STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	165601	A. BUILDING _____ B. WING _____	C 06/08/2023

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HARMONY WEST DES MOINES	5010 GRAND RIDGE DRIVE WEST DES MOINES, IA 50265

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F 000 ✓ ok/cp	INITIAL COMMENTS AMENDED 6/14/23 VW Correction date: July17, 2023 The following deficiencies resulted from a revisit of the recertification survey and complaint investigations ending March 14, 2023, along with investigation of complaints #111536-C, #111594-C, #111822-C, #111912-C, #111965-C, #112083-C, #112290-C, #112647-C, #113156-C, #113163-C, #113227-C and facility reported incident #112774-I, #113245-I, #113386-I conducted on May 15, 2023 to June 8, 2023. Complaint # 112083-C was unsubstantiated. Complaints # 111536-C, #111594-C, #111822-C, #111912-C, #111965-C, #112290-C, #112647-C, #113156-C, #113163-C, #113227-C were substantiated. Facility reported incidents #112774-I, #113245-I, #113386-I were substantiated. See code of Federal Regulations (42 CFR), Part 483, Subpart B-C.	F 000		
F 550 SS=D	Resident Rights/Exercise of Rights CFR(s): 483.10(a)(1)(2)(b)(1)(2)	F 550		
	§483.10(a) Resident Rights. The resident has a right to a dignified existence, self-determination, and communication with and access to persons and services inside and outside the facility, including those specified in this section. §483.10(a)(1) A facility must treat each resident with respect and dignity and care for each resident in a manner and in an environment that			

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

Rachel Reed | Administrator | 6-29-23

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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promotes maintenance or enhancement of his or her quality of life, recognizing each resident's individuality. The facility must protect and promote the rights of the resident.

§483.10(a)(2) The facility must provide equal access to quality care regardless of diagnosis, severity of condition, or payment source. A facility must establish and maintain identical policies and practices regarding transfer, discharge, and the provision of services under the State plan for all residents regardless of payment source.

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

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

§483.10(b)(2) The resident has the right to be free of interference, coercion, discrimination, and reprisal from the facility in exercising his or her rights and to be supported by the facility in the exercise of his or her rights as required under this subpart.
This REQUIREMENT is not met as evidenced by:
Based on clinical record review, observations, staff interview and facility policy review, the facility failed to treat each resident with dignity and respect for 2 of 10 residents reviewed for dignity and resident rights (Resident #3 and Resident #28). The facility staff identified a census of 86 residents.

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Findings include:

1. The Minimum Data Set (MDS) assessment dated 3/14/23 for Resident #3 revealed the resident was totally dependent upon 1 person physical assistance for eating. The MDS documented diagnoses that included sarcopenia (age related progressive loss of muscle mass and strength), diabetes mellitus, and dementia.

The Comprehensive Care Plan for Resident #3 revealed a focus area of assistance with Activities of Daily Living (ADLs) including bed mobility, transfers, dressing, walking, personal hygiene, eating and toileting.

Observation on 5/15/23 at 11:05 am revealed Resident #3 laid on her back with her call light clipped to her sheet lying on her chest. Observation revealed both of the resident's hands were severely contracted with the fingers curled in towards the palm, causing the resident to be unable to use her hands.

Observation on 5/16/23 at 7:55 am revealed Resident #3 laid on her back in bed with her breakfast tray sitting next to her bed on the bedside table with no staff in the room.

Observation on 5/16/23 at 12:40 pm revealed Staff D, Certified Nurse Aide (CNA), brought Resident #3's lunch tray to her room and left it at her bedside. At 12:52 pm Staff D returned to Resident #3's room to assist the resident to eat.

On 5/16/23 at 1:20 pm Staff D stated Resident #3 was completely dependent on cares and required 1 person assist to eat and 2 person assist for all other cares.

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Observation on 5/21/23 at 1:15 pm revealed Staff D sat next to Resident #3's bedside with her cell phone in her hands. Resident #3's lunch tray sat on the bedside table untouched. Staff D used her personal cell phone rather than assisting Resident #3 to eat.

On 5/22/23 at 10:02 the Director of Nursing (DON) stated she expected no staff to have a cell phone out when providing cares to a resident.

The policy titled Proper Cell Phone Use, Revision dated 2/26/21 documented: "Employees are strongly discouraged from making any personal phone calls or texting during work time."

2. The Minimum Data Set (MDS) assessment dated 5/4/23 revealed Resident #28 had diagnoses of Alzheimer's disease, dementia, schizophrenia, and anxiety disorder. The MDS documented a brief interview for mental status score of 9, which indicated cognition moderately impaired. The MDS revealed the resident required extensive assistance of one person for toileting, transfers and personal hygiene.

The Care Plan initiated 11/14/18 revealed Resident #28 had an ADL (activities of daily living) self-care deficit as evidenced by the need for assistance for self-cares. The Care Plan directives for staff included remind and assist the resident as needed with toileting at routine times such as before and after meals, and at bedtime, and provide assistance of one staff for toileting.

During observation on 5/19/23 at 7:21 PM, Resident #28 sat in a wheelchair by the nurse's

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F 550	Continued From page 4 station yelling "help me, help me please". At 7:37 PM, the resident continued to holler "hurry ma'am, hurry, restroom". At 7:38 PM, Staff J, Registered Nurse walked by the nurse's station and asked Resident #28 what she was doing. Resident #28 responded "bathroom". Staff J told the resident the bathroom at the nurse's station was not a resident bathroom. Resident #28 responded " how do I get to a bathroom?" Staff J walked into the bathroom but did not respond to the resident. At 7:49 PM, Resident #29 propelled her wheelchair down the hall and called out "help me, help me please". At 7:51 PM, Staff K, certified nursing assistant, walked by Resident #28 and told the resident she planned to assist the resident to bed soon. The facility's Privacy and Dignity policy, revised 7/28/22, revealed residents will not be addressed in an undignified manner by staff, and a resident's privacy and dignity respected by the staff at all times. The Resident Council Meeting Notes, dated 5/4/23 at 2:05 PM, revealed a lack of respect by staff at the facility, including staff refused to assist residents when the resident asked the staff members to assist the residents into bed. In an interview on 5/23/23 at 2:00 PM, the Director of Nursing reported she expected staff treated residents with dignity and respect, and expected staff to assist a resident to the bathroom when requested rather than ignore the resident.	F 550		
F 580 SS=D	Notify of Changes (Injury/Decline/Room, etc.) CFR(s): 483.10(g)(14)(i)-(iv)(15)	F 580		

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F 580	Continued From page 5 §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 §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).	F 580		

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F 580	Continued From page 6 §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 record review, family interview, staff interview interview, and policy review, the facility failed to notify the resident representative for 2 of 4 residents who had a change of condition (Resident #5 and #39). The facility staff identified a census of 86 residents. Findings include: 1. The significant change Minimum Data Set (MDS) assessment dated 3/26/23 for Resident #39 identified a Brief Interview of Mental Status (BIMS) score of 3. A BIMS score of 3 suggested he had severe cognitive impairment. The MDS revealed he required extensive assistance of two staff for bed mobility, transfers, dressing, toilet use, and personal hygiene. The MDS documented he required hospice services while a resident in the facility. The MDS documented the following diagnoses for Resident #39: sepsis, heart failure, diabetes mellitus, and depression. The Care Plan focus area, dated 3/14/23, identified Resident #39 received hospice services due to end-stage cardiac disease, severe deconditioning, and malnutrition. The Care Plan indicated the hospice team will integrate services and collaborate cares. The Care Plan also	F 580		

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indicated he had diabetes mellitus.

The Hospice Comprehensive Assessment and Plan of Care Update Report, dated 5/18/23, documented he started to receive hospice services on 3/13/2023.

Review of the resident's Electronic Health Record (EHR) revealed his blood sugar was checked on 5/29/23 at 10:22 AM by Staff CC, Certified Medication Assistant (CMA). His blood sugar was 536 milligram per deciliter (mg/dL).

Review of Resident #39's May 2023 Medication Administration Record (MAR) revealed Staff CC administered the resident's as needed (PRN) order of oxycodone 5 milligram (mg) 1 tablet on 5/29/23 at 10:58 AM.

Review of Resident #39's Progress Notes revealed the following note was documented by Staff F, Licensed Practical Nurse (LPN), on 5/29/23 at 3:42 PM: called to the room, resident lying in bed, starring at the ceiling. He looked at the nurse when his name was called. Vitals obtained: blood pressure 111/52, respirations 14, oxygen saturation 92% on room air, and temperature was 96.4 degrees Fahrenheit. She noted the urine in his drainage bag to be creamy green in color. She did not note any shortness of breath or respiratory distress. Gave an as needed (PRN) oxycodone (pain management) at 11:30 AM. She went back in to the room at 2:30 PM by the request of the Certified Nursing Assistant (CNA), resident was dead, no apical pulse, no breathing. Hospice was made aware.

On 5/30/23 at 7:00 PM, Staff DD, CNA, stated on 5/29/23 at 10:00 AM Resident #39 told her that he

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did not feel right and felt like he was dying. She noted his skin to be pale, he was cold to the touch, sweating profusely, and saw that his urine was cloudy and a dull gray color. She noticed his catheter site had a split with puss coming out. She reported to this to Staff F, LPN, but she was very nonchalant, told her the resident was on hospice. Staff DD added it bothered her when she found out the resident passed away. She thinks he died alone without family or hospice staff with him. She indicated she knows hospice would've came in if they were called but doesn't think hospice was called. She cried and didn't sleep very well because she kept thinking about the resident.

On 6/7/23 at 9:56 AM Resident #39's Durable Power of Attorney (DPOA) was called, she indicated the only time anyone called the day her dad passed away was when he had passed. She stated she had it written down that the hospice nurse called on 5/29/23 at 3:56 PM but she missed the call. The hospice staff called her back at 4:07 PM asking if she could go somewhere to talk, she knew he was gone. That was the only person that called her that day about her dad.

On 6/7/23 at 10:08 AM Staff F, LPN, stated she called Resident #39's daughter once, there was no answer so she left a voicemail to call her back. No call back was made and Staff F did acknowledge she did not chart that she attempted to call his daughter.

On 6/8/23 at 2:52 PM the Director of Nursing (DON) stated Staff F should have notified the family when she knew something was not right. The family could have changed the treatment plan, come off hospice, or go to the hospital. The

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family should have known so they could have come to the facility to be with him.

Review of the facility's Notification for Change of Condition with a revised date of 7/28/22 indicated the facility must immediately inform the resident; consult with the resident's physician and if known, notify the resident's legal representative or an interested family member when there is a significant change in the resident's physical, mental, or psychosocial status (i.e., a deterioration in health, mental, or psychosocial status in either life-threatening conditions or clinical complications); a need to alter treatment significantly (i.e., a need to discontinue an existing for of treatment due to adverse consequences, or to commence a new form of treatment); or a decision to transfer or discharge the resident from the facility as specified.

2. The Minimum Data Set (MDS) assessment dated 3/3/23 for Resident #5 documented an unplanned discharge to an acute care hospital on 3/3/23.

The clinical record lacked progress notes for Resident #5 dated 3/3/23. The most recent progress note documented a routine visit from the facility Nurse Practitioner with the resident on 3/2/23 at 10:38 am.

On 5/15/23 at 10:10 am, a family member of Resident #5 stated she had met with a hospice nurse on 3/2/23 regarding possibly enrolling Resident #5 in hospice. The family member stated that on 3/3/23 the resident's husband received a phone call from the Intensive Care Unit at an acute care hospital regarding Resident #5 notifying them the resident was in the hospital;

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F 580	Continued From page 10 no communication had been received from the facility to the family. The family member stated she then called the facility and the nurse who answered the phone was not aware the resident was not in the facility. The family member stated she was later told the resident had been sent to the hospital in the early morning hours and it was approximately 4-5 hours later before the phone call was received from the hospital. She stated Resident #3 stayed in the hospital for approximately 1 week prior to passing away in the hospital and nobody from the facility ever called any family during this time. On 5/22/23 at 10:02 am the Director of Nursing (DON) stated she expected staff to attempt to notify the family prior to sending a resident to a hospital or leave a message with family to call the facility. The policy titled Notification for Change of Condition, Revision dated 7/28/22 documented: The facility must immediately inform the resident, consult with the resident ' s physician, and if known, notify the resident ' s legal representative or an interested family member when there is A significant change in the resident's physical, mental or psychosocial status (i.e. deterioration in health, mental or psychosocial status in either life threatening conditions or clinical complications); A need to alter treatment significantly(i.e. a need to discontinue an existing form of treatment due to adverse consequences, or to commence a new form of treatment) or A decision to transfer or discharge the resident from the facility	F 580		
F 684 SS=K	Quality of Care CFR(s): 483.25	F 684		

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§ 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 interviews, and facility policy review the facility failed to assess and provide immediate interventions for Resident #39 who on 5/29/23 at 10:00 AM experienced a significant change in physical status and informed staff he didn't feel right and felt like he was dying. The resident presented with puss coming out of the urinary catheter insertion site, skin pale, statements of cold, sweating profusely, urine cloudy, and dull gray color, and blood sugar reading of 536 mg/dL. The staff failed to contact hospice or the primary care physician (PCP) for treatment orders and the resident passed away at approximately 2:30 PM. This resulted in an Immediate Jeopardy (IJ) to residents' health and safety. The facility also failed to initiate hospice orders after a new skin area was discovered by the hospice staff members. The facility reported a census of 86 residents, with 12 residents on hospice.

Findings included:

The State Agency informed the facility of the IJ on 6/2/23 at 1:00 PM and provided the IJ template. The IJ began on 5/29/23. The facility staff did not remove the immediacy prior to the exit of the

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on-site survey. The initial scope and severify of "K" remained at the time of exit.

Findings include:

The significant change Minimum Data Set (MDS) assessment, dated 3/26/23, for Resident #39 identified a Brief Interview of Mental Status (BIMS) score of 3. A BIMS score of 3 suggested he had severe cognitive impairment. The MDS revealed he required extensive assistance of 2 staff for bed mobility, transfers, dressing, toilet use, and personal hygiene. The MDS documented he required hospice services while a resident in the facility. The MDS documented the following diagnoses for Resident #39: sepsis, heart failure, diabetes mellitus, and depression.

The Care Plan focus area dated 3/14/23 identified Resident #39 received hospice services due to end-stage cardiac disease, severe deconditioning, and malnutrition. The Care Plan indicated the hospice team will integrate services and collaborate cares. The Care Plan also indicated he had diabetes mellitus.

The Hospice Comprehensive Assessment and Plan of Care Update Report dated 5/18/23 documented he started to receive hospice services on 3/13/2023.

Review of the resident's Electronic Health Record (EHR) revealed his blood sugar was checked on 5/29/23 at 10:22 AM by Staff CC, Certified Medication Assistant (CMA). His blood sugar was 536 milligram per deciliter (mg/dL).

Review of Resident #39's May 2023 Medication

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Administration Record (MAR) revealed Staff CC administered his as needed (PRN) order of oxycodone 5 milligram (mg) 1 tablet on 5/29/23 at 10:58 AM.

Resident #39's hospice binder cover and hard chart cover had the following sticky noted taped to both covers: #39 is a patient under hospice care. Please call us for any of the following: change in condition. The sticky note listed the phone number along with the attending physician's name.

a.) Review of Resident #39's Progress Notes revealed the following note was documented by Staff F Licensed Practical Nurse (LPN) on 5/29/23 at 3:42 PM: called to the room, resident lying in bed, starring at the ceiling. He looked at the nurse when his name was called. Vitals obtained: blood pressure 111/52, respirations 14, oxygen saturation 92% on room air, and temperature was 96.4 degrees Fahrenheit. Staff F noted the urine in his drainage bag to be creamy green in color. She did not note any shortness of breath or respiratory distress. Staff F gave an as needed (PRN) oxycodone (pain management) at 11:30 AM. She went back in to the room at 2:30 PM, by the request of the Certified Nursing Assistant (CNA), resident was dead, no apical pulse, no breathing. Hospice was made aware. His Progress Notes lacked documentation of notification of his hospice provider when he started to have a significant change in condition.

Review of Resident #39's Hospice Notes, provided by the hospice company, revealed a Visit Note Report dated 5/29/23 with the visit type listed as hospice death at home. The report

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documented the nurse was in the facility on 5/29/23 at 4:16 PM until 5/29/23 at 4:35 PM. Resident #39's hospice notes did not contain mention of the on-call hospice nurse or physician being notified of his emergent change in condition.

On 5/30/23 at 7:00 PM Staff DD Certified Nursing Assistant (CNA) stated on 5/29/23 at 10:00 AM Resident #39 told her that he did not feel right and felt like he was dying. She noted his skin to be pale, he was cold to the touch, sweating profusely, and saw that his urine was cloudy and a dull gray color. She reported to this to Staff F but she was very nonchalant, told her the resident was on hospice. She notified Staff CC of her concerns and she checked his blood sugar; it was 536 mg/dL. Staff F went in later to check on the resident and took his vital signs. The nurse told Staff DD there wasn't anything she could do about it other than call hospice. Staff DD was unsure if the nurse actually called hospice or not but does not think she did until the resident passed away around 2:30 PM. Staff DD indicated she, herself, frequently checked on him throughout her shift; every 30 minutes between her resident cares until she left at 2:00 PM. After her shift, he passed away about 15-20 minutes after she left her shift. She added only the nurses can contact hospice staff members. Staff DD added it bothered her when she found out the resident passed away. She thinks he died alone without family or hospice staff with him. She indicated she knows hospice would've came in if they were called but doesn't think hospice was called. She cried and didn't sleep very well because she kept thinking about the resident.

During a follow-up interview on 6/7/23 at 3:45 PM

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Staff DD reported she started her shift at 6:00 AM and did rounds on all of the residents on the hall she was assigned to. When she did rounds at 8:00 AM, Resident #39 was in bed and still sleeping. At 10:00 AM when she checked on the resident, he was awake but his color didn't look good so she asked him how he was doing. She added he was really pale. She asked the resident how he was feeling. The resident said he didn't feel well, didn't know what was wrong but thought he was dying. She let the nurse know right away after she spoke with Staff CC. She told her about the resident about 5 minutes after her encounter with the resident at 10:00 AM. She informed Staff F of what the resident said. The nurse said resident was on hospice. About 30-60 minutes later she heard Staff CC telling Staff F the symptoms the resident was having. Around lunchtime, 12:00 - 12:30 PM, when resident continued to complain of not feeling well, Staff F told Staff DD that she could check Resident #39's vital signs, but there was nothing she could do.

On 6/1/23 at 12:38 PM Staff CC stated on the day Resident #39 passed away she got report from the CNA that he was losing color, cold to the touch, sweating and clammy. Staff CC stated when she took care of him when he was upstairs, he had done this before and they would send him out to the hospital. When these concerns were reported to her, she checked his vitals and took his blood sugar which was like 536mg/dL. She reported her findings to the nurse on duty that day and Staff F told her he was on hospice and they would have to go through hospice to send him out. She was unsure if Staff F called hospice. Staff CC reported Resident #39 had a second episode where he lost his color, was clammy so she went back in there and he looked dead. She

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got Staff F, and she told Staff CC that she went in there his eyes rolled and had not expired at that time. Staff CC verified Resident #39 had a PRN order to have his blood sugar checked but had no insulin orders. When she saw his urine that day it was cloudy and a greenish color. He did ask for something for pain, so she gave that to him. When asked how he was prior to these episodes, she stated he did not eat much, but seemed like he was fine. When asked if the felt the nurse did everything she could have for him that day, she felt like she could have done more. She believed the call to hospice should have been done sooner. She believed Staff F had a lot on her plate that day; she was the only nurse with two CMAs downstairs that day.

On 6/1/23 at 1:14 PM Staff BB LPN was asked what she would do if a hospice resident became pale, cold to the touch, sweating profusely, had a blood sugar of 536 mg/dL and his catheter bag had cloudy, dull gray urine, she stated she would freak out then call hospice doctor. She would see what they needed to do for the resident. She would also notify hospice as well to see what they wanted to do.

On 6/1/23 at 1:16 PM Staff E when asked stated she would call hospice and notify the physician right away if a hospice resident was pale, cool to the touch, sweating profusely, had a blood sugar of 536 mg/dL and had cloudy, dull gray colored urine.

On 6/2/23 at 8:23 AM the Administrator with the hospice provider indicated she was on-call the day Resident #39 passed away. She indicated the only the time facility staff notified her was when he had passed away. She added their hospice

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staff always tell staff and the resident to call them even if it is nothing. She stated they tell them this with every hospice visit. When asked if the facility should have called them when he had an emergent change in condition, she said they should have so they could figure out the family's or resident's goal based on their symptoms. Hospice would call the physician to get orders for the best way to provide comfort for this resident. If the facility was unable to get ahold of the hospice nurse they could call the hospice physician for guidance as well. They encourage the facility staff to call the hospice nurse first then the physician. She indicated they have an on-call system that notifies the nurse on call of a facility making a call. If that on-call person does not return the call within 15 minutes, it will automatically call her.

On 6/2/23 at 9:41 AM Staff F indicated she primarily worked downstairs. She indicated on the day Resident #39 passed away they had a nurse call in so she was the only nurse downstairs with two CMAs. She added that is a lot of work for one nurse. She recalled staff wanted her to go in and check on Resident #39, he looked fine to her. She described his urine as a creamy thick spinach color. She told the CNA his body was shutting down and she had called hospice to get them at the facility immediately. She knew he was transitioning so she gave the PRN of oxycodone because he was also grimacing when he was touched or turned in bed. She believed he did not look any different that day. Staff then came to her and reported he had expired so she went in there, she did a sternal rub on him and he took a few breaths then passed away. When asked what CNAs were reporting concerns to her she stated there were like six on the floor that day and could

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not remember who it was. She did acknowledge that staff notified her of Resident #39 being pale, sweaty, and cool to the touch that day but when she went in there he was normal. His normal color was pale. When asked how much time had lapsed when she was notified by staff of their concerns until she went in the room; she stated not much time had went by. She was in the middle of a medication pass so she finished that then went in to his room. She added no one saw her going in to Resident #39's room only coming out. When asked if she contacted hospice that day, she stated she called them twice. She indicated she called about 10:30 AM and the on-call person told her she was busy and could not make it to the facility. When she did arrive at the facility it was about 1:30 PM-2:00 PM right after he passed away. Staff F stated she let the hospice staff take over when she got there. Staff F added when she first called them she was told to keep him comfortable since he was on hospice there was nothing to do. During a follow-up interview with Staff F on 6/7/23 at 10:08 AM she indicated she could not remember what time she initially went in to his room. She added she was so busy with three other residents transitioning that that time. She indicated she went right to his room after she was done with her medication pass. When asked if she was administering morning to noon medications at that time, she stated she thought it may have been about 11:00 AM but did not look at the clock. She indicated she immediately took his vitals to see where he was at then called hospice. She told her everything and the hospice staff member advised her to keep him comfortable. Staff F stated about 1:00 PM she called hospice again, she indicated the hospice person advised her not to call the physician because he would not do anything.

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Staff F stated she was unsure when his blood sugar was taken and was not sure why the staff member did that.

On 6/2/23 at 8:33 AM the Director of Nursing (DON) was asked if a hospice resident experienced a change in condition should their hospice provider be notified, she stated the nurse usually notifies hospice. When asked if this hospice resident had a change in urine characteristics and a high blood sugar, should hospice be notified she stated that is dependent on if they are close to end of life. It's a case by case decision. She acknowledged hospice should have been notified of Resident #39's change in condition, but it was her understanding that they were notified. In a follow-up interview on 6/8/23 at 2:52 PM she indicated she asked who Staff F spoke to and what she did once she was informed of Resident #39's elevated blood sugar. Staff F indicated she reached out to hospice in the morning and got the answering service, they told her they would get back to her. She called back again but did not take down the names of the person's she spoke to. The DON told her she should always take down the name of who you talk with. The DON then called the hospice provider to see when Staff F contacted them about Resident #39 on that day. The hospice provider indicated the facility only notified them of his passing. Staff F was then questioned if she notified the family or physician of the elevated blood sugar and she did not. She indicated the resident was on comfort measures. The DON explained to her the family has the right to change treatment or come off hospice. Staff F said that the resident was on hospice, she felt her job was to keep him comfortable and that is what she did. She provided holistic cares, pain

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management, repositioning, etc. She did acknowledge she called again when he passed away. When asked what the DON would have done in the situation, she stated she would have called the doctor and call the family to see what they would have wanted done. When the DON was informed the family was not notified, they did not have the option to be with him. She indicated she knew that and she would have notified them.

On 6/2/23 at 2:25 PM the Hospice Physician/Medical Director indicated he was not notified of Resident #39's change in condition the day he passed away. He added he was only made aware of his passing. The facility should have notified him of his condition and blood sugar so they could act accordingly.

On 6/8/23 at 2:18 PM the Administrator stated she would have expected Staff F to reach out hospice. If she was unable to do that then she should have called the physician or on-call nurse.

The facility's Care Path Symptoms of Acute Mental Status Change flowsheet contained the following guidance for staff with the symptoms Resident #39 had experienced on 5/29/23: New Mental Status Change Noted, staff were then directed to take vitals which included a blood sugar. If the blood sugar was over 300mg/dL the flowsheet instructed staff to notify the physician, then monitor response.

The facility's Change in Condition policy with a revision date of 11/2016, purpose was to provide guidance in the identification of clinical changes that may constitute a change in condition and require intervention and notification. CMS requires a facility must immediately inform the

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resident; consult with the resident's physician; and notify, consistent with his or her authority, the resident representative(s) when there is 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); a need to alter treatment significantly (that is, a need to discontinue to change an existing form of treatment due to adverse consequences, or to commence a new form of treatment).

According to the American Medical Directors Association (AMDA) Clinical Practice Guidelines-Acute Changes in Condition in the Long-Term Care Setting, immediate notification is recommended for any symptom, sign or apparent discomfort that is acute or sudden in onset or a marked change in relation to usual symptoms and signs, or is unrelieved by measures already prescribed.

b) The Progress Note dated 5/12/23 at 12:30 PM documented hospice came to visit Resident #39 and changed his Foley catheter. The hospice Registered Nurse (RN) reported a small sore on the right side of his penis, with a small amount of blood noted on the surface. The hospice nurse was going to report this to their doctor.

A Visit Note Report completed by the hospice nurse staff on 5/12/23 contained the following narrative: This nurse arrived to the resident's room for a routine nurse visit. This nurse changed the Foley catheter per orders. While cleansing his penis a 1-centimeter (cm) abrasion was noted on the right side of his penis. Resident denied pain to the area. This nurse spoke with Staff BB

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Agency Licensed Practical Nurse (LPN) regarding the wound and new orders to be faxed to the facility. This nurse will follow up with facility staff to confirm.

The Hospice documentation for Resident #39 included the following hospice physician order written on 5/12/23 at 9:53 AM with a start date of 5/13/2023: cleanse penis foreskin abrasion with soap and water, then pat dry. Apply triple antibiotic ointment two times daily (BID) and leave open to air. Hospice skilled nurse to provide wound care on hospice visit days and facility to provide wound care on non-hospice days. Hospice nurse to educate facility staff on signs and symptoms of infection. Facility staff to call hospice nurse with any signs and symptoms of infection.

Review of Resident #39's May 2023 Medication Administration Record (MAR) and Treatment Administration Record (TAR) revealed the hospice physician order that was written on 5/12/23 at 9:53 AM with a start date of 5/13/23 was not on the MAR or TAR to be completed as ordered by hospice.

On 6/1/23 at 1:14 PM Staff B acknowledged the hospice nurse found a sore on Resident #39's penis. She added the nurse told her he was taking care of it and put some treatment on it.

On 6/8/23 at 2:52 PM the Director of Nursing (DON) indicated when hospice writes a new order the hospice staff and their Advanced Registered Nurse Practitioner (ARNP) would sit together and put in new orders together. When she was made aware that the order for the abrasion on his penis was not initiated after it was written by hospice,

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F 684	Continued From page 23 she said ok. The facility's Following Physician Orders/Transcription of Orders policy with a revision date of 5/2023 indicated physician's orders will be received by a licensed nurse, therapist, or dietician. Orders may be received through written communication in the resident's chart, verbally or per telephone, via fax, or electronically entered in their charting system. If the order is for a medication or treatment, it should be entered in the MAR/TAR accordingly. Active orders should be followed and carried out as written/transcribed.	F 684		
F 686 SS=H	Treatment/Svcs to Prevent/Heal Pressure Ulcer CFR(s): 483.25(b)(1)(i)(ii) §483.25(b) Skin Integrity §483.25(b)(1) Pressure ulcers. Based on the comprehensive assessment of a resident, the facility must ensure that- (i) A resident receives care, consistent with professional standards of practice, to prevent pressure ulcers and does not develop pressure ulcers unless the individual's clinical condition demonstrates that they were unavoidable; and (ii) A resident with pressure ulcers receives necessary treatment and services, consistent with professional standards of practice, to promote healing, prevent infection and prevent new ulcers from developing. This REQUIREMENT is not met as evidenced by: Based on clinical record review, resident, family, physician, and staff interviews, and policy review, the facility failed to ensure residents provided with routine repositioning to prevent pressure ulcers (Resident #3, #16) and failed to evaluate and	F 686		

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provide appropriate sized equipment and initiate hospice orders for 1 resident (Resident #39) out of 4 residents reviewed for pressure ulcers. This resulted in harm to the residents due to residents developing facility acquired pressure ulcers. The facility staff identified 8 residents with pressure wounds at the time of the survey. The facility reported a census of 86 residents.

Findings include:

MDS Definitions of Pressure Ulcers

Stage 1 Pressure Injury: Non-blanchable erythema of intact skin Intact skin with a localized area of non-blanchable erythema, which may appear differently in darkly pigmented skin. Presence of blanchable erythema or changes in sensation, temperature, or firmness may precede visual changes. Color changes do not include purple or maroon discoloration; these may indicate deep tissue pressure injury.

Stage 2 Pressure Injury: Partial-thickness skin loss with exposed dermis Partial-thickness loss of skin with exposed dermis. The wound bed is viable, pink or red, moist, and may also present as an intact or ruptured serum-filled blister. Adipose (fat) is not visible and deeper tissues are not visible. Granulation tissue, slough and eschar are not present. These injuries commonly result from adverse microclimate and shear in the skin over the pelvis and shear in the heel. This stage should not be used to describe moisture associated skin damage (MASD) including incontinence associated dermatitis (IAD), intertriginous dermatitis (ITD), medical adhesive related skin injury (MARSI), or traumatic wounds

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(skin tears, burns, abrasions).

Stage 3 Pressure Injury: Full-thickness skin loss Full-thickness loss of skin, in which adipose (fat) is visible in the ulcer and granulation tissue and epibole (rolled wound edges) are often present. Slough and/or eschar may be visible. The depth of tissue damage varies by anatomical location; areas of significant adiposity can develop deep wounds. Undermining and tunneling may occur. Fascia, muscle, tendon, ligament, cartilage and/or bone are not exposed. If slough or eschar obscures the extent of tissue loss this is an Unstageable Pressure Injury.

Stage 4 Pressure Injury: Full-thickness skin and tissue loss Full-thickness skin and tissue loss with exposed or directly palpable fascia, muscle, tendon, ligament, cartilage or bone in the ulcer. Slough and/or eschar may be visible. Epibole (rolled edges), undermining and/or tunneling often occur. Depth varies by anatomical location. If slough or eschar obscures the extent of tissue loss this is an Unstageable Pressure Injury.

Unstageable Pressure Injury: Obscured full-thickness skin and tissue loss Full-thickness skin and tissue loss in which the extent of tissue damage within the ulcer cannot be confirmed because it is obscured by slough or eschar. If slough or eschar is removed, a Stage 3 or Stage 4 pressure injury will be revealed. Stable eschar (i.e. dry, adherent, intact without erythema or fluctuance) on the heel or ischemic limb should not be softened or removed.

Deep Tissue Pressure Injury: Persistent non-blanchable deep red, maroon or purple discoloration Intact or non-intact skin with

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localized area of persistent non-blanchable deep red, maroon, purple discoloration or epidermal separation revealing a dark wound bed or blood filled blister. Pain and temperature change often precede skin color changes. Discoloration may appear differently in darkly pigmented skin. This injury results from intense and/or prolonged pressure and shear forces at the bone-muscle interface. The wound may evolve rapidly to reveal the actual extent of tissue injury, or may resolve without tissue loss. If necrotic tissue, subcutaneous tissue, granulation tissue, fascia, muscle or other underlying structures are visible, this indicates a full thickness pressure injury (Unstageable, Stage 3 or Stage 4). Do not use DTPI to describe vascular, traumatic, neuropathic, or dermatologic conditions.

1. The Minimum Data Set (MDS) assessment dated 2/26/23 for Resident #3 revealed the resident totally dependent upon 2 person physical assistance for bed mobility and transfer. The MDS documented diagnoses that included sarcopenia (age related progressive loss of muscle mass and strength), diabetes mellitus, dementia, and morbid obesity. The MDS dated 3/14/23 documented a height of 62 inches and a weight of 386 pounds.

The Comprehensive Care Plan for Resident #3 revealed a focus area of impairment to skin integrity with multiple wounds including a Stage 3 pressure ulcer to sacrum. Interventions included off load heels as ordered and turn and reposition routinely and as needed.

The Progress Note dated 1/29/2023 at 6:33 pm documented Resident #3 had excoriated buttocks

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and stated buttucks painful when touched.

The Progress Note dated 1/31/23 at 2:57 pm documented staff placed a call to the facility Advanced Registered Nurse Practitioner (ARNP) regarding buttocks excoriation.

The Wound Evaluation and Management Summary dated 2/2/23 documented the resident as having a Stage III pressure wound to the sacrum. The documentation reflected this wound at Site #31 for wound evaluation. Prior to this visit, the wound physician had been treating the resident for 30 prior wounds. The Summary documented the wound as etiology of Pressure, Stage 3 and size of 2.0 centimeter (cm) x 0.5 cm x unmeasurable depth, 100% slough covered. The evaluation recorded diabetes and dementia as relevant conditions that contributed to wound healing. Recommendations made during the visit included off-loading the wound site and to reposition per facility protocol.

The Wound Evaluation and Management Summary dated 3/30/23 documented the Site #31 as Stage 3 Pressure, size of 2.0 cm x 0.5 cm x 0.1 cm, 100% granulation tissue, noted as healing. Recommendations remained as off-loading and repositioning.

On the 3/30/23 visit, additional wounds of numbers 41-47 were all documented as new wounds. The Summary documented Site 41 as etiology of Pressure, unstageable Deep Tissue Injury of the right heel. Sites 42-47 were documented as unstageable deep tissue injury to the fingers of both hands, all documented as pressure in etiology.

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The Wound Evaluation and Management Summary dated 5/5/23 documented Site #31 as Stage 3 Pressure, size of 1.5 cm x 0.5 cm x 0.2 cm (increasing in depth), 100% granulation tissue, noted as healing. Recommendations remained as off-loading and repositioning.

On the 5/5/23 visit, additional wounds of numbers 48-55 were all documented. The Summary documented Site 48 as non pressure, moisture associated skin damage to the right buttocks. Site 49 was documented as a Stage 4, etiology of pressure to the right, dorsal, lateral hand. Site 50 was documented as a venous wound of the left shin. Site 51 was documented as an unstageable deep tissue injury, etiology of pressure, to the left first finger. Site 52 was documented an unstageable deep tissue injury, etiology of pressure, to the left fifth finger. Site 53 was documented an unstageable deep tissue injury, etiology of pressure, to the right fifth finger. Site 54 was documented an unstageable deep tissue injury, etiology of pressure, to the right fourth finger. Site 55 was documented an unstageable deep tissue injury, etiology of pressure, to the right third finger.

On 5/15/23 at 9:56 am, a family member of Resident #3 stated every time she was in the facility to visit, Resident #3 was flat on her back. She stated she had never seen the resident turned to her side. She stated she wondered if due to the resident's obesity the facility was not capable of turning her but stated it's not good for the resident to be on her back all of the time.

Observeation on 5/15/23 at 11:05 am revealed Resident #3 laid on her back with a low air loss mattress in place on her bed. Observation

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revealed a treatment dressing in place on the resident's right hand and her left hand had multiple dark scabs on her knuckles.

Observation on 5/16/23 at 7:55 am revealed Resident #3 again laid on her back in bed.

On 5/16/23 at 10:28 am Staff A, Hospice Case Manager Registered Nurse (RN) and Staff B, Licenses Practical Nurse (LPN), with assistance from Staff C, Certified Medication Aide (CMA) performed wound care on the wounds to Resident #3's sacrum and right buttoks. Following wound care, the staff provided significant repositioning assistance and changed the resident's gown. The staff left the resident positioned on her back following cares.

On 5/16/23 at 10:59 am, Staff B, LPN, stated the resident stayed primarily on her back at all times but tilted with pillows. Staff B stated that was due to the resident having pain and due to her bariatric size.

Continuous observation occurred on 5/16/23 from 12:30 pm to 1:57 pm. The observation revealed no staff members entered Resident #3's room since wound care completed at 10:59 am. At 12:40 PM, Staff D, Certified Nurse Aide (CNA) dropped a lunch tray off in Resident #3's room and exited the door a moment later. At 12:52 pm, Staff D returned to assist Resident #3 to eat. At 1:06 pm, Staff D exited the room carrying the food tray and placed it in the kitchen cart. At 1:20 PM, Staff D stated that Resident #3 always stayed in bed. Staff D stated the resident required total assistance of 2 staff members to provide all cares except eating which required 1 staff person only. Staff D stated it took 2 people

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to reposition the resident and if the resident were to get out of bed, that would take 2 staff members using a hoyer lift (mechanical full body lift). At 1:57 PM, no staff members had cared for Resident #1 except for providing lunch; more than 3 hours had passed since the completion of wound cares.

Continuous observation occurred on 5/21/23 from 11:41am to 3:40 pm. Observation revealed at 11:41 am Resident #3 laid on her back with her heels floated. At 12:46 pm, Staff E, LPN stated she was unaware of what treatments were ordered for Resident #3 but she would look after she completed medication pass. Staff E stated her work hours were 6:00 am to 6:00 pm. At 1:10 pm, Staff D, CNA, entered the resident's room with a lunch tray. At 1:15 pm, Staff D sat on a bench in the resident's room using her personal cell phone with Resident #3's lunch tray sitting untouched next to her. At 1:35 pm, Resident #3 remained in the same position as at the beginning of the observation.. At 2:15 pm, Staff E, LPN and Staff F, LPN, Nursing Supervisor, stated they would provide wound care treatments. Staff F responded she expected Resident #3 to be assisted to reposition at least every 2 hours. Staff F stated due to incontinence, the resident would likely need assistance more often than every 2 hours. At 2:20 pm, Staff E stated she was not familiar with the orders for Resident #3 and she was having difficulty getting the computer to work in the room. At 2:25 pm, Staff E administered morphine to Resident #3 prior to beginning wound care. At 2:35 pm wound care was started. This was 2 hours and 54 minutes after the start of continuous observation. Multiple wounds were cleansed and dressed. At 3:20 pm an additional dose of morphine was given to

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Resident #3 for comfort during the remaining wound care. Wound care was stopped to allow the resident to rest while the morphine had time to take effect. Wound care resumed at 3:30 pm. Two additional staff members, Staff G, CNA and Staff H, CNA entered the room to assist with repositioning. Complete repositioning occurred along with bedding and gown change with continuous observation ending at 3:40 pm.

On 5/22/23 at 10:02 the Director of Nursing (DON) stated she expected that any resident who was unable to turn themselves should be repositioned a minimum of every two hours.

On 5/23/23 at 11:23 am, the Wound Care Physician stated she had most recently cared for Resident #3 the previous week. She stated the resident did not tolerate lying on her side for very long. She stated the biggest factors in wound healing are off loading the pressure and the use of the low air loss mattress. She further stated the resident had significant moisture associated skin damage. She said the pressure wound to her sacrum has had minimal change or improvement and the most important factor for it to heal was off loading pressure. She stated she felt it was unlikely to ever heal fully but it would be beneficial for the resident to lie on her side. She stated she was not in the building for long enough to know if staff were repositioning the resident every two hours but it was her recommendation that it be done.

The policy titled Skin Care Treatment Regimen, Revision dated 7/28/22 documented:
Residents who are not able to turn and reposition themselves will be turned and repositioned every two hours unless specified in the Physician Order

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F 686	Continued From page 32 Summary. Review of the Physician Order Summary has no additional orders for repositioning for Resident #3. 2. The admission MDS assessment dated 3/13/23 revealed Resident #16 admitted to the facility on 3/6/23 and had diagnoses of diabetes, urinary tract infection, and coronary artery disease. The MDS documented the resident had a Brief Interview for Mental Status (BIMS) score of 12, indicating moderately impaired cognition. The MDS revealed the resident had a risk for pressure ulcer development but had no skin problems or pressure sores. The significant change MDS dated 3/29/23 revealed the resident required extensive assistance of two for bed mobility, transfers, and toileting. The MDS documented the resident had a risk for pressure ulcer but had no skin problems or pressure sores. The MDS indicated the resident on hospice. The care plan initiated 3/7/23 revealed the resident had a risk for skin breakdown due to a history of dehydration, incontinence, diabetes, and immobility. The care plan documented the resident had a non-pressure wound on his right plantar lateral foot and a Stage 1 pressure sore on his right great toe. The care plan also revealed the resident required assistance with ADL's (activities of daily living) including bed mobility and transfers due to limited mobility and physical inactivity. The care plan directives for	F 686		

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staff initiated on 3/7/23 included administer treatments as ordered and monitor for effectiveness, apply bilateral heel protectors as indicated, float heels at all times when in bed, provide a pressure relieving/reducing device on the bed and in the chair, and turn and reposition the resident routinely and as needed.

The order summary report revealed the following:
.
a. Medex boots to heels for protection at all times while in bed started on 3/6/23
b. Body audit every Tuesday for skin observation started on 3/7/23
c. Right plantar foot wound: apply skin prep daily (started on 3/30/23); apply betadine and leave area open to air (started on 4/22/23); cleanse and apply gauze soaked in dakins quarter strength to the wound bed and cover with border gauze every day (started on 5/12/23).
d. Left plantar foot wound: apply betadine and leave open to air daily started on 4/22/23
e. Right foot first (great) toe: Apply skin prep daily started on 5/6/23.

The nursing admission assessment dated 3/6/23 revealed the resident had a small pinpoint area on his coccyx. The admission assessment revealed the resident scored 16 on the Braden Scale, indicating he had a high risk for pressure ulcer development however the top right side of the document revealed the category listed as "low risk" and a score of "7". The admission assessment revealed the following responses marked: the resident responded to verbal commands, but could not always communicate discomfort or the need to be turned, the resident had some sensory impairment which limited his ability to feel pain or discomfort in 1 or 2

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extremities, he had exposure to moisture at least once a day, had a slightly limited ability to change and control body position, and had a potential problem with friction and shear.

The progress notes revealed the following:
a.On 3/21/23 at 7:01 PM, the resident's wife notified Staff W, agency Registered Nurse (RN) the resident had a wound on the bottom of his right foot. Staff W observed a necrotic wound. The wound measured 0.8 centimeter (cm) x 0.6 cm. No drainage noted. The bottom of the left foot had a 0.2 cm x 0.2 cm wound. No drainage noted. Hospice contacted. Hospice staff stated a hospice nurse would come and assess the resident.

b. On 3/22/23 at 3:45 PM, the nurse practitioner (NP) documented the resident had a pressure ulcer on the anterior part of his right foot. The resident had pain rated at "4" out of 10, and was educated to elevate his leg. The NP documented the resident had a pressure ulcer present on both feet. The right lower extremity pressure ulcer measured 2.2 cm x 2 cm, and the left lower extremity wound measures 0.7 cm x 0.5 cm. The NP ordered a wound care physician (Dr) consult.

c. On 3/30/23 at 3:50 PM, resident seen by the wound care Dr. A non-pressure wound on the right plantar lateral foot measured 2 cm (L) (length) x 1.8 cm (W)(width). No new orders received.

d. On 4/7/23 at 7:28 AM, resident seen by the wound Dr on 4/6/23. A non-pressure wound of the right plantar lateral foot measured 2 cm (L) x 1.8 cm (W). No new orders received.

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e. A late entry progress note dated effective 4/13/23 at 2:12 PM, but created on 4/14/23 at 2:13 PM by Staff X, unit manager, revealed the resident seen by the wound Dr on "4/14/26". The resident's plantar lateral foot measured 2 cm (L) x 1.8 cm (W) and had a scab. New orders received and resident educated at the bedside.

f. Another late entry progress note created by Staff X on 4/21/23 at 4:02 PM but effective on 4/20/23 at 4:00 PM revealed the resident seen by the wound Dr. A non-pressure wound of the right plantar lateral foot scab measured 2 cm (L) x 1.8 cm (W). A non-pressure wound on the left plantar lateral foot measured 0.3 cm (L) x 0.3 cm (W). The periwound (tissue surrounding the wound) had purpura (purple spots). New orders received.

g. A late entry progress note created on 4/21/23 at 4:06 PM by Staff X but effective 4/20/23 at 10:05 AM revealed an end of bed extender lengthened by maintenance per request of the wound Dr due to the resident had a new foot wound.

h, On 4/27/23 at 5:22 PM, wound Dr saw the resident. A non-pressure wound of the right plantar lateral foot measured 2 cm (L) x 1.8 cm (W). The left plantar foot wound had resolved.

i. On 5/4/23 at 12:45 PM, a dark area noted to the right lateral foot. No redness or warmth surrounded the wound site. Resident compliant with wearing heel protectors.

j. On 5/5/23 at 11:02 AM, wound Dr saw the resident. The resident's right plantar lateral foot

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wound measured 2 cm (L) x 1.8 cm (W) and had 100% thick adherent black necrotic tissue. The resident also had a wound on the right first toe that measured 0.3cm (L) x 1.1 cm (W). No drainage noted. Skin prep applied daily.

k. On 5/11/23 at 3:23 PM, wound Dr saw the resident. The right plantar lateral foot non-pressure wound measured 2 cm (L) x 1.8 cm (W) and had 100% thick adherent black necrotic tissue. The right first toe wound measured 0.1cm (L) x 0.8 cm (W) x 0.1 (D).

l. On 5/18/23 at 3:06 PM, wound Dr saw the resident. A non-pressure wound of the right plantar lateral foot measured 2 cm (L) x 1.5cm (W) and had 100% thick adherent black necrotic tissue. The right first toe wound measured 0.1cm (L) x 0.8 cm (W).

The specialty physician wound evaluation and management summary revealed the following on the right plantar lateral foot:
a. On 3/30/23 a non-pressure ulcer measured 2 cm x 1.8 cm. The physician recommended to offload the wound, reposition per facility protocol, and apply skin prep daily.
b. On 4/6/23 the wound measured 2 cm x 1.8 cm. The physician recommended to offload the wound, reposition per facility protocol, and apply skin prep daily.
c. On 4/13/23 the wound measured 2 cm x 1.8 cm. The physician recommended to continue to offload the wound, reposition per facility protocol, and apply skin prep daily.
d. On 4/20/23, the wound measured 2 cm x 1.8 cm. The physician recommended removal of the bed foot board as the resident had a bed extender but his foot still pushed against the

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board.
e. On 4/27/23, the wound measured 2 cm x 1.8 cm. The wound depth not measurable due to presence of nonviable tissue and necrosis. The physician recommended removal of the bed foot board as the resident had a bed extender but his foot still pushed against the board, reposition per facility, and continue skin prep daily.
f. On 5/5/23 and 5/11/23, the wound measured 2 cm x 1.8 cm. The physician recommended removal of the bed foot board as the resident had a bed extender but his foot still pushed against the board, reposition per facility, and continue skin prep daily.

The skin alteration record dated 5/11/23 revealed the resident had an eschar wound on the right plantar foot measuring 2 cm x 1.8 cm.

A pressure ulcer healing chart used to monitor trends in PUSH scores over time revealed a record only for the right first toe. The document revealed on 5/5/23, a "PUSH" total score of 3 indicating the wound the size of 0.7 cm x 1.0 cm. On 5/11/23, a "PUSH" score of 1 indicating the wound less than 0.3 cm.

A pick-up/exchange ticket dated 5/18/23 revealed a 36 inch ultracare low air loss mattress picked up on 5/18/23.

Observations revealed the following:
a. On 5/16/23 at 8:10 AM, resident lying in bed with feet on the mattress.
b. On 5/16/23 at 9:15 AM, resident continued to lying in bed on his back and feet on the mattress. No pillow observed under the resident's legs.
c. On 5/16/23 10:15 AM, resident continued to ly in bed on his back.

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On 5/16/23 11:10 AM, resident continued to ly in bed on his back.
On 5/16/23 at 12:20 PM, Staff L, CNA, and Staff M, CNA, transferred the resident from the bed to the broda chair. Staff L and Staff M placed the foot platform (attached to the broda chair) in the down position. The top of the broda chair was in a semi-reclining position and the resident's feet extended over the end of the platform, The broda chair wasn't long enough for the height of the resident. Staff L placed a pillow under the resident's legs but the resident's feet and ankles were lying on the metal ridge of the foot platform on the broda chair.
On 5/16/23 at 2:46 PM, resident now lying in bed.
On 5/17/23 at 10:50 AM resident lying in bed with eyes closed. Bilateral feet lying on the mattress, no pillow under the resident's legs. A bed extender was observed on the end of the bed.
On 5/17/23 at 12:29 PM, the DON removed the dressing on the resident's right lateral plantar food. The right lateral plantar foot had a nickel-sized scabbed, necrotic area. At 12:40 PM, Staff E, LPN, donned gloves, cleansed the right lateral plantar foot wound, changed gloves and sanitized hands, then applied a dakin's soaked gauze to the wound bed, and a border dressing to the area. Staff E removed her gloves, sanitized hands donned gloves and applied skin prep to the right great toe.

During an interview 5/17/23 at 1:00 PM, Resident #16 reported he got a different bed a couple of days ago (on Monday 5/15/23, the day the surveyor entered the facility). The resident reported he was 6 foot 3 inches tall and the bed he had wasn't long enough. Staff had to put pillows in front of the end of the bed because his feet pressed up against the bedboard. The

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resident stated sometimes staff put a pillow under his legs to float his heels but sometimes it hurt his knees and unable to tolerate pillow at all times. The resident reported the Broda chair provided by hospice but his feet hung over the footboard because he was too tall. The resident reported staff placed a pillow under his legs whenever he sat in the chair.

During an interview 5/17/23 at 4:00 PM, the DON reported documentation on wounds and pressure ulcers in the progress notes, but she also had a skin book with documentation of current wounds. The DON stated a referral made to the wound Dr anytime a resident had a significant wound. The NP came to the facility every Wednesday and evaluated the resident's wound progress. The DON stated the wound Dr's wound documentation located in the resident's paper chart.

During an interview 5/18/23 at 3:15 PM, Staff Z, CNA, reported she had worked at the facility 14 years. Staff Z reported hospice staff came to the facility to see Resident #16 four times a week. Staff Z was unsure of the days when hospice visited. Staff Z reported Resident #16 required assistance with positioning in bed.

During an interview 5/19/23 at 8:30 PM, Staff J, Registered Nurse (RN), reported lots of residents required two staff for assistance and cares. Staff J reported several residents had developed pressure ulcers because the residents had not been repositioned like they should due to the lack of staffing.

During an interview 5/22/23 at 9:00 AM, Staff Q, RN, reported interventions such as positioning

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the resident put into place for prevention of pressure ulcer if a resident had a risk for pressure ulcer development. Staff Q reported the resident's skin risk level depended on if more specific interventions put into place.

During an interview 5/22/23 at 3:00 PM, Staff V, medical records assistant reported a box located at the nurse's station for nurses to put items to go to medical records. Staff V stated the box utilized by staff to place discharged resident records, and staff supposed to file documents in the hard (paper) chart for residents who remained at the facility. Staff V acknowledged she also had a file with some records for residents who remained in the facility. The surveyor looked at Resident #16's file with documents in medical records with Staff V. The medical records file contained a pick-up exchange ticket dated 5/18/23 for a low air loss mattress, and a delivery ticket dated 3/29/23 for a broda chair and a seat lift chair. Staff V stated she believed the resident just needed the mattress because the facility had their own beds and bariatric beds. Staff V reported a certain vendor delivered equipment for residents on hospice.

During an interview 5/22/23 at 3:35 PM, Staff AA, LPN, reported she let maintenance know if a resident needed a bed extender added to the bed.

During an interview 5/22/23 at 3:45 PM, the DON reported Resident #16 didn't qualify for a bigger bed per hospice. The facility had their own bariatric sized bed and provided the resident a larger bed. The DON was unsure of the date when a bariatric bed provided to the resident but stated the vendor picked up the air loss mattress

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on date listed on the pick-up ticket.

During an interview on 5/22/23 at 3:50 PM, the vendor reported the air loss mattress delivered on 3/20/23 and picked up on 5/18/23.

During an interview 5/23/23 at 10:30 AM, the NP reported she had been a NP for 2 ½ years and contracted to work as the NP with the facility for the past 10 months. The NP reported she was unable to speak on the minimum interventions put in place for a resident if a resident had a risk for a pressure ulcer. It depended on the resident. When asked if a resident not repositioned or whenever orders or treatments not done if there would be a decline with a wound, the NP responded she had no knowledge what staff were doing and couldn't speak to the surveyor's question. The NP reported most of the time if a resident alert and oriented she asked the resident if they had any skin issues. Otherwise it depended on the resident whether she performed a head to toe skin assessment when a resident admitted to the facility and during follow up visits. The NP stated no policy or protocol used when a pressure area developed to promote wound healing as they didn't have one. The NP confirmed she was notified of a wound on Resident #16's foot and saw the resident on 3/22/22. The NP stated the wound type was a lower extremity ulcer caused by pressure on his bilateral feet. She directed staff to talk to the wound Dr about wound care. The NP was unable to say if the wound was preventable because each resident was different on the things they liked to do or didn't do. A number of factors played a role in a patient getting a wound. The NP was unable to be more specific on what factors would play a role in development of

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Resident #16's wound. The NP reported she didn't do anything with a Broda chair so she wouldn't know proper positioning in a Broda chair or what staff do for positioning the resident in the Broda chair.

During an interview on 5/23/23 at 10:47 AM, the Maintenance Director revealed the facility had a process in place for work orders to be submitted if something needed fixed or replaced. He stated staff submitted a Maintenance Request Slip. He kept the requests in a notebook after the maintenance request completed. The maintenance director stated he received maintenance request slips for Resident #16 on 3/31/23 when he fixed the wall plate for his TV and extended his bed at that time about two feet. He then revealed on 5/15/23 he replaced Resident #16's bed with a bariatric bed.

During an interview 5/23/23 at 11:30 AM, the wound Dr reported if a resident had a risk for pressure ulcer, the minimum interventions expected put into place included the need to offload the area, do frequent position changes, and offload the heels if a resident stayed in bed. An air loss mattress used if a resident had a pressure injury. The resident's wound had a potential for decline if area not offloaded, especially if the resident not able to move on their own The wound Dr explained the importance of offloading the area in order to prevent development of a pressure area. The wound Dr reported Resident #16 had a nonpressure trauma injury wound on his right foot upon admission. The wound Dr stated she had no opinion on if the wound was preventable or not. If the resident had pressure for extended period of time without offloading the area then the area had an

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increased risk for development of a wound.

During an interview 5/24/23 at 9:55 AM, the Director of Nursing (DON) reported if a resident not wearing foam boots she expected a resident's heels floated by placement of a pillow under the resident's legs so the resident's feet did not touch the bed. The DON reported the importance for staff to get pressure off the resident's heels to prevent a pressure injury.

During an interview 5/30/23 at 12:50 PM, Staff E, LPN, reported skin assessments completed weekly and marked on the MAR when completed.

During an interview 5/30/23 at 1:00 PM, Staff Y, LPN, reported skin assessments performed by the wound Dr, DON, and/or unit manager every Thursday. A skin sheet filled out if a resident had a skin area of concern. Skin assessment documented by the wound Dr and on a skin sheet by the DON/unit manager. An order obtained for an air loss mattress or scoop mattress, and position the resident every 2 hours whenever a resident had a risk for pressure ulcer.

During an interview 6/1/23 at 12:20 PM, Staff X, RN, Unit Manager reported she worked as the unit manager for 6 months but left the facility 2 months ago. Staff X reported the admission assessment completed by the nurse on the floor or the admission nurse. Staff X acknowledged she wrote a progress note when she requested maintenance to remove or extend the end of the bed further on Resident #16. The wound Dr came on Thursdays, but she wrote the note on Friday 4/21/23. She noticed the resident's foot wound injury likely from resting on the end of the bed. She noticed a pressure area on the

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Thursday (4/13) prior to the week before the note she wrote on 4/21/23. The resident had two toe injuries upon admission that they were watching. She noticed a new location on the bony prominence on his right foot. It was a small pinpoint area. She noticed the resident was so tall and when repositioned the resident up in bed his feet still rested against the footrest on the bed. There wasn't anywhere else for him to go. She called maintenance and was told he could remove the end of the bed.

During an interview 6/1/23 at 2:00 PM, the DON reported the numbers on Resident #16's Nursing Admission Assessment should add up from each category under the Braden scale section. Resident #16's admission assessment in 3/2023 (3/6/23) should show "16" and "high risk", not a "7" and "low risk". She will follow up with IT (information technology) but the admission assessment is from when the prior company was at the facility. The new company took over 4/1/2023

A skin care treatment regimen policy revised 7/28/22 revealed it was the facility's policy to ensure prompt identification, documentation and obtaining appropriate treatment for residents who had skin breakdown. The charge nurses must document in the nurse's notes and/ or the Wound Report form any skin breakdown upon assessment and identification. A referral made to the skin care coordinator for review and management of any skin breakdown. The policy also revealed residents who are not able to turn and reposition themselves will be turned and repositioned every 2 hours unless specified in the physician's orders. Residents with Stage III and/or IV pressure ulcer placed in specialized air

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mattresses such as a low air loss mattress.

3. The significant change MDS assessment dated 3/26/23 for Resident #39 identified a Brief Interview of Mental Status BIMS score of 3. A BIMS score of 3 suggested he had severe cognitive impairment. The MDS revealed he quired extensive assistance of two staff for bed mobility, transfers, dressing, toilet use, and personal hygiene. The MDS indicated he was at risk for developing a pressure sore, had one stage one pressure injury and one stage two pressure ulcer present upon admission/entry or reentry. The MDS documented he had a pressure reducing device for his chair and bed, received pressure ulcer/injury care and received applications of ointments/medications other than to his feet. The MDS documented he required hospice services while a resident in the facility. The MDS documented the following diagnoses for Resident #39: sepsis, heart failure, diabetes mellitus, and depression.

The care plan focus area dated 3/14/23 documented he was admitted to the facility with pressure ulcers to his sacrum, right outer ankle, and bilateral heels. The care plan directed staff to apply wound treatments as ordered by the physician.

Review of Resident #39's hospice orders reviewed the following hospice physician order dated 5/9/23 at 11:55 AM: cleanse stage 1 right

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ankle wound with soap and water pat dry. Swab wound with betadine swabs then cover with foam bordered dressing and wrap with kerlix and secure with tape. Wound care is to be done daily and PRN for soilage or dislodgement. Hospice skilled nursing to provide wound care on hospice days and facility to provide wound care on non hospice days. Hospice nurse to educate staff on signs and symptoms of infection and to call hospice nurse with any signs and symptoms of infection.

Review of Resident #39's May 2023 Treatment Administration Record (TAR) reviewed it did not contain the order that hospice wrote on 5/9/23 at 11:55 AM to treat his stage 1 pressure ulcer to his right ankle.

On 6/2/23 at 8:23 AM the Administrator with the hospice provider indicated when a new order has been obtained the hospice nurse will let the facility staff know verbally but they typically send the order over via facsimile (fax). If the hospice staff is in the building they will ask the facility staff to put the order in their Electronic Health Record (EHR) while they are in house then the physician will sign off on the order.

On 6/8/23 at 2:52 PM the Director of Nursing (DON) indicated when hospice writes new order the hospice staff and their A Registered Nurse Practitioner (ARNP) would sit together and put in new orders together. When she was made aware that the order for his right ankle pressure ulcer was not initiated after it was written by hospice, she said ok.

The facility's Following Physician Orders/Transcription of orders policy with a

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F 686	Continued From page 47 revision date of 5/2023 indicated physician's orders will be received by a licensed nurse, therapist, or dietician. Orders may be received through written communication in the resident's chart, verbally or per telephone, via fax, or electronically entered in their charting system. If the order is for a medication or treatment, it should be entered in the MAR/TAR accordingly. Active orders should be followed and carried out as written/transcribed.	F 686		
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 clinical record review, observations, family and staff interviews, and facility policy review, the facility failed to evaluate and document an assessment and ensure a resident able to utilize a motorized wheelchair while indoors and outdoors safely for 1 of 1 residents reviewed with a motorized wheelchair (Resident #11). The facility staff also failed to follow the facility's fall pathway and properly intervene after a resident had a fall and moved the resident despite the resident complained of pain for 1 of 3 residents reviewed for a fall (Resident #40). The facility also failed to ensure portable oxygen safely stored for 1 of 3 residents reviewed for oxygen use (Resident #16), and failed to	F 689		

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appropriately supervise and redirect a cognitively impaired resident from accessing a fire panel with a fire extinguisher inside (Resident #15), and failed to ensure medications carts locked for 1 of 4 medication carts reviewed.

Findings include:

1. The Minimum Data Set (MDS) assessment dated 5/3/23 revealed Resident # 11 had diagnoses of stroke, diabetes, hemiplegia (paralysis on one side of the body), and sarcopenia (a gradual loss of muscle mass, strength and function). The MDS revealed the resident had a brief interview for mental status (BIMS) score of 15, indicating cognition intact. The MDS documented the resident used an electric wheelchair and independent with locomotion and movement on and off the unit.

The Care Plan initiated on 12/5/22 revealed the resident had an ADL (activities of daily living) self-care deficit related to physical limitations after a CVA (cerebrovascular accident) (stroke) with hemiplegia and weakness. The Care Plan revealed the resident was independent in a power wheelchair and desired to participate in outdoor weather activities.

The electronic health record and paper chart lacked an assessment performed or completed on the resident's capability to use a motorized wheelchair indoors and outdoors safely.

The Progress Notes revealed the following:
a. On 5/8/23 at 2:54 PM, the Director of Nursing (DON) was summoned outside. Resident #11 found lying on his back in a supine position. The resident stated he got too close to the sidewalk

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and drove his electric wheelchair partway up on the curb of the sidewalk, tipped the wheelchair over, and landed headfirst. The resident stated he hit his head and complained of head pain. 911 was called. An ambulance arrived and placed a c-collar (around the resident's neck). Resident transported to the hospital for further evaluation.
b. On 5/8/23 at 11:19 PM, resident arrived at facility via ambulance at about 11:00 PM. The resident had new diagnoses of acute non-intractable headache and a contusion on his left elbow. The resident rated his pain at a "3" out of 10, and had pain medication administered.
c. On 5/9/23 at 2:50 PM the Nurse Practitioner (NP) documented she saw the resident after he had a fall. Resident reported he used his wheelchair outside, got too close to the sidewalk, and tipped his wheelchair. The resident reported he landed on his head. Resident sent to the emergency department and evaluated. The resident reported the left side of his face and head hurt. Pain rated at 5 out of 10. The NP documented had acute left sided headache and jaw pain. The treatment plan included hydrocodone (pain medication) 5-325 milligrams (mg) orally every 4 hours as needed for pain.

A Fall Risk Evaluation dated 5/8/23 at 2:35 PM revealed the resident had a low risk for falls.

A Post Incident Follow Up dated 5/8/23 at 2:35 PM revealed the resident had a fall incident. The document revealed vital signs and a head to toe assessment completed and a new injury found, but unable to assess the resident's neck due to pain. The resident rated his pain at 10 out of 10.

Review of Occupational Therapy Evaluation and Notes 7/15/22- 1/23/23 and Physical Therapy

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Evaluation and Notes 12/2022 lacked a motorized wheelchair assessment and evaluation for Resident #11 to safely operate a motorized wheelchair indoors and outdoors.

A Physical Therapy evaluation dated 5/11/23 revealed Resident #11 referred to therapy for a wheelchair driving assessment due to recent fall outside when his wheelchair tipped over off of the curb. The resident was independent with motorized wheelchair previously. The resident's diagnoses included repeated falls, muscle wasting and atrophy, and sarcopenia. Therapy recommended the resident be modified independent with the electric wheelchair while indoors and outdoors.

During an interview on 5/24/23 at 9:55 AM, the DON reported Resident # 11 went outside in motorized wheelchair and while he passed by another resident on the sidewalk, the two wheels got caught between the sidewalk and curb and he tipped over in the wheelchair. An ambulance was called and the resident went to the hospital to be examined.
The resident was medically cleared and sent back to the facility. The DON stated a therapy evaluation requested upon resident's return from the hospital to determine if the resident safe to use a motorized wheelchair before he could use the electric wheelchair again. The DON reported she was unsure when the resident had an evaluation for use of motorized wheelchair before this incident.

During an interview on 5/30/23 at 9:25 AM, Staff U, Physical Therapy, reported therapy unable to access therapy notes and records after transition to new company because they no longer had

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access to the records. Staff U stated the surveyor needed to check with medical records for therapy notes and evaluations prior to transition to new company. Staff U reported Resident #11's last and most recent therapy evaluation completed 5/10/23.

On 5/30/23 at 10:00 AM, Staff V, medical records assistant, stated she was unable to obtain or provide records prior to switch in company. She would need to fill out a form and submit it to corporate to get the information requested by surveyor.

2. The MDS assessment dated 3/9/23 revealed Resident #40 had diagnoses of a muscle disorder and weakness, diabetes, and a fracture. The MDS recorded the resident had a BIMS of 6, which indicated severely impaired cognition. The MDS revealed the resident had no behaviors, and required limited assistance of one staff for bed mobility, supervision for transfers, ambulation in the room and corridor, and extensive assistance of one for toileting. The MDS documented the resident had a fall without injury but had no special treatment or therapies. The resident took opiod and diuretic medications during the 7 day look-back period.

The Care Plan initiated 6/20/21 revealed Resident #40 had limited mobility related to chronic back pain and a history of a L2 (second lumbar) (lower back) fracture. The Care Plan also revealed the resident had a risk for unavoidable falls due to a history of falls, weakness, dementia, chronic pain, and restlessness. The staff directives included the following:
·Reinforce the need to call for assistance. Anticipate resident needs due to noncompliant

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with call light and dementia (added 6/20/21).
·Encourage resident to stay in common areas when awake for increased observation (added 6/29/21).
·Provide a room close to the nurse's station (added 6/29/21).
·Scoop mattress on the bed to help identify bed boundaries (added 7/29/21); mattress checked and changed after a fall 8/11/22.
·Keep non-slip and well-fitting footwear on the resident (added 11/10/21).
·Provide and keep walker nearby (added 7/18/22).
·Keep bed in low position (added 12/20/22, cancelled on 1/26/23).
·Send to ED (Emergency Department) for evaluation (added 5/30/23).

A Fall Risk Evaluation dated 5/4/23 and 5/29/23 revealed the resident had a high risk for falls.

The Progress Notes revealed the following:
a. On 5/4/23 at 2:54 PM, a Change of Condition Note revealed the resident found on the floor in front of his bed, and resident stated he wanted to get off the floor. ROM (range of motion) within normal limits. Resident denied hitting his head, and had no skin alterations or bruises. Staff assisted resident off the floor.
b. On 5/15/23 at 2:59 PM, resident wandering the hallways without a walker. Resident educated to ask for assistance when ambulated.
c. On 5/29/23 at 8:27 PM, Staff II, agency LPN, documented she was called into the resident's room by the Certified Medication Assistant (CMA). Resident found on floor lying on his right side. The resident stated he was walking and lost his balance. Resident complained of increased pain with ROM and unable to bear weight on his

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right leg. Blood pressure and heart rate elevated. NP notified and order received to transfer the resident to the ED for further evaluation.
d. An Incident Note documented on 5/31/23 at 12:34 PM revealed Staff II charted: upon assessment resident had shortening on the right side and increased pain with movement. Resident stated area felt better when lying still. Scheduled dose of pain medication given.
d. On 5/31/23 at 7:23 PM, resident readmitted to the facility.

Incident Reports revealed the following:
a. On 1/21/23 at 1:10 PM, resident found lying on his right side on the floor in the dining room. The resident said the chair moved when he sat down and he fell. Resident assessed for injuries and had a hematoma (bruise) on the right side of his head. Two staff assisted the resident onto his feet. Physician and family notified.
b. On 1/23/23 at 3:43 PM, resident found on floor by the bed with walker in front of him. Resident tried to transfer from a lowered bed into a chair. Two staff used a gait belt and assisted the resident up.
c. On 2/16/23 at 11:59 PM, resident on floor and had back against the bed. The bed was at ground level. Vital signs obtained. Resident complained of some back pain when lifted back into bed.
d. On 2/27/23 at 5:32 PM, resident found on the floor and had increased pain to his right hip. Right foot abducted (moved away from the body) and right leg shorter than the left leg. Resident sent to the hospital.
e. On 5/29/23 at 8:03 PM, resident lying on the floor on his right side. Resident stated he was walking and lost his balance. The resident had increased pain with ROM and unable to bear

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weight onto his right leg. NP notified. Resident sent to the ED for further evaluation.

A Facility Investigation File provided to the surveyor on 6/6/23 revealed a self reported incident to the State Department of Inspections and Appeals (DIA) due to an accident with major injury that occurred on 5/29/23 at 8:02 PM. A CMA reported she heard a noise while standing at her medication cart. She found the resident lying on his right side in his room next to the privacy curtain. The resident had gripper socks on. No debris or moisture on the floor. Nurse notified of fall and assessment performed. Rated pain at "8" (on 1-10 scale). Resident incontinent of urine. NP notified due to resident pain and decreased ROM. Order received to transport to the ED for further evaluation. Last seen and last checked on when walked back from dinner at 6:30 PM. The Facility Investigatin File lacked witness statements from staff.

A History and Physical dated 5/29/23 at 10:42 PM revealed staff found the resident on the ground and complained of right hip pain. Right foot externally rotated. Oxycodone (narcotic pain medication) received prior to EMS (Emergency Medical Services) arrival. Resident unable to ambulate per usual. History of dementia, recurrent falls, and L2 compression fracture. Resident stated he got up without his usual 1-2 person assistance and got tangled up in stuff and fell forward. Per staff, resident found on the floor. Staff helped him up, however the resident unable to put weight on his right foot. Sent to the ED. Staff reported resident falls more often after his last hospitalization. Diagnosed with an L2 compression fracture at that time (in April). On examination, resident unable to move his right

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leg, and his left leg shorter than the right and turned outward. A pelvic CT (cat scan) revealed a nondisplaced fracture involving the posterior greater trochanter of the right hip. Ortho surgery consulted.

During an interview on 6/7/23 at 9:25 AM, Staff D, CNA, stated Resident #40 confused and tried to get up and walk on his own but forgot to take the walker with him. Staff always had to remind the resident to ask for assistance and to take his walker with him. Staff used a hoyer for transfers since the resident came back from the hospital because the resident fell and had a hip fracture. Staff D stated she was not working on the day the resident fell and fractured his hip.

During an interview on 6/7/23 at 9:50 AM, Resident #40 recalled he fell last week and went to the hospital. The hospital kept him overnight and gave him something for pain but he was unable to have surgery on his broken hip. The resident reported on the day of his fall incident he got out of bed, lost his balance, fell, and landed on his right side. The resident unable to recall if he had turned his call light on or not prior to the fall.

During an interview on 6/7/23 at 7:10 PM, Staff II, agency LPN, reported she had worked at the facility as agency off and on since 1/2023. Staff II reported Resident #40 had dementia, poor safety awareness, self transferred alot, and noncompliant with using his walker. The resident also had alot of anxiety. Prior to the resident's fall (on 5/29/23) he required assistance of one staff for cares and ambulated with a walker. On the night the resident fell, as she passed bedtime medications for other residents, a CMA on the

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West hall yelled a resident on the floor. She went into the resident's room, checked the resident's vital signs, assessed the resident and performed range ROM while the resident laid on the floor, The resident couldn't tell her what hurt. After she assessed the him, two CNA's stood the resident up. The resident said "Ow" and pointed to his right hip. The staff then pivot transferred him into bed. A CNA stood on each side of the resident and Staff II stood in front of him. She didn't have staff walk him but rather pivoted and transferred him into bed. The staff who assisted during this time were an agency CNA and a facility CNA but Staff II unable to recall their names. As the resident laid in bed, she assessed the resident more. He continued to complain of pain with movement but had no pain while at rest. She called the on-call NP, and transferred the resident to the hospital. Staff II reported adequate staffing on the evening of 5/29/23. She observed a call light clipped to the resident but no call light on when he fell.

During an interview on 6/7/23 at 2:30 PM, Staff JJ, CMA, reported she had worked at the facility since 9/2022. Staff JJ reported Resident #40 liked to wander and didn't stay in one place very long. He was constantly on the go and didn't ask for assistance. Resident #40 got up on his own and staff had to remind him to use his walker. Staff JJ reported she didn't think the resident had the mentality to ask for help. The resident recently fell and fractured his hip but still tried to stand up on his own. Staff JJ reported prior to the resident's fall he required assistance of one staff for ambulation and cares. On the day the resident fell and fractured his hip, she stood by the medication cart just outside the resident's room and prepared medications. She had just

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given Resident #40's roommate medication, walked out of the room, prepared Resident #40's medication, and heard the resident holler out. She turned around and saw the resident on the floor. Resident #40 was lying in bed when she had just gave his roommate medications. She found the resident lying on his right side on the floor by the privacy curtain. The resident told her he wanted to get up. She called for the nurse. The resident yelled "Ow" when staff started to move him. Staff JJ reported an agency nurse and agency CNA assisted the resident up but didn't know their names. Staff JJ reported the facility had so many staff coming and going, she couldn't keep up on who was who. The nurse entered the room first, then two CNA's came into the room. The nurse obtained the resident's vital signs, then sat him up on the floor. The resident started to yell out in pain. The nurse asked where his pain was, but the resident didn't tell her where he had pain. The nurse and two CNA's proceeded to stand the resident up and placed him into bed. The resident was unable to stand. The nurse tried to do ROM on the resident's legs, but the resident screamed in pain. The resident was sent to the hospital. Staff JJ reported whenever a resident had a fall, a nurse needed to assess the resident and ask the resident if he/she had any pain. If a resident had any pain then needed to leave the resident on the floor and call the ambulance. She isn't a nurse but that's what she had been instructed to do. Staff JJ reported she didn't want any part of moving him off the floor when the resident was in so much pain. Staff JJ reported she looked at the resident's kardex to know the cares needed and the interventions in place for the resident. Staff JJ reported interventions for Resident #40 included to ensure the resident had shoes and/or socks on

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his feet, make sure call light in reach, and remind the resident to use his walker and ask for assistance. Staff JJ recalled Resident #40 had socks on but not non-slip socks.

During an interview on 6/7/23 at 8:00 PM, Staff LL, agency CNA, reported Resident #40 had dementia, always on the move and tried to stand up but had poor balance. Staff told him all day long to sit down and kept him by the nurse's station so staff could keep an eye on him. She worked the evening when the resident fell last week but didn't know he had fallen until she saw the ambulance at the facility.

During an interview on 6/8/23 at 8:20 PM, Staff K, CNA, reported Resident #40 always tried to stand up or grab the bar in the hallway and stand up. On 5/29/23 evening, she assisted another resident but heard staff say this resident fell onto the ground when he tried to stand up by himself. She didn't help him off the floor. She just saw him when he had left the facility.

During an interview on 6/8/23 at 8:40 AM, Staff H, CNA, reported staff tried to keep eyes on Resident #40 during the shift even though not assigned to him. The resident tried to get up on own and in a wheelchair most of the time. He required assistance of one staff and used a walker prior to a fall with fractured hip. Since the resident had prior falls, she placed walker out of reach so he didn't try to get up by himself. On the day of his fall with fracture, she heard someone say Resident #40 lying on the floor. The nurse asked who could help. Staff H reported she was helping another resident at the time but after she assisted that resident she went to see if she could help Resident #40. The nurse did an assessment

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Staff H reported she recalled she placed a hoyer sling under the resident and moved him back to bed. The nurse asked the resident what part of his body hurt. The resident complained of pain in his leg as the nurse touched him. When the surveyor questioned mode of transfer after resident fell on 5/29/23 evening, Staff H then stated she couldn't remember if she helped stand the resident up or if they used a hoyer.

During an interview on 6/8/23 at 10:29 AM, Staff LL, CNA, reported Resident #40 pleasantly confused, used a walker during ambulation but now used a hoyer lift when transferred due to he had a fall and fractured his hip. Staff had to remind the resident to use his walker. She was on break when the resident fell.

During an interview on 6/8/23 at 2:50 PM, the DON reported whenever a resident had a fall, she expected the staff nurse conduct a head to toe assessment, get statements from people who witnessed the fall, and complete a pain and fall assessment. The DON stated she expected staff to call the physician if a resident had pain after a fall and not move the resident. The DON stated the resident's care plan reviewed and interventions added after a fall. Resident #40 is a busy body, and walked up and down the hallways but sometimes forgot to use his walker. Staff reminded him to get his walker. On the day of incident when the resident fell, staff told her the resident had just ate dinner, went to his room, and resting in bed. A CMA prepared medications in the hallway and heard the resident holler out. The CMA found the resident on the floor by the curtain. A nurse assessed the resident but said he didn't complain of pain while lying on the floor. When the nurse palpated areas of his body, then

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able to tell location of his pain. The floor was clean and dry, and he had gripper socks on. Unable to recall if the resident had incontinence. The resident was unable to bear weight, and had hip tenderness when the nurse palpated the area. Resident transported to the hospital. A therapy referral was made after he returned from the hospital. The DON reported she had only talked with the CMA and Nurse but unable to reach the CNA's involved after the resident had fallen. The DON reported the interventions in place for fall prevention included the resident kept in a common area and kept busy, his bed kept in low position, scoop mattress on the bed, and staff checked on him frequently.

A document dated 2011 titled Phase 1: Assess-initial plan of care revealed a plan of care developed if a resident at risk for falls or had a history of falls, and individualized interventions initiated. Fall reduction and injury prevention strategies that could be implemented upon admission may include:
· Orientation to surroundings and use of call light.
· Call light and and personal care items placed within reach.
· Provision of environmental modification such as a low bed and cushioned floor mats next to the bed.
·Use of appropriate footwear.
· Review of ordered medications for potential fall risk side effects.
· Referral to physical and occupational therapy.

An Interact Care Pathway for Falls dated 2014 revealed a fall is an unintentional change in position and coming to rest on the ground or onto the next lower surface. The care pathway directive included to perform an initial nursing

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evaluation for injury but do not move the resident off the floor until a complete exam performed. Contact the physician if a fracture or bone deformity suspected or had new or worsening cognition.

3. Observations revealed the following:
a. On 5/16/23 at 8:35 AM, a portable oxygen (O2) tank sat upright on the floor in Room 237. The oxygen had a seal over the top which indicated an unused tank.
b. On 5/16/23 at 12:20 PM, the portable O2 bottle remained in an upright position by the wall in the resident's room, not secured in a holder or rack.
c. On 5/19/23 at 7:20 PM a portable O2 tank sat upright on the floor in the 200 hall across from room 237, and not secured in a holder or rack.

The facility's Oxygen Storage policy revised 7/28/22 revealed oxygen stored safely and properly. Oxygen tanks needed restrained or secured at all times.

During an interview on 5/16/23 at 8:35 AM, a family member reported Resident #16 used oxygen as needed.

During an interview on 5/23/23 at 10:51 AM the facility's Maintenance Director revealed dollies used to transport oxygen canisters stored in the lower level and main level oxygen rooms. The Maintenance Director stated staff should use the dolly for transportation and storage of oxygen tanks. The Maintenance Director revealed the facility had plenty of dollies for oxygen canisters and the dollies available for staff to use.

During an interview on 5/24/23 at 9:55 AM, the DON reported O2 tanks stored in a roller cart or

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on the back of the wheelchair in a holder. The DON agreed O2 should not be left unsecured in an upright position on the floor, rather it needed placed in a cart or a holder.

4. The MDS assessment dated 4/13/23 revealed Resident #15 had diagnoses of hydrocephalus, seizure disorder, and legally blind. The MDS documented the resident had impaired short-term and long-term memory and severely impaired decision making skills.

The Care Plan initiated on 6/24/21 revealed the resident had cognitive loss related to hydrocephalus, TBI (traumatic brain injury), and at risk for behavior symptoms related to blindness, hearing deficit, and a potential to place non-edible things in his mouth and injest them. The staff directives included frequent supervision of the resident, not to leave the resident unattended in his wheelchair in his room, and lay the resident down in bed after each meal as the resident allowed and tolerated.

On 5/19/23 at 8:45 PM, Resident # 15 sat in a wheelchair facing the wall across from the nurse's station. The resident had the door that stored a fire extinguisher open. The resident reached inside the cabinet and attempted to grab the fire extinguisher.

During an interview on 5/23/23 at 10:49 AM, the facility's Maintenance Director revealed he had worked at the facility five years and had never had a resident pull a fire extinguisher from the wall.

During an interview on 5/24/23 at 9:55 AM, the DON reported staff needed to redirect a resident

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F 689	Continued From page 63 if a resident had their hand in the fire extinguisher box/panel or attempted to remove the fire extinguisher. 5. During an observation on 5/21/23 at 7:34 PM of the facility's long term care floor a medication cart was unlocked. No staff present in the hallway, two residents approximately 10 feet away were observed sitting in their wheelchairs. At 7:36 PM a staff member exited a residents room and went to the medication cart. During an observation on 5/21/23 at 7:40 PM of the facility's skilled unit floor a medication cart was observed unlocked. At 7:44 PM a staff member exited a residents room and went to the medication cart. The Director of Nursing (DON) provided a list of residents via e-mail correspondence on 5/23/23 at 2:10 PM who are cognitively impaired and independently mobile equaling 22 of the 86 residents in the facility. During an interview on 5/24/23 at 12:59 PM the DON revealed she would expect medication carts to be locked at all times when not in use. During an interview on 5/24/23 at 1:20 PM the Administrator revealed she would expect medication carts to be locked at all times when not in use.	F 689		
F 692 SS=D	Nutrition/Hydration Status Maintenance CFR(s): 483.25(g)(1)-(3) §483.25(g) Assisted nutrition and hydration. (Includes naso-gastric and gastrostomy tubes, both percutaneous endoscopic gastrostomy and	F 692		

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percutaneous endoscopic jejunostomy, and enteral fluids). Based on a resident's comprehensive assessment, the facility must ensure that a resident-

§483.25(g)(1) Maintains acceptable parameters of nutritional status, such as usual body weight or desirable body weight range and electrolyte balance, unless the resident's clinical condition demonstrates that this is not possible or resident preferences indicate otherwise;

§483.25(g)(2) Is offered sufficient fluid intake to maintain proper hydration and health;

§483.25(g)(3) Is offered a therapeutic diet when there is a nutritional problem and the health care provider orders a therapeutic diet.
This REQUIREMENT is not met as evidenced by:
Based on clinical record review, observation, resident and staff interview, and policy review, the facility failed to ensure residents had beverage placed within reach to maintain hydration for 1 resident (Resident #16) and failed to offer and/or provide water/beverage for 2 (Resident #3 and #33) out of 4 residents reviewed for hydration. The facility reported a census of 86 residents.

Findings include:

1. The Minimum Data Set (MDS) assessment dated 3/29/23 for Resident #16 identified a Brief Interview for Mental Status (BIMS) score of 12 indicating moderately impaired cognition. The MDS revealed the resident required supervision and set up assistance with eating and drinking. The MDS documented diagnoses that included diabetes, GERD (gastric esophageal reflux

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disease) and vascular disorder of the intestine. The MDS revealed the resident had no difficulty swallowing or loss of liquids or food during eating or drinking.

The care plan initiated 3/8/23 identified Resident #16 had a at risk for alteration in nutritional status related to diabetes and GERD. The directives for staff included to offer extra fluids if not contraindicated

During observation on 5/19/23 at 8:04 PM, Resident #16's overbed table located on the resident's left side of the bed and pushed up toward the wall at the head of the bed. A styrofoam cup full of a liquid beverage sat on the overbed table. The stryofoam cup and beverage was out of reach of the resident. On 5/19/23 at 9:44 PM, Resident #16 reported staff moved him to a different room 5/19/23. A styrofoam cup with water sat on an overbed table on the resident's left side and out of reach of the resident. The resident reported he needed the overbed table and water cup on his right side because he could not move his left arm.

A Hydration policy updated 7/27/22 revealed it is the facility's policy to ensure that residents are adequately hydrated. Fluid intake encouraged unless contraindicated.

During an interview 5/24/23 at 9:55 AM, the Director of Nursing (DON) reported she expected staff placed beverages within reach for residents who didn't require assistance for drinking water. The DON reported she expected staff offered fluids with each encounter to residents who are unable to obtain fluids on their own with each encounter.

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2. The MDS assessment dated 5/16/23 revealed Resident #33 had diagnosis of urinary tract infection in the past 30 days. The MDS assessment documented the resident had a BIMS of 15 indicating cognition intact. The MDS assessment indicated the resident had no swallowing issues. The MDS assessment revealed the care area assessment (CAA's) triggered dehydration and fluid maintenance. The CAA's indicate if further investigation of triggered areas required interventions and care planning.

The care plan initiated: 5/10/2023, revealed the resident had an infection related to recurrent UTI'S (urinary tract infection). The staff directives included encourage good nutrition and hydration, and offer extra fluids if not contraindicated.

During observation on 5/16/23 at 6:05 AM, Resident #33 reported she was thirsty and needed some water The resident reported she had been rationing the glass of water that sat on her overbed table. The water glass had under ¼ inch of water left in it. The resident reported staff had changed her during the night but didn't replenish her water. At 6:30 AM Resident #33 reported someone came into her room but didn't do anything. The resident stated she still needed water. Her water glass didn't have much left and she was trying to go slow in drinking what she had left in the cup so she didn't run out. At 6:42 AM, the social worker walked by the nurse's station and asked a CNA if she was getting waters. The social worker obtained a styrofoam cup of water and took the stryrofoam cup into the resident's room.

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During an interview 5/24/23 at 9:55 AM, the DON reported she expected staff passed water every shift and offered fluids with each encounter to residents who are unable to obtain fluids on their own with each encounter.

3. The Minimum Data Set (MDS) assessment dated 3/14/23 for Resident #3 revealed the resident totally dependent upon 1 person physical assistance for eating. The MDS documented diagnoses that included sarcopenia (age related progressive loss of muscle mass and strength), diabetes mellitus, and dementia.

The Comprehensive Care Plan of Resident #3 revealed a focus area of assistance with Activities of Daily Living (ADL's) including bed mobility, transfers, dressing, walking, personal hygiene, eating and toileting.

Continuous observation began on 5/21/23 at 11:41 am for Resident #3. At 1:15 pm Staff D, Certified Nurse Aide (CNA), sat next to Resident #3's bedside with her cell phone in her hands. Resident #3's lunch tray sat on the bedside table untouched. Staff D used her personal cell phone rather than feeding Resident #3. At 2:15 pm, Staff E, LPN and Staff F, LPN, Nursing Supervisor, stated they would provide wound care treatments. At 2:35 pm Staff E and Staff F began wound care treatments for Resident #3. At 3:35 pm all wound care treatments were completed. Observation revealed no staff offerred to assist the resident with fluid intake nor offer a drink.

On 5/22/23 at 10:02 the DON stated she expected that any resident who was unable to turn themself should be repositioned a minimum of every two hours and should be offered

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F 692	Continued From page 68 hydration at the same time.	F 692		
F 693 SS=G	Tube Feeding Mgmt/Restore Eating Skills CFR(s): 483.25(g)(4)(5) §483.25(g)(4)-(5) Enteral Nutrition (Includes naso-gastric and gastrostomy tubes, both percutaneous endoscopic gastrostomy and percutaneous endoscopic jejunostomy, and enteral fluids). Based on a resident's comprehensive assessment, the facility must ensure that a resident- §483.25(g)(4) A resident who has been able to eat enough alone or with assistance is not fed by enteral methods unless the resident's clinical condition demonstrates that enteral feeding was clinically indicated and consented to by the resident; and §483.25(g)(5) A resident who is fed by enteral means receives the appropriate treatment and services to restore, if possible, oral eating skills and to prevent complications of enteral feeding including but not limited to aspiration pneumonia, diarrhea, vomiting, dehydration, metabolic abnormalities, and nasal-pharyngeal ulcers. This REQUIREMENT is not met as evidenced by: Based on record review, staff interviews, and policy review the facility failed to administer medications through the correct port on a G-J tube (Gastrostomy-Jejunostomy tube - a tube placed into the stomach with three external ports) for 1 of 1 residents reviewed with a G-J tube (Resident #1). The failure led to the resident's transfer to the hospital due to a Gastric Outlet Obstruction when Staff Q, Registered Nurse (RN) administered medication into the balloon port of	F 693		

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G-J tube (the balloon is filled with normal saline and is used as an anchor inside the stomach to hold the G-J tube in place) instead of the correct port that is used to put medication into the body causing the balloon to pop inside the resident. The facility reported a census of 86 residents, with 1 resident receiving enteral feeding tube services at the time of the survey.

Findings include:

Record review of Resident #1's Minimum Data Set (MDS) log on the facility's Electronic Health Record (EHR) revealed the facility did not complete MDS's for Resident #1 during her stay at the facility.

Record review of Resident #1 Admission Record dated 5/22/2023 documented an admission date of 4/21/23 and a discharge date of 4/21/23.

The Progress Note dated 4/21/2023 at 11:45 AM documented the following admission note:
Resident #1 arrived by gurney from hospital.

The Progress Note dated 4/21/2023 at 6:42 PM documented the following change of condition note:
Resident #1 was sent to the local Emergency Room (ER) for displacement of her G-tube by ambulance.

The Medication Administration Record (MAR) and Treatment Administration Record (TAR) for Resident #1 documented one (1) medication given during her stay at the facility;
Acetaminophen (Tylenol) 325 milligrams (mg), give three (3) tablets via G-Tube every eight (8) hours, may also give orally for pain with a start

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date of 4/21/23.

Record review of Resident #1 Transfer Form assessment documented she was admitted to the facility on 4/21/23 for skilled care and was being transferred on 4/21/23 for G-tube displacement. The form also documented she had an enternal feeding tube.

Record review of a document titled, Chief Complaint and History of Present Illness, dated 4/21/23 at 8:29 PM documented the following: Daughter reports Resident #1 recently moved long term care facilities. Today one of the nurses put crushed up Tylenol with water down the wrong tube, which caused her G-J tube's balloon to pop. The daughter informed that getting the G-J tube placement was very challenging and had to be done at a larger hospital after multiple other attempts. Resident #1 has not been able to receive her normal medications today and she denies any acute symptoms at this time.

Record review of a document titled, Internal Medicine Health and Physical dated 4/21/23 at 10:10 PM for Resident #1 documented the following:
At the Skilled Nursing Facility (SNF) Resident #1 was accidentally given a medication via the wrong tube causing mechanical malfunction of the tube. Since this time she has had some intermittent abdominal pain. She has not been able to take any of her medications today.

Record review of a document titled, One-On-One In-service Record, dated 4/21/23 for Staff Q, Registered Nurse (RN) documented education he was shown the three different types of ports on residents G-J tube and was educated on the

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difference between ports.

Record review of a document titled, Incident Report - Patient Involved, signed on 4/24/23 by Staff Q, the Director of Nursing (DON) and the Administrator documented the following:
Description of incident: Staff Q administered medication through Resident #1 G-tube by pushing medication through the balloon port resulting in the malfunction of the G-tube.

Record review of a document titled, Investigation Summary, with a date of investigation of 4/25/23 for Resident #1 documented the following:
Summary of Alleged Incident: Malfunction G-J tube in resident with gastric outlet obstruction. The Nurse administered medication per tube with malfunction resulting in a burst of the balloon. Resident sent for evaluation and potential replacement, resulting in surgical intervention.
Action Taken During Investigation:
a. Train nurse involved immediately
b. Train all licensed nurses with continuing education
c. Quality Assurance of incident
Conclusion: Resident remains hospitalized for other health concerns unrelated

Record review of a document titled, Quality Assurance and Performance Improvement Committee Meeting dated 4/25/23 documented a new trend was identified for G-J tube malfunction and follow up is needed with staff education as the new mechanism requires nurse education plan.

Record review of a document titled, Attendance, dated 4/25/23 revealed the facility provided reeducation on J-G tubes for nursing staff.

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Record review of a document titled Self Report, of the facilities report to Iowa Department of Inspections and Appeals (DIA) with a submission date of 4/25/23 documented the following Incident Summary:
a. Chief complaint per hospital: Malfunction G-J tube for Resident #1 with gastric outlet obstruction. Nurse administration of medication per G-J tube, tube malfunctioned resulting in burst of balloon. Resident sent out for evaluation, resulting in surgery to replace the G-J tube and surgical intervention with intravenous radiology.
Corrective Action:
a. Sent to ER for evaluation
b. Education provided to nurse

Record review of Resident #1 Care Plan on 5/22/23 instructed she had a G-tube. The Care Plan lacked instruction on the type of tube she had, a G-J tube.

During an interview on 5/23/23 at 7:05 PM Staff Q, Registered Nurse (RN) revealed he worked for an agency staffing company an recalled Resident #1 had a G-J tube that was a specialty tube and placed prior to her admission to the facility on 4/21/23. He revealed the G-J tube had 3 ports on it, he instructed one of the ports was for draining bile. He recalled he checked placement of the tube by insertion of a little air into the port and he used a stethoscope to listen for a swooshing sound/bowel sounds prior to administration of medication. He then informed he gave Tylenol through another port and the resident had tube displacement. He informed Resident #1 had some pain and that is why he gave her something for pain. He revealed he suspected the tube was displaced and called the doctor because he didn't

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have an x-ray machine. Resident #1 had pain and the tube had some problems and was difficult to assess. He revealed the doctor said due to the complex nature of the resident and that she has had multiple tubes to send her to the local hospital. He then revealed he didn't flush the port after he gave the medication and later found out the tube was displaced. He then informed he was not used to the type of tube Resident #1 had as it was a special tube. He revealed whenever he was unsure of how to do something or not familiar with a process or procedure he checked the policy and looked up information on what to do by using a policy from a previous company.

During an interview on 5/24/23 at 1:00 PM the Director of Nursing (DON) revealed she was notified while Staff Q was talking with the Physician on the phone of the concern with Resident #1 G-J tube. She reported she went and spoke with Resident #1's family to find out what hospital they would like to go to. She revealed she educated Staff Q to make sure to check placement prior to administering medication and also revealed the facility had not had any tubes like that for the past two years. She informed Staff Q typically worked 3 nights a week and no education was provided to Staff Q regarding G-J tubes prior to the incident occurring. She then informed all agency nurses and facility staff nurses got training on enternal feeding tubes prior to working their first shift.

During an interview on 5/24/23 at 1:20 PM with the Administrator revealed she would expect education to be requested or provided as necessary to nurses regarding feeding tubes.

Record review of the facilities policy titled,

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F 693	Continued From page 74 Medication Pass, last reviewed on 3/28/23 lacked instruction to staff on how to administer medications to a G-J tube.	F 693		
F 725 SS=L	Sufficient Nursing Staff CFR(s): 483.35(a)(1)(2) §483.35(a) Sufficient Staff. The facility must have sufficient nursing staff with the appropriate competencies and skills sets to provide nursing and related services to assure resident safety and attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident, as determined by resident assessments and individual plans of care and considering the number, acuity and diagnoses of the facility's resident population in accordance with the facility assessment required at §483.70(e). §483.35(a)(1) The facility must provide services by sufficient numbers of each of the following types of personnel on a 24-hour basis to provide nursing care to all residents in accordance with resident care plans: (i) Except when waived under paragraph (e) of this section, licensed nurses; and (ii) Other nursing personnel, including but not limited to nurse aides. §483.35(a)(2) Except when waived under paragraph (e) of this section, the facility must designate a licensed nurse to serve as a charge nurse on each tour of duty. This REQUIREMENT is not met as evidenced by: Based on observations, clinical record review, resident, family, and staff interviews, resident council notes, and policy review the facility failed	F 725		

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to ensure sufficient and competent staff available to provide care to all residents as evidenced by residents with pressure ulcers and not being repositioned, lack of adequate staffing supervision of a resident observed near a hazard and a resident who tipped his motorized wheelchair when outdoor at the facility, and failure to administer treatments and medications timely. The facility staff also failed to ensure call lights within reach of residents and failed to ensure staff responded and answered residents' call lights within 15 minutes to meet residents' needs in a timely manner for 2 or 2 nursing units observed. The facility also failed to ensure adequate staff on duty to allow visitors entry into the facility for timely visitation with residents. The facility reported a census of 86 residents. This failure resulted in an immediate jeopardy situation.

The State Agency informed the facility of the IJ on 6/5/23 at 12:15 PM. The IJ began on 4/6/23 when the Resident Council first expressed a concern with shortages of staff. The facility staff failed to remove the immediacy prior to the survey exit resulting in the initial scope and severity of "L" remaining at the survey exit.

Findings include:

1. Observations revealed call light response greater than 15 minutes or call light out of reach for the following:
a. On 5/15/23 at 1:20 PM, three call lights on in the 200 hall on the main level of the facility. At 1:25 PM, the same call lights remained on. Staff B, Licensed Practical Nurse (LPN), stood by the medication cart and prepared medications. At 1:38 PM, call lights off in the 200 hall. The call

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light had been on a total of 18 minutes before staff answered the call light.
b. On 5/15/23 at 1:46 PM, Room 213 had call light on. At 2:00 PM, the Admissions Director entered room 213. The resident told the Admissions Director to leave his call light on as he waited for staff because he needed assistance to the bathroom. At 2:08 PM, Staff R, certified nursing assistant (CNA), entered room 213 and turned the call light off. Call light was on a total of 22 minutes.
c. On 5/16/23 at 6:05 AM, Resident # 33 lying in bed with pillow propped up on the headboard and her head and neck bent forward. The resident complained of being very uncomfortable and unable to operate her bed. The resident reported she was not able to reach her call light or bed control. The resident stated she didn't know where her call light was. The resident's call light laid on the floor under the bed out of reach of the resident.
d. On 5/17/23 at 10:52 AM room 237 had call light on. At 10:53 AM, Staff L, CNA, entered room 237 and turned the call light off. Staff L told the resident he would let the nurse know he needed something. At 11:15 AM, after continuous observation of the resident's room and hallway, no nurse had responded to the resident's room.
e. On 5/19/23 at 7:20 PM, room 211 and room 217 had call light on. At 7:41 PM, the call lights remained on for room 211 and 217, as well as room 219 and and a red (bathroom) light flashed outside room 213. At 8:00 PM room 213 call light remained on. Call lights for room 211 and 217 on a total of 40 minutes. The call light remained on in room 213 and continued past 19 minutes.
f. On 5/19/23 at 7:21 PM, Resident #28 sat in a wheelchair by the nurse's station yelling "help me,

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help me please". At 7:37 PM, the resident continued to holler "hurry, hurry, restroom". At 7:38 PM, Staff J, Registered Nurse walked by the nurse's station and asked Resident #28 what she was doing. Resident #28 responded "bathroom". Staff J told the resident the bathroom at the nurse's station was not a resident bathroom. Resident #28 responded " how do I get to a bathroom?" Staff J walked into the bathroom but did not respond to the resident. At 7:49 PM, Resident #28 propelled her wheelchair down the hall calling out "help me, help me please". At 7:51 PM, Staff K, certified nursing assistant, walked by Resident #28 and told the resident she planned to assist the resident to bed soon.
g. On 5/19/23 at 7:33 PM, call light on for room 103. Resident # 34 reported she had her call light on for the past 30 minutes but no staff had assisted her. The resident reported she had a clock on the wall in her room to know the time she turned her call light on. At 7:43 PM the resident's call light remained on. At 7:48 PM, room 103's call light off. Room 103's call light on a total of 45 minutes.

Review of Resident #34's Minimum Data Set (MDS) dated 4/28/23 revealed the resident had a BIMS of 15, indicating cognition intact. The resident required extensive assistance of two staff for toileting and transfers.

Resident #34's care plan updated 6/27/22 revealed the resident had an ADL (Activities of Daily Living) self-care deficit and at risk for falls due to the need for assistance with transfers and ADL's related to left-sided hemiplegia and weakness. The care plan directives for staff included to reinforce the need for her to call for assistance.

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During an interview 5/22/23 at 2:00 PM, the Director of Nursing (DON) reported she expected staff answered resident call lights within 15 minutes or as soon as possible.

The facility's Call Light Policy revised 4/2023 revealed the facility staff shall answer call lights in a timely manner. Call lights placed within reach of residents who are able to use a call light at all times but there is no reason to place the call light within the reach of a resident who is physically and cognitively unable to use the call light.

2. The Resident Council meeting notes dated 4/6/23 at 2:00 PM revealed residents voiced concerns the facility did not have enough staff. The resident council meeting notes dated 5/4/23 at 2:05 PM revealed the facility had a shortage of staff especially on the 2-10 PM shift. The notes revealed the residents voiced continued reports of not enough nursing and CNA (Certified Nurse Aide) staff. At the time of the meeting only one nurse worked the upper level of the facility. Residents reported call light response continued to be a problem, meaning it took greater than 15 minute before staff responsed, and some staff turned call lights off. In addition, some residents had not received their medications on time.

3. During confidential resident interviews 5/15/23 to 5/19/23, five of ten residents reported it took staff 20 minutes to 2 hours before staff answered their call light and provided assistance. The residents reported call light response depended on how many staff worked and what was going on. One resident reported he had to gauge the time of day when staff got him up in the chair because he required two staff for transfers, but

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when the facility only had one aide on duty he was left in the chair all night.

4. On 5/24/23 at 10:55 AM, a family member expressed concerns about visitors having to wait for staff to let them into the facility in order to visit their loved one. The family member reported when no staff at the desk to buzz visitors in, he pushed a button on the wall in the alcove. The buzzer rang at the nurse's station but if no staff by the desk, then visitors waited 20 minutes or longer for staff to let visitors in. The family member stated concerns the facility didn't have enough staff working to meet the needs of his loved one.

5. During confidential staff interview, Staff J, Registered Nurse (RN), reported residents' medications and treatments administered late or not administered because the facility was short staffed and staff lacked the time to administer the medications and/or treatments when scheduled and in a timely manner. Staff J reported lots of residents required two staff for assistance and cares. Staff J reported several residents had developed pressure ulcers because residents not getting repositioned like they should. Observations and clinical record review of residents sampled revealed 2 of 3 residents developed facility acquired pressure ulcers. The facility failed to ensure residents received the minimum standard of nursing care by providing routine repositioning to prevent pressure ulcers for Resident #3 and Resident #16.

6. During anonymous staff interviews, two staff members reported hesitancy to speak to the surveyor unless away from the Administrative offices for fear of being seen and retaliation.

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Four staff reported the Administrator and DON told staff whenever State (surveyors) asked the staff questions they needed to respond everything was fine. If they wanted a paycheck they better not say anything bad. Staff reported the CNA's schedule changed and hours were cut back after the new company took over. The facility was short-staffed and used alot of agency to fill hours, even though the facility's employed CNA's wanted and could work the hours. Staff were told options for schedule (8 hour shifts) and they could take it or leave it. However a CNA related to the DON got a special schedule created for her, and whenever this CNA worked, there was only one CNA on the hall assigned after 9 PM when that CNA's shift ended, and if residents not put in bed by 9 PM they were left up until another staff person came in after 10 PM. Staff reported being yelled at or treated rudely by the Administrator. Staff members reported names listed on daily assignment lists but staff not aware they were scheduled to work. The daily assignment sheets looked like they had adequate staff but in reality staff not scheduled to work. One staff reported lack of dietary staffing, and only had a cook and dietary aide who worked in the kitchen; suppose to have four staff in the kitchen during their shift. One staff member reported only 1 CNA scheduled on the West Hall on Garden level but suppose to have two staff. One CNA can't do everything needed for the residents on West hall; it's a heavy load. A lot of residents required two staff for assistance and transfers. Unable to provide showers and baths, answer call lights, and care for all of those residents without adequate number of staff working.

The facility assessment dated 10/2022 revealed a

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facility assessment utilized to determine the resources necessary to care for the resident population served during day to day operations as well as during emergenct situations. The facility assessment included the number of residents, the care required by the population in consideration of the types of diseases, conditions, physical and cognitive abilities, and overall acuity of the residents. The facility assessment also revealed staff competency necessary to provide the level and types of cares needed for the population. The facility assessment contained data from 10/2021 to 10/2022 about resident population and diagnoses.

The resident matrix provided by the facility on 5/15/23 revealed:
9 residents had pressure ulcers,
12 residents on hospice care,
1 resident required enteral tube feedings,
4 residents on dialysis,
11 residents had a catheter, and
2 residents had intravenous (IV) therapy.

A list of residents and the resident's transfer status as of 5/15/23, provided by the Director of Nursing on 5/16/23 to the surveyor, included the level of staff assistance required for transfers:
28 residents required assistance of one staff
3 residents required assistance of two staff
18 residents required use of a full mechanical lift
9 residents required a sit to stand lift.

A list of residents with skin concerns provided by the facility upon entrance revealed 13 residents had pressure ulcers and/or skin conditions.

The Resident Census and Condition of Residents report (CMS form 672) dated 6/5/23 revealed the

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following activities of daily living (ADL's) and the number of current residents who required one to two staff for activities of daily livings (ADL's):
Transfers: 70
Bathing: 72
Dressing: 73
Toileting: 72
Eating: 28

The 672 also revealed the following ADL's and the number of current residents dependent for ADL's:
Transfers: 2
Bathing: 14
Dressing: 2
Toileting: 1
Eating: 2

During an interview on 6/8/23 at 2:15 PM, the Administrator reported she completed the facility assessment and updated the assessment once a year. The Administrator reported facility assessment updated depending upon the resident demographics, census, vendors and providers, and emergency preparedness. She compiled data and information for the facility assessment placed the information in a binder, and submitted a copy of facility assessment to the corporate office. When the surveyor asked the Administrator if she reviewed the information or how she utilized the information if the facility assessment, the Administrator asked the surveyors how often she should look at the facility assessment. The Administrator reported she used a formula to determine staffing needs for each shift. The Administrator reported the following staff numbers for each each.

The staffing levels on Garden (downstairs) level

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included:
On the 6 AM-2 PM and 2 PM-10 PM shifts, a minimum of:
6 certified nursing assistants (CNA)
1 certified medication aide (CMA)
2 nurses

On the 10 PM-6 AM shift:
4 CNA's
2 nurses

The staffing levels on the Main (upstairs) level included:
On the 6 AM-2 PM and 2 PM-10 PM shifts, a minimum of:
2 CNA's
1 nurse

On the 10 PM-6 AM shift:
2 CNA's
1 nurse

The Administrator reported they tried to fill staffing needs with facility staff and agency staff.

During an interview on 5/22/23 at 2:00 PM, the DON reported staffing dependent on resident census. The ideal staffing numbers for each unit and shift included:
On the Garden (downstairs) level
6-2 PM shift:
5-6 CNA's
1 CMA
2 nurses

2-10 PM shift:
5 CNA's
1 CMA
2 nurses

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10 PM - 6 AM shift
3 CNA
1 nurse

On the Main (upstairs) level:
6 AM - 2 PM shift
2 CNA's
1 Nurse

2 PM- 10 PM shifts:
1 CNA
1 Nurse

10 PM - 6 AM shift
1 CNA
1 nurse

The DON reported the staff nurses and scheduler tried to cover staffing needs when they had call ins.

7. Staff Q, Registered Nurse (RN) administered medications into the balloon port (the balloon is filled with normal saline and is used as an anchor inside the stomach to hold the G-J tube in place) of Resident #1's G-J tube (Gastrostomy-Jejunostomy tube - a tube placed into the stomach with three external ports) instead of the correct port that is used to put medication into the body, causing the balloon to pop inside the resident. The resident had to transfer to the local hospital due to pain and a gastric outlet obstruction. The incompetent care of a resident's gastrojejunostomy tube and lack of staff training led to a burst balloon on the tube, infliction of pain, the need for surgical intervention, and hospitalization.

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8. The MDS assessment dated 5/3/23 revealed Resident # 11 had diagnoses of stroke, diabetes, hemiplegia (paralysis on one side of the body), and sarcopenia (a gradual loss of muscle mass, strength and function). The MDS revealed the resident had a brief interview for mental status (BIMS) score of 15, indicating cognition intact. The MDS documented the resident used an electric wheelchair and independent with locomotion and movement on and off the unit.

The care plan initiated on 12/5/22 revealed the resident had an ADL self-care deficit related to physical limitations after a CVA (cerebrovascular accident) (stroke) with hemiplegia and weakness. The care plan revealed the resident was independent in a power wheelchair and desired to participate in outdoor weather activities.

The progress notes revealed the following:
a. On 5/8/23 at 2:54 PM, the DON was summoned outside. Resident #11 found lying on his back in a supine position. The resident stated he got too close to the sidewalk and drove his electric wheelchair partway up on the curb of the sidewalk, tipped the wheelchair over, and landed headfirst. The resident stated he hit his head and complained of head pain. 911 called. An ambulance arrived and placed a c-collar (around the resident's neck). Resident transported to the hospital for further evaluation.

5/24/23 at 9:55 AM, the DON reported Resident # 11 went outside in motorized wheelchair and while he passed by another resident on the sidewalk, the two wheels got caught between the sidewalk and curb and he tipped over in the wheelchair. An ambulance was called and the resident went to the hospital to be examined.

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The facilty lacked adequate nursing supervision of the residents to prevent accidents and access to potential environmental hazards.

9. On 5/28/23 at 9:48 AM an anonymous voicemail was received that stated today was not a good day at the facility. The residents did not receive breakfast, they are short staffed and management does not care. The call back number was not accepting calls or voicemails.

On 5/30/23 at 7:00 PM Staff DD, CNA, stated there were a lot of staffing concerns at the facility and sometimes they only had one CNA on the lower level. Staff DD voiced that was not enough staff when there were residents who required two staff to assist them, answer call lights, give baths, etc.

On 6/1/23 at 12:58 PM Staff CC, Certified Medication Aide (CMA), stated there were staffing issues. She added resident tasks got completed based on what and how many staff were scheduled in addition to the amount of cares the residents required. They could have one aide on each hall; that's 12 residents that needed help getting up plus call lights going off. When asked if they had plenty of staff to help she indicated they did and they had access to other staff members but they were not utilizing them. If staff showed up to work but their names were not on the schedule management would send them home; even though they needed the help. If that staff member stayed to help they would not get paid because they were not on the schedule.

On 6/2/23 at 9:41 AM Staff F, Licensed Practical Nurse (LPN) stated that day Resident #39 passed

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away she was the only nurse on the lower level halls. She added she had two CMAs and like 6 CNAs on the floor. But that it still was a lot for one nurse to do: assessments, treatments, medications, etc. She added she was so busy running to both sides of the lower level halls to provided treatments, it was too much for just one nurse. The other nurse that was supposed to work called it that day. During a following up interview on 6/7/23 at 10:08 AM Staff F stated on 5/29/23 she called Staff GG, Registered Nurse Unit Manager, to come in and help. She was on-call that week and she told her she would not come in help her. She called Staff GG twice and she told the DON that as well. She was not blaming the facility for what she did not do but they set her up by being understaffed the day he passed away. There were like 65 people downstairs and it was just her and a CMA, plus the aides. She had three other residents transitioning, it was just too much for one nurse. The dynamic was not good there.

On 6/6/23 at 1:10 PM Resident #31 stated it could take about an hour for her call light to get answered. When asked how she knew that, the looked at the clock that was on the wall to the left of her TV. She added her call light did not get answered when there was not enough staff working and it happened on all three shifts. She reiterated there were just not enough staff.

On 6/6/23 at 1:47 PM Staff FF, CNA, stated on the 2:00 PM-10:00 PM shift they could use more staff on the floor to get their work done. If they had more staff things would be better; it would really help with taking care of the residents and the call lights would not be on for a long time because they would not be understaffed.

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F 725	Continued From page 88 10. The MDS dated 5/8/23 for Resident #32 documented a BIMS score of 7 indicating severe cognitive impairment. The MDS documented the need for setup help with supervision for walking, toilet use, and dressing. The MDS also listed diagnosis of hypertension, difficulty in walking, and repeated falls. During an interview on 5/18/23 at 11:38 AM Resident #32 stated she was getting tired of helping herself and it hurt so bad. She then revealed she did not know where the call light was and further explained it wasn't working right so she gave it up since no one responded. She then stated they wanted her to croak and just get it over with. Observation revealed the call light laid on a blanket approximately 6 feet away from the resident's chair. During an interview on 5/24/23 at 1:06 AM with the DON revealed she would expect call lights to be in reach for dependent residents in bed. During an interview on 5/24/23 at 1:22 PM the Administrator revealed she would expect dependent residents to have their call lights when they are in their room unattended if they can use them effectively.	F 725		
F 760 SS=E	Residents are Free of Significant Med Errors CFR(s): 483.45(f)(2) The facility must ensure that its- §483.45(f)(2) Residents are free of any significant medication errors. This REQUIREMENT is not met as evidenced by:	F 760		

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Based on record review, observation, staff interviews, and policy review a facility nurse (Staff N, Licensed Practical Nurse (LPN)) almost provided the wrong insulin to a resident if the surveyor did not intervene for 1 of 4 residents (Resident #23) observed for insulin administration. The facility also failed to administer insulin medications timely for two of four residents observed who received insulin (Resident #16 and #17), and 1 of 1 resident who received heparin (a blood thinner) medication (Resident #17). The facility reported a census of 86 residents.

Findings include:

1. The Minimum Data Set (MDS) dated 4/5/2023 for Resident #23 documented a Brief Interview of Mental Status (BIMS) of 7 indicating severe cognitive impairment. The MDS documented diagnosis of diabetes mellitus, Alzheimer disease, and bipolar disorder. The MDS also documented he takes insulin.

Record Review of Resident #23's Medication Administration Record (MAR) documented the following order:
Humalog (Insulin Lispro, a fast-acting insulin used to control high blood sugar in adults and children with diabetes). Give subcutaneously before meals, inject as per sliding scale: if 151 - 200 give 2 units, 201 - 250 give 4 units; 251 - 300 give 6 units; 301 - 350 give 8 units; 351 - 400 give 10 units, if less than 70 or greater than 400 call physician, Starting on 5/7/2023.

Record Review of Resident #23's MAR lacked an order for Novolog (Insulin Aspart, a fast-acting insulin that controls blood sugar around meal

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times for both type 1 and type 2 diabetes).

During an observation on 5/17/2023 at 12:45 PM of Staff N, revealed she checked Resident #23's blood sugar and revealed it was 188 milligrams (mg) per deciliter (dL). She reviewed Resident #23's insulin orders on the facility's Electronic Health Record (EHR) and it revealed the resident takes Humalog insulin. She reviewed the date on two (2) of the insulin vials the resident had and reported they were both expired. Staff N put them in the facility's sharp container and went to the medication room to obtain new insulin. Staff N returned with a different medication, the medication Novolog insulin. Staff N drew up the Novolog insulin to two (2) units for Resident #23 and showed it to the surveyor. Staff N was putting the insulin away and stated ok are you ready, the surveyor questioned the nurse on the insulin she was giving and she looked at the order that read Humalog and took the insulin bottle and said Insulin Aspart, that's Humalog. The nurse then read the brand name on the insulin bottle that read Novolog. Staff N stated, Oh no, that's wrong, that was close and put the Novolog insulin needle she drew up into the sharp container.

During an interview on 5/24/23 at 1:09 PM the Director of Nursing (DON) revealed she would expect the nurse to give residents the medications as they are ordered on the MAR and ensure checking the order against the MAR and the pharmacy packaging and follow the 5 rights of medication administration.

During an interview on 5/24/23 at 1:21 PM the Administrator revealed she would expect nurses to check the MAR and pharmacy label packaging to ensure correct medication was being

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administered.

Record review of the facilities policy titled, Diabetes Management, last reviewed on 7/27/2022 instructed staff on the following: If resident is on a sliding scale, administer Insulin as ordered.

2. The MDS assessment dated 3/29/23 revealed Resident #16 had diagnoses of diabetes mellitus, and took insulin 7 of 7 days during the look-back period. The resident had a BIMS of 12, indicating moderately impaired cognition.

The Care Plan initiated 5/4/23 revealed the resident had diabetes mellitus. The staff directives included administer diabetes medication as ordered by the physician.

The Physician's Order and Medication Administration Record (MAR) included an order for insulin glargine 10 units injected subcutaneously at bedtime for diabetes mellitus started on 3/29/23.

Review of the MAR location of administration report revealed insulin glargine administered late a total of 19 times during 4/1/23 - 4/30/23. The MAR location of administration report revealed the scheduled time at 9:00 PM and insulin administered on the following dates and times:
4/1/23 at 10:28 PM
4/2/23 at 10:09 PM
4/6/23 at 10:40 PM
4/7/23 at 11:02 PM
4/9/23 at 10:42 PM
Scheduled 4/12/23 at 9:00 PM, not administered until 4/13/23 at 12:01 AM
4/13/23 at 11:11 PM

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F 760	Continued From page 92 4/14/23 at 10:15 PM 4/15/23 at 10:29 PM 4/16/23 at 10:48 PM 4/17/23 at 11:17 PM 4/18/23 at 10:46 PM 4/19/23 at 11:09 PM 4/20/23 at 10:31 PM 4/21/23 at 11:12 PM 4/22/23 at 10:34 PM 4/25/23 at 10:44 PM 4/26/23 at 10:35 PM 4/28/23 at 10:45 PM The MAR 5/1/23 - 5/19/23 revealed insulin administered late 5 times. The MAR location of administration report revealed scheduled time at 9:00 PM and insulin administered on the following dates and times: Scheduled 5/8/23, not administered until 5/9/23 at 4:02 AM 5/11/23 at 11:13 PM 5/13/23 at 10:27 PM 5/16/23 at 10:10 PM 5/19/23 at 10:30 PM During an interview on 5/15/23 at 1:40 PM, Resident #16 reported he didn't get medications when he was supposed to at night. During an interview on 5/19/23 at 9:44 PM, Resident #16 reported it was almost 10:00 PM and he still had not received his evening pills or insulin. The resident reported he needed his medications and insulin, in order for his CPAP (continuous positive airway pressure) device applied, so he could go to sleep. The resident had a clock on the wall in his room to know the time of day and how long since he was supposed to get the medication.	F 760		

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During an interview on 5/19/23 at 8:30 PM, Staff J, Registered Nurse (RN), reported residents not getting medication or medications administered late because they were short staffed.

During observation on 5/19/23 at 10:08 PM, Staff T, Certified Nurse's Assistant (CNA) advised Staff S, Registered Nurse (RN), Resident #16 needed his medications because the resident wanted to go to sleep. On 5/19/23 at 10:09 PM, Staff S stood by the medication cart and looked at a computer screen. Several residents' names were highlighted in red, including Resident #16. The screen revealed metformin 500 milligrams (mg) and tylenol 500 mg scheduled for 8:00 PM, and glargine insulin 10 units SQ scheduled for 9:00 PM. Staff S prepared Resident #16's medications, then administered the PO and insulin medications at 10:25 PM.

During an interview on 5/22/23 at 3:45 PM, the DON reported the facility had no standard or set times for medication administration. For medications administered BID (twice a day) then would give at 6 AM and 6 PM or 8 AM and 8 PM. For medications ordered TID (three times a day), times set at 8 AM, 12 PM, and 4 PM, but it depended upon the medication. The DON reported the nurse practitioner entered orders into the EHR and set the time for when medications administered. The nurse manager or DON then checked and confirmed the orders. The DON stated the nurses entered telephone order or orders from outside appointment into the EHR.

During an interview on 5/23/23 at 10:30 AM, the Nurse Practitioner (NP) reported the NP or the nurses entered medication orders in the

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computer. The NP stated whenever she entered medication orders, she entered times for medication administration.

During an interview on 5/24/23 at 9:55 AM, the DON reported medications could be administered one hour before and one hour after the scheduled medication administration time or the medication considered late. For example if medication scheduled for 8 AM, the nursing staff had from 7 AM to 9 AM to administer the medication or the medication was considered late if administered after 9 AM. The DON stated she expected staff notify the physician whenever medication(s) administered late. The DON reported a visual audit performed on nurses and the medication administration for the right medication but no electronic health record report ran regarding scheduled administration times and actual administration of the medication. The DON checked the reports in the EHR and revealed the medication administration audit report ran last in 2013.

The facility Medication Pass Policy revised 3/28/23 lacked medication administration times.

Review of Resident's Meetings notes dated 5/4/23 revealed residents voiced concerns about not getting medications on time.

3. The Minimum Data Set (MDS) assessment dated 5/2/23 revealed Resident #17 had diagnoses of diabetes mellitus, and took insulin 7 of 7 days during the look-back period. The resident had a BIMS of 13, indicating cognition intact.

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The Care Plan initiated 4/25/23 revealed the resident had diabetes mellitus and fluctuating blood sugars. The staff directives included monitor blood sugar and administer medication as ordered by the physician.

The Physician's Order and Medication Administration Record (MAR) included an order for:
a. Insulin Glargine 20 units SQ two times a day for diabetes started on 4/25/23 and discontinued 5/19/23 at 2:10 PM
b. A physician's order started on 5/19/23 at 8:00 PM for insulin Glargine 25 units SQ two times a day.
c. Heparin sodium 5000 units per 1 ml injection SQ every 8 hours for DVT (deep vein thrombosis) (blood clot) prevention started on 4/26/23 at 2:00 PM.
d. Insulin Lispro per sliding scale started on 4/26/23.
e. Insulin Lispro 8 units SQ one time only for elevated blood sugar for total of 18 units with scheduled dose started on 5/19/23 at 12:00 PM. Recheck blood sugar at 8:30 PM and 10:30 PM. If blood sugar over 400 call Dr.

The EHR revealed a blood sugar performed on 5/19/23 at 9:41 PM was 435.

Review of the MAR location of administration report revealed insulin glargine administered late a total of 12 times during 5/1/23 - 5/19/23. The MAR location of administration report revealed the following scheduled time and the time the insulin administered:
Insulin Glargine Medication scheduled administration time at 8:00 AM but actually administered on

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F 760	Continued From page 96 5/13/23 11:37 AM 5/14/23 9:23 AM Insulin Glargine Medication scheduled time 8:00 PM administered on: 5/4/23 at 9:58 PM 5/11/23 at 10:36 PM 5/12/23 at 10:15 PM 5/13/23 at 10:06 PM 5/15/23 at 9:44 AM 5/16/23 at 10:02 PM 5/17/23 at 9:21 PM 5/18/23 at 9:32 PM 5/19/23 at 9:45 PM 5/20/23 at 9:54 PM Insulin Lispro scheduled administration time at 8:00 AM but medication administered on: 5/11/23 at 9:56 AM 5/13/23 at 11:37AM 5/14/23 at 9:23 AM Insulin Lispro scheduled administration time at 12:00 PM but medication administered on: 5/3/23 at 1:28 PM 5/13/23 at 3:11 PM Insulin Lispro scheduled administration time at 6:00 PM administered on: 5/4/23 8:36 PM In addition to insulin administered late, lispro insulin administered by same nurse on 5/13/23 at 11:37 AM (for dose scheduled at 8:00 AM), 3:11 PM (for dose scheduled at 12:00 PM), and 5:27 PM (for dose scheduled at 6 PM). Insulin administered just 2 hrs and 16 minutes after previous dose on 5/13/23 between 3:11 PM and 5:27 PM.	F 760		

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F 760	Continued From page 97 Heparin Sodium Injection 5000 UNIT/ML had the following scheduled administration times and actual injection administration times: 5/7/23 10:00 PM but not administered until 5/8/23 at 3:30 AM 5/8/23 10:00 PM but not administered until 5/9/23 at 3:57 AM 5/14/23 2:00 PM administered at 3:43 PM 5/17/23 2:00 PM administered at 6:00 PM 5/18/23 2:00 PM administered at 4:28 PM 5/19/23 10:00 PM administered at 11:29 PM During observation on 5/19/23 at 9:40 PM, Staff S, Registered Nurse (RN) checked Resident #17's blood sugar and reported blood sugar 435 (normal 80-120). Staff S reported planned to call the physician due to the resident's blood sugar reading high. At 9:50 PM, Staff S administered lantus 25 units to Resident #17's left arm.	F 760		
F 835 SS=L	Administration CFR(s): 483.70 §483.70 Administration. A facility must be administered in a manner that enables it to use its resources effectively and efficiently to attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident. This REQUIREMENT is not met as evidenced by: Based on observations, resident interviews, family interviews, staff interviews, clinical record review, facility assessment review, previous 2567 review, and employee file review, the facility's administration failed to effectively and efficiently maintain administrative responsibilities to ensure provision of ethical, high-quality health care	F 835		

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services. This resulted in an Immediate Jeopardy (IJ) to residents' health and safety affecting all residents. The facility reported a census of 86 residents.

Findings include:

The State Agency informed the facility of the IJ on 6/8/23 at 3:00 PM and provided the IJ template. The IJ began on 5/28/23 when the staff first reported issues with management not caring about their reported concerns. The survey team exited the facility prior to the IJ immediacy being removed. The initial scope and severity of "L" remained at the time of the survey exit.

Findings include:

Observation on 6/1/23 at 9:45 AM revealed a yellow sign on the doors leading to the Administrative offices that stated: NOTICE: please keep this door closed at all times. On 6/2/23 at 8:15 AM the signed remained on the door by the receptionist's desk. On 6/6/23 at 3:14 PM both doors leading to the Administrative offices were locked with the expectation one was to speak with the receptionist on what they needed then she could assist with the task. Observation on 6/7/23 at 7:30 AM revealed the administrative offices by the receptionist's desk was open upon surveyor entrance to the building. After it was noted the surveyor was in the building the receptionist went to the administrative offices, came back out and closed the door.

Review of the Administrator employee file revealed her hire date was 11/21/2020.

Review of the facility's survey results binder

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revealed the following repeated deficiencies since the Administrator's hire date of 11/21/2020:
- F550 during complaint surveys ending on 10/5/21, 3/9/22, 7/28/22, 11/4/22 and current survey
- F580 during complaint surveys ending on 12/10/20, 5/6/21, 7/28/22, and current survey
- F684 during the recertification surveys ending on 12/30/21, 3/14/23, and during complaint surveys ending on 5/6/21, 3/9/22, 7/28/22, 11/4/22 and current survey. This deficiency had an Immediate Jeopardy (IJ) scope and severity with harm associated with it for the surveys ending on 3/14/23 and current survey
- F686 during complaint surveys ending on 5/6/21, 3/9/22 and current survey. This deficiency had a harm level associated with it for the current survey.
- F689 during the recertification surveys ending on 12/30/21, 3/14/23 and complaint surveys ending on 12/10/20, 5/6/21, 3/9/22, 7/28/22, 11/4/22, and current survey. This deficiency had an IJ scope and severity with harm associated with it for the survey ending on 7/28/22 and harm level associated with it for the current survey.
- F725 during the recertification surveys ending on 12/30/21, 3/14/23 and complaint surveys ending on 3/9/22, 7/28/22 and current survey. This deficiency had an IJ scope and severity with harm associated with it for the current survey.
- F880 during the recertification surveys ending 12/30/21, 3/14/23 and complaint survey ending on 11/23/21 and current survey.

Review of the state agency's public website https://dia-hfd.iowa.gov/ contained the following certification actions during the following surveys:
- ending on 11/23/21 complaint survey resulted in denial of payment was imposed and civil money

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penalty was imposed
- ending on 12/30/21 recertification and intake survey resulted in civil money penalty imposed
- ending on 7/28/22 intake survey fining and citation was issued
- ending 10/10/22 intake survey resulted in denial of payment imposed
- ending 3/14/23 recertification survey results in civil money imposed, directed plan of correction imposed, and fining and citation was issued

Review of the state agency's public website https://dia-hfd.iowa.gov/ listed the following fines were paid by the facility:
- 02/11/22 $500.00
- 08/12/22 $9,750.00
- 08/12/22 $19,500.00

Review of the Administrator's Employee File revealed a Performance Appraisal with an appraisal date of 01/2021-12/2021 with the goal to decrease the number of citations during annual and complaints for 2022. Areas for improvement: decrease turnover rate and stabilize nursing department to improve regulatory outcomes. Her file contained the Administrator's job description that was signed and dated by the Administrator on 11/2/2020 with the following essential job functions:
- Resident Rights
- Knows and respects patient's right
- Ensures patient concerns/complaints are responded to with tact and urgency
- Administrator Provision of Services Responsibilities
- Directs the location staff to provide high quality in daily care which meets/exceeds all internal/external standards
- Listens to family questions and concerns,

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assists with resolving issues, and explains related company actions and decisions
- Completes rounds to assess resident climate and to address complaints or other issues; refers these issues to appropriate department head or other personnel
- Drives Quality Assurance program process in the center, and ensures the implementation of follow-up corrective action
- Intervenes as appropriate in potentially threatening situations and follows-up with staff after crisis has been resolved
- Oversees preparation for licensure certification surveys
- Administrator Human Resource Management Responsibilities
- Organizes the functions of the nursing home through appropriate departmentalization and the delegations of duties.
- Establishes formal means of accountability
- Promotes and maintains pro-active, positive employee relations programs
- Maintains frequent, daily, informal interaction and provides positive feedback to staff while they are working; maintains an open-door policy in dealing with staff
- Communicates clearly and responsively on issues arising in the facility to decision makers who are outside of the facility and follows-up to minimize impact of the issues

On 5/19/23 8:30 PM Staff J, RN, reported she had worked at the facility for 3 weeks and it was the worst place she had ever worked. Staff J stated the facility was so short staffed and when she tried to contact the DON regarding concerns for staffing she was told to utilize the other nurse on site to help her but only one other nurse

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worked on that day (the prior weekend). Staff J stated it was unsafe and had concern for her nursing license. Lots of residents needed two staff assistance. Residents not getting medications or medications administered late. Staff document treatments done on residents but treatments not done because they didn ' t have time to do them. Several residents had pressure ulcers because residents not getting repositioned like they should. Staff J then reported she ' d rather talk to the surveyor more when not at the facility because the DON had arrived at facility and didn ' t want the DON to see her talking with surveyor.

On 5/22/23 at 11:05 AM, Staff J reported Staff F, LPN, told staff on 5/22/23 to do whatever state wanted them to do and after state left, staff could do what they wanted. Staff J reported staffing terrible at the facility, treatments not getting done and medications administered late because only 1 nurse and 1 CMA worked on a shift.

On 5/30/23 at 7:00 PM Staff DD, CNA, stated the Administrator was not nice to staff and did not understand how she could be the abuse officer when she treated and talked to staff abusively. When trying to discuss staffing concerns, the Administrator would say she was not talking about it and it's a done deal.

On 6/7/23 at 10:08 AM Staff F, Licensed Practical Nurse (LPN), stated the dynamic was not good at the facility. The Administrator stood up for the Director of Nursing (DON) so she would not look into things that needed attention. Staff F voiced the Administrator needed to be more involved with things.

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On 6/8/23 at 2:18 PM the Administrator was asked why the sign was on the door to the administrative door and she indicated it was closed because those in the offices talked about many things and the foot traffic was high. The Administrator commented out of respect for the residents, they kept them closed to ensure the information being discussed was private and that residents and family could still go back there. When asked why the doors were locked, the Administrator responded defensively stating it had always been that way along with the sign. The survey team discussed with the Administrator during previous visits the door never had a sign and the doors were never locked. The sign and locked doors did not reflect the open door component of her job description. It was suggested the individuals within the offices could close their office door if they needed to have private conversations. Leaving the door locked with the sign to keep the door closed was not inviting for residents and family members to come to them with concerns, issues, etc.

On 6/5/23 at 12:20 PM, the Department of Inspections and Appeals (DIA) office attempted to call the Administrator as the DIA Bureau Chief (BC), surveyor, and Program Coordinator on the same conference phone call. The DIA BC spoke with a facility staff member and call transferred to the Administrator. The call went to the Administrator's voicemail box. At 12:25 PM the DIA BC repeatedly attempted to contact the Administrator by phone as the surveyor and PC on the same phone call. The phone call was transferred by facility staff to the Administrator's voicemail. At 12:34 PM, the BC attempted to contact the Administrator again. While the surveyor was on the phone with the BC and PC,

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the surveyor walked to the Administrator's office and advised the Administrator the DIA BC tried to reach her but the phone calls kept going to her voicemail. The surveyor placed the call from the BC on speaker and gave the phone to the Administrator. At that time, the BC provided information to the Administrator about concerns related to an Immediate Jeopardy.

On 6/5/23 at 1:45 PM, an attendant sat at the front entryway desk next to the door that led to the Administrative offices. The door was locked and had a sign "NOTICE this door to remain closed at all times". A second door to the Administrative offices just down the hall from the door by the attendant was locked. The Administrator, DON, Human Resources, and MDS staff not accessible. The attendant had to call Administrative staff if the surveyor needed something from an Administrative team member. During 6/5/23 AM and the prior survey weeks, the doors leading to the hallway to the Administrative offices were unlocked.

During anonymous staff interviews starting on 5/31/23 to 6/7/23, two staff members (Staff DD and Staff OO) reported hesitancy to speak to the surveyor unless away from the Administrative offices for fear of being seen and retaliation. Four staff (Staff OO, MM, NN, DD) reported the Administrator and DON told staff whenever State (surveyors) asked the staff questions they needed to respond everything was fine. If they wanted a paycheck they better not say anything bad. Staff reported the CNA's schedule changed and hours were cut back after the new company took over. The facility was short-staffed and used a lot of agency to fill hours, even though the facility's employed CNA's wanted and could work

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F 835	Continued From page 105 the hours. Staff were told options for schedule (8 hour shifts) and they could take it or leave it. Staff reported being yelled at or treated rudely by the Administrator Staff members reported names listed on daily assignment lists but staff not aware they were scheduled to work. The daily assignment sheets looked like they had adequate staff but in reality staff not scheduled to work. One staff reported lack of dietary staffing, and only had a cook and dietary aide who worked in the kitchen during her shift, but suppose to have four staff on shift. In an interview on 6/8/23 at 8:28 a.m., Staff PP reported fear of retaliation. Staff PP reported the Administrator was falsifying plan of correction audits by going back to April 2023 and back dating and filling in information related to quality assurance efforts and that the Administrator was directing other staff to do the same. Staff PP stated the management team verified several family members confirmed difficulties obtaining entrance into the facility related to a locked front door and no staff were available to answer the door; lengthy call light response times; 6 additional residents identified with pressure sores; for staff education related to the IJ removal plans, if staff did not respond, a blanket email with the information went out without verifying the staff competency; and original concern statements submitted by a CNA regarding the care of a resident was shredded. Staff PP reported concerns the administration was covering up quality of care concerns rather than putting in a good faith effort to address and fix the immediacy of the concerns from surveys.	F 835		
F 838 SS=F	Facility Assessment CFR(s): 483.70(e)(1)-(3)	F 838		

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F 838	Continued From page 106 §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, 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	F 838		

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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.
This REQUIREMENT is not met as evidenced by:
Based on observation, review of facility assessment, and resident and staff interview, the facility failed to adequately evaluate their resident population and identify required resources and staffing levels needed to provide the necessary care and services needed for all current residents. The facility reported a census of 86 residents.

Findings include:

A review of the Facility Assessment dated 10/2022, revealed the facility assessment reviewed annually and updated as indicated and whenever a significant change including facility capacity or the services provided. A facility

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assessment utilized to determine the resources needed to care for the resident population served during day-to-day operations as well as during emergency situations. The Centers for Medicare and Medicaid Services (CMS) require inclusion of the following components:
a. The facility's resident population included the number of residents and the care required by the population, taking in consideration the types of diseases, resident conditions, physical and cognitive disabilities, overall acuity, and other pertinent facts present within their population.
b. Staff competencies necessary to provide the level and types of care needed for the population
c. Physical environment, equipment, services, and other plant consideration necessary for the care of the resident population
d. Resources including but not limited to buildings and physical structures, medical and non-medical equipment, all personnel including contract staff competencies to provide care.

The facility's assessment ncluded the following:
- Average census = 94
- Average Skilled Care residents per day: 17.9
- Average long-term care residents per day: 76
- Top 7 diagnosis's of resident population (as coded on the MDS (minimum data set) assessment

The facilty assessment included an undated and unsigned Resident Census and Conditions of Resident (CMS form 672) document with an old provider number, a resident population profile report dated 10/24/21 to 10/23/22, and a resident diagnosis report dated 10/24/22. The assessment had no indication of the number of residents who required the use of mechanical lifts or other devices, or pertinent facts about the

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condition of current residents, physical disabilities, overall acuity of the resident population, or individualized care needs for population of residents at the facility, such as assistance needed for activities of daily living.

During confidential resident interviews 5/15/23 to 5/19/23, five of ten residents reported it took staff 20 minutes to 2 hours before staff answered their call light and provided assistance. The residents reported call light response depended on how many staff worked and what was going on. One resident reported he had to gauge the time of day when staff got him up in the chair because he required two staff for transfers, but when the facility only had one aide on duty he was left in the chair all night.

During an interview 5/19/23 at 8:30 PM, Staff J, Registered Nurse (RN), reported residents' medications and treatments administered late or not administered because the facility was short staffed and staff lacked the time to administer the medications and/or treatments when scheduled and in a timely manner. Staff J reported lots of residents required two staff for assistance and cares. Staff J reported several residents had developed pressure ulcers because residents not getting repositioned like they should. Staff J also reported she was the only nurse working with a CMA the weekend prior.

During an interview on 6/8/23 at 2:15 PM, the Administrator reported she completed the facility assessment and updated the assessment once a year. The Administrator reported facility assessment updated depending upon the resident demographics, census, vendors and providers, and emergency preparedness. She

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F 838	Continued From page 110 compiled data and information for the facility assessment, placed the information in a binder, and submitted a copy of facility assessment to the corporate office. The Administrator reported she used a formula to determine staffing needs for each shift. When the surveyor asked the Administrator if she reviewed the information or how she utilized the information in the facility assessment, the Administrator asked the surveyors how often she should look at the facility assessment.	F 838		
F 849 SS=K	Hospice Services CFR(s): 483.70(o)(1)-(4) §483.70(o) Hospice services. §483.70(o)(1) A long-term care (LTC) facility may do either of the following: (i) Arrange for the provision of hospice services through an agreement with one or more Medicare-certified hospices. (ii) Not arrange for the provision of hospice services at the facility through an agreement with a Medicare-certified hospice and assist the resident in transferring to a facility that will arrange for the provision of hospice services when a resident requests a transfer. §483.70(o)(2) If hospice care is furnished in an LTC facility through an agreement as specified in paragraph (o)(1)(i) of this section with a hospice, the LTC facility must meet the following requirements: (i) Ensure that the hospice services meet professional standards and principles that apply to individuals providing services in the facility, and to the timeliness of the services. (ii) Have a written agreement with the hospice that is signed by an authorized representative of	F 849		

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the hospice and an authorized representative of the LTC facility before hospice care is furnished to any resident. The written agreement must set out at least the following:
(A) The services the hospice will provide.
(B) The hospice's responsibilities for determining the appropriate hospice plan of care as specified in §418.112 (d) of this chapter.
(C) The services the LTC facility will continue to provide based on each resident's plan of care.
(D) A communication process, including how the communication will be documented between the LTC facility and the hospice provider, to ensure that the needs of the resident are addressed and met 24 hours per day.
(E) A provision that the LTC facility immediately notifies the hospice about the following:
(1) A significant change in the resident's physical, mental, social, or emotional status.
(2) Clinical complications that suggest a need to alter the plan of care.
(3) A need to transfer the resident from the facility for any condition.
(4) The resident's death.
(F) A provision stating that the hospice assumes responsibility for determining the appropriate course of hospice care, including the determination to change the level of services provided.
(G) An agreement that it is the LTC facility's responsibility to furnish 24-hour room and board care, meet the resident's personal care and nursing needs in coordination with the hospice representative, and ensure that the level of care provided is appropriately based on the individual resident's needs.
(H) A delineation of the hospice's responsibilities, including but not limited to, providing medical

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direction and management of the patient; nursing; counseling (including spiritual, dietary, and bereavement); social work; providing medical supplies, durable medical equipment, and drugs necessary for the palliation of pain and symptoms associated with the terminal illness and related conditions; and all other hospice services that are necessary for the care of the resident's terminal illness and related conditions.
(I) A provision that when the LTC facility personnel are responsible for the administration of prescribed therapies, including those therapies determined appropriate by the hospice and delineated in the hospice plan of care, the LTC facility personnel may administer the therapies where permitted by State law and as specified by the LTC facility.
(J) A provision stating that the LTC facility must report all alleged violations involving mistreatment, neglect, or verbal, mental, sexual, and physical abuse, including injuries of unknown source, and misappropriation of patient property by hospice personnel, to the hospice administrator immediately when the LTC facility becomes aware of the alleged violation.
(K) A delineation of the responsibilities of the hospice and the LTC facility to provide bereavement services to LTC facility staff.

§483.70(o)(3) Each LTC facility arranging for the provision of hospice care under a written agreement must designate a member of the facility's interdisciplinary team who is responsible for working with hospice representatives to coordinate care to the resident provided by the LTC facility staff and hospice staff. The interdisciplinary team member must have a clinical background, function within their State

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scope of practice act, and have the ability to assess the resident or have access to someone that has the skills and capabilities to assess the resident.
The designated interdisciplinary team member is responsible for the following:
(i) Collaborating with hospice representatives and coordinating LTC facility staff participation in the hospice care planning process for those residents receiving these services.
(ii) Communicating with hospice representatives and other healthcare providers participating in the provision of care for the terminal illness, related conditions, and other conditions, to ensure quality of care for the patient and family.
(iii) Ensuring that the LTC facility communicates with the hospice medical director, the patient's attending physician, and other practitioners participating in the provision of care to the patient as needed to coordinate the hospice care with the medical care provided by other physicians.
(iv) Obtaining the following information from the hospice:
(A) The most recent hospice plan of care specific to each patient.
(B) Hospice election form.
(C) Physician certification and recertification of the terminal illness specific to each patient.
(D) Names and contact information for hospice personnel involved in hospice care of each patient.
(E) Instructions on how to access the hospice's 24-hour on-call system.
(F) Hospice medication information specific to each patient.
(G) Hospice physician and attending physician (if any) orders specific to each patient.
(v) Ensuring that the LTC facility staff provides

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orientation in the policies and procedures of the facility, including patient rights, appropriate forms, and record keeping requirements, to hospice staff furnishing care to LTC residents.

§483.70(o)(4) Each LTC facility providing hospice care under a written agreement must ensure that each resident's written plan of care includes both the most recent hospice plan of care and a description of the services furnished by the LTC facility to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being, as required at §483.24.
This REQUIREMENT is not met as evidenced by:
Based on record review, staff and family interviews, hospice documents, hospice agreement, and facility policy review the facility failed to notify 1 of 3 resident's hospice provider when he had an emergent change in condition (Resident #39). On 5/29/23 at 10:00 AM, the resident indicated the resident did not feel good and stated he felt like he was dying. The staff member noticed he was pale in color, cold to the touch, profusely sweating, and dull gray urine present. The Certified Medication Aide (CMA) checked his blood sugar and it was 536 mg/dL and gave him a pain medication for discomfort. The hospice provider on-call personnel that day indicated she was not notified of Resident #39's emergent change in condition. The only time she was notified was when he passed away later that afternoon. This resulted in an Immediate Jeopardy (IJ) to residents' health and safety. The facility reported a census of 86 residents with 12 residents receiving hospice services.

The facility was notified of the IJ on 6/2/23 at 1:00 PM. The IJ began on 5/29/23. The facility staff

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did not remove the immediacy prior to the survey exit. The initial scope and severity of "K" remained at the time of the survey exit.

Findings include:

The significant change Minimum Data Set (MDS) assessment dated 3/26/23 for Resident #39 identified a Brief Interview of Mental Status (BIMS) score of 3 which indicated severe cognitive impairment. The MDS revealed he required extensive assistance of two staff for bed mobility, transfers, dressing, toilet use, and personal hygiene. The MDS documented he required hospice services while a resident in the facility. The MDS documented the following diagnoses for Resident #39: sepsis, heart failure, diabetes mellitus, and depression.

The care plan focus area dated 3/14/23 identified Resident #39 received hospice services due to end-stage cardiac disease, severe deconditioning, and malnutrition. The care plan indicated the hospice team will integrate services and collaborate cares.

Review of Resident #39's Iowa Physician Orders for Scope of Treatment (IPOST) indicated he wanted a Do No Attempt Resuscitation (DNR) and only wanted comfort measures. Use medications by any route, positioning, wound care and other measures to relieve pain and suffering. Resident prefered no transfer to the hospital for life-sustaining treatment. Transfer if comfort needs cannot be met in current location. This form was signed by his physician and Power of Attorney (POA).

The Hospice Comprehensive Assessment and

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Plan of Care Update Report dated 5/18/23 documented he started to receive hospice services on 3/13/2023.

Review of the resident's Electronic Health Record (EHR) revealed his blood sugar was checked on 5/29/23 at 10:22 AM by Staff CC, Certified Medication Assistant (CMA). His blood sugar was 536 milligram per deciliter (mg/dL).

Review of Resident #39's May 2023 Medication Administration Record (MAR) revealed Staff CC administered the resident's as needed (PRN) order of oxycodone (narcotic pain medication) 5 milligram (mg) 1 tablet on 5/29/23 at 10:58 AM.

Review of Resident #39's progress notes revealed the following note was documented by Staff F Licensed Practical Nurse (LPN) on 5/29/23 at 3:42 PM: called to the room, resident lying in bed, starring at the ceiling. He looked at the nurse when his name was called. Vitals obtained: blood pressure 111/52, respirations 14, oxygen saturation 92% on room air, and temperature was 96.4 degrees Fahrenheit. She noted the urine in his drainage bag to be creamy green in color. She did not note any shortness of breath or respiratory distress. Gave his PRN oxycodone at 11:30 AM. She went back in to the room at 2:30 PM by the request of the Certified Nursing Assistant (CNA), resident was dead, no apical pulse, no breathing. Hospice was made aware. His progress notes lacked documentation of notification of his hospice provider when he started to have a significant change in condition.

Review of Resident #39's hospice notes provided by the hospice company revealed a Visit Note Report dated 5/29/23 with the visit type listed as

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hospice death at home. The report documented the nurse was in the facility on 5/29/23 at 4:16 PM until 5/29/23 at 4:35 PM. His hospice notes did not contain mention of the on-call hospice nurse or physician being notified of his emergent change in condition earlier in the day.
Resident #39's hospice binder cover and hard chart cover had the following sticky noted taped to both covers: #39 is a patient under hospice care. Please call us for any of the following: change in condition. The sticky note listed the phone number along with the attending physician's name.

On 5/30/23 at 7:00 PM Staff DD, CNA, stated on 5/29/23 at 10:00 AM Resident #39 told her that he did not feel right and felt like he was dying. She noted his skin to be pale, he was cold to the touch, sweating profusely, and saw that his urine was cloudy and a dull gray color. She noticed his catheter site had a split with puss coming out. She reported to this to Staff F, Licensed Practical Nurse (LPN), but she was very nonchalant, told her the resident was on hospice. She notified Staff CC, CMA, of her concerns and she checked his blood sugar; it was 536 mg/dL. Staff F, LPN, went in later to check on the resident and took his vital signs. The nurse told Staff DD, CNA, there wasn't anything she could do about it other than call hospice. Staff DD, CNA, was unsure if the nurse actually called hospice or not but does not think Staff F did until the resident passed away around 2:30 PM. Staff DD, CNA, indicated she frequently checked on him throughout her shift; every 30 minutes between her resident cares until she left at 2:00 PM. After Staff DD's shift she was told the resident passed away about 15-20 minutes after she left her shift. Staff DD, CNA, added it bothered her when she found out the

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resident passed away. Staff DD stated she thought the resident died alone without family or hospice staff with him. Staff DD, CNA, indicated she knew hospice staff would've came in if they were called but didn't think hospice was called. Staff DD, CNA, cried and didn't sleep very well because she kept thinking about the resident.

On 6/1/23 at 12:38 PM Staff CC, CMA, stated on the day Resident #39 passed away she got report from the CNA that he was losing color, cold to the touch, sweating and clammy. Staff CC, CMA, stated when she took care of him when he was upstairs, he had done this before and they would sent him out to the hospital. When this was reported to her she checked his vitals and took his blood sugar which was like 536mg/dL. She reported her findings to the nurse on duty that day and Staff F, LPN, told her he was on hospice and they would have to go through hospice to send him out. She was unsure if Staff F, LPN, called hospice. Staff CC, CMA, reported Resident #39 had a second episode where he lost his color, was clammy so she went back in there and he looked dead. Staff F, LPN, reported to Staff CC, CMA, that she went in there his eyes rolled and had not expired at that time. Staff CC, CMA, verified Resident #39 had a PRN order to have his blood sugar checked but had no insulin orders. When she saw his urine that day it was cloudy and a greenish color but did not see his catheter site. He did ask for something for pain, so she gave that to him. When asked how he was prior to these episodes, she stated he did not eat much, but seemed like he was fine. When asked if the felt the nurse did everything she could have for him that day, she felt like she could have done more. She believed the call to hospice should have been done sooner. She believed Staff F,

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LPN, had a lot on her plate that; Staff F was the only nurse with two CMAs downstairs that day.

On 6/1/23 at 1:14 PM Staff BB, LPN, was asked what she would do if a hospice resident became pale, cold to the touch, sweating profusely, had a blood sugar of 536 mg/dL and his catheter bag had cloudy, dull gray urine, she stated she would freak out then call hospice doctor. She would see what they needed to do for the resident. She would also notify hospice as well to see what they wanted to do.

On 6/1/23 at 1:16 PM Staff E, LPN, stated she would call hospice and notify the physician right away if a hospice resident was pale, cool to the touch, sweating profusely, had a blood sugar of 536 mg/dL and had cloud, dull gray colored urine.

On 6/2/23 at 8:23 AM the Administrator with the hospice provider indicated she was on-call the day Resident #39 passed away. She indicated the only the time facility staff notified her was when he had passed away. She added their hospice staff always tell staff and the resident to call them even if it is nothing. She stated they tell them this with every hospice visit. When asked if the facility should have called them when he had an emergent change in condition, she said they should have so they could figure out the family's or resident's goal based on their symptoms. Hospice would call the physician to get orders for the best way to provide comfort for this resident. If the facility was unable to get ahold of the hospice nurse they could call the hospice physician for guidance as well. They encourage the facility staff to call the hospice nurse first then the physician. She indicated they have an on-call system that notifies the nurse on call of a facility

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making a call. If that on-call person does not return the call within 15 minutes, it will automatically call her.

On 6/2/23 at 9:41 AM Staff F, LPN, indicated she primarily worked downstairs. She indicated on the day Resident #39 passed away they had a nurse call in so she was the only nurse downstairs with two CMAs downstairs. She added that is a lot of work for one nurse. She recalled staff wanted her to go in and check on Resident #39. She described his urine as a creamy thick spinach color. She did not look at his catheter site. She told the CNA his body was shutting down and she had called hospice to get them at the facility immediately. She knew he was transitioning so she gave the PRN of oxycodone because he was also grimacing when he was touched or turned in bed. She believed he did not look any different that day. Staff then came to her and reported he was expired so she went in there, she did a sternal rub on him and he took a few breaths then passed away. When asked what CNAs were reporting concerns to her she stated there were like six on the floor that day and could not remember who it was. She did acknowledge that staff notified her of Resident #39 being pale, sweaty, and cool to the touch that day but when she went in there he was normal. His normal color was pale. When asked how much time had lapsed when she was notified by staff of their concerns until she went in the room; she stated not much time had went by. She was in the middle of a medication pass so she finished that then went in. She added no one saw her going in to Resident #39's room only coming out. When asked if she contacted hospice that day, she stated she called them twice. She indicated she called about 10:30 AM and the on-call person told

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her she was busy and could not make it to the facility. When she did arrive at the facility it was about 1:30 PM-2:00 PM right after he passed away. Staff F stated she let the hospice staff take over when she got there. Staff F added when she first called them she was told to keep him comfortable since he was on hospice there was nothing to do. During a follow-up interview with Staff F on 6/7/23 at 10:08 AM she indicated she could not remember what time she initially went in to his room. She added she was so busy with three other residents transitioning that that time. She indicated she went right to his room after she was done with her medication pass. When asked if she was administering morning to noon medications at that time, she stated she thought it may have been about 11:00 AM but did not look at the clock. She indicated she immediately took his vitals to see where he was at then called hospice. She told her everything and the hospice staff member advised her to keep him comfortable. Staff F stated about 1:00 PM she called hospice again, she indicated the hospice person advised her not to call the physician because he would not do anything. Staff F stated she was unsure when his blood sugar was taken and was not sure why the staff member did that.

On 6/2/23 at 8:33 AM the Director of Nursing (DON) was asked if a hospice resident experienced a change in condition should their hospice provider be notified, she stated the nurse usually notifies hospice. When asked if this hospice resident had a change in urine characteristics and a high blood sugar she stated that is dependent on if they are close to end of life. It's a case by case decision. She acknowledged hospice should have been notified of Resident #39's change in condition, but it was

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her understanding that they were notified. In a follow-up interview on 6/8/23 at 2:52 PM she indicated she asked who Staff F spoke to and what she did once she was informed of Resident #39's elevated blood sugar. Staff F indicated she reached out to hospice in the morning and got the answering service, they told her they would get back to her. She called back again but did not take down the names of the person's she spoke to. The DON told her she should always take down the name of who you talk with. The DON then called the hospice provider to see when Staff F contacted them about Resident #39 on that day. The hospice provider indicated the facility only notified them of his passing. Staff F was then questioned if she notified the family or physician of the elevated blood sugar and she did not. She indicated the resident was on comfort measures. The DON explained to her the family has the right to change treatment or come off hospice. Staff F said that the resident was on hospice, she felt her job was to keep him comfortable and that is what she did. She provided holistic cares, pain management, repositioning, etc. She did acknowledge she called again when he passed away. When asked what the DON would have done in the situation, she stated she would have called the doctor and call the family to see what they would have wanted done. When the DON was informed the family was not notified, they did not have the option to be with him. She indicated she knew that and she would have notified them.

On 6/2/23 at 2:25 PM the hospice physician/Medical Director indicated he was not notified of Resident #39's change in condition the day he passed away. He added he was only made aware of his passing. The facility should

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have notified him of his condition and blood sugar so they could act accordingly.

On 6/7/23 at 9:56 AM Resident #39's Durable Power of Attorney (DPOA) indicated the hospice staff notified her of his passing. She did not receive a call from the facility that day to notify her of any changes. She was really surprised he went that fast, he was doing well once on hospice.

On 6/8/23 at 2:18 PM the Administrator stated she would have expected Staff F to reach out hospice. If she was unable to do that then she should have called the physician or on-call nurse.

The facility provided the following hospice agreement between the facility and hospice provider. This agreement dated 12/8/21 is between the hospice provide and nursing facility:
1) Duties and Obligations of Facility: Facility will provide the services necessary to meet the Hospice Patient's personal care and nursing needs in coordination with the Hospice representative and will ensure the level of care provided is appropriately based on the Hospice Patient's needs. Facility will have available and will provide as needed and upon written authorization from Hospice, the following accommodations and support services for Hospice Patients:
- Nursing Services. Twenty-Four hour nursing care (including the services of a RN on duty every shift, 24 hours/day), sufficient to meet total nursing needs. Each Hospice Patient must receive all nursing services as prescribed and must be kept comfortable, clean, well-groomed, and protected from accident, injury, and infection.

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2) Designation of an Interdisciplinary Group Member. Facility will designate a member of the Facility's Interdisciplinary Group ("IDG Member") who is responsible to work with Hospice staff to coordinate care provide to the Hospice Patient. The IDG Member must have a clinical background, function within their state scope of practice act, and have the ability to assess the Hospice Patient of have access to another person who has the skills and capabilities to assess the Hospice Patient. The IDG member is responsible for the following:

- Collaborating with Hospice representatives and coordinating facility staff participation in the care planning process for those Hospice Patients receiving Hospice Services. This includes establishing how communication will be documented between Hospice and Facility to ensure the needs of the patient are addressed and met 24 hours per day.
- Communicating with Hospice representatives and other healthcare providers participating in the provision of care for patient's terminal illness, related conditions, and other conditions to ensure quality of care for the patient and family.
- Ensuring that Facility communicates with the Hospice medical director, the patient's attending physician and other practitioners participating in the provision of care to the patient as needed to coordinate the hospice care with the medical care provided by other physicians.
- Obtaining the following information from the Hospice:

a) The most recent Hospice Plan of Care for each Hospice Patient

d) Names and contact information for the Hospice personnel involved in the care of each Hospice Patient

e) Instructions on how to access Hospice's

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F 849	Continued From page 125 24 hour on call system f) Hospice medication information specific to each Hospice Patient g) Hospice physician and attending physician orders for each Hospice Patient 3) Notification to Hospice. Facility will immediately notify Hospice if: - A significant change in a Hospice Patient's physical, mental, social, or emotional status occurs - Clinical complications that suggest a need to alter the Plan of Care - A need to transfer a Hospice Patient from the Facility for any condition	F 849		
F 865 SS=F	QAPI Prgm/Plan, Disclosure/Good Faith Attmpt CFR(s): 483.75(a)(1)-(4)(b)(1)-(4)(f)(1)-(6)(h)(i) §483.75(a) Quality assurance and performance improvement (QAPI) program. Each LTC facility, including a facility that is part of a multiunit chain, must develop, implement, and maintain an effective, comprehensive, data-driven QAPI program that focuses on indicators of the outcomes of care and quality of life. The facility must: §483.75(a)(1) Maintain documentation and demonstrate evidence of its ongoing QAPI program that meets the requirements of this section. This may include but is not limited to systems and reports demonstrating systematic identification, reporting, investigation, analysis, and prevention of adverse events; and documentation demonstrating the development, implementation, and evaluation of corrective actions or performance improvement activities; §483.75(a)(2) Present its QAPI plan to the State	F 865		

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Survey Agency no later than 1 year after the promulgation of this regulation;

§483.75(a)(3) Present its QAPI plan to a State Survey Agency or Federal surveyor at each annual recertification survey and upon request during any other survey and to CMS upon request; and

§483.75(a)(4) Present documentation and evidence of its ongoing QAPI program's implementation and the facility's compliance with requirements to a State Survey Agency, Federal surveyor or CMS upon request.

§483.75(b) Program design and scope.
A facility must design its QAPI program to be ongoing, comprehensive, and to address the full range of care and services provided by the facility. It must:

§483.75(b)(1) Address all systems of care and management practices;

§483.75(b)(2) Include clinical care, quality of life, and resident choice;

§483.75(b)(3) Utilize the best available evidence to define and measure indicators of quality and facility goals that reflect processes of care and facility operations that have been shown to be predictive of desired outcomes for residents of a SNF or NF.

§483.75(b) (4) Reflect the complexities, unique care, and services that the facility provides.

§483.75(f) Governance and leadership.

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The governing body and/or executive leadership (or organized group or individual who assumes full legal authority and responsibility for operation of the facility) is responsible and accountable for ensuring that:

§483.75(f)(1) An ongoing QAPI program is defined, implemented, and maintained and addresses identified priorities.

§483.75(f)(2) The QAPI program is sustained during transitions in leadership and staffing;
§483.75(f)(3) The QAPI program is adequately resourced, including ensuring staff time, equipment, and technical training as needed;

§483.75(f)(4) The QAPI program identifies and prioritizes problems and opportunities that reflect organizational process, functions, and services provided to residents based on performance indicator data, and resident and staff input, and other information.

§483.75(f)(5) Corrective actions address gaps in systems, and are evaluated for effectiveness; and

§483.75(f)(6) Clear expectations are set around safety, quality, rights, choice, and respect.

§483.75(h) Disclosure of information.
A State or the Secretary may not require disclosure of the records of such committee except in so far as such disclosure is related to the compliance of such committee with the requirements of this section.

§483.75(i) Sanctions.
Good faith attempts by the committee to identify

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and correct quality deficiencies will not be used as a basis for sanctions.
This REQUIREMENT is not met as evidenced by:
Based on the facility's survey binder, State Agency Website, staff interviews and facility policy review the facility failed to make a good faith effort to correct their deficient practices resulting in repeated deficiencies to include harm level, fines, and certification actions which affected all residents. The facility reported a census of 86 residents.

Findings include:

Review of the facility's survey results binder revealed the following repeated deficiencies since the Administrator's hire date of 11/21/2020:
- F550 during complaint surveys ending on 10/5/21, 3/9/22, 7/28/22, 11/4/22 and current survey
- F580 during complaint surveys ending on 12/10/20, 5/6/21, 7/28/22, and current survey
- F684 during the recertification surveys ending on 12/30/21, 3/14/23, and during complaint surveys ending on 5/6/21, 3/9/22, 7/28/22, 11/4/22 and current survey. This deficiency had an Immediate Jeopardy (IJ) scope and severity with harm associated with it for the surveys ending on 3/14/23 and current survey
- F686 during complaint surveys ending on 5/6/21, 3/9/22 and current survey. This deficiency had a harm level associated with it for the current survey.
- F689 during the recertification surveys ending on 12/30/21, 3/14/23 and complaint surveys ending on 12/10/20, 5/6/21, 3/9/22, 7/28/22, 11/4/22, and current survey. This deficiency had an IJ scope and severity with harm associated

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with it for the survey ending on 7/28/22 and harm level associated with it for the current survey.
- F725 during the recertification surveys ending on 12/30/21, 3/14/23 and complaint surveys ending on 3/9/22, 7/28/22 and current survey. This deficiency had an IJ scope and severity with harm associated with it for the current survey.
- F880 during the recertification surveys ending 12/30/21, 3/14/23 and complaint survey ending on 11/23/21 and current survey.

Review of the state agency's public website https://dia-hfd.iowa.gov/ contained the following certification actions during the following surveys:
- ending on11/23/21 complaint survey resulted in denial of payment was imposed and civil money penalty was imposed
- ending on 12/30/21 recertification and intake survey resulted in civil money penalty imposed
- ending on 7/28/22 intake survey fining and citation was issued
- ending 10/10/22 intake survey resulted in denial of payment imposed
- ending 3/14/23 recertification survey results in civil money imposed, directed plan of correction imposed, and fining and citation was issued

Review of the state agency's public website https://dia-hfd.iowa.gov/ listed the following fines were paid by the facility:
- 02/11/22 $500.00
- 08/12/22 $9,750.00
- 08/12/22 $19,500.00

On 6/8/23 at 2:15 PM the Administrator stated they did not have a Quality Assurance (QA) policy, they just follow the federal regulation. When asked what takes place after a survey is completed she indicated they do a plan of

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F 865	Continued From page 130 correction specific to that deficiency received. They would do audits, do baselines and look at what other areas were affected by the tag cited. Their current audit time is 4-6 weeks but have been longer due to this survey. If the issues continue to be present they will do checks and balances to see if the plan worked or did not work. When asked what her thoughts were on repeated deficiencies over the last 2.5 years she stated that is all dependent on the situations at the time of the survey and different circumstances occurring; COVID-19 outbreak, staffing, agency issues, nothing have nurse management, etc.	F 865		
F 880 SS=F	Infection Prevention & Control CFR(s): 483.80(a)(1)(2)(4)(e)(f) §483.80 Infection Control The facility must establish and maintain an infection prevention and control program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of communicable diseases and infections. §483.80(a) Infection prevention and control program. The facility must establish an infection prevention and control program (IPCP) that must include, at a minimum, the following elements: §483.80(a)(1) A system for preventing, identifying, reporting, investigating, and controlling infections and communicable diseases for all residents, staff, volunteers, visitors, and other individuals providing services under a contractual arrangement based upon the facility assessment conducted according to §483.70(e) and following	F 880		

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F 880	Continued From page 131 accepted national standards; §483.80(a)(2) Written standards, policies, and procedures for the program, which must include, but are not limited to: (i) A system of surveillance designed to identify possible communicable diseases or infections before they can spread to other persons in the facility; (ii) When and to whom possible incidents of communicable disease or infections should be reported; (iii) Standard and transmission-based precautions to be followed to prevent spread of infections; (iv)When and how isolation should be used for a resident; including but not limited to: (A) The type and duration of the isolation, depending upon the infectious agent or organism involved, and (B) A requirement that the isolation should be the least restrictive possible for the resident under the circumstances. (v) The circumstances under which the facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease; and (vi)The hand hygiene procedures to be followed by staff involved in direct resident contact. §483.80(a)(4) A system for recording incidents identified under the facility's IPCP and the corrective actions taken by the facility. §483.80(e) Linens. Personnel must handle, store, process, and transport linens so as to prevent the spread of infection.	F 880		

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§483.80(f) Annual review.
The facility will conduct an annual review of its IPCP and update their program, as necessary.
This REQUIREMENT is not met as evidenced by:
Based on observation, record review, staff interview, and policy review the facility failed to have a tracking system in place for infections to ensure residents are receiving antibiotics only when necessary and to ensure infections are not spread throughout the facility when reviewing the facilities April infections and antibiotic use in the facility. The facility also failed to ensure during a dining observation 1 of 1 staff performed hand hygiene and appropriate disinfecting of utensils (Staff I, Certified Nurse Aide [CNA]) . The facility also failed to change gloves and sanitize hands when soiled before moving from a dirty to clean area for 1 of 3 residents observed for wound treatment (Resident #10). The facility also failed to dispose of used catheter bag that contained urine for 1 of 4 residents observed for catheter care (Resident #10). The facility also failed to ensure oxygen tubing was stored off of the floor for 1 of 3 reviewed for oxygen use and disinfect a blood sugar monitoring machine residents (Resident #10). The facility reported a census of 86 residents.

Findings include:

1. In response to a request to see the April 2023 infection tracking on on 5/22/23 at 11:20 AM, observation revealed the Director of Nursing (DON) printed an April 2023 antibiotic use log and manually went through and documented what the antibiotics were used for. The DON did not have a system in place to show if cultures had been

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completed to identify the type of infection, what type of infections residents had, what evaluation done for trends or documentation of residents that may have had symptoms of an infection but did not receive antibiotics in that month.

During an interview on 5/22/23 at 11:25 AM the DON revealed the facility was recently bought by another company and they started using a the new system in March of 2023. The DON revealed there had been no training on the new system of how they track infections, but there was a plan for training in the next 30 days.

Record review of the facilities policy titled, Infection Prevention and Control, last reviewed and revised on 3/10/2023 documented the following: The DON or designee will receive a monthly report from the Pharmacy of who received antibiotics at the facility. Report will be analyzed to determine if antibiotics are ordered accordingly, based on an appropriate diagnosis or based on a corresponding lab result.

During an interview on 5/24/23 at 1:25 PM the Administrator revealed the facility had a tracking system in place, the DON needed to get the data in.

2. During observation on 5/15/23 at 11:35 AM, Staff B, Licensed Practical Nurse (LPN) placed supplies on an overbed table. Staff B opened and folded a 4 x 4 gauze in half, laid the folded gauze on the overbed table, and placed a stack of 4x4 gauze on top of the folded piece of gauze. No other barrier placed on the overbed table. Staff B donned a pair of gloves, took the bed control and lowered the head of the bed,

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uncovered the resident, and moved the resident's urinary catheter bag onto the bed. Staff B assisted the resident to roll onto her right side, and removed the back half of the resident's brief. The resident's brief was soaked with urine. Staff B removed her gloves, opened the closet door, and obtained a clean brief. At 11:42 AM, Staff B left the room. At 11:44 AM, Staff B brought a bottle of hand sanitizer and Staff M, certified nursing assistant, into the room. Staff B and Staff M donned a pair of gloves and rolled the resident onto her right side. Staff B sprayed wound cleanser over the buttock/coccyx wounds, wiped the area with gauze, then used normal saline to wet a collagen dressing. Staff B placed the wet collagen dressing over the left coccyx wound, and then placed an optifoam dressing over both wound sites on the buttocks/coccyx area. The collagen dressing did not cover the wound on the right side of the coccyx. Staff B removed her gloves. Staff B reported no more gloves in the room, then reached into Staff M's uniform pocket, obtained a glove, and placed the glove onto her right hand. Staff B picked up the soiled gauze used to cleanse the resident's coccyx wounds, from the overbed table, and threw the soiled gauze into the trash. A liquid solution dripped off the gauze onto the overbed table and the floor by the resident's bed as the nurse picked up the soiled gauze from the overbed table and walked to the trashcan. Staff B removed the glove on her right hand, sanitized her hands, then placed a coffee cup and a styrofoam cup, kleenex, and cell phone on the overbed table. Staff B then took a kleenex and wiped the overbed table. A puddle of liquid remained on the floor by the overbed table.

During an interview 5/24/23 at 9:55 AM, the DON

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reported gloves changed whenever the gloves became soiled and whenever going from a dirty area to a clean area. The DON stated collagen dressing applied to the wound bed but it depended if the physician ordered collagen application as wet or dry. The DON reported if collagen ordered but no order to moisten the collagen dressing then staff should not wet the collagen.

During an interview 5/23/23 at 11:30 AM, the wound physician reported moisture needed to activate collagen product. The wound bed dressing should be a little wet but not soaked.

The Infection Prevention and Control policy revised 3/10/23 revealed standard precautions based on principle that all blood, body fluids, and secretions may contain transmissible infectious agents. Infection prevention practices included hand hygiene. Hand hygiene performed before and after direct patient contact and after each situation that necessitated hand hygiene. All visibly and potentially contaminated surfaces such as overbed tables needed thoroughly cleansed and disinfected. The policy also revealed barriers needed changed before handling clean items and to prevent cross contamination.

3. On 5/16/23 at 7:32 AM, the DON removed the resident's catheter and disposed of the catheter and catheter bag with urine contents into a trash can by the resident's bed. The DON assisted Staff M, CNA, with incontineuce cares. At 7:40 AM, Staff M removed the plastic bag with trash including the catheter bag with urine contents and took the trash bag to the soiled utility room. Staff M placed the bag with catheter/urine contents into

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a larger plastic bag and trash container in the soiled utility room. Neither staff emptied the catheter bag.

During an interview 5/24/23 at 9:55 AM, the DON reported no policy for disposal of catheter bag with urine. The DON stated it would be the same as throwing a brief in the trash.

A Urinary Catheter policy revised 7/28/22 revealed catheter drainage bag emptied and disposable items discarded into a designated container.

4. On 5/19/23 at 9:40 PM, Staff S, Registered Nurse (RN) took a plastic bin with blood sugar supplies into Resident #17's room and placed the plastic bin with supplies on an overbed table. The overbed table had a room tray with food and juice spilled over the top of the overbed table. Staff S donned gloves and performed a blood sugar check on the resident. Staff S took the blood sugar machine and placed it in the pink plastic bin, then placed the blood sugar machine and plastic bin inside the medication cart.

On 5/19/23 at 10:09 PM, Staff S performed a blood sugar check on Resident #36. Staff S placed the blood sugar machine into an orange plastic bin and placed the bin in the medication cart. Staff S did not disinfect the blood sugar machine after use.

In an interview 5/19/23 at 9:40 PM, Staff S confirmed a blood sugar machine kept on each medication cart and used for the residents who had a blood sugar ordered. Staff S reported residents didn't have their own blood sugar machine.

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During an interview 5/24/23 at 9:55 AM, the DON reported she expected the blood sugar machine disinfected with disinfectant wipes between each resident.

A facility Glucose Meter Cleaning policy revised 7/28/22 revealed blood glucose meters cleansed in accordance to CDC guidelines and manufacturer's instructions to help prevent blood borne pathogen exposure. Glucose meters disinfected with Clorox bleach germicidal wipes, microkill or microdot wipes before and after each resident use. Glucose meter surfaces wrapped with disinfectant wipe for a minimum of 60 seconds. Glucose meter always cleansed and disinfected before stored with other clean equipment.

The Infection Prevention and Control policy revised 3/10/23 revealed blood sugar monitoring devices disinfected with bleach wipes for one to four minutes depending on the brand used.

5. Observations revealed the following:
a. On 5/15/23 at 10:50 AM Resident #10's O2 tubing with nasal cannula lying on the floor next to the dresser in the resident's room. The O2 tubing had no date listed on it.
b. On 5/15/23 at 11:44 AM, Resident #10's O2 tubing with nasal cannula lying on the floor next to the dresser. Staff B, LPN, and Staff M, CNA, left the room after they provided cares for the resident. The O2 tubing continued to ly on the floor.
c. On 5/16/23 at 7:10 AM, Resident #10's O2 tubing with nasal cannula continued to ly on the floor by the dresser.

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The facility's Oxygen Storage policy revised 7/28/22 did not address storage of oxygen tubing.

During an interview 5/24/23 at 5:30 PM, the DON reported she expected staff discarded oxygen tubing if the nasal cannula touched the floor.

6. The Comprehensive Care Plan of Resident #27 revealed a focus area of Activities of Daily Living (ADL deficit due to weakness, debility, dementia. Interventions included assisting with daily hygiene, grooming, dressing oral care and eating as needed.

The Comprehensive Care Plan of Resident #28 revealed a focus area of risk for alteration in nutritional status related to hypertension, anxiety, bipolar, schizophrenia, depression. Interventions included adaptive equipment: two handled cups and built up utensils.

Continuous dining room observation began on 5/17/23 at 12:21 pm.

On 5/15/23 at 12:40 pm, Staff I, Certified Nurse Aide (CNA) was walking around the dining room and began to assist Resident #27 with her meal. Resident #27 was sitting in her wheelchair and Staff I stood next to her offering her bites of her meal. Staff I was seen walking around the dining room assisting various residents with opening milk, getting ice creams, etc and then returning to assist Resident #27. Staff I was not observed performing hand hygiene between tasks.

On 5/15/23 at 12:51 pm a resident sitting behind Resident #27 left the dining room. Staff I

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gathered his dirty dishes and placed them on the cart and then returned to Resident #27 and offered her a bite of food. She then went into the connecting dining room and gathered dirty dishes from that area.

On 5/15/23 at 12:54 pm, Resident #28 dropped her fork on the floor. Resident #28 uses weighted silverware/adaptive equipment for meals. Staff I picked the fork up and took it to the sink. She asked Resident #28 if she was done using the fork. Resident #28 replied she still needed it. Staff I washed the fork by hand in the sink. No dish soap was observed as being available at the sink, only hand soap. Staff I then returned the fork to Resident #28 to complete eating her meal.

On 5/15/23 at 1:00 pm, Staff I returned to Resident #27 and continues to assist her in eating in between gathering dirty clothing protectors and dirty dishes from other residents. Sporadic hand hygiene with hand sanitizer is witnessed but is most frequently going from task to task without using hand sanitizer between tasks.

On 5/15/23 at 1:04 pm Resident #27 asked for a straw. Staff I gathered a straw, opened the paper wrapper, removed the straw with her bare hands from the wrapper and placed it in the the resident ' s drink glass.

On 5/15/23 at 1:11 pm, Staff I continued to gather dirty clothing protectors and trays and return to the side of Resident #27 to continue to assist her with her meal. Three instances of using hand sanitizer were witnessed during the observation period.

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HARMONY WEST DES MOINES	5010 GRAND RIDGE DRIVE WEST DES MOINES, IA 50265

(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 880	Continued From page 140 On 5/22/23 at 10:02 am the Director of Nursing (DON) stated her expectation is for staff to use hand sanitizer between each task assisting residents. She additionally stated if a resident drops silverware on the floor her expectation is to provide the resident with new, clean silverware. The policy titled Hand Hygiene, Revision date 7/28/22 documented: Hand Hygiene using alcohol based hand rub is recommended during the following situations: Before and after direct resident contact Before and after assisting a resident with meals.	F 880		
F 882 SS=F	Infection Preventionist Qualifications/Role CFR(s): 483.80(b)(1)-(4) §483.80(b) Infection preventionist The facility must designate one or more individual(s) as the infection preventionist(s) (IP) (s) who are responsible for the facility's IPCP. The IP must: §483.80(b)(1) Have primary professional training in nursing, medical technology, microbiology, epidemiology, or other related field; §483.80(b)(2) Be qualified by education, training, experience or certification; §483.80(b)(3) Work at least part-time at the facility; and §483.80(b)(4) Have completed specialized training in infection prevention and control. This REQUIREMENT is not met as evidenced by: Based on record review, staff interview, and policy review the facility failed to ensure they had	F 882		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	165601	A. BUILDING _____ B. WING _____	C 06/08/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HARMONY WEST DES MOINES	5010 GRAND RIDGE DRIVE WEST DES MOINES, IA 50265

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F 882	Continued From page 141 a qualified professional serve as the facilities Infection Preventionist. The facility reported a census of 86 residents. Findings include: Record review of The Centers for Disease Control and Prevention (CDC) Certificate provided by the Director of Nursing (DON) on 5/15/23 revealed on 12/2/2020 the DON had completed one course. Record review of the DON's CDC transcript on 5/22/23 revealed she has not completed the following two (2) courses for the Infection Preventionist: a. Module 12C, Preventing Viral Respiratory Infections b. End of Training Plan Verification and Continuing Education (CE) Information. Record review of a CDC certificate documented as of 5/23/23 revealed the DON completed the Nursing Home Infection Preventionist Training Course. During an interview on 5/24/23 at 1:29 PM the Administrator revealed she expected to have an Infection Preventionist employed by the facility. Record review of the facilities policy titled, Infection Prevention and Control, last reviewed and revised on 3/10/2023 documented the following: The facility will have an Infection Preventionist to assist and oversee the infection control program.	F 882		
F 947 SS=D	Required In-Service Training for Nurse Aides CFR(s): 483.95(g)(1)-(4)	F 947		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	165601	A. BUILDING _____ B. WING _____	C 06/08/2023

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HARMONY WEST DES MOINES	5010 GRAND RIDGE DRIVE WEST DES MOINES, IA 50265

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F 947	Continued From page 142 §483.95(g) Required in-service training for nurse aides. In-service training must- §483.95(g)(1) Be sufficient to ensure the continuing competence of nurse aides, but must be no less than 12 hours per year. §483.95(g)(2) Include dementia management training and resident abuse prevention training. §483.95(g)(3) Address areas of weakness as determined in nurse aides' performance reviews and facility assessment at § 483.70(e) and may address the special needs of residents as determined by the facility staff. §483.95(g)(4) For nurse aides providing services to individuals with cognitive impairments, also address the care of the cognitively impaired. This REQUIREMENT is not met as evidenced by: Based on record review and staff interview the facility failed to ensure 1 of 6 staff completed the State of Iowa Department of Health and Human Services (HHS) Dependent Adult Abuse Mandatory Reporter Training within six months of hire (Staff O, Certified Nurse Aide). The facility reported a census of 86 residents. Findings include: Record review of a untitled and undated document provided by the facility documented Staff O was hired on 2/11/2022 and had not completed the Dependent Adult Abuse Mandatory Reporter Training.	F 947		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	165601	A. BUILDING _____ B. WING _____	C 06/08/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HARMONY WEST DES MOINES	**5010 GRAND RIDGE DRIVE WEST DES MOINES, IA 50265**

(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 947	Continued From page 143 Record review of an e-mail correspondence with the Director of Nursing (DON) on 5/24/2023 at 9:58 AM revealed Staff O was terminated on 5/9/23. During an interview on 5/24/23 at 1:35 PM the Administrator revealed she would expect all staff to have their Dependent Adult Abuse Mandatory Reporter Training completed within six (6) months of hire and keep it up to date.	F 947		

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West Des Moines, Iowa 50265

F550

facility must treat each resident with respect and dignity and care for each resident in a manner and in an environment that promotes maintenance or enhancement of his or her quality of life, recognizing each resident's individuality. The facility must protect and promote the rights of the resident.
§483.10(a)(2) The facility must provide equal access to quality care regardless of diagnosis, severity of condition, or payment source. A facility must establish and maintain identical policies and practices regarding transfer, discharge, and the provision of services under the State plan for all residents regardless of payment source.

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

Resident #3 no longer resides in the center.
Resident #28 was assessed with no negative findings.

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

Residents residing in the facility have the potential to be affected.

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

- Staff will be re-educated on providing care in a dignified and respectful manner including not using cell phones in care area – education started on 6/8/23 and on-going.

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

- The Director of Nursing (DON)/designee will complete random audits weekly x4 weeks to validate residents are treated in a dignified and respectful way.

- Identified concerns shall be reviewed by the facility's QAA Committee. Recommendations for further corrective action will be discussed and implemented to sustain compliance.

Compliance Date: 7/17/2023

F 580 Notify of Changes (Injury/Decline/Room, etc)

CFR(s): 483.10 (g)(14)(i)-(iv)(15)
§483.10(g) A facility must immediately inform the resident; consult with the residents physician; and notify, consistent with his or her authority, the resident representative when there is- (B) A significant change in the residents 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

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

Resident #5 and #39 no longer reside in the center.

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

Residents in the facility with a change of condition have the potential to be affected.

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

Re-education initiated and ongoing to licensed nurses regarding notification to physician, family and hospice-if applicable when a change in condition occurs.

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

DON/Designee will audit progress notes to validate physician, family, and hospice if applicable, are notified of change in condition and documented daily during clinical meeting x 4 weeks, will follow up promptly with findings.

Identified concerns shall be reviewed by the facility's QAA Committee. Recommendations for further corrective action will be discussed and implemented to sustain compliance.

Compliance Date: 7/17/23

F684

§483.25 *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.*

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

- Resident #39 no longer reside at facility.

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

Residents residing in the facility with change in condition have the potential to be affected.

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

- House wide audit completed to include base line assessments of current resident's conditions. 6/5 and 6/9. Based on findings, treatment changes or plan of care changes documented if applicable. MD and family notification completed for any change in condition identified, hospice notified if applicable.
- Re-education to licensed nursing staff to include change in condition nursing procedure and assessment/intervention care pathways as well documentation of change in condition assessment initiated on 6/8 and ongoing.
- Re-Education to nursing assistants/CMAs on notification to nurse of changes in condition, if nurse not following up then to call the nurse manager on call initiated on 6/8 and ongoing.
- Re- Education to nursing management team on expectations of call and ensuring licensed nursing staff are addressing needs of the residents.
- Facility hospice partners met for a status update and a provider collaboration meeting.

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

DON/designee will complete daily audit Monday-Friday x4 weeks and then weekly times 4 weeks to review residents with changes in condition and validate MD/family and hospice if applicable are notified and documented and interventions are in place per MD order.

Identified concerns shall be reviewed by the facility's QAA Committee. Recommendations for further corrective action will be discussed and implemented to sustain compliance.

Compliance Date: 6/19/2023

F686 Treatment/Services to Prevent/Heal Pressure Ulcer

483.25(b) Skin Integrity

483.25(b)(1) Pressure ulcers

(i) A resident receives care, consistent with professional standards of practice, to prevent pressure ulcers and does not develop pressure ulcers unless the individuals clinical condition demonstrates that they were unavoidable; and (ii) A resident with pressure ulcers receives necessary treatment and services, consistent with professional standards of practice, to promote healing, prevent infections ad prevent new ulcers from developing.

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

Resident's #3, #16, and #39 no longer reside in the center.

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

Residents residing in the facility who are dependent on staff for repositioning have the potential to be affected.

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

IDT re-educated on evaluating appropriately sized equipment prior to admission and as needed.

Audit completed on 6/8/23 to ensure residents are on appropriately sized equipment to reduce risk of pressure injury.

Licensed nursing staff re-educated on initiating orders, repositioning, and interventions to minimize risk of pressure injury on 6/8/23 and ongoing.

Nurse aides and CMAs re-educated on repositioning and interventions to minimize risk of pressure injury on 6/8/23 and ongoing.

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

DON/designee to conduct weekly audits x8 weeks to validate repositioning, interventions in place to minimize risk of pressure injury including initiating of orders and patients have appropriately sized equipment.

Identified concerns shall be reviewed by the facility's QAA Committee. Recommendations for further corrective action will be discussed and implemented to sustain compliance.

Compliance Date: 6/19/23

F689
§483.24(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.*

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

Resident #40 remains in the facility, fall care plan reviewed and updated 6/9/23.
Resident #11 therapy evaluation completed by Promedica on 7/15/2022, 12/3/2022 and again post fall on 5/11/2023.
Resident # 15 was assessed, no negative findings on 6/5/23.
Resident # 16 was assessed on 6/2/23 with no negative findings. Resident no longer resides in the facility.

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

Residents that fall and report complaints of pain with ROM have the potential to be affected.
Residents who are cognitively impaired and wander have the potential to be affected.
Residents who use portable oxygen have the potential to be affected.
Residents who utilize a motorized wheelchair have the potential to be affected.

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

- Licensed nursing staff educated on assessments/fall care paths, supervision, oxygen systems, and securing medication cart when not in view on 6/8/2023 and ongoing.
- Nursing aides educated on frequent rounds/supervision, task Kardex and oxygen storage.
- Validation completed to confirm residents utilizing motorized wheelchair had been reviewed by therapy with Promedica and/or Harmony.

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

- DON/designee will conduct weekly environmental audits x8 weeks to validate safe oxygen storage, environmental observations to include medication carts locked and cognitively impaired residents are not observed near a hazard.
- DON/designee will conduct weekly audits x8 weeks on post fall assessments/documentation to validate patients with pain with ROM are not moved from floor.

Identified concerns shall be reviewed by the facility's QAA Committee. Recommendations for further corrective action will be discussed and implemented to sustain compliance.

Compliance Date: 6/19/2023

F692 Nutrition/Hydration Status Maintenance

483.25(g) Assisted nutrition and hydration. 483.25(g)(1) Maintains acceptable parameters of nutritional status, such as usual body weight or desirable body weight range and electrolyte balance, unless the residents clinical condition demonstrates that this is not possible or resident preference indicate otherwise; 483.25(g)(2) Is offered sufficient fluid intake to maintain proper hydration and health; 483.25(g)(3) Is offered a therapeutic diet when there is a nutritional problem and the health care provider orders a therapeutic diet.

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

Resident's #3 and #16 no longer reside in the center.

Resident #33 remains in the facility, assessment completed without negative finding on 6/6/2023.

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

Residents residing in the facility who require assistance with nutrition/hydration have the potential to be affected.

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

Nursing staff education on passing fluids, placing fluids within reach, and assisting with fluids for those resident's requiring assistance, completed on 6/8/2023 and ongoing.

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

DON/designee to conduct weekly audits x4 weeks to validate fluids are at bedside within reach and being offered/assistance provided to those residents who require assistance.

Identified concerns shall be reviewed by the facility's QAA Committee. Recommendations for further corrective action will be discussed and implemented to sustain compliance.

Completion Date: 7/17/23

F693 Tube Feeding Mgmt/Restore Eating Skills CFR(s): 483.25(g)(4)(5)

§483.25(g)(4)-(5) Enteral Nutrition (Includes naso-gastric and gastrostomy tubes, both percutaneous endoscopic gastrostomy and percutaneous endoscopic jejunostomy, and enteral fluids). Based on a resident's comprehensive assessment, the facility must ensure that a resident- §483.25(g)(4) A resident who has been able to eat enough alone or with assistance is not fed by enteral methods unless the resident's clinical condition demonstrates that enteral feeding was clinically indicated and consented to by the resident; and §483.25(g)(5) A resident who is fed by enteral means receives the appropriate treatment and services to restore, if possible, oral eating skills and to prevent complications of enteral feeding including but not limited to aspiration pneumonia, diarrhea, vomiting, dehydration, metabolic abnormalities, and nasal-pharyngeal ulcers

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

Resident #1 no longer resides in the center.

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

-Residents in the facility with a G-J tube have the potential to be affected.

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

Re-education to licensed nurses regarding Enteral feeding tube medication administration initiated 6/8/23 and ongoing.

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

-DON/Designee will audit Medication administration of enteral tube weekly x8 weeks and reassess the frequency and need of continued audits.

Identified concerns shall be reviewed by the facility's QAA Committee. Recommendations for further corrective action will be discussed and implemented to sustain compliance.

Completion Date: 6/19/2023

F725

§483.35(a)(1) *The facility must provide services by sufficient numbers of each of the following types of personnel on a 24-hour basis to provide nursing care to all resident s in accordance with resident care plans:*

(i) Except when waived under paragraph € of this section, licensed nurses; and

(ii) Other nursing personnel, including but not limited to nurse aids.

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

No residents cited; all residents have the potential to be affected.

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

Residents residing in the facility have the potential to be affected.

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

- Completion of licensed nurse competencies and CNA competencies/skills to include identified areas of pressure injury care & repositioning, supervision and ensuring residents are safe from hazards, administering medications & treatments timely, responding to call lights, and monitoring and assisting visitors with entry to facility on 6/8/23 & on-going.
- Re-education for licensed nursing staff on skills/competencies, interact care paths, call lights and ensuring needs are met, repositioning assistance, skin quick reference guide, g-tube, significant medication errors, medication administration including high alert medications including high alert medications, nursing supervision/frequent rounding, customer service/concern process, and answering the doorbell on 6/8/23 and ongoing.
- Re-education initiated for nursing assistance on competencies to include call lights and ensuring needs are met, repositioning, skin quick reference guide, frequent rounding, answering the doorbell, customer service/concern process, and following the task Kardex on 6/8/23 and ongoing.
- Designated team member assigned to address staffing needs as they arise each shift and to ensure staff report to correct location.
- Reception hours revised 7:30am until 8pm Monday through Friday. Weekend coverage 8am-4:30pm.
- Monitoring implemented for every shift change starting 6/9 for 4 weeks, will assess frequency of monitoring on week 4 and will continue to monitor an additional 4 weeks.

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

- The DON/designee will validate completion of competencies/skills validation for current staff, new hires and agency staff scheduled prior to them working.
- The DON/designee will complete weekly audits x8 weeks to review residents with pressure ulcers, high alert medications, g-tubes, observations of residents during rounds to validate

free from hazard, repositioning, interview patients to confirm needs are being met and validate staffing is adequate to meet the needs of the residents.

- Social service/designee will complete weekly audit x8 weeks conducting interviews with patient representative for non-interview able residents to include any issues related to excessive wait time to enter the building.
- Identified concerns shall be reviewed by the facility's QAA Committee. Recommendations for further corrective action will be discussed and implemented to sustain compliance.

Compliance Date: 6/19/2023

F760 Residents are Free of Significant Med Errors

483.45(f)(2) Residents are free of any significant medication errors.

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

Resident's #16 and #17 no longer reside in the center.

Resident #23 remains in the facility, assessment completed on 6/5/23 without negative finding.

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

Residents residing in the facility on high-risk medications have the potential to be affected.

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

Licensed nursing staff educated on medication administration, 6 rights and completing documentation at the time of administration on 6/8/23 and ongoing.

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

DON/designee to conduct weekly audits x4 weeks to validate medication administration is within timeframe and 6 rights of medication administration are followed.

Identified concerns shall be reviewed by the facility's QAA Committee. Recommendations for further corrective action will be discussed and implemented to sustain compliance.

Compliance Date: 7/17/2023

F835 Administration

483.70 A facility must be administered in a manner that enables it to use its resources effectively and efficiently to attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident.

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

No residents identified as being affected.

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

Residents residing in the facility have the potential to be affected.

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

Interim Administrator and DON appointed on 6/9/2023.

IDT educated on open door policy and doors to back offices remaining unlocked during business hours on 6/9/2023.

Staff education on grievance/concern process, corporate compliance, lighthouse services and postings were and remain posted throughout the facility initiated on 6/8/23 and ongoing.

HRD education on implementing and conducting routine small group meetings to hear staff feedback on 6/9/23. Meetings conducted quarterly.

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

RDO/designee to conduct weekly audits x4 weeks and monthly audits x3 months to validate effective administration.

Social Service/designee to conduct weekly audits x8 weeks on resident satisfaction.

Identified concerns shall be reviewed by the facility's QAA Committee. Recommendations for further corrective action will be discussed and implemented to sustain compliance.

Compliance Date: 6/19/2023

F838
§483.70(e)(3) A facility-based and community-based risk assessment, utilizing an all-hazards approach.

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

- No residents found to be directly affected by the alleged deficient practice.

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

- Residents that reside in the facility have the potential to be affected.

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

- Facility Assessment updated with current information including, but not limited to, resident population, facility resources and community-based risk assessment on 6/13/23.

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

- Administrator/designee to conduct audits monthly x3 months to validate assessment is updated with resident population.

- Identified concerns shall be reviewed by the facility's QAA Committee. Recommendations for further corrective action will be discussed and implemented to sustain compliance.

Completion Date: 7/17/23

F849 Hospice Service

483.70(o)(1) A LTC facility may do either of the following: (i) Arrange for the provision of hospice services through an agreement with one or more Medicare-certified hospices. (ii) Not arrange for the provision of hospice services at the facility through an agreement with a Medicare-certified hospice and assist the resident in transferring to a facility that will arrange for the provision of hospice services when a resident requests a transfer. 483.70(o)(2) If hospice care is furnished in an LTC facility through an agreement as specified in paragraph (o)(1)(i) of this section with a hospice, the LTC facility must meet the following requirements: (i) Ensure that the hospice services meet professional standards and principles that apply to individuals providing services in the facility, and to the timeliness of the services. (ii) Have a written agreement with the hospice that is signed by an authorized representative of the hospice and an authorized representative of the LTC facility before hospice care is furnished to any resident. 483.70(o)(3) Each LTC facility arranging for the provision of hospice care must designate a member of the IDT who is responsible for working with hospice representatives to coordinate care to the resident provided by the LTC facility staff and hospice staff. 483.70(o)(4) Each LTC facility providing hospice care must ensure that each resident's plan of care includes both the most recent hospice plan of care and a description of the services furnished by the LTC facility to attain or maintain the residents highest practicable well being as required at 483.24.

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

Resident #39 no longer resides in the facility.

How the center will identify other residents having the potential to be affected by the same deficient practice. Residents residing in the facility on hospice services have the potential to be affected.

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

House wide audit conducted to include baseline assessment of patients on hospice services on 6/2, 6/5 and 6/8/23.

Facility staff member designated to assume responsibility for collaboration between LTC and hospice.

Licensed nursing staff educated on notifying hospice with changes in condition, how to identify if a patient is on hospice services and contact information for hospice collaboration on 6/8/23 and ongoing.

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

DON/designee to conduct daily audits M-F x4 weeks and then weekly audits x4 weeks to validate changes in condition are called to hospice and documented.

Admin/designee to conduct weekly audits x8 weeks to review coordination of care with hospice and validate plan of care integration.

Identified concerns shall be reviewed by the facility's QAA Committee. Recommendations for further corrective action will be discussed and implemented to sustain compliance.

Compliance Date: 6/19/2023

F865
§483.75(i) Sanctions. Good faith attempts by the committee to identify and correct quality deficiencies will not be used as a basis for sanctions.

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

No residents found to be directly affected by the alleged deficient practice.

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

Residents that reside in the facility have the potential to be affected.

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

- Updated Harmony West Des Moines QAPI statement on 6/16/2023.
- The IDT educated on QAPI process on 6/16/2023.

Quality Assurance /Plan to monitor performance to make sure corrections are achieved and are permanent.

RDO/designee to conduct weekly audits x4 weeks of concern/grievance trends.

RNC/designee to complete weekly summaries of the daily clinical meeting notes that review changes in condition and risk resolution x4 weeks.

Ongoing quarterly review will be completed to ensure the facility consistently implements and maintains an effective comprehensive QAPI program, that addresses the full range of services.

Identified concerns shall be reviewed by the facility's QAA Committee. Recommendations for further corrective action will be discussed and implemented to sustain compliance.

Compliance Date: 7/17/2023

F880
§483.80(f) Annual review. The facility will conduct an annual review of its IPCP and update their program, as necessary.

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

Resident #10 no longer residents at the facility.

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

Residents that reside in the facility have the potential to be affected.

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

- Infection tracking system updated 5/23/23 and will be updated monthly with pharmacy reports for trending.
- Nursing assistants re-educated on hand hygiene, meal service and oxygen storage on 6/8/23 and ongoing.
- Licensed nursing staff re-educated on hand hygiene, ppe/glove changes, oxygen delivery systems and glucometer cleaning on 6/8/23 and ongoing.

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

IP/designee to conduct weekly audits x4 weeks to validate hand hygiene during meals and treatment changes, glucometer cleaning, and oxygen storage.

DON/designee to conduct monthly audits x3 months on infection tracking system.

Identified concerns shall be reviewed by the facility's QAA Committee. Recommendations for further corrective action will be discussed and implemented to sustain compliance.

Completion Date: 7/17/23

Harmony of West Des Moines
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West Des Moines, Iowa 50265

This plan of correction represents the center's allegation of compliance. The following combined plan of correction and allegation of compliance is not an admission to any of the alleged deficiencies and is submitted at the request of the Iowa Department of Public Health. Preparations and execution of this response and plan of correction does not constitute an admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because it is required by the provision of federal and state law.

F882 Infection Preventionist Qualifications/Role
Facility must designate one or more individual(s) as the IP who are responsible for the facility's IPCP. The IP must: 483.80(b)(2) Be qualified by education, training, experience, or certification; 483.80(b)(3) work at least part-time at the facility; and 483.30(b)(4) have completed specialized training in infection prevention and control.

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

No cited residents affected by deficient practice.

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

Residents residing in the facility have the potential to be affected.

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

- DON completed additional coursework necessary and provided on 5/23/23.
- HRD will validate certification for the designated IP staff upon hire and annually.

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

- HRD/designee will audit monthly x 3 months to validate facility has individual(s) who have completed IP certification and are employed at least part-time.

- Identified concerns shall be reviewed by the facility's QAA Committee. Recommendations for further corrective action will be discussed and implemented to sustain compliance.

Compliance Date: 7/17/2023

F947 Required In-Service Training for Nurse Aides

In-service training must – 483.85(g)(1) Be sufficient to ensure continuing competence of nurse aides, no less than 12 hours per year. 483.95(g)(2) Include dementia management training and resident abuse prevention training. 483.95(g)(3) Address areas on weakness as determined in nurse aides performance reviews and facility assessment at 483.70 and may address the special needs of residents as determined by the facility staff. 483.95(g)(4) For nurse aides providing services to individuals with cognitive impairments, also address the care of the cognitively impaired.

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

No residents cited as being affected.

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

Residents residing in the facility have the potential to be affected.

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

House wide audit conducted of staff to validate Dependent Adult Abuse Mandatory Reporter training completed within six months of hire on 6/2/23 and again 6/19/23.

HRD educated on new hire training requirements, tracking system for current staff education, and ongoing education requirements of nurse aides.

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

HRD/designee to conduct monthly audits x3 months to validate Dependent Adult Abuse Mandatory Reporter training is completed for new hires within 6 months of hire and current staff members are up to date.

Identified concerns shall be reviewed by the facility's QAA Committee. Recommendations for further corrective action will be discussed and implemented to sustain compliance.

Completion Date: 7/17/23