DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

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 12/13/2024

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 ✓ ok/CP	INITIAL COMMENTS Correction Date January 17, 2025 Urbandale Health Care Center is not in substantial compliance with 42 CFR Part 483 Requirements for Long Term Care Facilities. The following deficiencies resulted from facility Complaints #124494-C and #124805-C and Facility Self Reported Incidents #124874-I and #124890-I conducted November 14, 2024 thru December 13, 2024. Complaints #124494-C, and #124805-C were substantiated. Facility Reported Incidents #124874-I, and #124890-I were substantiated. The facility identified a census of 83 residents.	F 000		
F 550 SS=E	Resident Rights/Exercise of Rights CFR(s): 483.10(a)(1)(2)(b)(1)(2) §483.10(a) Resident Rights. The resident has a right to a dignified existence, self-determination, and communication with and access to persons and services inside and outside the facility, including those specified in this section. §483.10(a)(1) A facility must treat each resident with respect and dignity and care for each resident in a manner and in an environment that promotes maintenance or enhancement of his or her quality of life, recognizing each resident's individuality. The facility must protect and promote the rights of the resident. §483.10(a)(2) The facility must provide equal access to quality care regardless of diagnosis, severity of condition, or payment source. A facility must establish and maintain identical policies and	F 550		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE: Administrator | (X6) DATE: 01/14/2025

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

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

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

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

§483.10(b)(2) The resident has the right to be free of interference, coercion, discrimination, and reprisal from the facility in exercising his or her rights and to be supported by the facility in the exercise of his or her rights as required under this subpart.
This REQUIREMENT is not met as evidenced by:
Based on observation, clinical record review, staff interview and facility policy review the facility failed to allow residents to make their own choices (Resident #2) and treat 3 of 3 residents with dignity and respect when they spoke with two (2) residents (Res #7 and #18) and failed to knock and wait for an invitation to enter a residents room/home for 2 residents reviewed (Resident #1 and #2). The facility identified a census of 83 residents.

Finding include:

1. During an interview 11.14.24 at 1:35 p.m. Res #2, identified by the facility as interviewable, indicated she had a problem with Staff B, Certified Nursing Assistant (CNA) who made her

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go to bed when she had not been ready and had been rough with her during direct resident cares.

2. During an interview 12.3.24 at 1:28 p.m. Resident # 7, identified as interviewable by the facility, indicated Staff B presented as rude, disrespectful or unkind. The resident further described a recent incident when she asked the staff member where her call light had been positioned. The staff member then slapped her on the belly and threw her call light/button in the direction of her face which landed on her neck. The resident indicated the incident startled her.

The resident also indicated she witnessed the same staff member as she treated her roommate rude, disrespectful and unkind around the same time but not on the same date. The resident indicated as she sat in her wheel chair on her side of the room she looked at the mirror over the sink and observed the staff member as she transferred her roommate without a required lift device into bed as her roommate cried stop, stop. The staff member then said to the resident, do not start with me now old lady.

During an interview 11.22.24 at 12 p.m. Staff E, Certified Medication Aide (CMA) and CNA confirmed she witnessed random staff as they provided resident cares with an attitude and a poor tone of voice.

3. An observation 11.15.24 at 10:25 a.m. Staff A, Licensed Practical Nurse (LPN) Nurse Manager/Supervisor knocked and walked right into the room of Resident #1 without an invitation to enter. During an interview with the resident at the same time he indicated staff knock and walk right into his room at times which startled him.

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F 550	Continued From page 3 An observation 11.21.24 at 2:21 p.m. revealed Staff P, Activities as he knocked and walked right into the room of Resident #2 without an invitation to enter and while staff flushed and cleansed the resident's supra pubic catheter site. During an interview 12.3.24 at 1:30 p.m. Staff D, CNA confirmed there had been times staff walked directly into resident rooms without knocking and waiting for an invitation to enter. In fact, she had been guilty herself. During an interview 11.22.24 at 12 p.m. Staff E, CNA/CMA confirmed she observed staff as they knocked and walked right into resident rooms uninvited. The staff member stated, what had been the point to knock if a person walked right into the room. 4. An Abuse Policy (not dated) included the following directive: The residents had a right to have been treated with respect and dignity.	F 550		
F 558 SS=E	Reasonable Accommodations Needs/Preferences CFR(s): 483.10(e)(3) §483.10(e)(3) The right to reside and receive services in the facility with reasonable accommodation of resident needs and preferences except when to do so would endanger the health or safety of the resident or other residents. This REQUIREMENT is not met as evidenced by: Based on observation, staff interview, resident interview and facility policy review, the facility	F 558		

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failed to maintain call lights in reach of 4 of 4 residents reviewed. The facility identified a census of 83 residents.

Findings include:

An observation 11.14.24 at 1:10 p.m. revealed the call light light/button positioned on the floor on the left side/window side of the Resident#13's bed while the resident had been positioned in bed and not in reach.

An observation 11.14.24 at 1:24 p.m. revealed a pad type call light as it hung down the left side of the bed of Resident #12. The resident flagged down the surveyor and requested assistance to call his wife. As Staff A, Licensed Practical Nurse (LPN)/Nursing Supervisor/Manager ambulated down the hallway she had been informed the resident required assistance. When asked the resident where his call light had been located he reached for the positioning bar of the bed along wall side. When the call light had been pointed at on the left side of his bed/closest to the door the resident attempted to reach the device but had been unable to do so. During an interview at 1:28 p.m. Staff A confirmed the call light as not in reach.

A photo taken 11.14.24 at 1:29 p.m. revealed the call light/button positioned on the floor to the left of the bed of Resident #13 while she had been positioned in the bed.

During an interview 11.15.24 at 10:25 a.m. Resident #1 confirmed his call light/button had not always within his reach so when that occurred he yelled for assistance. When staff responded he let them have it.

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F 558	Continued From page 5 During an interview 12.5.24 at 1:06 p.m., Staff C, Certified Nursing Assistant (CNA) confirmed every once in awhile she noticed call lights/buttons positioned out of reach of residents. The staff member indicated she noted them hooked to the light fixture or curtain which she described as ridiculous. During an interview 12.3.24 at 1:30 p.m., Staff D, CNA confirmed she found resident call lights/buttons positioned under their bed spreads and out of reach of the residents. During an interview 11.22.24 at 12 p.m. Staff E, Certified Medication Aide (CMA) and CNA indicated the resident's call lights/buttons as not at all in reach of residents. Activities of Daily Living (ADL's) Supporting with revised date of March 2018 directed staff as follows; Residents will be provided care, treatment, and services as appropriate to maintain their ability to carry out activites of daily living.	F 558		
F 584 SS=E	Safe/Clean/Comfortable/Homelike Environment CFR(s): 483.10(i)(1)-(7) §483.10(i) Safe Environment. The resident has a right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely. The facility must provide- §483.10(i)(1) A safe, clean, comfortable, and homelike environment, allowing the resident to use his or her personal belongings to the extent	F 584		

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possible.
(i) This includes ensuring that the resident can receive care and services safely and that the physical layout of the facility maximizes resident independence and does not pose a safety risk.
(ii) The facility shall exercise reasonable care for the protection of the resident's property from loss or theft.

§483.10(i)(2) Housekeeping and maintenance services necessary to maintain a sanitary, orderly, and comfortable interior;

§483.10(i)(3) Clean bed and bath linens that are in good condition;

§483.10(i)(4) Private closet space in each resident room, as specified in §483.90 (e)(2)(iv);

§483.10(i)(5) Adequate and comfortable lighting levels in all areas;

§483.10(i)(6) Comfortable and safe temperature levels. Facilities initially certified after October 1, 1990 must maintain a temperature range of 71 to 81°F; and

§483.10(i)(7) For the maintenance of comfortable sound levels.
This REQUIREMENT is not met as evidenced by:
Based on observation, facility record review, staff interview and facility policy review, the facility failed to provide a clean, sanitary and homelike atmosphere for the residents who resided in the facility and failed to maintain the cleanliness of resident transfer devices. The facility identified a census of 83 residents.

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Findings included:

A photo taken 11.19.24 at 1:45 p.m. revealed a .25 cent size area of dried and hard oatmeal and other food debris on the bedside stand of Resident #3 along with dried food on the floor between the resident's bed and the wall, a brown stain consistent with a bowl movement on the wall beside the resident's bed and a long silver metal tray under the resident's bed with a large amount of a dried black substance with the appearance of dried coffee or a dried loose bowel movement with a dead bug adhered to the area.

During an interview 12.4.24 at 1:25 p.m. Staff G, Licensed Practical Nurse (LPN) described resident's rooms as in disarray.

During an interview 11.22.24 at 12 p.m. Staff E, Certified Nursing Assistant/Certified Medication Aide (CNA/CMA) confirmed she observed dried food in resident rooms.

During a tour of the facility 11.15.24 at 10:36 a.m. noted a long lasting foul odor of urine present on Terrace A hallway.

During a tour of the facility 11.22.24 at 10:30 a.m. noted a long lasting foul odor of urine present on the Terrace A hallway.

During a tour of the facility 11.19.24 at 12:30 p.m. a long lasting foul odor of urine had been present down Generation C hallway.

During an interview 11.22.24 at 12 p.m. Staff E, CNA/CMA confirmed she noted a foul long lasting smell of urine in the Terrace and Generation neighborhoods.

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F 584	Continued From page 8 A Safe Resident Handling/Transfers policy (not dated) indicated the policy assured the facility staff handled and transferred residents safely for prevention or minimized risks for injury and provided and promoted a safe, secure and comfortable experience for the resident. The Compliance Guidelines included the following: a. The lifts would have been cleansed and disinfected according to the manufacturer's instructions and after each resident's use.	F 584		
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 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	F 656		

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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, staff interview and policy review the facility failed implement Care Plans for one (1) resident reviewed (Resident #6) The facility reported a census of 83 residents.

Findings include:

A Minimum Data Sent (MDS) assessment form dated 9.5.24 indicated Resident #6 as dependent on staff with personal hygiene, which included shaving.

A Care Plan with a Focus area revised 11.4.24 indicated the resident required assistance with her activities of daily living (ADL's) due to Multiple

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F 656	Continued From page 10 Sclerosis (MS). The Interventions included the following: a. The resident preferred 1 staff assistance with personal hygiene (revised 11.4.24). An observation 12.3.24 at 2:50 p.m. revealed approximately ¼ to ½ inch long whiskers on her chin. An observation 12.3.24 at 4 p.m. revealed approximately ¼ to ½ inch long whiskers on her chin. During an interview at the same time the resident indicated she wanted them shaved and she had not liked them on her chin. Activities of Daily Living (ADL's) Supporting Policy with revised date March 2018 directed staff as follows; Residents who are unable to carry out activities of daily living independently will receive the services necessary to maintain good nutrition, grooming and person and oral hygiene. Appropriate care and services will be provided for resident who are unable to carry out ADL's independently, with the consent of the resident and in accordance with the plan of care, indcluding appropriate support and assistance with: a. Hygiene (bathing, dressing, grooming, and oral care) b. Mobility (transfer and ambulation, including walking) c. Elimination (toileting) d. Dining (meals and snacks) e. Communication (speech, language, and any functional communication systems).	F 656		
F 658 SS=D	Services Provided Meet Professional Standards CFR(s): 483.21(b)(3)(i)	F 658		

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§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, staff interview and facility policy review, a facility staff member documented she performed a treatment for one (1) resident on the Treatment Administration Record (TAR) (Resident #10) when the treatment had not been performed. The facility identified a census of 83 residents.

Findings include:

A TAR dated 11.1.24 thru 11.30.24 for Resident #10 indicated the resident received a Physician Order dated 10.30.24 as follows:

a. Ammonium Lactate Lotion 12% applied to his bilateral lower extremities (BLE) one time a day (QD) for his Xeroderma (skin condition), covered with a super absorb and non-adherent dressing over the open areas, wrap with Kerlix gauze and secured with Ace Wraps.

On 11.19.24 Staff J, Licensed Practical Nurse (LPN) initialed the treatment as completed.

During an observation and interview 11.20.24 at 2:14 p.m. Staff J, LPN confirmed the bandages on the resident's legs as dated 11.18.24. The staff member confirmed the Physician ordered dressing changes QD.

During clinical record review and an interview on

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F 658	Continued From page 12 11.20.24 at 2:43 p.m. the TAR form dated 11.1.24 thru 11.30.24 for Resident #10 revealed on 11.19.24 Staff J initialed the treatment order which indicated she performed the treatment. When questioned the staff member confirmed she initialed the order because Staff Q, LPN told her she performed the treatment. Administering Medications Policy with revised date December 2012 included directions for staff as follows; a. the individual administering the medication must document such in the Electronic Medication Administration Record (EMAR) system after giving each medication and before administering the next ones. b. the individual administering medications must verify the right resident, right medication, right dosage, rigth time and right method (route) of administration before giving the medication	F 658		
F 677 SS=E	ADL Care Provided for Dependent Residents CFR(s): 483.24(a)(2) §483.24(a)(2) A resident who is unable to carry out activities of daily living receives the necessary services to maintain good nutrition, grooming, and personal and oral hygiene; This REQUIREMENT is not met as evidenced by: Based on observation, clinical record review, staff interview and facility policy review the facility failed to properly transfer one (1) resident who required an assistive device (Resident #18), failed to provide appropriate oral cares for 2 residents reviewed (Resident #4 and #11) and failed to properly groom female resident's facial hair for 1 resident (Resident #6). The facility identified a census of 83 residents.	F 677		

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Findings include:

1. A Quarterly Minimum Data Set (MDS) assessment form dated 11.14.24 indicated Resident #18 with diagnosis that included Non-Alzheimer's Dementia and Venous Insufficiency. The assessment indicated the resident with moderately impaired cognitive skills and as dependent on staff with transfers with an assistive lift device.

A Care Plan identified Focus areas that included the resident sustained an actual fall revised 4.30.24 and required assistance with activities of daily living (ADL's) revised 11.2.23. The Interventions included the following:

a. Staff education provided to have utilized an assistive device when the resident appeared acutely weaker than her baseline (revised 9.10.24).

b. The resident preferred transfers with two (2) staff assistance, a front wheeled walker and a pivot transfer (revised 1.9.22).

During an interview 12.3.24 at 1:28 p.m. Resident #7, identified by the facility as interviewable, indicated she witnessed Staff B, Certified Nursing Assistant (CNA) as she transferred Resident #18 independently and without the use of a required assistive device from her chair to bed as the resident cried out stop, stop.

During an interview 11.22.24 at 12 p.m. Staff E, CNA/Certified Medication Aide (CMA) confirmed she observed random CNA's as they entered and exited resident rooms with an assistive lift device

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so it had been obvious they transferred the resident by themselves.

During an interview 12.5.24 at 3:15 p.m. Staff N, Physical Therapy Director confirmed she expected staff to have transferred a resident with any lift device with two (2) staff assistance.

During an interview 12.5.24 at 1:06 p.m., Staff C, Certified Nursing Assistant/Certified Medication Aide (CNA/CMA) confirmed she witnessed random staff as they transferred residents who require a lift device independently. The staff member also confirmed she felt like in the morning staff rushed to get random residents up for meals and failed to provide appropriate oral cares as she noted guck on resident's teeth.

2. A photo taken 11.21.24 at 2:58 p.m. revealed the denture cup for Resident #11 dated 6.24.24. The photo of the partial plate in the denture cup taken 11.21.24 at 2:59 p.m. revealed the denture plate with a build of a large amount of a brown substance/food particles.

A photo taken 11.21.24 at 2:58 p.m. revealed the only tooth brush present for Resident #4 entangled with a moderate amount of dark colored longer hair from a resident/person's head.

During an interview 11.22.24 at 12 p.m. Staff E, CNA/CMA described resident tooth brushes as disgusting and obviously not used.

3. A Minimum Data Sent (MDS) assessment form dated 9.5.24 indicated Resident #6 as dependent on staff with personal hygiene, which included shaving.

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A Care Plan with a Focus area revised 11.4.24 indicated the resident required assistance with her activities of daily living (ADL's) due to Multiple Sclerosis (MS). The Interventions included the following:

a. The resident preferred one (1) staff assistance with personal hygiene (revised 11.4.24).

An observation 12.3.24 at 2:50 p.m. revealed approximately ¼ to ½ inch long whiskers on her chin.

An observation 12.3.24 at 4 p.m. revealed approximately ¼ to ½ inch long whiskers on her chin. During an interview at the same time the resident indicated she wanted them shaved and she had not liked them on her chin.

According to an email 12.12.24 at 2:31 p.m. the Director of Nursing (DON) expected the facility staff to have groomed/removed female facial hair on shower days and as residents requested.

A Safe Resident Handling/Transfers policy (not dated) indicated the policy assured the facility staff handled and transferred residents safely for prevention or minimized risks for injury and provided and promoted a safe, secure and comfortable experience for the resident. The Compliance Guidelines included the following:

a. Resident lifts and transfers preformed according to the resident's individual plan of care.
b. Staff performed mechanical lifts/transfers according to the manufacturer's instructions for the use of the device.
c. The lifts would have been cleansed and

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F 677	Continued From page 16 disinfected according to the manufacturer's instructions and after each resident's use. The user's manual for assistive lift devices recommended the assistance of 2 staff members when such devices had been used for transfers. An Activities of Daily Living (ADL's), Supporting policy (revised 3.2018) included the following Policy Statement: Resident unable to have carried out ADL's independently received the services necessary to have maintained good nutrition, grooming, personal and oral hygiene. The Policy Interpretation and Implementation included the following: a. Appropriate care and services provided for resident unable to have carried out ADL'S independently, with consent of the resident and in accordance with the plan of care, including the appropriate support and assistance with the following: 1. Hygiene (bathing, dressing, grooming and oral cares).	F 677		
F 684 SS=E	Quality of Care CFR(s): 483.25 § 483.25 Quality of care Quality of care is a fundamental principle that applies to all treatment and care provided to facility residents. Based on the comprehensive assessment of a resident, the facility must ensure that residents receive treatment and care in accordance with professional standards of	F 684		

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practice, the comprehensive person-centered care plan, and the residents' choices.
This REQUIREMENT is not met as evidenced by:
Based on observation, clinical record review, staff interview and facility policy review, the facility staff failed to properly assess 2 of 3 following a fall, an injury and/or change of condition (Resident #5 and #8) and failed to follow Physician orders for 2 of 3 residents reviewed. (Resident #2 and #17) The facility identified a census of 83 residents.

Findings include:

1. A Quarterly Minimum Data Set (MDS) form dated 8.8.24 indicated Resident #8 had diagnosis that included Non-Alzheimer's Dementia, Neurocognitive disorder with Lewy Bodies, muscle weakness, difficulty walking and unsteadiness on her feet. The assessment identified the Resident had severely impaired cognitive skills, short and long term memory deficits, dependent on staff with transfers and non-ambulatory.

A Care Plan identified the resident required staff assistance with her activities of daily living (ADL's) (revised 7.5.22) and transfers due to impaired mobility and at risk for falls (revised 3.16.23). The Interventions included the following areas:

a. Transferred with two (2) staff assistance and an assistive device (revised 6.22.23).
b. Mobility with one (1) staff assistance positioned in a modified wheel chair (revised 10.9.24).

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An Incident Report form dated 11.29.24 at 4:15 p.m. indicated the resident fell in her room and landed on her right side on the floor and sustained a hematoma (a bruise that appeared swollen, discolored and a lump under the skin) on her forehead.

During an interview 12.5.24 at 12:47 p.m. Staff C, CMA/CNA confirmed she worked the afternoon the resident fell. At the time, the resident had been position in her specialized wheel chair in the Terrace B hallway as she became agitated and cried. Staff G, Licensed Practical Nurse (LPN) directed Staff C to take the resident to her to her room as it had been a facility standard of practice when the resident became agitated. Staff C propelled the resident to her room and positioned her with the back of the specialized chair against her bed facing the door and leaned her chair as far back as possible. At the time the resident had not leaned one direction or the other while positioned with wheel chair. The staff member then told her planned to return later. The staff member stated it had not been very long later when she heard a crash and when she entered the resident's room she noted her positioned on her right side on the floor with the wheel chair partially over on it's side, the foot pedal between the resident's legs and the bed side stand was tipped over on the right side. The staff member noted a goose egg size protrusion with bruising as it started to form on the resident's right forehead.

Review of the Resident's Progress Notes revealed staff failed to properly assess the resident per facility policy on the following dates and shifts post fall:

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a. 11.30.24 afternoon/evening shift, 12.1.24 afternoon/evening shift and 12.2.24 all shifts.

A Falls Management System policy (revised 2019) directed the facility staff to have provided follow-up and assessment document for a minimum of every shift for 72 hours.

2. An observation 11.14.24 at 3:19 p.m. revealed the Resident #5 as he propelled through the dining room in his wheel chair Noted Band-Aid on left mid elbow area with dried blood and yellow on the 2 x 2 covered with clear Tegaderm with no date or staff initials. Clinical record review revealed no treatment ordered but an entry in the Progress Notes dated 11.11.24 at 10:36 p.m. the resident sustained a left forearm-small skin tear with no further documentation present pertaining to the resident's skin condition and/or treatment.

A Progress Notes entry dated 11.12.24 at 2:21 p.m. indicated the resident's skin as intact with no dressing changes.

A Progress Notes entry dated 11.13.24 at 6:38 p.m. indicated the resident's skin with scattered bruises/scabs on his bilateral arms with no documentation as to the cause or the skin tear.

A Progress Notes entry dated 11.14.24 at 4:04 p.m. indicated the resident with a left arm skin tear with no further documentation present pertaining to the resident's skin condition and/or treatment.

A photo taken 11.15.24 at 10:57 a.m. revealed a dressing on the left elbow of Resident #5 with the clear covered dressing partially folded up and the white 2 x 2 bandage under the clear dressing 3/4

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covered with dark red blood which circled around a tanish colored drainage.

During an interview 11.14.24 at 4:51 p.m. the resident indicated he had been unaware of when and how he received the open area on his arm covered with a bandage. All he said was "I don't know, I got it here".

An Incident Report dated 11.11.24 at 8:01 p.m., not located in the electronic medical record, rather emailed 11.21.24 at 12:51 p.m. by the Interim Administrator, indicated the resident sustained a skin tear to his left anterior elbow that measured 1.0 centimeters (cm's) by (x) 1.0 cm and 0.1 cm deep with a small amount of thin, serosanguinous exudate caused from placement of his arm between the wheel chair and the wheel. There had been no follow up assessments provided on the form.

Review of the resident's Treatment Administration Record (TAR) dared 11.1.24 thru 11.30.24 revealed no treatment order to the skin tear.

3. A photo taken 11.20.24 at 2:18 p.m. revealed a leg dressing that consisted of gauze and tape for Resident #10 dated 11.18.24.

A Treatment Administration Record (TAR) dated 11.1.24 thru 11.30.24 for Resident #10 indicated the resident received a Physician Order dated 10.30.24 as follows:

a. Ammonium Lactate Lotion 12% applied to his bilateral lower extremities (BLE) one time a day (QD) for his Xeroderma (skin condition), covered with a super absorbed non-adherent dressing over the open areas, wrap with Kerlix

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gauze and secured with Ace Wraps.

During an observation and interview 11.20.24 at 2:14 p.m. Staff J, Licensed Practical Nurse (LPN) confirmed the bandages on the resident's legs as dated 11.18.24. The staff member confirmed the Physician ordered dressing changes every day.

During an interview 11.22.24 at 12 p.m. Staff E, Certified Nurses Aide/Certified Medication Aide (CNA/CMA) indicated she performed random daily resident treatments as prescribed and then had been off work for a couple of days and when she returned her bandage had still been in place as noted by the date and her initials on the bandage

During clinical record review and an interview 11.20.24 at 2:43 p.m. the resident's MAR and TAR dated 11.1.24 thru 11.30.24 revealed on 11.19.24 Staff J initialed the treatment order which indicated she performed the treatment. When questioned the staff member confirmed she initialed the order because Staff Q, LPN told her she performed the treatment.

4. Review of the facilities Medication Administration Times form (not dated) revealed staff had been directed to administer medications within the following time span.

a. Early AM: 5 a.m. 7 a.m.
b. AM (morning): 7 a.m. until 10 a.m.
c. MID (mid day): 11 a.m. until 2 p.m.
d. PM (afternoon/evening): 3 p.m. until 6:30 p.m.
e. HS (hour of sleep): 7 p.m. until 10 p.m.

5. Review of a Medication Administration Audit

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Report form dated 11.20.24 at 4:03 p.m. Resident #2 maintained the following Physician orders to have been administered according to the Medication Administration Record (MAR) dated 11.1.24 thru 11.30.24:

a. Daptomycin Intravenous Solution Reconstituted Use 650 mg intravenously in the evening for positive Vancomycin Resistant Enterococci (VRE) in urine for 12 days: Administered 11.14.24 at 9:47 p.m.

b. Omeprazone, Soifenacin Succcinate, Flonase nasal spray, Meloxicam, Polythylene Glycol Powder, Senna-Docusate Sodium, Cranberry Concentrate, Cholecalciferol, Tizanidine, Baclofen, Buspar, Simethicone, Oxcarbazepine, Duloxetine, Vitamin B12, Lyrica and Midodrine all ordered in the AM but administered on 11.16.24 between 10:31 a.m. and 10:46 a.m.

6. Review of a Medication Administration Audit Report form dated 11.15.24 for Resident #17 revealed the facility staff failed to administer the following medications ordered in the AM.

a. Namenda, Iron, Cymbalta, Pantoprazole, Lidocaine External Patch 4 % and Nandolol all administered at 1:11 p.m.
b. Tylenol, Amlodipine Besylate, Polethylene Glycol 3350 Powder and Vitamin D all administered at 1:12 p.m.

7. An Administering Medications policy revised 12.2012 directed the facility staff medications should have been administered in a safe and timely manner and as prescribed. The Policy Interpretation and Implementation portion

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F 684	Continued From page 23 included the following: a. The individual that administered the medications documented such in the Electronic Medication Administration Record (eMAR)system after each medication administration.	F 684		
F 689 SS=D	Free of Accident Hazards/Supervision/Devices CFR(s): 483.25(d)(1)(2) §483.25(d) Accidents. The facility must ensure that - §483.25(d)(1) The resident environment remains as free of accident hazards as is possible; and §483.25(d)(2)Each resident receives adequate supervision and assistance devices to prevent accidents. This REQUIREMENT is not met as evidenced by: Based on observation and staff interview the facility staff failed to maintain a locked and secured treatment cart and failed to provide appropriate nursing supervision to prevent a fall for one resident.(Resident #8). The facility identified a census of 83 residents. Findings include: On 11.21.24 at a time unknown the Interim Administrator identified 13 residents who wandered in the facility. Observations revealed the following as dated and timed: a. 11.14.24 at 1:11 p.m. a treatment cart in area of emergency crash cart across from nurse's station on the Terrace neighborhood left unlocked	F 689		

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and unattended with no staff present.

b. 11.19.24 at 12:09 p.m. observed the above treatment cart, in the same location, unlocked and unattended.

c. 11.19.24 at 12:59 p.m. observed an unlocked and unattended medication cart positioned along the wall outside the nurse's station across from the emergency crash cart location on Terrace neighborhood.

d. 11.20.24 at 10:04 a.m. Terrace cart B and C had been unlocked and unattended medication cart positioned along the outer wall of the nurse's station.

e. 11.20.24 at approximately. 3 p.m. observed an unlocked and unattended medication cart located along the nurse's station wall on Generation neighborhood.

During an interview 11.22.24 at 12 p.m. Staff E, Certified Medication Aide (CMA) and CNA confirmed she sometimes observed unlocked and unattended medication and treatment carts.

An Administering Medications policy revised 12.2012 directed the facility staff medications should have been administered in a safe and timely manner and as prescribed. The Policy Interpretation and Implementation portion included the following:

a. During the administration of the medications, the medication cart would have been kept closed and locked when out of sight of the nurse or CMA.

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2. A Minimum Data Set Assessment (MDS) form dated 8.8.24 indicated Resident #8 had diagnosis that included Non-Alzheimer's Dementia, Neurocognitive disorder with Lewy Bodies, muscle weakness, difficulty walking and unsteadiness on her feet. The assessment identified the Resident had severely impaired cognitive skills, short and long term memory deficits, dependent on staff with transfers and non-ambulatory.

A Care Plan identified the resident required staff assistance with her activities of daily living (ADL's) (revised 7.5.22) and transfers due to impaired mobility and at risk for falls (revised 3.16.23). The Interventions included the following areas:

a. Transferred with two (2) staff assistance and an assistive device (revised 6.22.23).
b. Mobility with one (1) staff assistance positioned in a modified wheel chair (revised 10.9.24).

An Incident Report form dated 11.29.24 at 4:15 p.m. indicated the resident fell in her room and landed on her right side on the floor and sustained a hematoma (a bruise that appeared swollen, discolored and a lump under the skin) on her forehead.

During an interview 12.5.24 at 12:47 p.m. Staff C, CMA/CNA confirmed she worked the afternoon the resident fell. At the time, the resident had been position in her specialized wheel chair in the Terrace B hallway as she became agitated and cried. Staff G, Licensed Practical Nurse (LPN) directed Staff C to take the resident to her to her room as it had been a facility standard of practice

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F 689	Continued From page 26 when the resident became agitated. Staff C propelled the resident to her room and positioned her with the back of the specialized chair against her bed facing the door and leaned her chair as far back as possible. At the time the resident had not leaned one direction or the other while positioned with wheel chair. The staff member then told her planned to return later. The staff member stated it had not been very long later when she heard a crash and when she entered the resident's room she noted her positioned on her right side on the floor with the wheel chair partially over on it's side, the foot pedal between the resident's legs and the bed side stand was tipped over on the right side. The staff member noted a goose egg size protrusion with bruising as it started to form on the resident's right forehead. The staff member confirmed a resident identified as a fall risk, positioned in a specialized wheel chair and dependent on staff should not have been left unattended in her room. During an interview 12.5.24 at 2:25 p.m. the Director of Nursing (DON)confirmed any resident documented as a fall risk should not have been left unattended in their room and/or rooms.	F 689		
F 755 SS=J	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(f). The facility may permit unlicensed personnel to administer drugs if State law permits, but only under the general supervision of	F 755		

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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 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 observation, clinical record review, staff interview and facility policy review the facility failed to follow professional standards of practice as they allowed the Unit Managers/Supervisors to draw up liquid Morphine (pain medication) and Lorazepam (anti-anxiety medication) in one (1) milliliter (ml) syringes and placed them labeled and unlabeled in the medication carts 3 residents (Res #8, #11 and #13). The staff that drew up the medications failed to dispense the medications and were not licensed pharmacists. The facility also failed to provide sufficient detail to enable an accurate reconciliation and drug records in order

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to account for all controlled drugs. (Res #2 and #13) The facility identified a census of 83 residents.

The State Agency informed the facility of the Immediate Jeopardy (IJ) that began as of November 11, 2024 at 3:21 p.m. The Facility Staff removed the Immediate Jeopardy on November 22, 2024 through the following actions:

a. Assessment of all medication carts and treatment carts for assurance all medications and treatment ointments/creams and etc. were appropriately labeled.

b. Staff education on appropriate labeling and administration of narcotic and anti-anxiety medications.

c. Medication administration education updates dated November 20, 2024.

d. Destruction of all liquid narcotic and anti-anxiety medications on November 15 2024.

e. Pain assessments on all residents completed November 20, 2024.

f. QAPI meeting conducted on November 20, 2024.

g. Assurance of ongoing monitoring and review.

The scope lowered from a "J" to "G" at the time of the survey after ensuring the facility implemented education and their policy and procedures

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Findings include:

1. During an observation and interview 11.20.24 at 10:10 a.m. revealed a plastic container in the Terrace A and B medication cart contained nine (9) unlabeled Morphine syringes as identified by Staff I, Licensed Practical Nurse (LPN) who confirmed the Nurse Managers/Supervisors drew up liquid Morphine and Lorazepam in unlabeled syringes for 2 months.

During an interview 11.20.24 at 10:40 a.m., Staff A, LPN/Nurse Manager/Supervisor confirmed she pre-drew up the liquid Morphine as an estimate to how many a resident may have used in a 24 hour period of time based on the Physician orders. At 10:45 a.m. the staff member confirmed she pre-drew up Resident #13's Morphine syringes, not labeled.

During an interview 11.20.24 at 10:40 p.m., the Interim Director of Nursing (DON) confirmed the above described liquid Morphine for Resident #13 had been pre-drawn on 11.17.24 at which time Staff A changed her verbiage and indicated she drew up resident's Morphine and Lorazepam every 24 hours as needed (PRN).

During an interview 11.20.24 at 11:31 a.m., Staff J, LPN verbalized frustration because she had pulled Staff A aside that morning and told her the above documented practice had not been acceptable.

An email dated 12.20.24 at 1:15 p.m. addressed Staff A pre-drew up liquid Morphine and/or Lorazepam for Resident #8, #11 and #13.

2. Review of the Controlled Drug Record form

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for Resident #2 with the first date of 11.1.24 revealed several open spaces where staff failed to reconcile Pregabalin (Gabapentin) 100 milligram (mg) tablets delivered on 10.25.24 at a count of 90 pills.

According to an email dated 12.13.24 at 12:44 p.m. the Director of Nursing (DON) confirmed the facility staff failed to count the medication with two (2) staff members according to policy and procedure on 11.1.24 ,11.3,11.4, 11.7 thru 11.19, 11.25, 11.29, 11.30 and 12.1 thru 12.4.24.

3. Review of the Controlled Drug Record form for Resident #13 with the first date of 12.3.24 revealed several open spaces where staff failed to reconcile Morphine Sulfate Solution 20 mg/ml. delivered 12.3.24 with the amount of 30 cc/ml in the bottle.

According to an email dated 12.13.24 at 3:17 p.m. the DON confirmed the facility staff failed to count the medication with 2 staff members on 12.3 thru 12.12.2024.

Review of the Controlled Drug Record form for Resident #13 with the first date of 12.10.24 revealed several open spaces where staff failed to reconcile Fentanyl patches.

According to an email dated 12.13.24 at 3:33 p.m. the DON confirmed the facility staff failed to count the medication with 2 staff members 11.23, 11.24, 11.26, 11.27, 11.29, 11.30, 12.1, 12.3, and 12.4.

A Storage of Medications policy revised 4.2007 indicated the Policy Statement included the following:

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The facility should have stored all drugs and biological's in a safe secure and orderly manner.

The Policy Interpretation and Implementation included the following:

a. Drugs and biological's should have been stored in the packaging, containers or other dispensed systems in which received. Only the issuing pharmacy had been authorized to transfer medications between containers.

b. Drug containers that had missing, incomplete, improper or incorrect labels should have been returned to the pharmacy for proper labels before storage.

The facilities Controlled Substances policy revised 12.2021 indicated the Policy Statement included the following:

The facility complied with all laws, regulations and other requirement related to handling, storage, disposal and documentation of Schedule II and other controlled substances.

The Policy Interpretation and Implementation included the following:

a. The Charge Nurse on duty maintained the keys to the controlled substance containers. The Director of Nursing (DON) would maintain the set of back-up keys for all medication storage areas which included the controlled substance containers.

b. Nursing staff must have counted controlled medications at the end of each shifts. The nurse

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F 755	Continued From page 32 that came on duty and the nurse that went off duty counted together. They must have documented and reported any discrepancies to the DON. c. The DON maintained and disseminated to appropriate individuals a lit of personnel who had access to medication storage areas and controlled substance containers.	F 755		
F 761 SS=D	Label/Store Drugs and Biologicals CFR(s): 483.45(g)(h)(1)(2) §483.45(g) Labeling of Drugs and Biologicals Drugs and biologicals used in the facility must be labeled in accordance with currently accepted professional principles, and include the appropriate accessory and cautionary instructions, and the expiration date when applicable. §483.45(h) Storage of Drugs and Biologicals §483.45(h)(1) In accordance with State and Federal laws, the facility must store all drugs and biologicals in locked compartments under proper temperature controls, and permit only authorized personnel to have access to the keys. §483.45(h)(2) The facility must provide separately locked, permanently affixed compartments for storage of controlled drugs listed in Schedule II of the Comprehensive Drug Abuse Prevention and Control Act of 1976 and other drugs subject to abuse, except when the facility uses single unit package drug distribution systems in which the quantity stored is minimal and a missing dose can be readily detected. This REQUIREMENT is not met as evidenced	F 761		

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by:
Based on observation, clinical record review, staff interview and facility policy review the facility failed to label liquid Morphine (narcotic) and Lorazepam (anti-anxiety medications) as expected for 3 of 3 residents reviewed. (Resident #8, #11 and #13) The facility identified a census of 83 residents.

Findings include:

During an observation and interview 11.20.24 at 10:10 a.m. revealed a plastic container in the Terrace A and B medication cart contained nine (9) unlabeled Morphine syringes as identified by Staff I, Licensed Practical Nurse (LPN) who confirmed the Nurse Managers/Supervisors drew up liquid Morphine and Lorazepam in unlabeled syringes for 2 months.

During an interview 11.20.24 at 10:40 a.m., Staff A, LPN/Nurse Manager/Supervisor confirmed she pre-drew up the liquid Morphine as an estimate to how many a resident may have used in a 24 hour period of time based on the Physician orders. At 10:45 a.m. the staff member confirmed she pre-drew up Resident #13's Morphine syringes, not labeled.

During an interview 11.20.24 at 10:40 p.m., the Interim Director of Nursing (DON) confirmed the above described liquid Morphine for Resident #13 had been pre-drawn on 11.17.24 at which time Staff A changed her verbiage and indicated she drew up resident's Morphine and Lorazepam every 24 hours as needed (PRN).

During an interview 11.20.24 at 11:31 a.m., Staff J, LPN verbalized frustration because she had

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pulled Staff A aside that morning and told her the above documented practice had not been acceptable.

An email dated 12.20.24 at 1:15 p.m. addressed Staff A pre-drew up liquid Morphine and/or Lorazepam for Resident #8, #11 and #13.

An observation and interview 11.20.24 at 11:35 a.m. revealed Staff A, Interim DON and the Regional Director of Clinical Operations as they ambulated to the office of Staff A. Staff A unlocked her office door and confirmed herself and the Interim Administrator had keys to her office. All entered the office as Staff A pulled the narcotic box from the file cabinet located next to her desk. The box contained two (2) bottles of liquid Morphine Sulfate. One bottle had no Controlled Drug Record form sheet present and had been opened but not dated when opened with 27 milliliters (ml's) present as confirmed by the Interim DON. Staff began to search for the Controlled Drug record and at 12:30 p.m. found the form on the floor beside the desk.

The 2nd bottle presented as unopened and contained a Controlled Drug Record form which stated the bottle arrived 10.8.24.

During an interview 12.11.24 at 12:13 p.m., Staff A volunteered she heard it right then from nursing school, if you had not drawn up the medication you are not to have administered the medication.

During an interview 11.15.24 at 12:10 p.m., the Interim DON indicated the above documented process went on since prior to December 2023.

During an interview 12.5.24 at 1:06 p.m., Staff C,

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Certified Nursing Assistant/Certified Medication Aide (CNA/CMA) confirmed she administered liquid Morphine and Lorazepam to residents which the facilities Nursing Supervisors/Managers pre-drew up in syringes unlabeled in various medication carts for administration.

During an interview 12.4.24 at 1:25 p.m. Staff G, Licensed Practical Nurse (LPN) confirmed she administered liquid Morphine and Lorazepam to residents which the facilities Nursing Supervisors/Managers pre-drew up in syringes unlabeled in various medication carts for administration.

During an interview 11.22.24 at 12 p.m. Staff E, CNA/CMA confirmed she administered liquid Morphine and Lorazepam to residents which the facilities Nursing Supervisors/Managers pre-drew up in syringes unlabeled in various medication carts for administration.

During an interview 11.20.24 at 10:30 a.m., Staff F, LPN confirmed she liquid Morphine had been pre-drawn and not labeled in the medication carts and she had administered those unlabeled syringes to residents.

During an interview 11.20.24 at 12:55 p.m., Staff J, LPN confirmed the above documented procedure had not been an acceptable standard of practice.

During an interview 11.20.24 at 12:55 p.m. Staff I, LPN indicated the facilities Managers had pre-set up liquid Morphine and Lorazepam since she began employment 2 months prior and she had verbalized concerns about the process with Staff A. The staff member indicated there had been

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times the syringes presented as hand labeled by Staff A but most of the time they contained no labels.

During an interview 11.20.24 at 4:16 p.m., Staff J, LPN/Nurse Manager/Supervisor confirmed she pre-drew up liquid Lorazepam for an unknown resident an verbalized her concern with the procedure to the Interim Administrator. The staff member confirmed she had been aware that only a Pharmacist can pre-set up liquid narcotics and anti-anxiety medications.

An observation and interview 11.20.24 at 11 a.m. revealed Staff I, as she entered the facilities conference room and obtained the keys for two (2) medication carts for Terrace hallway from Staff A, which also contained the narcotic lock box key, from Staff A. Staff A confirmed she failed to count the medications located in the lock box of the said medication cart prior to the forfeit of the keys to Staff I.

A Storage of Medications policy revised 4.2007 indicated the Policy Statement included the following:

The facility should have stored all drugs and biological's in a safe secure and orderly manner.

The Policy Interpretation and Implementation included the following:

a. Drugs and biological's should have been stored in the packaging, containers or other dispensed systems in which received. Only the issuing pharmacy had been authorized to transfer medications between containers.

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F 761	Continued From page 37 b. Drug containers that had missing, incomplete, improper or incorrect labels should have been returned to the pharmacy for proper labels before storage. The facilities Controlled Substances policy revised 12.2021 indicated the Policy Statement included the following: The facility complied with all laws, regulations and other requirement related to handling, storage, disposal and documentation of Schedule II and other controlled substances. The Policy Interpretation and Implementation included the following: a. The Charge Nurse on duty maintained the keys to the controlled substance containers. The Director of Nursing (DON) would maintain the set of back-up keys for all medication storage areas which included the controlled substance containers. b. Nursing staff must have counted controlled medications at the end of each shifts. The nurse that came on duty and the nurse that went off duty counted together. They must have documented and reported any discrepancies to the DON. c. The DON maintained and disseminated to appropriate individuals a lit of personnel who had access to medication storage areas and controlled substance containers.	F 761		
F 880 SS=D	Infection Prevention & Control CFR(s): 483.80(a)(1)(2)(4)(e)(f)	F 880		

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F 880	Continued From page 38 §483.80 Infection Control The facility must establish and maintain an infection prevention and control program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of communicable diseases and infections. §483.80(a) Infection prevention and control program. The facility must establish an infection prevention and control program (IPCP) that must include, at a minimum, the following elements: §483.80(a)(1) A system for preventing, identifying, reporting, investigating, and controlling infections and communicable diseases for all residents, staff, volunteers, visitors, and other individuals providing services under a contractual arrangement based upon the facility assessment conducted according to §483.71 and following accepted national standards; §483.80(a)(2) Written standards, policies, and procedures for the program, which must include, but are not limited to: (i) A system of surveillance designed to identify possible communicable diseases or infections before they can spread to other persons in the facility; (ii) When and to whom possible incidents of communicable disease or infections should be reported; (iii) Standard and transmission-based precautions to be followed to prevent spread of infections; (iv)When and how isolation should be used for a resident; including but not limited to: (A) The type and duration of the isolation,	F 880		

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depending upon the infectious agent or organism involved, and
(B) A requirement that the isolation should be the least restrictive possible for the resident under the circumstances.
(v) The circumstances under which the facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease; and
(vi)The hand hygiene procedures to be followed by staff involved in direct resident contact.

§483.80(a)(4) A system for recording incidents identified under the facility's IPCP and the corrective actions taken by the facility.

§483.80(e) Linens.
Personnel must handle, store, process, and transport linens so as to prevent the spread of infection.

§483.80(f) Annual review.
The facility will conduct an annual review of its IPCP and update their program, as necessary.
This REQUIREMENT is not met as evidenced by:
Based on observation, facility record review, staff interview and facility policy review, the facility staff failed to DONN (put on) Personal Protective Equipment (PPE) while they provided direct resident cares with catheters, PICC lines and open skin treatments for 3 of 3 residents reviewed (Resident #2, #10), and failed to maintain a proper catheter tubing placement as a means to prevent infection for one (1) resident reviewed. (Resident #9) The facility identified a census of 83 residents.

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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 880	Continued From page 40	F 880		

Findings include:

1. A photo dated 11.21.24 at 2:59 p.m. of an Enhanced Barrier Precautions sign posted on resident doors with such precautions included the following PPE directives to DONN when caring for residents:

a. Gloves and gowns worn with the following high contact resident care activities:
1. Dressing, bathing/showering, transfers, linen changes, provision of hygiene, brief changes, toileting assistance, device care or use of a central line, urinary catheter, feeding tube or tracheotomy and wound care.

2. A photo taken 11.21.24 at 2:34 p.m. revealed the above documented signage on the door of Resident #2.

An observation 11.20.24 at 4:30 p.m. revealed Staff O, Registered Nurse (RN) as she entered the resident's room, washed hands and gloved but failed to DONN a gown. The staff member then observed the resident's peripherally inserted central catheter (PICC) line located on her left inner arm dated 11.8.24 and removed the antibiotic bulb attached to the PICC line port, used an alcohol (ETOH) pad and cleansed the port, flushed it with 10 cubic centimeters (CC) of normal saline (NS) and replaced the cap to the PICC line. The staff member then washed her hands, regloved and pulled/removed the resident's PICC line but failed to gown as directed.

An observation 11.21.24 at 2:21 p.m. revealed Staff G, Licensed Practical Nurse (LPN) as she entered the resident's room along with Staff K,

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F 880	Continued From page 41	F 880		

LPN/Nurse Manager/Supervisor. Staff G washed her hands and gloved but failed to DONN a gown. The staff member then poured Acetic Acid into graduate labeled 11.21.24, filled a syringe with 60 cc of Acetic Acid, approached the resident, disconnected the supra pubic catheter from the catheter bag tubing, flushed catheter, reconnected the devices but failed to cleanse the port with ETOH. Staff member then used the same gloved hands and touched the skin around the resident's supra pubic catheter as she stated that she needed to cleanse the site because of drainage. The staff member then proceeded to touch the resident's person, bedding and clothing with the same gloved hands. Staff G. Rachel removed gloves, washed hands and left room to gather supplies to cleanse around the site.

During an interview 11.21.24 at 2:35 P.M. Staff K confirmed Staff G failed to DONN a gown, touched the resident's bedding with the gloved hands and failed to cleanse the catheter connecting site with ETOH. Note: supplies available in a three (3) compartment plastic storage container located in the resident's room/home.

During an observation and interview 11.20.24 at 2:14 p.m. Staff J, LPN entered the room of Resident #10 washed her hands and gloved but failed to DONN a gown as removed a soiled bandage from the resident's left lower leg which contained a small amount of green drainage and then proceeded to perform the treatment as prescribed. During an interview at the same time the staff member confirmed she failed to DONN a gown as expected.

3. A photo taken 11.15.24 at 10:28 a.m. revealed

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F 880	Continued From page 42 the catheter tubing for Resident #9 directly positioned on the floor in his room. 4. During an interview 12.3.24 at 1:30 p.m., Staff D, Certified Nursing Assistant (CNA) confirmed she witnessed some staff failed to properly DONN PPE during provision of direct resident cares with catheters and PICC lines.	F 880		
F 925 SS=E	Maintains Effective Pest Control Program CFR(s): 483.90(i)(4) §483.90(i)(4) Maintain an effective pest control program so that the facility is free of pests and rodents. This REQUIREMENT is not met as evidenced by: Based on observation, facility pesticide invoices and staff interviews, the facility failed to provide a resident environment free of cock roaches. The facility identified a census of 83 residents. Findings include: During an interview 11.22.24 at 12 p.m. Staff E, CNA/CMA confirmed she observed cock roaches everywhere in the facility, in fact she killed a cock roach as it climbed/scattered across her medication cart that morning. The staff member observed cock roaches as they came out of resident sinks and resident rooms, up to and including a dead cock roach in the bed of Resident #20. During an interview 12.12.24 at 2:14 p.m. a family member confirmed he observed an alive cockroach on the sink in his mom's room just the other day.	F 925		

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F 925	Continued From page 43	F 925		

A photo taken 11.22.24 at 12:41 p.m. revealed multiple over 21 dead cock roaches in a trap in room of Resident #19 which is occupied by a resident with multiple cock roaches in a trap.

During an observation and interview 12.3.24 at 1:50 p.m. revealed two (2) house cleaners in room of Resident #19 as they cleaned with the resident positioned in her bed. During an interview Staff L, housekeeper confirmed she observed both dead and alive cock roaches in the resident's room in the traps and in various other places around the room.

During an interview 12.3.24 at 1:52 p.m. Staff M, housekeeper confirmed he observed dead and alive cockroaches on "this end of the building" (200 hallway) but mostly dead.

Review of the facilities extermination invoices as dated below revealed the following information:

a. 10.16.24 from 11:55 a.m. until 1 p.m. - Sprayed a specified insecticide, a broad spectrum chemical that exterminated a variety of vermin including roaches. The operator/applicator also place many sticky traps.

b. 9.20.24 from 1:52 p.m. until 2:52 p.m. - Sprayed a different specified insecticide which targeted mice in the kitchen areas where rodent feeding had been observed. The operator/applicator also applied gel type and a glue board specified insecticide which targeted cock roaches in the kitchen where activity had been observed. The invoice detailed the following infestation information:

1. At 2:40 p.m. - German Roaches found

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F 925	Continued From page 44	F 925		

in the kitchen with an infestation of 11 to 25.

2. 2:40 p.m. - Spiders found in the kitchen with an infestation of 5 to 10.

3. 2:31 p.m. - Rodent feeding/infestation around the exterior parameter of the facility ran at 50-75%.

During an interview 12.12.24 at 11:34 a.m. the exterminator companies manager clarified the following as documented above from the invoices:

a. The pesticides the company utilized the extermination of bugs and vermin had been considered broad spectrum which exterminated basically, everything under the sun. The manager indicated the agents had not been considered a direct kill, rather a residual effect with high activity and when considered a high infestation. The exterminator company had reached out to management staff on various occasions (example maintenance and the Administrator) who indicated they required corporate approval for appropriate treatment and an increase in services to terminate all of the vermin and bugs.

b. Roaches task information had been described as they made a home and regenerate so they observed clumps of roaches in a nesting area of which they commonly preferred a warm environment such as appliances and etc.

c. If the facility staff observed roaches in resident sink drains he described that situation as a pretty bad infestation.

d. The definition of activity found on an invoiced referred to the fact roaches, mice and

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F 925	Continued From page 45 other bugs had been found alive. According to Google A1 Overview (not dated) website cock roaches could have been threat to humans health because they contaminate food, food preparation surfaces, dishes and eating utensils with disease pathogens and could cause infections left behind by cockroaches as the area could have became infected because of the bacteria carried by the pests.	F 925		

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

Date of Investigation: November 14- December 13, 2024

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-550 Resident Rights/Exercise of Rights

- The facility does allow residents to make their own choices and treat them with dignity and respect.
- Resident #2 has been care planned to go to bed at the time of her choice on 1.16.25.
- Resident #2, 7, and 18 have been audited by the guardian angel program and have had no further complaints by 1.14.25.
- Resident #1 no longer resides at the facility.
- All residents have been audited by the guardian angel program with no further complaints and will be care planned if they have specific requests related to their care by 1.14.25.
- All staff have been reeducated regarding resident choice, knocking and waiting for a response prior to entering resident's rooms, and always providing customer service when attending to residents on 12.17.24.
- Admin/DON/SS/Designee will perform audits regarding residents' choice, knocking and waiting for a response prior to entering resident's rooms, and always providing customer service when attending to residents by interviewing residents and observing cares weekly x 4 and then monthly x 2 with results discussed at QA Meeting for further review of continued compliance.

Responsible Party: Admin/DON/SS/Designee

Compliance Date: 1.16.25

F-558 Reasonable Accommodations Needs/Preferences

- The facility does maintain call lights in reach of residents.
- Resident #13 and 12 have been audited by the guardian angel program and have had no further complaints by 1.14.25.
- Resident #1 no longer resides in the facility.

- All residents have been audited by the guardian angel program with no further complaints and will be put through the grievance program going forward if they do have a complaint regarding call light placement by 1.16.25.
- All staff have been educated regarding having call lights within reach on 12.17.24.
- Admin/DON/SS/Designee will perform audits regarding call light placement by observing and rounding weekly x 4 and then monthly x 2 with results discussed at QA Meeting for further review of continued compliance.

Responsible Party: Admin/DON/SS/Designee

Compliance Date: 1.16.25

F-584 Safe/Clean/Comfortable/Homelike Environment

- The facility does provide a clean, sanitary and homelike atmosphere for the residents who reside in the facility and maintain cleanliness of the resident transfer devices.
- Resident #3's room was deep cleaned on 1.16.25.
- Terrace A Hallway and Generations C Hallway have been deep cleaned to remove urine odor on 1.15.25.
- All resident lifts were cleaned on 1.16.25.
- All resident rooms have been cleaned as of 1.16.25. All common areas have been cleaned to remove urine odor on 1.15.25. All resident lifts were cleaned on 1.16.25.
- All staff, including housekeeping staff, have been educated regarding cleanliness of resident rooms, common facility areas being odor controlled, and resident lifts being cleaned after using per manufacture guidelines on 12.17.24.
- Admin/DON/EVS Director/Designee will perform audits of resident rooms, common areas of the facility, and resident lifts by observing weekly x 4 and then monthly x 2 with results discussed at QA Meeting for further review of continued compliance.

Responsible Party: Admin/DON/EVS Director/Designee

Compliance Date: 1.16.25

F-656 Develop/Implement Comprehensive Care Plan

- The facility does implement care plans for residents.
- Resident #6's care plan was reviewed on 1.16.25 and was assisted with having her facial hair shaved on 1.16.25.

- All residents' ADL care plans have been reviewed on 1.16.25 and all residents have been audited for unwanted facial hair and shaved on 1.16.25.
- All nursing staff have been educated regarding ADL assistance and grooming on 12.17.24.
- Admin/DON/DON/Designee will perform audits regarding ADL care plans and grooming by observing and interviewing residents weekly x 4 and then monthly x 2 with results discussed at QA Meeting for further review of continued compliance.

Responsible Party: Admin/DON/Designee

Compliance Date: 1.16.25

F-658 Services Provided Meet Professional Standards

- The facility does document services provided.
- Resident #10 no longer resides at the facility.
- All residents were audited to make sure the ordered treatments were completed and documented on 1.9.25.
- All nurses have been educated regarding completing treatments as ordered and documenting correct and accurate information on 12.17.24.
- Admin/DON/Designee will perform audits by observing treatments completed and documented as ordered weekly x 4 and then monthly x 2 with results discussed at QA Meeting for further review of continued compliance.

Responsible Party: Admin/DON/Designee

Compliance Date: 1.14.25

F-677 ADL Care Provided for Dependent Residents

- The facility does properly transfer residents, provide oral cares, and groom female residents' facial hair.
- Resident #18's set sheet and care plan have been reviewed and updated regarding transfer status on 1.16.25.
- All residents set sheets and care plans have been reviewed and updated regarding transfer status by 1.17.25.
- Resident # 11's denture cup was replaced on 1.17.25.
- All residents have had their denture cups replaced on 1.17.25.

- Resident #6's care plan was reviewed on 1.16.25 and was assisted with having her facial hair shaved on 1.16.25.
- All residents' ADL care plans have been reviewed on 1.16.25 and all residents have been audited for unwanted facial hair and shaved on 1.16.25.
- All nursing staff have been educated regarding transfer status per care plan and proper transfer such as the need for additional staff present, cleaning and replacing denture cups as scheduled, and ADL assistance and grooming on 12.17.24.
- Admin/DON/Designee will perform audits regarding transfers done per regulation, denture cup cleaning and replacement, and ADL assistance and grooming weekly x 4 and then monthly x 2 with results discussed at QA Meeting for further review of continued compliance.

Responsible Party: Admin/DON/Designee

Compliance Date: 1.17.25

F-684 Quality of Care

- The facility does properly assess residents with fall, injury, or change of condition and follows physician's orders.
- Resident #8 has been assessed and has no further concerns related to falling on 1.9.25.
- Resident # 5 has been assessed and has no further concerns related to skin as of on 1.9.25.
- Resident #10 no longer resides at the facility.
- Resident #2's IV meds were completed on 11.21.24.
- Resident #2 has been receiving her meds and the nurse not giving meds timely has been disciplined on 1.17.25.
- Resident #17 has been receiving her meds and the nurse not giving meds timely has been disciplined on 1.17.25.
- All residents have been assessed for injury or concern and documented with no further concerns on 1.17.25.
- All nurses staff have been educated regarding investigation and assessment following a fall, skin concern, and treatments with accurate and complete documentation as well as medication administration and time frames on 12.17.25.
- Admin/DON/Designee will perform audits regarding fall assessments, skin assessments, completing treatments as ordered, ordered medication times

weekly x 4 and then monthly x 2 with results discussed at QA Meeting for further review of continued compliance.

Responsible Party: Admin/DON/Designee

Compliance Date: 1.17.25.

F-689 Free of Accident Hazards/Supervision/Devices

- The facility does maintain a locked and secure treatment cart and provides appropriate nursing supervision to prevent falls.
- Resident #8 has had no negative effects related to unlocked treatment carts and has not been left in the room unattended as of 1.14.25.
- All residents have had no negative effects related to unlocked treatment carts and those care planned not to be left in room unattended have not been left in room alone on 1.14.25.
- All nursing staff have been educated regarding locking medication carts when unattended and not leaving residents in a room unattended if care planned as on 12.17.24.
- Admin/DON/Designee will perform audits regarding medications being locked and residents not being left unattended in the room if care planned weekly x 4 and then monthly x 2 with results discussed at QA Meeting for further review of continued compliance.

Responsible Party: Admin/DON/Designee

Compliance Date: 1.14.25

F-755 Pharmacy Services/Procedures/Pharmacist Records

- The facility does follow professional standards of practice including reconciliation of drug records.
- Resident #2 and 13's drugs in syringes were immediately destroyed by 2 nurses and reordered from pharmacy on 11.20.24. All narcotics in the cart have been counted and reconciled as of 11.20.24.
- All residents receiving liquid medications will have a pain assessment to ensure their pain is being managed on 11.20.24.
- All med carts were assessed to ensure all medications, treatments, ointments and creams were properly labeled and counted on 11.20.24

- All nurses and CMAs received immediate education regarding storage, administration, professional standards, and pharmacy services immediately including not administering any medication that is not properly labeled, only dispensing medication from the pharmacy's original container and counting narcotics every shift change on 11.20.24.
- An ad hoc Quality Assurance and Performance Improvement (QAPI) meeting was conducted to review policy on medication administration, medication storage, pharmacy services, and professional standards on 11.20.24.
- Admin/DON/Designee will perform audits of all medication carts for unlabeled medications and narcotics being counted with each shift change ongoing every Tuesday and Thursday for two months and then monthly for 12 months with results discussed at QA Meeting for further review of continued compliance.

Responsible Party: Admin/DON/Designee

Compliance Date: 11.20.24

F-761 Label/Store Drugs and Biologicals

- The facility does label medications.
- Resident #8, 11, and 13 syringes of medication have been destroyed and reordered from pharmacy on 11.20.24.
- All medication carts were audited for unlabeled medications with no further concerns on 11.20.24.
- All nurses and med aides have been educated regarding medication storage and administration on 11.20.24.
- Admin/DON/Designee will perform audits of all medication carts for unlabeled medications ongoing every Tuesday and Thursday for two months and then monthly for 12 months with results discussed at QA Meeting for further review of continued compliance.

Responsible Party: Admin/DON/Designee

Compliance Date: 1.14.25

F-880 Infection Prevention and Control

- The facility does DONN PPE while providing direct care with residents and maintains proper catheter tubing placement to prevent infection.
- Residents #2 had no adverse effects from improper PPE use as of 1.14.25.
- Resident #10 no longer resides at the facility.

- Resident #9 no longer resides at the facility.
- All residents with isolation have been audited to ensure proper PPE use and catheters are not on the floor on 1.17.25.
- All nursing staff have been educated regarding proper PPE and catheter tubing placement on 12.17.24.
- Admin/DON/Designee will perform audits regarding proper PPE and placement of catheter tubing weekly x 4 and then monthly x 2 with results discussed at QA Meeting for further review of continued compliance.

Responsible Party: Admin/DON/Designee

Compliance Date: 1.17.25

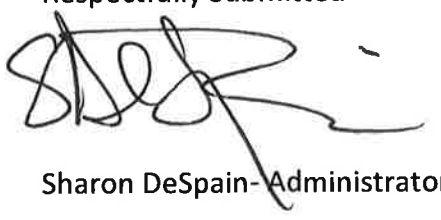
F-925 Maintains Effective Pest Control Program

- The facility does provide an environment free of cock roaches.
- The contract was changed from Terminex to Orkin and Orkin serviced the facility on 12.19.24.
- Orkin will follow up as scheduled on 1.23.25.
- All staff have been educated to report any sighting of pests in TELS for maintenance to address timely on 12.17.25.
- Admin/Maintenance/Designee will perform audits regarding pests in the facility by observation and interviews weekly x 4 and then monthly x 2 with results discussed at QA Meeting for further review of continued compliance.

Responsible Party: Admin/DON/Designee

Compliance Date: 1.14.25

Respectfully Submitted



Sharon DeSpain- Administrator

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