DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	165255	A. BUILDING _____ B. WING _____	C 04/15/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CARLISLE CENTER FOR WELLNESS AND REHAB	680 COLE STREET CARLISLE, IA 50047

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F 000	INITIAL COMMENTS Correction date 4/16/2020 The following deficiency resulted from the investigation of facility self-reported incident #90400-I. See the Code of Federal Regulations (42CFR) Part 483, Subpart B-C. Amended 5/5/20 JM, RN	F 000	This shall serve as an allegation of compliance; all deficiencies will be corrected by the correction date. The preparation of the following correction for these deficiencies does not constitute and should not be interpreted as an admission nor an agreement by the facility of the truth of the facts alleged or the conclusion set forth in the statement of deficiencies. The plan of correction prepared for the deficiencies was executed sole to the provisions of the state and federal law require it.	4/10/2020
F 689 SS=J	Free of Accident Hazards/Supervision/Devices CFR(s): 483.25(d)(1)(2) §483.25(d) Accidents. The facility must ensure that - §483.25(d)(1) The resident environment remains as free of accident hazards as is possible; and §483.25(d)(2)Each resident receives adequate supervision and assistance devices to prevent accidents. This REQUIREMENT is not met as evidenced by: Based on clinical record review, observation, staff interview, and facility record review, the facility failed to provide adequate nursing supervision to prevent hazards from self or others for 1 of 4 residents reviewed for adequate nursing supervision (Resident #1). The facility failed to ensure all staff were aware of a cognitively impaired resident's risk and history of putting non-food/foreign objects in his mouth, and failed to remove all potential choking hazards from the CCDI (Chronic Confusion and Dementing Illness) unit where the resident resided. On 2/6/20, a dentist found foreign material (cotton ball or toilet paper) wrapped around the resident's tooth; on	F 689	Resident #1 still resides in the CCDI unit. Administrator provided education to staff on the 4/10/2020 for Resident #1 tendencies of putting non-food items in his mouth. Education has been added to the orientation process for all new hires. Administrator or Designee will perform random audits to ensure compliance. All findings or concerns will be presented through the QA committee in a timely manner. On 4/10/2020 Assistant Director of Nursing initiated hourly checks in Resident #1 mouth in addition to checks after meals and med pass. Assistant Director of Nursing provided education to nursing staff on use of a new 24 hour report process. All nurses will print off an "end of shift" report, ensuring all event documented will be passed along to on coming charge nurse.	4/10/2020 4/10/2020

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

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

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F 689	Continued From page 1 2/18/20 staff found a golf ball-sized wad of toilet paper in the resident's mouth; and on 3/20/20 staff found puzzle pieces in the resident's mouth, but were able to instruct him to spit them all out at that time. On 3/24/20 the resident ingested an entire puzzle and required transport to the hospital for evaluation and removal of additional puzzle pieces under anesthesia. These events resulted in an immediate jeopardy to the resident's health and safety. The facility reported a census of 63 residents. Findings include: The annual Minimum Data Set (MDS) assessment dated 3/18/20 for Resident #1 identified a Brief Interview for Mental Status (BIMS) score of 3 (without signs/symptoms of delirium). A score of 3 indicated severe cognitive impairment. The MDS revealed the resident required supervision with assist of 1 staff for transfers, walking in the room, and locomotion on the unit. The resident remained independent with ambulation (walking) in the corridor and required supervision with set-up help only for eating. The MDS documented diagnoses that included non-Alzheimer's dementia and obsessive-compulsive disorder (OCD) and recorded the resident received a mechanically altered diet. The Wandering Risk Scale assessment for Resident #1 completed 3/18/20 identified a score of 14.0, which categorized the resident as someone at high risk for wandering. The Oral Health Assessment for Resident #1 completed on 3/18/20 identified problems with swallowing.	F 689	ADON or Designee will perform random audits to ensure compliance. All findings will be brought through the QA committee in a timely manor. Resident #1 Care Plan was reviewed on 4/10/2020 by the Interdisciplinary team to ensure it was all up to date with all interventions. MDS Coordinator will ensure all care plans are up to date and accurate. DON or Designee to perform random audits to ensure compliance. All finding will be brought through t he QA committee in a timely manner. Facility ADON on 4/10/2020 requested a Doctor visit evaluation for Resident #1 concerning behaviors. MDS or designee to monitor and perform random audits to ensure behaviors and diagnoses match. All findings will be brought through the QA committee in a timely manner. On 4/10/2020 facility increased staffing in the CDDI unit to two staff members from 6:00am-10:00 pm; to ensure adequate supervision. To increase staff supervision, facility will also implement on call nurse to adjust hours to work evening shift; to cover areas of supervision needed.	4/10/2020 4/10/2020 4/10/2020

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F 689	Continued From page 2 The care plan focus area revised 2/26/19 identified an ADL (Activities of Daily Living) self-care deficit. The interventions informed staff the resident transferred and ambulated independently throughout the CCDI unit with cuing needed if lost, and needed reminders to take a step. The interventions also informed staff the resident remained independent with staff set-up help for eating and directed to cue the resident to eat slowly. The care plan focus area revised 7/2/19 identified a potential nutritional problem. The interventions included a diet of pureed texture with thickened liquids and staff to monitor/document/report as needed any signs/symptoms of dysphagia (pocketing, choking, coughing, drooling, holding food in mouth, several attempts at swallowing, refusing to eat, or appearance of concern during meals). The care plan focus area revised 10/8/19 identified a communication deficit with unclear speech and revealed the resident sometimes understood. The care plan identified impaired cognitive function with impaired thought processes related to a diagnosis of dementia. The interventions directed staff to cue, reorient, and supervise as needed. The care plan focus area revised 12/20/19 identified a risk for activity deficit. The interventions lacked updates related to the resident's risk of putting puzzle pieces into his mouth or the need to keep puzzles in a locked area. The care plan focus area revised 1/6/20 identified	F 689	Administrator or Designee will perform random audits to ensure staffing is covered for supervision in the cottage. All findings will be brought through the QA committee in a timely manor. Facility performed a sweep of the CCDI unit on 4/10/2020 to ensure all items labeled "keep out of reach of children" are placed away out of sight and out of mind. To ensure the safety of all residents in the CCDI including Resident #1. Administrator or Designee will perform random audits to ensure all items are placed away, out of sight and out of mind. All concerns will be brought through the QA committee in a timely manor. On 4/10/2020 facility initiated for Resident #1 to reside in a private room. To ensure Resident #1 did not eat or place non-food/foreign items in his mouth that belongs to a roommate; and to also reduce the number of personal items in the room. On 4/10/2020 facility implemented a new training packet for new and/or agency staff. Included in the packet is education on Resident #1 and all his interventions. New employees will receive this information during orientation provided by Human Resources Director of Designee, while agency staff will obtain this information from our Staffing Coordinator or Designee before the beginning of their first shift.	4/10/2020 4/10/2020 4/10/2020

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F 689	Continued From page 3 an elopement risk as the resident wandered and paced the hallway going into other residents' rooms and turning on televisions. The care plan documented the resident had a history of going into other residents' rooms he enjoyed watching TV in the commons area. The care plan focus area initiated 1/24/19 identified a behavior deficit related to compulsive, OCD-type behaviors. The care plan revisions included the following documentation: a. 1/24/19 - the resident had history of eating hand sanitizer, toothpaste, and hand soap. b. 2/18/20 - same information related to history of eating hand sanitizer, toothpaste, and hand soap. c. 3/23/20 - the revision included behavior of putting non-food items in his mouth. d. 3/26/20 - the revision identified the resident put non-food items/foreign objects in his mouth. The interventions were updated to include staff to monitor the resident throughout the day to check for foreign objects in his mouth and to redirect/encourage him not to put items into his mouth. The Dental Care visit notes dated 2/6/20 documented the patient pocketed some sort of cotton like material in his mouth and it was discussed with his nurse. The Physician Fax communication form dated 2/6/20 documented the dentist reported he found a pocketed foreign object approximately the size of a grape in the resident's mouth which looked like toilet paper or cotton. The form recorded an order: okay to check the resident's mouth every 2 hours and between meals as a nursing intervention to monitor for pocketing.	F 689	Administrator or Designee will perform random audits to ensure compliance. All findings will be brought through the QA committee in a timely manner.	

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F 689	Continued From page 4 The Medication Review Report dated 4/8/20 listed orders for: a. CCDI level of care active 8/28/18 b. General diet, pureed texture, nectar thick consistency for dysphagia (difficulty swallowing) active 10/3/19. c. Okay to send to ER (Emergency Room) to evaluate and treat 3/24/20. The Progress Notes included the following entries: a. On 2/6/20 at 12:48 p.m. the dentist examined the resident and reported he found foreign objects pocketed in the resident's mouth of cotton, toilet paper, and/or another foreign material wedged in his cheek wrapped around a tooth. Staff initiated a nursing intervention to check the resident's mouth after every meal, every 2 hours, and when brushing teeth. The entry noted the resident at risk for choking and on thickened liquids with a pureed diet. b. On 2/18/20 at 9:18 a.m. staff found a golf ball sized piece of toilet paper in the resident's mouth that morning when getting the resident out of bed prior to breakfast. The entry noted the resident did not choke and the CNA (Certified Nurse Aide) removed the toilet paper from his mouth. The nurse removed all toilet paper and paper towels from the resident's room. The nurse placed the information on the 24 hour report sheet used by the nurses to communicate issues to monitor closely) and notified staff to no longer keep paper products in the resident's room. c. Entries from 2/19/20 thru 3/19/20 contained daily documentation of monitoring for items in the mouth except for 2/25/20 and 3/11/20 with	F 689		

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F 689	Continued From page 5 nothing found. d. On 3/20/20 at 4:12 p.m. Staff C, Licensed Practical Nurse (LPN), wrote the resident noted with several pieces of puzzle in his mouth that morning after breakfast, but he spit them out when asked. The entry contained no other details of the incident. e. Entries from 3/21/20 thru 3/23/20 contained daily documentation of monitoring for items in the mouth with nothing found. The entries contained no follow up assessments related to the resident having puzzle pieces in his mouth on3/20/20. f. On 3/24/20 at 1:34 p.m. Staff A, LPN from temporary staffing agency, wrote the residentwas in the activity room when she went in to give medications and found puzzle pieces in his mouth. Staff A pulled out the puzzle pieces and discovered some stuck in the resident's throat. Other nurses and CNAs assisted and stayed with the resident until the ambulance arrived. g. On 3/24/20 at 1:42 p.m. the Assistant Director of Nursing (ADON) wrote she was called to the CCDI unit to help the charge nurse due to the resident eating puzzle pieces. The resident sat at a table in the TV room with mucus coming out of his nose and mouth. The charge nurse and ADON attempted to remove puzzle pieces from the resident's mouth with very large amount of pieces removed. Instruction given to the resident to cough but he did not and he gagged multiple times with audible wheezing heard. The nurse documented vital signs of temperature 97.6 degrees, 18 respirations per minute, 114 heart rate per minute (mayo clinic defines normal resting heart rate tat 60 to 100 beats per minute), and blood pressure of 149/86 (a top number above 120 indicated elevated blood pressure). The ADON directed the charge nurse to call 911 while she stayed with the resident until EMTs	F 689		

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F 689	Continued From page 6 (Emergency Medical Technicians) arrived. h. On 3/24/20 at 3:58 p.m. the ER report described the resident as calm and waiting for GI (Gastrointestinal consult) to evaluate the resident. The resident was still gurgling at that time with a clear airway. i. On 3/24/20 at 6:29 p.m. the ER documented resident to be kept overnight for monitoring as they were unable to get all puzzle pieces out, the resident wheezed and gurgled, and they were waiting for the puzzle pieces to pass. j. On 3/24/20 at 6:46 p.m. the ER reported the resident went to surgery to retrieve the puzzle pieces lodged in the resident's esophagus. k. On 3/26/20 at 6:45 a.m. the hospital reported 4 puzzle pieces retrieved from the resident's esophagus during surgery, and the resident would have a repeat chest x-ray later that day as the x-ray the day before confirmed possible other pieces still in the resident's esophagus. The resident ran a low grade temperature of 100.3 degrees, and struggled to swallow; he needed a swallow study prior to being able to return to the facility. l. On 3/27/20 at 9:50 a.m. the hospital doctor reported the resident failed the swallow study. m. On 3/27/20 at 4:23 p.m. the resident arrived back at the facility from the hospital. n. Entries from 3/29/20 thru 4/9/20 contained daily documentation of monitoring for items in the mouth except for 4/5/20 with nothing found. o. On 4/10/20 at 8:31 a.m. an evaluation requested in regard to the resident's behaviors of consuming foreign objects and pocketing food in cheeks. The hospital ED Nursing Record dated 3/24/20 at 2:06 p.m. documented a triage note the resident took a handful of puzzle pieces, swallowed them,	F 689		

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F 689	Continued From page 7	F 689		

and was drooling with audible wheezes present. At 2:25 p.m. hospital staff assessed the presence of a productive, spontaneous cough with lung sounds of rhonchi (continuous low pitched, rattling sound that often resembles snoring; obstruction or secretions in larger airways frequent causes) and stridor (abnormal, high-pitched, musical breathing sound; caused by a blockage or narrowing in the upper airways). At 2:36 p.m. the ED physician documented the resident spit up another large puzzle piece on arrival and inspection revealed it to be cardboard-paper. At 6:11 p.m. the hospital record documented attempts made to give the resident water to drink in order to assess puzzle pieces. The resident had a gargle in his throat when talking and drooling of water at times after swallowing.

The hospital Consult report dated 3/25/20 at 7:13 a.m. documented the resident vomited some of the puzzle pieces in the ED and overnight on the floor.

The hospital Operative Report dated 3/25/20 at 6:20 p.m. documented an EGD (Esophagogastroduodenoscopy) [a procedure that examines the esophagus, stomach and first portion of the small intestine using a long flexible tube with a camera] completed under general anesthesia due to foreign body ingestion with dysphagia, inability to tolerate secretions, and drooling. The endoscope removed 4 pieces of cardboard puzzle from the oral cavity.

The hospital Progress Notes dated 3/27/20 at 8:19 a.m. documented the resident had some ongoing fevers and tachycardia (increased heart rate) and would be monitored for aspiration

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F 689	Continued From page 8	F 689		

pneumonia (lung infection which occurs after inhaling something into the lungs).

The hospital Surgical Pathology Final Report dated 3/27/20 at 3:56 p.m. documented a diagnosis of foreign body (puzzle piece). The Gross Description documented the foreign body extraction consisted of multiple pieces of gray cardboard consistent with pieces of puzzle, measured at 8 by 8 by 0.5 cm (centimeters) in aggregate.

Facility Investigation

Staff A, LPN, witness statement signed 3/26/20 included the following:
Staff A signed for the medications at 11:30 a.m. and went to give medications when Resident #1 refused to take them at that time. Staff A placed medication in the top of the locked nurse's cart to attempt again later. The last time Staff A saw Resident #1 was when she passed food trays and he ate his lunch in the activity room with Staff B, CNA, at 12:30 p.m. Staff A attempted to five the meds around 1:00 p.m. when she found Resident #1 with puzzle pieces inside his mouth. Staff A called for CNAs help and destroyed medications. After no success, Staff A instructed CNA to go find another nurse for help.

The ADON witness statement signed without a date included the following:
The ADON was at the east nurses station when Staff B approached her from the cottage (CCDI unit) and said the cottage nurse needed assistance because Resident #1 ate puzzle pieces. Upon entering the activity room in the cottage, the resident sat at the table. Staff A stood

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F 689	Continued From page 9 next to him attempting to remove puzzle pieces from his mouth. The ADON applied gloves and attempted to assist Staff A. Resident #1 noted had an excessive amount of saliva coming from his mouth she instructed him to spit out the puzzle pieces at that time. Resident #1's cognitive deficits made him unable to follow instructions at that time. The ADON asked the resident to open his mouth, but the resident clenched teeth and began to have audible wheezing. The ADON instructed Staff A to call 911 while the ADON stayed with the resident until EMTs arrived. Review of signed interview notes dated 3/26/20 at 12:15 p.m. revealed Staff B, CNA, last saw the resident at 12:30 p.m. when she returned from break and sat with him during lunch. Staff B could not recall how long the resident normally took to eat lunch. The signed, undated statement written by the Admissions and Marketing Coordinator (AMC), included the following: On 3/25/20 the ADON and AMC walked through the CCDI activity room and found several puzzles in unlocked cabinets and on the table. All puzzles removed from the cottage and given to the Activity Director. Several locked activity cupboards contained games and items smaller than fist sized such as checkers, dice, and additional puzzles. Those items also removed from the cottage and given to the Activity Director. An activity list posted in the CCDI activity room which listed activities that included items of inappropriate size. The list removed and a new policy for size requirements for activities posted. The facility policy titled CCDI Activities	F 689		

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F 689	Continued From page 10	F 689		

implemented 03/2020 included the following with 16 staff signatures:
Purpose -
To ensure the safety of our residents in the CCDI unit.
Procedure -
There will be no activities in the CCDI unit that are smaller than an adult fist.
If there is an activity to be done that has pieces smaller than an adult fist, it will be locked up away from residents for their safety. Such activities can only be used while in the presence of a staff member. When an activity completed, the activity will be placed back behind a locked door.

Staff Interviews

On 4/9/20 at 6:38 p.m. Staff C, LPN, reported she started working at the facility a year prior. Staff C confirmed she worked as the charge nurse on the CCDI unit on 3/20/20. Staff C recalled her progress note for that day and documenting she found puzzle pieces in Resident #1's mouth. Staff C stated Resident #1 sat in the TV room after lunch when she found a few pieces of puzzle in his mouth. Staff C reported the resident able to follow command to spit them out but he couldn't get 1 piece past his teeth. Staff C responded prior to that incident, she was never made aware of or received education from the facility about the resident's behavior of ingesting non-food items. Staff C stated she knew they had to sit with Resident #1 when he ate as she heard he would shovel food in his mouth. Staff C responded she was not aware of the 2/6/20 incident of the dentist finding cotton in the resident's mouth or the 2/18/20 incident of the resident having toilet paper in his mouth. Staff C

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F 689	Continued From page 11	F 689		

commented she felt if she had known then she would have put the resident on more frequent charting, 24 hour report, or incident report. Staff C voiced at the time she didn't think 2 or 3 pieces of the puzzle a big deal because it was an adult puzzle so the pieces were small: she had seen piece sticking out. Staff C responded she did not tell Staff E, LPN, of the incident during end of shift report 3/20/20. Staff C responded she didn't receive any education after 3/24/20 incident, and just found out through word of mouth that the resident went to the hospital for ingesting puzzle pieces that day. Staff C commented no education happening and the communication was not good. Staff C said communication consisted of whatever the nurse relieving her told her to follow-up on. Staff C reported no one was very good about looking at the care plans, but a snapshot for personal cares was mounted on the bathroom doors. Staff C stated Resident #1 stayed where staff put him and rarely got up on his own.

On 4/10/20 at 2:30 p.m. Staff M, CNA/RA (Restorative Aide), reported she started at the facility on 2/14/20 in the Restorative Aide (RA) role. Staff M recalled she worked in the CCDI unit on 3/20/20 when pulled off the unit to give a shower. Staff M reported when she returned, Staff C, LPN, told her she needed to watch Resident #1 more closely and showed her puzzle pieces removed from his mouth; Staff M assumed Staff C put the puzzle away. Staff M commented the puzzle pieces on 3/20/20 were already out of the resident's mouth at the time Staff C told her to watch him more. Staff M stated the day Resident #1 went to the hospital, 3/24/20, she asked what happened. Staff Msaid other aides knew about the puzzle pieces Staff C

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	165255	A. BUILDING _____ B. WING _____	C 04/15/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CARLISLE CENTER FOR WELLNESS AND REHAB	680 COLE STREET CARLISLE, IA 50047

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 689	Continued From page 12	F 689		

removed on 3/20/20 because Staff M told them but Staff M had not told any other nurses or management as she thought Staff C took care of it. Staff M commented she had never seen that before and if she had she wouldn't have had the puzzle out on the table. Staff M responded she had not received education from the facility before or after the incident for any actions taken to mitigate the risk of choking hazards for Resident #1. Staff M stated her first education occurred the day of the interview, 4/10/20, and showed a paper she had just received. Staff M said she heard what happened on 3/24/20 through the grapevine. Staff M responded she was not aware of Resident #1's incidents on 2/6/20 or 2/18/20 of foreign objects being in his mouth, and commented the only other thing she was taught was to keep out of reach of children items put away.

On 4/10/20 at 12:07 p.m. Staff K, CNA/Housekeeping Manager, recalled working on the CCDI unit on 3/20/20 starting at 4:00 p.m. Staff K responded she had not been told anything from Staff C or Staff E about Resident #1 having puzzle pieces in his mouth that day nor had she ever seen that behavior before. Staff K stated she was aware of the resident's history of going to the hospital on 3/24/20 due to eating puzzle pieces. Staff K responded after the 3/24/20 incident she did not receive any orientation with regard to actions taken to mitigate further risks of choking for Resident #1.

On 4/9/20 at 12:23 p.m. Staff E, LPN, reported she was hired 2/27/20 and she was familiar with Resident #1. Staff E stated she received orientation then once or twice worked in the CCDI unit. Staff E responded she was not aware she

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	165255	A. BUILDING _____ B. WING _____	C 04/15/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CARLISLE CENTER FOR WELLNESS AND REHAB	680 COLE STREET CARLISLE, IA 50047

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 689	Continued From page 13	F 689		

needed to watch Resident #1 for pocketing of pills or food. Staff E verified she worked the night of 3/20/20 but did not recall being aware the resident ingested puzzle pieces that day. Staff E stated she did not know until after the resident went to the hospital that he would put things in his mouth. Staff E commented she had not worked on the CCDI unit since the resident was sent to the hospital on 3/24/20 and had not she received any education about the facility's action plan. Staff E responded no one told her about the toilet paper found in the resident's mouth in February and was Staff E stated she was not aware of any protocols about locking items up. Staff E explained the day room had a puzzle on a table, she did not know if they put it away at certain times, and it looked like a regular sized puzzle.

On 4/9/20 at 10:49 a.m. Staff A, LPN, recalled the event on 3/24/20 at noon with Resident #1. Staff A responded she did not work often for the facility but lately had regular hours (12 hour shifts, 3 times a week). Staff A reported she had only worked on the CCDI unit a handful of times, and reported it was just she and Staff B assigned and working in the unit that day. Staff A reported the resident wouldn't take his noon pills at first, so she set them on top of the cart to retry. Staff A stated the resident ate lunch with Staff B in the room and then Staff A attempted to give him his medicine again. Staff A reported she discovered puzzle pieces in the resident's mouth and then removed a "ridiculous" amount. Staff A said the resident would not open his mouth further and then bit her, so she sent Staff B to get the ADON for help. Staff A reported other nurses came and called the ambulance and the family. The EMTs arrived and the ADON had been able to remove a few more pieces, but more could be seen in his

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	165255	A. BUILDING _____ B. WING _____	C 04/15/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CARLISLE CENTER FOR WELLNESS AND REHAB	680 COLE STREET CARLISLE, IA 50047

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 689	Continued From page 14	F 689		

throat and he would not allow anyone to retrieve them. When asked, Staff A responded she was not told the resident had a history of eating foreign objects, but was told he would pocket food so she would check after pills and meals for food. Staff A stated they kept a puzzle kept on the table to keep the residents busy and if she would have known Staff A didn't think she would have left the room. Staff A described the puzzle as regular size and she did not know how many pieces were in the box, but the resident put the entire box in his mouth. Staff A said she thought the puzzle was less than a 100 piece puzzle and not tiny pieces; possibly a 24 piece puzzle. Staff A recalled a "mountain" of puzzle pieces on the table comprised of what she removed from his mouth. Staff A commented the resident must have eaten the puzzle fast as Staff B cleaned up the dining room and took other residents back to their rooms after lunch. Staff A thought the incident occurred maybe around 12:30 p.m. and Resident #1 was not alone in the community room long before she found him. Staff A reported she had never seen the resident ingest foreign material before. Staff A stated Resident #1 was able to ambulate on his own, and responded she didn't think the incident could have been prevented if it had never happened before. Staff A commented she had "never, ever" heard of him eating anything other than food. Staff A responded she was not aware the resident ate puzzle pieces on 3/20/20 and never told of his history of pocketing toilet paper.

On 4/10/20 at 12:15 p.m. Staff B, CNA, reported she started working at the facility in January 2020 and not told Resident #1 could eat foreign objects. Staff B stated she got word someone found cotton in Resident #1's teeth. Staff B

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	165255	A. BUILDING _____ B. WING _____	C 04/15/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CARLISLE CENTER FOR WELLNESS AND REHAB	680 COLE STREET CARLISLE, IA 50047

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 689	Continued From page 15	F 689		

recalled working in the CCDI unit on 3/24/20. Staff B said she and an agency nurse, Staff A, worked the unit and Resident #1 was okay in the TV room with supervision given at the table. Staff B said once Resident #1 finished eating, she asked him if he wanted to go sit in his room. Staff B reported the resident wanted to stay in the TV room and there were a couple of puzzles out on the table. Staff B said a tray table with a regular puzzle box of 300 or 500 pieces was present and they were big pieces. Staff B reported she went to talk to everyone else and going to rooms to get food trays. Staff B stated Staff A then found puzzle pieces in Resident #1's mouth and asked her for assistance. Staff B stated the resident refused to let them help, clenched his teeth, and they could see gray puzzle pieces in his mouth. Staff B went to get the ADON. Staff B recalled a couple other staff also arrived to help. Staff B stated one of the nurses told her to come back and make phone calls and she saw them trying to get the resident to spit out the pieces when the ambulance arrived. When asked, Staff B stated she was not aware of the 3/20/20 incident of Resident #1 putting puzzle pieces in his mouth or of the dentist incident on 2/6/20. Staff B commented the communication at the facility not very good as information did not get communicated especially when she worked other halls. Staff B stated 1 aide and 1 nurse not enough staff when residents had behaviors that got out of hand on the CCDI unit. Staff B did not remember formal education completed after the 3/24/20 incident but she told someone she put the puzzle pieces away in the cupboard.

On 4/9/20 at 12:39 p.m. the ADON reported she started working at the facility on 2/10/20. The

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	165255	A. BUILDING _____ B. WING _____	C 04/15/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CARLISLE CENTER FOR WELLNESS AND REHAB	680 COLE STREET CARLISLE, IA 50047

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 689	Continued From page 16 ADON stated she became familiar with Resident #1 and knew the nurses charted hourly checks in regards to not pocketing food. She recalled on 3/24/20 around lunch time Staff B told her Resident #1 ate puzzle pieces, so she walked into the unit to find Staff A encouraging Resident #1 to spit out puzzle pieces as he sat at the activity table. The ADON stated the resident did not appear to be choking; no noises, no gurgling, but presented with audible wheezes so she told Staff A to call 911 while she stayed with the resident until EMTs arrived. The ADON stated she tried to encourage the resident to cough and spit out the puzzle pieces but he leaned forward and did not try due to his cognition. The ADON reported there were quite a lot of normal sized puzzle pieces from probably a 100 piece puzzle and was not sure if the puzzle box got thrown away. The ADON responded she was not aware at that time resident had put puzzle pieces in his mouth on 3/20/20. She said it was known the resident pocketed food and meds, but the ADON would have expected Staff C, LPN, to put the 3/20/20 incident on hot charting (24 hour report sheet used by the nurses for communication). The ADON responded she knew about the dental appointment 2/6/20 beforehand and toilet paper and paper towels removed from Resident #1's room. The ADON reported she did not do a lot with care plans, and did not know of any staff education completed in relation to Resident #1 and his risk to ingest foreign objects Additional Staff Interviews On 4/9/20 at 2:50 p.m. the Administrator responded she was aware the dentist found a cotton ball in Resident #1's mouth on 2/6/20, but was not aware of the 2/18/20 incident with the	F 689		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	165255	A. BUILDING _____ B. WING _____	C 04/15/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CARLISLE CENTER FOR WELLNESS AND REHAB	680 COLE STREET CARLISLE, IA 50047

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 689	Continued From page 17	F 689		

golf ball sized wad of toilet paper in his mouth or that the care plan lacked information until 3/23/20. She responded she could not say for certain if the facility had anything on paper regarding education to staff about Resident #1's risk of ingesting foreign objects. The Administrator stated she remembered a conversation in a morning meeting where she told the previous DON (Director of Nursing) to follow up and make sure everyone knew. The Administrator said she did not know until 2 hours before the interview that Resident #1 put puzzle pieces in his mouth on 3/20/20. The Administrator stated she needed to speak to Staff C about why she didn't tell anyone and said she needed to educate all staff. The Administrator said she took a copy of the activity policy and had the staff that worked on the CCDI unit sign it, but acknowledged the 16 signatures would not represent all the staff would possibly work on the CCDI unit. The Administrator stated she knew the Admissions Marketing Coordinator and the Activity Director did a full sweep of the CCDI unit and removed everything that was smaller than a fist.

On 4/9/20 at 1:54 p.m. Staff D, LPN, reported she worked at the facility for 2 years full time and she was familiar with Resident #1. Staff D responded she first became aware Resident #1 would ingest foreign objects after a dentist reported finding a cotton ball in the resident's mouth and from then on she checked his mouth 3 to 4 times a day. Staff D responded there was not a formal place to document those checks; it was on the 24 hour report to pass on to the next shift to check for items. Staff D responded she was aware of the 2/18/20 incident of Resident #1 having toilet paper in his mouth. Staff D

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	165255	A. BUILDING _____ B. WING _____	C 04/15/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CARLISLE CENTER FOR WELLNESS AND REHAB	680 COLE STREET CARLISLE, IA 50047

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 689	Continued From page 18	F 689		

responded a new nurse or agency nurse would know to monitor the resident from having it passed on in report. Staff D stated she was not aware of the 3/20/20 incident and the only education she knew management did was remove the puzzle from the unit and they went thru the unit to look for other items. Staff D commented she identified the previous evening an agency nurse hung up Easter eggs which Staff D could put in her mouth so the next day Staff D took them down. Staff D commented the resident monitored quite closely.

On 4/9/20 at 2:120 p.m. the Activities Director reported the new activity policy anything smaller than fist sized has to be monitored and not allowing puzzles on the CCDI unit for now. The Activities Director explained facility education done thru a group me app and a copy posted on the activity cupboards in the cottage for staff . The Activities Director stated staff need the keys to get something out. The Activities Director reported she had always known the resident may put toilet paper or paper towels in his mouth as long as she had known him, but never anything weird. The Activities Director stated one time about a month or so prior the resident tried to put a poker chip for bingo in his mouth so they switched to giving him a slid card. The Activities Director said the puzzle pieces had been out for months so it took everyone by surprise. The Activities Director voiced they would finish a puzzle, come get another one, and typically 100 or less puzzle pieces size used with the Alzheimer's unit.

On 4/9/20 at 3:07 p.m. the Social Service Designee (SSD) verified she revised Resident #1's care plan on 3/23/20 to include the non-food

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	165255	A. BUILDING _____ B. WING _____	C 04/15/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CARLISLE CENTER FOR WELLNESS AND REHAB	680 COLE STREET CARLISLE, IA 50047

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 689	Continued From page 19	F 689		

items, she did not know if that was enough, and so on 3/26/20 she added the non-food/foreign objects portion. The SSD stated she did recall anyone telling her about the dentist finding a cotton ball in the resident's mouth or reading the note about the golf-ball sized toilet paper. The SSD stated because she read the progress notes documenting the incident 3/20/20 with puzzle pieces, she updated the care plan to mention foreign objects.

On 4/9/20 at 5:59 p.m. Staff F, Certified Medication Aide (CMA), reported she was familiar with Resident #1. Staff F stated she experienced once about a year prior the resident put a napkin in his mouth that he tried to eat. Staff F said since that time she had not seen the behavior but she knew it happened off and on. Staff F reported she got report about the dentist finding the cotton on 2/6/20 and on 2/18/20 all toilet paper taken out of the resident's room. Staff F commented Resident #1 didn't really wander in to others rooms. Staff F said the resident spent a lot of time in the TV room and the puzzle always out. Staff F responded she had no idea the resident put puzzle pieces in his mouth 3/202/20. Staff F responded after 3/24/20 she did not really get formal education of action plan but she was pretty much aware they all knew to watch him. Staff F responded new staff or agency staff would know to watch the resident thru word of mouth.

On 4/9/20 at 6:26 p.m. Staff I, CMA, reported she worked for the facility just over 6 months and familiar with Resident #1. Staff I stated she heard about the incident 3/24/20 after it occurred. Staff I commented she thought there was 1 instance of the dentist finding something, but she was not sure as she did not work back on the CCDI unit

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	165255	A. BUILDING _____ B. WING _____	C 04/15/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CARLISLE CENTER FOR WELLNESS AND REHAB	680 COLE STREET CARLISLE, IA 50047

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 689	Continued From page 20	F 689		

often. Staff I stated she was educated after 3/24/20 that nothing less than the size of a fist could be left out and if so had to be locked up. Staff I responded new staff or agency staff would get education by staff telling would tell. Staff I stated a care plan in place on the back of the resident's door and the nurses did a 24 hour report but she was not sure if the resident's care plan said anything about the risk.

On 4/9/20 at 6:35 p.m. Staff J, RN, reported she started working at the facility 1/10/20 and only back in the CCDI unit 1 or 2 days. Staff J stated when she was trained they said Resident #1 needed to be monitored closely and things needed to be out of reach that were not necessary as the resident would pretty much eat anything if put in his mouth. Staff J responded she was not aware of the 2/6/20 or 2/18/20 incidents specifically, but said to watch in bathroom as the resident eats the toilet paper. Staff J reported she last worked in the CCDI unit 2 to 3 weeks prior a day or 2 after the resident came back from the hospital. Staff J stated she was just told he got back from being in the hospital but no specific training with her on mitigation plan or efforts. Staff J responded she was not sure how a new nurse or agency nurse would know what to monitor for unless other staff told them; she would assume that type of information would be on a profile or potentially in paper chart.

On 4/10/20 at 6:31 a.m. Staff G, LPN, reported working at the facility for 2 years. Staff G responded she was aware Resident #1 could put foreign objects in his mouth and ever since she first started the resident had chewed on tissues or paper. Staff G responded she was not aware of

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	165255	A. BUILDING _____ B. WING _____	C 04/15/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CARLISLE CENTER FOR WELLNESS AND REHAB	680 COLE STREET CARLISLE, IA 50047

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 689	Continued From page 21 the incidents on 2/6/20 or 2/18/20. Staff G explained nurse report entailed going into detail when shift started and the previous nurse let her know what happen on their shift by telling you to read the 24 hour report sheet. Staff G said if the previous nurse didn't tell her things then it was not passed on. Staff G responded she did not get any formal education about what to do for Resident #1. On 4/10/20 at 3:15 p.m. the Administrator reported anything smaller than an adult fist was to be out of sight and in a drawer on the CCDI unit. Observations Observation on 4/10/20 at 11:45 a.m. revealed the following with a walk-through the CCDI unit room to room: a. TV room/community room with a drawerwhich 7 cardboard bingo cards; each approximately the size of the palm of a hand. b. Resident #1 ate lunch sitting in his recliner in his room with direct supervision and cueing from Staff H, LPN. Observation of a drawer by the sink in the room revealed 2 small sample size tubes of toothpaste present, each 3/4th full both with labels that read keep out of reach of children less than 6 years old; if accidentally swallowed call poison control if more than amount used for brushing. The bathroom contained 48 cloth wipes and a toilet paper roll. c. Several other resident rooms contained personal care items with labels reading keep out of reach of children present on the sink countertops in line of sight. Observation on 4/10/20 at 3:23 p.m. revealed	F 689		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	165255	A. BUILDING _____ B. WING _____	C 04/15/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CARLISLE CENTER FOR WELLNESS AND REHAB	680 COLE STREET CARLISLE, IA 50047

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 689	Continued From page 22 Resident #1 ambulated in the hallway out of his room to the nurse's station. Staff H provided the resident with water and Staff H redirected the resident several times to not mess with an oscillating fan by the medication cart. Resident #1 gave no indication he sought anything and he hung around in the hallway by the nurse without displaying wandering type behaviors. The facility abated the Immediate Jeopardy on 4/10/20 by implementing the following corrective actions: 1. Education to all nursing staff regarding Resident #1's behavior and tendency to pocket food and non-food items: a. Check the resident's mouth after medication pass and meals, and also every hour throughout the day. b. Document item pocketed and/or removed from the mouth and notify oncoming shift and nurse manager. 2. Updated Resident #1's Care Card to reflect history of pocketing and consuming food and non-edible items. 3. Requested physician evaluation of resident regarding these behaviors. 4. Increased staffing to 2 staff members scheduled on CCDI unit at all times 6:00 a.m. to 10:00 p.m. 5. Adjusted On-Call Nurse hours to later in the evening with a focus on supervision of the CCDI unit. 6. Placed all "keep out of reach of children" in resident drawers to keep out of reach of people and out of sight.	F 689		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	165255	A. BUILDING _____ B. WING _____	C 04/15/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CARLISLE CENTER FOR WELLNESS AND REHAB	**680 COLE STREET CARLISLE, IA 50047**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 689	Continued From page 23 7. Resident #1 in a private room to reduce the amount of personal items in the room from a roommate. g. Developed a new 24 hour report sheet to track resident information communicated from nurseto nurse. h. Implemented new audits to ensure above interventions followed and track new and agency staff education prior to starting work in the facility.	F 689		