STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	165612	A. BUILDING _____ B. WING _____	C 04/08/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
TRINITY CENTER AT LUTHER PARK	1565 HULL AVENUE DES MOINES, IA 50316

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 000	INITIAL COMMENTS Amended: October 25, 2021 following IIDR. Amended: April 30, 2021 Correction date 4/30/2021 A Recertification Survey and Complaints #95938 and #96496 and Facility Reported Incidents #93593, #96380 and #96670 were conducted March 29, 2021 to April 22, 2021. Complaint #95938-C was substantiated. Complaint #96496-C was substantiated. Facility Reported Incident #93593-I was not substantiated. Facility Reported Incident #96380-I was substantiated. Facility reported Incidet #96670-I was substantiated. See the Code of Federal Regulations (42CFR) Part 483, Subpart B-C.	F 000		
F 609 SS=D	Reporting of Alleged Violations CFR(s): 483.12(c)(1)(4) §483.12(c) In response to allegations of abuse, neglect, exploitation, or mistreatment, the facility must: §483.12(c)(1) Ensure that all alleged violations involving abuse, neglect, exploitation or mistreatment, including injuries of unknown source and misappropriation of resident property, are reported immediately, but not later than 2	F 609		

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

JOHN RIEKE | CEO/Administrator | 04/29/2021

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

11/1/2021

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hours after the allegation is made, if the events that cause the allegation involve abuse or result in serious bodily injury, or not later than 24 hours if the events that cause the allegation do not involve abuse and do not result in serious bodily injury, to the administrator of the facility and to other officials (including to the State Survey Agency and adult protective services where state law provides for jurisdiction in long-term care facilities) in accordance with State law through established procedures.

§483.12(c)(4) Report the results of all investigations to the administrator or his or her designated representative and to other officials in accordance with State law, including to the State Survey Agency, within 5 working days of the incident, and if the alleged violation is verified appropriate corrective action must be taken.
This REQUIREMENT is not met as evidenced by:
Based on clinical record review, staff interviews, and facility record review, the facility failed to report an allegation of abuse to the Department of Inspections & Appeals within 24 hours for one of one residents sampled (Resident #94) who reported missing valuables. The facility reported a census of 100 residents.

Findings include:

The Minimum Data Set (MDS) assessment dated 1/17/21 revealed Resident #94 had diagnoses of diabetes, cancer, cerebrovascular accident, depression, and altered mental status. The MDS documented the resident had a Brief Interview for Mental Status score of 7, which indicated severely impaired cognition. The MDS documented the resident had no behaviors or

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F 609	Continued From page 2 wandering. The MDS indicated the resident had a hearing aid. The Care Plan revised 3/4/21 revealed the resident had impaired cognition and impaired communication related to vascular dementia. The staff directives included to provide hearing aids to the resident. A Resident's Personal Admission Inventory sheet dated 8/27/19 revealed Resident #94 admitted to the facility with two rings and bilateral hearing aids listed. A Grievance Form dated 3/4/21 completed by the Social Worker (SW), revealed a family member reported Resident #94's wedding rings missing. The alleged grievance occurred on 2/24/21. A follow up response included the measures the facility took, which included the residents' rooms searched, laundry and common areas checked, and the hospital and transportation service contacted. The SW documented a resolution that they were unable to locate the rings, and pictures of the rings had been provided to the unit staff. Review of the Department of Inspections and Appeals on-line reporting list provided to the surveyor upon entrance, revealed the facility had not reported the allegation of Resident #94's missing belongings. The Progress Notes dated 3/4/21 at 1:06 p.m., revealed family reported resident's wedding rings (a plain gold band, and a gold ring with diamonds) had been missing since 2/24/21. All upstairs and Hall A (downstairs) unit medication carts searched. Resident rooms and common area upstairs searched. The SW contacted the	F 609		

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ambulance service on 2/24/21, but reported they had no rings in their possession. The Family spoke with the Administrator about the missing items.

During an interview on 3/31/21 at 11:00 a.m., Staff Q (Certified Nursing Assistant) reported when a resident reported something missing, she let the nurse know, checked the laundry, and asked her coworkers if they have seen the missing item. Staff Q reported she filled out a form about the missing belongings and placed the form in the Director of Nurses mailbox.

During an interview on 3/31/21 at 4:50 p.m., Staff O (Certified Nurse Aide) reported she notified the charge nurse and a form filled out whenever a resident reported something missing. Staff O reported the facility completed an investigation and checked the cameras.

During an interview on 3/31/21 at 5:10 p.m., Staff P (Certified Nurse Aide) reported she worked the night shift and some evening shifts. Staff P stated whenever belongings reported missing, she reported it to the nurse and looked for the missing item. Staff P reported she filled out a form kept at the nurse's station, and if the item not found, someone let the family know.

During an interview on 4/1/21 at 1:52 p.m., the Social Worker stated a family member believed the resident's rings reported missing since 2/24/21. The resident had the rings on when he went to an appointment, but after he arrived at the hospital, he had no rings on. The Social Worker reported they looked through camera footage to see when the resident last had the rings but couldn't go back very far on the video.

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F 609	Continued From page 4 The Social Worker reported they looked for the rings in places where the resident sat or had been in the facility, searched the laundry, and contacted the transportation service and the hospital but no rings found. The Social Worker reported staff had reported to her that they had seen the rings on the resident, but one staff person reported he had not seen or noticed if the resident had the rings on when the resident went to the hospital Emergency Room. The Social Worker stated they had not reimbursed family for the lost rings because the rings had more sentimental value for the family. During an interview on 4/5/21 at 2:10 p.m., the Director of Nursing (DON) reported she became aware of Resident #94's missing rings when the resident had gone to the hospital. The DON reported she started an investigation and spoke with the nurse who had sent the resident to the hospital. The nurse thought the resident had the rings on but unable to say for sure. She searched the resident's room, other residents' rooms, and the laundry, contacted the transportation company and the Emergency Room, but no rings found. The facility offered to replace the missing rings but the family demanded the original rings. They continued to search for the rings but had been unable to locate the missing rings. During an interview on 4/6/21 at 2:25 p.m., Staff R (Registered Nurse) worked on unit where the resident resided. Staff R reported she couldn't recall if Resident #94 wore a hearing aid, but had been informed of a concern for resident's missing rings. Staff R stated whenever someone reported missing items, she let housekeeping and laundry know, filled out a grievance form, and searched	F 609		

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F 609	Continued From page 5 for the missing item. Staff R stated an inventory of belongings completed whenever a resident admitted to the facility. During an interview on 4/7/21 at 9:45 a.m., the Administrator reported the Resident's Handbook had information regarding lost and missing items, and they followed the grievance process whenever someone reported belongings or valuables missing. The Administrator stated a grievance form filled out when someone reported Resident #94's rings missing and staff looked for them. The Administrator reported they had not found the resident's rings. A family member reported the resident had rings on when he went to a doctor's appointment. The resident came back to the facility, then later went to the hospital. They contacted the Emergency Room staff, hospital, and transportation company, but they had not found the rings. The Administrator acknowledged she had not reported the missing rings to the Department when she was notified of the missing jewelry. The administrator reported the facility offered to replace the rings, but the family wanted the original rings back. During an interview on 4/7/21 at 2:30 p.m., Staff S (Licensed Practical Nurse) reported he worked on the unit where Resident #94 resided. Staff S reported the resident left the facility for a doctor's appointment on 2/24/21, then returned to the facility, and later transferred to the hospital. Staff S stated he didn't pay attention and not certain whether the resident had any rings on prior to when the resident left the facility. Staff S stated he asked the Nurse Aides about the rings and was told the resident normally kept track of his rings.	F 609		

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F 609	Continued From page 6 Review of an undated Resident Handbook, revealed any lost, missing, or broken items needed reported to a staff member immediately, a grievance form completed, and an investigation initiated. The facility is not an insurer of resident's belongings. To the extent possible, the facility requested no valuables, expensive jewelry, money brought to the facility, as some items may have sentimental value and could never be replaced. In a Resident Inventory/Valuables Policy dated 3/9/21 revealed personal possessions identified and recorded upon admission and a record kept in the resident's chart. An inventor/valuables form completed at admission by the admission's nurse and/or Nurse Aide. Photos of valuables (such as rings, glasses) uploaded to the electronic medical records. A facility's Abuse Policy updated 6/2019 revealed all allegations of resident abuse and misappropriation of resident property needed reported to the supervisor on duty and management on-call/Administrator immediately, and to the Department of Inspections and Appeals no later than two hours after the allegation made. Misappropriation of resident property included misplacement of resident's belongings without the resident's consent. A Grievance Policy dated 10/17/19 revealed upon receipt of a grievance or concern, the Grievance Official, reviewed the grievance and determined immediately if the grievance met a reportable complaint. The facility Administrator and Grievance Official immediately report all alleged violations which involved abuse or misappropriation of resident property to the	F 609		

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F 609	Continued From page 7 administrator as required by State law.	F 609		
F 658 SS=D	Services Provided Meet Professional Standards CFR(s): 483.21(b)(3)(i) §483.21(b)(3) Comprehensive Care Plans The services provided or arranged by the facility, as outlined by the comprehensive care plan, must- (i) Meet professional standards of quality. This REQUIREMENT is not met as evidenced by: Based on clinical record review, and staff interviews, the facility failed to administer medications as ordered by physician for 1 of 18 sampled (Resident #17). The facility reported a census of 100 residents. Findings include: 1. The Minimum Data Set assessment dated 3/28/21 indicated Resident #17 had a diagnosis of right hip fracture, hypertension, dementia, and depression. Resident #17 had a Brief Interview for Mental Status score of 6 indicating severe cognitive impairments. Resident #17 had a risk for falls. Facility document titled Note to Attending Physician/Prescriber, dated 1/5/21 revealed a Gradual Dose Reduction (GDR) review due on the following psychotropic medications: Seroquel 12.5 milligrams (mg) twice a day for diagnosis of Lewy body dementia and Sertraline 25 mg every day for diagnosis of depression. Pharmacy recommendations: facility has requested a dose reduction. Please consider reducing the Seroquel to 12.5 mg every bedtime and increase the Sertraline to 50 mg every day." GDR was signed	F 658		

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F 658	Continued From page 8 and dated on 1/13/21 documented "okay." Facility document titled Medication Administration Record dated 1/1/21-1/31/21 revealed Seroquel dose change to 12.5 mg every bedtime did not occur until 1/19/21 and Resident #17 received 5 additional doses of Seroquel. Facility document titled Medication Administration Record dated 1/1/21-1/31/21 revealed Sertraline dose change to 50 mg every day did not occur until 1/19/21, physician order received on 1/13/21, resulting in Resident #17 missing 6 doses of medication increase. The Medication and Treatment Orders sheet dated 7/16 revealed Medication orders and treatment will be administered by nursing service personnel as soon as the order has been received. During an interview with Staff K (Licensed Practical Nurse) on 4/06/21 at 1:30 p.m., Staff K stated they did not follow the order correctly as she reviewed the Medication Administration Record and the Pharmacy should of provided additional lines for their documentation. During an interview the Director of Nurses (DON) on 4/7/21 at 10:05 p.m. she stated she talked to the Nurse Practitioner who stated the pharmacy recommended the GDR and she approved the order. The DON reported she was not sure what caused the delay in initiating the order. During an interview with Assistant Director of Nursing 4/7/21 at 2:25 p.m. revealed she is unsure why the medication dose changes were delayed and the policy was not followed.	F 658		

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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, observations, facility policy review and staff interviews, the facility failed to provide an environment free of accidents hazards and failed to provide adequate supervision for six residents. The facility failed to adequately assess and implement effective interventions for Resident #21, at risk for elopement, who removed his wander-guard device. Resident #21 eloped from a 2nd floor alarmed door and ambulated down 16 concrete stairs with a walker and exited the facility without staff knowledge. The facility failed to properly transfer Resident #33, #81, #90. Resident #90 sustained a laceration to the lower extremity requiring 14 sutures. Resident #81 hit her head. The staff failed to safely transport Resident #90 her wheelchair. The facility failed to assess the safety of a power chair for Resident #82. Resident #82 lost control of the power wheelchair and had her feet pinned between the power chair and the wall. Resident #82 sustained a rolled skin tear that required a transfer to the emergency department for repair. The facility reported a census of 100 residents. 1. Elopement:	F 689		

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F 689	Continued From page 10 The Minimum Data Set (MDS) assessment dated 1/20/21 indicated Resident #21 had a diagnosis that included diabetes, dementia, vascular dementia, depression, asthma, mood disorder, spinal stenosis, Chronic Obstructive Pulmonary Disease, and falls. Resident #21 had a Brief Interview for Mental Status (BIMS) score of 5, indicating severe cognitive impairments. The MDS documented physical behaviors and wandered 1-3 days during the lookback period. Resident #21 had independence with bed mobility, transfers, and walking in and out of the room. Resident #21 required staff assist of one for dressing and toileting. Resident #21 not steady when moving from seated to standing position, required the use of assistive devices at all times for balance. Resident #21 wore wander/elopement alarm daily. Review of Care Plan, updated 2/25/21 revealed resident had major depressive disorder with psychotic symptoms and received an anti-depressant. The Care Plan revealed Resident #21 at risk for wandering due to dementia, noncompliant, and refused to wear a wander-guard. The Care Plan directed staff to complete wander-guard checks each shift, if staff notice wander-guard off, locate it and reapply, and complete elopement assessment per protocol. Progress notes revealed the following: a. On 2/27/2021 at 11:52 a.m., Resident #21 exhibited anxious behaviors and was moving from chair to chair. Resident unable to follow direction at times related to dementia. Resident #21 often unaware of safety needs and does not ask for assistance. Observed Resident #21	F 689		

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standup from his chair, begin walking without his walker, lose balance, and fell to his knees. No injuries were noted and the staff notified the physician and family. The staff implemented an intervention when exhibiting anxious behaviors, offer activities i.e. walking, snack, drinks, etc. to see if this will help calm down and eliminate risk of getting up from chair to chair. The staff documented Resident #21 continued to remain at risk for falls.

b. On 2/27/2021 at 11:32 p.m., Resident hard to redirect, going to other residents rooms and not using his walker as instructed.

c. On 3/19/2021 at 12:25 a.m., Resident awake and wandering around the hallway. Will continue to monitor.

d. On 3/29/2021 at 9:52 p.m., Resident #21 outside to the courtyard between B1 and C1 halls from the B-2 hallway door. Resident #21 eloped without any witnesses. The Nurse shut off the alarm when noticed it was alarming, and proceeded to locate all residents. A Nurse Aide noticed Resident #21 outside in the courtyard and assisted him back to C1 hall.

e. On 3/30/2021 at 7:50 a.m., the staff notified the Physician of the incident from last night and received an order to place a wander-guard that was discontinued last month.

Review of the Treatment Administration Record (TAR) dated 2/1/21 to 2/28/21 revealed wander-guard initiated on 7/8/20 and discontinued on 2/25/21. The TAR ordered the staff to check the placement and function of the wander-guard every shift.

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F 689	Continued From page 12 The TAR dated 3/1/21 to 3/31/21 revealed wander-guard placement check every shift for elopement risk initiated 3/29/21. Elopement Assessment dated 2/25/21 revealed Resident #21 scored "1", indicating an elopement risk and a wander-guard needed. A fall risk evaluation dated 1/10/21 revealed Resident #21 at risk for falls. A 24 Hour Report sheet dated 2/25/21 revealed Resident #21's wander-guard discontinued and an elopement assessment completed. An Elopement Wandering Policy revised March 2021 revealed, the facility ensured that residents who exhibit wandering behavior and/or are at risk for elopement receive adequate supervision to prevent accident, and receive care in accordance with their person-centered plan of care addressing the unique factors contributing to wandering or elopement. A Daily Clinical sheet dated 2/26/21 revealed Resident #21's wander-guard removed due to Resident #21 removing the wander-guard by himself. The sheet documented elopement assessment completed to evaluate behavior of wandering versus elopement and Resident #21 not seeking an exit. Review of Video Surveillance on 3/30/21 from 7:08 p.m. to 7:18 p.m. showed Resident #21 exiting 2nd floor B hall; Staff N approach the exit door, turned off the alarm and pulled the door shut; Resident #21 walked in courtyard past the 1st floor window on C hall; resident brought inside	F 689		

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F 689	Continued From page 13 to common area on C hall on 1st floor. During an interview on 3/30/21 at 2:28 p.m., the Director if Nurses reported Resident #21 had no previous attempts of exit seeking behavior until this incident. Resident #21 had dementia and this was the first time he had exited through the exit door. Resident #21's had a usual behavior of walking from his room to the common area (on 2nd floor), walk to/from meals, and walk back to his room. During an interview on 3/30/21 at 2:43 p.m., Staff N (Registered Nurse) reported working at the time of the Resident #21's elopement. Staff N worked at the facility for 3 years and had no knowledge of the elopement policy. Staff N did not hear an alarm sound but noticed the exit door on hall B had a red light instead of green light. Staff N walked to the door and ensured it was shut and then heard the alarm and turned it off. Staff N reported the staff working did not hear the exit door alarm from the common area. He thought someone wearing a wander-guard tripped the alarm. Staff N did not open the door and look to see if anyone exited. Staff N checked to see if the two residents he thought were wearing wander-guards were on the unit. He saw a man with a walker, thought it was Resident #21, and the other man was in bed. Staff N had no knowledge Resident #21's wander-guard was removed the month prior. Staff N did not think it should ever come off due to Resident #21's wandering behaviors. When Staff N learned Resident #21 eloped he notified the manager. When Resident #21 returned to the unit the staff placed a new wander-guard on him. Staff N reported Resident #21 requested to go home when he eloped. Staff N was surprised resident	F 689		

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#21 met the criteria to have the wander-guard removed. Staff N had concerns for Resident #21 walking down a flight of concrete stairs carrying his walker due to balance issues.

During an interview on 3/31/21 at 9:27 a.m., Staff L (Clinical Administrative Assistant) reported Staff N (Registered Nurse) notified her on 3/29/21 at 7:30 p.m. of the elopement. Staff L reviewed the surveillance camera footage and placed a new wander-guard on resident #21's right wrist. Staff L reported Resident #21 had a wander-guard removed in February as he wouldn't leave on. On Monday 3/29/21, Staff L implemented another style of wander-guard that requires to be cut off and not reusable. Staff L reported in February 2021, Resident #21 did not have exit seeking behaviors when assessed for elopement and that he scored low enough to not require a wander-guard.

During an interview on 3/31/21 at 10:45 a.m., Staff U (Maintenance) reported he reported to the facility the evening of 3/29/21 to make ensure the exit doors and alarms functioned properly. He pulled and tested the doors to ensure they were working. He did not find any issues. Staff U reported when the exit door is pushed open an alarm goes off. If the bar on the door is pushed for 15 seconds the door opens. While pushing on door, you hear beeping, light on magnet turns from light green to amber color and then door opens. Goes into alarm, a solid tone goes to radios. Get message the door has been breached and which door breached or needs checked. He gets message on his company phone about door alarms, but only says "door breach". On 3/29/21, a resident without a wander bracelet went through the fire exit doorway on

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Redwood "B". System does self-check daily. Email report automatically sent to facility manager/ maintenance supervisor every day at 6:45 a.m. The nurse pull system, call buttons, wander management, and door security are all tied into one system.

During an interview on 3/31/21 at 11:00 a.m., Staff Q (Certified Nurse Aide) reported she observed Resident #21 on 3/29/21 between 5:00 p.m. and 6:00 p.m. in the Courtyard with his walker. Staff Q ran outside, placed gait belt on Resident #21 and assisted him inside. Staff Q reported Resident #21 walks independently with a walker, but often forgets to take walker with him. Resident #21 had a steadier gate later in day.

During an interview on 3/31/21 at 1:30 p.m., the Director of Nurses (DON) reported Staff U (Maintenance) verifies the wander-guard is functioning correctly by running a daily report. Staff L (Clinical Administrative Assistant) had the training on how to initiate a wander-guard into the system and set up a new bracelet. The DON reported all residents should have an order if they are to wear a wander-guard and have a care plan indicating this as well as resident behaviors. When Resident #21 had his wander-guard discontinued it was documented on the 24 hour report sheet. He had been ripping off his wander-guard and was not demonstrating exit seeking behaviors prior to the incident. DON stated they do have an elopement binder where high risk resident pictures are kept at the nurses' station. DON stated resident #21 needs more supervision and when a bed is available on the 1st floor they would like to move him. DON stated it is everyone's responsibility to check when an alarm sounds. The facility started education with

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F 689	Continued From page 16 staff on 3/31/21. During an interview on 3/31/21 at 4:50 p.m., Staff O (Certified Nurse Aide) reported he looked out the window on 3/29/21 and saw another Nurse Aide from a different neighborhood running. He looked to see what was going on and observed Resident #21 standing by the courtyard gate. He then realized why the Nurse Aide was running towards the gate. Staff O informed Staff N (Registered Nurse) that Resident #21 eloped. The exit door should not open and Resident #21 should have a wander-guard on his wrist. Staff O reported the nursing staff utilize a walkie. The call buttons ring to the walkie and they have 15 min to respond to the resident's needs. Staff O stated the facility changed the call service at the beginning of the year. Staff have to enter a number to get out of any door, but that didn't happen on Monday night. Resident #21 pushed on the door and walked through it and there was not an alarm or alert on the walkie. Resident #21 had a wander-guard bracelet but didn't have one on at the time of the incident. Staff O stated if Resident #21 would have had wander-guard on and he got near the door, he would've received a message on his walkie to tell him which resident and what door resident at. It would let him know, but on Monday, he didn't get any kind of notification, not even that the door alarm had went off. Staff had training on new alarm system/call system when started to use new system. Had an in-service. Staff O believed something was wrong with the system. Staff L and Staff O tested the door after the incident happened. When they held the door for 2 seconds, they could open the door and get out. There was a "system fault",	F 689		

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something wasn't right, he stated. The fire emergency door shouldn't just open when you push on it. There is a delay (per sign on door, need to hold x 15 sec before door latch releases). Staff L had tried the door first, pushed on it for 2 seconds, opened the door, then reset the alarm, then Staff O tried it and the same thing happened. Staff O revealed staff is supposed to get alert on computer, but no one could hear the alarm. Maintenance had to come in and check the system and doors after the incident. Staff O said he isn't sure which residents have wander-guards on and knows when he gets an alert on the walkie, to visually go check for a resident.

During an interview on 3/31/21 at 5:10 p.m. with Staff P (Certified Nurse Aide) reported Staff Q Nurse Aide) was in break area getting a drink of water when she saw a resident outside in the courtyard. The resident pushed on the door/gate trying to get out but the door was locked. Staff P reported the staff assisted Resident #21 to the Cedar common area, and called the nurse upstairs to see if they were aware of a resident missing. Within a few minutes Staff L (Registered Nurse) entered the Cedar common area wondering what happened and why they didn't hear the alarm. Staff O (Nurse Aide) assisted Resident #21 back upstairs to his unit. Resident #21 had his walker when she observed him outside. Staff P wondered how he got downstairs without anyone noticing. The staff all carry walkies and when an alarm goes off, an alert goes to the walkie and indicates the location of the door and unit. On 3/29/21 she did not get alert or alarm message. Staff P checks residents at night during her shift to check for a bracelet on their ankle or wrist. She knows which residents

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F 689	Continued From page 18 wear a wander-guard. During observation of door checks by Health Facilities Surveyors on 4/1/21 at 9:00 a.m. the surveyor sounded the door alarm at the far end of Hall A on the second floor and it took 10 seconds to release to open. The door alarm was an intermittent high pitched tone for the 10 seconds prior to release. At the time the door released the alarm tone become a solid high pitched tone. Two additional surveyors were located in the common area where all hallways meet. One surveyor reported she was able to faintly hear the alarm while the third surveyor was not able to hear the high pitched tone. Staff H (Nurse Aide) walked past and stated "what is that noise?" An activity staff member who was present in the common area stated, "O don't hear anything". Staff H carried a walkie that sounded with a notification that an emergency door on opened on Hall A. Staff H proceeded down the hall looking into the rooms as she passed. She disabled the alarm and went through the door to look down the stairs. Two minutes lapsed between the notification on the walkie and the staff response. The surveyor proceeded to test the door in hallway B where there was a 10 second delay before the door released. Two staff responded to this alarm within 45 seconds. During an interview on 4/1/21 at 10:40 a.m., Staff R (Registered Nurse) reported she worked at the facility for two years. The staff complete elopement risk assessments every 3 months, as well as whenever staff noticed any resident behaviors, or a near elopement incident. The elopement risk assessment helped determine whether residents needed a wander guard device. Staff R reported Staff Z (Licensed	F 689		

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Practical Nurse) completed an elopement assessment on Resident #21. Staff R reported Resident #21 had a wander risk due to dementia, he ambulated up and down the hallways but had no exit seeking. Resident #21 had a wander-guard for a period of time, but noncompliant with wearing it. During an Interdisciplinary Team (IDT) meeting, they discussed whether the resident an elopement risk versus a wander risk. They determined the resident not an elopement risk. Staff R reported the IDT team met around 2/26/21 and discussed Resident #21, who kept removing the wander-guard bracelet off. Staff R stated she was unsure why they didn't use an alternative type of wander-guard, and did not recall any discussion about getting or using something else. Staff R reported the facility had switched to a new type of wander-guard band due to a new alarm system installed. The resident had a wander-guard on when had the old system. Staff R acknowledged she entered a late entry progress note 3/29/21 at 8:29 p.m., but made the progress note effective 2/25/21. Staff R stated there had been confusion as to whether the floor nurse who worked 2/25/21 documented or progress note when the wander-guard for Resident #21 discontinued. It was brought to her attention by the DON that no note had been entered, so she entered the progress note 3/29/21 evening regarding Resident #21's wander-guard discontinued last month. The resident's wander-guard had been off as of 2/25/21. Staff R reported staff wrote on the 24 hour report sheet whenever changes on a resident or to know if a wander-guard removed. Staff documented the wander-guard checked on the Treatment Administration Record, and each unit had a wander binder with which residents

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F 689	Continued From page 20 had a wander-guard. During an interview 4/1/21 at 3:25 p.m., Staff X (Certified Nurse Aid) acknowledged she had education on 3/30/21 about alarms after an incident had occurred with one of the residents. Staff X stated if an alarm went off they are to run towards the alarm and stop the resident from exiting. Staff X reported residents who are at risk had bracelets or a wander-guard. The wander-guard got checked by the nurses each shift. During an interview 4/1/21 at 3:28 p.m., Staff K (Licensed Practical Nurse) reported she just heard about the incident and received instructions by management personnel on how to respond to alarms. Staff K reported wander-guards checked by ensuring the resident had the wander-guard on and lit up, which meant the wander-guard worked. Staff K reported when a resident moved close to an exit or tried to enter a code, an alarm sounded on the walkie system and alerted them that a resident loitering at a door/exit and needed to go investigate. Staff K reported if she wasn't able to get to the resident fast enough, other staff could run and get to the resident in time. During an interview 4/1/21 at 3:25 p.m., Staff Y (Certified Nurse Aide) reported when she heard an alarm sound, she went and investigated the source, and looked to ensure residents on the unit were accounted for. Staff Y reported an alarm signal came over the walkie with the location of the alarm. Staff Y acknowledged he had training regarding the new alarm system, what to do whenever she heard an alarm, and the process for checking the alarm.	F 689		

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F 689	Continued From page 21 During an interview 4/1/21 at 3:21 p.m., Staff V (Certified Medication Aide) acknowledged she had been educated on 4/1/21 about the door alarms before her shift. Staff V stated whenever an alarm heard, she needed to check the doors, check the stairs, let other staff know, and take a census of all residents in the unit. During an interview 4/1/21 at 3:25 p.m., Staff E (Certified Nurse Aide) stated she had received education on 4/1/21 about the wander-guards and door alarms. If a door alarm sounded, she would check the door and look down the stairs, reset the door alarm, and report to the nurse. Staff E reported if she heard a wander-guard alarm, she needed to check for the resident and the area. During an interview on 4/1/21 at 3:31 p.m., Staff W (Certified Nurse Aide) had been educated on the alarms, call lights, and wander guards. Staff W reported if heard alarm, he checked on the resident, notified the nurse or a coworker. The facility was notified of the Immediate Jeopardy on 4/1/21 at 12:55 p.m. The Immediate Jeopardy was removed on 4/1/21 as the facility provided all staff education on the revised the elopement policy, revised the elopement policy, conducted new elopement assessments on all residents, which included response to door alarms, a plan to complete elopement assessments upon admission, quarterly and with any significant change, a plan to conduct alarm drills three times a week on alternating units and shifts, and audit all staff knowledge of the elopement process with satisfactory answer of an elopement quiz. These corrective actions were verified while onsite on	F 689		

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F 689	Continued From page 22 4/1/21. The scope was lowered from a "J" to a "G" due to the additional findings at a harm level. 2. Improper Transfer: An MDS dated 12/8/20 documented Resident #90 had diagnoses of atrial fibrillation, coronary artery disease, hypertension, hyperlipidemia, thyroid disorder, depression, muscle weakness, multiple falls, and idiopathic peripheral autonomic neuropathy. The MDS revealed the resident had a cognition score of 7 out of 15, indicating severe cognitive impairments. Resident #90 had a fall prior to admission to the facility. Resident #90's Care Plan dated 12/10/20 revealed impaired though process and unawareness of safety. The resident is care planned as a risk for falls and skin integrity issues due to fragile skin and needing assistance with transfers. The care plan revealed the resident required assistance of one staff member to transfer. A fall risk assessment dated 12/10/21 revealed Resident #90 at risk for falls. #170 Skin Concern sheet dated 3/2/21 at 9:45 p.m., revealed resident #90 sustained a skin tear to right lower front leg during a staff assisted transfer. Resident #90 assessed for pain, area cleansed with normal saline, patted dry and steri strips applied. A Progress Note dated 3/3/21 9:58 p.m., revealed Resident #90 unstable in her recliner and attempted to get out more than once. Redirecting the resident failed. Staff attempted to transfer the	F 689		

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F 689	Continued From page 23 resident and Resident #90 tried to fight back and slipped attempting to sit on the floor. Staff pulled her back from falling to the floor and another staff member assisted the resident into the recliner. The Nurse Aide transferred the resident to the wheelchair a cut noted to left inner thigh with scant bleeding. Manager notified, evening supervisor notified and a skin picture taken. The area to left leg cleaned and covered with gauze. The on-call physician notified and advised to send to the hospital for evaluation. Resident transferred to the hospital at 9:30 p.m. A Progress Note dated 3/4/21 at 12:34 a.m. revealed the resident returned from the hospital with sutures. An Emergency Department sheet dated 3/3/21revealed Resident #90 sustained 6 centimeter (cm) (length) by 3 cm depth laceration to the left knee during a transfer. The laceration required 14 sutures. The Facility Investigation of the incident showed the incident occurred on 3/3/21. The resident sent to the ER for evaluation and sustained a 2-inch laceration on left knee during a transfer. The summary of the investigation revealed a root cause of the laceration due to improper transfer techniques. Witness statements showed Staff A (Registered Nurse) attempted to transfer the resident by placing his arms around the resident's upper body trunk. Staff B (Certified Nurse Aide) attempted to lift the resident the same way by putting her arms around the resident's upper body with her leg in between the resident's legs. After the resident transferred, Staff B noticed a skin tear to the resident's left leg. Resident at the time of the incident a one-person transfer.	F 689		

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F 689	Continued From page 24 A written statement dated 3/4/21, Staff A (Registered Nurse) reported he tried to transfer the resident, the resident started to slip. He reported he put her back in the chair and Staff B and assisted the resident to the wheel chair and Staff B noticed her pants were wet and the resident's thigh had a cut on it. Staff A reported he had nothing in his pockets would have caused the cut on the resident's leg. A written statement from Staff B (Certified Nurse Aide) reported she saw Staff A moving the resident from her chair to the wheel chair by lifting Resident #90 by the upper arms. Staff B reported Staff A almost dropped Resident #90 and she reported telling him to put the resident back in the chair. Staff B reported she told Staff A there is a proper way to transfer the resident. Staff B reported she wanted to get a gait belt but felt Staff A did not want to wait and wanted to get the resident in the chair. Staff B reported she told Resident #90 to give her a hug and Staff B stood up the resident and transferred the resident to the wheel chair. She reported Staff A requested to have the resident stand again so he could place a chair alarm. Staff B wrote Resident #90 put her left leg in between Staff B's legs when the resident stood up. Staff B reported the resident never complained about pain but when the resident sat back down, Staff B reported her leg wet. Staff B reported fat tissue and blood on her pant leg. Staff B reported #90 had a gash in her leg and brought it to Staff A and her night supervisor's attention. An employee education dated 3/4/21 revealed ten staff present for the time of the education on transfers for Resident #90.	F 689		

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F 689	Continued From page 25 A Gait Belt Transfers and Ambulation policy reviewed 3/4/21 revealed staff are to utilize a gait belt, non-skid socks, slippers or proper fitting shoes. Staff should have push up from chair or bed when standing up. Resident should be on the edge of the chair or the bed with feet uncrossed. Staff should have resident support a weaker side. While lifting support is given around the waist by means of gait belt. Remind the residents to support themselves by placing hands on the arms of a chair. Staff are to move with the resident and to lower themselves with resident and bend their knees. During an interview on 3/30/21 at 1:06 p.m., Staff B (Certified Nurse Aide) reported she witnessed Staff A (Registered Nurses) attempt to transfer the resident by putting his arms around the residents upper body and move Resident #90 from her chair to the wheelchair. Staff B reported Resident #90 almost fell. Staff B reported she educated Staff A to utilize a gait belt for transfers for residents. Staff B reported she wanted to go grab a gait belt but saw Staff A grab the resident's arm as if to lift up Resident #90 again. Staff B reported she stopped him and transferred the resident herself by placing her arms around her and transferring her to the wheelchair. She reported the resident stood with no difficulty. Staff B reported Staff A told her to get Resident #90 up because he needed to place the chair alarm under her. Staff B reported she helped stand up the resident and put her knee between her legs to help her stand. Staff B reported when she sat Resident #90 back down to her wheel chair she noticed her leg wet and saw blood and fat tissue on her pant leg. Staff B noted a skin tear in the resident's thigh. Staff B reported she	F 689		

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	165612	A. BUILDING _____ B. WING _____	C 04/08/2021

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TRINITY CENTER AT LUTHER PARK	1666 HULL AVENUE DES MOINES, IA 50316

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F 689	Continued From page 26 told the night supervisor what occurred. Staff B reported she was suspended the next day for improper use of transfer for resident safety. During an interview 4/01/21 9:34 a.m., the DON reported she felt the injury to Resident #90's leg was due to staff improperly transferring the resident. The DON reported she spoke with a physician regarding the resident's wound and what occurred and the physician reported the pressure from their knee could cause a skin tear. 3. Hazard: A MDS assessment dated 12/27/21 revealed the Resident #9 revealed the resident had diagnoses of hypertension, Alzheimer's, anxiety, depression, psychotic disorder, and metabolic encephalopathy. The MDS revealed the resident's cognition is severely impaired. The resident required assistance of two staff members for transfers and does not ambulate. Resident #9's MDS revealed resident required assistance with a wheelchair for mobilization. A Care Plan revealed the resident required assistance of two for transfers and used a wheelchair for locomotion on the unit and staff are to assist resident with backing up from the table in her wheelchair. Care plan reported Resident #9 has altered mobility and self-propels in wheelchair. Resident #9 has impaired cognition. A fall risk assessment dated 3/20/21 revealed the resident at risk for falls. During an observation on 3/30/21 at 9:08 a.m., a staff member pushed resident up to her table in	F 689		

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F 689	Continued From page 27 her wheelchair. Resident #9 did not have pedals on her wheelchair. Staff member pushed the resident's wheelchair forward towards the table in a distance approximately six feet. During a second observation on 4/1/21 at 8:26 a.m., Staff C (Certified Nurse Aide) pushed the resident into her room from the hallway for cares. The resident at the time did not have pedals on her wheelchair. The staff member pushed the resident in her wheelchair approximately 12 feet. During an interview on 4/6/21 at 2:21 p.m., the DON reported she expected staff to use wheel chair pedals for residents when pushing a resident in a wheelchair. The DON presented a policy for safe transportation to and from resident's room, to an activity, and or safe assistance from staff and or family regarding locomotion on and off the unit dated April 2021. The policy directed staff to utilize wheel chair pedals when pushing a resident in the wheel chair. 4. Improper Transfer: The annual MDS assessment dated 2/28/21 for Resident #81 revealed BIMS score of 13 that indicated intact cognition for decision-making. The MDS included she required extensive assistance of one staff for transfers and walking in room and used a walker and include diagnoses of arthritis, osteoporosis, and fracture. Further included she had falls with injury since her prior assessment. Resident #81's Care Plan revised on 8/28/19 included self-care deficit with limited physical mobility and required assist of 1 staff with all	F 689		

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F 689	Continued From page 28 cares transfers, mobility and positioning, ambulation with her using a walker. If further included a focus are of high risk for falls and required a gait belt for all ambulation. The facilities Fall- Witnessed report dated 2/28/21 at 2:39 p.m., revealed a Nurse Aide reported the resident fell while she was assisting her. The Nurse found the resident on her right side with her head on the floor towards the roommate's bed. The walker with the gait belt on it in front of resident towards her TV. Resident stated she fell back coming from the toilet with assistance. The aide left her to grab something and she lost her balance and fell. Resident verbalized she did hit her head twice and it was hurting. The Gait Belt Transfers and Ambulation policy reviewed 1/20/21 included the following when assisting a resident with ambulation: a. Put the gait belt around the resident securely. b. Assist the resident to a standing position. c. Walk on the resident weaker side. d. Walk with the resident by placing one hand around the back of the waist and the other in the loop of the gait belt. e. Walk the resident according to the Care Plan. During an interview on 4/6/21 at 8:02 a.m., Staff H (Registered Nurse) explained a Nurse Aide reported Resident #81 fell. Staff H found the resident on the floor. The gait belt on the walker. When the aide left the room she asked the Resident what happened and she explained she	F 689		

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F 689	Continued From page 29 left me for a minute and I fell. During an interview on 4/6/21 at 8:13 a.m., Staff E (Certified Nurse Aide) confirmed she assisted Resident #81 to the bathroom. When finished after standing, removed her gait belt to pull up her pants and forgot to put it back on. Staff E explained she had one hand on the Residents back and used the other hand to change the pad in the chair when the resident fell. 5. Improper Transfer: The quarterly MDS assessment dated 1/24/21 for Resident #33 revealed BIMS score of 9 that indicated impaired cognition for decision-making. The MDS included he required extensive assistance of one staff for transfers and walking in room and used a walker and include diagnoses of heart failure, hypertension, respiratory failure and repeated falls. Resident #33's Care Plan dated 2/8/21 included him at risk for falls and to assist as needed with transfers and ambulation. Observation on 3/30/21 at 6:21a.m. Staff H CNA used hand sanitizer and donned gloves. Sat Resident on edge of the bed put his walker in front of him assisted him to stand. Walked Resident to recliner without the use of a gait belt. An interview on 4/5/21 at 1:52 p.m., with the DON reported an expectation of staff to utilize a gait belt with transfers. 6. Hazard:	F 689		

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F 689	Continued From page 30 The quarterly MDS assessment dated 2/28/21 for Resident #82 revealed BIMS score of 15 that indicated intact cognition for decision-making. The MDS included she required extensive assistance of one staff for transfers, walking in room and toilet use with the use of a wheelchair and include diagnoses of heart failure, abnormalities of gait and mobility and visual hallucinations. Resident #82's Care Plan revised 6/26/19 included a self-care performance deficit with gait disturbance and directed staff to assist as need using walker and requires assistance of 1 staff for transfers, walking and toileting. The Skin Concern dated 12/30/20 revealed the staff found Resident #82 in her room at 3:00 p.m. with her feet pinned into the corner of the wall by her bathroom and her power chair facing the wardrobe, her legs were out to the left side of the footrest on the power chair which caused them to get pinned against the corner of the wall. Resident stated she was going to the restroom and lost control of her power chair. Resident states she lost control of her chair controls and instead of going backwards, she went forward into the wall. Noted that Resident used power wheelchair for mobility throughout the unit. Resident sent to the ER due to the size and appearance of the skin tear, staff unable to retract the skin back without causing pain to the Resident. The Therapy Communication sheet dated 9/22/20 included information to walk resident to and from the bathroom using walker and gait belt with assistance of 1 staff.	F 689		

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F 689	Continued From page 31 The Occupational Therapy Treatment Encounter Notes dated 9/18/20 summary for daily skilled services included the following; worked with Resident #82 on safety in powered wheelchair around room and facility to ensure good safety with use of it. Resident applied seat belt with cues. She kept the powered wheelchair at an appropriate speed to maneuver around obstacles and able to propel herself appropriately up to the dining table for meals. Resident had no close calls and demonstrated good safety on this date. Resident able to continue use of her power wheelchair in facility at this time. Will work on safety with self-transfers from power wheelchair to toilet. Resident #82's medical record lacked a Therapy Communication to the facility as to safe use of the power wheelchair use in the facility. The Occupational Therapy Treatment Encounter Notes dated 3/16/21 summary for daily skilled services included the following; Resident # 82 and therapist go over discharge this date. Per report completing toileting routine with assist of 1 and plans to continue for safety. Brings powered wheelchair to doorway and walks in with front wheeled walker with stand by assistance. Resident # 82 completes power wheel chair mobility to dining area without difficulty for meals. Educated on progressing toward goals and discharge occurring this date. Verbalizes agreement understanding and states no additional concerns at this time. Therapy Communication to the facility dated 4/6/21 included the following information; Resident is safe to use her power wheelchair in the facility and her room. She is not to use it in	F 689		

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F 689	Continued From page 32 her bathroom. She will call for assistance of staff and walk to the bathroom. During an observation on 3/31/21 at 10:48 a.m., Resident #82 going down the hallway in her power wheelchair from her room to go to the dining room for lunch. During an interview on 3/30/21 at 1:10 p.m., Resident #82 explained she had a fall a few months ago and had to go to the hospital to have the skin unrolled. During an interview on 4/5/21 at 9:59 a.m., with the DON acknowledged she could not find an incident report of the time Resident #82 hit the wall with the power chair or an assessment for the safe use of the power wheelchair. During an interview on 4/5/21 at 10:24 a.m., with the DON she explained she called the nurse in to complete the incident report for 12/30/20 and provided the report. The DON further explained they had therapy working with the resident on power wheelchair safety, since she ran into the door and injured herself. During an interview on 4/05/21 at 11:54 a.m., the DON explained Resident #82 admitted with the power wheelchair and they did not have and assessment for safe use of it. During an interview on 4/6/21 at 7:02 a.m. with the DON acknowledged therapy notes show discharge date of 3/16/21. The DON explained she would expect therapy communication to be done right away so that everyone knows she is safe to use the power wheelchair	F 689		

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F 695	Continued From page 33	F 695		
F 695 SS=D	Respiratory/Tracheostomy Care and Suctioning CFR(s): 483.25(i) § 483.25(i) Respiratory care, including tracheostomy care and tracheal suctioning. The facility must ensure that a resident who needs respiratory care, including tracheostomy care and tracheal suctioning, is provided such care, consistent with professional standards of practice, the comprehensive person-centered care plan, the residents' goals and preferences, and 483.65 of this subpart. This REQUIREMENT is not met as evidenced by: Based on clinical record review, policy review and staff interviews the facility failed to initiate an order for oxygen and failed clarify the as needed use or the continued use of oxygen for 1 of 4 sampled (Resident #95) for the use of oxygen. The facility reported a census of 100. Findings include: The Minimum Data Set (MDS) assessment dated 1/27/21 documented Resident #95 had a Brief Interview for Mental Status score of 8, indicating moderately impaired decision making and required extensive assistance of 2 staff for bed mobility, transfers and dressing. The MDS documented diagnoses of atrial fibrillation, heart failure, hip fracture, chronic obstructive pulmonary disease, chronic lung disease and respiratory failure and had shortness of breath with exertion and when lying flat and received oxygen therapy. Resident #95's Care Plan dated 2/5/21 included altered cardiovascular status related to heart failure and atrial fibrillation and directed the use of	F 695		

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F 695	Continued From page 34 oxygen with 2 Liters Per Minute (LPM) per nasal cannula continuous. The admission Oxygen Administration Order dated 1/19/21 ordered Oxygen as needed at 2 LPM via nasal cannula and titrate to maintain Oxygen saturation equal to or greater than 88%. The New Admission Progress Note dated 1/21/21 documented Resident #95 had severe chronic obstructive pulmonary disease, kyposcoliosis (an abnormal curve of the spine on two planes), restrictive lung disease, and Oxygen dependent at 2 Liters. The note included a plan for a Complete Blood Count with Comprehensive Metabolic Panel, continue same medications, and Oxygen. The Facility Order dated 1/23/21 at 6:59 a.m., ordered to send Resident #95 to the Emergency Room for a blood transfusion due to a low Hemoglobin level of 6.7 . The Medication Administration Record (MAR) and Treatment Administration Record (TAR) from 1/21/21 to 2/21/21 lacked an Oxygen order and monitoring of Resident #95's oxygen saturation levels. Review of the Order Summary Report dated 2/5/21 lacked an order for Oxygen. The Vital Sign section in the Electronic Medical Record (EMR) included documentation between 1/20/21 and 2/9/21. During that time listed the use of oxygen via nasal cannula most days and no oxygen (room air) on 1/27, 1/31, 2/4 and 2/5. The facility Medication and Treatment Order	F 695		

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F 695	Continued From page 35 Policy dated 3/5/20 included the following: a. Medications she be administered only upon the written or verbal order of a person duly licensed and authorized to prescribe such medications in this state. b. Medications orders and treatment will be administered by nursing service personnel as soon as the order has need received. c. Drug and biological orders must be recorded on the Physician's Order Sheet and or EMR in the resident's chart. During an interview on 4/1/21 at 8:13 a.m. Staff D (Certified Nurse Aide) acknowledged she provided care for Resident #95 and she used oxygen all the time. Staff D explained one time Resident #95 complained she could not breathe, obtained her oxygen level of 89%. Staff D reported to the nurse and she completed and assessment. During an interview on 4/1/21 at 1:10 p.m., Staff G (Registered Nurse) acknowledged Resident #95 used oxygen all the time. During an interview on 4/6/21 at 8:49 a.m., the Director of Nursing (DON) verified the admission Oxygen order directed as needed Oxygen at 2 LPM via nasal cannula. During an interview on 4/7/21 at 8:30 a.m., the Physician explained he visited Resident #95 and the admission assessment took a long time to complete. The Physician reported Resident #95 should have been on Oxygen at 2 LPM continuous. The Physician reported he/she	F 695		

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F 695	Continued From page 36 documented such in the narrative section of the assessment. During an interview on 4/7/21 at 4:12 p.m., the Director of Nurses indicated an expectation of the Oxygen order to be located on the MAR/TAR and should include Oxygen saturation checks every four hours.	F 695		
F 760 SS=D	Residents are Free of Significant Med Errors CFR(s): 483.45(f)(2) The facility must ensure that its- §483.45(f)(2) Residents are free of any significant medication errors. This REQUIREMENT is not met as evidenced by: Based on clinical record review, observation, staff interview the facility failed to properly administer insulin for one of two residents (Resident #248) observed during medication pass in accordance with professional standards of care. The facility reported a census of 100 residents. Findings include: The Medical Diagnosis list dated 4/6/21 revealed Resident #248 had a diagnosis of Type 2 diabetes mellitus. The Order Summary Report dated 3/25/21 revealed an order for Lispro (insulin) 4 units subcutaneously with meals for diabetes. The Medication Administration Record (MAR) dated 3/1/2021 to 3/31/2021 revealed the staff administered Lispro insulin 4 units subcutaneously on 3/30/21 at 12:00 p.m.	F 760		

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F 760	Continued From page 37 During observation on 3/30/21 at 11:12 a.m., Staff G (Registered Nurse) prepared Lispro insulin for Resident #248. Staff G attached a needle onto the end of a Lispro insulin flexpen and dialed the pen to 2 units. Staff G pushed the injection button at the end of the flexpen but did not remove the cap to the needle and held the flexpen horizontally as she primed the needle. Staff G dialed the flexpen to "4" (units). Staff G administered the insulin into the resident's left upper arm at the top of the deltoid, quickly counted to "3", and then removed the needle from the resident's arm. Staff G failed to ensure the dial showed zero, or hold the flexpen with the needle in the skin for a count of at least 6 seconds after the medication administered. Staff R (Assistant Director of Nursing) stood in the resident's room and observed Staff G. During an interview 3/30/21 at 3:00 p.m., the Director of Nursing (DON) reported the facility lacked a policy for administering flexpen insulin. The DON reported she expected staff to follow the manufacturer guidelines when administering flexpen insulin. The Lispro manufacturer instructions revised 2/2020 revealed the following procedural steps when using a flexpen and gave Lispro insulin injection: a. Pull the pen cap off. b. Wipe the rubber seal with an alcohol swab. c. Pull the paper tab from the outer needle shield and push the capped needle straight onto the pen, twist the needle on until it is tight.	F 760		

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F 760	Continued From page 38 d. Prime the pen before each injection. Priming the pen means removal of air from the needle and cartridge and to ensure the pen worked correctly. Too much or too little insulin may be administered if the pen had not been primed properly before each injection. e. To prime the pen, turn the dose knob to select 2 units. Hold the pen with the needle pointed up. Tap the cartridge holder gently to collect air bubbles at the top. Continue to hold the pen with the needle pointed up. Push the dose knob in until it stops, and a "0" seen in the dose window. Hold the dose knob in and count to 5 slowly. Repeat steps until insulin seen at the tip of the needle, up to 4 times. f. To administer the insulin: Turn the dose knob to select the number of units (of insulin) needed to inject. Choose an injection site and inject the needle subcutaneously under the skin of the stomach area, buttocks, upper legs or upper arms. Push the dose knob all the way in and continue to hold the dose knob in and slowly count to "5" before removing the needle.	F 760		
F 812 SS=F	Food Procurement,Store/Prepare/Serve-Sanitary CFR(s): 483.60(i)(1)(2) §483.60(i) Food safety requirements. The facility must - §483.60(i)(1) - Procure food from sources approved or considered satisfactory by federal, state or local authorities. (i) This may include food items obtained directly from local producers, subject to applicable State and local laws or regulations.	F 812		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	166612	A. BUILDING _____ B. WING _____	C 04/08/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
TRINITY CENTER AT LUTHER PARK	1555 HULL AVENUE DES MOINES, IA 50316

(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 812	Continued From page 39 (ii) This provision does not prohibit or prevent facilities from using produce grown in facility gardens, subject to compliance with applicable safe growing and food-handling practices. (iii) This provision does not preclude residents from consuming foods not procured by the facility. §483.60(l)(2) - Store, prepare, distribute and serve food in accordance with professional standards for food service safety. This REQUIREMENT is not met as evidenced by: Based on observation, policy review and staff interview the facility failed to label and store food in accordance with professional standards of food service safety. The facility reported a census of 100 residents. Findings include: During the initial tour of the kitchen and unit kitchenettes on 3/29/21 from 8:45 a.m. to 9:15 a.m. revealed the following: a. 3, 4 ounce bottles of ice tea concentrate opened and not dated in the refrigerator. b. Frozen cookies not sealed in package or dated when opened 10 sugar cookies, 82 ginger snaps cookies and 40 oatmeal cookies in walk in freezer. c. A package of sliced ham under the shelves on the floor in the walk in refrigerator. d. A small cup in the sugar storage container, down in the sugar. e. 4 desert cups not covered or dated in unit	F 812		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	166612	A. BUILDING _____ B. WING _____	C 04/08/2021

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F 812	Continued From page 40 refrigerator. f. A container of thickened orange juice ¾ full not dated when opened in Cedar unit refrigerator. g. A container of prune juice ¾ full not dated when opened in Cedar unit refrigerator. h. 6 small containers of resident's personal food placed in the unit kitchenette freezer. The items contained a name and no dates. During an interview on 3/29/21 at 9:15 a.m., the Certified Dietary Manager acknowledged resident's personal food should be stored in the kitchenette refrigerator or freezer. She explained the staff received education on dating and labeling items. She reported an expectation of staff to date and label items when opened. The facility Policy Food from Outside Sources revised 1/21/21 documented the facility recognized outside sources of food can unintentionally pose a risk to the whole community and it was determined risks outweigh the benefits. The policy contained the following procedures: a. Residents will be discourage from have food brought in from sources other than the facility's food service. Every attempt will be made to satisfy the resident's food and beverage preferences from internal sources. b. If a residents receives food from other sources than the facility's food service; the food should be in compliance with any therapeutic diet orders in place for the residents and the facility will make every attempt to discourage/redirect the resident	F 812		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	165612	A. BUILDING _____ B. WING _____	C 04/08/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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F 812	Continued From page 41 from consuming such foods however residents maintain the right to enjoy family provides foods and beverages. c. Only individually packaged, shelf stable items can be accepted of immediate or later consumption. d. No homemade or potentially hazardous foods can be accepted for later consumption. If such foods are presented to a resident, the family must serve the food directly to resident, maintaining full responsibility for its contents and safety. e. Any uneaten food will be disposed of properly right after the meal. There is no safe storage for these foods. f. Food and beverages brought in by family members may not be stored in Culinary nutrition center refrigerators. The facility Policy Food Storage effective date 5/1/20 reviewed 1/21/21 included the following documentation; Food storage is conducted in a manner that prevent the contamination of product, the transmission of disease carrying organisms and the maintenance of high quality food items. The Certified Dietary Manager is ultimately responsible for receiving and storing all food and supplies in a proper area. The actual process is typically delegated to other dietary staff. Any unlabeled, dated or damaged product will be removed from inventory.	F 812		

Trinity Center at Luther Park

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Des Moines, Iowa 50316

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F 609

It is the practice of this facility to report alleged violations including missing valuable belongings.

Corrective action taken for residents found to have been affected by the deficient practice.

Resident # 94 deceased. A search was conducted in the facility unable to locate the belongings. Phone calls made to the ambulance that transported resident to the ER, Mercy ER and Hospital unable to locate the missing items. Family did not want reimbursement. Revision to Trinity Center's Inventory-Valuable's policy was made and staff was educated on the policy.

How the center will identify other residents having the potential to be affected by the same deficient practice.

When allegations of abuse have been reported, Upon admission and when new items are brought into the facility or when items are removed from the facility via resident's POA or family member, the inventory sheet will be updated.

What changes will be put in place to ensure the problem will be corrected and will not recur

- Re-education of the DON, social services, clinical team assistant administrator and administrator on mandatory abuse allegation
- The DON, Social worker and administrator will make a determination of whether to report the alleged missing items, potential for or suspicion of theft will be reported to state.

Quality Assurance plan to monitor performance to make sure corrections are achieved and are permanent

- Weekly audit of abuse allegations x 4 weeks then it will be introduced into monthly QA audit rotation.
- Scheduled audits to follow PRN Audits if concerns were identified.

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F 658

The facility strives to ensure residents medications are administered as ordered by the physician and physician order changes are implemented as ordered.

Corrective action taken to ensure the resident affected by the deficiency

- Incident report for medication error was completed on 4/7/2021, per facility protocol, resident # 17 was assessed on 4/7/21 for adverse effects related to medication error, no adverse effects reported. Medication & Treatment orders Policy was revised and staff was educated.

How the center will identify other residents having the potential to be affected by the same deficient practice.

All residents living at Trinity center will have MARS & TARS reviewed, new practices including triple checking of orders by management has been introduced into routine protocol in following with the revisions made to the Medication & Treatment Orders Policy.

What changes will be put in place to ensure the problem will be corrected and will not recur

- The policy for Medication and Treatment orders has been revised with attention to the processing of orders.
- Education for the revised medication and treatment orders was conducted explaining the new procedure for processing orders which started on 4/23/21 and is ongoing.
- All physician orders will be double noted by floor nurses with a triple check by nurse management.
- The ADON/assigned designee will review all physician orders on the next day before they are filed in the chart.

Quality Assurance plan to monitor performance to make sure corrections are achieved and are permanent

- Random audits will be conducted on designated hallways weekly x 4 weeks, then random audits will be introduced into the monthly QA audit rotation.
- Scheduled audits to follow PRN audits when and if concerns were identified.

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F689 (1)

It is the intent of the facility to provide adequate supervision to cognitively impaired residents displaying exit seeking behaviors, assess and implement effective interventions for a resident at risk for elopement and respond to a sounding door alarm.

Corrective action taken for residents found to have been affected by deficient practice

Resident was re-directed back to the building. Physical assessment completed, no injuries. Elopement assessment was completed, a wonder-guard was placed on the resident with nursing measures to check for placement every shift.

How the center will identify other residents having the potential to be affected by the same deficient practice

Residents residing at the facility that have cognitive impairment and display exit seeking behaviors, through elopement assessments upon admission, quarterly and as needed.

What changes will be put into place to ensure that the problem will be corrected and will not recur

- Elopement policy has been reviewed and revised.
- Elopement assessment will be reviewed and revised.
- New elopement assessments will be conducted on all residents currently living at trinity center with interventions put place.
- All Staff will be educated on elopement policy, which includes response to alarms at doors.
- Elopement assessments will be completed upon admission, quarterly or any significant change.

Quality assurance plan to monitor performance to make sure corrections are achieved and are permanent.

- Auditing staff knowledge of elopement process with satisfactory answer of an elopement quiz.
- Door alarm drill audits will be conducted three times a week, alternating shifts and units x 3 weeks. If there no concerns we will go to 1 drill per week x 3 weeks alternating units and shifts. Then monthly on alternating shift and units. Maintenance staff will complete the door alarm audits

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F689 (2)

The Facility Strives to provide a safe environment free from accidents, hazards that each resident receives adequate supervision to prevent elopement, the staff respond to a sounding door alarm to prevent elopement, provide safe transfer techniques to prevent injuries, assess equipment such as power chairs for safety before resident use, transport residents who use wheelchair as per the facility policy and provide communication to staff after therapy has finished evaluation and treatment and update the care plans.

Corrective action taken for residents found to have been affected by the deficient practice.

- An elopement assessment was completed for resident # 21, wander-guard placed, care plan updated. Resident was assessed on 3/29/21, no noted injuries related to the incident. Labs were completed, resident treated for UTI.
- Resident # 90 was sent to the emergency room, received sutures, send back to the facility. Orders for PT/ OT were obtained, evaluation completed, care plan updated. Resident has been followed by the wound doctor, Left thigh wound healed, the right shin wound is in the healing stages.
- Resident #33 was assessed, no injuries related to the incident, care plan for transfers updated.
- Resident # 9 was assessed, no injuries noted in relation to the incident, resident has a bag on the wheelchair for foot pedals, care plan updated.
- Resident # 82 was assessed by therapy and deemed safe to drive the power chair, therapy communication given to the nursing staff on 4/6/2021, care plan updated. Resident is followed by the wound doctor weekly, wound improving at the healing stages.
- Resident # 81 was sent to the ER, assessed and sent back to the facility. Residents care plan has been reviewed and updated. Bump to the head has resolved.

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F695

The facility strives to ensure residents receive respiratory treatments as ordered by the physician.

Corrective action taken for residents found to have been affected by the deficient practice.

- Resident # 95 no-longer resides at Trinity center
- All residents using oxygen had an audit conducted of MARs/&TARs to ensure they were in compliance with physician orders.

How the center will identify other residents having the potential to be affected by the same deficient practice.

- Through order reviews of all residents residing at Trinity Center or admitting at Trinity center who have physician orders for oxygen use or recieves new orders for oxygen use.

What changes will be put in place to ensure the problem will be corrected and will not recur

- A policy for medication and treatment orders has been reviewed, revised, education started and ongoing
- A review of all residents at the facility with oxygen to ensure they have a physician orders for oxygen.
- All new admits or residents with new orders for oxygen will be reviewed and measures put in place for implementation.

Quality Assurance plan to monitor performance to make sure corrections are achieved and are permanent

- The DON will assign a staff to complete Weekly audits for residents with oxygen to ensure they have physician orders in place x4 weeks then random audits will be introduced into the monthly QA audit rotation.
- Scheduled audits to follow PRN audits when and if concerns were identified.

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F760

The facility will strive to ensure residents are free from significant medication errors.

Corrective action taken to ensure the resident affected by the deficiency

- A medication error was completed on 3/30/202. Resident assessed for adverse effects, no injuries or adverse effects related to the incident.

How the center will identify other residents having the potential to be affected by the same deficient practice

- Medication & Treatment Orders policy has been revised with an attention to accurate and present orders on the MAR & TARs will include a triple check process to ensure accuracy.
- then random audits will be introduced into the monthly QA audit rotation.
- Scheduled audits to follow PRN audits when and if concerns were identified.
- A policy specific to insulin administration using an insulin pen was written and education provided to nursing staff.

What changes will be put in place to ensure the problem will be corrected and will not recur

- A review of insulin administration process has been completed and education initiated.
- The DON will assign a designee to complete audits on insulin administration 3 times a week x 4 weeks then monthly

Quality Assurance plan to monitor performance to make sure corrections are achieved and are permanent

- The DON will assign staff to complete audits on insulin administration 3 times a week x 4 weeks then monthly x 3 months, then it will be introduced into monthly QA audit rotation.
- Scheduled audits to follow PRN Audits if concerns were identified.

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F812

The facility strives to ensure residents food is procured, stored, prepared, and served in accordance with the professional standards of food service safety.

Corrective action taken for residents found to have been affected by the deficient practice

- Food storage areas will continue to be filled/checked by kitchen staff as part of their daily routine.
- CDM, Executive Chef or Culinary Supervisor will audit areas to ensure sites are compliant.
    - Areas of non-compliance with our 'Food Storage', 'Food from Outside Sources' or 'Nutrition Center' policies will be corrected immediately.
    - If errors are found in any the work, the staff associated will be re-trained

How the center will identify other residents having the potential to be affected by the same deficient

- All resident food storage sites within Trinity will be treated in the same manner.

What changes will be put in place to ensure the problem will be corrected and will not recur

- Newsletter article being drafted to re-educate families of our Food from Outside Sources policy.
- Copies of the printed policy are available for families/guests at Trinity main entrance doors.
- All Trinity staff will be trained on the Culinary policy of 'Food from Outside Sources' (See attached form I)
- All Culinary staff will be re-trained on focused areas of concern (See attached forms II and III)
- Updated reminder note has been placed on the front of all Nutrition Center refrigerator units. (See attached form IV)

Quality assurance plan to monitor performance to make sure corrections are achieved and are permanent.

- Audit line added to daily Nutrition Center fill checklist which will be completed 3 times per week by CDM, Executive Chef or Culinary Supervisor beginning the week of 4/19/2021 and continuing for no less than 12 weeks, reducing to sporadically only if a consistent pattern of compliance has been demonstrated. (See attached form V)
- Weekly audits of all Culinary responsibilities will continue indefinitely as best practice.