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	165260	A. BUILDING _____ B. WING _____	11/09/2023

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 000	INITIAL COMMENTS Correction date: _____ The following deficiencies resulted from the facility's Annual Recertification survey and investigation of Complaints #106930-C, #107260-C, #109398-C, #109796-C, #111439-C, #116334-C and #116616-C, and Facility Reported Incident #116658-I conducted November 6, 2023 to November 9, 2023. Complaint #106930-C, #107260-C, #109398-C, #111439-C and #116616-C were substantiated. See Code of Federal Regulations (42CFR) Part 483, Subpart B-C.	F 000		
F 580 SS=D	Notify of Changes (Injury/Decline/Room, etc.) CFR(s): 483.10(g)(14)(i)-(iv)(15) §483.10(g)(14) Notification of Changes. (i) A facility must immediately inform the resident; consult with the resident's physician; and notify, consistent with his or her authority, the resident representative(s) when there is- (A) An accident involving the resident which results in injury and has the potential for requiring physician intervention; (B) A significant change in the resident's physical, mental, or psychosocial status (that is, a deterioration in health, mental, or psychosocial status in either life-threatening conditions or clinical complications); (C) A need to alter treatment significantly (that is, a need to discontinue an existing form of treatment due to adverse consequences, or to commence a new form of treatment); or (D) A decision to transfer or discharge the resident from the facility as specified in	F 580		

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

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F 580	Continued From page 1 §483.15(c)(1)(ii). (ii) When making notification under paragraph (g)(14)(i) of this section, the facility must ensure that all pertinent information specified in §483.15(c)(2) is available and provided upon request to the physician. (iii) The facility must also promptly notify the resident and the resident representative, if any, when there is- (A) A change in room or roommate assignment as specified in §483.10(e)(6); or (B) A change in resident rights under Federal or State law or regulations as specified in paragraph (e)(10) of this section. (iv) The facility must record and periodically update the address (mailing and email) and phone number of the resident representative(s). §483.10(g)(15) Admission to a composite distinct part. A facility that is a composite distinct part (as defined in §483.5) must disclose in its admission agreement its physical configuration, including the various locations that comprise the composite distinct part, and must specify the policies that apply to room changes between its different locations under §483.15(c)(9). This REQUIREMENT is not met as evidenced by: Based on observation, interview, and record review the facility failed to ensure the Physician was notified following resident blood sugar of 475 for one of three residents reviewed for notification (Resident #1). The facility reported a census 14 residents. Findings include:	F 580		

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1. The Minimum Data Set (MDS) assessment for Resident #1 dated 10/10/23 revealed the resident scored 6 out of 15 on a Brief Interview for Mental Status (BIMS) exam, which indicated severe cognitive impairment. Per this assessment, the resident received insulin injections for seven of the last seven days.

The Care Plan dated 11/3/23 documented, [Resident #1] has Diabetes Mellitus. The Intervention, also dated 11/3/23, documented, Notify MD (Medical Doctor) as needed.

Review of Blood Sugar documentation for the resident revealed the following:

a. 10/31/23 at 8:47 PM: 475.0 mg/dL (milligram/deciliter)
b. 11/1/2023 at 8:22 AM: 170.0 mg/dL

The Progress Note dated 10/31/23 at 8:53 PM documented, Upon Checking Resident routine Glucometer At HS (night) to his Long acting Levemir Insulin per order resident reading was 475. Resident alert and denies adverse effects of Hyperglycemia. Resident agrees that he has eaten Candy and Sweet desserts due to Halloween Party and Trick or treaters. Will continue to monitor Glucometer as ordered and as needed.

Progress Notes lacked documentation of Physician Notification following the resident's blood sugar documented as 475.

On 11/9/23 at 8:50 AM when queried about physician notification, Staff G, MDS Coordinator acknowledged they would chart notification in the progress note and 24 hour report. When queried

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F 580	Continued From page 3 as to the process if there were no blood sugar parameters, Staff G explained she would look over the resident's baseline, and anything completely out of normal she would call. Staff G also explained if the resident was symptomatic she would call. When queried about a blood sugar of 475, Staff G explained she would call. On 11/9/23 at 9:48 AM when queried about blood sugar notification, the Director of Nursing (DON) explained there were standing orders for below 70 and above 400. When queried about expectation to notify if blood sugar level 475, the DON explained yes, and acknowledged expectation to notify over 400 in the standing orders. The Facility Policy titled Change in Condition/Incident Reporting dated August 2021 documented, Policy: When a resident exhibits a change in condition, action will be taken to coordinate appropriate care to meet resident needs. The Policy also documented, 3. If there is an actual change in condition, the resident's physician is notified promptly and validated as to information. Family/Responsible Party notified promptly. 4. Document the date/time of contacts and with whom you spoke. Document any new physician orders if indicated. Document resident condition and change in condition in nursing notes/SBAR (situation, background, assessment, recommendations).	F 580		
F 622 SS=D	Transfer and Discharge Requirements CFR(s): 483.15(c)(1)(i)(ii)(2)(i)-(iii) §483.15(c) Transfer and discharge- §483.15(c)(1) Facility requirements- (i) The facility must permit each resident to	F 622		

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remain in the facility, and not transfer or discharge the resident from the facility unless-
(A) The transfer or discharge is necessary for the resident's welfare and the resident's needs cannot be met in the facility;
(B) The transfer or discharge is appropriate because the resident's health has improved sufficiently so the resident no longer needs the services provided by the facility;
(C) The safety of individuals in the facility is endangered due to the clinical or behavioral status of the resident;
(D) The health of individuals in the facility would otherwise be endangered;
(E) The resident has failed, after reasonable and appropriate notice, to pay for (or to have paid under Medicare or Medicaid) a stay at the facility. Nonpayment applies if the resident does not submit the necessary paperwork for third party payment or after the third party, including Medicare or Medicaid, denies the claim and the resident refuses to pay for his or her stay. For a resident who becomes eligible for Medicaid after admission to a facility, the facility may charge a resident only allowable charges under Medicaid; or
(F) The facility ceases to operate.
(ii) The facility may not transfer or discharge the resident while the appeal is pending, pursuant to § 431.230 of this chapter, when a resident exercises his or her right to appeal a transfer or discharge notice from the facility pursuant to § 431.220(a)(3) of this chapter, unless the failure to discharge or transfer would endanger the health or safety of the resident or other individuals in the facility. The facility must document the danger that failure to transfer or discharge would pose.

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F 622	Continued From page 5 §483.15(c)(2) Documentation. When the facility transfers or discharges a resident under any of the circumstances specified in paragraphs (c)(1)(i)(A) through (F) of this section, the facility must ensure that the transfer or discharge is documented in the resident's medical record and appropriate information is communicated to the receiving health care institution or provider. (i) Documentation in the resident's medical record must include: (A) The basis for the transfer per paragraph (c)(1)(i) of this section. (B) In the case of paragraph (c)(1)(i)(A) of this section, the specific resident need(s) that cannot be met, facility attempts to meet the resident needs, and the service available at the receiving facility to meet the need(s). (ii) The documentation required by paragraph (c)(2)(i) of this section must be made by- (A) The resident's physician when transfer or discharge is necessary under paragraph (c) (1) (A) or (B) of this section; and (B) A physician when transfer or discharge is necessary under paragraph (c)(1)(i)(C) or (D) of this section. (iii) Information provided to the receiving provider must include a minimum of the following: (A) Contact information of the practitioner responsible for the care of the resident. (B) Resident representative information including contact information (C) Advance Directive information (D) All special instructions or precautions for ongoing care, as appropriate. (E) Comprehensive care plan goals; (F) All other necessary information, including a copy of the resident's discharge summary,	F 622		

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consistent with §483.21(c)(2) as applicable, and any other documentation, as applicable, to ensure a safe and effective transition of care.
This REQUIREMENT is not met as evidenced by:
Based on clinical record review, facility policy, and staff interview the facility failed to follow proper discharge procedures for 1 of 2 residents (Resident #110). The facility reports a census of 14 residents.

Findings include:

1. The Minimum Data Set (MDS) assessment tool, dated 8/25/23, listed diagnosis for Resident #110 included unspecified dementia, unspecified severity without behavioral disturbances, and chronic pain. The MDS listed the resident's Brief Interview for Mental Status (BIMS) score as 7 out of 15, indicating severe cognitive impairment.

A clinical record review revealed an admission date of 8/24/22 from a Geriatric Behavioral Health unit.

Hospital discharge records, dated 8/24/22, revealed the following admission diagnosis of: Alzheimer's disease; major neurocognitive disorder due to multiple etiologies with behavioral disturbance; and major neurocognitive disorder probably due to vascular disease, with behavioral disturbance.

A review of Progress Notes revealed:
a. On 8/24/23 at 6:30 PM while assisting the resident to the day room, the resident began to curse at staff calling them a "piece of shit", and "dumb bitch". When the staff attempted to again assist the resident he grabbed ahold of one of the

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Certified Nursing Assistants (CNA) and would not let go, while also swinging and spitting at staff.
b. On 8/24/23 between 8:16 PM and 8:19 PM, the resident received Trazadone 50 mg 1 tab PRN (as needed) every 8 hours for agitation, and Quetiapine 200 mg 1 tab for unspecified dementia without behavioral disturbance.
c. On 8/24/23 at 11:59 PM, the resident continued to have agitation and when staff attempted to assist the resident with a transfer, he responded by yelling, swearing and swinging at staff.
d. On 8/25/23 at 4:06 PM, the resident threw himself on the floor, and hit staff attempting to assist him. He grabbed a staff arm and twisted their arm and would not let go. The facility called 911, and the resident was taken to the local emergency room for evaluation.

The clinical record lacked documentation of communication with the provider, hospital, and the family.

Census records revealed the facility stopped billing for the resident on 8/25/23.

The clinical records lacked documentation of a discharge notice, and right to appeal.

During an interview on 11/6/23 at 1:13 PM, the Director of Nursing (DON) stated if the facility decided to involuntary discharge a resident she would expect the resident /family or Power of Attorney would be informed, and given written notice with direction on the right to appeal.

The facility policy, dated 1-/2023, titled Discharge Plan failed to address involuntary discharges.

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F 622	Continued From page 8 The facility provided an example of a form regarding Notice of Proposed Involuntary Discharge for Transfer. The document revealed a statement informing the recipient ...pending further discussion with you, the facility is currently planning to discharge {resident name} to the following location (discharging address). If you prefer (resident name) to be discharge to an alternate location, we will work with you and (Resident name) on locating such placement. The form informed the resident ...you have the right to appeal this discharge.	F 622		
F 636 SS=E	Comprehensive Assessments & Timing CFR(s): 483.20(b)(1)(2)(i)(iii) §483.20 Resident Assessment The facility must conduct initially and periodically a comprehensive, accurate, standardized reproducible assessment of each resident's functional capacity. §483.20(b) Comprehensive Assessments §483.20(b)(1) Resident Assessment Instrument. A facility must make a comprehensive assessment of a resident's needs, strengths, goals, life history and preferences, using the resident assessment instrument (RAI) specified by CMS. The assessment must include at least the following: (i) Identification and demographic information (ii) Customary routine. (iii) Cognitive patterns. (iv) Communication. (v) Vision. (vi) Mood and behavior patterns. (vii) Psychological well-being. (viii) Physical functioning and structural problems.	F 636		

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(ix) Continence.
(x) Disease diagnosis and health conditions.
(xi) Dental and nutritional status.
(xii) Skin Conditions.
(xiii) Activity pursuit.
(xiv) Medications.
(xv) Special treatments and procedures.
(xvi) Discharge planning.
(xvii) Documentation of summary information regarding the additional assessment performed on the care areas triggered by the completion of the Minimum Data Set (MDS).
(xviii) Documentation of participation in assessment. The assessment process must include direct observation and communication with the resident, as well as communication with licensed and nonlicensed direct care staff members on all shifts.

§483.20(b)(2) When required. Subject to the timeframes prescribed in §413.343(b) of this chapter, a facility must conduct a comprehensive assessment of a resident in accordance with the timeframes specified in paragraphs (b)(2)(i) through (iii) of this section. The timeframes prescribed in §413.343(b) of this chapter do not apply to CAHs.
(i) Within 14 calendar days after admission, excluding readmissions in which there is no significant change in the resident's physical or mental condition. (For purposes of this section, "readmission" means a return to the facility following a temporary absence for hospitalization or therapeutic leave.)
(iii)Not less than once every 12 months.
This REQUIREMENT is not met as evidenced by:
Based on interview, record review, and facility policy review the facility failed to complete

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comprehensive Minimum Data Set (MDS) assessments timely for four of four residents reviewed for comprehensive assessment timeliness (Resident #1, Resident #4, Resident #6, Resident #113). The facility reported a census of 14 residents.

Findings include:

1. Review of Resident #1's admission MDS assessment, Assessment Reference Date (ARD) 10/10/23, revealed an entry date of 10/3/23 for the resident. Further review of the MDS assessment revealed a completion date of 10/28/23 for the assessment.

2. Review of Resident #4's admission MDS assessment, ARD Date 10/16/23, revealed an entry date of 10/5/23 for the resident. Further review of the MDS assessment revealed a completion date of 10/29/23 for the assessment.

3. Review of Resident #6's admission MDS assessment, ARD Date 10/11/23, revealed an entry date of 10/4/23 for the resident. Further review of the MDS revealed a completion date of 10/28/23 for the assessment.

4. On 11/7/23, review of Resident #113's admission MDS, ARD Date 10/30/23, revealed an entry date of 10/23/23 for the resident. Further review of the MDS revealed the status of the assessment as in progress. The Complete MDS box on the MDS Summary documented, Complete by 11/05/2023.

On 11/9/23 at 8:48 AM, Staff G, MDS Coordinator, explained they had recently started in the position. When queried who covered in her

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F 636	Continued From page 11 absence, Staff G explained the Director of Nursing (DON). On 11/9/23 at 9:50 AM, the Director of Nursing (DON) acknowledged the concern with MDS timeliness. The Facility Policy titled RAI (Resident Assessment Instrument)/Care Planning Management dated October 2023 documented, The MDS is completed by the 14th day on all new admissions into the facility.	F 636		
F 655 SS=D	Baseline Care Plan CFR(s): 483.21(a)(1)-(3) §483.21 Comprehensive Person-Centered Care Planning §483.21(a) Baseline Care Plans §483.21(a)(1) The facility must develop and implement a baseline care plan for each resident that includes the instructions needed to provide effective and person-centered care of the resident that meet professional standards of quality care. The baseline care plan must- (i) Be developed within 48 hours of a resident's admission. (ii) Include the minimum healthcare information necessary to properly care for a resident including, but not limited to- (A) Initial goals based on admission orders. (B) Physician orders. (C) Dietary orders. (D) Therapy services. (E) Social services. (F) PASARR recommendation, if applicable. §483.21(a)(2) The facility may develop a comprehensive care plan in place of the baseline	F 655		

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care plan if the comprehensive care plan-
(i) Is developed within 48 hours of the resident's admission.
(ii) Meets the requirements set forth in paragraph (b) of this section (excepting paragraph (b)(2)(i) of this section).

§483.21(a)(3) The facility must provide the resident and their representative with a summary of the baseline care plan that includes but is not limited to:
(i) The initial goals of the resident.
(ii) A summary of the resident's medications and dietary instructions.
(iii) Any services and treatments to be administered by the facility and personnel acting on behalf of the facility.
(iv) Any updated information based on the details of the comprehensive care plan, as necessary.
This REQUIREMENT is not met as evidenced by:
Based on observation, interview, and record review the facility failed to ensure accurate completion of a Baseline Care Plan for two of three residents reviewed for Baseline Care Plans (Resident #1, Resident #113). The facility reported a census of 14 residents.

Findings include:

1. The Minimum Data Set (MDS) assessment for Resident #1 dated 10/10/23 revealed the resident scored 6 out of 15 on a Brief Interview for Mental Status (BIMS) exam, which indicated severe cognitive impairment. The assessment revealed an entry date of 10/3/23 for the resident.

The Physician Order dated 10/4/23 documented, Fluoxetine HCl Oral Tablet 20 MG (milligram), an

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antidepressant medication, with directions to give 1 tablet by mouth one time a day.

The Medication Administration Record (MAR) for Resident #1 revealed Fluoxetine 20 MG administration initiated 10/4/23.

The Baseline Care Plan dated 10/4/23, locked 10/10/23, lacked documentation the resident received psychotropic medications.

2. The MDS assessment for Resident #113 dated 10/30/23 revealed the resident scored 15 out of 15 on a BIMS exam, which indicated intact cognition. The assessment revealed an entry date of 10/23/23 for the resident.

The Physician Order dated 10/23/23 documented, Trazodone HCl Oral Tablet 100 MG, an antidepressant medication, with directions to give 1 tablet by mouth at bedtime for depressive disorder.

The Physician Order dated 10/23/23 documented, Alprazolam Oral Tablet 0.25 MG, an antianxiety medication, with directions to give 1 tablet by mouth every 24 hours as needed for insomnia.

The MAR dated October 2023 for Resident #113 revealed the resident received both medications on 10/23/23.

The Baseline Care Plan dated 10/23/23, locked 10/25/23, lacked documentation the resident received psychotropic medications and PRN psychotopics.

On 11/9/23 at 9:52 AM when queried about

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F 655	Continued From page 14 Baseline Care Plans, the Director of Nursing (DON) explained she did all the Baseline Care Plans. The Facility Policy titled RAI (Resident Assessment Instrument)/Care Plan Management dated 10/23 documented the following per Interim Baseline Care Plan: The interim baseline care plan is developed within 48 hours of admission to the facility and is based on resident needs identified in the admission nursing assessments, Initial goals based on admission orders, Physician Orders, Dietary orders, Therapy services, Social Services, PASSAR (Pre Admission Screening and Resident Review) recommendation, if applicable and other pertinent information. The interim care plan is updated following completion of all assessments no later than 48 hours of admission.	F 655		
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. (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	F 657		

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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, facility policy and staff interview, the facility failed to update and implement personalized care plan interventions for residents with a high fall risk after a fall for 2 for 4 residents (Resident #3, and Resident #108). The facility reported a census of 14 residents.

Findings include:

1. The Minimum Data Set (MDS) assessment tool, dated , listed diagnosis for Resident #3 included type 2 diabetes, depression, and anxiety disorder. The MDS listed the resident's Brief Interview for Mental Status (BIMS) score as 15 out of 15, indicating intact cognition.

A Move in Note, dated 10/2/23 documented the resident arrival at the facility.

The Baseline Care Plan, dated 10/2/23, indicated the resident walked in her room and in the corridor with no set up or physical help from staff.

A Progress Note revealed the resident experienced an unwitnessed fall on 10/14/23, The fall resulted in a laceration on her forehead

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measuring 3.8 cm (centimeters) x 0.8 cm with unknown depth.

A Progress note dated 10/14/23, indicated the resident went to the local emergency room for evaluation and treatment after the fall.

The Incident Report, dated 10/14/23, lacked new interventions to be implemented as a result of the fall.

The Baseline Care Plan lacked any interventions related to the 10/14/23 fall.

The Care Plan, dated 11/2/23 revealed the resident is at risk for falls due to a history of falls and medications. The plan noted the resident had a fall resulting in a laceration on 10/14/23. All interventions on the Care Plan initiated on 11/2/23.

2. The Minimum Data Set (MDS) assessment tool, dated 9/23/23 , listed diagnosis for Resident #108 included left hip fracture, non-Alzheimer's dementia, and rheumatoid arthritis. The MDS assessed the resident required limited assistance of one person for bed mobility. Assessment for transfers, and walking did not occur or only occurred once or twice The MDS listed the resident ' s Brief Interview for Mental Status (BIMS) score as 15 out of 15, indicating intact cognition.

The Electronic Health Record (EHR) Census indicated an admission date of 9/20/23.

The Baseline Care Plan, dated 9/20/23, revealed

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the resident required a two person assist with transfers. The plan indicated walking in the room or corridor as areas not assessed.

The Baseline Care Plan lacked updated interventions after the 9/22/23 fall.

The Care Plan, dated 9/26/23, revealed a focus area of moderate fall risk for falls. The plan noted a fall occurred on 9/22/23 with resulting Physical Therapy and Occupational Therapy revaluation. The plan lacked further personalized safety interventions.

A Progress Note, dated 10/16/23 at 2:00 PM revealed the resident had an unwitnessed fall in her room. The note documented their resident's right leg appears bent in and out to the side. The resident was ordered to be taken to the local emergency room for evaluation and treatment.

A Progress Note dated 10/16/23 at 2:24 PM indicated a facility nurse contacted the hospital for a report. The hospital informed the nurse the resident incurred a right hip fracture.

During an interview on 11/6/23 at 1:19 PM, the Director of Nursing stated she would expect a new intervention to be developed and implemented immediately after any fall.

The facility policy, dated 8/2021, titled Fall Management Standard, Section Post Standard directed staff to:
a. Review the Fall Risk Assessment/Pain Assessment to identify any changes in condition.
b. Review the Plan of Care.
c. Discuss the findings and interventions with the resident and family for inclusion in the

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F 657	Continued From page 18 interdisciplinary Plan of Care. d. Revise/Update interventions on the Plan of Care.	F 657		
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 observation, facility policy, and staff interviews the facility failed to use follow standard nursing practices during medication administration for 1 of 5 residents (Resident #113). The facility reported a census of 14 residents. Findings include: 1. During an observation on 11/9/23 at 7:26 AM, Staff H, Licensed Practical Nurse (LPN) spilled three medications from a medication cup. The medications spilled included: Myrbetriq (medication for overactive bladder), Risperidone (antipsychotic medication), and Vitamin D3. At 7:31 AM, after punching out a new dose of each medication spilled, Staff H walked away from the medication cart into the dining room. The three spilled medications remained on top of the cart. At 7:34 AM, Staff H returned to the med cart, picked up the three pills and put them in a medication cup and moved them to the back of	F 658		

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the cart.

At 7:35 AM, Staff H walked away from the cart into the medication room. The medication cup with the three spilled pills remained on the back of the cart.

At 7:36 AM, Staff H returned to the med cart and began to prepare medications for the next resident.

AT 7:42 AM, Staff H walked away from the cart to administer the newly prepared medications.

When queried about the medication left on top of the medication cart in the cup, Staff H stopped and moved the medication to the locked medication room.

During an interview on 11/9/23 at 11:40 AM, Staff H stated if medication fall out of the cup or are dropped on the floor they should be wasted in the drug buster bottle, or placed in the sharps container. Staff H stated she should not have left the spilled mediation on top of the cart, or in the med cup moved back on the cart.

2. The Physician Orders for Resident #113 revealed an order for Metformin 500 MG 2 tablets by mouth two times a day for diabetes.

During an observation on 11/9/23 at 8:55 AM, Staff H punched one tablet from a Metformin 500 MG bubble pack into the medication cup. When queried about the number of Metformin tablets punched out for Resident #113, Staff H stated one tablet.

Staff H administered Resident #113 his Metformin

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at 8:57 AM.

During an interview at 11:45 AM, Staff H stated she administered two tablets of Metformin 500 mg to Resident #113.

Staff H looked through the medication cart to find the Metformin bubble packs for Resident #113. She located one cart with Metformin 500 mg with each bubble containing 1 tablet. Staff H was unable to locate another Metformin card either with tablets or an exhausted supply.

During an interview on 11/9/23 at 1:06 PM, the Director of Nursing (DON) stated she would expect staff to immediately waste any medications that spill out of a medication cup or have falls to the floor. The DON stated the medications should not be left on top of the cart, even if moved to the back of the cart.

The DON stated if a medication calls for two tablets, and only one tablet is in each bubble of the card, she would expect the nurse to punch out two pills from the same card.

The facility policy, dated January 2018, titled Medication Administration Guidelines directed staff as follows: all medications that are to be destroyed are to be taken off the medication cart and properly destroyed per the guidelines.

The policy section General and Specific Guidelines on Administration of Medication by Routes, section A, c. directed staff to compare the MAR (Medication Administration Record) with the label of each medication for the following vi. right dose.

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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 record review, staff interview, and facility policy review the facility failed to ensure skin assessments were done on a weekly basis per physician order for one of three residents reviewed for assessment/intervention (Resident #1). The facility reported a census of 14 residents. Findings include: 1. The Minimum Data Set (MDS) assessment for Resident #1 dated 10/10/23 revealed the resident scored 6 out of 15 on a Brief Interview for Mental Status (BIMS) exam, which indicated severe cognitive impairment. The Care Plan dated 11/3/23 documented, [Resident #1] is at risk for skin breakdown due to impaired mobility, and incontinence. Interventions did not address frequency of skin assessments. The Physician Order dated 10/3/23 documented, Skin Check Weekly. one time a day every Tue (Tuesday). The Skin Only Evaluation dated 10/3/23	F 684		

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F 684	Continued From page 22 documented the resident had a new issue to the right lower leg, described as a lesion, which measured 2 centimeters (cm) by 1 cm. The wound bed section documented granulation. Review of the October 2023 TAR revealed the weekly skin check dated 10/10/23 left blank on the TAR, 10/17/23 marked as n (no), 10/24/23 marked with a code of "1", which indicated away from center with meds. On 11/9/23 at 9:56 AM, the Director of Nursing (DON) explained residents had skin assessments done for the first three weeks, and then during their showers. The DON acknowledged they would be done by the nurse, and should be in the assessment tab. The Facility Policy titled Skin Management Standard, undated, documented, All residents will receive a head-to-toe body audit by a licensed nurse on admission, transfer, re-admission, weekly, and upon change in condition.	F 684		
F 689 SS=D	Free of Accident Hazards/Supervision/Devices CFR(s): 483.25(d)(1)(2) §483.25(d) Accidents. The facility must ensure that - §483.25(d)(1) The resident environment remains as free of accident hazards as is possible; and §483.25(d)(2)Each resident receives adequate supervision and assistance devices to prevent accidents. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and record review the facility failed to ensure foot pedals	F 689		

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F 689	Continued From page 23 were utilized when a resident was assisted in a wheelchair by staff for one of one resident reviewed for wheelchair transport (Resident #1). The facility reported a census of 14 residents. Findings include: 1. The Minimum Data Set (MDS) assessment for Resident #1 dated 10/10/23 revealed the resident scored 6 out of 15 on a Brief Interview for Mental Status (BIMS) exam, which indicated severe cognitive impairment. Observation on 11/06/23 at 3:11 PM revealed Resident #1 assisted down the hall by staff without wheelchair foot pedals present. Observation revealed the resident held their feet up. On 11/6/23 at 3:14 PM, Resident #1 pedaled their feet in the wheelchair while a staff member pushed the chair. On 11/9/23 at 9:54 AM, the Director of Nursing (DON) explained Resident #1 was not supposed to be pushed as the resident moved around himself. Review of a slide provided by the facility titled Wheelchair Management and Fall Prevention, undated, documented, If a resident utilizes a wheelchair, we must consider the following...Footrests are present on all wheelchairs.	F 689		
F 803 SS=F	Menus Meet Resident Nds/Prep in Adv/Followed CFR(s): 483.60(c)(1)-(7) §483.60(c) Menus and nutritional adequacy.	F 803		

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F 803	Continued From page 24 Menus must- §483.60(c)(1) Meet the nutritional needs of residents in accordance with established national guidelines.; §483.60(c)(2) Be prepared in advance; §483.60(c)(3) Be followed; §483.60(c)(4) Reflect, based on a facility's reasonable efforts, the religious, cultural and ethnic needs of the resident population, as well as input received from residents and resident groups; §483.60(c)(5) Be updated periodically; §483.60(c)(6) Be reviewed by the facility's dietitian or other clinically qualified nutrition professional for nutritional adequacy; and §483.60(c)(7) Nothing in this paragraph should be construed to limit the resident's right to make personal dietary choices. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and facility Diet Spreadsheet review the facility failed to follow their planned menus and further failed to ensure residents were provided appropriate starch portion sizes to meet their nutritional needs. The facility reported a census of 14 residents. Findings include: An initial observation of staff serving the lunch meal conducted on 11/06/23 at 11:15 AM revealed the following observations:	F 803		

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a. Green beans were served instead of Italian vegetable blend. When queried, the main cook advised this is what she is supposed to use today.
b. Buttered noodles were served for the starch portion. The cook used the beige spoodle which is 3 1/4 ounces which is not congruent with the diet spreadsheet of 4 ounces.

On 11/07/23 11:14 AM a second observation of staff serving the lunch meal was conducted and revealed the following observations:
a. Corn was served instead of the seasoned fresh zucchini listed on the facility diet spreadsheet.
b. Rice pilaf was served for the starch portion. The cook used the beige spoodle which is 3 1/4 ounces which is not consistent with the facility diet spreadsheet of 4 ounces.

During the observation on 11/07/23 the Dietary Manager brought out a blue binder to the cook and stated, "Here you go, this is what you need." and as he set the binder on the prep table stated to no one in particular, "This binder is disgusting." The Cook asked what it was and the Dietary Manager responded, "Portion sizes,"
When queried, the cook advised she had never seen the blue binder before it was just provided to her.

11/09/23 09:17 AM the Dietary Manager was asked about serving corn instead of the listed menu item of zucchini and he advised the zucchini was not on the truck so they had to make a quick substitution. When queried about portion sizes the Dietary Manager reported we didn't have the the dietary charts printed out and they have since been printed. He advised he was going by what he did at the previous facility he

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F 803	Continued From page 26 had been employed with.	F 803		
F 836 SS=D	License/Comply w/ Fed/State/Locl Law/Prof Std CFR(s): 483.70(a)-(c) §483.70(a) Licensure. A facility must be licensed under applicable State and local law. §483.70(b) Compliance with Federal, State, and Local Laws and Professional Standards. The facility must operate and provide services in compliance with all applicable Federal, State, and local laws, regulations, and codes, and with accepted professional standards and principles that apply to professionals providing services in such a facility. §483.70(c) Relationship to Other HHS Regulations. In addition to compliance with the regulations set forth in this subpart, facilities are obliged to meet the applicable provisions of other HHS regulations, including but not limited to those pertaining to nondiscrimination on the basis of race, color, or national origin (45 CFR part 80); nondiscrimination on the basis of disability (45 CFR part 84); nondiscrimination on the basis of age (45 CFR part 91); nondiscrimination on the basis of race, color, national origin, sex, age, or disability (45 CFR part 92); protection of human subjects of research (45 CFR part 46); and fraud and abuse (42 CFR part 455) and protection of individually identifiable health information (45 CFR parts 160 and 164). Violations of such other provisions may result in a finding of non-compliance with this paragraph. This REQUIREMENT is not met as evidenced by:	F 836		

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F 836	Continued From page 27 THE FOLLOWING DEFICIENCIES RELATE TO THE IOWA ADMINISTRATIVE CODE (IAC) CHAPTER 58. 58.12(135C) Admission, transfer, and discharge. 58.12(1) General admission policies. l. For all residents residing in a health care facility receiving reimbursement through the medical assistance program under Iowa Code chapter 249A on July 1, 2003, and all others subsequently admitted, the facility shall collect and report information regarding the resident's eligibility or potential eligibility for benefits through the Federal Department of Veterans Affairs as requested by the Iowa commission on Veterans Affairs. The facility shall collect and report the information on forms and by the procedures prescribed by the Iowa commissions on veterans affairs. Where appropriate, the facility may also report such information to the Iowa department of human services. In the event that a resident is unable to assist the facility in obtaining the information, the facility shall seek the requested information from the resident's family members or responsible party. For all new admissions, the facility shall collect and report the required information regarding the resident's eligibility or potential eligibility to the Iowa commission on veterans' affairs within 30 days of the resident's admission. For residents residing in the facility as of July 1, 2003, and prior to May 5, 2004, the facility shall collect and report the required information regarding the resident's eligibility or potential eligibility to the Iowa commission on veterans' affairs within 90 days after May 5, 2004.	F 836		

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If a resident is eligible for benefits through the federal Department of Affairs or other third-party payor, the facility shall seek reimbursement from such benefits to the maximum extent available before seeking reimbursement from the medical assistance program established under Iowa Code chapter 249A.

The provisions of this paragraph shall not apply to the admission of an individual as a resident to a state mental health institute for acute psychiatric care or to the admission of an individual to the Iowa Veterans Home. (II,III)

This REQUIREMENT is not met as evidenced by:Based on record review, facility policy review, and staff interview, the facility failed to ensure veteran status submitted timely following admission to the facility for one of two resident information submitted to Veterans Affairs (VA) (Resident #209). The facility reported a census of 14 residents.

Findings include:

Review of the clinical record for Resident #209 revealed the resident admitted to the facility 10/5/23.

Review of the Iowa Department of Veterans Affairs Resident Eligibility form provided by the facility documented the resident admitted on 10/5/23, with information received 11/6/23.

On 11/9/23 at 1:46PM, the facility ' s Administrator confirmed access to the system occurred on Monday.

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F 836	Continued From page 29 The Facility Policy titled Admission, transfer, and discharge dated 9/23 documented, For all new admissions, the facility shall collect and report the required information regarding the resident ' s eligibility or potential eligibility to the Iowa commission on Veterans affairs within 30 days of the resident ' s admission.	F 836		
F 883 SS=D	Influenza and Pneumococcal Immunizations CFR(s): 483.80(d)(1)(2) §483.80(d) Influenza and pneumococcal immunizations §483.80(d)(1) Influenza. The facility must develop policies and procedures to ensure that- (i) Before offering the influenza immunization, each resident or the resident's representative receives education regarding the benefits and potential side effects of the immunization; (ii) Each resident is offered an influenza immunization October 1 through March 31 annually, unless the immunization is medically contraindicated or the resident has already been immunized during this time period; (iii) The resident or the resident's representative has the opportunity to refuse immunization; and (iv)The resident's medical record includes documentation that indicates, at a minimum, the following: (A) That the resident or resident's representative was provided education regarding the benefits and potential side effects of influenza immunization; and (B) That the resident either received the influenza immunization or did not receive the influenza immunization due to medical contraindications or refusal. §483.80(d)(2) Pneumococcal disease. The facility	F 883		

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must develop policies and procedures to ensure that-
(i) Before offering the pneumococcal immunization, each resident or the resident's representative receives education regarding the benefits and potential side effects of the immunization;
(ii) Each resident is offered a pneumococcal immunization, unless the immunization is medically contraindicated or the resident has already been immunized;
(iii) The resident or the resident's representative has the opportunity to refuse immunization; and
(iv)The resident's medical record includes documentation that indicates, at a minimum, the following:
(A) That the resident or resident's representative was provided education regarding the benefits and potential side effects of pneumococcal immunization; and
(B) That the resident either received the pneumococcal immunization or did not receive the pneumococcal immunization due to medical contraindication or refusal.
This REQUIREMENT is not met as evidenced by:
Based on record review, resident and staff interview, the facility failed to administer and document the resident had been offered the Influenza vaccination after admission to the facility for two of five residents reviewed (Residents #6 and #57). The facility reported a census of 14 residents.

Findings include:

1. The Minimum Data Set (MDS) dated 10/11/23 identified Resident #6 as cognitively intact with a BIMS (Brief Interview for Mental Status) of 15 and

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had the following diagnoses: Seizure Activity, Depression and Chronic Obstructive Pulmonary Disease.

A review of the census tab in the electronic medical record revealed the resident was admitted to the facility on 10/4/23.

A review of the immunization records revealed the resident had not received the influenza vaccine since admission.

2. The Minimum Data Set (MDS) dated 10/25/23 identified Resident #57 as cognitively intact with a BIMS (Brief Interview for Mental Status) of 14 and had the following diagnoses: Atrial Fibrillation, Renal Insufficiency and Diabetes Mellitus. The MDS also identified Resident #47 as independent with most activities of daily living and did not identify the resident had problems with behaviors.

In an interview on 11/8/23 at 8:46 AM, Resident #57 reported had had repeatedly asked the staff to give him his COVID, RSV and flu shots. He still had not received any this year. The staff informed him that they are in the in the process of ordering some from a pharmacy from the Quad Cities. His twin brother died of COVID a few years ago, that is why he wants these vaccinations.

A review of the census tab in the electronic medical record revealed the resident was admitted to the facility on 10/17/23.

A review of the immunization records revealed the resident has not received any vaccinations since admission.

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F 883	Continued From page 32 A review of the facility policy titled: Immunizations: Standing Orders dated as last reviewed September 2023 had documentation of the following: Procedure: a. Screen the resident on admission to determine if they have received the following adult immunizations: aa. Annual Influenza bb. Pneumonia cc. Covid b. Pull this immunization record from IRIS upon admission and update resident immunization in the electronic medical record. c. Counsel resident and/or family on the benefits and adverse effects of each vaccine prior to the administration of the vaccines. Refer to the CDC Information Sheets in this manual. d. Obtain a physician's order for the following immunizations on admission or after the resident signs the information and request form as applicable: aa. Influenza bb. Pneumonia cc. Covid e. Document all immunizations on the immunization record and maintain the resident's medical record electronically in Point Click Care under the immunization tab.	F 883		
F 887 SS=D	COVID-19 Immunization CFR(s): 483.80(d)(3)(i)-(vii) §483.80(d) (3) COVID-19 immunizations. The LTC facility must develop and implement policies and procedures to ensure all the following: (i) When COVID-19 vaccine is available to the facility, each resident and staff member is offered the COVID-19 vaccine unless the	F 887		

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immunization is medically contraindicated or the resident or staff member has already been immunized;
(ii) Before offering COVID-19 vaccine, all staff members are provided with education regarding the benefits and risks and potential side effects associated with the vaccine;
(iii) Before offering COVID-19 vaccine, each resident or the resident representative receives education regarding the benefits and risks and potential side effects associated with the COVID-19 vaccine;
(iv) In situations where COVID-19 vaccination requires multiple doses, the resident, resident representative, or staff member is provided with current information regarding those additional doses, including any changes in the benefits or risks and potential side effects associated with the COVID-19 vaccine, before requesting consent for administration of any additional doses;
(v) The resident, resident representative, or staff member has the opportunity to accept or refuse a COVID-19 vaccine, and change their decision;
(vi) The resident's medical record includes documentation that indicates, at a minimum, the following:
(A) That the resident or resident representative was provided education regarding the benefits and potential risks associated with COVID-19 vaccine; and
(B) Each dose of COVID-19 vaccine administered to the resident; or
(C) If the resident did not receive the COVID-19 vaccine due to medical contraindications or refusal; and
(vii) The facility maintains documentation related to staff COVID-19 vaccination that

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includes at a minimum, the following:
(A) That staff were provided education regarding the benefits and potential risks associated with COVID-19 vaccine;
(B) Staff were offered the COVID-19 vaccine or information on obtaining COVID-19 vaccine; and
(C) The COVID-19 vaccine status of staff and related information as indicated by the Centers for Disease Control and Prevention's National Healthcare Safety Network (NHSN).
This REQUIREMENT is not met as evidenced by:
Based on record review, resident and staff interview, the facility failed to administer and document the resident had been offered the COVID vaccination after admission to the facility for one of five residents reviewed (Resident #57). The facility reported a census of 14 residents.

Findings include:

The Minimum Data Set (MDS) dated 10/25/23 identified Resident #57 as cognitively intact with a BIMS (Brief Interview for Mental Status) of 14 and had the following diagnoses: Atrial Fibrillation, Renal Insufficiency and Diabetes Mellitus. The MDS also identified Resident #47 as independent with most activities of daily living and did not identify the resident had problems with behaviors.

In an interview on 11/8/23 at 8:46 AM, Resident #57 reported had had repeatedly asked the staff to give him his COVID, RSV and flu shots. He still had not received any this year. The staff informed him that they are in the in the process of ordering some from a pharmacy from the Quad Cities. His twin brother died of COVID a few years ago, that is why he wants these vaccinations.

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A review of the census tab in the electronic medical record revealed the resident was admitted to the facility on 10/17/23.

A review of the immunization records revealed the resident has not received any vaccinations since admission.

A review of the facility policy titled: Immunizations: Standing Orders dated as last reviewed September 2023 had documentation of the following:
Procedure:
a. Screen the resident on admission to determine if they have received the following adult immunizations:
aa. Annual Influenza
bb. Pneumonia
cc. Covid
b. Pull this immunization record from IRIS upon admission and update resident immunization in the electronic medical record.
c. Counsel resident and/or family on the benefits and adverse effects of each vaccine prior to the administration of the vaccines. Refer to the CDC Information Sheets in this manual.
d. Obtain a physician's order for the following immunizations on admission or after the resident signs the information and request form as applicable:
aa. Influenza
bb. Pneumonia
cc. Covid
e. Document all immunizations on the immunization record and maintain the resident's medical record electronically in Point Click Care under the immunization tab.