p>			
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	<p>facility does monthly mandatory education. Staff DD reported if medication errors happened in the facility she would expect some education.</p> <p>On 4/18/23 at 5:22 PM, Staff FF, CMA confirmed she administered the wrong medication to Resident # 19 on 7/10/22. She stated the nurse sent him to the hospital because he seemed very sleepy. Staff FF said she just started at the facility the two residents looked alike.</p> <p>Staff FF stated the facility provided her educated to pay attention, if unsure who the residents are, ask another staff.</p> <p>On 4/18/23 at 2:04 PM, the Assist Director of Nursing (ADON), reported the Medication Aide administered Resident #19 the wrong medication on 7/10/22. She reported the nurse called her and reported the medication error. The ADON stated the Medication Aide completed a return demonstration on medication administrations. The ADON reported she failed to document the education provided to the CMA.</p> <p>On 4/18/23 at 2:15 PM, the Director of Nursing DON stated she expected medications administered per the Physician's Order.</p>			
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58.24(5)	<p>On 4/19/23 at 10:21 AM, Staff H, Advanced Registered Nurse Practitioner (ARNP) stated she knew staff administered Resident #19 medications that belonged to another resident. Staff H stated the nurses sent Resident # 19 to the ER related a lethargic condition. Staff H stated the Hospital administered intravenous (IV) fluids and sent the resident back to the facility for staff to monitor.</p> <p>The facility policy titled Medication Administration dated 3/23, directed medications are administered by licensed nurses, or other staff who are legally authorized to do so in this state, as ordered by the physician and in accordance with professional standards of practice, in a manner to prevent contamination or infection.</p> <p>Policy Explanation and Compliance Guidelines: point #3 directed; Identify resident by photo in the Medication Administration R (MAR) Record.</p>	CLASS I	\$7,000.00 (HELD IN SUSPENSION)	UPON RECEIPT
	<p>481—58.24(135C) Dietary. 58.24(5) Food handling, preparation and service. All food shall be handled, prepared and served in compliance with the requirements of the Food and Drug Administration Food Code adopted under provisions of Iowa Code section 137F.2. (I, II, III)</p>			

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	<p>DESCRIPTION:</p> <p>Based on observations, staff interviews and record review, the facility failed to store, prepare and serve residents' food under sanitary conditions that met professional standards of food service, for 5 of 5 observed resident meals. These failures resulted in a possible endangerment to the health and safety of the residents creating an immediate jeopardy (IJ) situation. The facility reported a census of 69 residents.</p> <p>Findings include:</p> <p>The initial kitchen observations for the Main Kitchen on 4/11/23 with the Dietary Manager (DM) at 9:00 AM, revealed the following:</p> <ul style="list-style-type: none"> a. Plate warmer located inside the door did not work according to the DM. b. Plate warmer contained visible dry food debris of chips and cereal on the bottom shelf; the middle shelf contained a dried-on, pink colored substance on the surface and outside edge; and the top shelf contained a dried pink substance sporadically across the surface. 			
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	<p>c. The middle shelf was noted to have a tray of clean drinking glasses and a banana lying on them.</p> <p>d. Inside the main kitchen South entry door was a fire extinguisher. Beside the extinguisher was noted brown buildup substance on the wall.</p> <p>e. All walls inside of the microwave contained a dried brown substance.</p> <p>f. The bottom of the toaster had approximately a quarter inch thick buildup of brown substance.</p> <p>g. A visible brown substance present on the bottom of the Glove brand mixer and the clear plastic attachment sticky to touch.</p> <p>h. A white wheeled container approximately 3 feet by 3 feet by 2 feet in size contained a dried light brown substance and a couple of buildup nickel size darker brown spots of a sticky consistency.</p> <p>i. Above the food prep stainless steel table, a cluttered shelf observed with stickers hanging down at various lengths, a personal cell phone, an opened partially drank plastic water bottle with no date or name, and a slightly wet linen cloth approximately 6 inches by 6 inches in size.</p> <p>j. The milk cooler contained a visible dried yellow substance across the front, lower half of the cooler.</p> <p>k. The six gas burners of the gas range with a build-up of black substance with an adjacent griddle that contained a dried black substance on the griddle and across the back.</p>			
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	<p>l. To the left of the South bend range, the ceiling contained a circular heating, ventilation, air conditioner (HVAC) vent that had been approximately two feet in diameter. Adjacent to the vent the ceiling white paint had been visible for approximately two inches and then noted a dark ring approximately 19-24 inches in diameter where air blows out of the vent.</p> <p>m. A Motak freezer located against the left wall of the kitchen contained a dried dark substance across the bottom of the horizontal vents and the wheeled casters; the inside contained a sticky pink substance across the bottom shelf and dried food contents.</p> <p>n. The refrigerator labeled number 1 contained a dried dark gray and black substance on the horizontal vents at the bottom.</p> <p>o. Freezer #1 contained dried contents around the handles and the wheeled casters had a gray substance. The top left outside of the freezer had a gray visible substance that included a one-inch length piece dangling vertically.</p> <p>p. Freezer #2; and noted across the bottom horizontal vent and the bottom of the right shelf had been pieces to include freezer burnt french fry and cardboard box pieces.</p> <p>q. Adjacent to the second Freezer #2 was a small porcelain white handwashing sink that had a buildup of brown substance around both water faucets, and noted beside the sink was a plastic trash can with</p>			
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	<p>visible soiling on the top of lid and several items stuck to the outside of lid.</p> <p>r. On the wall above the clean dishes' storage, a Garrisons brand portable air conditioner had visible gray substance built up on all horizontal vents. The top of the Garrison brand air condition had a buildup of gray substance.</p> <p>s. Below the air conditioner, on the same wall, an Ecolab dishwasher machine noted on the floor area with discarded disposable plastic cups, pieces of paper, visible debris, and polyvinyl chloride (pvc) pipe had a buildup of a gray substance.</p> <p>t. Clean dishes rack with clear acrylic drinking glasses with white residue on the inside of several glasses.</p> <p>u. The separate dry goods storage room noted with dry uncooked noodles on the floor, storage wood shelves with peeling white paint and a gritty substance to touch. A large can storage rack noted to have a visible brown dust substance on the unused shelves.</p> <p>On 4/11/23 at 11:25 AM, an initial observation took place of the North Dining Room Kitchenette with the following noted:</p> <p>a. On the left wall, brown stains dried vertically beside on the wall.</p> <p>b. A Haier brand refrigerator with a sign, for residents and staff, full of to-go containers, drinks, and sacks</p>			
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	<p>with few names or dates. Outside surface of the refrigerator door had a dried brown substance splattered across the front.</p> <p>c. On top was a gray color silverware container and the front of the container noted to have dried brown substance in streaks.</p> <p>d. A small Hisense brand refrigerator with a buildup of a gray substance.</p> <p>e. Inside of the microwave, dried bright yellow substance on the clear rotating tray and all walls inside the microwave, observed a brown color substance buildup</p> <p>f. The steamer noted to have a brown dried substance on the outside right and noted on the lower shelf was dried material and food content. The wall surface between the steam table and serving window was noted to have a brown dried substance.</p> <p>g. On the kitchenette back wall noted a stainless-steel sink with a buildup of brown substance around the water faucets and the sink itself had dried brown stains. The cold-water faucet was not working, as no water flowed when the faucet was turned on. Noted below the sink was a cabinet floor with visible brown and loose gray substance, and noted storage of Behr brand paint cans, Ecolab brand lime-a-way, and Ecolab cleaning gel. Paint cans had apparent rust on lids. When opening the left side door, a few small winged insects had flown out.</p>			
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	<p>h. A large area of liquid brown color substance drying and dry coffee grounds across the counter by the Keurig small coffee pot.</p> <p>i. A commercial Warine brand coffee pot was noted to be on as a green light was noted. The outside of the coffee pot contained brown streaks down the left side.</p> <p>Observations on 4/11/23 at 9:00 AM and on 4/12/23 at 7:44 AM revealed Staff P, Dietary, wore a hair net that did not cover all scalp hair while in the main kitchen. On the right and left side of Staff P ' s face there was approximately one to two inches of thick hair hanging past facial chin.</p> <p>Observation on 4/12/23 at 11:00 AM revealed two plastic oscillating fans approximately two feet in height present on the prep counter in the main kitchen. Observation revealed both fans contained a visible gray substance on the fan blades and the blade cover; both fans positioned to produce air flow over the prep table and gas range area.</p> <p>Observation on 4/12/23 at 11:20 AM, revealed Staff P, Cook did not wash her hands nor don gloves prior to preparing resident lunch food. Staff P touched her face cheek area, then facial chin and then touched silverware to assemble for residents' lunch. Staff P</p>			
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	<p>continued in this manner touching her bare skin on arms, clothing and then took plated food from the cook and put a plastic lid over the plate.</p> <p>On 4/12/23 at 12:06 PM, observed a male dietary staff enter the kitchen and not wash his hands. The male staff touched his facial skin and arms and then pulled aluminum foil sheets with bare hands and Staff P picked up the foil to cover a resident's plated food. The male staff transferred cooked steam table container pans of resident food items to a plastic cart for transport to the North Dining room kitchenette.</p> <p>On 4/12/23 at 12:30 PM, the Dietary Manager (DM) observed in the North Dining Room kitchenette did not wash her hands, touching resident coffee cups to fill and putting vegetables in the microwave that had not temped on the steam table.</p> <p>On 4/12/23 at 4:03 PM, in an interview with the DM, she showed a Daily Cleaning Checklist instituted in the last month. When asked who would be responsible to follow-up on the check sheets and verify the cleaning completed, the DM stated that was her responsibility. During the interview an opened 5-pound bag of shredded cheddar cheese was noted left out on the stainless-steel counter, with the bottom contents noted to be melting. No Dietary Staff present. The</p>			
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Facility Administrator

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Health Facilities Division
Citation**

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	<p>floor dirty with a discarded disposable glove and a piece of bread. Staff T, Cook entered the kitchen and the DM asked Staff T about the cheese and then requested the oscillating fans be put away. Staff T responded using profanity. The DM observed shaking her head.</p> <p>On 4/13/23 at 7:55 AM, observation of the North Dining Room kitchenette showed Staff P enter the kitchen and noted there was no handwashing, Staff P touched her skin and then was observed making coffee in the Warin coffee pot.</p> <p>An observation on 4/13/23 at 8:16 AM, showed Staff U transport breakfast food to the North Dining Room kitchenette. Staff U touched her bare skin arms, face and then put gloves on without washing hands. Staff U observed using a personal cell phone, placed the phone in a pocket and then continued to plate resident food.</p> <p>At 8:18 AM, Staff U asked if the kitchenette sink had working water faucets and Staff U stated unaware if the water worked. Noted no paper towels on the kitchenette counter.</p> <p>On 4/18/23 at 12:15 PM, an observation of the main kitchen had shown Staff V, Dietary Aide was working at the food prep table area with no hairnet worn. Staff</p>			
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	<p>V wore white framed plastic sunglasses on top of her head. When Staff V asked about wearing a hairnet, she stated that her mind had just been going while taking items out of a refrigerator.</p> <p>On 4/20/23 at 11:00 A.M. an observation of the North Dining room kitchenette had taken place and the following noted:</p> <ul style="list-style-type: none"> a. The black plastic trash can lid was off with trash overflowing to the floor. b. A black dried and partially wet circle of liquid noted on the trash can and on the linoleum floor around the garbage can. c. Winged insects noted flying around the garbage can. e. The floor noted with empty cardboard boxes, silver aluminum piece, food, and white condiment packets. f. The toaster on the counter observed with winged insects on the tray and the tray stained with a dark brown substance. <p>2. Observation in the facility kitchen on 5/31/23 at 11:03 a.m. revealed:</p> <ul style="list-style-type: none"> a. Water temperature at the handwash sink was cool, and did not warm when the faucet was left on for over a minute. b. The low-temp dishwasher in operation, the exit 			
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	<p>surface/counter from the dishwasher approximately 7 feet long, clean dishes in dishwasher racks were on the exit counter and a window type of Air Conditioning (AC) unit positioned on the wall, at the end and approximately 24 inches above the counter surface, and blew down over the dishes on the counter. The grates on the lower ½ of the AC unit, through which the cold air blew, were covered with a gray dusty substance approximately 2 to 3 millimeters (mm) thick, that looked similar to lint from a clothes dryer.</p> <p>c. An opened box with 24 Chocolate Mighty Shakes (a dairy-based 4-ounce nutritional supplement shipped and stored in a frozen state, served after thawed) and an unopened box of 50 Mighty Shakes that were not dated when the containers were removed from frozen storage. The product expires 3 days after removed from frozen storage.</p> <p>d. A scoop positioned in a bin container of dry oats used for oatmeal.</p> <p>e. Broken thermometers located in a 3-door refrigerator located next to the 3-compartment sink, and in the milk cooler where various 8 ounce cartons of milk were stored, at least 200 cartons in milk crates inside the cooler.</p> <p>Observation in the facility kitchen on 5/31/23 at 12:50 p.m. revealed:</p>			
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	<p>a. Water temperature at the handwash sink remained cool, did not warm when faucet was left on for over 3 minutes.</p> <p>b. The wall AC unit continued to have dust that covered the grate on the lower half of the unit and blew down on cleaned dishes in dishwasher racks positioned on the dishwasher exit counter.</p> <p>c. Two air return vent grates located in the ceiling above food preparation counters, approximately 24 inches square, that were covered with gray colored dusty substance approximately 2 to 3 mm thick.</p> <p>d. The daily cleaning assignments and schedule did not list the ceiling vents or wall AC unit.</p> <p>During an interview 5/31/23 at 12:56 p.m., Staff RR, the interim Dietary Manager was informed that the window AC and ceiling air return grates were covered with what appeared to be dust, the scoop in the oats bin and broken thermometers found in the refrigerators. Staff RR stated she cleaned the wall AC grate and ceiling air return grates on 5/28/23, a contracted company came on 5/19/23 and cleaned the Kitchen floor, she cleaned the other Kitchen issues on that date and after that were identified as concerns on the initial annual survey exit on 5/1/23.</p> <p>During an interview 5/31/23 at 1:03 p.m., the facility Administrator was informed there was no hot water</p>			
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	<p>at the handwash sink in the Kitchen.</p> <p>During an interview 5/31/23 at 2:55 p.m., the facility Administrator stated the handwash sink water temperature was fixed, it was a mixing valve issue that Staff TT, the Maintenance Director had taken care of, and had not been reported as a problem by any of the dietary staff.</p> <p>Observation on 5/31/23 at 4:10 p.m. in the North Kitchenette revealed:</p> <ul style="list-style-type: none"> a. A strong odor of coffee that came from an approximate 20 inch by 5 to 6-inch puddle of coffee that dripped on the counter from the Coffee dispenser that was turned on and in use above the area. b. A microwave unit with 6 to 7 dried brown spots that varied in size from 2 - 3 mm to 6 - 10 mm located inside on the bottom of the unit, located between the door and the edge of the glass turntable plate. There were no staff in the area and the microwave was not in use. c. Four chocolate Mighty Shake containers in the refrigerator, fully thawed, undated when pulled from frozen storage. <p>Observation on 5/31/23 at 4:20 p.m. in the facility Kitchen revealed:</p>			
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	<p>a. Hot water from the handwash sink faucet.</p> <p>b. The wall AC unit grate and ceiling air return grates unchanged in appearance, remained covered in dust-like substance.</p> <p>c. Staff RR, interim Dietary Manager, observed the open box with undated and thawed Mighty Shakes, and the unopened box of 50 Mighty Shakes in the refrigerator. Staff RR stated she did not know when the opened box was pulled from the freezer, would throw the cartons away, the unopened box was pulled from the freezer that day and she wrote 5/31/23 with a marker on the outside of the unopened box of Might Shakes.</p> <p>On 5/31/23 at 4:33 p.m., the Surveyor requested to speak to Staff TT, maintenance Director, in reference to the ceiling air return vents in the Kitchen, and informed Staff TT had left for the day but could return.</p> <p>On 5/31/23 at 5:14 p.m., the facility Administrator stated staff TT returned, the window AC grate and ceiling air return grates had a greasy-residue substance under the dust, they ran them through the dishwasher, they were cleaned and the ceiling air return vents were added to Staff TT's duties to clean/inspect.</p>			
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	<p>Observations on 5/31/23 between 6:18 p.m. and 6:37 p.m. revealed Staff R, Cook, plated the evening meal from the steam table in the North Kitchenette and wore the same gloves throughout the process. At 6:29 p.m., Staff R grabbed 4 chicken nugget pieces with the same gloves worn throughout the plating process and did not use serving utensils, or remove his gloves and apply new gloves.</p> <p>On 6/1/23 at 9:50 a.m., the Surveyor requested a report from the facility's computer-based staff education program that listed the dietary staff's completion of food sanitation and safety education, and education on following the planned menu, both mandated upon initial employment for dietary duties.</p> <p>On 6/1/23 at 2:18 p.m., the facility's Chief Clinical Officer stated the facility could not provide documentation the dietary employees had received the required education upon hire, he ensured all the dietary staff on duty would receive the education that afternoon, and if a dietary employee wasn't on duty, they would receive the education prior to work on their next day assigned in the Kitchen.</p> <p>On 6/1/23 at 3:44 p.m., the facility's Chief Clinical Officer stated they had provided education to the dietary staff and wanted the Immediate Jeopardy</p>			
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	<p>status to be abated as of that time because they provided the required education. As of that time, there were 9 employees listed on the dietary employee roster, their position and hire date listed below:</p> <p>Staff Q, Cook, hired 1/2/23 Staff R, Cook, hired 12/15/22 Staff S, Cook, hired 10/19/21 Staff T, Cook, hired 12/27/21 Staff V, Dietary Aide, hired 8/6/21 Staff W, Dietary Aide, hired 6/8/22 Staff RR, interim Dietary Manager, hired 11/26/21 Staff UU, Cook, hired 1/17/22</p> <p>During an interview 6/5/23 at 7:19 a.m., Staff Q, Cook, in the facility Kitchen and in process of breakfast meal preparation, stated she had not received education related to food safety or following the planned menu on 6/1/23, she didn't work that day, she had received education on the cleaning schedule at a staff meeting that she thought occurred on 5/30/23. Staff S, Cook, also present in the Kitchen at the time, stated Staff Q didn't work on 6/1/23 and wasn't there when they went over that education. Staff Q was unaware that she required the training before she worked again.</p> <p>Observation on 6/5/23 at 11:25 a.m. revealed Staff Q</p>			
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	<p>in the administrator's office with education in process.</p> <p>Observation on 6/5/23 at 12:23 p.m. revealed 19 residents seated in the Dining Room for the noon meal, resident room trays for the North A and B Halls and food for the steamtable in the Kitchenette had not been distributed by the dietary department. During an interview on 5/31/23 at 9:39 a.m., a dietary employee stated room trays for the noon meal went out to the North A and B Halls at approximately 12:00 noon, with meal service to the Dining Room immediately after that.</p> <p>Observation on 6/5/23 at 12:25 p.m., through the glass window of the Kitchen door, revealed Staff RR, Interim Dietary Manager and 2 dietary employees, 1 that appeared texting on a cell phone, all positioned by the prep counter. Staff RR responded to the knock at the door, emerged from the Kitchen with the cart used for the A Hall room trays, said they would be going out now and transported the cart to the A Hall.</p> <p>Observation on 6/5/23 at 12:34 p.m. revealed the B hall room trays and food for the Kitchenette not dispensed from the dietary department, 21 residents were seated in the Dining Room.</p> <p>On 6/5/23 at 12:34 p.m., the facility RDL was</p>			
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	<p>informed of the meal status for B Hall room trays and Dining Room residents, and concern for the number of insulin dependent diabetic residents who had not received their noon meal as of that time. The RDLD went into the Kitchen immediately, returned from the Kitchen at 12:40 p.m. and stated dietary staff were finishing up on some things for the front/skilled hall, would take the food to the North Kitchenette after that for the meal service, and they were running behind due to the required education for Staff Q.</p> <p>Observation on 6/5/23 at 12:50 p.m. revealed the dietary department had not delivered food for the North Kitchenette/Dining Room residents, 22 residents seated there, 1 of the residents asked when they could have their food, stated they were hungry and had waited for a long time for their lunch, then stated don ' t you work for the State, can ' t you make them serve our food?</p> <p>Observation on 6/5/23 at 12:57 p.m. revealed dietary staff delivered food for the North Kitchenette steamtable and meal service commenced.</p> <p>Observation on 6/5/23 at 1:08 p.m. through the service window at the North Kitchenette revealed Staff S, Cook, wore gloves throughout meal plating, grabbed a handful of French Fries and served to a</p>			
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58.43(9)	<p>resident without changing gloves, and did not have a utensil present to serve with. The RDLD was informed of that at that time, went to the Kitchenette, observed Staff S did not have a utensil for the French Fries and addressed the matter with the employee.</p> <p>During an interview 6/5/23 at 1:11 p.m., the RDLD stated staff should always use serving utensils, should not touch or handle food, and if unavoidable, staff should apply clean, single use gloves if they had to handle resident food.</p> <p>481—58.43(135C) Resident abuse prohibited. Each resident shall receive kind and considerate care at all times and shall be free from mental, physical, sexual, and verbal abuse, exploitation, neglect, and physical injury.</p> <p>58.43(9) Allegations of dependent adult abuse. Allegations of dependent adult abuse shall be reported and investigated pursuant to Iowa Code chapter 235E and 481—Chapter 52. (I, II, III)</p>	CLASS II	\$500.00 (HELD IN SUSPENSION)	UPON RECEIPT
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	<p>DESCRIPTION:</p> <p>Based on record review, staff interviews and policy review, the facility failed to report an allegation of abuse for 3 of 10 residents reviewed for abuse (Residents #12, #21, and # 70). The facility reported a census of 69 residents.</p> <p>Findings Include:</p> <p>1. The Minimum Data Set (MDS) Assessment Tool, dated 1/3/23, listed diagnoses for Resident #70 which included heart failure, paraplegia (paralysis from the waist down), and anxiety disorder. The MDS documented the resident required supervision assistance of 2 staff for personal hygiene, limited assistance of 2 staff for transfers, extensive assistance of 1 staff for dressing, extensive assistance of 2 staff for toilet use, and depended completely on 2 staff for bathing. The MDS listed the resident's Brief Interview for Mental Status Score (BIMS) of 14 out of 15, indicating intact cognition.</p> <p>A 5/30/22 Behavior Note for Resident #70 stated Resident #70 rammed her wheelchair into Resident #21 and then Resident #21 stood up to hit Resident #70.</p>			
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	<p>A 5/31/22 Physician Note for Resident #70 documented the resident admitted to punching a 92-year-old (Resident #21) resident and no injuries were sustained.</p> <p>A 6/2/22 Physician Note for Resident #21 stated the resident denied being punched.</p> <p>An 8/27/22 General Note documented Resident #70 and her roommate (Resident #12) threw water at each other and the resident changed rooms.</p> <p>A 7/19/22 Care Plan entry stated the resident could be verbally aggressive related to ineffective coping skills and poor impulse control. An 11/25/22 revision of the entry stated on 11/10 the resident was physically aggressive and required 1:1 monitoring.</p> <p>The Care Plan lacked documentation of alleged physical altercations prior to 11/25/22.</p> <p>In an interview on 4/25/23 at 8:35 a.m., Staff JJ, Licensed Practical Nurse (LPN) stated Resident #70 had physical altercations with other residents. She stated once Resident #70 smoked outside and she threw a lit cigarette on another resident. She stated she did not see this but heard about it.</p>			
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	<p>In an interview on 4/25/23 at 1:00 p.m., the Director of Nursing (DON) stated she heard about the allegation that the resident threw a lit cigarette. She stated staff should report physical altercations between residents and the facility would separate the residents and interview residents and staff. She stated the Care Plan should address the resident's behaviors.</p> <p>In an interview on 4/27/23 at 10:50 a.m., the Administrator stated staff should report allegations of abuse within 2 hours. She stated the facility would investigate the allegation and would separate the residents.</p> <p>The facility lacked documentation of an investigation related to the above altercations and lacked documentation they reported the allegations to the State Agency or separated the resident from other residents.</p> <p>The facility policy "Abuse, Neglect, and Exploitation", dated March 2023, stated the facility would provide protection for the health, welfare, and rights of each resident by developing and implementing written policies and procedures that prohibited and prevented abuse, neglect, exploitation, and misappropriation of resident property. The policy stated the facility would complete an immediate</p>			
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	investigation and ensure all residents were protected upon a suspicion of abuse. FACILITY RESPONSE:			
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