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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 165286	(X2) MULTIPLE CONSTRUCTION A. BUILDING ______ B. WING ______	(X3) DATE SURVEY COMPLETED C 10/21/2021
NAME OF PROVIDER OR SUPPLIER: SUNRISE HILL CARE CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE: 909 6TH STREET TRAER, IA 50675	

(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 Correction Date: 11 18 2021 A Focused COVID-19 Infection Control Survey and an investigation of facility reported incidents 96193-I and 100286-I was conducted on October 11 - 21, 2021. The facility was NOT in compliance with CMS and Centers for Disease Control and Prevention (CDC) recommended practices to prepare for COVID-19. Total residents: 48 Both facility reported incidents were substantiated. (See the Code of Federal Regulations (42CFR) Part 483, Subpart B-C).	F 000		
F 689 SS=G	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 observation, clinical record review, and staff and family interviews, the facility failed to provide each resident adequate supervision and assistance devices to prevent accidents for 3 of 4 residents reviewed (Resident #1). On 5/20/21, Staff J, Certified Nursing Assistant (CNA) walked with the resident toward the bed without using a	F 689		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: [signature] TITLE: Administrator (X6) DATE: 11/03/2021

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.

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gait belt around the resident's waist in accordance with facility policy. As Staff J pulled back the covers on the bed, the resident stumbled backward, fell into a cabinet, and slid to the floor. On 5/22/21, Resident #1 could not bear weight on the right leg and exhibited facial grimacing and staff sent Resident #1 to the Emergency Room (ER). The resident subsequently admitted to the hospital with a right hip fracture. The facility reported a census of 48 residents.

Findings Include:

Based on observation, clinical record review, and staff and family interviews, the facility failed to adequate supervision to protect against self, others, or hazards in the environment for 3 of 4 residents reviewed (Resident #1). On 5/20/21, Staff J, Certified Nursing Assistant (CNA) walked with the resident toward the bed without using a gait belt around the resident's waist in accordance with facility policy. As Staff J pulled back the covers on the bed, the resident stumbled backward, fell into a cabinet, and slid to the floor. On 5/22/21, Resident #1 could not bear weight on the right leg and exhibited facial grimacing and staff sent Resident #1 to the Emergency Room (ER). The resident subsequently admitted to the hospital with a right hip fracture. The facility reported a census of 48 residents.

Findings include:

1. According to the Minimum Data Set (MDS) assessment tool dated 4/15/21, Resident #1 had

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F 689	Continued From page 2 diagnoses that included Alzheimer's Disease and non-Alzheimer's dementia. The MDS documented staff could not administer the Brief Interview for Mental Status (BIMS) test because they could rarely/never understand the resident. The MDS also documented Resident #1 required extensive assist of 1 staff for bed mobility and dressing, and extensive assist of 2 staff for transfers, ambulation (walking), toilet use, and personal hygiene. The care plan initiated 2/5/21 documented Resident #1 required assistance with all activities of daily living (ADLs). An intervention updated on 4/23/21 directed to transfer the resident with assist of 1 staff. The progress notes contained the following entries: a. On 5/20/21 at 7:45 PM - Nurse summoned to unit. Staff reported they were walking the resident to bed and staff stopped to pull back the bedding. The resident then stumbled backward, their left shoulder fell into a cabinet, and the resident slid to floor. Staff assessed the resident's range of motion (ROM) as within normal limits (WNL) and found no signs/symptoms (s/s) of injury or skin issues. Two (2) staff then assisted the resident to transfer from the floor to the bed and noted no facial s/s of discomfort with movement and weight bearing. b. On 5/22/21 at 12:30 PM - Staff reported resident the required assist of 2 staff, needed a wheelchair to transport, and could not to bear weight on the right leg. The nurse documented the resident winced and exhibited facial grimacing with ROM to right leg, but able to perform ROM to	F 689		

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left leg without difficulties.

c. On 5/22/21 at 2:30 PM - Physician on call ordered staff to send Resident #1 to ER to evaluate and treat.

d. On 5/22/21 at 5:48 PM - Staff placed call to hospital ER and spoke with staff: "She has a broken hip, we are admitting her."

A Fall/Incident Report dated 5/20/21 7:45 PM, documented when staff walked Resident #1 to bed and then pulled the bedding back, the resident stumbled backwards, right shoulder fell against cabinet, and the resident slid to floor.

A Radiology Report dated 5/22/21, documented an x-ray of Resident #1's right hip contained findings of a mid-cervical fracture, right femoral neck (fracture of right hip).

During an interview on 10/14/21 at 3:16 PM, Staff J, CNA stated she was in Resident #1's room with the resident and was going to assist the resident to bed. Staff J, CNA stated the resident flared with her arms, lost her balance, fell, and landed on her right hip: more on her side than her bottom. Staff J stated she did not have a gait belt on the resident, did not know the resident needed assist of 2 staff. She added she thought Resident #1 needed stand-by assistance only. Staff J, CNA stated, "I probably should have put a gait belt on her."

The Gait Belt facility policy updated 7/29/06 directed staff to use a gait belt for all residents requiring assistance with transfers and/or ambulation. It serves as a handle to grasp if the resident begins to fall, to help prevent the fall, or

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F 689	Continued From page 4 control the resident's descent. During an interview on 10/14/21 at 11:25 AM, Staff L, CNA stated prior to fracturing her hip, Resident #1 required assist of 1 staff with a gait belt, for transfers and ambulation. During an interview on 10/14/21 at 11:58 AM, Staff M, CNA stated prior to fracturing her hip, Resident #1 required assist of 1 staff with a gait belt, for transfers and ambulation. During an interview on 10/19/21 at 12:10 PM, Staff K, CNA stated if she needed to know how to transfer a resident, she would review the care plan books located at the nurses' station. Staff K, CNA stated she does not carry a CNA information sheet for her hall. During an interview on 10/19/21 at 12:45 PM, the Assistant Director of Nursing (ADON) stated the facility provides CNAs information hall sheets if they want them, although some CNAs do not carry them. The information sheets contain directives related to whether or not a resident experiences urinary incontinence or uses Ted Hose, glasses, or dentures, how many staff required for assistance. During an interview on 10/18/21 at 12:12 PM, the ADON stated expectation that anytime staff have to help a resident to transfer, the staff are to use a gait belt and if a resident is care planned for assist of 1 or 2 for transfers, should always use a gait belt. Review of statement signed by ADON, dated 10/19/21, documented the ADON spoke with the Director of Nursing (DON) and the DON stated	F 689		

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she discussed Resident#1's fall with Staff J, CNA and Staff J, CNA admitted she should not have let go of the resident and did not have a gait belt on the resident.

2. According to the MDS assessment dated 9/16/21, Resident #2 had diagnoses that included diagnoses of Alzheimer's disease and diabetes. The MDS documented the resident needed extensive assist of 1 staff for bed mobility, transfers, dressing, toilet use, and personal hygiene. The MDS revealed the resident scored 3 of 15 possible points on the BIMS test, which meant the resident demonstrated severely impaired cognitive abilities.

During an observation in the living room on 10/12/21 at 11:22 AM, Staff A, CNA transferred Resident #2 from the couch to a wheelchair by placing their hand/arm under the resident's arm and pulling up on the resident. Staff A, CNA did not use a gait belt to transfer the resident.

Review of Resident #2's care plan initiated 7/1/21 documented a focus of ADL/Falls with an intervention updated on 8/19/21 that directed staff to transfer the resident with assist of 1 person.

During an interview on 10/19/21 at 2:30 PM, the ADON reported the facility's expectation for staff to transfer Resident #2 with a gait belt and assist of 1 staff.

3. According to the MDS assessment dated 8/5/21, Resident #3 had diagnoses that included anxiety disorder, depression, and other fracture. The MDS documented the resident needed limited assist of 1 staff for transfers and extensive

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assist of 1 staff for bed mobility, ambulation, dressing, toilet use, and personal hygiene. The MDS also documented the resident scored 12 of 15 possible points on the BIMS test which meant the resident displayed moderate cognitive impairment.

Review of a care plan initiated 8/12/21 documented a focus of self-care/ambulation/falls with a history of left femur (upper leg bone) fracture from a fall prior to admission. A care plan updated 9/2/21 documented Resident #3's has been transferring by themselves and also taking themselves to the toilet, despite education regarding the need for assist and alarm placed for safety. A care plan intervention added 9/2/21 directed staff to ensure placement/functioning of alarms every shift.

An observation on 10/19/21 at 10:50 AM revealed Resident #3 sat in her wheelchair in the living room with a pressure alarm pad under her which flashed green.

The progress notes contained the following entries:

a. 10/4/21 at 1:45 PM - Nurse summoned to Resident #3's room by staff and found the resident on both (bilateral) knees on the floor in front of the bed; resident not sure what she was doing and denies pain or hitting head. Resident placed in wheelchair with alarm on and functioning correctly, and taken to the living room for an activity.

b. 10/5/21 at 10:19 AM - Resident noted with intact red/purple bruise which measured 2.5 centimeters (cm) x 8.5 cm to lateral left hip

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F 689	Continued From page 7 related to fall sustained on 10/4/21. c. 10/6/21 at 8:49 AM - Resident noted with intact purple bruise that measured 8 cm x 4.3 cm to medial right hand related to fall that occurred 10/4/21. Review of the fall/incident report, dated 10/4/21 at 1:45 PM, documented Resident #3 found on bilateral knees in front of bed. During an interview on 10/14/21 at 11:40 AM, Staff L, CNA, stated on 10/4/21 a resident in the hallway reported Resident #3 was on the floor. Staff L reported she went to Resident#3's room with Staff N, CNA and observed the resident on the floor. Staff L reported she was unsure if the resident's alarm positioned in her recliner was going off or not. Staff L stated there is a frequent beep when the alarm battery is going dead and then the battery is replaced. During an interview on 10/14/21 at 2:22 PM, Staff O, LPN stated on 10/4/21, she found Resident #3 on the floor on both of her knees. Staff O stated the alarm was not going off when she found the resident and the alarm did not go off while it was in the recliner. Staff O stated after caring for the resident, she changed the batteries in the alarm and the alarm did work. Staff O stated they check alarms on rounds and at shift change and the nurses sign off to show the alarms are working every shift, because they are supposed to be checked every shift. During an interview on 10/19/21 at 10:53 AM, Staff N, CNA stated on 10/4/21 she was walking by Resident #3's room and observed the resident on the floor on her knees. Staff N, CNA stated the	F 689		

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alarm was in the resident's recliner but was not going off, and she reported the alarm not going off to Staff P, LPN.

Review of facility's "Personal Alarm Monitor Sheet" for Resident #3 documented, signature acknowledges alarm is correctly placed and functioning, and appropriate use for this resident with 10/4/21 days initialed by Staff O, LPN.

During an interview on 10/14/21 at 2:45 PM, Staff P, LPN stated alarms are checked at the beginning of the shift to make sure in place, but she does not always check to be sure the alarms are turned on. Staff P, LPN also stated she documented in the book every night that alarms were on and present, but she does not always verify the alarms are in working order every shift even though she signs off in the book as completed.

During an interview on 10/19/21 at 11:10 AM, Staff O, LPN stated on 10/4/21, she checked Resident #3's alarm at the beginning of her shift (6 AM-10 PM) and heard the alarm going off when staff got the resident up that morning and other times throughout the day. Staff O, LPN stated CNAs from the 2 shifts, at shift change, check the alarms together, then she walks the halls later in her shift to check the alarms and checks the alarms again at bedtime. Staff O, LPN stated she always checks the alarms herself and signs off in the book, as the facility has a policy to check alarms.

Review of facility's policy titled "Personal Alert Monitors", updated 8/28/06, documented: Purpose to alert staff to any potential risky behaviors a resident may have that could result in

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F 689	Continued From page 9 a fall. Each shift, the charge nurse documents that the monitor is present and functioning properly. Be aware when the monitor seems to be sounding weaker as this could indicate the battery needs to be changed.	F 689		
F 880 SS=E	Infection Prevention & Control CFR(s): 483.80(a)(1)(2)(4)(e)(f) §483.80 Infection Control The facility must establish and maintain an infection prevention and control program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of communicable diseases and infections. §483.80(a) Infection prevention and control program. The facility must establish an infection prevention and control program (IPCP) that must include, at a minimum, the following elements: §483.80(a)(1) A system for preventing, identifying, reporting, investigating, and controlling infections and communicable diseases for all residents, staff, volunteers, visitors, and other individuals providing services under a contractual arrangement based upon the facility assessment conducted according to §483.70(e) and following accepted national standards; §483.80(a)(2) Written standards, policies, and procedures for the program, which must include, but are not limited to: (i) A system of surveillance designed to identify possible communicable diseases or infections before they can spread to other persons in the facility;	F 880		

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F 880	Continued From page 10 (ii) When and to whom possible incidents of communicable disease or infections should be reported; (iii) Standard and transmission-based precautions to be followed to prevent spread of infections; (iv)When and how isolation should be used for a resident; including but not limited to: (A) The type and duration of the isolation, depending upon the infectious agent or organism involved, and (B) A requirement that the isolation should be the least restrictive possible for the resident under the circumstances. (v) The circumstances under which the facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease; and (vi)The hand hygiene procedures to be followed by staff involved in direct resident contact. §483.80(a)(4) A system for recording incidents identified under the facility's IPCP and the corrective actions taken by the facility. §483.80(e) Linens. Personnel must handle, store, process, and transport linens so as to prevent the spread of infection. §483.80(f) Annual review. The facility will conduct an annual review of its IPCP and update their program, as necessary. This REQUIREMENT is not met as evidenced by: Based on observation, staff interview, and policy review, the facility failed to ensure the staff used acceptable infection control standards of practices to protect from potential infection by not	F 880		

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performing hand hygiene between resident contact and after resident care, and failed to comply with current infection control standards for proper use of eye protection. The facility reported a census of 48 residents.

Findings include:

1. In an observation on 10/12/21 at 11:25 AM, Staff A, Certified Nurse's Aide (CNA), removed a resident's facemask and placed the facemask on the handle of the resident's wheelchair. Staff A, CNA, without performing hand hygiene, proceeded to remove 2 more residents' facemasks and place them on the handles of the residents' wheelchairs. Without performing hand hygiene, Staff A, CNA then assisted a resident to dine.

During an observation on 10/12/21 at 11:31 AM, Staff B, Dietary, cut up food for a resident by touching the fork that had been touched by the resident and then Staff B, Dietary. Without performing hand hygiene, Staff B proceeded to serve another resident and cut up the resident's food.

During an observation on 10/13/21 at 12:30 PM, Staff C, CNA applied gloves and provided incontinence care for a resident. While wearing the same gloves, Staff C, CNA, touched the resident's blanket and call light, gathered the trash bag with dirty clothes, exited the resident's room, took the trash bag to the trash room, and then applied hand sanitizer.

Review of the Hand Hygiene facility policy dated 4/1/20, documented indications for hand washing with soap and water:

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a. before serving food and/or assisting residents with eating

Indications for hand washing with soap and water or alcohol-based hand sanitizer:

b. before having direct contact with residents
c. before and after each procedure involving residents or equipment
d. when handling dirty or used linen
d. if moving from a contaminated body site to a clean body site during resident care
e. before applying and after removing gloves

2. During an observation on 10/12/21 at 12:31 PM, Staff D, Social Services wore a facemask only with no eye protection and in a room talking with 2 residents. Staff D exited the room and began talking with another resident with her hand on the resident's back.

During an observation on 10/21/21 at 5:00 PM, Staff E, CNA and Staff F, CNA both assisted residents on the unit wearing facemasks, but no eye protection.

During an observation on 10/13/21 at 11:26 AM, Staff G, Licensed Practical Nurse, LPN, wearing a facemask only, no eye protection, was assisting 2 residents to dine.

During an observation on 10/13/21 at 4:15 PM, Staff H, CNA wearing facemask only and goggles on top of her head, assisted resident to transfer to a recliner.

During an observation on 10/13/21 at 4:45 PM,

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SUNRISE HILL CARE CENTER	909 6TH STREET TRAER, IA 50675

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F 880	Continued From page 13 Staff I, CNA, wearing a facemask and goggles on top of his head, pushed a resident, in a wheelchair, down the hallway. Centers for Disease Control and Prevention regulation titled, " Recommendations for Healthcare Personnel During the Coronavirus Disease 2019 (COVID-19) Pandemic updated 9/10/21, documented health care personnel working in facilities located in counties with substantial or high transmission should also use personal protective equipment including eye protection(i.e., goggles or a face shield that covers the front and sides of the face) should be worn during all patient care encounters. During an interview on 10/18/21 at 3:45 PM, the Assistant Director of Nursing (ADON) confirmed the county's transmission rate was high on 10/12/21 and 10/18/21 and stated the facility's current requirement is for staff to wear facemasks at all times and goggles or side shields (on glasses) within 6 feet of residents. The ADON stated expectation for staff to use hand sanitizer between resident contact and after cares to remove gloves and complete hand hygiene.	F 880		

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Preparation and/or execution of this plan does not constitute admission or agreement by the provider that a deficiency exists.
This response is also not to be construed as an admission of fault by the facility, its employees, agents or other individuals who draft or may be discussed in this response and plan of correction. This plan of correction is submitted as the facility's credible allegation of compliance.

1. **Immediate action(s) taken for the resident(s) found to have been affected include:**

   The Assistant Director of Nursing initiated:

QAPI on gait belts

Education

Policy revised and renewed with staff

Return demos with staff

Added to orientation check list

Will review policy with yearly evals

2. **Identification of other residents having the potential to be affected was accomplished by:**

   The facility has determined that all residents have the potential to be affected.

3. **Actions taken/systems put into place to reduce the risk of future occurrence include:**

   The Administrator and/or Director of Nursing and their designee have:

QAPI on gait belts

Education

Policy revised and renewed with staff

Return demos with staff

Added to orientation check list

Will review policy with yearly evals

All staff will be in-serviced on the policy and procedure on the facility policy.

All resident falls/accidents will be reviewed daily by the nursing management team to ensure appropriate implementation of safety interventions including updating the plan of care .

4. **How the corrective action(s) will be monitored to ensure the practice will not reoccur:**

   The nursing team will conduct routine gait belt checks

   Findings of routine checks will be documented and kept for further review.

Audited records will be reviewed by the Risk Management/Quality Assurance Committee until such time consistent substantial compliance has been achieved as determined by the committee.

Audit results will be shared with the Resident/Family Group Council for comment and suggestions.

Corrective action completion date 11/18/2021

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1. **Immediate action(s) taken for the resident(s) found to have been affected include:**

   The Assistant Director of Nursing initiated:

   QAPI on handwashing
   Staff observed in dining room and after cares

   QAPI on eyewear
   Observation

2. **Identification of other residents having the potential to be affected was accomplished by:**

   The facility has determined that all residents have the potential to be affected.

3. **Actions taken/systems put into place to reduce the risk of future occurrence include:**
   QAPI on handwashing
   Staff observed in dining room and after cares

   QAPI on eyewear
   Observation

   All personnel will be in-serviced on hand hygiene and eyewear. In-service training includes random observation of personnel performing hand hygiene procedures according to facility policy. Findings are reviewed with all personnel. Corrective action is provided as needed.

PPE lessons:

https://www.youtube.com/watch?v=YYTATw9yav4&feature=youtu.be Sparkling Surfaces:
https://www.youtube.com/watch?v=t7OH8ORr5lg&feature=youtu.be Clean Hands:
https://www.youtube.com/watch?v=xmYMUly7qiE&feature=youtu.be Keep COVID OUT:
https://www.youtube.com/watch?v=7srwrF9MGdw&feature=youtu.be

4. **How the corrective action(s) will be monitored to ensure the practice will not recur:**

The Director of Nursing Services (DNS), or designee, will complete random *Validation Checklists* of personnel and the timing and technique of hand hygiene procedure. To ensure personnel are performing the procedure in accordance with our facility's *Practice Guideline,* random monitoring will occur each week for 4 weeks.

Findings of this audit will be discussed with the Resident Council.

This plan of correction will be monitored at the monthly Quality Assurance meeting until such time consistent substantial compliance has been met.

Corrective action completion date: 11/18/2021