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	165260	A. BUILDING _____ B. WING _____	06/30/2022

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F 000	INITIAL COMMENTS	F 000		
POC OK 7/25/22 SjS	Correction date: 7/20/22 The following deficiencies resulted from the facility's annual recertification survey and investigation of complaints #103634-C, #103520-C, #103981-C, #105289-C conducted on June 27, 2022 to June 30, 2022. Complaints #103981-C and #105289-C were substantiated. Complaints #103520-C and #103634-C were not substantiated. See Code of Federal Regulations (42 CFR) Part 483, Subpart B-C.			
F 656 SS=E	Develop/Implement Comprehensive Care Plan CFR(s): 483.21(b)(1) §483.21(b) Comprehensive Care Plans §483.21(b)(1) The facility must develop and implement a comprehensive person-centered care plan for each resident, consistent with the resident rights set forth at §483.10(c)(2) and §483.10(c)(3), that includes measurable objectives and timeframes to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment. The comprehensive care plan must describe the following - (i) The services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §483.24, §483.25 or §483.40; and (ii) Any services that would otherwise be required under §483.24, §483.25 or §483.40 but are not provided due to the resident's exercise of rights	F 656		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE: Administrator | (X6) DATE: 7/20/2022

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

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F 656	Continued From page 1 under §483.10, including the right to refuse treatment under §483.10(c)(6). (iii) Any specialized services or specialized rehabilitative services the nursing facility will provide as a result of PASARR recommendations. If a facility disagrees with the findings of the PASARR, it must indicate its rationale in the resident's medical record. (iv)In consultation with the resident and the resident's representative(s)- (A) The resident's goals for admission and desired outcomes. (B) The resident's preference and potential for future discharge. Facilities must document whether the resident's desire to return to the community was assessed and any referrals to local contact agencies and/or other appropriate entities, for this purpose. (C) Discharge plans in the comprehensive care plan, as appropriate, in accordance with the requirements set forth in paragraph (c) of this section. This REQUIREMENT is not met as evidenced by: Based on clinical record review, staff interviews, and facility policy review, the facility failed to develop and implement comprehensive care plans that addressed the individual care needs of each resident to assist residents in attaining or maintaining his/her highest practicable level of wellbeing for 4 (Residents #18, #40, #42, and #46) of 11 sampled residents reviewed for activities of daily living (ADLs), dementia care, wounds, and pressure ulcers. The facility reported a census of 48 current residents. Findings included: A review of the facility policy titled, "RAI [Resident	F 656		

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F 656	Continued From page 2 Assessment Instrument]/Care Planning Management," revised August 2021, revealed direction that the Comprehensive Care Plan is completed within seven (7) days after the MDS [Minimum Data Set] is completed (at no time will this time frame exceed 21 days), and reviewed quarterly thereafter. If modifications, deletions, additions are necessary, changes should be made at the time of occurrence. Care plans are to be accessible for clinical staff in order to facilitate care plan interventions or to update as indicated due to resident condition change. The policy also indicated that after the team reviewed the triggered area of concern, a care plan decision would be made. Problems will be identified and written in an interdisciplinary, CAA [Care Area Assessment] integrated format. A discharge plan will be included in the care plan at admission. Goals will be resident specific, measurable and realistic. Interventions will be action verb directed and specific to each resident. 1. A review of Resident #42's Admission Record revealed the facility admitted Resident #42 on 3/25/22 with diagnoses including morbid (severe) obesity due to excess calories and disruption of a wound. Review of a quarterly Minimum Data Set (MDS) assessment dated 6/10/22 revealed Resident #42 scored 15 on a Brief Interview for Mental Status (BIMS), indicating the resident was cognitively intact. The resident required limited assistance of one person for transfers, extensive assistance of one person for dressing, and extensive assistance of two people for toilet use. The MDS identified the resident did not have ulcers, wounds or skin problems at the time of the assessment.	F 656		

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F 656	Continued From page 3 The resident's Order Summary Report, printed 6/29/22, indicated Resident #42 had a physician's order dated 6/21/22 for wound care. The directions were for Vaseline gauze to be cut to size, then covered with Mepilex to the right-side abdominal fold tear daily and as needed (PRN). As of 6/30/22, a review of the resident's care plan, dated as last reviewed on 6/11/22, revealed the resident's wound care and need for assistance with activities of daily living (ADLs) were not addressed on the care plan. During an interview on 6/30/22 at 9:10 AM, Staff K, Certified Nursing Assistant (CNA), stated she knew how to take care of a resident based on what was entered into the care plan. During an interview on 6/30/22 at 10:52 AM, Staff H, the MDS Coordinator, stated she was made aware of what needed to be placed on the care plan by the assessments the Director of Nursing (DON) input into the system upon admission. Staff H stated the facility also a white board that she monitored when there was a new admission or a change in a resident's condition, such as a fall or if a resident was placed on antibiotics. Staff H stated the comprehensive care plan was completed to make sure all the care areas were listed on the resident's care plan, so the resident would be cared for properly. Staff H acknowledged the area of ADL assistance as not included on Resident #42's care plan and stated she did not know why it had not been included. During an interview on 6/30/22 at 12:02 PM, the DON stated the care plan process for newly admitted residents consisted of completing a	F 656		

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F 656	Continued From page 4	F 656		

baseline care plan within 48 hours, completing the entry MDS, and then completing the care plan within seven days. She indicated the care plan was reviewed quarterly and with any change in condition, or when anything changed or was added. The DON stated she was made aware of what needed to be on the care plan during the morning meetings and by looking at the white board in the Administrator's office. She indicated the MDS Coordinator brought her computer to the morning meetings and entered information into the care plan to ensure accuracy. The DON revealed someone from the corporate office and a nurse consultant performed oversight of the care plans. She indicated the corporate office staff informed her and the facility about two weeks ago there were some care plans that needed to be updated, but it had not been completed yet. The DON stated that wounds and ADLs should be on the care plan, and she expected for the care plans to be completed with all areas of concern for a resident.

During an interview on 6/30/22 at 2:15 PM, the Administrator stated he would expect the care plan to contain ADLs and any wounds.

2. Review of an Order Summary Report, printed 6/29/22, revealed Resident #40 had diagnoses including Parkinson's disease, tremor, and vascular dementia.

Review of the MDS assessment dated 6/13/22 revealed Resident #40 scored 6 on a Brief Interview for Mental Status (BIMS), indicating the resident had severe cognitive impairment. The MDS recorded Resident #40 required extensive assistance of one person for bed mobility, transfer, locomotion, dressing, and toilet use.

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F 656	Continued From page 5 Resident #40's Care Plan, dated as last reviewed on 6/28/22, revealed the resident's need for assistance with ADLs was not addressed on the care plan. 3. Review of a significant change MDS assessment, dated 6/16/22, revealed Resident #46 had a diagnosis of Alzheimer's disease and scored 4 on a BIMS, indicating the resident had severe cognitive impairment. Per the MDS, the resident had no behavioral symptoms during the assessment period. The Care Area Assessment (CAA) Summary, electronically signed by the DON on 6/20/22, revealed Cognitive Loss/Dementia triggered as a care area for further assessment. Column B of the CAA Summary indicated this care area was to be addressed in the resident's care plan. A review of Resident #46's Care Plan, dated as last reviewed 6/22/22, revealed the care plan did not address the resident's care related to Alzheimer's disease. During an interview on 6/30/2022 at 10:42 AM, Staff H stated the comprehensive care plan should capture all areas to guide the team when caring for the resident. The MDS Coordinator was unable to provide evidence that ADLs were careplanned for Resident #40, nor that Alzheimer's disease management was care planned for Resident #46. Staff H stated both of the residents had special needs, and their care plans were not developed, stating that was her mistake. The MDS Coordinator further stated that she had been in her current role since January 2022 and had been provided with some training with the corporate office and the DON but was	F 656		

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F 656	Continued From page 6 unfamiliar with the Care Area Assessments (CAAs) and how they related to the comprehensive care plan. During an interview on 6/30/22 at 12:05 PM, the DON was unable to explain why a care plan for dementia care/Alzheimer's disease was not developed for Resident #46, nor why a care plan for ADLs was not developed for Resident #40. The DON stated the ADLs and dementia care should be documented on the comprehensive care plan. On 6/30/22 at 2:15 PM, the Administrator stated he would expect that all areas pertaining to the care of a resident be reflected in the comprehensive care plan. He indicated he was unaware that there were areas that were not addressed for Resident #40 and Resident #46. 4. Review of Resident #18's Face Sheet revealed the facility admitted the resident with diagnoses including acute and chronic respiratory failure, chronic obstructive pulmonary disease (COPD), schizoaffective disorder, spina bifida, bitten or stung by nonvenomous insect, sepsis, and diabetes mellitus. Review of Resident #18's admission MDS assessment, dated 5/10/22, revealed the resident was cognitively intact as evidenced by a BIMS score of 14 out of 15. Per the MDS, the resident required total assistance from staff for all ADLs except self-feeding for which the resident required set-up assistance only. The MDS noted Resident #18 was at risk for the development of pressure ulcers, but the assessment did not indicate the presence of any unhealed pressure ulcers on admission.	F 656		

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F 656	Continued From page 7 Review of a physician order dated 6/1/22 directed staff to apply a collagen sheet (applied as adjunct wound healing therapy to promote healing) then hydrogel (a dressing providing moist wound healing and scab prevention) to wounds on Resident #18's buttocks, then to cover both with Mepilex (foam absorbent dressing) and change daily and pro re nata (PRN; as needed) if soiled. The resident's care plan, dated 5/3/22, contained interventions regarding bowel incontinence, full code status, leisure activities, ADL assistance, fall risk, diuretic therapy, pain medication, psychotropic medication, anxiety medication, and urostomy. Further review revealed no care plan interventions related to pressure sores or skin breakdown. An interview on 6/29/22 at 12:07 PM with Staff B, Licensed Practical Nurse, revealed she had never reconciled orders and thought management was responsible for that. Staff B stated when a resident admitted to the facility, the floor nurse completed a full head-to-toe assessment and checked vital signs and the resident's skin. Staff B stated she completed Resident #18's admission on 5/3/22 and completed a head-to-toe assessment of the resident. Staff B stated that, on or about 5/17/22, a night nurse reported a sore on Resident #18's buttocks had some black tissue and Staff B asked how they were treating it. During an interview on 6/30/22 at 10:24 AM, Staff H stated that for a new admission, the DON or MDS Coordinator initiated a baseline care plan immediately. The MDS Coordinator stated the care plan was updated when there were any changes in a resident's condition. Staff H, MDS	F 656		

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F 656	Continued From page 8 Coordinator stated morning meetings were held daily, noting the facility also had a white board at the nurses' station that listed weights, wounds, falls, and laboratory testing/results, but she was not sure if the white board was updated daily. The MDS Coordinator stated care plans were reviewed quarterly or when a new order was entered into Point Click Care (PCC). Per the MDS Coordinator, the DON let her know during morning meetings when a care plan needed to be updated. The MDS Coordinator stated there was not any system in place to catch if an order was not entered or an assessment was not completed to ensure care plans were updated. The MDS Coordinator stated it was her understanding that a care plan was important because it listed what care should be provided for the residents. The MDS Coordinator stated she did not know the meaning of a CAA process. The MDS Coordinator stated Resident #18 should have wound care directives on the care plan, confirmed such directives were not on the care plan, and was not sure how or why such directives were missed. An interview on 6/30/22 at 11:54 AM with the DON revealed a baseline care plan should be completed within 48 hours of a resident's admission. The DON stated the MDS Coordinator completed the entry and the facility then had seven days to complete the comprehensive care plan. The DON stated care plans were reviewed quarterly and after any change in condition. The DON stated that during morning meetings, any changes in a resident's condition were discussed. The DON stated the MDS Coordinator had her computer with her during the meetings and care plans were to be updated in real time during those meetings. The DON stated she spoke with	F 656		

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F 656	Continued From page 9 the MDS Coordinator about the issues with care plans not being implemented or revised, and the MDS Coordinator told her she was unsure of what she was doing but was afraid to ask for assistance. The DON stated corporate and regional staff reviewed care plans periodically but there were no set timeframes or residents who were reviewed. Per the DON, facility staff sent weekly updates to corporate staff to inform them which residents had any changes so they could review the care plans. The DON stated the facility was notified by corporate staff two weeks prior that some care plans needed updating, but she said they did not identify specific residents, only noting that care plans needed to be reviewed. The DON stated she was unaware that wound care directives were not care planned for Resident #18 and stated that wounds should be care planned and she was not sure how it was missed. An interview on 6/30/22 at 2:14 PM with the Administrator revealed he expected staff to include wound care directives on a resident's care plan.	F 656		
F 657 SS=D	Care Plan Timing and Revision CFR(s): 483.21(b)(2)(i)-(iii) §483.21(b) Comprehensive Care Plans §483.21(b)(2) A comprehensive care plan must be- (i) Developed within 7 days after completion of the comprehensive assessment. (ii) Prepared by an interdisciplinary team, that includes but is not limited to– (A) The attending physician. (B) A registered nurse with responsibility for the resident.	F 657		

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F 657	Continued From page 10 (C) A nurse aide with responsibility for the resident. (D) A member of food and nutrition services staff. (E) To the extent practicable, the participation of the resident and the resident's representative(s). An explanation must be included in a resident's medical record if the participation of the resident and their resident representative is determined not practicable for the development of the resident's care plan. (F) Other appropriate staff or professionals in disciplines as determined by the resident's needs or as requested by the resident. (iii)Reviewed and revised by the interdisciplinary team after each assessment, including both the comprehensive and quarterly review assessments. This REQUIREMENT is not met as evidenced by: Based on clinical record review, staff interviews, and facility policy review, the facility failed to review and revise the comprehensive care plans for two of five residents (Residents #36 and #40) reviewed for care plans related to falls. The facility identified a census of 48 current residents. Findings include: The facility's policy titled, 'RAI [Resident Assessment Instrument]/Care Planning Management,' revised August 2021, instructed the Comprehensive Care Plan is completed within seven (7) days after the MDS was completed (at no time will this time frame exceed 21 days), and reviewed quarterly thereafter. If modifications, deletions, additions were necessary, changes should be made at the time of occurrence. Modifications are made by deleting the item in the electronic medical record and	F 657		

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adding the new information. The Interim Baseline care plan will be the guide for the comprehensive care plan.

1. Review of Resident #36's quarterly Minimum Data Set (MDS) assessment dated 6/9/22 revealed Resident #36's cognitive skills for daily decision making were severely impaired, according to the Staff Assessment for Mental Status. According to the MDS, Resident #36 had not had any falls since the prior assessment, which was dated 3/15/22.

Review of Resident #36's incident reports revealed the resident had experienced four falls. The resident's falls included the following:
a. On 4/14/22, Resident #36 had a witnessed fall while attempting to walk without a walker. There was no injury.
b. On 4/17/22, Resident #36 was found on the floor. There was no injury.
c. On 5/7/22, Resident #36 was found lying on their stomach with a skin tear to their finger.
d. On 6/14/22, Resident #36 missed the chair when sitting down and landed on the floor. There was no injury.

Review of Resident #36's comprehensive care plan, created 6/14/22 and revised 6/28/22, indicated the resident was at risk for falls and fell on 6/14/22. Interventions included education given to the resident regarding the need to use chairs that have the arm rest on them so the resident could reach back to the chair and lower (initiated 6/28/22), staff should attempt to guide the resident to a sofa or recliner to sit in (initiated 6/14/22), and to ensure the call light was available to the resident (initiated 6/22/22).

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Resident #36 also had a care plan, initiated 10/06/20 and revised 7/19/21, indicating the resident was at a high risk for falls related to confusion, gait/balance problems, vision problems, and being unaware of safety needs. A review of the interventions revealed there had been no revisions to the interventions since 6/10/21.

Further review of Resident #36's comprehensive care plan did not reveal any further entries or interventions for the falls of 4/14/22, 4/17/22 and 5/7/22.

The facility provided fall incident reports for Resident #36 for falls dated 4/14/22, 4/17/22, 5/7/22, and 6/14/22. The incident report dated 4/17/22 indicated the immediate action taken following the fall included assisting the resident to bed and removing the fall mat from the bedside floor to allow a clear path for mobility. The incident report dated 5/7/22 indicated the immediate action taken following the fall included notice to the physician of the fall and the resident's low blood pressure. The physician gave orders to include additional directions to the antihypertensive medication.

During interview on 6/29/22 at 12:06 PM, Staff B, Licensed Practical Nurse (LPN) stated that when a resident fell, the role of the nurse was to check for injury, measure vital signs, and complete neurological checks (if an unwitnessed fall or if the resident hit their head). The information about the resident fall was communicated to the oncoming nursing staff and the certified nursing assistants (CNAs) and posted on the white board in the nurse's station. Staff B further stated that once the incident report was opened, both the

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	165260	A. BUILDING _____ B. WING _____	06/30/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ASPIRE OF DONNELLSON	901 STATE STREET DONNELLSON, IA 52625

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Director of Nursing (DON) and Administrator (ADM) had to sign off on the report and therapy was usually involved. Staff B stated that she would normally try to determine the cause of the fall and initiate an intervention, but she was not sure of the facility policy. Staff B further stated that the DON and MDS Coordinator updated the care plans following a fall. Staff B stated she had never been educated on the care plans whenever a resident fell, staff notified the DON. Staff B stated if a fall happened off shift, the staff called the DON and let her know what occurred. Staff B stated that Resident #36 was a fall risk, mainly due to their dementia, often forgetting to use their walker, and needed constant reminders. Staff B further stated she was not familiar with the care plan interventions for Resident #36.

On 6/29/22 at 3:15 PM, Staff C, CNA stated that Resident #36 had good days and bad days and the resident had lots of falls related to not using their walker. Staff C stated that Resident #36 had been told and knew to make sure their walker was in front of or right beside them.

2. Review of Resident #40's annual MDS assessment dated 6/13/22 revealed Resident #40 was severely cognitively impaired with a Brief Interview for Mental Status score of 6. The assessment documented Resident #40 had two or more falls with no injuries since the previous assessment.

A review of Resident #40's clinical record revealed the resident fell 13 times between 2/23/22 and 5/25/22. All falls were without injury.

A review of Resident #40's comprehensive care plan, revised 6/28/22, revealed the resident was

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F 657	Continued From page 14 at a high risk for falls related to gait/balance problems. The resident fell on 4/17, 5/10, 5/14 and 5/25/22. There were interventions following those four falls that included: a. Schedule an appointment with a mental health provider to address resident's increased agitation and increased behaviors (initiated 4/18/22). b. Offer snacks (initiated 6/28/22). c. Place fall mat on day room floor and have the resident sleep there so that way the resident will be able to be watched closely by staff. That would make it very difficult for the resident to fall since the resident was unable to get up independently from the floor (initiated 5/15/22). d. Increase frequency of offering resident to go to the bathroom (initiated 6/28/22 but related to a fall on 5/25/22). Additional interventions included anticipating and meeting the resident's needs (initiated 10/28/21), a therapy screen for a fall on 2/7/22 (initiated 2/7/22), following facility fall protocol (initiated 10/28/21), and providing diversional activities as tolerated (initiated 11/22/21). Further review of Resident #40's comprehensive care plan revealed the care plan did not include any other interventions to prevent Resident #40 from further falls following the other nine falls the resident had between 2/23/22 and 5/25/22. During interview on 6/29/22 at 1:41 PM, Staff D, LPN stated she did not know who did the root cause analysis following a fall; she assumed it was done on the care plan. Staff D further stated the DON, MDS Coordinator, and the ADM met every morning to review clinical information and she assumed that falls were part of that discussion. Staff D was unable to state who identified and initiated interventions following a	F 657		

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fall but that the nursing staff received a report sheet and the DON or MDS Coordinator would put interventions on the report sheet. Staff D stated that Resident #40 had a lot of falls. The staff were unable to watch the resident closely enough to prevent falls, and despite adjusting medications and initiating fall mats, Resident #40 continued to be at risk for falls.

On 6/29/22 at 3:21 PM, Staff C, CNA stated that Resident #40's falls had decreased a lot recently. The resident had Parkinson's disease and the disease was getting worse. Staff C stated the resident had an intervention to place the fall mats on the floor as the resident's preference was to lie or sit on the floor.

During interview on 6/30/22 at 11:06 AM, Staff H, MDS Coordinator reviewed the falls for Residents #36 and #40. Staff H stated she could not speak to why all the falls were not addressed at the time of the falls. Staff H stated all falls were discussed at the morning meeting and the care plan should be updated at that time. Any interventions should be addressed in the fall incident reports. Staff H further stated she is supposed to put the information on the care plan.

On 6/30/22 at 12:24 PM, an interview with the DON revealed the facility's process for falls required that the nurse complete a 'fall package' and the fall incident report and the DON should be notified. The nurse involved at the time of the fall was required to do an immediate root cause analysis. The interdisciplinary team (IDT) then discussed the fall, identified the interventions, and it was at that moment that staff updated a resident's care plan. The DON was made aware of Resident #36 and Resident #40 did not have

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F 657	Continued From page 16 interventions entered into their comprehensive care plans following multiple falls. The DON did not have a reason as to why the care plans for the residents did not have updates. The DON stated there was no process in house to review that the care plans were appropriately updated. The DON indicated the corporate office did a review and had recently made her aware of care plans that needed reviewing and updating. The DON did not know which specific residents' care plans needed reviewed. During interview on 6/30/22 at 2:15 PM, the ADM stated that when a fall occurred, the DON and ADM were notified, and the expectation was to enter the information into the fall incident report. The ADM further stated that he and the DON both monitored the report to review the interventions. The ADM indicated the IDT discussed falls every day, so the team knew of the interventions in place to prevent falls from happening again. The ADM stated his expectation was that all falls were captured on the comprehensive care plan.	F 657		
F 684 SS=D	Quality of Care CFR(s): 483.25 § 483.25 Quality of care Quality of care is a fundamental principle that applies to all treatment and care provided to facility residents. Based on the comprehensive assessment of a resident, the facility must ensure that residents receive treatment and care in accordance with professional standards of practice, the comprehensive person-centered care plan, and the residents' choices. This REQUIREMENT is not met as evidenced by: Based on clinical record review, facility policy	F 684		

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review and staff interview, facility failed to ensure one resident (#47) of two residents reviewed for skin concerns received treatment and care in accordance with professional standards of practice and the physician's order. Specifically, the facility failed to ensure that Resident #47's necrotic wounds were covered as ordered. The facility identified a census of 48 current residents.

Findings included:

Review of the facility policy titled, 'Physician Services', dated August 2021, revealed the standard of the facility is that all medication and treatment protocols are ordered by the resident's attending physician or designee. No medications, treatments, diet orders, therapy or procedures of any kind are to be administered to a resident without a physician's order. A licensed nurse will review all physicians' orders at the end of each month, to ensure that orders are current, accurate and appropriate. The licensed nurse will verify his or her review through electronic signature in the electronic medical record."

Review of the facility's undated policy titled, 'Skin Management Standard', revealed with necrotic wounds, the protocol directed to clean wounds with an approved cleanser, apply a physician-ordered debriding ointment to a gauze pad and cover the necrotic area making sure the ointment comes in contact with the tissue you wish to debride and to change the dressing as ordered per the physician.

Review of the electronic medical record (EMR) revealed the facility admitted Resident #47 on 6/2/22 and discharged the resident to the hospital on 6/25/22. The resident's diagnoses list listed he

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F 684	Continued From page 18 admitted with diagnoses which included chronic kidney disease and type 2 diabetes mellitus with diabetic nephropathy. There was no diagnosis for wounds. A review of the resident's baseline care plan dated 6/2/22 revealed Resident #47 had skin integrity issues on his right foot (toes), left foot (toes), bilateral (both) heels, and coccyx. The resident's Minimum Data Set (MDS) assessment dated 6/17/22 documented Resident #47 had a Brief Interview for Mental Status (BIMS) score of 13 out of 15, which indicated no cognitive impairment. Further review of the MDS, revealed Resident #47 had one Stage 2 pressure ulcer/injury and two venous or arterial ulcers present. The resident had a diabetic foot ulcer, an infection of the foot, and received application of dressings to the feet. Review of the resident's Inpatient Discharge Instructions from the hospital, printed on 6/2/22, revealed handwritten orders under the Treatments section. These orders included: a. Apply Benadryl daily and leave open to air for wound care for the black areas on bilateral feet. b. Apply mupirocin to the bilateral heels, cover with foam and tape twice daily. Review of the resident's wound care instructions from the wound clinic, dated 6/13/22, revealed the following orders: a. Paint daily with Betadine. This order was for the bilateral toes and distal foot wounds. b. Apply a 50/50 mix of Santyl and mupirocin 2% ointment to the wound bed, cover with foam, secure with tape and change daily. This order was for the right and left heels.	F 684		

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The resident's care plan detail report dated 6/20/22 identified areas of focus that included pressure ulcers, wound care, and infection of the wounds. Interventions directed to provide the resident's wound care per treatment order.

During an interview on 6/28/22 at 1:44 PM, Staff F, CNA (Certified Nursing Assistant) stated that dressings were removed or covered before a shower, and after the shower the nurse would be made aware if the dressing needed to be replaced. Staff F stated Resident #47's dressing would frequently come off and would need to be reapplied.

During an interview on 6/28/22 at 2:09 PM, Family Member #1 revealed Resident #47 admitted to the facility with wounds to the feet and the resident was aware they would need an amputation in the future. Family Member #1 stated they witnessed Resident #47 sitting outside with both feet exposed and no dressing in place to cover the wounds. Family Member #1 observed flies on the wounds. Resident #47 had surgery to amputate a portion of their foot on 6/27/22, but the amputation was initially scheduled to occur on 6/30/22.

The resident's progress note dated 6/24/22 indicated Resident #47 could not sit outside, as the wounds were not stable and the fly infestation of wounds could cause life threatening complications.

During an interview on 6/29/22 at 1:40 PM, Staff D, LPN (Licensed Practical Nurse) stated when Resident #47 admitted to the facility, his toes were black and necrotic. Staff D revealed she

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was aware Resident #47 went outside on one occasion without the foot wounds being covered as ordered by the physician; there was a lapse in time from the shower before the dressing was put back on. Staff D could not identify the amount of time that passed without a dressing in place, but once she became aware Resident #47 was outside without dressings on his feet she went outside and encouraged Resident #47 and Family Member #1 to come back in. Staff D stated she reapplied the dressing when Resident #47 came back into the building. Staff D stated facility staff would be responsible to ensure the resident did not go outside without the wounds being dressed and covered as prescribed by the physician. Staff D indicated a few days after the resident was outside without a dressing applied, she witnessed maggots on the resident's feet.

During an interview with Family Member #2 on 6/30/22 at 10:25 AM, they indicated Resident #47 and Family Member #1 were sitting outside on 6/22/22 when the wounds were left uncovered. On 6/23/022, Family Member #2 stated they witnessed Resident #47 and Family Member #1 sitting outside visiting. One foot was covered, and on the other foot the toes were exposed. Family Member #2 stated that flies were swarming, and they attempted to keep them away when a staff member came out to check on Resident #47. Family Member #2 reported to the staff member the flies were swarming their feet and the staff member brought back a sheet to wrap the resident's feet in.

On 6/30/22 at 12:55 PM, interview with the Director of Nursing (DON) revealed she was not aware of a time that Resident #47 went outside with no dressings applied to his feet. The DON

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F 684	Continued From page 21 indicated Resident #47 did not have an order to keep the toes covered but did have an order for the wounds on the heels to be covered. The DON indicated she would expect staff to follow the treatment orders for wound care. During an interview on 6/30/22 at 2:30 PM, the Administrator indicated it was expected for facility staff to follow physician's orders.	F 684		
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 interviews, record review, and document review, it was determined the facility failed to ensure the safety of Resident #9 during a transfer that resulted in Resident #9 falling to the ground and sustaining a right hip fracture that required surgical intervention. This affected 1 (Resident #9) out of 5 residents reviewed for falls. The facility reported a census of 48 current residents. Findings include: The facility policy titled, "Fall Management Standard," dated June 2017, was reviewed. The policy did not contain information relevant to this deficient practice.	F 689		

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F 689	Continued From page 22 A review of a "Transfer/Discharge Report" revealed Resident #9 had diagnoses that included abdominal aortic aneurysm, displaced subtrochanteric fracture of the right femur, lack of coordination, and dementia with behavioral disturbance. A review of a quarterly Minimum Data Set (MDS), dated 11/25/2021, revealed Resident #9 was cognitively intact as evidenced by a Brief Interview for Mental Status (BIMS) score of 14. Per the MDS, Resident #9 required extensive assistance of two persons with transfers and was totally dependent on two persons for toileting. The MDS noted Resident #9 used a wheelchair for a mobility device. A review of the "MDS Kardex Report For [facility name]," with an assessment reference date (ARD) of 11/25/2021, revealed Resident #9 required extensive assistance of two persons with transfers and was totally dependent on two persons with toileting. The report was accessible to certified nursing assistants (CNAs) in the electronic health record and served to inform CNAs of residents' care needs. A review of Resident #9's care plan, dated 03/03/2021, revealed the resident had an activities of daily living (ADL) self-care performance deficit related to limited mobility. Interventions in place included using the "Stand-EZ" (a sit-to-stand lift) for toileting. The plan noted the resident was dependent on staff for activities of daily living (ADLs). Further review revealed there were no interventions or documentation related to the specific number of staff required for ADLs.	F 689		

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F 689	Continued From page 23 A review of a fall incident report, dated 02/05/2022, revealed that, at 7:30 AM, Staff P, Licensed Practical Nurse (LPN), was called to Resident #9's room by Staff O, CNA, who stated the resident fell during a transfer from the toilet to the wheelchair. The nurse entered the resident's room and observed the resident lying in the bathroom doorway with the resident's head facing the room door and their feet out, lying on the right side. Staff O stated during a transfer with the gait belt and walker, the room door began to close. Staff O let go of resident with one hand to move the door out of their path. At that time, the resident took a step, lost their balance, and fell to the floor. The resident was lifted from the floor to the wheelchair with assistance from Staff O and Staff P and the resident tolerated the transfer well. There were no signs or symptoms of pain noted at that time. At 8:45 AM, the resident was in the dining room eating breakfast and began to yell out in pain. Staff P asked the resident where the pain was located and the resident pointed to their right hip. Staff P dispatched emergency medical services (EMS) for transportation to the hospital for an x-ray of the right hip. At 11:00 AM, Staff P called the emergency room for an update on the resident's condition and was informed that the resident had a right hip fracture and would be admitted to the hospital. A review of "Progress Notes," dated 02/06/2022 at 5:34 AM, revealed the hospital called for follow-up, and Resident #9 had surgery scheduled for Monday (02/07/2022). A review of "Progress Notes," dated 02/09/2022 at 1:30 PM, revealed the facility received a report from the hospital indicating Resident #9 had right	F 689		

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hip pinning on 02/07/2022. The resident required assistance of two staff with pivot transfers and had nine staples to the right hip that were to be removed in two weeks. Resident #9 returned to the facility on this date.

A phone call interview was attempted with Staff P on 06/29/2022 at 2:40 PM. The surveyor called and left a message for Staff P to return the call and that the call was about the incident report completed on 02/05/2022, but the surveyor did not receive a return call.

An interview on 06/29/2022 at 3:03 PM with Staff F, CNA, revealed that, from shift-to-shift, off going CNA staff provided verbal report to oncoming CNA staff regarding any occurrences during the prior shift. She stated CNAs had access to the electronic health record, but noted she was still learning how to use it.

An interview on 06/30/2022 at 8:59 AM with Staff K, CNA, revealed a nurse would have to verbally report a resident's assistance level. She stated there was nothing documented in writing other than in the electronic health record for staff who knew how to access the record. Staff K indicated "a lot" of the staff did not know how to use the electronic health record and the staff would benefit from training since training had not been provided.

An interview on 06/30/2022 at 9:47 AM with Staff O revealed she was a former employee. Staff O stated when she worked at the facility she was aware of a resident's required assistance and current interventions in place by referring to a piece of paper that was hung up in the resident's closet. Staff O stated Resident #9 was a fall risk

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F 689	Continued From page 25 and had a fall mat in place and a low bed. Staff O stated that on 02/05/2022 she was toileting Resident #9 alone and was walking the resident out of the bathroom when the bedroom door hit the bathroom door, knocking both the staff and resident down. Staff O stated Resident #9 required assistance of one staff, to her knowledge, but could not remember if staff specified this anywhere. Staff O thought she may have received some education about providing staff assistance during transfers after the fall occurred, but she could not recall. Staff O stated Resident #9 required the assistance of two persons after the fall on 02/05/2022. Staff O stated nobody told her the required staff assistance changed, and it was never documented, but it was common sense that it should be two people since Resident #9 suffered a broken hip because of the fall. An interview on 06/30/2022 at 11:54 AM with the Director of Nursing (DON) revealed that on 02/05/2022, Staff O was ambulating Resident #9 with a gait belt while toileting the resident when the door shut, and Staff O tried to place Resident #9 on the floor. The DON stated she was called the evening the fall occurred, and Staff O wrote a statement and Staff P provided a nurse's report. The DON stated she did not check to ensure that staff used the right staff assistance, but she reviewed the care plan. The DON stated she did not notice on the MDS that was completed on 11/25/2021 or on the Kardex that Resident #9 was coded as requiring two-person assistance with transfers or toileting. The DON stated staff did not receive any education about ensuring the proper number of staff were assisting with transfers and toileting.	F 689		

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	165260	A. BUILDING _____ B. WING _____	06/30/2022

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F 689	Continued From page 26 An interview on 06/30/2022 at 2:14 PM with the Administrator revealed he was unaware that Resident #9 was coded as requiring two-person assistance with transfers and toileting on the 11/25/2021 MDS. The Administrator also stated he did not remember if the MDS or Kardex was reviewed during the fall investigation. The Administrator stated staff could refer to their electronic health record system or the Kardex to check what type of assistance a resident required. He also stated he agreed that care plans should be more specific and state the exact type and amount of staff assistance that was required with transfers and toileting.	F 689		
F 812 SS=E	Food Procurement,Store/Prepare/Serve-Sanitary CFR(s): 483.60(i)(1)(2) §483.60(i) Food safety requirements. The facility must - §483.60(i)(1) - Procure food from sources approved or considered satisfactory by federal, state or local authorities. (i) This may include food items obtained directly from local producers, subject to applicable State and local laws or regulations. (ii) This provision does not prohibit or prevent facilities from using produce grown in facility gardens, subject to compliance with applicable safe growing and food-handling practices. (iii) This provision does not preclude residents from consuming foods not procured by the facility. §483.60(i)(2) - Store, prepare, distribute and serve food in accordance with professional standards for food service safety. This REQUIREMENT is not met as evidenced by:	F 812		

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F 812	Continued From page 27 Based on observations, staff interviews, and facility policy review, the facility failed to ensure food was labeled and dated as to when it was received and opened, that bread was discarded when beyond its shelf life, and that dietary staff changed gloves between dirty and clean tasks to prevent potential food borne illness for 47 residents who received food from the kitchen. The facility identified a census of 48 residents. Findings included: The facility's policy titled 'Chapter IV Food Production Management', dated 2014 instructed under the Prevention of Contamination Guidelines to wash hands before handling any food or when you are beginning any food preparation procedure. Hands should be washed regularly using proper procedure for handwashing. The policy also instructed to always use a clean, appropriate serving utensil to serve food - never use your hand. If hands must be used (i.e. [such as] for sandwiches, cookies, etc. [et cetera]), wear clean disposable gloves. A food storage policy was requested from the Dietary Supervisor but not received. 1. Observations during the initial tour of the kitchen on 6/27/22 at 10:04 AM revealed the following concerns in the dry storage area: a. One opened package of hamburger buns dated as expired on 6/24/22; b. Nine unopened packages of hamburger buns with an expiration date of 4/29/22; c. One package of whole wheat sandwich bread dated 2/27/22, with several small green areas located on the bread slices; d. Thirteen packages of hamburger buns with no	F 812		

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F 812	Continued From page 28 date identified on the package. During an interview on 6/27/22 at 10:05 AM, the Dietary Supervisor, Staff I, stated the green spots on the wheat bread were the mold. During an interview on 6/29/22 at 3:18 PM, Staff I stated he had spoken to the facility's food supplier representative and determined the date on the bread was the production date, and that it was good for 260 days frozen. Unfrozen, it had a shelf life of five to seven days. At 4:39 PM Staff I stated he received the bread frozen, and placed it on the shelf in the dry storage area when he received it. 2. During observations on 6/28/22 at 11:30 AM, Staff J, Dietary Aide, applied gloves to her hands and began plating food for the residents' lunch. Continued observation of Staff J revealed the following: a. At 11:36 AM, Staff J used her gloved hands to pull down the back of her shirt, then continued to place food on the plates without changing her gloves. Staff J placed her gloved thumb on the surfaces of the plates. b. At 11:38 AM, Staff J adjusted her mask with her gloved hands and returned to plating food without performing hand hygiene or changing gloves. c. At 11:42 AM, Staff J placed her gloved hands on an over-the-bed rolling table. Her gloved hands touched the surface underneath the table when moving it. Staff J returned to plating food with the same gloved hands. d. At 11:46 AM, Staff J readjusted her mask, touching the interior surface of the mask as she did so, then immediately picked up a plate, touching the surface where food was being placed, without changing her gloves.	F 812		

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F 812	Continued From page 29 During an interview on 6/28/22 at 4:34 PM, Staff J indicated she had been trained on hand hygiene when handling or plating food. Staff J stated that handwashing and changing of her gloves should have occurred when she touched her mask or when she touched anything besides the food. On 6/28/22 at 4:43 PM, Staff I stated that employees were trained to wash their hands after they removed their gloves and to apply clean gloves. Dietary staff were also trained if they accidentally touched something else, they should remove their gloves, wash their hands, and re-glove.	F 812		
F 838 SS=F	Facility Assessment CFR(s): 483.70(e)(1)-(3) §483.70(e) Facility assessment. The facility must conduct and document a facility-wide assessment to determine what resources are necessary to care for its residents competently during both day-to-day operations and emergencies. The facility must review and update that assessment, as necessary, and at least annually. The facility must also review and update this assessment whenever there is, or the facility plans for, any change that would require a substantial modification to any part of this assessment. The facility assessment must address or include: §483.70(e)(1) The facility's resident population, including, but not limited to, (i) Both the number of residents and the facility's resident capacity; (ii) The care required by the resident population considering the types of diseases, conditions,	F 838		

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F 838	Continued From page 30 physical and cognitive disabilities, overall acuity, and other pertinent facts that are present within that population; (iii) The staff competencies that are necessary to provide the level and types of care needed for the resident population; (iv) The physical environment, equipment, services, and other physical plant considerations that are necessary to care for this population; and (v) Any ethnic, cultural, or religious factors that may potentially affect the care provided by the facility, including, but not limited to, activities and food and nutrition services. §483.70(e)(2) The facility's resources, including but not limited to, (i) All buildings and/or other physical structures and vehicles; (ii) Equipment (medical and non- medical); (iii) Services provided, such as physical therapy, pharmacy, and specific rehabilitation therapies; (iv) All personnel, including managers, staff (both employees and those who provide services under contract), and volunteers, as well as their education and/or training and any competencies related to resident care; (v) Contracts, memorandums of understanding, or other agreements with third parties to provide services or equipment to the facility during both normal operations and emergencies; and (vi) Health information technology resources, such as systems for electronically managing patient records and electronically sharing information with other organizations. §483.70(e)(3) A facility-based and community-based risk assessment, utilizing an all-hazards approach.	F 838		

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F 838	Continued From page 31 This REQUIREMENT is not met as evidenced by: Based on review of the facility assessment, facility policy review and staff interview, the facility failed to thoroughly assess the needs of it's resident population and the required resources to provide the care and services the residents needed as evidenced by an incomplete facility assessment which had the potential to affect all residents. The facility identified a census of 48 current residents. Findings include: Upon surveyor request, the Administrator (ADM) provided the Facility Assessment Tool dated 1/23/22. A review of the document revealed the only section completed was Part 1: Our Resident Profile. The remaining sections were incomplete. These sections included: Part 2: Services and Care We Offer Based on our Resident's Needs, Staffing Plan, and Physical environment and building/plant needs. The Facility Assessment Tool indicated it was an optional template provided for nursing facilities, and if used, may be modified. Each facility has flexibility to decide the best way to comply with this requirement. Further review of the Facility Assessment Tool revealed facility staff members had either failed to modify the information to reflect the current state of the facility's population/needs or the staff members had not completed the form accurately in order to describe the services and care provided to meet the resident needs, including the medical care needs of the residents, staff type available to provide the care, the services provided, the staffing plan to meet those needs, and the physical environment (including	F 838		

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F 838	Continued From page 32 equipment and building structure). During an interview on 6/30/22 at 2:29 PM, the ADM stated the facility opted to utilize the tool provided rather than re-create a facility assessment. The ADM was not aware that the facility assessment as provided was incomplete in the areas described. The ADM stated the team was working hard on organizing the facility. The facility had been through a lot of different owners. The ADM stated his intent to improve the facility assessment.	F 838		

Plan of Correction – Aspire of Donnellson

07/20/2022

Administrator Andrew Harris

Phone 217-430-2932

F656 – Develop/Implement Comprehensive Care Plan.

MDS Education on comprehensive care plan development within 7 days of admission and focus on person centered care and measurable goals. From thus date forward the MDS Coordinator will update care plans with ADL functions and wound care if there are any changes. This will be monitored by the DON or designee.

Compliance Date: 7/20/2022

F657 – Care Plan Timing and Revision.

Education provided to MDS nurse on revision of care plans with any changes or falls updated immediately. Care plans updated daily. This will be monitored by the DON or designee. All care plans reviewed on cited residents, and all similarly situated residents.

Compliance Date: 7/20/2022

F684 – Quality of Care.

All nurses have been re-educated on the expectations of following all physician orders and to update orders immediately. The MDS coordinator will update the care plan immediately. Compliance will be monitored by the DON or designee.

Compliance Date: 7/20/2022

F689 – Free of Accidents Hazards/Supervision/Devices.

Education has been provided to staff on utilization of POC on point click care to be able to see care plans. Care cards also known as Kardex's have been initiated and put in resident rooms for staff to read. Care plans have also been updated as well as care cards will be updated when there are any changes to the care plan. Compliance will be monitored by the DON or designee. Resident #9 and all similarity situated residents have been reviewed for safety needs and interventions implemented as appropriate. Resident #1 is an assist of one and no other issues noted.

Compliance Date: 7/1/2022

F812 – Food Procurement, Store/prepare/Serve-Sanitary.

Education has been supplied to all dietary staff on food safety and hand hygiene. This education was provided in an Inservice to all staff on 7.6.2022. A demonstration was preformed by the DON on the purpose of hand-hygiene and safe food handling. Compliance will be Monitored by the CDM.

Compliance date: 7/20/2022

F838 – Facility Assessment.

The facility Assessment will be updated by the administrator in accordance with the Medicaid and Medicare regulations. The compliance of this will be monitored by the Administrator of the facility.

Compliance Date: 7/1/2022

Please accept this as our credible allegation of compliance.

Sincerely,

Andrew Harris (LNHA)
Aspire of Donnellson
Nursing Home Administrator
217-430-2932
aharris@donnellsonltc.com

ASPIRE
of Donnellson