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BIRKWOOD VILLAGE OF FORT MADISON	1702 41ST STREET FORT MADISON, IA 52627

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F 000	INITIAL COMMENTS F000 Initial Commen ✓ Correction date: 7/20/24 KG The following deficiencies resulted from the facility's annual recertification survey and investigation of complaints #120801-C, # 120838-C, and facility reported incidents # 121177-I, #121246-I, conducted June 17, 2024 to June 20, 2024. Facility reported incidents #121177-I and #121246-I were substantiated. See Code of Federal Regulations (42CFR) Part 483, Subpart B-C.	F 000		
F 550 SS=D	Resident Rights/Exercise of Rights CFR(s): 483.10(a)(1)(2)(b)(1)(2) §483.10(a) Resident Rights. The resident has a right to a dignified existence, self-determination, and communication with and access to persons and services inside and outside the facility, including those specified in this section. §483.10(a)(1) A facility must treat each resident with respect and dignity and care for each resident in a manner and in an environment that promotes maintenance or enhancement of his or her quality of life, recognizing each resident's individuality. The facility must protect and promote the rights of the resident. §483.10(a)(2) The facility must provide equal access to quality care regardless of diagnosis, severity of condition, or payment source. A facility	F 550		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Tara Pope | TITLE: Administrator | (X6) DATE: 7/12/24

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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must establish and maintain identical policies and practices regarding transfer, discharge, and the provision of services under the State plan for all residents regardless of payment source.

§483.10(b) Exercise of Rights.
The resident has the right to exercise his or her rights as a resident of the facility and as a citizen or resident of the United States.

§483.10(b)(1) The facility must ensure that the resident can exercise his or her rights without interference, coercion, discrimination, or reprisal from the facility.

§483.10(b)(2) The resident has the right to be free of interference, coercion, discrimination, and reprisal from the facility in exercising his or her rights and to be supported by the facility in the exercise of his or her rights as required under this subpart.
This REQUIREMENT is not met as evidenced by:
Based on interviews, clinical record review, and facility Human Resources documentation, the facility failed to ensure residents were treated in a dignified manner while speaking to residents and during incontinent care for 1 of 3 residents reviewed (Resident #50). The facility reported a census of 59 residents.

Findings include:

The Minimum Data Set (MDS) assessment, dated 3/25/24, revealed Resident #50 scored a 15 out of 15 on the Brief Interview for Mental Status (BIMS), which indicated intact cognition. The MDS assessed the resident dependent on staff for assistance with toileting hygiene and

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frequently incontinent of bowel and bladder.

The Care Plan, dated 4/19/24, revealed a focus area to address grieving related to the unexpected loss of her husband. The Interventions included encourage the resident to live one day at a time and encourage the resident to recognize grief situations.

Staff H, Certified Nursing Assistant (CNA) personnel file revealed the following information:
a. Documentation of termination on 5/30/24. Reason indicated - outcome related to facility investigation of abuse accusations.
b. Mandatory Reporter training for Dependent Adult Abuse completed on 4/1/23.
c. Training completed on the importance of effective communication in health care on 3/17/23 and 4/10/24.
d. Training on Resident's Rights completed on 3/17/23.
e. Signed acknowledgement of CNA job description dated 3/15/23.
f. Signed acknowledgement form stating understand the obligation to report potential abuse, and received/discussed the Abuse Prevention, Identification and Reporting Policy [October 2022] on 3/15/23.

Per the undated, Facility Investigation documents regarding the incident involving Resident #50:
a. On May 28, Resident #50 reported to the ADON (Assistant Director of Nursing), Staff H, CNA talked to her in an aggressive accusatory manner about a relationship with a peer. Resident #50 claimed Staff H stated "It's disgusting, your husband has only been dead for 2 weeks". Resident #50 claimed Staff H refused to answer the call light and jabbed a finger at her when

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talking. Resident #50 claimed Staff H made comments about her incontinence and with an aggressive, raised voice questioned her why she didn't use her call light to use the bed pan. Resident #50 did state she yelled at Staff H to "shut up and get out". Resident #50 stated Staff H shut the call light off and said she can't help her and walked out of the room. Resident #50 reported Staff I, CNA was in the room during this incident. Resident #50 reported Staff H pushed her to propel her own wheelchair and told other staff not to help her. Resident #50 reported she felt intimidated by Staff H and denied any previous problems with Staff H.

b. Staff H, during an interview for the facility investigation, confirmed she had a disagreement with Resident #50. Staff H reported Resident #50 asked her opinion on the relationship she formed with another resident. Staff H reported she told Resident #50, it was a bad idea, but they are both adults and can make their own decisions. At that time Staff H claimed Resident #50 yelled at her to shut up and get out, as Staff H left the room the nurse walked in and finished assisting with the transfer. Staff H went on to say that her and Resident #50 didn't mesh well and she felt that therapy encouraged her to encourage the resident to do more for herself it created animosity with the resident. Staff H stated that she removed herself from the situation. Staff H reported the day after the incident, she went into the room to shut off the call light and let her know staff was on lunch break and she wasn't allowed in the resident's room. In initial interview Staff H stated she wanted to report how Resident #50 treated her and she wanted to report what the resident done to her too. Staff H then stated the resident was going to get Staff H kicked on her hall and demanded the resident be moved to a

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different hallway.
c. Staff I, during an interview for the facility investigation, could not verify if Staff H or Resident #50 commented first but Staff H commented on Resident #50 deceased husband and that she thought Resident #50 moving to fast with another resident. Staff I stated both Staff H and Resident #50 raised their voices.
d. Investigation documentation revealed on 5/28/24, Staff H sent home and placed on administrative leave pending further investigation. No previous discipline in file for Staff H noted. No incident report or nurses note on topic and after thorough investigation the allegation of abuse considered substantiated, the employee terminated from the facility. Abuse isolated to one employee, no root cause analysis necessary.

During an interview on 6/17/24 at 3:07 PM, Resident #50 stated she felt like she had a target on her back with Staff H worked at the facility. Resident #50 stated Staff H babbled about the resident and her tablemate and said she saw the tablemate kissing Resident #50 up and down the arm and Resident #50 should be ashamed of herself since her husband died 2 weeks ago. Resident #50 stated she felt angry, then upset, and then didn't know what to do. Resident #50 stated she didn't entirely feel safe and requested Staff H not to take care of her. Resident #50 stated she felt like Staff H was verbally abusive to her.

During an interview on 6/19/24 at 4:44 PM, Staff H, CNA stated before she was terminated she didn't go into Resident #50 room or speak to her. She stated her and Staff J, CNA switched residents. Staff H stated she didn't chart on Resident #50 or answer her call light. Staff H

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stated Resident #50 asked her about a relationship she had with another resident and Staff H kept saying she didn't want to get into it but Resident #50 persisted so Staff H told her she thought it was inappropriate and not respectful to her husband who died 2 weeks prior. Staff H stated Resident #50 told her to shut up and get out of her room so Staff H had Staff I come into the room and take over cares. Staff H stated a week and half or two weeks later she was called to the office and told she was verbally abusive and suspended. Staff H stated according to therapy Resident #50 needed to push herself and sometimes Resident #50 had full blown bowel movements or urinary incontinence and didn't even try to push the call light. Staff H stated when she found the big messes, she asked Resident #50 why she didn't use her call light, like she was supposed to do.

During an interview on 6/19/24 at 5:35 PM, Staff K, RN (Registered Nurse) stated Staff H and Resident #50 didn't get along. Staff K stated the last incident with Staff H and Resident #50, she was called into the room and Staff H came out and Resident #50 stated she didn't want Staff H in her room anymore. Staff K stated immediately Staff H and Staff J traded residents and Staff K thought the issue solved. Staff K thought the incident happened a few weeks prior to the DON (Director of Nursing) questioning her. Staff K stated Staff H came to her and told Staff K that she didn't think the relationship between Resident #50 and another resident appropriate. Staff K stated she told her they were adults and could do what they wanted.

During an interview on 6/20/24 at 9:29 AM, Staff J, CNA stated she had resident tell her staff were

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rough with them. Staff J stated the residents named Staff H. Staff J stated one weekend she worked with Staff H and Staff H asked her to switch residents with her because Staff H thought Resident #50 a "b" word. Staff J stated Resident #50 told her Staff H told Resident #50 she was being inappropriate with another resident. Staff J also stated that Staff H stated Resident #50 asked for her opinion so she gave it. Staff J stated that her and Staff H went to the ADON (Assistant Director of Nursing) after the incident and told her they switched residents and the ADON thought it an appropriate alternative to keep the staff member and resident apart. Staff J stated the situation got worse because Staff H refused to take care of Resident #50 and would turn off her call light while Resident #50 on the bed pan so she reported it to the DON.

During an interview on 6/20/24 at 11:47 AM, Staff D, CNA stated Resident #50 told her that Staff H didn't speak to her very politely and refused to do cares on her. Staff D stated she witnessed Staff H refuse cares for Resident #50 when they worked Hall 4 together and Staff D would go and help Resident #50.

During an interview on 6/20/24 at 12:24 PM, Staff I, CNA stated she witnessed an incident when Staff H found out about Resident #50 talking with another resident and Staff H went into Resident #50 room and in a loud voice told Resident #50 she should be ashamed of herself and should be grieving for her husband. Staff I stated she witnessed another incident when Staff H performed incontinent cares on Resident #50 and asked the resident why she didn't use the bed pan and Staff H told the resident if they could work a phone, they could use a bed pan. Staff I

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stated after the comment, Resident #50 told Staff H to shut up and get out of her room and from then on Staff H refused to do cares on Resident #50. Staff I stated a week or two later, Staff H was suspended. Staff H stated a few times after the incident Resident #50 asked what she did to deserve care like that.

During an interview on 6/20/24 at 1:10 PM, the ADON stated when she interviewed Resident #50, the resident stated Staff H refused to answer her call light and accused her of being inappropriate for giving her husband's ring to someone else. The ADON stated Resident #50 expressed she didn't feel comfortable with Staff H doing her cares anymore. The ADON stated during her investigation, the staff mentioned Staff H could be short and abrasive with people. The ADON stated when she interviewed Staff H initially, Staff H called Resident #50 a curse word and stated she was going to get her fired. The ADON stated her conclusion at the end of the investigation stated the knew they didn't want Staff H taking care of their residents anymore and Staff H bedside manner not appropriate.

During an interview on 6/20/24 at 4:06 PM, the DON stated Staff H exhibited behaviors were not appropriate for the facility and she wished the staff would of came to her sooner. The DON stated Resident #50 became very upset and crying when she spoke to her after the incident.

During an interview on 6/20/24 at 4:22 PM, the Interim Administrator stated her conclusion of the investigation was Staff H could no longer work at the facility. She stated she was a huge advocate for their residents and even if a resident was not being nice, the staff needed to be nice to them.

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F 550	Continued From page 8 The Certified Nurse Aide Job Description, signed on 3/15/23, included the following essential functions: a. Provide resident cares in a manner that promoted resident comfort and security while allowed time for the resident participation and rehabilitation. b. Follow resident rights policies at all times	F 550		
F 607 SS=D	Develop/Implement Abuse/Neglect Policies CFR(s): 483.12(b)(1)-(5)(ii)(iii) §483.12(b) The facility must develop and implement written policies and procedures that: §483.12(b)(1) Prohibit and prevent abuse, neglect, and exploitation of residents and misappropriation of resident property, §483.12(b)(2) Establish policies and procedures to investigate any such allegations, and §483.12(b)(3) Include training as required at paragraph §483.95, §483.12(b)(4) Establish coordination with the QAPI program required under §483.75. §483.12(b)(5) Ensure reporting of crimes occurring in federally-funded long-term care facilities in accordance with section 1150B of the Act. The policies and procedures must include but are not limited to the following elements. §483.12(b)(5)(ii) Posting a conspicuous notice of employee rights, as defined at section 1150B(d)(3) of the Act.	F 607		

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§483.12(b)(5)(iii) Prohibiting and preventing retaliation, as defined at section 1150B(d)(1) and (2) of the Act.
This REQUIREMENT is not met as evidenced by:
Based on clinical record review, facility policy review, and staff interviews, the facility failed to follow their abuse policy when staff did not notify management of concerns with potential abuse of 1 of 2 residents reviewed (Resident #50). The facility reported a census of 59 residents.

Findings include:

The Minimum Data Set (MDS) assessment dated 3/25/24 revealed Resident #50 scored a 15 out of 15 on the Brief Interview for Mental Status (BIMS) exam, which indicated cognition intact. The MDS revealed resident dependent with toileting hygiene and frequently incontinent of bowel and bladder.

A review of facility investigation notes revealed on 5/28/24, Resident #50 reported to the Assistant Director Nursing (ADON) Staff H, Certified Nursing Assistant (CNA) talked to her in an aggressive, accusatory manor in regards to a discussion about a relationship with another peer.

The investigation revealed:
a. Staff H confirmed she had a disagreement with Resident #50.
b. Staff I, CNA stated Staff H and Resident #50 raised their voices during the disagreement.
c. Staff H sent home on 5/28/24 and placed on administrative leave pending further investigations.

The facility submitted a Self Report on 5/28/24 at

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2:08 PM revealed the following information:
a. Reporting Type: Allegation of Abuse
b. Approximate Date Time Occurred: 5/28/24 at 12:10- PM
c. Location occurred: Resident's Room
d. Date Aware: 5/28/24
e. Incident Summary: Resident reported to ADON that the CNA assigned to the hall she lived on wasn't nice to her. Stated that the CNA had told her that it was "disrespectful to her husband who had only been dead 2 weeks and you already have a new boyfriend." Resident stated that this CNA had told other CNAs not to come and help her because she needed to exercise.
f. Corrective Action Description: CNA has been suspended pending our investigation

During an interview on 6/17/24 at 3:11 PM, Resident #50 stated she felt Staff H verbally abusive to her for a good 2 to 3 months and it really bothered her what Staff H said about her husband of 37 years. Resident #50 stated she just put up with it and then told staff after it happened.

During an interview on 6/19/24 at 5:35 PM, Staff K, RN (Registered Nurse) stated Staff H and Resident #50 didn't get along. Staff K stated the last incident with Staff H and Resident #50, she was called into the room and Staff H came out and Resident #50 stated she didn't want Staff H in her room anymore. Staff K stated immediately Staff H and Staff J traded residents and Staff K thought the issue solved. Staff K thought the incident happened a few weeks prior to the DON (Director of Nursing) questioning her.

During an interview on 6/19/24 at 5:57 PM, Staff G, CNA stated she reported to her nurse Staff H

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aggressive with a resident in Hall 4. She stated the resident had an accident in his pants and she yelled at him. Staff G stated Staff H called the resident a butt hole and refused to lay him down so she told the nurse. Staff G stated she didn't know the nurse's name and they worked for agency staffing.

During an interview on 6/20/24 at 9:29 AM, Staff J, CNA stated she had resident tell her staff were rough with them. Staff J stated the residents named Staff H. Staff J stated one weekend she worked with Staff H and Staff H asked her to switch residents with her because Staff H thought Resident #50 a "b" word.

Staff J stated that her and Staff H went to the ADON (Assistant Director of Nursing) after the incident and told her they switched residents and the ADON thought it an appropriate alternative to keep the staff member and resident apart. Staff J stated the situation got worse because Staff H refused to take care of Resident #50 and would turn off her call light while Resident #50 on the bed pan so she reported it to the DON.

During an interview on 6/20/24 at 11:47 AM, Staff D, CNA stated Resident #50 told her that Staff H didn't speak to her very politely and refused to do cares on her. Staff D stated she witnessed Staff H refuse cares for Resident #50 when they worked Hall 4 together and Staff D would go and help Resident #50.

During an interview on 6/20/24 at 12:24 PM, Staff I, CNA stated she worked with Staff H she witnessed an incident when Staff H found out about Resident #50 talking with another resident and Staff H went into Resident #50 room and in a

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loud voice told Resident #50 she should be ashamed of herself and should be grieving for her husband.

Staff I stated she witnessed another incident when Staff H performed incontinent cares on Resident #50 and asked the resident why she didn't use the bed pan and Staff H told the resident if they could work a phone, they could use a bed pan. Staff I stated after the comment, Resident #50 told Staff H to shut up and get out of her room and from then on Staff H refused to do cares on Resident #50. Staff I stated she helped Staff H with a mechanical lift with a resident and Staff H called the resident lazy because he needed to stand up and needed their help. Staff I stated Staff H knew what she did because she made comments not to say anything to anyone because Staff H didn't want moved from her hall. Staff I stated she never told anyone until she was pulled into the office because she thought it couldn't have been the first time Staff H spoke to the resident that way. Staff I stated this was her first CNA job and didn't know what to say and maybe she was wrong.

During an interview on 6/20/24 at 4:06 PM, the DON stated Staff H exhibited behaviors were not appropriate for the facility and she wished the staff would of came to her sooner. The DON confirmed she would of liked the staff to come to her soon and they completed education on abuse and even if the staff unsure if abuse to still report it. She stated the staff knew how to report and to report as soon as possible.

The Facility Abuse Policy dated 7/19 revealed the following information:
a. All allegations of resident abuse, neglect,

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F 607	Continued From page 13 exploitation, mistreatment, injuries of unknown origin and misappropriation should be reported immediately to the charge nurse. The charge nurse responsible for immediately reporting the allegations of abuse to the Administrator, or designated representative.	F 607		
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 staff interview, clinical record review, and facility policy review, the facility failed to ensure documented assessment of pain and symptoms timely upon presentation for one of one resident reviewed for professional standards of practice (Resident #109). The facility reported a census of 59 residents. Findings include: Review of the Minimum Data Set (MDS) assessment for Resident #109 revealed the resident was rarely to never understood. Per the mobility section of the MDS assessment, Resident #109 was dependent for chair/bed-to-chair transfer. The Care Plan dated 9/24/21 revealed the resident has impaired cognitive function/dementia or impaired thought processes r/t (related to) Alzheimer's.	F 658		

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The Progress Note authored by Staff K, Registered Nurse (RN), dated 5/10/24 at 12:36 PM revealed, CNA's (Certified Nursing Assistants) notified this nurse that resident's right knee swollen. Upon assessment resident's knee swollen without redness or warm to the touch.

The Health Status Note dated 5/10/24 at 12:37 PM revealed, [Name Redacted] ARNP (Advanced Registered Nurse Practitioner) notified of resident's right knee swollen without redness or warmth to the touch. No new orders.

Review of the Encounter Note by the Nurse Practitioner, date of service 5/13/24, revealed, Patient being evaluated today with concerns of swelling in her right knee and now apparent bruising. It was reported on 5/10 it was mildly edematous without redness or warmth. Patient was not exhibiting any pain behaviors at that time.

The Health Status Note dated 5/10/24 at 12:38 PM revealed, [Name Redacted], resident's daughter/POA (Power of Attorney) notified of resident's swollen knee. [Name Redacted] voices understanding.

Review of the ED (Emergency Department) Note-Physician dated 5/13/24 at 5:06 PM documented, in part, [Family] report noticing increasing right knee swelling and patient acting "off" since since Friday.

On 6/19/24 at 5:45 PM, Staff K, Registered Nurse (RN) explained she worked with the resident on Friday, Saturday, and Sunday. Per Staff K, she worked that weekend and we noticed Resident #109's knee was swollen. Staff K explained she got ahold of [ARNP name redacted]. Per Staff K,

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the resident seemed to be in some discomfort and was not herself. Staff K further explained on Saturday, there was very light purple bruising up on the resident's thigh, and on Sunday it was a little more discolored. Staff K explained on Saturday the resident didn't seem to be in as much discomfort as Friday, on Sunday was more herself, and on Sunday the resident even ate. Staff K explained on Friday the resident did not eat, and the resident ate some on Saturday, and on Sunday the resident ate and seemed more herself and did not seem to be in discomfort.

Staff K further explained on Saturday and Sunday the resident's knee was not as swollen as on Friday. Per Staff K, on Friday they noticed her knee was swollen and in discomfort, which was when assessment done and [ARNP name redacted] notified. When queried if the resident fell on Staff K's shift Friday, Saturday, or Sunday, Staff K responded no. Per Staff K, the resident hadn't fallen for a long time. When queried if anything had been reported to Staff K from midnight to day shift (Staff K's shift), Staff K responded no, not that she recalled.

On 6/20/24 at 3:52 PM, the facility's Director of Nursing queried when the resident first started to have pain, and explained she would need to look at the notes. When queried where she would look, the DON responded the progress notes. When queried if that was where staff would chart the pain, the DON responded yes. When queried about a pain score, the DON responded if giving pain medicine would do that, and the DON's standard would be if having pain to treat the pain. The DON explained effectiveness of pain medicine would not be charted if scheduled medication, and would be done if PRN (as

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F 658	Continued From page 16 needed). Review of the Registered Nurse Job Description, undated, revealed, 17. Perform and document comprehensive assessments of each resident.	F 658		
F 692 SS=D	Nutrition/Hydration Status Maintenance CFR(s): 483.25(g)(1)-(3) §483.25(g) Assisted nutrition and hydration. (Includes naso-gastric and gastrostomy tubes, both percutaneous endoscopic gastrostomy and percutaneous endoscopic jejunostomy, and enteral fluids). Based on a resident's comprehensive assessment, the facility must ensure that a resident- §483.25(g)(1) Maintains acceptable parameters of nutritional status, such as usual body weight or desirable body weight range and electrolyte balance, unless the resident's clinical condition demonstrates that this is not possible or resident preferences indicate otherwise; §483.25(g)(2) Is offered sufficient fluid intake to maintain proper hydration and health; §483.25(g)(3) Is offered a therapeutic diet when there is a nutritional problem and the health care provider orders a therapeutic diet. This REQUIREMENT is not met as evidenced by: Based on clinical record review, observations, and staff interviews review the facility failed to ensure residents maintained acceptable nutritional standards and identify a weight loss, for one resident (Resident #31) out of three residents reviewed for weight loss. The facility reported a census of 59 residents.	F 692		

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Findings include:

The Minimum Data Set (MDS) assessment dated 5/1/2024 for Resident #31 identified a Brief Interview for Mental Status (BIMS) score of 99 indicating a severe cognitive impairment. The MDS revealed the resident required supervision and set up assistance with eating and drinking. The MDS documented diagnoses that included unspecified dementia, severe, without behavioral disturbance, metabolic encephalopathy, and acute kidney failure. The MDS revealed the resident requires supervision or touching assistance when eating including verbal cues and/or touching, steadying and/or contact guard.

The Care Plan, dated 5/6/2024, included a focus area to maintain adequate nutritional status as evidenced by maintaining weight, no signs or symptoms of malnutrition and consuming at least 50% of at least 3 meals daily through the review date. The directives for staff included to monitor/record/ report to MD as needed for signs or symptoms of malnutrition, emaciation, muscle wasting, significant weight loss: 3 lbs (pounds) in a week, >5% in 1 month, >7.5% in 3 months, >10% in 6 months. Obtain resident weights per facility protocol, provide assistance with meals as needed and to provide and serve diet as ordered and to monitor intake and record each meal.

On 6/19/24, a review of Weights and Vitals documentation revealed the following results: On 4/30/24, Resident #31 weighed 152.3 pounds, and on 5/27/24 the same resident weighed 141.4 which is a 7.16% weight loss in one month.

During an observation on 06/19/24 at 5:44 PM,

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Resident #31 sat in the dining area with other residents. The resident took small bites of her meal on her own. Staff M, Licensed Practical Nurse (LPN), revealed sometimes the resident will eat on her own, it depends what mood she is in. Sometimes verbal prompting works and other times she needs to be fed.

During an interview on 06/19/24 at 5:55 PM, the Director of Nursing, (DON) stated she does not believe there are any weight loss concerns with Resident #31. Upon review of the Resident #31's file the DON stated the weight loss did not trigger in the facility notes and it should have triggered since it was over a 5% weight loss in one month. The DON then checked dietician notes and did not see anything about a weight loss concern. She stated she was now able see there was a significant loss in that one month period. Sometimes she eats sometimes she doesn't. Sometimes we put the food on the silverware for her and sometimes she won't eat that way either. The resident gets a snack at night. The resident is not on any supplementals. The DON advised a change of 3 pounds either direction needs to be reported to the nurse for reweigh. Somehow we missed this. The DON shared they had started to see some outliers with resident's weights and they have implemented weighing all residents on the same scale and if the resident is high risk for weigh loss or has a weight loss concern they are now weighed more frequently. They have also implemented weekly weight loss meetings and anyone triggering as a concern or any resident they have weight loss concerns with are discussed at the meeting. The DON stated she is upset that this resident's weigh loss was not caught. We have a system that didn't trigger and staff didn't catch it either.

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F 692	Continued From page 19 During an interview on 06/20/24 at 8:40 AM, the facility Registered Dietitian, (RD) stated she had been with the facility since October of 2023. Upon request, she was able to review her documentation and advised she was not aware of a weight loss concern with this resident. The RD advised most of her work is done offsite but she does come to the facility on a quarterly basis and is present remotely for the weekly weight meeting. She has never met this resident. If for some reason the facilty electronic health record (EHR) system does not trigger a significant weight loss, more than 5% in one month, she stated she would think someone would catch it when they enter the weights. During an interview on 06/20/24 at 1:18 PM, the Dietary Manager, (DM) stated his spreadsheets will trigger if a resident is outside of the normal or acceptable guidelines for weight gain or weight loss. During our weekly weight meetings we go through any triggers that have come up in the EHR. If there is a weight loss or gain greater than 5 percent that resident would be discussed in the weekly weight loss meetings. The DM advised he believes this resident's weight loss had been discussed in a previous weight loss meeting but is unable to locate any documentation regarding this. He then advised somehow we must of her of missed her. The DM is not sure how a situation like this would be handled if it didn't automatically trigger in the facility's system. During an interview on 06/20/24 at 2:15 PM, the Director of Nursing stated she now realized the system had triggered the significant weight loss for Resident #31 and she had somehow inadvertently deleted it in error.	F 692		

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F 692	Continued From page 20 The facilty lacked a policy regarding weight loss.	F 692		
F 725 SS=D	Sufficient Nursing Staff CFR(s): 483.35(a)(1)(2) §483.35(a) Sufficient Staff. The facility must have sufficient nursing staff with the appropriate competencies and skills sets to provide nursing and related services to assure resident safety and attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident, as determined by resident assessments and individual plans of care and considering the number, acuity and diagnoses of the facility's resident population in accordance with the facility assessment required at §483.70(e). §483.35(a)(1) The facility must provide services by sufficient numbers of each of the following types of personnel on a 24-hour basis to provide nursing care to all residents in accordance with resident care plans: (i) Except when waived under paragraph (e) of this section, licensed nurses; and (ii) Other nursing personnel, including but not limited to nurse aides. §483.35(a)(2) Except when waived under paragraph (e) of this section, the facility must designate a licensed nurse to serve as a charge nurse on each tour of duty. This REQUIREMENT is not met as evidenced by: Based on observation, clinical record review, and staff interview, the facility failed to ensure adequate number of staff to assist residents with dining for two of two residents reviewed for dining	F 725		

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assistance (Resident #20, Resident #40). The facility reported a census of 59 residents.

Findings include:

a. Review of the Minimum Data Set (MDS) assessment dated 4/4/24 for Resident #20 revealed the resident had severely impaired cognitive skills for daily decision making, and required partial/moderate assistance for eating.

b. Review of the MDS assessment for Resident #40 dated 4/18/24 revealed the resident scored 5 out of 15 on a Brief Interview for Mental Status (BIMS) exam, which indicated severely impaired cognition. Per this assessment, the resident required supervision or touching assistance for eating.

Observation conducted on 6/19/24 in the dining room closest to the front of the facility revealed the following:

a. 8:38 AM: Resident #20 and Resident #40 present in the dining room without assistance or food present. The residents did not have staff present at their table.

b. 8:43 AM: Resident #20 and Resident #40 at table without staff present,

c. 8:44 AM: Resident #20 and Resident #40 both appeared to be resting in their chairs at the table.

d. 8:52 AM: Resident #40 requested some chocolate milk. Staff N, Dietary Staff, asked another staff who was assisting another resident if she could get the resident chocolate milk, and response provided was to wait.

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g. 8:55 AM: Resident #40 at table with no food or drink in front of them.

h. 8:56 AM: Resident #20, present at the table with Resident #40, had a glass in front of them, and nothing else.

i. 8:59 AM: Staff N provided a drink to Resident #40, then walked away. The resident did not have food at the time of observation.

j. 9:04 AM: Staff N asked Resident #40 if they wanted their glass thrown away, and took the resident's glass.

k. 9:09 AM: Resident #20 served food, and a staff member got a clothing protector for Resident #20.

l. 9:11 AM: Resident #20 observed with food in front of them, but staff not present. At 9:12 AM, a staff member asked Resident #20 if they were hungry. Resident #40, present at the same table, did not have food or drink and looked toward Resident #20.

m. 9:14 AM: Staff N provided another drink to Resident #40.

n. 9:15 AM: Resident #40's tray delivered to the resident.

On 6/19/24 at 6:10 PM, Staff G, Certified Nursing Assistant (CNA) queried about staffing during dining, and responded it was horrible. Staff G responded it was overwhelming because of a lot of people and hard to get everyone attended to. Per Staff G, they used to be able to take a stool and scoot back and forth, but currently when sit

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needed to stay at one spot. Per Staff G, some days it was very hard and some days it was easier. Staff G acknowledged this (dining assistance) as the hardest part of the day. Staff G explained they normally would assist two people, and used one hand for one person and one for another. Staff G explained being told if residents not fed for awhile, told to put the residents in the activity room and turn the television on.

On 6/20/24 at 10:30 AM, Staff E, CNA queried if there were enough staff to assist with dining, and responded sometimes. When queried about wait time for residents who needed assist, Staff E responded they felt like 10 to 15 minutes was too long sometimes, and sometimes once residents were gotten up, sometimes they were put in the activity room before the table, and sometimes they were put at the table. Per Staff E, some residents did have behaviors if they came up too early.

On 6/20/24 at 11:09 AM, Staff F, CNA queried about dining staffing. Per Staff F, the current week was an odd week, and it usually was not like that, usually more. Per Staff F, the current week was odd, and usually everyone helped out. When queried about enough staff to help in the dining room, Staff F responded there was a quirk in one of the days, and someone went home sick.

On 6/20/24 at 3:46 PM when queried as to a time frame for residents to sit at the table without food, drink, or help to eat, the Director of Nursing (DON) explained there was a resident who liked to sit in the dining room early. When queried how long was too long, the DON responded an hour to two hours. Per the DON, concerns with dining staffing had not been reported to her.

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F 758 SS=D	Free from Unnec Psychotropic Meds/PRN Use CFR(s): 483.45(c)(3)(e)(1)-(5) §483.45(e) Psychotropic Drugs. §483.45(c)(3) A psychotropic drug is any drug that affects brain activities associated with mental processes and behavior. These drugs include, but are not limited to, drugs in the following categories: (i) Anti-psychotic; (ii) Anti-depressant; (iii) Anti-anxiety; and (iv) Hypnotic Based on a comprehensive assessment of a resident, the facility must ensure that--- §483.45(e)(1) Residents who have not used psychotropic drugs are not given these drugs unless the medication is necessary to treat a specific condition as diagnosed and documented in the clinical record; §483.45(e)(2) Residents who use psychotropic drugs receive gradual dose reductions, and behavioral interventions, unless clinically contraindicated, in an effort to discontinue these drugs; §483.45(e)(3) Residents do not receive psychotropic drugs pursuant to a PRN order unless that medication is necessary to treat a diagnosed specific condition that is documented in the clinical record; and §483.45(e)(4) PRN orders for psychotropic drugs are limited to 14 days. Except as provided in §483.45(e)(5), if the attending physician or prescribing practitioner believes that it is appropriate for the PRN order to be extended	F 758		

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beyond 14 days, he or she should document their rationale in the resident's medical record and indicate the duration for the PRN order.

§483.45(e)(5) PRN orders for anti-psychotic drugs are limited to 14 days and cannot be renewed unless the attending physician or prescribing practitioner evaluates the resident for the appropriateness of that medication.
This REQUIREMENT is not met as evidenced by:
Based on clinical record review, interviews, and facility policy review the facility failed to ensure targeted behaviors and triggers are identified for the antipsychotic medication olanzapine for 1of 5 residents reviewed for unnecessary medications (Resident #4). The facility reported a census of 59 residents.

Findings include:

The Minimum Data Set (MDS) assessment dated 4/18/24 for Resident #4 listed a Brief Interview for Mental Status (BIMS) score of 15 out of 15, indicating intact cognition, The MDS listed diagnoses included: unspecified dementia, unspecified severity, without behavioral disturbance, psychological disturbance, mood disturbance, or anxiety; non-Alzheimer's Disease; anxiety disorder, and depression. The MDS revealed resident took antipsychotic and antidepressant medications.

The Care Plan, revision date of 4/30/24, included a Focus area to address psychotropic medications, antidepressant, and antipsychotic related to major depressive disorder, generalized anxiety disorder, dementia, adjustment disorder, and unspecified mood disorder. The Interventions

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BIRKWOOD VILLAGE OF FORT MADISON	1702 41ST STREET FORT MADISON, IA 52627

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included monitoring for [medication] side effects, and notification to the nurse or medical doctor for antidepressant and antipsychotic effects.

The Care Plan, dated 8/9/21, included a Focus Area regarding a diagnosis of depression. The Interventions listed included encourage resident to attend activities; the resident enjoyed word searches, coloring, feeding the birds, reading books, playing cats and dogs, and watching squirrels; utilized laptop; enjoyed playing Bingo; and liked spending time outdoors looking at flowers when nice outside; and enjoyed watching sitcoms, westerns, and the Olympics.

The Care Plan lacked information identifying triggers and behaviors with interventions indicating a need for prescribed antipsychotic medications.

The Electronic Medical Record (EMR) revealed the following diagnoses:
a. Unspecified dementia, unspecified severity, without behavioral disturbance, psychotic disturbance, mood disturbance, and anxiety.
b. Adjustment disorder, unspecified.
c. Major depressive disorder, recurrent, severe with psychotic symptoms.
d. Other persistent mood disorders
e. Adjustment disorder with depressed mood
f. Generalized anxiety disorder

The EMR Physician Orders revealed the following medications:
a. topiramate oral tablet 25 mg (milligrams)- give 1 tablet by mouth one time a day
b. topiramate oral tablet 50 mg- give 1 tablet by mouth at bedtime
c. olanzapine oral tablet 2.5 mg- give 1 tablet by

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mouth at bedtime every 2 day(s)
d. sertraline HCl (hydrochloride) oral tablet 100 mg- give 1.5 tablet by mouth at bedtime

During an interview on 6/19/24 at 12:05 PM, Staff C, LPN (Licensed Practical Nurse) stated Resident #4 would get upset and yell at staff. She stated the resident got upset when the staff didn't do what she wanted them to do and something she wanted the staff to do, they couldn't. Staff C stated she went and spoke to Resident #4 when she got upset and explained the CNA were trying to help her, they just couldn't do what she asked because it was not in their job classifications. Staff C stated they documented behaviors every time the resident displayed them on the EMR. Staff C stated the resident got more angry than cried, and when you let the resident vent, the residents behaviors improved.

During an interview on 6/20/24 at 11:03 AM, the MDS Coordinator queried if the resident's behaviors care planned and she stated they went off the residents symptoms. She stated Resident #4 didn't show any issues or behaviors at this time.

During an interview on 6/20/24 at 1:00 PM, the MDS Coordinator stated the olanzapine started prior to admission and they attempted GDR (Gradual Dose Reduction) but didn't know the response. The MDS Coordinator stated the resident struggles to socialize and stayed in her room a lot. She stated the resident visited with staff. The MDS Coordinator asked if the resident displayed any triggers or behaviors and she stated she didn't know off the top of her head but the nurses charted them when the resident displayed them. The MDS Coordinator asked if

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F 758	Continued From page 28 the behaviors were addressed in the Care Plan stated they looked for trends and if they didn't see any behaviors in the 14 day window and since the resident didn't have any behaviors presently, they didn't Care Plan for them. During an interview on 6/20/24 at 4:03 PM, the DON (Director of Nursing) queried on the resident's prescription for olanzapine and asked if the behaviors and triggers needed Care Planned and the DON stated it depended on why they took the medication. The DON queried on the resident's diagnosis of major depressive disorder with psychosis and what the facility looked when with the diagnosis and she stated they looked for self isolation, confusion, paranoia. The DON confirmed the nurses only charted for behaviors when the resident displayed them or had medication changes they needed to monitor. The DON asked if the resident displayed behaviors what interventions the staff did and she stated they would give her space, talk things out with the resident, or do a 1 on 1. The DON confirmed the interventions should be on the Care Plan. The Facility Anti-Psychotics Policy updated 1/23 lacked documentation for antipsychotic to be addressed on the Care Plan for behaviors and interventions.	F 758		
F 759 SS=D	Free of Medication Error Rts 5 Prcnt or More CFR(s): 483.45(f)(1) §483.45(f) Medication Errors. The facility must ensure that its- §483.45(f)(1) Medication error rates are not 5 percent or greater; This REQUIREMENT is not met as evidenced	F 759		

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by:
Based on observation, staff interview, and record review, the facility failed to ensure a medication error rate less than five percent when two medication errors were observed from a total of thirty-two opportunities for 2 of 3 residents reviewed for medication administration (Resident #36, Resident #41). The facility reported a census of 59 residents.

Findings include:

1. Review of the Minimum Data Set (MDS) assessment for Resident #41 dated 3/6/24 revealed the resident scored 12 out of 15 on a Brief Interview for Mental Status (BIMS) exam, which indicated moderately impaired cognition.

The Physician Order dated 2/10/24 revealed, Senna Oral Tablet 8.6 mg (milligram) with instructions to give 2 tablets by mouth one time a day every other day.

On 6/19/24 at approximately 7:20 AM, Staff A, Licensed Practical Nurse (LPN), prepared two Senna Plus, which contained Senna and Docusate Sodium, tabs to administer to the resident. The medications were administered to Resident #41.

2. Review of the MDS assessment for Resident #36 dated 5/23/24 revealed the resident scored 12 out of 15 on a BIMS exam, which indicated moderately impaired cognition.

The Physician Order dated 6/18/24 revealed, Furosemide (also called Lasix) oral tablet 40 mg with instruction to give 1 tablet by mouth two times a day for edema for 3 Days AND Give 1

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F 759	Continued From page 30 tablet by mouth one time a day for edema. On 6/19/24 at approximately 7:36 AM, Staff B, Registered Nurse (RN), prepared Lasix 20 mg to administer to the resident, and administered Resident #36's medications. On 6/19/24 at 7:46 AM, Staff B queried about the resident's Lasix, responded he needs two, prepared another medication, and administered the medication to the resident. On 6/20/24 at 3:42 PM, the facility's Director of Nursing (DON) explained Resident #36 just had a recent increase of the medication. When queried as to how staff verified the correct medication, the DON explained need to compare the pharmacy label on the medication, and if the prescription matched what was in [the electronic health record]. Per the DON, if stock, read the stock bottle to make sure matched the order in the [electronic health record system]. The Facility Policy titled Medication Administration effective 10/10/19 revealed the following: Medications shall be administered per physician order.	F 759		
F 791 SS=D	Routine/Emergency Dental Srvcs in NFs CFR(s): 483.55(b)(1)-(5) §483.55 Dental Services The facility must assist residents in obtaining routine and 24-hour emergency dental care. §483.55(b) Nursing Facilities. The facility- §483.55(b)(1) Must provide or obtain from an outside resource, in accordance with §483.70(g)	F 791		

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of this part, the following dental services to meet the needs of each resident:
(i) Routine dental services (to the extent covered under the State plan); and
(ii) Emergency dental services;

§483.55(b)(2) Must, if necessary or if requested, assist the resident-
(i) In making appointments; and
(ii) By arranging for transportation to and from the dental services locations;

§483.55(b)(3) Must promptly, within 3 days, refer residents with lost or damaged dentures for dental services. If a referral does not occur within 3 days, the facility must provide documentation of what they did to ensure the resident could still eat and drink adequately while awaiting dental services and the extenuating circumstances that led to the delay;

§483.55(b)(4) Must have a policy identifying those circumstances when the loss or damage of dentures is the facility's responsibility and may not charge a resident for the loss or damage of dentures determined in accordance with facility policy to be the facility's responsibility; and

§483.55(b)(5) Must assist residents who are eligible and wish to participate to apply for reimbursement of dental services as an incurred medical expense under the State plan.
This REQUIREMENT is not met as evidenced by:
Based on clinical record review, resident and staff interviews the facility failed to ensure timely dental care for 1 of 1 residents (Resident #6) reviewed. The facility reported a census of 59 residents.

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Findings include:

The Minimum Data Set, (MDS) assessment dated 06/06/2024 Brief Interview for Mental Status (BIMS) score of 13 out of 15, indicating cognitively intact. The MDS diagnoses included Non-surgical Orthopedic/Musculoskeletal, unilateral primary osteoarthritis and chronic diastolic heart failure.

A Health Status Note on 9/9/2023 documented the following: This nurse performed Heimlich maneuver on resident at lunch choking on an onion. After resident was able to breath it took 30 minutes of intervention to get the onion to dislodge. Residents' lungs are currently clear, and she is functioning normally. Checks for aspiration are being placed per shift. Dentures are currently missing for the event and are being searched for. PCP has been notified of the event and received new orders for swallow study and to make mechanical soft until test results. POA voicemail left to return call.

The Care Plan revised on 3/18/24 did not address dental care, dentures or denture replacement.

On 06/18/24 at 9:59 AM an interview with Resident #6 was conducted. The resident stated she choked on a long piece of onion and while she was coughing and vomiting staff told her to take her dentures out and then they lost them. Resident #6 reported staff members looked all over and couldn't find them. The resident shared it was her top dentures only. She can not wear bottom dentures because there is not enough bridge/bone to support them. Resident #6 stated she never the left dining table and they

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disappeared that quickly. The resident reported she was unable to chew so they put her on a pureed diet and she started losing weight. Resident #6 stated it has been at least a year that she has been without her dentures. The resident stated she has since been changed back to a regular texture diet and has gained some weight back.

During an interview on 06/19/24 at 7:54 AM, the Director of Nursing, (DON) stated Resident #6 had lost her dentures and had a change in diet. The DON stated the resident put her dentures in a tissue when she was choking and the dentures disappeared from there. The DON advised, from a medical standpoint it would be common practice to remove the dentures when someone is choking because it a loose object in the resident's mouth. The resident only wore top dentures. The DON stated they have been working with area dentists to get new dentures but no one will accept State benefits. Just recently they found a dental company that will come to the facility to see the residents and she believes Resident #6 is scheduled to see them.

During an interview on 06/20/24 at 12:34 PM, the Social Service Coordinator stated the facility recently started using an outside dental agency that will come to the facility to see the residents. The dental agency started in March 2024 and they were at the facility in March, April, and May. The dentist does all of the dentures and the fillings for the facility. The Social Service staff advised Resident #6 was seen by the dentist in March and an oral cancer screen and gums cleaning was completed. In April, they did impressions for her bottom dentures. On 6/12/24 there was a note from the dentist advising the

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resident has very little bone density for lower dentures so an impression was made for upper dentures. The Social Service staff member advised Resident #6 has seen the dentist all three times they have been to the facility. Prior to March 2024 there was no dental care on site and she believes the resident would have had to go offsite for any dental care.

During an interview on 06/19/24 at 12:36 PM, Staff C, Licensed Practical Nurse (LPN) stated she was present when Resident #6 started choking. Resident #6 had taken her dentures out and set them on the table. After the incident the resident finished eating. Before the resident left the table and the dining room her dentures were missing. She believes dietary staff had already cleared the table. At that time numerous staff members looked everywhere for the dentures and were unable to locate them. The resident was upset that they were missing. Staff advised the resident had been trying to get new dentures prior to the incident and had been asking staff about new ones.

During an interview on 06/20/24 at 9:02 AM, the Registered Dietician, (RD) stated Resident #6 is currently on a general diet, with added mashed potatoes for added nutrition supplement. She advised the resident typically eats only what she wants to. She will not drink the supplements. There was some weight fluctuation. The RD advised when she started at this facility in December 2023 the resident was on a mechanical soft, thin liquids at that time because of the chocking incident and not having her dentures. The RD shared she thinks staff were working on a program to help cover for her dentures. Some of the resident's weight

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F 791	Continued From page 35 fluctuation was likely due to not having dentures. The facility lacked a policy on dentures.	F 791		
F 804 SS=E	Nutritive Value/Appear, Palatable/Prefer Temp CFR(s): 483.60(d)(1)(2) §483.60(d) Food and drink Each resident receives and the facility provides- §483.60(d)(1) Food prepared by methods that conserve nutritive value, flavor, and appearance; §483.60(d)(2) Food and drink that is palatable, attractive, and at a safe and appetizing temperature. This REQUIREMENT is not met as evidenced by: Based on observations, clinical record review, facility policy review, and staff interviews the facility failed to ensure adequate food temperatures prior to service and hold an appropriate after delivering of food to the resident for 2 of 2 dietary services reviewed for food temperatures and for 1 of 1 residents reviewed for food. The facility reported a census of 59 residents. Findings include: During an observation on 6/17/24 Staff B, Dietary Cook took food temperatures with the following results: a. At 11:31 AM - 142 degrees Fahrenheit (F) for the breaded pork chop b. At 11:39 AM - 127 degrees F for the ground up pork c. At 11:45 AM - 165 degrees F after putting the pureed pork on the steam table	F 804		

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Post temperatures taken by Staff B on 6/17/24 at 12:23 PM were as follows:
a. 139.5 degrees F for the breaded pork chop
b. 139.4 degrees F for the fish fillet
c. 150.2 degrees F for the pureed pork

The Minimum Data Set (MDS) assessment dated 5/31/24 listed Resident #29 Brief Interview for Mental Status (BIMS) score as 13 out of 15 on the exam, indicating intact cognition. The MDS revealed the resident needed set up or clean up assistance with eating on admission.

During an interview on 6/17/24 at 3:49 PM, Resident #29 stated the food was terrible, and it just started. She stated when she first came here, the food tasted better, and now it doesn't. She stated the issues with the food were the taste, temperature, and the look of the food. Resident #29 stated the food rarely warm in her dining room. Resident #29 stated the fish she ate today wasn't hot. Resident #29 asked about the flavor and she stated it was as flavorful as something made into a little fish.

On 6/18/24 at 11:46 AM, the Dietary Manager (DM) delivered trays to the 300 Hall in a portable warmer and once when arrived into the dining room plugged the warmer into an outlet.

On 6/18/24 at 11:55 AM, after the delivering the last tray, the DM took the temperatures of a tray with the following results:
a. 121.4 degrees F for the green beans
b. 148.7 degrees F for ham slice

During an interview on 6/19/24 at 10:01 AM, Staff B, Dietary Cook queried on what the

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temperatures of ground meat should be upon serving and he stated the temperature need to be at least 175 to 180 degrees. Staff B stated the temperatures the other day were a little lower than usual. Staff B asked what the temperature of meat and fish needed to be served at and he stated probably 175 degrees. Staff B stated he should of put a lid on the breaded pork when he took it out of oven. Staff B queried on what the holding temperatures for meat were and he stated around 180 degrees. Staff B stated they used warmer plates on hall 3 because in the past the residents stated the food not hot enough.

During an interview on 6/20/24 at 9:20 AM, the DM queried what the food temperatures needed to be on the steam table for meats and he stated his preference was 165 degrees or higher. The DM asked what the expected the vegetable food temperatures on the trays delivered to the hallways and he stated 165 degrees. The DM stated he expected the food being delivered to the halls needed to be at least 135 degrees. The DM confirmed the green beans on the hall tray temped at 121 degrees.

During an interview on 6/20/24 at 4:26 PM, the Interim Administrator stated she expected the food to be at the appropriate temperatures and she would of expected the food to be at least 165 prior to service and had a holding temperature between 155 degrees and 165 degrees.

The Facility Dietary Policies and Procedures dated 4/17 revealed the following information:
a. Hot foods must be served at a minimum temperature of 135 degrees F, preferably at 160 degrees F or higher. Reheated items and pureed items must be heated to 165 degrees F or above.

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F 804	Continued From page 38 b. It was the cook's responsibility to see all the food were at the proper temperature.	F 804		
F 810 SS=D	Assistive Devices - Eating Equipment/Utensils CFR(s): 483.60(g) §483.60(g) Assistive devices The facility must provide special eating equipment and utensils for residents who need them and appropriate assistance to ensure that the resident can use the assistive devices when consuming meals and snacks. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and record review, the facility failed to ensure assistive devices for eating to include a straw were utilized per the resident's diet order for 1 of 2 residents (Resident #8) reviewed for assistive devices for dining. The facility reported a census of 59 residents. Findings include: 1. Review of the Minimum Data Set dated 4/26/24 revealed the resident scored 3 out of 15 on a Brief Interview for Mental Status (BIMS) exam, which indicated severely impaired cognition. The Care Plan dated 10/31/23, revised 6/6/24, revealed the following: NUTRITION: Nutritional status related to need for therapeutic diet due to Dx (diagnosis) of diabetes, changes in texture related to poor dentition and adaptive plate. Hx (history) of significant weight changes. The Intervention dated 10/31/23 revealed, Assistive devices at meals as ordered.	F 810		

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	165227	A. BUILDING _____ B. WING _____	C 06/20/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BIRKWOOD VILLAGE OF FORT MADISON	1702 41ST STREET FORT MADISON, IA 52627

(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 810	Continued From page 39	F 810		

The Nutrition/Dietary Note dated 4/28/24 at 3:38 PM documented by the Registered Dietician (RD) revealed, Meal PO (oral) intake > (less than) 75% at most meals independently after set up help. Uses a plate guard. Goal to encourage fluids, assist, straws preferred vs (versus) cup, pinch straw or take out of mouth to prevent taking more than 2 sips at a time.

The Physician Order dated 12/26/22 revealed, House diabetic diet pureed texture, regular consistency, plate guard, encourage fluids, assist, straws preferred vs cup, pinch straw or take out of mouth to prevent taking more than 2 sips at a time.

Observation on 6/19/24 at 7:26 AM revealed Resident #8 at a table in dining room, and resident observed to drink from a regular cup.

Observation on 6/19/24 at 7:44 AM revealed Resident #8 in the dining room, and the resident had a regular cup.

Observation on 6/19/24 at 11:54 AM Revealed Resident #8 at a table in the dining room with another resident. Resident #8 had a regular cup with no straw in front of them.

On 6/20/24 at 9:37 AM, interview with the Registered Dietician revealed she last saw the resident in April. When queried if the resident was supposed to have a straw, the Registered Dietician said that she would go off of the diet order.

On 6/20/24 at 11:59 AM, Staff D, Certified Nursing Assistant (CNA) explained she believed the resident drank out of a normal cup. When

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F 810	Continued From page 40 queried about whether the resident used straws or not, Staff D explained she was not sure, and further explained dietary should know. Per Staff D, the menu tickets with each meal would say on the bottom if specialized cups, thickened or not. On 6/20/24 at 1:39 PM, the Dietary Manager (DM) queried about use of straws for Resident #8. Per the Dietary Manager, he thought the resident could ask for them, and outside of that not sure. Per the Dietary Manager, that would be the CNAs, and straws were not kept in the kitchen side. On 6/20/24 at 1:45 PM, the Dietary Manager explained there was not anything on the menus about straws. On 6/20/24 at 3:44 PM when queried about the situation, the Director of Nursing (DON) explained it would depend on the wording (of order) if the resident was to have straws or could use straws, and it would depend on the Physician and speech. On 6/20/24 at 4:27 PM, the DON acknowledged not sure how this information would be communicated. The Facility Policy titled Adaptive Self-Feeding Devices, dated 4/17, revealed, When a resident requires adaptive equipment, it will be identified on the nutritional assessment form. Ongoing need and effectiveness will be evaluated by nursing, dietary, and therapies.	F 810		
F 880 SS=E	Infection Prevention & Control CFR(s): 483.80(a)(1)(2)(4)(e)(f)	F 880		

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F 880	Continued From page 41 §483.80 Infection Control The facility must establish and maintain an infection prevention and control program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of communicable diseases and infections. §483.80(a) Infection prevention and control program. The facility must establish an infection prevention and control program (IPCP) that must include, at a minimum, the following elements: §483.80(a)(1) A system for preventing, identifying, reporting, investigating, and controlling infections and communicable diseases for all residents, staff, volunteers, visitors, and other individuals providing services under a contractual arrangement based upon the facility assessment conducted according to §483.70(e) and following accepted national standards; §483.80(a)(2) Written standards, policies, and procedures for the program, which must include, but are not limited to: (i) A system of surveillance designed to identify possible communicable diseases or infections before they can spread to other persons in the facility; (ii) When and to whom possible incidents of communicable disease or infections should be reported; (iii) Standard and transmission-based precautions to be followed to prevent spread of infections; (iv)When and how isolation should be used for a resident; including but not limited to: (A) The type and duration of the isolation,	F 880		

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F 880	Continued From page 42	F 880		

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, interview, and record review, the facility failed to ensure adequate infection control practices implemented during medication administration when staff handled medications, including stock medication and resident specific medication for Resident #38, with bare hands for 1 of 3 residents reviewed for medication administration. The facility reported a census of 59 residents.

Findings include:

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F 880	Continued From page 43 Observation conducted 6/20/24 at approximately 7:31 AM revealed Staff C, Licensed Practical Nurse, prepared medications to administer to Resident #38. Observation revealed Staff C touched the resident's Levitracetam medication and Pregabalin medication with bare hands in the process of putting the medications into the medication cup. Staff C also prepared Calcium with Vitamin D3 to administer to the resident, which was a stock medication. Observation revealed Staff C tipped medications into the top cap of the medication bottle, and when dispensing the medication, Staff C touched a tablet in the medication cap with bare hands. On 6/20/24 at 3:31 PM when queried about picking up a pill and placing it in the cup, the Infection Preventionist explained that was not ok, would borrow from a different day, and would let the pharmacy know so that the borrowed pill could be replaced. On 6/20/24 at 3:40 PM, the Director of Nursing (DON) explained if a pill was dropped it should be replaced. The Facility Policy titled Medication Administration, effective 10/10/19, did not address the area of concern.	F 880		
F 881 SS=D	Antibiotic Stewardship Program CFR(s): 483.80(a)(3) §483.80(a) Infection prevention and control program. The facility must establish an infection prevention and control program (IPCP) that must include, at	F 881		

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F 881	Continued From page 44	F 881		

a minimum, the following elements:

§483.80(a)(3) An antibiotic stewardship program that includes antibiotic use protocols and a system to monitor antibiotic use.
This REQUIREMENT is not met as evidenced by:
Based on clinical review, staff interview, and facility policy review, facility staff failed to follow infection control practices in reducing the use of antibiotics when test results indicate unnecessary or inappropriate antibiotic use. The facility reported a census of 59 residents.

Findings include:

On 6/20/24 The facility Antibiotic Report dated January April and May 2024 was received and reviewed. The facility report documents and tracks the resident's name, hall, room number, diagnosis, antibiotic order, symptoms, physician, antibiotic start date and name or organism. Additionally, as part of this document there is a heading titled, Inappropriate Antibiotic Starts. This documentation and tracking reflects in January 2024 ten residents had inappropriate antibiotic starts, in April 2024 8 residents had inappropriate antibiotic starts and in May 2024 5 residents had inappropriate antibiotic starts. The corrective action documented: Education.

On 6/20/2024 at 11:55 AM The Infection Preventionist, (IP) was queried for additional information regarding reducing the use of antibiotics and reducing or stopping them when a culture comes back negative. She advised she tracks all of the antibiotics prescribed to the residents and tracks the order, diagnostic testing,

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F 881	Continued From page 45	F 881		

results and corrective action. She advised often times the physician will prescribe an antibiotic based on symptoms without having test results. When this happens the resident typically continues to receive the antibiotic for the duration of the prescription. The IP reported she provides education to staff and other professionals regarding McGeer Criteria. The number of inappropriate antibiotic starts has been reduced by 50 percent since January 2024.

On 6/20/24 at 3:46 PM The Antibiotic Stewardship Policy, Long Term Care dated 11-28-17 was received and reviewed. The goal of the Antibiotic Stewardship Program is to promote the appropriate use of antibiotics in order to maximize treatment outcomes and minimize unintended consequences of antibiotic therapy. The Antibiotic Stewardship program aims to improve antibiotic prescribing practices through the development and implementation of antibiotic use protocols and a system to monitor antibiotic use.

Birkwood Village of Fort Madison

1702 41st St.

Fort Madison, Ia. 52627

Date survey completed: 6/20/24

Preparation and/or execution of this plan of correction do not constitute admission or agreement by provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because the provisions of federal and state law require it.

F550

Staff H was terminated at the completion of the facility investigation.

Facility administration reviewed and provided a paper copy of the Abuse Policy and reporting abuse with staff at an All-Staff In-service meeting on 6/27/24.

All staff will complete the CEU (education) module regarding F550. This education module will continue to be required annually for all employees.

DON or designated representative will audit for compliance, identified concerns shall be reviewed by facility QAPI team and recommendations for further corrective actions will be discussed and implemented as needed.

Identified concerns shall be reviewed by the facility's QAPI team. Recommendations for further corrective action will be discussed and implemented as needed.

Date Completed: 7/20/24

F607

Facility administration reviewed and provided a paper copy of the Abuse Policy and reporting abuse with staff at an All-Staff in-service meeting on 6/27/24.

Director of Nursing will periodically question staff regarding the Abuse Policy and any concerns with current staff.

Identified concerns shall be reviewed by the facility's QAPI team. Recommendations for further corrective action will be discussed and implemented as needed.

Date Completed: 7/20/24

F658

If a change in condition is noted with a resident that is unable to make their needs known, PAINAD assessments will be initiated every shift.

Director of Nursing and/or designated representative will periodically audit charts for pain assessment and implementation.

Identified concerns shall be reviewed by the facility's QAPI team. Recommendations for further corrective action will be discussed and implemented as needed.

Date Completed: 7/20/24

F692

Staff education provided on 7/2/24 to not clear significant weight triggers/alerts in Point Click Care.

Staff education provided at All Staff in-service on 6/27/24 on significant weight change and definition.

Director of Nursing or designated representative will audit charts for cleared weight triggers/alerts.

Identified concerns shall be reviewed by the facility's QAPI team. Recommendations for further corrective action will be discussed and implemented as needed.

Date Completed: 7/20/24

F725

Staff education provided during All Staff in-service on 6/27/24 regarding dining room assistance for those residents who need assistance with eating. Staff education will be provided ongoing at daily shift change huddles as well.

Director of Nursing or designated representative will periodically monitor the dining room for evaluation of staff assistance for those residents who require assistance with eating.

Identified concerns shall be reviewed by the facility's QAPI team. Recommendations for further corrective action will be discussed and implemented as needed.

Date Completed: 7/20/24

F758

Resident #4 care plan updated on 7/8/24 identifying triggers and behaviors to indicate the use of anti-psychotic medications.

Director of Nursing or designated representative will periodically monitor care plans for those residents receiving anti-psychotics.

Identified concerns shall be reviewed by the facility's QAPI team. Recommendations for further corrective action will be discussed and implemented as needed.

Date Completed: 7/20/24

F759

Staff education will be provided and completed by 7/26/24 on Rights of Medication Administration.

Director of Nursing or designated representative will periodically audit medication passes.

Identified concerns shall be reviewed by the facility's QAPI team. Recommendations for further corrective action will be discussed and implemented as needed.

Date Completed: 7/20/24

F791

Staff education provided at All Staff in-service on 6/27/24 regarding F791 and requirement for dental referral within 3 days for missing or broken dentures. Staff education provided to notify Administrator and/or Director of Nursing of missing or broken dentures upon discovery.

Identified concerns shall be reviewed by the facility's QAPI team. Recommendations for further corrective action will be discussed and implemented as needed.

Date Completed: 7/20/24

F804

Dietary staff education provided on 6/24/24 about not using the hot box for proteins that need to be hot as they do not keep food hot enough through food service. Staff educated on covering food and placing it in oven if the food is done cooking prior to start of food service. Education provided to cooks on importance of using the plate warmer. Education provided to staff to put food back in the oven if food does not reach proper temperatures while on the steam table.

Dietary Manager or designated representative will periodically do test trays to check for food temperature.

Dietary Manager or designated representative will check cooking equipment monthly to ensure proper operation.

Identified concerns shall be reviewed by the facility's QAPI team. Recommendations for further corrective action will be discussed and implemented as needed.

Date Completed: 7/20/24

F810

All staff provided education at All Staff in-service on 6/27/24 regarding the use of assistive devices and communication on meal tickets.

Dietary staff will include assistive devices on resident meal tickets.

Dietary Manager will periodically audit meal tickets for assistive devices.

Identified concerns shall be reviewed by the facility's QAPI team. Recommendations for further corrective action will be discussed and implemented as needed.

Date Completed: 7/20/24

F880

Staff education provided at All Staff in-service on 6/27/24 regarding medication administration and infection control in regards to handling medications with bare hands.

Infection Preventionist or designated representative will periodically audit medication administration passes.

Identified concerns shall be reviewed by the facility's QAPI team. Recommendations for further corrective action will be discussed and implemented as needed.

Date Completed: 7/20/24

F881

Education provided to staff at All-Staff in-service on 6/27/24 regarding the Antibiotic Stewardship program.

An antibiotic time-out assessment will be implemented as appropriate to review continued usage.

Infection Preventionist or designated representative will monitor prescribed antibiotics for appropriateness.

Identified concerns shall be reviewed by the facility's QAPI team. Recommendations for further corrective action will be discussed and implemented as needed.

Date Completed: 7/20/24