STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	165580	A. BUILDING _____ B. WING _____	C 12/06/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
URBANDALE HEALTH CARE CENTER	4614 NW 84TH STREET URBANDALE, IA 50322

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 000	INITIAL COMMENTS Correction date: 12/27/23 A complaint investigation for complaint #116039-C, #116140-C, #116697C, #116740-C, 116997-C, #117231-C and facility reported incident #115946-I was conducted on November 27, 2023 to December 6, 2023. The following deficiencies relate to the investigation of complaints #116740-C, #116997-C, and facility reported incident #115946-I Complaint #116039-C, 116140-C, 116697-C, and 117231-C were unsubtantiated. Complaint #116740-C and 116997-C were substantiated. Findings for facility reported incident #115946-M will be sent to the facility at a later date under separate cover. See the Code of Federal Regulations (42CFR) Part 483, Subpart B-C.	F 000		
Ok Lg ✓				
F 656 SS=D	Develop/Implement Comprehensive Care Plan CFR(s): 483.21(b)(1)(3) §483.21(b) Comprehensive Care Plans §483.21(b)(1) The facility must develop and implement a comprehensive person-centered care plan for each resident, consistent with the resident rights set forth at §483.10(c)(2) and §483.10(c)(3), that includes measurable objectives and timeframes to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment. The comprehensive care plan must describe the following - (i) The services that are to be furnished to attain	F 656		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE Administrator | (X6) DATE 12/27/23

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.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	165580	A. BUILDING _____ B. WING _____	C 12/06/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
URBANDALE HEALTH CARE CENTER	4614 NW 84TH STREET URBANDALE, IA 50322

(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 656	Continued From page 1	F 656		

or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §483.24, §483.25 or §483.40; and
(ii) Any services that would otherwise be required under §483.24, §483.25 or §483.40 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(c)(6).
(iii) Any specialized services or specialized rehabilitative services the nursing facility will provide as a result of PASARR recommendations. If a facility disagrees with the findings of the PASARR, it must indicate its rationale in the resident's medical record.
(iv)In consultation with the resident and the resident's representative(s)-
(A) The resident's goals for admission and desired outcomes.
(B) The resident's preference and potential for future discharge. Facilities must document whether the resident's desire to return to the community was assessed and any referrals to local contact agencies and/or other appropriate entities, for this purpose.
(C) Discharge plans in the comprehensive care plan, as appropriate, in accordance with the requirements set forth in paragraph (c) of this section.
§483.21(b)(3) The services provided or arranged by the facility, as outlined by the comprehensive care plan, must-
(iii) Be culturally-competent and trauma-informed.
This REQUIREMENT is not met as evidenced by:
Based on clinical record review, observations, resident and staff interviews, and facility policy review, the facility failed to develop comprehensive care plans for three of four residents reviewed (Resident #6, #7, and #9).

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	165580	A. BUILDING _____ B. WING _____	C 12/06/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
URBANDALE HEALTH CARE CENTER	4614 NW 84TH STREET URBANDALE, IA 50322

(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 656	Continued From page 2	F 656		

The facility reported a census of 81 residents.

Findings include:

1. The Minimum Data Set (MDS) assessment dated 10/12/23 identified Resident #6 had diagnoses of COVID-19, asthma, and sleep apnea. The MDS documented the resident used oxygen.

The Care Plan revised 1/10/22 revealed the resident at risk for alteration in skin integrity and required ear cushions on his oxygen tubing at all times. The Care Plan lacked information regarding oxygen use, care, and settings.

The Bedside Kardex Report dated 11/30/23 lacked information about oxygen use or staff directives for oxygen application and care.

The Order Summary Report revealed an order for supplemental oxygen 2-3 liters (L) per nasal cannula (NC) continuously started on 11/3/22.

Observation revealed:
a. On 11/28/23 at 9:15 AM, Resident #6 had oxygen on via NC while lying in bed.
b. On 11/28/23 at 2:15 PM, the resident had oxygen on via NC while lying in bed.
c. On 11/29/23 at 7:35 AM, the resident had oxygen on via NC while lying in bed.

During an interview 12/6/23 at 10:45 AM, the MDS Coordinator, reported she completed the MDS and care plans for the residents. The MDS Coordinator reported the facility had a transition period when the Assistant Director of Nursing (ADON) was responsible for completion of care plans on skilled residents, and she mainly worked

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	165580	A. BUILDING _____ B. WING _____	C 12/06/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
URBANDALE HEALTH CARE CENTER	4614 NW 84TH STREET URBANDALE, IA 50322

(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 656	Continued From page 3	F 656		

on MDS and care plans for the other units. She stated that for awhile, there was no ADON on the skilled unit so she completed MDS assessments on all of the residents at the facility, and also worked on reviewing and updating resident care plans one day a month for the entire building when she had time to work on them. The transition period without an ADON lasted 2-3 months but there had been three transitions in the past year. The MDS Coordinator reported a baseline care plan completed and she built the care plan from there. The MDS Coordinator reported she obtained information for care plans from the resident's MDS assessment, hospital notes, progress notes, medication and treatment records, and from meetings about transition of resident care and their needs. The ADON's updated the "set sheet" for staff reference about resident cares. The MDS Coordinator reported she expected oxygen listed on the care plan if a resident had oxygen. She typically entered oxygen under the pertinent diagnoses to show the reason why a resident used oxygen.

The Care Plan policy revised 9/2022 revealed a comprehensive, person-centered care plan developed and implemented for each resident to meet the resident's physical, psychosocial, and functional needs. The Interdisciplinary Team (IDT), in conjunction with the resident and his/her representative, developed and implemented a comprehensive, person-centered care plan for each resident. The care plan interventions were derived from a thorough analysis of the information gathered as part of the comprehensive assessment. The comprehensive, person-centered care plan described the services to attain or maintain the resident's highest practicable physical, mental,

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	165580	A. BUILDING _____ B. WING _____	C 12/06/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
URBANDALE HEALTH CARE CENTER	4614 NW 84TH STREET URBANDALE, IA 50322

(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 656	Continued From page 4	F 656		

and psychosocial well-being; Care plans revised as information about the residents and the residents' conditions changed. Care plans reviewed at least quarterly and updated when a significant change in the resident's condition or whenever desired outcomes not met.

2. The MDS assessment dated 10/13/23 identified Resident #7 had diagnoses of cerebrovascular accident (CVA) (stroke), dementia, and pressure ulcer. The MDS documented the resident had total dependence on staff for dressing, toileting, personal hygiene, and transfers. The MDS also revealed the resident had a risk for pressure ulcer. The MDS recorded the resident had no hearing aids.

The Care Plan updated 10/31/23 revealed the resident had chronic pain and increased risk for injury related to history of hip dislocation and spinal stenosis. The Care Plan lacked information or staff directives for activities of daily living (ADL's), interventions for management of skin integrity, or adaptive devices such as hearing aids used.

Observations revealed the following:
a. On 11/28/23 at 2:15 PM the resident sat in a recliner chair and had a sling under him.
b. On 11/29/23 at 8:40 AM, Staff P, certified nursing assistant (CNA), and Staff Q, CNA, provided incontinence cares for Resident #7, then used a mechanical lift and transferred the resident from the bed to a recliner. Observed Staff Q place hearing aids in the resident's ears.

During an interview on 12/6/23 at 10:45 AM, the MDS Coordinator, reported she expected ADL's

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	165580	A. BUILDING _____ B. WING _____	C 12/06/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
URBANDALE HEALTH CARE CENTER	4614 NW 84TH STREET URBANDALE, IA 50322

(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 656	Continued From page 5	F 656		

such as how a resident transferred, toileted, and if required feeding assistance, be listed on the resident's care plan.

3. The MDS assessment dated 9/12/23, revealed Resident #9 had diagnosis of diabetes and cellulitis (bacterial skin infection) on the right lower limb. The MDS documented the resident had a risk for pressure ulcers but had no current pressure ulcers or skin concerns. The MDS indicated the resident required assistance of one for bed mobility and transfers. The MDS indicated the resident had a Brief Interview for Mental Status (BIMS) score of 15 out of 15, indicating cognition intact.

The electronic health record diagnoses list revealed the following: right lower limb cellulitis (added 7/27/23), Stage 2 pressure ulcer left heel (added 10/16/23), Stage 3 pressure ulcer to the right heel (added 11/14/23), and an open wound on the right toe (added 11/27/23).

The Care Plan revised 8/30/23 revealed Resident #9 had an activities of daily living (ADL) self-care deficit. The staff directives included to provide assistance of one for bed mobility. The care plan lacked information regarding altered skin integrity or pressure ulcers, as well as the interventions to prevent development of pressure areas and monitoring of the resident's skin condition.

The progress notes revealed the following:
a. On 10/8/23 at 8:23 AM, pressure ulcer on the right outer heel below the ankle measured 2 centimeter (cm) x 4.2 cm. The outer aspect of left heel below the ankle had an intact fluid filled blister 3 cm x 3.2 cm. Orders received for

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	165580	A. BUILDING _____ B. WING _____	C 12/06/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
URBANDALE HEALTH CARE CENTER	4614 NW 84TH STREET URBANDALE, IA 50322

(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 656	Continued From page 6	F 656		

treatments and to float bilateral heels on pillows while in bed.
b. On 11/27/23 at 2:22 PM, resident had a right lateral heel wound (Stage 3 pressure area) measured 2.1 cm x 1.0 cm x 0.4 cm and left lateral heel (Stage 3 pressure ulcer) measured 4.0 cm x 5.0 cm x 0.2cm (2 areas). Orders to continue treatment to bilateral heel wounds: cleanse with cleanser of choice, apply calcium alginate with silver to wound bed, cover with heel foam dressing, wrap with gauze wrap, and secure with tape three times a week and PRN (as needed). The resident also had a diabetic foot ulcer to the left 4th digit. Order to cleanse with cleanser of choice and apply skin prep daily and PRN. Other orders place air mattress to promote wound healing and Prafo boots to bilateral feet on during the day and off at HS (bedtime) to promote wound healing

On 11/28/23 at 2:45 PM, observed Staff K, Registered Nurse (RN), perform a treatment and dressing changes to Resident #9's bilateral heels and left 4th toe as he sat in his recliner. The resident's right lateral heel had an open area with a moderate amount of purulent drainage. The left lateral and back of the heel had a necrotic area. Staff K encouraged the resident to keep his legs elevated and heels floated.

During an interview 12/6/23 at 10:45 AM, the MDS Coordinator reported she expected a pressure sore or wound listed on the care plan under focus area of skin, along with the devices needed such as a cushion, mattress, floating heels, etc. if a resident had a pressure area. The MDS Coordinator reported she knew Resident #9 had pressure ulcers and seen by a wound provider. She expected interventions for

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	165580	A. BUILDING _____ B. WING _____	C 12/06/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
URBANDALE HEALTH CARE CENTER	4614 NW 84TH STREET URBANDALE, IA 50322

(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 656	Continued From page 7 pressure ulcers placed on the care plan but she hadn't gotten to Resident #9's care plan yet.	F 656		
F 658 SS=D	Services Provided Meet Professional Standards CFR(s): 483.21(b)(3)(i) §483.21(b)(3) Comprehensive Care Plans The services provided or arranged by the facility, as outlined by the comprehensive care plan, must- (i) Meet professional standards of quality. This REQUIREMENT is not met as evidenced by: Based on clinical record review, observation, resident and staff interviews, and facility policy review, the facility staff failed to follow physician's orders for a treatment and dressing change performed for 1 of 3 residents reviewed for treatment and dressing changes (Resident #5). The facility also failed to follow physician's orders and ensure a resident had oxygen on when a resident was sent out of the facility to a doctor's appointment for 1 of 3 residents reviewed for oxygen use (Resident #4). The facility reported a census of 81 residents. Findings include: 1. The Minimum Data Set (MDS) assessment dated 7/18/23 revealed Resident #5 had diagnoses of cerebral palsy, Parkinson's Disease, and renal disease. The MDS also revealed the resident had a surgical wound. Resident #5's Care Plan revised on 12/16/22 revealed the resident had a chronic buttock wound and impaired skin integrity related to a surgical dehiscence. Staff directives included to apply treatments per doctor's order.	F 658		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	165580	A. BUILDING _____ B. WING _____	C 12/06/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
URBANDALE HEALTH CARE CENTER	4614 NW 84TH STREET URBANDALE, IA 50322

(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 658	Continued From page 8	F 658		

The Order Summary Report revealed orders to cleanse the left buttock wound with quarter strength Dakins (a strong topical antiseptic widely used to clean infected wounds), apply scant amount of triple antibiotic ointment (TAO) to the wound bed, loosely pack wound cavity with calcium alginate with silver, and cover with silicone super absorbent dressing daily and as needed (PRN) started on 10/9/23.

The electronic health record (EHR) order screen revealed an order to cleanse the left buttock wound with quarter strength Dakins', apply scant amount of TAO to wound bed, loosely pack wound cavity with calcium alginate with silver, and cover with silicone super absorbent dressing daily and PRN started 10/9/23.

The Medication Administration Record revealed an order to apply Dakins (1/4 strength) external solution to left buttocks topically one time a day for wound care that started on 7/6/23. Staff C, Registered Nurse, initials documented on the MAR on 9/29/23.

During observation on 11/29/23 at 7:10 AM, Staff C, Registered Nurse (RN) sanitized her hands, obtained supplies, placed the supplies on paper towels on an overbed table by the resident's bed and donned gloves. The resident positioned himself lying on his right side in bed. Staff C took 4 x 4 gauze and placed it over the opening of a bottle of ¼ strength Dakins' solution and poured the solution onto the gauze, then placed the wet dressing on a barrier on the table. Staff C removed the tabs on the resident's brief. Staff C removed the soiled dressing that covered the left buttock wound area. Staff C changed gloves,

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	165580	A. BUILDING _____ B. WING _____	C 12/06/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
URBANDALE HEALTH CARE CENTER	4614 NW 84TH STREET URBANDALE, IA 50322

(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 658	Continued From page 9	F 658		

then took gauze with Dakins' solution and cleansed the buttock wound. Staff C changed her gloves, then applied Dakins' solution to another gauze dressing and placed the Dakins' soaked gauze over the wounds. Staff C applied a silicone dressing over the Dakins' gauze dressing, removed her gloves and washed her hands.

During an interview on 11/30/23 at 4:35 PM, the Director of Nursing (DON) reported she followed up on the treatment order for Resident #5, and talked with Staff C who did the treatment with the surveyor on 11/29/23. Staff C told her she got frazzled and nervous when she performed Resident #5's dressing change on 11/29/23, and the reason she didn't do the treatment as ordered. The DON stated Staff C went in later and redid Resident #5's treatment. The surveyor however was not present when Staff C did that treatment and dressing change.

During an interview 11/30/23 at 2:50 PM, Staff J, Nurse Practitioner (NP) reported the wound NP saw Resident #5. Staff J checked the computer and reported Resident #5's treatment orders since 7/18/23 to cleanse the left buttock wound with quarter strength Dakins, apply triple antibiotic ointment to wound bed, loosely pack wound cavity with calcium alginate with silver, and cover with a silicone super absorbent dressing daily and PRN. Staff J reported she thought maybe when Resident #5 went to the hospital, the previous order wasn't closed out or discontinued in the computer. Staff J reported she expected staff to follow orders for treatments.

During an interview on 12/4/23 at 11:25 AM, the wound NP reported Resident #5 had wounds on

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	165580	A. BUILDING _____ B. WING _____	C 12/06/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
URBANDALE HEALTH CARE CENTER	4614 NW 84TH STREET URBANDALE, IA 50322

(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 658	Continued From page 10	F 658		

his buttocks for a long time. He had two wounds that merged into one large wound but now had to two wounds. The treatment consisted of cleansing the wound area with Dakins' solution, then apply triple antibiotic ointment, calcium alginate with silver, and a silicone dressing to the area. The wound NP reported she added the TAO when the resident developed pseudomonas in the wound.

A Skin Integrity Nursing Protocol effective 9/2023 revealed the resident with pressure injuries shall receive necessary treatment and services consistent with professional standards of practice to promote healing, prevent infection, and prevent new ulcers from developing. Treatments provided to heal the area when a pressure injury is present.

2. The MDS assessment dated 10/1/23 revealed Resident #4 had diagnoses of heart failure, breast cancer, and seizures. The MDS documented the resident had severely impaired cognition. The MDS indicated the resident had shortness of breath when lying flat and used oxygen.

The Care Plan revised on 8/7/23 revealed Resident #4 on oxygen therapy related to a respiratory illness. The staff directives included to apply oxygen as ordered.

The Order Summary Report revealed an order for continuous oxygen at 2-4 liters (L) per nasal cannula (NC) to keep oxygen greater than 88 % (percent), and monitor oxygen every shift started on 8/4/23.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	165580	A. BUILDING _____ B. WING _____	C 12/06/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
URBANDALE HEALTH CARE CENTER	4614 NW 84TH STREET URBANDALE, IA 50322

(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 658	Continued From page 11	F 658		

The Treatment Administration Record revealed documentation of oxygen set at 3 L and oxygen saturation 93% on 11/6/23.

A physician's Progress Note dated 11/6/23 revealed Resident #4 arrived at doctor's office again without any oxygen (which she required chronically) and the clinic had to supply with hospital supplies. This had happened multiple times on 7/24/23 and 11/6/23 and is poor patient care. This resulted in mismanaged time away from the appointment time and caused the patient distress.

During an interview on 11/27/23 at 1:55 PM, clinic staff reported the facility sent Resident #4 to her appointment on 11/6/23 without oxygen. The resident needed oxygen 24/7. This was the second time this had happened. The first time the resident came to her appointment without oxygen was on 7/24/23. The resident appeared to struggle without oxygen. A pulse ox was taken, and it was 91 %. The pulse ox reading was 98 % after oxygen applied. The clinic staff reported the resident would've went approximately two hours without oxygen if they had not been able to get her supplemental oxygen there. The timeframe included travel time to and from appointment and time at the appointment.

During an interview on 11/30/23 4:35 PM, the DON reported whenever a resident is on oxygen and went to a doctor's appointment, she expected the resident continued on oxygen and an oxygen tank went with the resident. The DON stated there had been times when a resident went to an appointment without oxygen. Resident #4 is supposed to be on oxygen at all times. The facility switched oxygen vendors in 9/2023. The

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	165580	A. BUILDING _____ B. WING _____	C 12/06/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
URBANDALE HEALTH CARE CENTER	4614 NW 84TH STREET URBANDALE, IA 50322

(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 658	Continued From page 12	F 658		

former respiratory vendor came and took Resident #4's concentrator and didn't replace with an oxygen tank. The new vendor hadn't delivered oxygen yet to replace the one she had and it turned out to be a big incident. She contacted the former respiratory vendor and made them aware of what happened.

During an interview on 12/4/23 at 12:45 PM, Staff L, certified nursing assistant (CNA) stated she had only worked at the facility a month. When asked how she knew what cares needed to be done for resident and to know if a resident used oxygen she reported she just watched residents to see if they need help, and asked another staff person what to do for the resident. Staff L stated she didn't look at the computer to check the residents' care plan.

During an interview 12/4/23 at 12:50 PM, the Administrator reported there was an incident when Resident #4 went to a doctor's appointment and didn't have her oxygen. The facility got a call from doctor's office and sent a staff person from the facility to the clinic to deliver oxygen for the resident.

During an interview on 12/5/23 at 2:10 PM, Staff M, CNA, reported there are no care plans or pocket care plan for CNA's to view in order to know what to do for the residents. Staff M stated she goes off the information other people told her on what to do for the residents. Staff M reported she had worked other places and always had a care plan to know what the residents needed done. The facility had a lot of agency, and they don't know what to do either. Staff M agreed if a resident used oxygen, she should know about it and it should be on the care plan. However the

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	165580	A. BUILDING _____ B. WING _____	C 12/06/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
URBANDALE HEALTH CARE CENTER	4614 NW 84TH STREET URBANDALE, IA 50322

(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 658	Continued From page 13 facility had no care plan or anything that showed information such as a resident's oxygen use. Staff M stated she just watched and learned how to do things. During an interview on 12/5/23 at 4:25 PM, clinic staff reported Resident #4 presented to the clinic without oxygen several times. The physician wrote a progress note to the facility that Resident #4 needed oxygen and concerns about the resident coming to appointments without oxygen on more than one occasion. The clinic staff verified no oxygen tank brought in by facility staff to the doctor's office on 11/6/23 after Resident #4 arrived to her appointment without oxygen on. A policy and procedure for oxygen storage, handling and delivery revised 10/5/15 revealed oxygen administered per physician's orders.	F 658		
F 686 SS=G	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:	F 686		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	165580	A. BUILDING _____ B. WING _____	C 12/06/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
URBANDALE HEALTH CARE CENTER	4614 NW 84TH STREET URBANDALE, IA 50322

(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 686	Continued From page 14	F 686		

Based on clinical record review, observation, resident and staff interviews, provider interview, and facility policy review the facility failed to ensure 1 of 3 residents (Resident #9) reviewed for pressure ulcers received care and services to prevent pressure ulcers from forming while resided at the facility. The facility reported a census of 81 residents.

Findings include:

The MDS (Minimum Data Set) assessment identifies the definition of pressure ulcers:

Stage I is an intact skin with non-blanchable redness of a localized area usually over a bony prominence. Darkly pigmented skin may not have a visible blanching; in dark skin tones only it may appear with persistent blue or purple hues.

Stage II is partial thickness loss of dermis presenting as a shallow open ulcer with a red or pink wound bed, without slough (dead tissue, usually cream or yellow in color). May also present as an intact or open/ruptured blister.

Stage III Full thickness tissue loss. Subcutaneous fat may be visible but bone, tendon or muscle is not exposed. Slough may be present but does not obscure the depth of tissue loss. May include undermining and tunneling.

Stage IV is full thickness tissue loss with exposed bone, tendon or muscle. Slough or eschar (dry, black, hard necrotic tissue). may be present on some parts of the wound bed. Often includes undermining and tunneling or eschar.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	165580	A. BUILDING _____ B. WING _____	C 12/06/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
URBANDALE HEALTH CARE CENTER	4614 NW 84TH STREET URBANDALE, IA 50322

(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 686	Continued From page 15	F 686		

Unstageable Ulcer: inability to see the wound bed.

Other staging considerations include:
Deep Tissue Pressure Injury (DTPI): Persistent non-blanchable deep red, maroon or purple discoloration. Intact skin with localized area of persistent non-blanchable deep red, maroon, purple discoloration due to damage of underlying soft tissue. This area may be preceded by tissue that is painful, firm, mushy, boggy, warmer or cooler as compared to adjacent tissue. These changes often precede skin color changes and 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 admission Minimum Data Set (MDS) assessment dated 7/31/23, revealed Resident #9 had diagnosis of sepsis, diabetes, septicemia (bacterial infection in the blood), and cellulitis (bacterial skin infection) on the right lower limb. The MDS documented the resident admitted to the facility on 7/27/23. The MDS documented the resident had a risk for pressure ulcers but had no skin wounds or concerns.

The MDS assessment dated 9/12/23, documented the resident had a risk for pressure ulcers but had no current pressure ulcers or skin concerns. The MDS indicated the resident required assistance of one for bed mobility and transfers. The MDS indicated the resident had a Brief Interview for Mental Status (BIMS) score of 15 out of 15, indicating cognition intact.

The electronic health record diagnoses list revealed the following:

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	165580	A. BUILDING _____ B. WING _____	C 12/06/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
URBANDALE HEALTH CARE CENTER	4614 NW 84TH STREET URBANDALE, IA 50322

(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 686	Continued From page 16	F 686		

right lower limb cellulitis (added 7/27/23), Stage 2 pressure ulcer left heel (added 10/16/23), Stage 3 pressure ulcer to the right heel (added 11/14/23), and an open wound on the right toe (added 11/27/23).

The Admission Narrative Bundle assessment dated 9/7/23 revealed the Braden score of 17, indicating the resident at risk for development of pressure ulcers.

The Care Plan revised 8/30/23 revealed Resident #9 had an activities of daily living (ADL) self-care deficit. The staff directives included to provide assistance of one for bed mobility. The Care Plan revealed the diagnoses of diabetes mellitus and directed staff to inspect the feet daily for open areas, sores, and pressure areas. The Care Plan lacked information regarding altered skin integrity or pressure ulcers, as well as the interventions to prevent development of pressure areas.

The Order Summary Report included the following orders:
-Weekly skin assessment every Thursday on the evening shift started on 9/7/23.
-Extra strength (ES) acetaminophen (Tylenol) 500 milligrams (mg) give 2 tablets by mouth (PO) every 8 hours as needed (PRN) for increased pain started on 10/7/23.
-Float bilateral heels on pillows while in bed for skin integrity started on 10/8/23.
-Tramadol (opioid pain medication) 50 mg PO every 6 hours PRN for pain started on 10/8/23.
-Encourage resident to keep shoes off when not weight bearing to promote wound healing started on 10/12/23.
-Place Prevalon boots (used to keep heels floated and relieve pressure to help reduce risk of

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	165580	A. BUILDING _____ B. WING _____	C 12/06/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
URBANDALE HEALTH CARE CENTER	4614 NW 84TH STREET URBANDALE, IA 50322

(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 686	Continued From page 17	F 686		

bedsores) on bilateral feet at bedtime (HS) to promote wound healing for blister on left heel and wound on the right heel started on 10/12/23.
-Apply skin prep to the left outer heel topically two times a day for a fluid filled intact blister. Stop skin prep and notify the doctor if the blister opened. The order started on 10/8/23 at 7:00 PM, and discontinued on 10/23/23.
-Cleanse left and right heel wound with cleanser of choice, apply silver alginate (dressing to absorb wound fluid) to wound bed, cover with heel foam dressing, wrap with gauze wrap, secure with tape daily and PRN ordered on 11/14/2023.
-Cleanse left foot 4th digit with cleanser of choice and apply skin prep daily started on 11/27/23.
-Prafo (device to offload and manage pressure to heel/ankles) boots to bilateral feet on during the day, off at HS to promote wound healing started 11/29/23.

The Treatment Administration Record (TAR) dated 10/1 -10/31/23 revealed a portable x-ray of the right heel and foot for his foot wound documented as completed on 10/31/23. The TAR 10/1 - 11/30/23 lacked documentation of wound treatment to the left heel wound on 10/26/23, 11/14/23, and 11/21/23. The TAR also lacked documentation of the right heel wound treatment on 11/14/23 and 11/21/23, and weekly skin assessment on 10/26/23. The TAR dated 11/1 - 11/30/23 had an entry for an air mattress to promote wound healing due to bilateral heel wounds added on 11/28/23 at 2:00 PM, and documented as completed on 11/28/23.

The Medication Administration Record (MAR) dated 10/1/23-10/31/23 revealed the following orders:

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	165580	A. BUILDING _____ B. WING _____	C 12/06/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
URBANDALE HEALTH CARE CENTER	4614 NW 84TH STREET URBANDALE, IA 50322

(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 686	Continued From page 18	F 686		

-ES Tylenol 500 mg two tablets every 8 hours PRN for increased pain started on 10/7/23. PRN ES Tylenol administered on 10/11, 10/12, 10/16/23 for pain rated up to "5" on a 1-10 scale. This was in addition to scheduled doses of ES Tylenol administered.
-Tramadol 50 mg PO every 6 hours PRN for pain started on 10/8/23. A total of 17 doses were administered to the resident between 10/16 - 10/30/23 for pain rated up to "7" on a 1-10 pain scale.
-Levaquin (antibiotic) 500 mg PO for wound administered 10/12/23 to 10/21/23.
-Prevalon Boots to bilateral feet at HS to promote wound healing to blister on the left heel and wound on the right heel started on 10/12/23 at 6:00 PM and discontinued on 11/28/23.

The MAR dated 11/1/23 - 11/30/23 revealed:
-Tramadol 50 mg PO every 6 hours PRN for pain administered 9 times 11/1 to 11/14/23 for pain rated at up to "9" on a 1-10 pain scale.
-Juven (protein supplement) in the evening related to stage 2 pressure ulcer to left heel and stage 3 pressure ulcer to right heel started on 11/14/23.
-Flagyl (antibiotic) 500 mg PO three times a day for wound care started on 11/15/23 to 11/22/23.
-Levaquin 750 mg PO daily for wound started on 11/16/23 until 11/22/23.
-ES Tylenol 500 mg two tablets every 8 hours PRN for increased pain started on 10/7/23. ES Tylenol administered on 11/2/23 for pain rated at 5, 11/14/23 for pain rated at 6, 11/21/23 for pain rated at 4, and 11/22/23 for pain rated at 5.
-A wound culture of right lateral heel wound completed 11/28/23 at 2:02 PM.

The Progress Notes for the resident revealed the

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	165580	A. BUILDING _____ B. WING _____	C 12/06/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
URBANDALE HEALTH CARE CENTER	4614 NW 84TH STREET URBANDALE, IA 50322

(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 686	Continued From page 19	F 686		

following:
-On 8/2/23 at 9:48 AM, no open areas or skin issues, and no surgical wounds.
-On 8/29/23 at 4:28 PM, resident had an unwitnessed fall and sent to the hospital.
-On 9/1/23 at 5:16 PM, resident readmitted to the facility.
-On 9/4/23 at 2:07 PM, resident sent to the hospital for weakness and altered mental status.
-On 9/7/23 at 11:40 AM, readmitted to facility from the hospital. Skin assessment abnormalities included abrasions to bilateral knees and the left lower extremity, and a pressure ulcer to the left buttock.
-On 9/22/23 at 2:14 PM, no open areas/skin issues and no surgical wounds
-On 10/7/23 at 6:00 AM, resident had increased pain during the shift from a right outer ankle pressure sore. Tylenol administered.
-On 10/8/23 at 8:23 AM, pressure ulcer on the right outer heel below the ankle measured 2 centimeter (cm) x 4.2 cm. Wound bed dark in color with 50% wound bed slough. The bed sheet and resident's sock had a moderate amount of serosanguinous drainage. Surrounding skin moist, boggy, and pale in color. Area cleansed with normal saline and an optifoam border dressing applied. Resident complains of pain in right foot and heel "off and on". Pain is most severe while lying in bed. Resident educated to keep bilateral lower extremities (BLE) elevated on a pillow while in bed. The outer aspect of left heel below the ankle had an intact fluid filled blister 3 cm x 3.2 cm. Orders received to cleanse skin over blister with normal saline and apply skin prep twice a day while blister remained intact. Placed on wound nurse practitioner's list to evaluate and treat resident on 10/9/23. Order also received for Tramadol 50mg 1 tab PO every

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	165580	A. BUILDING _____ B. WING _____	C 12/06/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
URBANDALE HEALTH CARE CENTER	4614 NW 84TH STREET URBANDALE, IA 50322

(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 686	Continued From page 20	F 686		

6 hours PRN and to float bilateral heels on pillows while in bed.
-On 10/9/23 at 9:37 PM, wound provider saw resident to assess area of concern to buttock and bilateral heels. Staff report the resident had been in and out of the hospital secondary to falls and sepsis in early to mid-September. No recent hospitalization in the past month. He has Type 2 diabetes. He requires staff assistance for transfers. He is able to ambulate short distances with staff assistance and a wheeled walker. He has tennis shoes that are not new and in good repair. Foam cushion in the wheelchair. He reports his right heel is tender. There is a foam dressing on the right heel and odor noted upon removal of the dressing.
The resident had a right lateral heel unstageable pressure ulcer measuring 2.8 cm x 1.5 cm x 0.1cm and had a moderate amount of thin, serous drainage. The surrounding skin appeared macerated, and reddened. Pain rated at a 2-3 on a 1 to 10 scale. The treatment order included to cleanse wound with cleanser of choice, apply silver alginate to the wound bed, wrap with gauze wrap, and secure with tape daily and PRN.
A left lateral heel Stage 2 pressure ulcer measured 3.0 cm x 3.0 cm x 0.1cm and had an intact serous blister. Treatment order included to cleanse area with cleanser of choice and apply skin prep daily and PRN.
Additional orders included to administer Bactrim DS 1 tab PO for 10 days for right heel infection, apply Prevalon boots at HS, and encourage the resident to keep shoes off when not weight bearing to promote wound healing.
-On 10/11/23 at 3:32 PM, order to start Levaquin 500mg PO daily for 10 days for wound care.
-On 10/15/23 at 10:09 PM, resident complained of pain to bilateral heels. Open blisters noted

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	165580	A. BUILDING _____ B. WING _____	C 12/06/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
URBANDALE HEALTH CARE CENTER	4614 NW 84TH STREET URBANDALE, IA 50322

(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 686	Continued From page 21	F 686		

upon assessment. Legs offloaded with pillow and gauze bandage applied to heels. Scheduled Tramadol administered.
-On 10/16/23 at 4:43 PM, resident continues on Levaquin for wound infection. Bilateral heels in bunny boots. Will continue to monitor.
-On 10/17/23 at 2:22 AM, at approximately 11:40 PM, while repositioning resident in bed, observed the treatment dressings on both heels had fallen off in the bed. Bilateral heel wounds cleansed with normal saline and treatment performed as ordered. Wound beds dark purple in color and dry. Pain at 8/10 on pain scale with touch and when treatment performed. Resident repositioned in bed, protective boots applied to BLE's, and PRN Tramadol administered.
-On 11/1/23 at 3:55 PM, wound round notes from 10/30/23 entered. The notes included: Resident seen to assess area of concern to bilateral heels. Resident wears his tennis shoes when working in therapy. Resident encouraged to take shoes off when not working in therapy. Resident stated he would rather give up his feet then give up his shoes. Education provided about shoes not recommended until the wounds healed. Resident had tenderness to right heel. The right lateral heel wound (Stage 3 pressure area) measured 3.2 cm x 1.8 cm x 0.2 cm and had 100 % unstable eschar and a moderate amount of this serous drainage. Resident rated pain 3-4 out of 10. The left lateral heel (Stage 3 pressure ulcer) measured 3.2 cm x 5.0 cm x 0.1cm (2 areas) and had a moderate amount of serous drainage. The resident rated pain 0-2 out of 10. Treatment to both wounds included to cleanse with cleanser of choice, apply calcium alginate with silver to wound bed, cover with heel foam dressing, wrap with gauze wrap, and secure with tape three times a week and PRN.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	165580	A. BUILDING _____ B. WING _____	C 12/06/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
URBANDALE HEALTH CARE CENTER	4614 NW 84TH STREET URBANDALE, IA 50322

(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 686	Continued From page 22	F 686		

-On 11/27/23 at 2:22 PM, resident wears tennis shoes when working in therapy. Encouraged to take shoes off when not working in therapy. Recommendation not followed well by the resident. Resident reports he does not wear his Prevalon boots at HS. He is sitting in recliner upon entry into room with feet in a dependent position. Resident had tenderness to bilateral heel wounds. The left heel had no heel foam dressing on. Staff reported their supply is nearly exhausted.
The right lateral heel wound (Stage 3 pressure area) measured 2.1 cm x 1.0 cm x 0.4 cm and had a moderate amount of this serous drainage. Resident rated pain 1-3 out of 10. The left lateral heel (Stage 3 pressure ulcer) measured 4.0 cm x 5.0 cm x 0.2 cm (2 areas) and had a moderate amount of serous drainage. The wound bed was boggy and not able to assess. The resident rated pain 0-1 out of 10. Orders to continue treatment to bilateral heel wounds: cleanse with cleanser of choice, apply calcium alginate with silver to wound bed, cover with heel foam dressing, wrap with gauze wrap, and secure with tape three times a week and PRN.
A diabetic foot ulcer to the left 4th digit measured 0.5 cm x 0.6 cm x 0.1 cm with eschar. Order to cleanse with cleanser of choice and apply skin prep daily and PRN. In addition, a PCR DNA wound culture obtained of the right lateral heel. Orders included:
-Discontinue Prevalon boots per resident request
-Place air mattress to promote wound healing
-Prafo boots to bilateral feet on during the day and off at HS to promote wound healing

On 11/28/23 at 2:45 PM, observed Staff K, Registered Nurse (RN), perform a treatment and dressing changes to Resident #9's bilateral heels

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	165580	A. BUILDING _____ B. WING _____	C 12/06/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
URBANDALE HEALTH CARE CENTER	4614 NW 84TH STREET URBANDALE, IA 50322

(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 686	Continued From page 23	F 686		

and left 4th toe as he sat in his recliner. The resident's right lateral heel had an open area with a moderate amount of purulent drainage. The left lateral and back of the heel had a necrotic area. Resident #9 asked Staff K if he was going to need his feet cut off. Staff K told the resident no, but she had not seen his wounds before. Prevalon boots sat on top of a large cabinet in the resident's room. The resident refused to wear the boots. Staff K encouraged the resident to keep his legs elevated and heels floated.

During an interview on 12/4/23 at 10:15 AM, Resident #9 reported he had wounds on both heels for about 4 months. The staff treated it with silver and placed dressings on the area. One wound started out as a blister about the size of a half dollar, then it opened up, and it was painful. He stated the wounds don't hurt as bad when he received pain medication, but sometimes he had trouble getting pain medication.

During an interview on 12/4/23 at 11:25 AM, the wound Nurse Practitioner (NP) reported Resident #9 had wounds on both heels, and wounds classified as pressure ulcers. The NP stated she didn't know if the resident had pressure sores on feet when he came to the facility, she only saw the resident when staff had notified her to see the resident because he had wounds. The resident had been in and out of the hospital. The NP reported the heel wounds treated with calcium alginate, heel foam dressing, and wrapped with kerlix. The wound treatment order changed last week by an on-call provider who wasn't familiar with the treatment being done for the resident. The NP changed orders back to calcium alginate and heel foam dressing on 12/4/23. The NP reported the resident not always compliant with

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	165580	A. BUILDING _____ B. WING _____	C 12/06/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
URBANDALE HEALTH CARE CENTER	4614 NW 84TH STREET URBANDALE, IA 50322

(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 686	Continued From page 24	F 686		

recommendations. The resident had Prevalon boots but said he wasn't going to wear them. She ordered Prafo boots to offload the area and allow the resident to walk in them but they were waiting for delivery of the boots.

During an interview on 12/4/23 at 12:45 PM, Staff L, certified nursing assistant (CNA) reported she just watched residents and saw if they needed help, and helped residents with ADL's. Staff L reported she didn't look at the computer or know anything about a pocket care plan to reference on what resident needed for cares or interventions, she just asked someone what to do for the resident.

During an interview on 12/4/23 at 1:00 PM, Staff N, Licensed Practical Nurse (LPN) reported the nurse performed a head to toe skin assessment whenever a resident admitted to the facility, and documented the assessment on the computer. A Braden scale filled out upon admission, and a head to toe skin assessment completed weekly on each resident. Staff also filled out a shower sheet and marked if any skin concerns observed and the nurse on duty checked the resident's skin and signed off on shower sheet. A progress note entered if staff noted any skin concerns. If a resident at risk for pressure sores, staff repositioned and toileted the resident every 2-3 hours. A roho cushion or air mattress used if needed, depending upon the resident's skin risk.

During an interview on 12/4/23 at 1:40 PM, Staff F, Assistant Director of Nursing (ADON) reported a skin assessment completed upon admission or at least within the first 24 hours of a resident's admission. A Braden scale completed with the admission bundle assessment. The ADON

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	165580	A. BUILDING _____ B. WING _____	C 12/06/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
URBANDALE HEALTH CARE CENTER	4614 NW 84TH STREET URBANDALE, IA 50322

(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 686	Continued From page 25	F 686		

reported interventions if a resident at risk for developing a pressure ulcer, such as an air mattress placed on the bed, education provided to resident about moving off their bottom, and encourage resident to wear different pants to prevent clothes from rubbing the area. Bunny boots used if the skin looked or felt boggy and heels floated as much as possible. Resident encouraged to consume protein and supplements, and a referral made to the dietician. A resident also added to the wound provider's list to see the resident when a wound developed.

During an interview on 12/4/23 at 1:50 PM, Staff E, ADON, reported the resident skin assessments completed upon admission and weekly by the nurses. The admission skin assessment documented on the admission assessment bundle, that included the Braden scale assessment. Weekly skin assessments typically done to coincide with the resident's shower day, and recorded on the TAR. Interventions put into place if a resident had a risk for pressure ulcer. Interventions such as limited linens on the bed, use one chux, and skin checks by CNA's during cares. An air mattress placed on the bed if a resident had skin issues. Treatments documented on the TAR. Staff E reported she expected interventions in place to prevent pressure ulcers if the resident is at risk for pressure ulcers. Staff E reported Resident #9 noncompliant and liked to sit with his feet down or on foot pedals. The resident developed pressure areas on heels after admission to the facility. He refused to wear bunny boots. Resident told staff he would rather donate his feet then wear bunny boots, and he would rather go to jail then give up his shoes. Staff E reported Prafo boots are on order.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	165580	A. BUILDING _____ B. WING _____	C 12/06/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
URBANDALE HEALTH CARE CENTER	4614 NW 84TH STREET URBANDALE, IA 50322

(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 686	Continued From page 26	F 686		

During an interview on 12/5/23 at 2:10 PM, Staff M, CNA, reported no care plans or pocket care plan for her to know what to do for the residents. She went off what people told her about the residents and what cares and things needed done. Staff M reported she didn't have access to look at the residents' care plan on the computer.

During an interview on 12/6/23 at 10:15 AM, Staff O, CNA, reported she had worked at the facility awhile and normally assigned to work on the same hall, so she was familiar with the residents and what they needed. Staff O reported sometimes they had a "set sheet" to look at but if no set sheet available, then took a form with resident names and room number and wrote down things needed for the residents. Staff O reported she had the capability to look things up on the computer. Staff O reported Staff F and the DON updated the set sheet. The set sheet included how a resident transferred, if resident needed assistance with eating, if used glasses or dentures, and how the resident liked things done. Pressure ulcer not included on the set sheet. If a resident had a pressure sore and she didn't have certain devices such as bunny boots in place, someone stopped and told her the resident needed them on.

During an interview on 12/6/23 at 10:45 AM, the MDS Coordinator, reported she completed the MDS and care plans for the residents. The MDS Coordinator reported the facility had a transition period when the ADON was responsible for completion of care plans on skilled residents, and she mainly worked on MDS and care plans for the other units. For awhile, no ADON on the skilled unit so she worked on MDS completions

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	165580	A. BUILDING _____ B. WING _____	C 12/06/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
URBANDALE HEALTH CARE CENTER	4614 NW 84TH STREET URBANDALE, IA 50322

(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 686	Continued From page 27	F 686		

and worked on resident care plans one day a month for the entire building when she had time to work on them. The transition period without an ADON lasted 2-3 months but there had been three transitions in the past year. The MDS Coordinator reported a baseline care plan completed and care plan built from there. The MDS Coordinator reported she obtained information for care plans from MDS assessment, hospital notes, progress notes, MAR, TAR, and meetings about transition of resident care and needs. The ADON's updated the set sheet for staff reference about resident cares. The MDS Coordinator reported a pressure sore or wound listed on the care plan under focus area of skin, along with the devices needed such as a cushion, mattress, floating heels, etc. if a resident had a pressure area. The MDS Coordinator reported she knew Resident #9 had pressure ulcers and seen by a wound provider. She expected interventions for pressure ulcers placed on the care plan but she hadn't gotten to Resident #9's care plan yet.

A Skin Integrity and Pressure Injuries Protocol effective 9/2023 revealed the resident received care consistent with professional standards of practice to prevent pressure injuries and will not develop pressure injuries unless the individual's clinical condition demonstrated pressure injury unavoidable. The resident with pressure injuries received the necessary treatment and services to promote healing, prevent infection, and prevent development of new ulcers. Prevention guidelines included: identification of residents at risk for developing a pressure injury upon admission, quarterly, and a change in condition utilizing the Braden risk scale. Evaluation of risk factors and changes in condition that may impact

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	165580	A. BUILDING _____ B. WING _____	C 12/06/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
URBANDALE HEALTH CARE CENTER	4614 NW 84TH STREET URBANDALE, IA 50322

(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 686	Continued From page 28 development and healing of pressure injury, and implementation of interventions to reduce or remove underlying risk factors. Based on assessment and the resident's clinical condition, basic or routine care include but not limited to interventions such as provide appropriate pressure redistributing, support surfaces, non-irritation surfaces, maintain or improve nutrition and hydration status, and provide treatment to prevent the development of additional pressure injuries.	F 686		
F 695 SS=G	Respiratory/Tracheostomy Care and Suctioning CFR(s): 483.25(i) § 483.25(i) Respiratory care, including tracheostomy care and tracheal suctioning. The facility must ensure that a resident who needs respiratory care, including tracheostomy care and tracheal suctioning, is provided such care, consistent with professional standards of practice, the comprehensive person-centered care plan, the residents' goals and preferences, and 483.65 of this subpart. This REQUIREMENT is not met as evidenced by: Based on clinical record review, staff interview, and facility policy review, the facility staff failed to ensure a resident who needed respiratory care was provided oxygen for a doctor's appointment for 1 of 3 residents reviewed for oxygen use (Resident #4). The facility reported a census of 81 residents. Findings include: The Minimum Data Set (MDS) assessment dated 10/1/23 revealed Resident #4 had diagnoses of heart failure, breast cancer, and seizures. The	F 695		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	165580	A. BUILDING _____ B. WING _____	C 12/06/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
URBANDALE HEALTH CARE CENTER	4614 NW 84TH STREET URBANDALE, IA 50322

(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 695	Continued From page 29	F 695		

MDS documented the resident had severely impaired cognition. The MDS indicated the resident had shortness of breath when lying flat and used oxygen.

The Care Plan revised on 8/7/23 revealed Resident #4 on oxygen therapy related to a respiratory illness. The staff directives included to apply oxygen as ordered.

The Order Summary Report revealed an order started on 8/4/23 for continuous oxygen at 2-4 liters (L) per nasal cannula (NC) to keep oxygen greater than 88 % (percent), and monitor oxygen every shift.

The Treatment Administration Record revealed documentation of oxygen set at 3 L and oxygen saturation 93% on 11/6/23.

A physician's Progress Note dated 11/6/23 revealed Resident #4 arrived at doctor's office again without any oxygen (which she required chronically) and the clinic had to supply with hospital supplies. This had happened multiple times on 7/24/23 and 11/6/23 and is poor patient care. This resulted in mismanaged time away from the appointment time and caused the patient distress.

During an interview on 11/27/23 at 1:55 PM, clinic staff reported the facility sent Resident #4 to her appointment on 11/6/23 without oxygen. The resident needed oxygen 24/7. This was the second time this had happened. The first time the resident came to her appointment without oxygen was on 7/24/23. The resident appeared to struggle without oxygen. A pulse ox was taken, and it was 91 %. The pulse ox reading was 98 %

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	165580	A. BUILDING _____ B. WING _____	C 12/06/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
URBANDALE HEALTH CARE CENTER	4614 NW 84TH STREET URBANDALE, IA 50322

(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 695	Continued From page 30	F 695		

after oxygen applied. The clinic staff reported the resident would've went approximately two hours without oxygen if they had not been able to get her supplemental oxygen there. The timeframe included travel time to and from appointment and time at the appointment.

During an interview on 11/30/23 at 4:35 PM, the Director of Nursing (DON) reported whenever a resident is on oxygen and went to a doctor's appointment, she expected the resident continued on oxygen and an oxygen tank went with the resident. The DON stated there had been times when a resident went to an appointment without oxygen. Resident #4 supposed to be on oxygen at all times. The facility switched oxygen vendors in 9/2023. The former respiratory vendor came and took Resident #4's concentrator and didn't replace with an oxygen tank. The new vendor hadn't delivered oxygen yet to replace the one she had. It turned out to be a big incident. She contacted the former respiratory vendor and made them aware of what happened.

During an interview on 12/4/23 at 12:45 PM, Staff L, certified nursing assistant (CNA) stated she had only worked at the facility a month. When asked how she knew what cares needed done for residents and to know if a resident used oxygen she reported she just watched residents to see if they need help, and asked another staff person what to do for the resident. Staff L stated she didn't look at the computer to check the residents' care plan.

During an interview on 12/4/23 at 12:50 PM, the Administrator reported there was an incident when Resident #4 went to a doctor's appointment and didn't have her oxygen. The facility got a call

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	165580	A. BUILDING _____ B. WING _____	C 12/06/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
URBANDALE HEALTH CARE CENTER	4614 NW 84TH STREET URBANDALE, IA 50322

(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 695	Continued From page 31	F 695		

from doctor's office and sent a staff person from the facility to the clinic to deliver oxygen for the resident.

During an interview on 12/5/23 at 2:10 PM, Staff M, CNA, reported there are no care plans or pocket care plan for CNA's to view in order to know what to do for the residents. Staff M stated she goes off the information other people told her on what to do for the residents. Staff M reported she had worked other places and always had a care plan to know what the residents needed done. The facility had a lot of agency, and they don't know what to do either. Staff M agreed if a resident used oxygen, she should know about it and it should be on the care plan about how many liters of oxygen needed, so she could can check the setting. However the facility had no care plan or anything that showed information such as a resident's oxygen use. Staff M stated she just watched and learned how to do things.

During an interview on 12/5/23 at 4:25 PM, clinic staff reported Resident #4 presented to the clinic without oxygen several times. The physician wrote a progress note to the facility that Resident #4 needed oxygen and concerns about the resident coming to appointments without oxygen on more than one occasion. The clinic staff verified no oxygen tank brought in by facility staff to the doctor's office on 11/6/23 after Resident #4 arrived to her appointment without oxygen on.

During an interview on 12/6/23 at 10:45 AM, the MDS Coordinator, reported she completed the MDS and care plans for the residents, and the ADON's helped review the care plan. The MDS Coordinator reported she expected oxygen listed on the care plan if a resident had oxygen. She

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	165580	A. BUILDING _____ B. WING _____	C 12/06/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
URBANDALE HEALTH CARE CENTER	4614 NW 84TH STREET URBANDALE, IA 50322

(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 695	Continued From page 32 typically entered oxygen under the pertinent diagnoses to show the reason why a resident used oxygen. A policy and procedure for oxygen storage, handling and delivery revised 10/5/15 revealed oxygen administered per physician's orders. Oxygen orders included the liter flow, mode of administration, and frequency of use.	F 695		
F 755 SS=E	Pharmacy Srvcs/Procedures/Pharmacist/Records CFR(s): 483.45(a)(b)(1)-(3) §483.45 Pharmacy Services The facility must provide routine and emergency drugs and biologicals to its residents, or obtain them under an agreement described in §483.70(g). The facility may permit unlicensed personnel to administer drugs if State law permits, but only under the general supervision of a licensed nurse. §483.45(a) Procedures. A facility must provide pharmaceutical services (including procedures that assure the accurate acquiring, receiving, dispensing, and administering of all drugs and biologicals) to meet the needs of each resident. §483.45(b) Service Consultation. The facility must employ or obtain the services of a licensed pharmacist who- §483.45(b)(1) Provides consultation on all aspects of the provision of pharmacy services in the facility. §483.45(b)(2) Establishes a system of records of receipt and disposition of all controlled drugs in sufficient detail to enable an accurate	F 755		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	165580	A. BUILDING _____ B. WING _____	C 12/06/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
URBANDALE HEALTH CARE CENTER	4614 NW 84TH STREET URBANDALE, IA 50322

(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 755	Continued From page 33	F 755		

reconciliation; and

§483.45(b)(3) Determines that drug records are in order and that an account of all controlled drugs is maintained and periodically reconciled.
This REQUIREMENT is not met as evidenced by:
Based on clinical record review, staff interview, and facility policy review, the facility failed to ensure staff accurately recorded controlled substance medications counts, and failed to ensure proper destruction of controlled substances for 1 of 3 residents (Resident #1) reviewed for use of controlled substances. The facility also failed to ensure the facility staff documented two staff signatures to indicate they performed and witnessed the narcotic counts whenever the facility had a transition in staff for 2 of 2 medication carts reviewed. The facility reported a census of 81 residents.

Findings include:

1. The Minimum Data Set (MDS) assessment dated 7/18/23, revealed Resident #1 had diagnoses of non-Alzheimer's dementia, Parkinson's Disease, and renal insufficiency. The MDS documented the resident had a Brief Interview for Mental Status score of "6", indicating severely impaired cognition. The MDS indicated the resident took scheduled and PRN (as needed) opioid pain medication 4 of 7 days during the look-back period. The resident rated pain at a "4" on a 1-10 pain scale.

Resident #1's Care Plan revised 7/13/23 revealed the resident had a risk for pain related to cervical disc degeneration. The resident also had impaired cognition related to dementia and

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	165580	A. BUILDING _____ B. WING _____	C 12/06/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
URBANDALE HEALTH CARE CENTER	4614 NW 84TH STREET URBANDALE, IA 50322

(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 755	Continued From page 34	F 755		

Parkinson's. The staff directives included to administer medications as ordered, and monitor for side effects and effectiveness.

The Order Summary revealed the following:
-Tramadol 50 milligrams (mg) by mouth (PO) three times a day (TID) for pain started on 8/30/23.
-Tramadol changed to 100 mg PO TID for moderate pain started on 9/8/23.
-Hydrocodone 5/325 mg PO TID for pain started on 9/20/23.

The Progress Notes documented by Staff A, Registered Nurse (RN) revealed the following:
-On 8/12/23 at 2:25 PM, residents pain well controlled with scheduled APAP (Tylenol) and muscle rub this shift. Continue to monitor.
-On 8/27/23 at 1:28 PM, resident complained of pain in his neck and left knee. PRN Tramadol given with effective results.
-On 8/30/23 at 1:09 PM, new order received per advanced registered nurse practitioner (ARNP) to discontinue Tramadol 25 mg and start Tramadol 50 mg TID.
-On 9/8/23 at 2:42 PM, resident sent to the Emergency Department (ED) for possible DVT (deep vein thrombosis) (blood clot) in his RLE (right lower extremity). Resident left at 11:15 AM by ambulance, and returned to the facility at 2:00 PM. Diagnosed with RLE calf muscle strain.
-On 9/8/23 at 2:47 PM, the MDS Coordinator documented: new order from ARNP to increase Tramadol to 100 mg TID, if Tramadol does not help, provider plans to start low dose Hydrocodone.
-On 9/20/23 at 12:23 PM, resident had increased pain in his bilateral lower extremities (BLE). Resident flinches when legs and feet gently

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	165580	A. BUILDING _____ B. WING _____	C 12/06/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
URBANDALE HEALTH CARE CENTER	4614 NW 84TH STREET URBANDALE, IA 50322

(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 755	Continued From page 35	F 755		

touched. Resident stated "both my legs hurt really bad today". Staff noticed resident appeared to struggle while ambulating in the hall and appeared short of breath. New orders received per ARNP to discontinue Tramadol and start Hydrocodone 5/325 milligrams (mg) three times a day (TID).
-On 9/23/23 at 2:16 PM, resident complained of pain in BLE, and states his "right foot and ankle hurts really bad". Scheduled Hydrocodone given and unsure of effectiveness. Continue to monitor.

The Medication Administration Record (MAR) dated 9/1/23 to 9/30/23 revealed:
-Tramadol 50 mg PO TID for pain started on 8/30/23 and discontinued on 9/8/23.
-Tramadol 100 mg PO TID for moderate pain started on 9/8/23 and discontinued on 9/20/23 at 11:07 AM.
-Hydrocodone 5-325 mg tablets PO TID for pain started on 9/20/23.

The MAR revealed Staff A's initials documented on the MAR 9/8/23 as giving the last dose of Tramadol 50 mg, and on 9/20/23 as giving the last dose of Tramadol 100 mg. The MAR also revealed Staff A's initials documented the mid-morning dose of Hydrocodone administered on 9/23/23.

The Medication Administration Audit Report dated 9/23/23 revealed Hydrocodone 5/325 mg administered at 10:55 AM by Staff A.

The facility's investigation summary for self-report revealed on 9/23/23, Staff A, RN, worked on Station 1A hall cart on the 6 AM-6 PM shift. Staff C, RN, was the oncoming nurse at 6 PM who took over Station 1A hall cart. Staff B, RN,

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	165580	A. BUILDING _____ B. WING _____	C 12/06/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
URBANDALE HEALTH CARE CENTER	4614 NW 84TH STREET URBANDALE, IA 50322

(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 755	Continued From page 36	F 755		

worked on Station 1C hall cart on the 2-10 PM shift. As Staff A was leaving she stated to Staff C, by the way we already took care of Resident #1's meds". Staff C later asked Staff B what Staff A meant by that statement. Staff B and Staff C then went to the ADON's box on station 1 to retrieve the empty narcotic sheets and cards out of the box. Staff B and Staff C examined the narcotic log sheet and the three empty cards. The Narcotic sheet for Resident #1 for Tramadol 50 mg tab had instructions to take 2 tablets (50 mg each) PO TID. There were also three empty Tramadol cards in which all medication had been popped out. The last logged amount indicated 86 bubbles of medication for a total 172 -50mg pills. On the top right corner of the narcotic log sheet, Staff A indicated a destruction took place of 86 pills on 9/23/23 via a drug buster. On the second signature line the initials "EW" written in. Staff B observed the "EW" and knew this was not her signature, and knew she did not complete any medication destruction with Staff A. Resident #1 had an order for Tramadol 100 mg TID a day for pain was discontinued on 9/20/23. Hydrocodone 5-325 mg TID was started on 9/20/23. Staff E, ADON, notified the Director of Nursing (DON) on 9/23/23 at 7:02 PM that Staff B and Staff C approached Staff E about a concern regarding wasted narcotics completed by Staff A earlier in the day. Staff E reported Staff B found her initials on a narcotic sheet indicating she was a witness to the destruction of Resident #1's Tramadol but did not witness or have knowledge of the destruction. Investigation began by DON and Staff E, and interviews completed with Staff A, Staff B, and Staff C. Staff A reported Staff B went to B-Bops for a break between 4 - 4:30 PM, and medication destruction took place between 4-6 PM. Staff A stated she popped the pills into a

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	165580	A. BUILDING _____ B. WING _____	C 12/06/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
URBANDALE HEALTH CARE CENTER	4614 NW 84TH STREET URBANDALE, IA 50322

(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 755	Continued From page 37	F 755		

medication cup at the nurse's station and dumped them all into the drug buster. Staff B stated she neither witnessed nor co-signed any destruction of 86 pills of Tramadol with Staff A. Staff C stated Staff A told her she took care of Resident #1's Tramadol, and she brought it up in conversation with Staff B. Staff B denied any knowledge of the event and brought concerns to Staff E who was on duty at that time. Staff A was put on suspension during the initial investigation interview conducted by the DON and Staff E, as Staff A was the witness on 9/23/23. Staff interviews completed and the Police Department notified. Education provided to certified medication aides (CMA's) and nurses on 9/27/23. Education included processes on how to: administer controlled medications, reconcile narcotics, documenting on the narcotic log, receiving narcotics, and the new process for all destruction of medications to be completed by the DON and designee.

The facility's investigation file included the following:
-A written staff statement, signed by Staff B, dated 9/23/23 revealed on return from a 30-minute break, Staff B neither witnessed nor co-signed the destruction of narcotic medication (Tramadol) as alleged by Staff A. When she returned from a 30-minute break she realized from the incoming nurse her initials had been forged by the outgoing nurse as witnessing the destruction of 86 tabs of Tramadol.
-A written statement dated 9/23/23, and signed by Staff C, revealed Staff C arrived at work at 6 PM and was told by the outgoing nurse she "took care of Resident #1's Tramadol" which had been discontinued for over a week. Staff B worked on the other hall and stopped by. She stated "finally

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	165580	A. BUILDING _____ B. WING _____	C 12/06/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
URBANDALE HEALTH CARE CENTER	4614 NW 84TH STREET URBANDALE, IA 50322

(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 755	Continued From page 38	F 755		

we have more room on this cart because Staff A said the Tramadol had been wasted." Staff B said she was here since 2 PM and didn't destroy any narcotics with Staff A. Staff C states she went to the ADON's office door with Staff B and noticed Staff A had forged her signature on the narcotic count sheet so they immediately reported this to the ADON present at the facility.
-A typed witness statement dated 9/23/23 and signed by Staff E revealed between 6 - 6:30 PM, Staff B and Staff C approached this nurse at Station 3 and reported a concern. Staff C informed her that after controlled substance count completed, she received report from Staff A, the off going nurse. Staff A made a comment to Staff C they had already took care of Resident #1's meds. Staff C didn't think much of it but once Staff A had clocked out and left the building, a few minutes later Staff C asked Staff B what Staff A meant by the comment to which Staff B responded, "We?" I don't recall anything with Resident #1's meds. Staff C then went to the ADON's mailbox and retrieved 3 empty controlled substance cards and the correlated forms for Resident #1. They inspected the forms and empty cards and brought them to Staff E. The cards for Tramadol 50 mg 2 tabs in each pill pocket to equal the dose 100 mg for Resident #1 and the signed controlled substance log that correlated with the cards. However, Staff B, the other nurse that would have witnessed it or signed initials, stated she didn't witness the destruction of these meds and did not sign the form to witness the waste. All pill pockets had been emptied (90 slots, 2 pills each = 180 total). Upon further assessment of the forms, a total of 86 pills were destroyed as 4 doses had been used previously which equaled a total of 172 pills destroyed. On the log/form there was a line

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	165580	A. BUILDING _____ B. WING _____	C 12/06/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
URBANDALE HEALTH CARE CENTER	4614 NW 84TH STREET URBANDALE, IA 50322

(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 755	Continued From page 39	F 755		

diagonally through the empty space of the form where future dosages would be documented with the words "DESTROYED" on it, and in the top right hand corner of the form a box for destruction of medication were the signatures of Staff A as the first witness and "EW" on the second witness line. Upon assessment of signatures and in comparison to Staff B's previous signatures it is obvious the EW was not Staff B's signature style. The signature on the form was light and in a cursive style. Staff E contacted the DON and informed her of the situation. Staff E and the DON spoke with Staff A and asked about the events. Staff A stated she was on the Hall A cart, and Staff B was on Hall C cart. Staff A confirmed she did a drug destruction while on duty between 4-6 PM for Resident #1's Tramadol. She stated she went to the medication room with Staff B after Staff B returned from a break at B-Bops, and Staff B witnessed the destruction of 172 pills and she signed the form she was the second witness. Staff A asked a couple times in the conversation what was wrong and to conclude the conversation. The DON informed Staff A would be suspended from work pending investigation as the nurse witness verification could not be confirmed at this time. Staff A said "well let me know when I am off suspension, I guess it doesn't matter, I guess just let me know what happens with the investigation," and the call ended. Staff E asked Staff B follow up questions. Staff B said she went to B-Bops and returned with fries and after she returned, she went to the nurse's station, then sat to chart and eat. She denied going into the medication room with Staff A for a med destruction. She denied signing Resident #1's controlled substance form for anything or a drug destruction. She didn't know a medication destruction took place during her shift on A Hall

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	165580	A. BUILDING _____ B. WING _____	C 12/06/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
URBANDALE HEALTH CARE CENTER	4614 NW 84TH STREET URBANDALE, IA 50322

(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 755	Continued From page 40	F 755		

on 9/23/23. Staff E concluded a drug diversion took place. To add to the evidence, the destruction of 172 pills and 86 pockets to empty would take at least 5 to 10 minutes and would be rememberable. When Staff E spoke with Staff F, ADON, the next day she stated why would she have destroyed them anyway. Staff E just told her and all of her staff that even though the order changed from PRN to scheduled the resident could still use the pills and they could simply update the order on the form and cards so he didn't get charged for both refills. Police contacted between 10:30-11:00 PM and informed of possible theft and concern to make a police report. An officer was sent the following day to take a report.
-Staff education provided by the DON on 6/21/23 to all nursing staff regarding Fentanyl patches and a second nurse or CMA signature required on the administration narcotic log line. Two nurses or nurse/CMA observed the destruction of Fentanyl patch into the drug buster. On 7/26/23, education provided to all nursing staff and medication aides regarding the medication destruction policy. All discontinued medications need pulled from the cart immediately to be destroyed or sent to pharmacy to prevent medication errors.

During an interview on 11/27/23 at 3:10 PM, Staff B reported two nurses are required to witnessed the destruction of controlled substances. Controlled substances counted with another staff person and the keys handed over at shift change as well as if going to be away from the facility for an extended time. Two staff signed off on the narcotic log sheets when a narcotic count completed. Staff notified the ADON if there is a discrepancy in the narcotic count. Staff B

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	165580	A. BUILDING _____ B. WING _____	C 12/06/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
URBANDALE HEALTH CARE CENTER	4614 NW 84TH STREET URBANDALE, IA 50322

(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 755	Continued From page 41	F 755		

reported sometimes a narcotic medication administered but didn't get signed out, or a counting error occurred. Staff B reported she looked at the computer to see if the medication was given and if it had been signed out. Narcotic medication documented on the electronic MAR and signed out on the controlled drug record when the medication administered. Staff B reported the facility had a lot of discrepancies with controlled substance medications when she started working at the facility. The DON and ADON were the only ones who could waste narcotic medications. Staff B reported on the day of the incident (with Tramadol), she worked the 2-10 PM shift on Station 1 Hall C, and Staff A worked on Station 1 Hall A. Each nurse had keys to their assigned medication cart. Staff B stated she told Staff A she was going on break. Staff B kept the keys to the Hall C medication cart while on break. Staff B reported she walked to B-Bops. When she returned to the facility, she ate the food in the break room. After break, she started to pass medications in the dining room. After she completed passing medications to residents in the dining room, she wheeled the medication cart back to her hall and passed medications to residents in their rooms. Staff B reported she saw Staff C pass by the dining room while she was in the dining room passing pills but didn't get a chance to talk to her at that time. Staff B stated when she walked up to the nurse's station where Staff C sat, Staff C told her Staff A told her the narcotics had already been taken care of and destroyed. Staff B said she questioned in her mind how? Resident #1's medication order had changed from Tramadol to Hydrocodone but the Tramadol was kept in the medication cart and they continued to count the medication at shift change. Staff B reported she did not count the

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	165580	A. BUILDING _____ B. WING _____	C 12/06/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
URBANDALE HEALTH CARE CENTER	4614 NW 84TH STREET URBANDALE, IA 50322

(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 755	Continued From page 42	F 755		

narcotics on Hall A's medication cart at the start of her shift because it wasn't her assigned cart. It was Staff A's cart. Staff B reported she only counted the narcotics for Hall C medication cart. Staff B reported whenever the medication bubble card emptied, they placed the bubble card in the mailbox holder by the ADON's door. Staff B reported she had an instinct, and out of curiosity, she checked the card in the ADON's mailbox and saw the controlled drug record for Resident #1's Tramadol. She looked at the controlled drug record wrapped around the medication cards and saw there were 86 doses disposed and the form had her initials listed but the initials or signature were not her, and no credentials with RN or LPN by the initials written on the form. Staff B stated she did not see Staff A or anyone pop the pills out the medication card bubble packs or witness the wastage of the Tramadol for Resident #1. Staff B reported Staff A had already left the facility. Staff B reported her concerns to Staff E who was working at the facility. Staff B told Staff E it wasn't her signature or initials listed by the disposition of doses, and there were 86 Tramadol missing. Staff C was the nurse who took over Hall A medication cart from Staff A. Staff B reported she did not notice any behaviors or concerns of Staff A being under the influence of drugs when she worked with Staff A during the shift but Staff A worked the opposite hall and on a different medication cart than Staff B.

During an interview on 11/28/23 at 10:40 AM, Staff C reported the process with controlled substances. Pharmacy delivered the narcotics to the facility, and two nurses or a nurse and CMA entered the medications into the medication cart and signed the controlled substance sheet. Controlled substance recorded on the controlled

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	165580	A. BUILDING _____ B. WING _____	C 12/06/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
URBANDALE HEALTH CARE CENTER	4614 NW 84TH STREET URBANDALE, IA 50322

(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 755	Continued From page 43	F 755		

drug record whenever staff took medication out of the medication cart. A narcotic count completed at the end of the shift with the on-coming shift nurse or CMA. The nurse or CMA going off shift checked the controlled drug forms in the book, while the on-coming nurse or CMA checked the medication cards for the number of pills left in each card. If a discrepancy found in the count as they compared the card with the controlled drug record for each resident then they tried to figure out what happened. Staff C reported sometimes a resident had scheduled medication such as twice a day, the nurse gave the medication and recorded on the MAR but the medication dose didn't get recorded on the controlled drug record in the book. Staff C reported each nurse/ CMA had keys to their assigned medication cart only. Staff normally kept the medication cart/narcotic keys whenever they went on break. Staff C reported controlled substances placed in the drug buster with another nurse/CMA, and she recorded the number of pills wasted on the narcotic sheet. Both staff who witnessed the waste had to sign the controlled drug record. Staff C reported on the day of the incident (9/23/23), she worked the 6 PM- 6 AM shifts on Hall A. She followed Staff A who was going off shift. Staff C confirmed the Tramadol pills for Resident #1 had been in the medication cart and counted at the end of the shift. He was no longer on the medication but the medication remained in the medication cart. On the day of the incident, Staff C reported she completed the narcotic count with Staff A. Staff A said she "took care of the meds" for Resident #1. Staff C stated she didn't think too much about it. The narcotic count was correct. Staff A left after they counted the narcotics. When Staff B came by the desk, Staff C said to Staff B they finally had some room in

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	165580	A. BUILDING _____ B. WING _____	C 12/06/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
URBANDALE HEALTH CARE CENTER	4614 NW 84TH STREET URBANDALE, IA 50322

(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 755	Continued From page 44	F 755		

the medication cart because Staff A said she took care of medication. Staff B asked Staff C what do you mean she took care of the meds? Staff C stated Staff A took care of the Tramadol. Staff B asked Staff C who did she check the medications with? Staff C said I don't know, Staff A said she destroyed them.
Staff C reported whenever a narcotic medication card emptied and taken out of the medication cart, the empty card and controlled drug record placed into the manager's mailbox. Staff B was curious and they went to the manager's mailbox, took out the medication cards and paper inside the mailbox, and looked at the form and the empty cards. Staff C asked Staff B if the initials on the controlled drug record were for Staff B. The initials EW was listed on the form. Staff C reported they spoke to Staff E about what they found. Staff E called Staff A and asked her about the Tramadol. Staff A said she wasted it with Staff B. Staff B said she didn't waste the Tramadol with Staff A or see her waste it. Staff C stated she wrote a statement about the incident before she left work on 9/24/23 AM. Staff C reported she had not worked with Staff A other than receiving a brief report and counting narcotics at shift change. Staff C reported she had not noticed anything unusual or had concerns of staff or noticed Staff A being under the influence of drugs or alcohol.

During an interview on 11/29/23 at 1:20 PM, Staff D, RN, reported she worked the 10 PM- 6 AM shift, and worked all areas. Staff D stated no controlled substance medication wasted unless she dropped a pill or a resident changed their mind and didn't want the medication, then the medication wasted and placed in the drug buster and two licensed staff had to witness the

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	165580	A. BUILDING _____ B. WING _____	C 12/06/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
URBANDALE HEALTH CARE CENTER	4614 NW 84TH STREET URBANDALE, IA 50322

(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 755	Continued From page 45	F 755		

destruction. Staff D reported narcotic counts done at shift change by two staff. She and another staff person counted the number of cards in the medication cart and wrote the count on the narcotic count sheet, then they counted the quantity of pills left of each resident's medication card and compared the number to the controlled drug record. They also signed each controlled drug record form with the quantity left. The on-call manager notified if unable to resolve the discrepancy or figure out what happened. Staff D stated she would call the on-call nurse if she had a concern about staff who appeared under the influence of drugs or alcohol. Narcotics signed out on the narcotic sheet and documented on the MAR when a narcotic given.

During an interview on 11/28/23 at 12:30 PM, Staff E reported she had worked at the facility since 2/1/23. Staff E stated the facility had adjusted their process with controlled substance due to a couple of drug diversions at the facility this past year. The controlled substance medication process entailed both nurses counted the number of medication cards in the medication cart and matched it to the narcotic count sheet in the book, then staff read off the number of pills left in the medication card, and checked the controlled drug record forms to ensure the numbers matched. Both nurses signed off on the narcotic count sheet if the narcotic count correct. Staff E reported she had worked agency at other facilities before and the process was done that way too. The process got adjusted after the state agency visited the facility, and now staff had to sign off on each residents' controlled record form a "count" line and the amount of medication left in the card. Pharmacy delivered controlled substance medication, and the only way to obtain

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	165580	A. BUILDING _____ B. WING _____	C 12/06/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
URBANDALE HEALTH CARE CENTER	4614 NW 84TH STREET URBANDALE, IA 50322

(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 755	Continued From page 46	F 755		

a refill was through the facility's online software program or a fax sent to the pharmacy. The nurse checked the delivery slip and confirmed the medications delivered to the facility, signed the controlled drug record form, and then delivered the medication to the nurse for that unit. The nurse on the unit received the medication and also signed the controlled drug record form. Staff E reported the facility had no automated system for narcotics and no camera in the medication room. Staff E reported only the nurse had keys and access to their assigned medication cart. Anytime they had a transfer in the keys, she expected a narcotic count completed and a "count" signed off on each resident's form. If the nurse chose to take a break, she offered to take their keys and do a narcotic count when the nurse left and returned from break. Staff E acknowledged she worked on the day of the incident with Tramadol. Staff E reported she got called into work the 6-10 PM shift on Station 3. She had just completed the narcotic counts on her medication cart when Staff C came to her with a controlled drug record and medication cards. Staff B came to work at 2:00 PM. Staff B went to B-Bops to get food, and asked Staff A if she wanted anything. It was around 5:00 PM or so. Staff B left the facility and came back with food. Staff C and Staff A completed the narcotic count. Staff A told Staff C oh by the way don't worry about Resident #1's medication, they took care of it. Staff B walked in. Staff B asked Staff C what Staff A meant by Resident #1's meds. Staff B didn't know about Resident #1's medications. Prior to 9/2023, two nurse's destroyed medications. After 9/2023, the empty cards and corresponding sheets placed in the ADON's mailbox outside the office door. Staff B didn't know what she meant and went to the

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	165580	A. BUILDING _____ B. WING _____	C 12/06/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
URBANDALE HEALTH CARE CENTER	4614 NW 84TH STREET URBANDALE, IA 50322

(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 755	Continued From page 47	F 755		

ADON's mailbox and pulled the cards and form out. Staff B said the initials/signature was not hers. Staff E reported when she looked at Resident #1's controlled drug record form it was not Staff B's signature. Staff E stated she does audits all of the time and knows staff signatures/initials. Staff B used the same pen for a period of time. The pen color on the form with staff initials under the medication destruction, was not the same pen color of pen Staff B used and the initials looked different from other signatures of this nurse. Staff E stated she called the DON. The DON called Staff A on speaker phone. The DON asked questions, about if any medication destruction took place on her shift, for which resident, and where the destruction took place. At first Staff A said it took place at the medication cart but then she said it took place in the medication room. Staff A told them Staff B signed off on the destruction of the Tramadol. Staff A asked her what this was about, and what's going on. The DON told her she had to suspend her. Staff A responded ok let me know then. Staff A didn't offer to come in or try to figure out what happened. Staff A had put in her notice, then retracted. She had applied for an ADON job, but then this incident happened. Staff E stated the next day she spoke with Staff F, ADON. Staff F said she told staff and Staff A face to face not to destroy the Tramadol for Resident #1 because he got charged for them and she wanted to hold on it. Staff E thought the resident's medication had changed from scheduled to PRN, but not exactly sure. Staff E reported there were 86 bubble packs with 2 pills in each bubble pack, for a total of 172 pills missing. Staff E reported staff who worked at the facility were also familiar with Staff A from working with her at other facilities. Staff A had injured her shoulder sometime but not at this

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	165580	A. BUILDING _____ B. WING _____	C 12/06/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
URBANDALE HEALTH CARE CENTER	4614 NW 84TH STREET URBANDALE, IA 50322

(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 755	Continued From page 48	F 755		

facility. She made it clear to residents and staff she was in a lot of pain, had a sling on all of the time. She also had financial issues. Staff B told Staff E she never went into the medication room, had no recollection of popping pills from the medication cards, and no recollection of signing the narcotic destruction form. Staff E reported narcotic medications are supposed to be destroyed in the drug buster and witnessed by two nurses. Staff B had a certain pen she used during that time. She had a sparkly blue pen. However, it looked like a black pen was used to sign Staff B's initials. Since incident (with the Tramadol) happened, the facility changed the way the narcotics are handled. No major destructions done by staff. If a pill dropped or the resident refused the medication, the nurses could waste and sign off on this but not an excess number of narcotic pills. Narcotics placed in a double locked lockbox in Station 2's medication room. The DON and ADON had a key to the lock box, and destroyed the narcotics now. The facility also did away with liquid morphine since the prior investigation by State for a drug diversion.

During an interview on 11/29/23 at 11:30 AM, the Director of Nursing (DON) reported she had worked at the facility for a year. The DON stated the process how controlled substances handled: pharmacy delivered medications to the facility. Two nurses counted medications, logged the number of pills, and a "count" documented on each controlled drug sheet. The nurses counted the number of cards in the medication cart, entered the number of cards on the narcotic log sheet and both nurses signed the narcotic log sheet. The DON stated she expected narcotics counted whenever the nurse or certified medication aides had a handover of keys, and

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	165580	A. BUILDING _____ B. WING _____	C 12/06/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
URBANDALE HEALTH CARE CENTER	4614 NW 84TH STREET URBANDALE, IA 50322

(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 755	Continued From page 49	F 755		

both staff signed the narcotic count sheet. The DON reported whenever a controlled substance medication administered, staff documented on the resident's electronic MAR as well as the controlled drug record. The empty medication cards placed in ADON mailbox along with controlled drug sheet for the ADON to review for auditing purposes. The DON reported controlled substances destroyed by two nurses or a nurse and CMA and placed in the drug buster. The date / time when medication destroyed, how much destroyed, and the two nurses who witnessed the waste/destruction is entered on controlled substance log. The DON confirmed no camera in the medication room or by the nurse's station. The DON reported Staff E called her on the day of the incident, 9/23/23. Staff B and Staff C reported to Staff E nobody observed the destruction of Resident #1's Tramadol. Staff E was in the facility working on another unit. Staff A had already left the facility. The DON stated she spoke with Staff B and Staff E. They had retrieved empty medication cards and the signature page for Resident #1's Tramadol. Staff B said she didn't waste the medication with Staff A but her initials had been put on the form as the person who witnessed the medication destruction. Staff B heard Staff C she was told in report by Staff A by the way they took care of the Tramadol. Staff B asked Staff C what do you mean it was taken care of? They went to the ADON's mailbox, pulled out the empty cards and sheet and looked at it. It wasn't Staff B's signature on the form. She called Staff A with Staff E on the call. Staff A didn't answer at first, so she tried to call her again with Staff E on the call. Staff A told them Staff B wasted the Tramadol with her. Staff A said she popped the pills out of the medication cards at medication

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	165580	A. BUILDING _____ B. WING _____	C 12/06/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
URBANDALE HEALTH CARE CENTER	4614 NW 84TH STREET URBANDALE, IA 50322

(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 755	Continued From page 50	F 755		

cart, took the pills into the medication room, and placed the pills in the drug buster. Staff A asked if there's a problem and why the DON asked her questions about it. The DON placed Staff A on immediate suspension due to the circumstances, and no second nurse witnessed or observed the destruction of Tramadol. Staff A responded "Ok let me know when I'm off suspension." The DON reported Staff B told Staff E and the DON she didn't witness any waste or destruction of medication with Staff A that day. Staff A had put notice in at the beginning of 9/2023 for a term date at the end of 9/2023. The DON reported she did not allow Staff A to return to work at the facility. The DON stated she called the administrator and Regional Consultant and started an investigation. She had staff write up statements. No written statement from Staff A because she was suspended. Police contacted and made a report. After this incident, she and ADON's reviewed controlled substance cards and nurse destruction of medications, and checked the PRN controlled substance medications administered. The DON stated Resident #1 had more pain, and his medication got switched from Tramadol to Hydrocodone TID on 9/20/23.

During an interview on 11/28/23 at 5:10 PM, Staff G, CNA, confirmed he worked 9/23/32 on the 2:00 - 10:00 PM shift. Staff G reported he never witnessed a nurse or CMA punching out a number of medications from a medication card, but he doesn't do anything with medications, he focused on the tasks he needed to do in caring for residents. Staff G didn't notice anything on the days he worked with Staff A or other nurses. Staff G stated he had not worked with staff who appeared under the influence of drugs or alcohol but he would report it if had any concerns or

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	165580	A. BUILDING _____ B. WING _____	C 12/06/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
URBANDALE HEALTH CARE CENTER	4614 NW 84TH STREET URBANDALE, IA 50322

(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 755	Continued From page 51	F 755		

suspicion to management.

During an interview on 11/28/23 at 5:20 PM, Staff H, CNA, confirmed he worked the 2-10 PM shift on Station 1 on 9/23/23. Staff H stated he did not observe nursing staff or anyone punching out multiple pills from medication cards on 9/23/23 or other days when he worked. Staff H reported he had not worked with anyone who appeared to be under the influence of drugs or other chemicals that he knew about. He would report to the manager if he had concerns or observed something.

During an interview on 11/28/23 at 5:30 PM, Staff I, CNA, confirmed he worked the 2:00 PM to 6:00 AM shift on 9/23/23, and worked on Station 1 and Station 2. Staff I stated he had not witnessed staff punching a number of medications from medication cards or take medication when he worked. Staff I reported he was not aware of any staff being under the influence of drugs or alcohol at work, but would report it to the charge nurse if he had seen this.

During an interview 11/29/23 at 3:30 PM, Staff F, Licensed Practical Nurse and ADON reported she had worked at the facility 2 ½ years, and 1 ½ years as the ADON for Station 1. Staff F reported she told staff not to discontinue Tramadol or waste Tramadol on Resident #1 because he still had an active order. The ARNP had changed pain medication order to Hydrocodone but the medication had not come from pharmacy and she wanted her staff to give Resident #1 (Tramadol) pain medication until the Hydrocodone arrived. They were headed into the weekend and there was a delay in getting the medication delivered. Staff F stated she told staff face-to-face not to

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	165580	A. BUILDING _____ B. WING _____	C 12/06/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
URBANDALE HEALTH CARE CENTER	4614 NW 84TH STREET URBANDALE, IA 50322

(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 755	Continued From page 52	F 755		

touch the Tramadol or waste it, and ensured it was passed on in report so everyone knew. She worked on Friday 9/22/23 until late in the day. The next day, Staff E notified her via text that Tramadol medication was missing. Staff F reported Staff B and Staff C reported to Staff E Resident #'1 medication documented as wasted but Staff B and her initials on the form, but Staff B didn't witness the destruction of the medication. Staff A told Staff C in report not to worry, they already took care of the medication. After controlled substance medication cards emptied, staff placed the cards and the paper in her mailbox. Staff B checked the form and noticed it wasn't her signature, but her initials written on the form. Staff F reported she expected two nurses counted narcotics at change of each shift. Narcotic cards counted in the cart and enter the number of cards added or removed from the cart on the narcotic count form. Both staff checked the card and verified the amount written on the controlled drug record, and then both nurses signed the form. The nurses also signed the individual resident controlled drug form with the "count" at shift change. Staff F reported only the DON and ADON's wasted the narcotics, since the incident. Staff F reported Staff B had a definitive signature with a certain angle and manuscript. Staff B also used a special pen (blue). Staff F confirmed the initials under the disposition of remaining doses on Resident #1's controlled drug record was not Staff B's initials/ signature. Staff F reported Staff B was adamant it wasn't her ink or her initials.

In a follow-up interview on 12/4/23 at 12:10 PM, Staff B confirmed when she came back from B-Bops, she had to pass by the nurse's station, to get to the breakroom. She handed Staff A some

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	165580	A. BUILDING _____ B. WING _____	C 12/06/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
URBANDALE HEALTH CARE CENTER	4614 NW 84TH STREET URBANDALE, IA 50322

(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 755	Continued From page 53	F 755		

fries, then went to the breakroom to eat her food. Staff A sat by the desk working on the computer. Staff B confirmed Staff A was not by the medication cart or standing by the nurse's station when she returned from B-Bops or her break. Staff B reported after she returned from the breakroom, she recalled she hadn't given Resident #12 her pills so she gave the resident her pills then went to the dining room and passed medications.

During an interview on 12/4/23 at 1:50 PM, Staff E reported no staff conflicts between nurses, Staff A and Staff B and they worked together. Staff E stated Staff B always signed her initials but after the Tramadol incident, she changed the way she signed documents, signing her name instead of just her initials. Staff E reported she expected anytime staff left the building, keys handed over and a narcotic count completed by nursing staff.

Staff education dated 6/21/23, and attended by Staff A, revealed administration of narcotic patches must be completed by a nurse and a second signature of CMA or nurse required on the narcotic log. Two nurses or CMA/nurse observed the destruction of pain patches and placed into the drug buster. Staff education dated 7/26/23 revealed all discontinued medication pulled from the cart immediately and destroyed or sent to pharmacy to prevent medication errors.

A policy for Controlled Substances effective 9/2023 revealed the facility shall comply with all laws and regulations related to handling, disposal, and documentation of controlled substances. The charge nurse on duty maintained the keys to

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	165580	A. BUILDING _____ B. WING _____	C 12/06/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
URBANDALE HEALTH CARE CENTER	4614 NW 84TH STREET URBANDALE, IA 50322

(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 755	Continued From page 54	F 755		

controlled substances. Controlled medications counted at the end of each shift by the on-coming and off-going nurse. Controlled substances disposed of in a secure and safe method per State and Federal guidelines. The policy addressed disposal of Fentanyl patches.

An Abuse Prevention Program revised 8/2022 revealed residents protected from abuse by facility staff. Activities that constitute abuse, exploitation, and misappropriation of resident property included theft of resident's belongings and exploitation of a resident.

2. The hall A Narcotic Count Sheet dated 9/12/23 to 9/25/23 revealed only one staff signature documented 9/18/23 at 2:00 PM and 9/22/23 at 6:00 AM. The hall C Narcotic Count Sheet revealed only one staff signature documented for controlled substance count at shift change on 9/23/23 at 6:00 PM, 9/24/23 at 2:00 PM, 10/1/23 at 6:00 PM and 10:00 PM.

3. The schedule assignment sheet dated 9/22/23 Week 2 revealed shift changes occurred with nursing staff at 6:00 AM, 2:00 PM, 6:00 PM, and 10:00 PM.

The hall A Narcotic Count Sheet revealed narcotic counts occurred on 9/22/23 at 6:00 AM and only the off-duty nurse signed the narcotic count completed. The narcotic count sheet lacked narcotic counts completed 9/22/23 at 2:00 PM, 6:00 PM, and 10:00 PM, and lacked a second staff signature for completion of narcotic count on 9/22/2 at 6:00 AM.

During an interview on 12/1/23 at 10:05 AM, Staff A looked at the narcotic count sheet and staff

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	165580	A. BUILDING _____ B. WING _____	C 12/06/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
URBANDALE HEALTH CARE CENTER	4614 NW 84TH STREET URBANDALE, IA 50322

(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 755	Continued From page 55 assignment sheet for hall A on 9/22/23 and 9/23/23 with the surveyor. Staff A confirmed no second staff signature on 9/22/23 at 6:00 AM to indicate 2 staff verified the narcotic count at change of shift. Staff A also confirmed she had called in on 9/22/23. Staff A reported there should've been narcotic counts each time a different staff person came on duty. There should've been a count 9/22/23 at 6:00 AM with whomever worked the night shift, then at 2:00 PM, then another one at 6:00 PM, and another one at 10:00 PM. In addition, Staff A confirmed the number of cards as 32 on 9/23/23 AM when she counted with off duty nurse. She removed 3 cards for Resident #1 during her shift, so had 29 cards left in the med cart when counted on 9/23/23 at 6:00 PM.	F 755		

Plan of Correction for Urbandale Health Care Center-Provider #165580

Date of Investigation: November 27- December 6, 2023

Plan and/or execution of this plan of correction does not constitute admission or agreement by this provider of the truth of deficiencies. The plan of correction is prepared and executed solely because it is required in accordance with State and Federal Law.

F-656 Develop/Implement Comprehensive Care Plan

- The facility does develop comprehensive care plans.
- All resident care plans have been reviewed for accuracy.
- Nursing management staff have been re-educated regarding building a person-centered care plan starting at admission to include resident's physical, psychosocial, and functional needs and to be reviewed quarterly or if there is a significant change.
- DON/ADON/MDS/Designee will perform audits regarding care plans on admission and reviewing quarterly or with significant changes weekly x 4 and then monthly x 2 with results discussed at QA Meeting for further review of continued compliance.

Responsible Party: DON/ADON/MDS/Designee

Compliance Date: 12.27.23

F-658 Services Provided Meet Professional Standards

- The facility does follow physician's orders for treatments and dressing changes as well as oxygen use.
- All physician orders have been reviewed for accuracy.
- All nursing staff have been re-educated regarding following physician's orders, especially for treatments, dressing changed and oxygen use.
- DON/ADON/Designee will monitor physician's orders for accuracy and completion daily Monday through Friday for 2 weeks, then 3 times weekly for 2 weeks, then weekly thereafter with results discussed at QA Meeting for further review of continued compliance.

Responsible Party: DON/ADON/Designee

Compliance Date: 12.27.23

F-686 Treatment/Services to Prevent/Heal Pressure Ulcer

- The facility does ensure residents reviewed for pressure ulcers received care and services to prevent pressure ulcers from forming.
- Resident #9 care plan has been updated to include risk for altered skin integrity and pressure ulcers. Preventative measures have been added to care plan on 12.7.23.

- All residents' care plans reviewed for skin integrity risk. All residents with skin breakdown have been added to the set sheets on 12.19.23.
- Nursing staff have been re-educated regarding wound policy and identifying residents at risk on the care plan as well as updating set sheets on 12.19.23.
- DON/ADON/Designee will perform audits regarding wound risk identified, care planning, following physician's orders, and updating set sheets weekly x 4 and then monthly x 2 with results discussed at QA Meeting for further review of continued compliance.

Responsible Party: DON/ADON/Designee

Compliance Date: 12.19.23

F-695 Respiratory/Tracheostomy Care and Suctioning

- The facility does ensure residents who need respiratory care are provided oxygen for doctor's appointments.
- Resident #4 oxygen orders have been clarified and staff has been re-educated regarding oxygen use and application including being added to the set sheets on 12.19.23.
- Residents who wear oxygen have the potential to be affected by the alleged deficient practice.
- All residents with oxygen orders have been reviewed for accuracy and completeness.
- Nursing staff have been re-educated regarding following oxygen orders and updating the care plan and set sheet.
- DON/ADON/Designee will perform audits regarding oxygen orders, application, care plan and set sheets updated with follow up weekly x 4 and then monthly x 2 with results discussed at QA Meeting for further review of continued compliance.

Responsible Party: DON/ADON/Designee

Compliance Date: 12.19.23

F-755 Pharmacy Services/Procedures/Pharmacist Records

- The facility does ensure staff accurately record controlled substance medication counts and proper destruction of controlled substances.
- Staff A is no longer working at the facility.
- Licensed nursing staff have been re-educated regarding narcotic count and destruction and added intervention for destruction to happen between DON and ADON going forward.
- DON/ADON/Designee will perform audits regarding narcotic counts, and destruction by DON/ADON weekly x 4 and then monthly x 2 with results discussed at QA Meeting for further review of continued compliance.

Responsible Party: DON/ADON/Designee

Compliance Date: 12.27.23

Respectfully Submitted

Jennifer Reiter- Administrator

515-270-6838