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
	165197	A. BUILDING _____ B. WING _____	C 12/21/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CEDAR FALLS HEALTH CARE CENTER	1728 WEST EIGHTH STREET CEDAR FALLS, IA 50613

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F 000	INITIAL COMMENTS Amended 2/1/23 Correction date: 2/1/23 The following deficiencies resulted from the facility's annual recertification survey and investigation of intakes #108821-C, # 109296-C, #109362-C, #108605-I, #109311-I, #109313-I, #109356-I and #1009384-I conducted December 5, 2022 to December 21, 2022. Complaint #108821 was substantiated. Complaint #109296 was substantiated. Complaint #109362 was substantiated. Facility reported incident #108605 was not substantiated. Facility reported incident #109311 was substantiated. Facility reported incident #109313 was not substantiated. Facility reported incident #109356 was substantiated. Facility reported incident #109384 was substantiated. See Code of Federal Regulations (42CFR) Part 483, Subpart B-C.		The Plan on Correction does not constitute an admission or agreement by Cedar Falls Health Care Center of the truth of the facts alleged or the conclusions set forth in the statement of deficiencies. This plan of correction is prepared solely because it is required by State and Federal law. This plan of correction shall serve as Cedar Falls Health Care Center credible allegation of compliance.	
F 582 SS=D	Medicaid/Medicare Coverage/Liability Notice CFR(s): 483.10(g)(17)(18)(i)-(v) §483.10(g)(17) The facility must-- (i) Inform each Medicaid-eligible resident, in writing, at the time of admission to the nursing facility and when the resident becomes eligible for Medicaid of- (A) The items and services that are included in nursing facility services under the State plan and	F 582	F 582 1. Resident #1 was discharged from the facility on 1/26/23. Resident #206 was discharged from the facility on 8/12/22. Social Services Director or designee will contact resident # 48 to assure beneficiary notice is completed as required on or before 02/01/23. 2. On or before 02/01/23 the Social Services Director or designee will audit skilled care discharges for the last 30 days to validate beneficiary notices were given as required and make corrections as indicated. 3. On or before 02/01/23 the Regional Business of Manager or designee will provide re-education for the Social Services Director and Administrator regarding beneficiary notices.	2/1/23

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Mega Davis | TITLE: Administrator | (X6) DATE: 01/24/2023

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

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F 582	Continued From page 1 for which the resident may not be charged; (B) Those other items and services that the facility offers and for which the resident may be charged, and the amount of charges for those services; and (ii) Inform each Medicaid-eligible resident when changes are made to the items and services specified in §483.10(g)(17)(i)(A) and (B) of this section. §483.10(g)(18) The facility must inform each resident before, or at the time of admission, and periodically during the resident's stay, of services available in the facility and of charges for those services, including any charges for services not covered under Medicare/ Medicaid or by the facility's per diem rate. (i) Where changes in coverage are made to items and services covered by Medicare and/or by the Medicaid State plan, the facility must provide notice to residents of the change as soon as is reasonably possible. (ii) Where changes are made to charges for other items and services that the facility offers, the facility must inform the resident in writing at least 60 days prior to implementation of the change. (iii) If a resident dies or is hospitalized or is transferred and does not return to the facility, the facility must refund to the resident, resident representative, or estate, as applicable, any deposit or charges already paid, less the facility's per diem rate, for the days the resident actually resided or reserved or retained a bed in the facility, regardless of any minimum stay or discharge notice requirements. (iv) The facility must refund to the resident or resident representative any and all refunds due the resident within 30 days from the resident's	F 582	4. The Administrator or designee will audit beneficiary notices weekly for 4 weeks then monthly for 2 months to validate notices continue to be given timely and form is completed accurately. Results of these audits will be taken to monthly QA meeting for 3 months for review and recommendations as needed. Administrator is responsible for monitoring and follow up as needed.	2/1/23

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date of discharge from the facility.
(v) The terms of an admission contract by or on behalf of an individual seeking admission to the facility must not conflict with the requirements of these regulations.
This REQUIREMENT is not met as evidenced by:
Based on clinical record review and staff interviews the facility failed to completely fill out the Skilled Nursing Facility (SNF) Advance Beneficiary Notice (ABN) of Non-coverage form CMS-10055 and Notice of Medicare Non-coverage form (NOMNC) CMS 10123 for 2 of 3 residents reviewed (Residents #1 and #48). The facility reported a census of 55.

1. Resident #1's clinical record lacked a completed Skilled Nursing Facility Advance Beneficiary Notice of Non-coverage form CMS-10055.

The SNF Beneficiary Protection Notice Form completed by the facility indicated that skilled services started on 11/1/22 and ended on 11/25/22 for Resident #1. Resident #1 discharged to the facility. The form included a written statement indicating the person responsible for completing the form failed training. The writer indicated they did not know the proper steps at the time.

2. Resident #48's clinical record lacked a completed Skilled Nursing Facility Advance Beneficiary Notice of Non-coverage form CMS-10055.

The SNF Beneficiary Protection Notice Form completed by the facility indicated that skilled services started on 9/16/22 and ended on

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F 582	Continued From page 3 10/27/22 for Resident #48. Resident #48 discharged to the facility. The form included a written statement indicating the person responsible for completing the form failed training. The writer indicated they did not know the proper steps at the time. On 12/8/22 at 11:40 AM the Social Worker explained that when she filled out the SNF Beneficiary Protection Notification paperwork that she lacked training and did not know which forms needed to be filled out when a resident discharged to home versus staying in the facility. The Social Worker reported that she knew now and would do it in the future.	F 582		
F 600 SS=J	Free from Abuse and Neglect CFR(s): 483.12(a)(1) §483.12 Freedom from Abuse, Neglect, and Exploitation The resident has the right to be free from abuse, neglect, misappropriation of resident property, and exploitation as defined in this subpart. This includes but is not limited to freedom from corporal punishment, involuntary seclusion and any physical or chemical restraint not required to treat the resident's medical symptoms. §483.12(a) The facility must- §483.12(a)(1) Not use verbal, mental, sexual, or physical abuse, corporal punishment, or involuntary seclusion; This REQUIREMENT is not met as evidenced by: Based on observations, clinical record reviews, facility policy review, resident, and staff interviews, the facility failed to ensure 1 of 9	F 600	F 600 1. Resident #22 Care Plan has been reviewed and updated by the DON or designee on 1/13/2023 with interventions regarding his history of physically aggressive behavior to ensure protection of residents and staff from physical abuse. Resident #22 had psych appointments on 12/12/22, 1/11/23 and continues with follow up appointments. Resident #41 remains free from abuse. 2. An audit was completed by the DON/ Designee on 1/18/23 to identify residents with known violent behaviors to ensure their Care Plan has intervention regarding aggressive behavior. 3. Regional Director of Clinical Services or designee educated the Social Service Designee and Director of Nursing on 1/18/23 related to the requirements of implementing a plan of care that includes interventions for residents with aggressive behavior. 4. DON or designee will complete audits of 24-hour Communication Progress Notes Report weekly for 12 weeks to ensure residents with aggressive behavior continue to have Care Plan	

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F 600	Continued From page 4 residents reviewed (Resident #41) was free from physical abuse resulting in injury. The facility failed to put interventions in place for a resident with a known history of violent behavior (Resident #22) to protect residents. This incident constituted immediate jeopardy (IJ) to the resident's health and safety. The Iowa Department of Inspections and Appeals notified the facility of the IJ on 12/8/22 at 1:20 PM. The facility reported a census of 55 residents. Findings include: 1. The admission Minimum Data Set (MDS) dated 10/10/22 for Resident #22 documented an admission date of 10/3/22 from a psychiatric hospital. Resident #22 had Level II Preadmission Screening Resident Review (PASRR) in place. The MDS identified a Brief Interview for Mental Status (BIMS) of 15, indicating intact cognition. The MDS included diagnoses of anxiety, depression, schizophrenia, and dementia with other behavioral disturbances. Resident #22 could independently complete most activities of daily living including ambulation. The Preadmission Screening and Resident Review (PASRR) form completed 9/20/22 by a local hospital behavioral health center revealed Resident #22 had a known behavior of physical aggression. The PASRR documented the admitting nursing facility must incorporate PASRR findings as part of the individual's plan of care. The PASRR further documented that Resident #22 went to the emergency department (ED) at a local hospital behavioral health center the day after he hit a resident at another nursing facility. This had been the third time of being seen in the ED in the previous several days because	F 600	interventions implemented to address the aggressive behaviors. Results of these audits will be presented to the QAPI meeting monthly for 3 months for review and recommendations as needed. The DON is responsible for monitoring and follow up as needed.	1/18/23

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Resident #22 chose not to take his medications and had been physically forceful with others. The resident admitted to the hospital under an emergency detention order by the State District Court of the local county after a petition had been filed by the hospital alleging the resident to be seriously mentally impaired and a harm to himself and others. A copy of the court order had been provided with the PASRR assessment. Staff at the prior nursing home documented that they did not feel Resident #22 was safe to be around others due to his physical behaviors. The PASRR included that he told his doctor that he believed that someone poisoned his food, that he heard noises that other people did not hear and voices in his head. Resident #22 had a history of talking to himself, quickly changing moods, irritability, being rude, screaming, yelling, threatening, physically forceful with others, slamming doors, restlessness, demanding of others, and seeking attention from others.

Resident #22's Care Plan revised 10/27/22 revealed the resident had the potential to demonstrate verbally abusive behaviors such as yelling and having loud outbursts related to dementia. Resident #22 had ineffective coping skills and a mental/emotional illness such as schizophrenia. Resident #22 could sometimes have behaviors or hallucinations where he might yell rambled words. In addition he can also yell and be verbally abusive toward staff and or residents at times. The Care Plan included the following interventions:
a. Staff to intervene when he became agitated before the agitation escalated, guide away from the source of distress, and engage calmly in conversation. If Resident #22 responded aggressively, the staff should calmly walk away

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and approach later.

The Care Plan dated 10/27/22 identified Resident #22 had a psychosocial well-being problem (actual or potential) related to the disease process of schizophrenia, dementia, intellectual disability, anxiety, and ineffective coping. The Care Plan included the following interventions dated 10/27/22:
a. When conflict arises, remove the Resident to a calm safe environment and allow him to vent/share feelings.
b. The Resident needs assistance, encouragement, and support to identify problems that cannot be controlled.
c. Allow the Resident time to answer questions, verbalize feelings, perceptions, and fears frequently.
The Care Plan lacked direction in regards to potential violent behavior towards others, incorporation of the PASRR recommendations, and how to provide safety for the staff and other residents.

2. The quarterly MDS for Resident #41 identified a BIMS score of 15, indicating intact cognition. The MDS documented included diagnoses of anxiety, depression and cancer. Resident #41 was independent with activities of daily living (ADLs).

Resident #41's Care Plan revised 11/15/22 documented that Resident #41 had a psychosocial well-being problem (actual or potential) related to diagnoses of anxiety disorder and depression disorder. The Care Plan included an intervention of when conflict arises, remove to a calm, safe environment, and allow him to vent/share his feelings.

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During an interview 12/5/22 at 12:52 PM, Resident #41 revealed that Resident #22 came up to him recently and said he was mad at him for something. Resident #41 stated two days later Resident #22 came up to him, punched him in the left eye, and said "there you go." Resident #41 stated after Resident #22 hit him, he held his face and walked away from him. Resident #41 further stated that he never did anything to Resident #22 and that he shouldn't be doing that to people. Resident #41 stated he had to have an eye procedure rescheduled due to the swelling from being punched in the eye by Resident #22 and stated the area hurt when he touched it.

The Facility Incident Report dated 11/26/22 at 12:00 PM completed by Staff L, Licensed Practical Nurse (LPN), indicated that a Certified Medication Aide (CMA) called the nurses to the front nurses' station and informed them that Resident #22 hit Resident #41. The Incident Report further documented when the nurses went to Resident #22's room they observed him with a bruise and a big lump under his left eye. Resident #41 informed them that Resident #22 hit him.

During an interview on 12/7/22 at 10:14 AM, Staff E, CMA, reported that on Thanksgiving Day she worked the C/D hall when she heard Resident #41 yelling. She stated that she saw Resident #22 in front of Resident #41 punching into the air in front of him screaming, "I'm going to kill you! I'm going to kill you!" Staff E explained that she left the medication cart to separate the two residents and directed Resident #41 to sit back down in the chair, in which he did. Staff E stated that she went back to the medication cart to complete the narcotic count. Staff E stated she

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then heard Resident #22 holler out again and as she turned around from the medication cart she saw Resident #22 hit Resident #41 in the eye. Staff E stated that she couldn't remember which eye was hit or which hand Resident #22 used but Resident #41's eye was black the Saturday after Thanksgiving.

The facility policy titled, Abuse Prevention and Reporting, revised August 2019 revealed residents must not be subjected to abuse by anyone including other residents. The policy directed staff to identify, correct, and intervene in situations where resident to resident abuse is most likely to occur and provide protection by immediately separating the residents involved, moving the resident to another room or unit, providing 1:1 monitoring as appropriate, implementing discharge process immediately if the resident is a danger to themselves or others and initiating behavior crisis management interventions as applicable.

During an interview on 12/13/22 at 9:35 AM, the Director of Nursing (DON) reported that if Resident #22 was being that aggressive toward Resident #41, she would have separated the two completely to a different room and contacted the provider in regards to the behavior including directing the use of as needed medication, contacting psychiatry and most likely starting a one on one (1:1). The DON further revealed that she expected the staff to intervene in order to prevent abuse, to give Resident #22 space, then ensure residents and staff stay away from him. The DON added Staff G, Registered Nurse (RN), remained sore after being hit by Resident #22.

During an interview on 12/19/22 at 11:24 AM, the

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Administrator revealed it is an expectation that staff keep residents safe from abuse by intervening when needed, following policy, reporting to the Director of Nursing and/or Administrator as needed.

The Abuse Prevention and Reporting Policy, dated August 2019, provided by the facility stated the facility prohibited the mistreatment, neglect, and abuse of resident, and misappropriation of resident property by anyone including but not limited to staff, family, or friends. Residents have the right to be free from verbal, sexual, and mental abuse, neglect, misappropriation of resident property, corporal punishment, involuntary seclusion, and any physical or chemical restraint not required to treat the resident's medical symptoms. The Policy defined Resident to Resident abuse as resident to resident physical contact that occurs, which includes but is not limited to where residents are hit, slapped, pinched or kicked and results in physical harm, pain or mental anguish. The Policy directed the staff to provide for the immediate safety of the resident upon identification of suspected abuse, neglect or mistreatment by immediately separating the resident from the alleged perpetrator, moving resident to another room, providing 1:1 monitoring as appropriate and implementing discharge processes immediately if the resident is a danger to self or to others.

During an interview on 12/5/22 at 11:04 AM Resident #25 reported that Resident #22 at the end of her hallway is dangerous. He is hitting everyone. He punched a guy that lives on the A hallway. We should not have to live in danger every day. The staff lets him do whatever he

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wants to do because they are all afraid of him.

During an interview on 12/5/22 at 11:05 AM Resident #16 reported she is tired of living in fear and shouldn't have to live in fear every day.

On 12/12/22 at 3:48 PM the Administrator provided additional documentation of staff education for 1:1 supervision to all staff and updated the education on handling agitated/aggressive behaviors to ensure staff had received the required information. The Administrator or her Designees provided staff education on-site and via telephone to employees regarding the requirements of 1:1 supervision. The facility implemented the use of walkie talkies to communicate if someone needed to come takeover 1:1 supervision for Resident #22. They revised the daily wing schedules to assign the employee responsible for providing the 1:1 supervision and implemented the use of a sign in/out sheet for those staff providing the 1:1 supervision. The 1:1 supervision education specified Resident #22 to be under supervision at all times. When the Resident is in his room staff may remain outside of the room door. If the Resident is in the hallway, they must be within arms-length of the Resident. The Plan was submitted to the Surveyor via email at 3:48 PM.

During an interview on 12/13/22 at 6:03 AM Staff Z, CNA, reported that she had been assigned to do one to one supervision for Resident #22. She reported she had been with him from 11:00 PM until 6:00 AM that morning. He had been in the front lounge until around midnight, then he went back to his room, and went to bed. Resident #22 slept from midnight to 5 AM, when she reported at 5 AM she got him up and brought him out to

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the dining room for coffee and cookies. Resident #22 observed at this time sitting at the dining room table drinking coffee and eating cookies, under 1:1 supervision.

During an interview on 12/13/22 at 6:13 AM Staff X reported they were able to monitor Resident #22 with 1:1 for supervision during the night. He reported the resident had a good night sleeping from midnight to 5 AM which is his normal routine. He reported he planned to talk with the Director of Nursing (DON) and Administrator about covering the resident's mirror or taking the mirrors out of the room since the mirror seems to trigger his screaming and yelling.

During an interview on 12/13/22 at 9:35 AM the Director of Nursing (DON) reported if a resident is aggressive the resident should be separated back to a different room. The physician should be contacted to give direction on what to do. She would probably put the resident on one to one supervision. When Resident #22 was at the hospital. They had done medication management on him and he didn't have behaviors and had been pleasant. He had bouts in front of the mirror but did not have physical aggression with anyone. She said there were no changes in the Care Plan after the staff observed him air punching, punching the back of the couches, and the door. She told the staff that his sister-in-law was very adamant that he has to get his medications to stay stable for his mental condition. If he didn't take his medications, they would re-approach him, and find a different staff member to try to get his medication administered. If that was unsuccessful, the staff were to try to call the sister-in-law to see if she could convince him to take his medications. The last resort is to call the

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CEDAR FALLS HEALTH CARE CENTER	1728 WEST EIGHTH STREET CEDAR FALLS, IA 50613

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DON to come give his medication. He has a delusional thought process. Some employees state they will not intervene as they do not want to get hit, but she has educated if any other residents come within the vicinity of Resident #22 they need to try to keep the other resident out of Resident #22's space.

The Behavioral Management, Care Management Reference Anger and Aggression Policy dated 5/15 provided by the facility as a policy for accident/supervision documented the following approaches to be utilized:
Dementia and/or related disorders:
1. Rule out potential causes of delirium or infection
2. Respond to cues of stress
3. Evaluate for pain, hunger and need to toilet
4. Reduce potential for injury
5. Plan for regular exercise
6. Be consistent

Psychiatric Disorder:
1. Maintain a safe distance for caregivers and other resident/patients and visitors
2. Remove dangerous objects as able
3. Evaluate for depression and/or psychosis
4. Utilize behavior tracking records to determine time, place, possible triggers and meanings of behavior
5. Listen and validate feelings related to loss and grief
6. Acknowledge anger
7. Avoid rationalization and arguments
8. Include resident/patient and family/responsible party in planning the day and associated cares as much as possible; allow the resident/patient to have control over decisions as much as possible

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F 600	Continued From page 13 The Facility abated the immediate jeopardy on 12/12/22, decreasing the scope and severity to a "D" level deficiency.	F 600		
F 623 SS=B	Notice Requirements Before Transfer/Discharge CFR(s): 483.15(c)(3)-(6)(8) §483.15(c)(3) Notice before transfer. Before a facility transfers or discharges a resident, the facility must- (i) Notify the resident and the resident's representative(s) of the transfer or discharge and the reasons for the move in writing and in a language and manner they understand. The facility must send a copy of the notice to a representative of the Office of the State Long-Term Care Ombudsman. (ii) Record the reasons for the transfer or discharge in the resident's medical record in accordance with paragraph (c)(2) of this section; and (iii) Include in the notice the items described in paragraph (c)(5) of this section. §483.15(c)(4) Timing of the notice. (i) Except as specified in paragraphs (c)(4)(ii) and (c)(8) of this section, the notice of transfer or discharge required under this section must be made by the facility at least 30 days before the resident is transferred or discharged. (ii) Notice must be made as soon as practicable before transfer or discharge when- (A) The safety of individuals in the facility would be endangered under paragraph (c)(1)(i)(C) of this section; (B) The health of individuals in the facility would be endangered, under paragraph (c)(1)(i)(D) of this section; (C) The resident's health improves sufficiently to	F 623	F 623 1. On or before 02/01/23 the Administrator notified the Ombudsman of discharge for resident # 14. 2. On or before 02/01/23 the Administrator or designee will audit discharges for December 2022 and January 2023 to validate the Ombudsman was notified and complete notifications as needed. 3. On or before 02/01/23 the Regional Director of Clinical Services or designee re-educated the Administrator, Business Office Manager and Director of Nursing regarding process for Ombudsman notifications. 4. Administrator or designee will audit weekly for 4 weeks then monthly for 2 months to validate the Ombudsman notifications continues to be completed as required. Results of these audits will be presented to the QAPI meeting monthly for 3 months for review and recommendations as needed. The Administrator is responsible for monitoring and follow up as needed.	2/1/23

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allow a more immediate transfer or discharge, under paragraph (c)(1)(i)(B) of this section;
(D) An immediate transfer or discharge is required by the resident's urgent medical needs, under paragraph (c)(1)(i)(A) of this section; or
(E) A resident has not resided in the facility for 30 days.

§483.15(c)(5) Contents of the notice. The written notice specified in paragraph (c)(3) of this section must include the following:
(i) The reason for transfer or discharge;
(ii) The effective date of transfer or discharge;
(iii) The location to which the resident is transferred or discharged;
(iv) A statement of the resident's appeal rights, including the name, address (mailing and email), and telephone number of the entity which receives such requests; and information on how to obtain an appeal form and assistance in completing the form and submitting the appeal hearing request;
(v) The name, address (mailing and email) and telephone number of the Office of the State Long-Term Care Ombudsman;
(vi) For nursing facility residents with intellectual and developmental disabilities or related disabilities, the mailing and email address and telephone number of the agency responsible for the protection and advocacy of individuals with developmental disabilities established under Part C of the Developmental Disabilities Assistance and Bill of Rights Act of 2000 (Pub. L. 106-402, codified at 42 U.S.C. 15001 et seq.); and
(vii) For nursing facility residents with a mental disorder or related disabilities, the mailing and email address and telephone number of the agency responsible for the protection and

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advocacy of individuals with a mental disorder established under the Protection and Advocacy for Mentally Ill Individuals Act.

§483.15(c)(6) Changes to the notice.
If the information in the notice changes prior to effecting the transfer or discharge, the facility must update the recipients of the notice as soon as practicable once the updated information becomes available.

§483.15(c)(8) Notice in advance of facility closure
In the case of facility closure, the individual who is the administrator of the facility must provide written notification prior to the impending closure to the State Survey Agency, the Office of the State Long-Term Care Ombudsman, residents of the facility, and the resident representatives, as well as the plan for the transfer and adequate relocation of the residents, as required at § 483.70(l).
This REQUIREMENT is not met as evidenced by:
Based on clinical record review and staff interview the facility failed to inform the Long-Term Care Ombudsman office of a Resident discharge from the facility for 1 of 1 Resident's reviewed (Resident #14) for hospitalization. The facility identified a census of 55 residents.

Findings include:

A review of the Electronic Health Record Census documented Resident #14 as out to the hospital on 9/24/22 and readmitted to the facility on 9/27/22.

The Facility failed to have documentation showing

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F 623	Continued From page 16 the LTC Ombudsman Office had been notified of the Resident's discharge. During an interview on 12/07/22 at 10:13 a.m. the Social Worker reported she had come on staff at the facility in June 2022. She reported she had not been aware she needed to notify the Long-Term Care Ombudsman of discharges from the facility. She stated she had just learned that today and she had reached out to try to get some direction on how to get that done. During an interview on 12/07/22 at 10:13 a.m. the Administrator reported they had not been notifying the Long-Term Care Ombudsman office discharges from the facility and they had failed at that one, but were working to get back in compliance. An email from the Administrator on 12/07/22 at 10:16 a.m. documented the facility had not been completing the Veteran Administration checks, but were working on going forward.	F 623		
F 625 SS=B	Notice of Bed Hold Policy Before/Upon Trnsfr CFR(s): 483.15(d)(1)(2) §483.15(d) Notice of bed-hold policy and return- §483.15(d)(1) Notice before transfer. Before a nursing facility transfers a resident to a hospital or the resident goes on therapeutic leave, the nursing facility must provide written information to the resident or resident representative that specifies- (i) The duration of the state bed-hold policy, if any, during which the resident is permitted to return and resume residence in the nursing facility;	F 625	F 625 1. On or before 02/01/2023 the Administrator or designee will assure bed hold information has been provided to resident # 14. 2. On or before 02/01/23 the Administrator or designee will audit discharges for the past 30 days to validate bed hold information was provided to the resident/POA any concerns were addressed at the time of the audit. 3. On or before 02/01/2023 the Administrator or designee will re-educate the licensed nurses regarding bed hold policy/process to be used at the time of discharge. 4. The Administrator or designee will complete audits of discharges weekly for 12 weeks to assure bed hold information continues to be provided as required . Results of these audits	

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F 625	Continued From page 17 (ii) The reserve bed payment policy in the state plan, under § 447.40 of this chapter, if any; (iii) The nursing facility's policies regarding bed-hold periods, which must be consistent with paragraph (e)(1) of this section, permitting a resident to return; and (iv) The information specified in paragraph (e)(1) of this section. §483.15(d)(2) Bed-hold notice upon transfer. At the time of transfer of a resident for hospitalization or therapeutic leave, a nursing facility must provide to the resident and the resident representative written notice which specifies the duration of the bed-hold policy described in paragraph (d)(1) of this section. This REQUIREMENT is not met as evidenced by: Based on clinical record review and staff interview the facility failed to provide a bed hold to 1 of 1 Resident (Resident #14) within 24 hours of leaving the facility and being admitted to the hospital. The facility identified a census of 55 residents. Findings include: A review of the Electronic Health Record Census documented Resident #14 had been sent out to the local emergency department on 9/24/22 and readmitted to the facility on 9/27/22. The facility failed to have documentation to show a bed hold had been provided to the Resident or the Resident's legal representative. During an interview on 12/07/22 at 10:13 a.m. the Social Worker reported she had not been aware that she needed to serve a bed hold notice when	F 625	will be presented to the QAPI meeting monthly for 3 months for review and recommendations as needed. The Administrator is responsible for monitoring and follow up as needed.	2/1/23

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F 625	Continued From page 18 a resident discharges from the facility. She reported she would start doing that going forward.	F 625		
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 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	F 656	F 656 1. Resident #22' care plan was reviewed and updated on 12/8/22 and 01/13/23 by the Social Services /Designee to include interventions for aggressive behaviors. 2. On or before 02/01/23 the Social Services / Designee will audit care plans for residents with a history of aggressive behaviors to ensure care plan interventions have been implemented. Any concerns identified will be addressed at the time of the audit. 3. On or before 02/01/23 the DON or designee will re-educate the Social Services Director/ Designee regarding the requirements of implementing care plan interventions to meet the residents needs including interventions for aggressive behaviors. 4. Social Services or designee will complete audits weekly for 4 weeks then monthly for 2 months to validate care plan interventions continue to be implemented for residents with aggressive behaviors. Results of these audits will be presented to the QAPI meeting monthly for 3 months for review and recommendations as needed. The Administrator is responsible for monitoring and follow up as needed.	2/1/23

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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 observation, clinical record review and staff interview the facility failed to develop a comprehensive care plan incorporating the Preadmission Screening and Resident Review (PASRR) behaviors for physical aggression for 1 of 17 residents (Resident #22 sampled). The facility reported a census of 55 residents.

Findings include:

An Electronic Health Care Census Record showed Resident #22 admitted to the facility on 10/03/22.

A Review of the PASRR completed by a local hospital behavioral health center with a determination date of 9/20/22 revealed Resident #22 had a known behavior of physical aggression. The PASRR documented the admitting nursing facility must incorporate PASRR findings as part of the individual's plan of care. The PASRR further documented Resident #22 had been taken to the emergency department (ED) at a local hospital behavioral health center the day after he hit a resident at another nursing facility. This had been the third tine the resident

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had been seen in the ED in the previous several days because Resident #22 chose not to take their medications and had been physically forceful with others. The Resident had been admitted under an emergency detention order by the Iowa District Court of the local county after a petition had been filed by the hospital alleging the Resident to be seriously mentally impaired and a harm to themselves and others. A copy of the court order had been provided with the PASRR assessment. Staff at the prior nursing had documented they did not feel Resident #22 was safe to be around others. The PASRR documented Resident #22 with behaviors of believing things that are not true, belief that the food is poisoned, hearing noises that other people do not hear and voice in their head, talking to yourself, quickly changing moods, irritability, being rude, screaming, yelling, threatening and being physically forceful with other, slamming doors, restlessness, being demanding of others and seeking attention from others.

The Baseline Care Plan dated 10/03/22 documented Resident #22 had hit a resident at another facility and directed the staff to monitor the Resident and watch out for aggressive behaviors. The Baseline Care Plan gave no other behavior intervention direction to the staff in how to monitor him.

The Minimum Data Set (MDS) dated 10/10/22 showed a Brief Interview for Mental Status (BIMS) score of 15 indicating intact cognition. The MDS documented Resident #22 did not exhibit evidence of a change of condition, inattention (being easily distractible or having difficulty keeping track of what was said), disorganized thinking ((rambling or irrelevant

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conversation, unclear or illogical flow of ideas, or unpredictable switching from subject to subject), altered level of consciousness, hallucinations or delusions. The Resident was independently ambulatory with a walker. The MDS listed a diagnosis of schizophrenia, anxiety and depression.

The Care Plan dated 10/27/22 identified Resident #22 had a psychosocial well-being problem (actual or potential) related to the disease process of schizophrenia, dementia, intellectual disability, anxiety, and ineffective coping. The Care Plan directed the staff in the following:
1. Allow the Resident time to answer questions and to verbalize feelings perceptions, and fears frequently, dated
10/27/22.
2. The Resident needs assistance, encouragement, and support to identify problems that cannot be controlled, dated
10/27/22.
3. When conflict arises, remove the Resident to a calm safe environment and allow to vent/share feelings, dated
10/27/22.

The Care Plan dated 10/27/22 contained a focus problem that Resident #22 had potential to demonstrate verbally abusive behaviors such as yelling and having loud outbursts related to dementia, ineffective coping skills and mental/emotional illness such as Schizophrenia. The Care Plan directed the staff in the following interventions:
1. When Resident #22 becomes agitated, intervene before agitation escalates, guide away from source of distress
and engage calmly in conversation. If

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response is aggressive, staff should walk calmly away and approach later,
dated 10/27/22.

During an interview on 12/05/22 at 12:00 p.m. Staff F, Certified Nursing Assistant (C.N.A.) stated management do not give any direction. Resident #22 punched Resident #41 last week. Resident #22 is petrifying. She can usually get him calmed down but if he comes out on a rampage they just let him go because they don't want to get in his way. It's been going on for over a month. The nurses know about it. She said lately he has been punching the walls and screaming into the mirror. Resident #22 came from a locked unit.

During an interview on 12/05/22 at 12:56 p.m. Staff F reported Resident #22 has had behaviors of screaming/yelling, hitting the walls since he admitted. He will say things like, "No God damn it. Don't shit in my mouth." He sounds like he has another resident inside of him. He hits the wall so hard his knuckles bleed and he has had to go get band aids. He hit another resident about a week ago. He has been in the lounge punching the back of the couch. She is not sure if other residents are afraid of him. She feels he could hit another resident. You can hear other resident yelling at him. She doesn't feel like they get any direction from management on how to intervene with the resident.

During an observation on 12/05/22 at 1:02 p.m. Resident #22 walked behind a male resident in the wheelchair stating, "I'm going to kill him. I'm going to kill him." He did not make any movements toward the male in the wheelchair in front of him. Staff F intervened. He walked with

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using a wheeled walker behind the resident through the double doors of the D hallway, through the dining room and into the C hallway. He did not make any physical gestures and did not make any more verbal remarks. Staff F stated it has crossed her mind that Resident #22 could hurt her, but it hasn't happened, but it has crossed her mind that he could physically hurt her.

The Care Plan failed to address Resident #22 had violent aggressive behaviors incorporating the PASRR and direct the staff on how to keep Resident #22 and all other residents safe from start of admission on 10/03/22.

During an interview on 12/19/22 at 1:57 p.m. the DON reported she expects when they do stand up meetings if there is something that needs to be put in the resident, the care plan will be updated. If staff are reporting, for example, new wounds or behaviors, she would expect that information to be in the plan of care. The goal is to get to the point where the care plans can be updated day to day.

The Care Plan Development Policy dated 8/15 provided by the facility directed an interim care plan would be developed within 24 hours of admission. To assure resident's immediate needs are met this care plan will be initiated by nursing or the designee and developed further as needed until the comprehensive plan is complete. This may include but is not limited to the following:
1. Risk for falls.
2. Pain
3. Activity of daily living needs or strengths
4. Skin condition

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F 656	Continued From page 24 5. Incontinence 6. Mood and/or behaviors The Comprehensive Care plan is developed by the interdisciplinary team with input from the resident/family/legal guardian and information derived from the MDS and Care Area Assessments. A Comprehensive care plan is designed to: 1. Include identified resident needs and strengths 2. Include risk factors associated with needs 3. Build upon resident strengths and abilities 4. Indicate goals and objectives that are measurable and obtainable and are derived from information supplied by the resident/family/legal guardian and MDS data 5. The Care plan will be reviewed and revised as needed, when a significant change in condition is noted, when outcomes were not achieved or when outcomes are completed, and at least every 92 days 6. Distinguish team members are responsible for each component of care	F 656		
F 657 SS=D	Care Plan Timing and Revision CFR(s): 483.21(b)(2)(i)-(iii) §483.21(b) Comprehensive Care Plans §483.21(b)(2) A comprehensive care plan must be- (i) Developed within 7 days after completion of the comprehensive assessment. (ii) Prepared by an interdisciplinary team, that includes but is not limited to-- (A) The attending physician. (B) A registered nurse with responsibility for the resident. (C) A nurse aide with responsibility for the	F 657	F 657 1. Resident #22 care plan was reviewed and updated on 12/8/22 and 1/13/23 by the Social Services Director or designee to reflect the resident's current condition and needs including interventions for aggressive behaviors. 2. On or before 02/01/23 the Social Services Director or designee will audit residents with known history of agressive behaviors to validate Interventions are implemented on the care plan. 3. On or before 02/01/23 the Regional Director of Clinical Services re-educated the interdisciplinary team regarding the requirement of completing care plan updates in a timely manner. 4. Social Services Director or designee will audit	

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F 657	Continued From page 25 resident. (D) A member of food and nutrition services staff. (E) To the extent practicable, the participation of the resident and the resident's representative(s). An explanation must be included in a resident's medical record if the participation of the resident and their resident representative is determined not practicable for the development of the resident's care plan. (F) Other appropriate staff or professionals in disciplines as determined by the resident's needs or as requested by the resident. (iii)Reviewed and revised by the interdisciplinary team after each assessment, including both the comprehensive and quarterly review assessments. This REQUIREMENT is not met as evidenced by: Based on observation, clinical record review and staff interview the facility failed to revise the care plan with a change in behaviors, a resident to resident altercation and an altercation with staff for 1 of 17 residents (Resident #22)reviewed. The facility identified a census of 55 residents. Findings include: An Electronic Health Care Census Record showed Resident #22 admitted to the facility on 10/03/22. A Review of the Preadmission Screening and Resident Review (PASRR) completed by a local hospital behavioral health center with a determination date of 9/20/22 revealed Resident #22 had a known behavior of physical aggression. The PASRR documented the admitting nursing facility must incorporate PASRR findings as part of the individual's plan of care.	F 657	care plan on residents with behaviors weekly for 4 weeks then monthly for 2 months to ensure care plan interventions continue to be implemented as required. Results of audits will be taken to the monthly QAPI meeting for 3 months for review and recommendations as needed. DON is responsible for monitoring and follow up as needed.	2/1/23

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The PASRR further documented Resident #22 had been taken to the emergency department (ED) at a local hospital behavioral health center the day after he hit a resident at another nursing facility. This had been the third tine the resident had been seen in the ED in the previous several days because Resident #22 chose not to take their medications and had been physically forceful with others. The Resident had been admitted under an emergency detention order by the Iowa District Court of the local county after a petition had been filed by the hospital alleging the Resident to be seriously mentally impaired and a harm to themselves and others. A copy of the court order had been provided with the PASRR assessment. Staff at the prior nursing had documented they did not feel Resident #22 was safe to be around others. The PASRR documented Resident #22 with behaviors of believing things that are not true, belief that the food is poisoned, hearing noises that other people do not hear and voice in their head, talking to yourself, quickly changing moods, irritability, being rude, screaming, yelling, threatening and being physically forceful with other, slamming doors, restlessness, being demanding of others and seeking attention from others.

The Minimum Data Set (MDS) dated 10/10/22 showed a Brief Interview for Mental Status (BIMS) score of 15 indicating intact cognition. The MDS documented Resident #22 did not exhibit evidence of a change of condition, inattention (being easily distractible or having difficulty keeping track of what was said), disorganized thinking ((rambling or irrelevant conversation, unclear or illogical flow of ideas, or unpredictable switching from subject to subject), altered level of consciousness, hallucinations or

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delusions. The Resident was independently ambulatory with a walker. The MDS listed a diagnosis of schizophrenia, anxiety and depression.

The Care Plan dated 10/27/22 identified Resident #22 had a psychosocial well-being problem (actual or potential) related to the disease process of schizophrenia, dementia, intellectual disability, anxiety, and ineffective coping. The Care Plan directed the staff in the following:
1. Allow the Resident time to answer questions and to verbalize feelings perceptions, and fears frequently, dated
10/27/22.
2. The Resident needs assistance, encouragement, and support to identify problems that cannot be controlled, dated
10/27/22.
3. When conflict arises, remove the Resident to a calm safe environment and allow to vent/share feelings, dated
10/27/22.

The Care Plan dated 10/27/22 contained a focus problem that Resident #22 had potential to demonstrate verbally abusive behaviors such as yelling and having loud outbursts related to dementia, ineffective coping skills and mental/emotional illness such as Schizophrenia. The Care Plan directed the staff in the following interventions:
1. When Resident #22 becomes agitated, intervene before agitation escalates, guide away from source of distress
and engage calmly in conversation. If response is aggressive, staff should walk calmly away and approach later.

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An Incident Report dated 11/26/22 at 12:00 p.m. documented Resident #22 had hit Resident #41. The Incident Report documented Resident #41 exhibited a bruise and a big lump under his left eye. Both Resident #22 verbalized he had hit Resident #41.

During an interview on 12/05/22 at 12:00 p.m. Staff F, Certified Nursing Assistant (C.N.A.) stated management do not give any direction. Resident #22 punched Resident #41 last week. Resident #22 is petrifying. She can usually get him calmed down but if he comes out on a rampage they just let him go because they don't want to get in his way. It's been going on for over a month. The nurses know about it. She said lately he has been punching the walls and screaming into the mirror. Resident #22 came from a locked unit.

During an interview on 12/05/22 at 12:56 p.m. Staff F reported Resident #22 has had behaviors of screaming/yelling, hitting the walls since he admitted. He will say things like, "No God damn it. Don't shit in my mouth." He sounds like he has another resident inside of him. He hits the wall so hard his knuckles bleed and he has had to go get band aids. He hit another resident about a week ago. He has been in the lounge punching the back of the couch. She is not sure if other residents are afraid of him. She feels he could hit another resident. You can hear other resident yelling at him. She doesn't feel like they get any direction from management on how to intervene with the resident.

During an observation on 12/05/22 at 1:02 p.m. Resident #22 walked behind a male resident in the wheelchair stating, "I'm going to kill him. I'm

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going to kill him." He did not make any movements toward the male in the wheelchair in front of him. Staff F intervened. He walked with using a wheeled walker behind the resident through the double doors of the D hallway, through the dining room and into the C hallway. He did not make any physical gestures and did not make any more verbal remarks. Staff F stated it has crossed her mind that Resident #22 could hurt her, but it hasn't happened, but it has crossed her mind that he could physically hurt her.

During an interview on 12/06/22 at 9:55 a.m. Staff G, Registered Nurse (RN), reported she had been struck in the jaw and neck by Resident #22.

Observation on 12/06/22 at 10:00 a.m. revealed the local police department on site at the facility assessing the situation for Resident #22.

During an interview on 12/06/22 at 10:04 a.m. Staff F stated she had seen Resident #22 punch the wall yesterday.

During an observation on 12/06/22 at 10:05 a.m. Resident #22 told the police officer that he had hit Staff G because he needed a cigarette. The Emergency Medical Service (EMS) personnel arrived and started to assess the Resident. Resident #22 cooperated with the Police and EMS personnel.

During an interview on 12/06/22 at 10:05 a.m. Staff G stated she needed to go stand outside until Resident #22 is taken out. She then left the area.

Observation on 12/06/22 at 10:11 a.m. revealed

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EMS personnel taking Resident #22 out of the facility to the local emergency department (ED).

During an interview on 12/06/22 at 11:38 a.m. Staff K stated Resident #22 had wanted to be called by his middle name the last two days. He always called her by a shortened version of her name, but right before he hit her, he used her full first name stating he wanted a cigarette then he hit her so hard it knocked her dentures to the other side of her mouth. She then reported she went behind the nurses' station behind the other staff. She had been scared and reported she is now scared of Resident #22. She hadn't always been afraid of him but she verbalized she is not afraid of Resident #22. She stated Resident #22 has hit other residents. Staff K verbalized fear that Resident #22 will come back to the facility.

During an interview on 12/06/22 at approximately 2:30 p.m. the Administrator reported if Resident #22 returns, he will be put on one to one observation by the Staff.

A review of the Care Plan on 12/08/22 at 4:00 p.m. revealed the Facility had not made any revisions to Resident #22's care plan to identify his air punching and hitting the walls. The Care Plan lacked revision of interventions after Resident #41 had been hit by Resident #22 to keep all residents safe, new interventions for safety after hitting a staff nurse on 12/06/22. The Care Plan had not been revised until 12/12/22 to include the 1:1 supervision.

During an interview on 12/13/22 at 9:35 a.m. the DON reported there were no changes in the care plan after staff observed him air punching, punching the back of the couches and doors.

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F 657	Continued From page 31 She told the staff that the family had been very adamant that he has to get his medications to stay stable for his mental condition. If he didn't take his medications, they would re-approach him and find a different staff member to try to get his medication administered. The also try to call the family to see if they can convince him to take his medications. The last resort is to call the DON to come give his medication. He has a delusional thought process. A Review of the Care Plan on 12/13/22 at 10:00 a.m. revealed the care plan did not address that Resident #22 refused medications. During an interview on 12/19/22 at 1:57 p.m. the DON reported she expects when they do stand up meetings if there is something that needs to be put in the resident, the care plan will be updated. If staff are reporting, for example, new wounds or behaviors, she would expect that information to be in the plan of care. The goal is to get to the point where the care plans can be updated day to day. The Care Plan Development Policy dated 8/15 provided by the facility directed the care plan will be reviewed and revised as needed, when a significant change in condition is noted, when outcomes were not achieved or when outcomes are completed and at least every 92 days. The Policy further documented the care plan must be consistent with the residents plan of care and revisions will be done on an as needed basis and can be done by any member of the Interdisciplinary team.	F 657		
F 658 SS=D	Services Provided Meet Professional Standards CFR(s): 483.21(b)(3)(i)	F 658		

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F 658	Continued From page 32 §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, policy review and staff interview the facility failed follow physician orders to provide blood glucose checks and wound care for 2 residents (Resident #5 and #54) and failed to follow up on significant weight changes (Resident #33 and #45) for a total of 4 out of 13 residents sampled. The facility identified a census of 55 residents. Findings include: 1. The Minimum Data Set (MDS) dated 6/08/22 for Resident #54 showed a Brief Interview for Mental Status (BIMS) score of 15 indicating intact cognition. The MDS documented a diagnosis of diabetes mellitus and identified the resident received insulin injections. A Progress Note documented Resident #54 discharged to the hospital emergency department on 8/29/22 and returned to the facility on 8/31/22. A Hospital Physician Transfer Order Report dated 8/29/22 noted by the facility nurse on 8/29/22 included the following physician orders: 1. Insulin Detemir (Levemir) 100 unit/milliliter (ml) inject 16 units into the skin daily. 2. Insulin Detemir (Levemir) 100 unit/ml inject 36 units into the skin nightly. 3. Continue taking Insulin Aspart (Novolog) 100 unit/ml injection inject 23 units into the skin three	F 658	F 658 1. Resident #5 was discharged from the facility on 1/23/23. Resident # 54 was discharged from the facility on 11/14/2022. Residents # 33's physician was notified of significant weight changes on or before 2/1/23. Resident #45's physician was notified of significant weight changes on or before 2/1/23 2. On or before 02/01/23 the DON or designee will audit weights for past 30 days to verify physician and or dietitian have been informed of significant changes in weight. On or before 02/01/23 the DON or designee will audit treatments and blood sugar checks to verify they are being completed as ordered. 3. On or before 02/01/23 the DON or designee will re-educate nursing department regarding following physician's orders and communication of weight changes. 4. DON or designee will complete audits weekly for 4 weeks then monthly for 2 months to validate treatments and blood sugar checks continue to be completed per physician's orders, and significant weight changes continue to be communicated to the physician with RD follow up as needed.	2/1/23

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times a daily
before meals.

A Long Term Care Facility Admission Physician Visit Note dated 9/1/22 under Type 2 Diabetes, Lab Results documented a Hemoglobin A1c (a simple blood test that measures your average blood sugar levels over the past 3 months) of 9.9 (high) and to continue the following:
1. Continue Levemir now 16 units in the a.m. and 36 units at bedtime
2. Continue Novolog to 23 units three times a day
3. Continue point of care testing (POCT) four times daily (Point of Care Testing is a widely used tool to enable
immediate determination of glucose levels in patients and facilitate rapid treatment decisions in response to
fluctuations in glycemia (blood sugar levels).
4. Continue Tradjenta, Aspirin, statin, ARB and gabapentin (dose change)

The Care Plan dated with an initial date of 10/23/22 documented Resident #54 had a diagnosis of diabetes mellitus and directed the nurses to give diabetic medications as ordered by the doctor. Monitor/document for side effects and effectiveness. The Care Plan failed to address blood sugars as physician ordered.

A Progress Note dated 11/02/22 at 10:04 p.m. completed by Staff H, Licensed Practical Nurse (LPN), documented Resident #54 requested the staff to take her blood sugar. Resident #54 registered a blood sugar of 585. The Nurse Practitioner gave an order to administer 12 units of Novolog and give the Levemir insulin as ordered. Recheck the blood sugar in 1 hour and

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blood glucose checks three times a day before meals x 3 days.

A Telephone Order dated 11/03/22 at 11:45 a.m. documented a physician order to check blood sugars four times a day for diabetes mellitus.

A Review on 12/07/22 at 11:00 a.m. of the May, June and July 2022 Medication Administration (MAR's) show the Resident had blood sugar checks completed three times a day prior to insulin administration. Further review of the August, September and October MAR's revealed no scheduled point of care glucose testing prior to insulin administration. The November MAR documented on 11/03/22 the facility initiated point of care blood glucose testing four times a day prior to insulin administration.

During an interview on 12/07/22 at 11:34 a.m. the Advanced Registered Nurse Practitioner (ARNP) reported a week prior to the Resident's death a nurse from the facility had called after hours to report an issue with the Resident's blood sugar. She stated when that happens they do a blood sugar review. She had accessed the Resident's blood sugar record in the facilities electronic healthcare record (EHR) and found that blood sugars had not been being taken prior to the insulin administration which is not safe to be administering insulin without knowing the blood sugar.

A Review of the Blood Sugars from the EHR showed the following blood sugars documented for Resident #54:
1. 9/27/22 5:06 p.m. 235 milligrams (mg/deciliter (dl)
2. 9/28/22 8:07 a.m. 99 mg/dl

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3. 9/28/22 11:44 a.m. 186 mg/dl
4. 10/2/22 4:53 p.m. 319 mg/dl
5. 10/21/22 11:06 342 mg/dl
6. 10/25/22 6:36 a.m. 238 mg/dl
7. 10/25/22 11:35 a.m. 352 mg/dl
8. 10/26/22 11:04 a.m. 270 mg/dl
9. 10/28/22 11:58 a.m. 316 mg/dl
10. 10/30/22 6:59 a.m. 185 mg/dl
11. 10/31/22 11:33 a.m. 363 mg/dl
12. 11/03/22 1:15 a.m. 403 mg/dl
13. 11/03/22 10:41 a.m. 272 mg/dl
14. 11/03/22 1:12 p.m. 300 mg/dl
15. 11/03/22 8:13 p.m. 267 mg/dl

During interview on 12/07/22 at 1:41 p.m. Staff G, Registered Nurse (RN) reported when a resident returns from an appointment or physician visit the facility usually has a desk nurse and nurses on the A, B, and D hallway that can review the notes and note any orders.

During an interview on 12/07/22 at 2:00 p.m. Staff H, Licensed Practical Nurse (LPN), reported when they receive notes back from a physician visit or orders, it is usually the desk nurse that will review and note the orders, but if they do not have a desk nurse, then any of the A, B, D hallway nurses can note the orders. He reported the do good teamwork and any of the nurses can actually review the papers and note the physician orders.

During an interview on 12/07/22 at 2:30 p.m. Staff I, LPN, reported when the physician visit notes are returned, any of the nurses can note the orders. She reported the nurses generally scan the visit notes, but do not read the entire note. They focus on the portion under orders at the bottom of the note. She herself does not read the

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entire physician visit note, she just scans and focuses on the orders part of the visit note.

During an interview on 12/13/22 at 9:54 a.m. the DON reported she would expect the nurses to clarify a physician order for blood sugars if the resident is receiving insulin. She reported she would expect the nurses to review the entire physician visit note and clarify any physician orders that need clarified. She reported the nurses need a lot of education and she is working on it.

During an interview on 12/14/22 at 9:14 a.m. the DON reported she thought there had been other blood sugar orders in that time frame but confirmed she did not find any additional physician orders regarding blood glucose checks until the 11/03/22 physician order.

The Medication Administration Policy revised 2/27/20 provided by the facility as the Policy for following physician orders documented a purpose to follow according to the principles of medication administration, including right medication, to the right resident/patient at the right time and in the right dose and route. The Procedure directed the following:
1. Verify physician's orders for the medications to be administered.
2. Review any special precautions and perform needed evaluations prior to administering medication to the
resident/patient.
a. Review the resident's/patient's allergies
b. Review pertinent lab results, as indicated (e.g. PT/INR (a prothrombin time test (PT) measures the time it takes
for a clot to form in a blood sample), blood

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F 658	Continued From page 37 glucose) c. Perform needed evaluations prior to administering specific medications (e.g, pulse, blood pressure, blood glucose). 2. The quarterly Minimum Data Set (MDS) dated 12/1/22 for Resident #33 documented a Brief Interview for Mental Status (BIMS) of 14 indicating intact cognition for decision making and had diagnoses of diabetes mellitus (DM), septicemia and depression. The MDS further documented the resident was independent with eating and required set-up assistance only with meals, had a 5% or more weight loss in the last month or loss of 10% or more in the last 6 months. The Care Plan revised 08/29/2022 revealed Resident #33 had potential nutritional problems due to diagnoses of morbid obesity, vitamin deficiency and gastro-esophageal reflux. The Care Plan directed staff to monitor/record/report to Medical Director (MD) signs and symptoms of malnutrition including emaciation (cachexia), muscle wasting, and significant weight loss of more than 5% in 1 month or 10% in 6 months. The Care Plan further directed the Registered Dietician (RD) to evaluate and make diet change recommendations as needed. During an interview 12/6/22 at 11:02 AM, Resident #33 revealed he doesn't have an appetite and is losing weight. Review of progress notes for Resident #33 documented the following weights and lacked follow-up documentation from the Registered	F 658		

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Dietician (RD) including physician notification:

a. 11/26/2022- 230.2 pounds
b. 11/21/2022- 238.4 pounds
c. 11/19/2022- 238.4 pounds
d. 11/16/2022- 250.0 pounds

3. The quarterly MDS dated 11/11/22 for Resident #45 lacked a BIMS score and documented Resident #45 had diagnoses including dysphagia (trouble swallowing), weakness and cerebellar ataxia (poor muscle control) with defective deoxyribonucleic acid (DNA) repair. The MDS further documented the resident required supervision and assist of 1 person with eating and had a weight loss of 5% or more in the last month or 10% or more in last 6 months.

Review of progress notes for Resident #45 documented the following weights and lacked follow-up documentation from the RD including physician notification:

a. 12/5/2022- 132.2 pounds
b. 11/14/2022- 132.3 pounds
c. 10/1/2022- 184.3 pounds
d. 9/4/2022- 183.6 pounds

The Care Plan initiated 11/17/22 revealed Resident #45 had potential nutritional problems related to recent hospitalization and diagnoses of dysphagia with recent diet upgrade. The Care Plan directed staff to monitor/record/report to MD signs and symptoms of malnutrition including emaciation, muscle wasting, and significant weight loss: 3lbs in 1 week, >5% in 1 month, >7.5% in 3months, >10% in 6 months. The Care Plan further directed the Registered Dietician (RD) to evaluate and make diet change

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F 658	Continued From page 39 recommendations as needed. Review of facility policy titled Nutrition Practice dated June 2015 revealed the nutritional status of the resident/patient is evaluated routinely and appropriate nutrition interventions are implemented to prevent weight loss. The policy further revealed weight changes are evaluated and monitored by the nutrition services staff and appropriate interventions are implemented to reverse the weight change as indicated. During an interview 12/07/22 at 1:05 PM the Administrator revealed the physician was not notified regarding Resident #33's and #45's significant weight change as expected. During an interview 12/13/22 at 9:28 AM, the Director of Nursing revealed she would expect the RD would follow-up and notify the physician in regards to significant weight changes. 3. During an observation on 12/8/22 at 12:07 PM Staff O Registered Nurse (RN) completed a dressing change to Resident #5 right foot. The treatment to the top of the right foot was completed correctly but the RN had removed the dressing to the right heel and did not complete that dressing change as ordered. The RN cleansed right heel with saline and applied a gauze 4x4 dressing then wrapped the entire foot with gauze wrap and taped.	F 658		

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F 658	Continued From page 40 Physician order dated 12/6/22 Apply 1/8 strength of Dakin's to moist gauze after cleaning right heel with soap and water. Cover with Mepilex. During an interview on 12/8/22 at 12:07 PM Resident #5 stated his right foot "hurt like hell", and that the dressing did not get changed the night before. 12/8/22 1:20 PM the Director of nursing stated she would expect the nurse to do the treatment as ordered by the physician.	F 658		
F 684 SS=J	Quality of Care CFR(s): 483.25 § 483.25 Quality of care Quality of care is a fundamental principle that applies to all treatment and care provided to facility residents. Based on the comprehensive assessment of a resident, the facility must ensure that residents receive treatment and care in accordance with professional standards of practice, the comprehensive person-centered care plan, and the residents' choices. This REQUIREMENT is not met as evidenced by: Based on observations, clinical record reviews, resident, family, and staff interviews, the facility failed to assess and intervene for the necessary care and services, to maintain a resident's highest practical physical well-being. The clinical record review revealed the nursing staff failed to provide a timely thorough assessment for 1 of 13 residents reviewed (Resident #5). The facility's failure to provide a timely assessment and intervention resulted in an immediate jeopardy (IJ) to the residents of the facility. The Iowa Department of Inspections and Appeals notified	F 684	F684 1. Resident #5 was discharged from the facility on 1/23/23. 2. DON reviewed the 24 Hour Communication Progress Notes Report on 1/18/23 for signs and symptoms of change in condition to ensure assessment and physician notifications are completed timely. 3. The Director of Nursing or designee educated License Nurses on 1/18/23 related to completing timely assessments when resident present with a change of condition. License Nurses that have not completed education by 1/18/23 will complete education prior to next scheduled shift. 4. DON/Designee will complete audits weekly for 12 weeks to ensure residents continue to be provided timely assessments for changes of condition and physician notification as needed. Results of these audits will be presented to the QAPI meeting monthly for 3 months for review and recommendations as needed. The Director of Nursing is responsible for monitoring and follow up as needed.	1/18/23

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the facility of the IJ on 12/8/22 at 9:53 AM. The facility decreased the citation to a "D" level prior to exit of the survey. The facility reported a census of 55 residents.

Findings include:

The Minimum Data Set (MDS) dated 9/30/22 for Resident #5 revealed a Brief Interview for Mental Status (BIMS) score of 15, indicating intact cognition. The MDS included diagnoses of coronary artery disease (CAD), heart disease, diabetes, and seizures. The MDS indicated that Resident #5 had an inability to walk and needed two persons to assist with transfers from their bed to their wheelchair using a sit to stand lift.

The Care Plan dated 10/21/22 for Resident #5 directed staff to monitor his blood pressure, notify the physician of any abnormal readings, and monitor/document/report to the physician any symptoms of coronary artery disease (CAD) to include chest pain or shortness of breath.

During an interview on 12/7/22 at 12:46 PM Resident #5 stated about two weeks before, he had trouble breathing for four days, he didn't feel well, he slurred his words and the nurse did not check on him. Resident #5 stated Staff F, Certified Nursing Assistant (CNA), took him to the front office as he couldn't breath and he wanted to call for help. Resident #5 stated Staff G, Registered Nurse (RN), took his blood pressure then left. Resident #5 stated after that Staff F told the 2 PM - 10 PM nurse, Staff I, Licensed Practical Nurse (LPN), who assessed him and called the physician.

During an interview on 12/6/22 at 10:15 AM Staff

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F explained that she notified Staff G that Resident #5's leg was very swollen, "And they blew it off". Staff F stated a week later (12/1/22) Resident #5 was having difficulty breathing with a blood pressure of 243/101 (average blood pressure is 120/80), extremely high. Staff F reported that she told Staff G who took a manual blood pressure and stated it was 143/92. Staff F stated "she lied." Staff DD, Director of Physical Therapy (DPT) took Resident #5's blood pressure and reported it was over 200. Staff F stated she reported the elevated blood pressure to Staff G again who replied that the nurses were going into report. Staff F stated Staff I was the next nurse on duty, who assessed Resident #5 and sent him to the hospital.

During an interview on 12/7/22 at 2 PM Staff I explained that Resident #5 stayed in the hospital for two weeks. Staff I reported that when she came to work on 12/1/22, she saw Resident #5 with Staff F in front of the Director of Nursing's office, "they were checking his blood pressure." Staff I stated Staff G reported Resident #5 blood pressure as 140/unsure. Staff I said she went and assessed Resident #5's blood pressure. She got a reading of 200/105, Resident #5 complained about shortness of breath, and had diminished lung sounds. Staff I added that she offered Resident #5 to go to the emergency department (ED), "If he wants to go to the hospital, that's serious, because he never wants to go." Staff I stated the Emergency Medical Staff (EMS) were in the facility for another resident but took Resident #5 first as "he was more serious".

During an interview on 12/7/22 at 1:19 PM Resident #5's Representative said that she visited on 11/25/22. She explained that "he looked like the Hulk", as his right arm appeared "swollen

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three times its normal size." Resident #5's Representative stated the nurse was not worried about him. Resident #5's Representative stated Resident #5 called on 12/1/22, claiming that he couldn't breath and that he was on his way to the hospital. Resident #5's Representative stated Resident #5 legs were very swollen, "they removed 18 pounds of fluid off of him." Resident #5's Representative stated the hospital doctor told her to keep on at the nursing home to weigh him daily. Resident #5's Representative stated the facility had not weighed the resident yet as of the time of the interview.

During an interview on 12/7/22 at 3:04 PM Staff H, LPN, stated he worked before 11/25/22 and didn't assess Resident #5, "He follows cardiology and his legs are always swollen".

The Physician's Order dated 9/26/22 directed to weigh Resident #5 daily.

During an interview on 12/8/22 at 12:15 PM Staff F said the could not weigh Resident #5 due to the mechanical lift scale being broken.

The Nurses' Notes dated 11/23/22 at 12:51 PM, the Physical Therapist (PT) notified the nurse of 2-3 pitting swelling in both of Resident #5's legs. The nurse notified the physician and requested an order for compression socks if approved by the wound clinic.

The Health Status Note dated 11/23/22 at 6:58 PM indicated that Resident #5's primary care provider (PCP) called regarding the request for compression stockings. The PCP directed to let the Wound Clinic decide the course of action.

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The Health Status Note dated 11/25/22 at 10:55 AM documented a call placed to the Wound Clinic. The Wound Clinic reported that had no provider that day and they planned to assess him on his next appointment on 12/2/22. The nurse notified the physician office who would not give an order for an antibiotic therapy at that time. The physician's office directed to monitor his site and if necessary he could be seen in the Wound Clinic earlier in the week.

The Nurses' Notes dated 12/1/22 at 3:15 PM indicated that Resident #5 had shortness of breath, a pale face, an elevated blood pressure of 200/105, a pulse of 89, respirations of 28, diminished lung sounds throughout and a negative COVID-19 test. The nurse notified the physician, who provided an order to transfer Resident #5 to the hospital. At the time of the order an ambulance was at the facility, and the nurse notified the daughter of transport to the hospital.

Resident #5's clinical record lacked additional assessments prior to his admission to the hospital on 12/1/22.

Resident #5's Hospitalist History and Physical dated 12/1/22 at 6:33 PM indicated that he presented to the ED for high blood pressure and shortness of breath. He had a past medical history significant for CAD, heart failure with preserved ejection fraction (EF, a measurement used to determine the amount of blood that leaves your heart each time it contracts), type 2 diabetes insulin dependent, essential hypertension, and epilepsy. Resident #5 reported that he had high blood pressure that day and went to the ED. He reported having shortness of

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breath for at least a few days, worse with activity, but improved with rest. His shortness of breath improved after receiving Lasix (diuretic, releasing excess fluid from the body) in the ED. The ED course indicated he had no fever with a blood pressure on admission in the hypertensive urgency/emergency ranges (dangerous blood pressures), hypoxic (decreased oxygen) down to 88% that improved to 100% on 3 Liters (L). A chest x-ray revealed vascular congestion (fluid around his heart). The assessment determined a blood pressure of 186/92 and a weight of 291. The Impression indicated Resident #5's principle problem as a hypertensive emergency (high blood pressure) with active problems of acute decompensated heart failure, elevated troponin, benign hypertension, CAD, hyperkalemia (elevated potassium), type 2 diabetes, and anemia. Resident #5 denied chest pain but did have nitroglycerin in the ambulance.

Resident #5's Hospital Notes dated 12/4/22 at 3:32 PM revealed he had a stroke due to being severely hypertensive (high blood pressure) on admission to hospital. The diuretic medication removed 18 pounds of fluid, with a weight of 273 pounds, and blood pressure stable at 120/56.

On 12/8/22 at 10:41 AM the Director of Nursing (DON) stated she did not assess Resident #5 when he was brought up to her office.

During a follow-up interview on 12/8/22 at 1:20 PM the DON stated she would expect the nurse to do treatments as ordered. The DON stated they are working on more specialized training and will have a new ADON next week.

The facility removed the IJ and decreased the

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F 684	Continued From page 46 severity to a "D" level deficiency on 12/8/22 by doing the following: a. On 12/8/22 the nurses assessed the residents for signs and symptoms of a change in condition. The nurses notified the physician as necessary. b. The DON/Designee educated the licensed nurses on 12/8/22 related to completing timely assessments when a resident presents with a change of condition. Any licensed nurse who did not receive their education on 12/8/22 will complete their education prior to their next scheduled shift.	F 684		
F 689 SS=J	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, resident and staff interviews, record review and policy review, the facility failed to provide appropriate supervision in order to prevent physical abuse of 1 of 9 residents reviewed (Resident #41) resulting in injury and one staff member, Staff G, Registered Nurse (RN). The facility failed to put interventions in place for a resident with a known history of violent behavior (Resident #22) to protect residents and staff from abuse. Resident #22's admitted to the facility from a psychiatric hospital after assaulting another resident at a different facility. These incidents constituted Immediate	F 689	F 689 1. Resident #22's care plan was reviewed and updated on 12/8/22 and 1/13/23 to include interventions for aggressive behaviors. The Administrator verified that interventions remain in place for on 1/18/2023. 2. An audit was completed by DON or designee on 1/18/2023 of Communication Progress Note report for the last 10 days to identify residents with known aggressive behaviors to ensure they remain without threats to other residents and peers. Resident #22 had psych appointments on 12/12/22, 1/11/23 and continues ongoing follow-up appointments. 3. On 1/18/2023 DON or designee educated clinical staff on the requirements of providing increased supervision for resident during periods of aggressive behavior. Staff that have not completed education by 1/18/2023 will complete education prior to next scheduled shift. 4. DON or designee will complete audits weekly for 12 weeks to ensure staff continue to provide increased supervision for residents during periods of aggressive behaviors. Results of these audits will be presented to the QAPI meeting monthly for 3 months for review and recommendations as needed. The DON is responsible for monitoring and follow up as needed.	1/18/23

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Jeopardy to the resident's and staff's health and safety. The facility reported a census of 55 residents.

Findings include:

The admission Minimum Data Set (MDS) dated 10/10/22 for Resident #22 documented an admission date of 10/3/22 from a psychiatric hospital. Resident #22 had Level II Preadmission Screening Resident Review (PASRR) in place. The MDS identified a Brief Interview for Mental Status (BIMS) of 15, indicating intact cognition. The MDS included diagnoses of anxiety, depression, schizophrenia, and dementia with other behavioral disturbances. Resident #22 could independently complete most activities of daily living including ambulation.

The Preadmission Screening and Resident Review (PASRR) form completed 9/20/22 by a local hospital behavioral health center revealed Resident #22 had a known behavior of physical aggression. The PASRR documented the admitting nursing facility must incorporate PASRR findings as part of the individual's plan of care. The PASRR further documented that Resident #22 went to the emergency department (ED) at a local hospital behavioral health center the day after he hit a resident at another nursing facility. This had been the third time of being seen in the ED in the previous several days because Resident #22 chose not to take his medications and had been physically forceful with others. The resident admitted to the hospital under an emergency detention order by the State District Court of the local county after a petition had been filed by the hospital alleging the resident to be seriously mentally impaired and a harm to himself

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and others. A copy of the court order had been provided with the PASRR assessment. Staff at the prior nursing home documented that they did not feel Resident #22 was safe to be around others due to his physical behaviors. The PASRR included that he told his doctor that he believed that someone poisoned his food, that he heard noises that other people did not hear and voices in his head. Resident #22 had a history of talking to himself, quickly changing moods, irritability, being rude, screaming, yelling, threatening, physically forceful with others, slamming doors, restlessness, demanding of others, and seeking attention from others.

Resident #22's Care Plan revised 10/27/22 revealed the resident had the potential to demonstrate verbally abusive behaviors such as yelling and having loud outbursts related to dementia. Resident #22 had ineffective coping skills and a mental/emotional illness such as schizophrenia. Resident #22 could sometimes have behaviors or hallucinations where he might yell rambled words. In addition he can also yell and be verbally abusive toward staff and or residents at times. The Care Plan included the following interventions:
a. Staff to intervene when he became agitated before the agitation escalated, guide away from the source of distress, and engage calmly in conversation. If Resident #22 responded aggressively, the staff should calmly walk away and approach later.

The Care Plan dated 10/27/22 identified Resident #22 had a psychosocial well-being problem (actual or potential) related to the disease process of schizophrenia, dementia, intellectual disability, anxiety, and ineffective coping. The

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Care Plan included the following interventions dated 10/27/22:
a. When conflict arises, remove the Resident to a calm safe environment and allow him to vent/share feelings.
b. The Resident needs assistance, encouragement, and support to identify problems that cannot be controlled.
c. Allow the Resident time to answer questions, verbalize feelings, perceptions, and fears frequently.

The Care Plan lacked direction in regards to potential violent behavior towards others, incorporation of the PASRR recommendations, and how to provide safety for the staff and other residents.

2. The quarterly MDS for Resident #41 documented a BIMS of 15 out of 15 indicating intact cognition. The MDS documented the resident had diagnoses of anxiety, depression and cancer and was independent with activities of daily living.

The Care Plan for Resident #41 initiated 11/13/22 documented Resident #41 had a psychosocial well-being (actual or potential) related to diagnoses of anxiety disorder and depression disorder with the intervention when conflict arises, remove to a calm, safe environment.

During an interview 12/5/22 at 12:52 PM, Resident #41 revealed Resident #22 came up to him recently and said he was mad at him for something. Resident #41 stated two days later Resident #22 came up to him and punched him in the left eye and said "there you go". Resident #41 stated after Resident #22 hit him he held his face

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and walked away from Resident #22. Resident #41 further stated that he had never done anything to Resident #22 and he shouldn't be doing that to people. Resident #41 stated he had to have an eye procedure rescheduled due to the swelling that was a result of being punched in the eye by Resident #22 and stated the area hurt when he touched it.

Review of facility incident report dated 11/26/22 at 12:00 PM completed by Staff L, Licensed Practical Nurse (LPN) revealed nurses were called to the front nurse's station and informed Resident #41 had been hit by Resident #22. The incident report further documented when the nurse's went to Resident #22's room they observed him to have a bruise and a big lump under his left eye and the resident informed them he had been hit by Resident #22.

During an interview 12/7/22 at 10:14 AM, Staff E, Certified Medication Aide (CMA) revealed on Thanksgiving day she was working the C/D hall when she heard Resident #41 yelling. She stated Resident #22 in front of Resident #41 punching into the air in front of him screaming, "I'm going to kill you! I'm going to kill you!" Staff E stated she left the medication cart to separate the two residents and directed Resident #41 to sit back down in the chair in which he did. Staff E stated she then went back to the medication cart to complete the narcotic count. Staff E stated she then heard Resident #22 holler out again and as she turned around from the medication cart she saw Resident #22 hit Resident #41 in the eye. Staff E stated she couldn't remember which eye was hit or which hand Resident #22 used but Resident #41's eye was black the Saturday after Thanksgiving.

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Review of facility policy titled, Abuse Prevention and Reporting, revised August 2019 revealed residents must not be subjected to abuse by anyone including other residents. The policy directed staff to identify, correct and intervene in situations where resident to resident abuse is most likely to occur and provide protection by immediately separating the residents involved, moving the resident to another room or unit, providing 1:1 monitoring as appropriate, implementing discharge process immediately if the resident is a danger to self or others and initiating behavior crisis management interventions as applicable.

During an interview 12/13/22 at 9:35 AM, the Director of Nursing (DON) revealed if Resident #22 was being that aggressive toward Resident #41 she would have separated the two completely to a different room and contacted the provider in regards to the behavior including directing the use of as needed medication, contacting psychiatry and most likely starting a 1:1. The DON further revealed the expectation would be for staff to intervene in order to prevent abuse, to give Resident #22 space and ensure residents and staff stay away from him. The DON then revealed Staff G that was hit by Resident #22 was still sore.

During an interview 12/19/22 at 11:24 AM, the Administrator revealed it is an expectation staff keep residents safe from abuse by intervening when needed, following policy, reporting to the Director of Nursing and/or Administrator as needed.

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During an interview on 12/5/22 at 11:04 AM Resident #25 reported that Resident #22 at the end of her hallway is dangerous. He is hitting everyone. He punched a guy that lives on the A hallway. We should not have to live in danger every day. The staff lets him do whatever he wants to do because they are all afraid of him.

During an interview on 12/5/22 at 11:05 AM Resident #16 reported she is tired of living in fear and shouldn't have to live in fear every day.

During an observation on 12/5/22 at 11:49 AM Resident #22 ambulated with a four wheeled walker through the D hallway back to his room. The staff passed room trays saying hello to Resident #22's by his first name. As Resident #22 entered his room doorway, he hit the left side of his door frame with his left hand closed into a fist. He yelled that his name was not his first name, but his middle name. He proceeded to yell if you don't know English, then don't talk to me, then repeatedly yelled his name (referring to his middle name).

During an observation on 12/5/22 at 11:58 AM Resident #22 sat in the room yelling loudly damn you all to hell. I told her before that I want to be left alone! Just leave me alone! God damn it! No staff or other residents were present in the room with Resident #22. Resident #22's yelling could be clearly heard up to the double doors at the entrance of the D hallway.

During an interview on 12/5/22 at 12:00 PM Staff F, Certified Nursing Assistant (CNA), said that management did not give any direction. Resident

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#22 punched Resident #41 last week. Resident #22 is petrifying. She can usually get him calmed down but if he goes out on a rampage they just let him go because they don't want to get in his way. It's been going on for over a month. The nurses know about it. She said lately he has been punching the walls and screaming into the mirror. Staff F reported that Resident #22 came from a locked unit.

During an interview on 12/5/22 at 12:50 PM Staff K, CNA, reported that Resident #22 mostly has been in his room yelling at himself. If other residents say something to him, he may yell back at the other residents. He does raise his voice at other residents, but then he will get really quiet. Staff K reported she is not afraid of him, but she does stay back because he may try to hit. She tries to keep her distance. When Resident #22 starts to scream he is ready to go at you, so you have to be careful.

During an interview on 12/5/22 at 12:56 PM Staff F reported that Resident #22 has had behaviors of screaming/yelling, hitting the walls since his admission. He will say things like, "No God damn it. Don't shit in my mouth." He sounds like he has another resident inside of him. He hits the wall so hard his knuckles bleed and he has had to go get band aids. He hit another resident about a week ago. He has been in the lounge punching the back of the couch. She is not sure if other residents are afraid of him. She feels he could hit another resident. You can hear other residents yelling at him. She doesn't feel like they get any direction from management on how to intervene with the resident.

During an observation on 12/5/22 at 1:02 PM

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Resident #22 walked behind a male resident in a wheelchair stating, "I'm going to kill him. I'm going to kill him." He did not make any movements toward the male in the wheelchair in front of him, Staff F intervened. He walked using a wheeled walker behind the resident through the double doors of the D hallway, through the dining room, and into the C hallway. He did not make any physical gestures and did not make any more verbal remarks. Staff F stated it has crossed her mind that Resident #22 could hurt her, but it hasn't happened, but it has crossed her mind that he could physically hurt her.

During an interview on 12/5/22 at 1:11 PM Staff O, Registered Nurse (RN), reported that Resident #22 has exhibited yelling and punching with his fist into the air, like he is hitting an imaginary person. She does believe that he could hit another resident. She has not had any reports of him hitting staff and has not heard any staff state they are afraid of him. When Resident #22 is yelling and air punching, they just stay away from him. Staff O is not sure what they have instructed the staff to do in situations like that. She has not had any residents state they are afraid of him, but they do state this is not the place for him.

A handwritten statement dated 12/6/22 by Staff G documented that Resident #22 sat in the dining room at 9:45 AM demanding to be called by his middle name. He screamed that he wanted to go have a cigarette and demanded Staff G let him go right now. Resident #22 then stood up and struck Staff G in the left neck/jawline. Staff N, LPN, witnessed the incident and called 911. Resident #22 sat back down in the chair and stated, "don't let them take me."

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An undated handwritten statement written by Staff N revealed that she sat at the nurses' desk charting, while Resident #22 sat in a chair in the dining room screaming he wanted a cigarette. The CNA's were running behind for smoke breaks. Resident #22 got up and walked over to Staff G and with a closed fist hit her on the left side of her jaw and neckline.

During an interview on 12/6/22 at 9:55 AM Staff G reported that Resident #22 struck her in the jaw and neck.

On 12/6/22 at 10:00 AM observed the local police department on site at the facility assessing the situation for Resident #22.

During an interview on 12/6/22 at 10:04 AM Staff F stated she saw Resident #22 punched the wall yesterday.

During an observation on 12/6/22 at 10:05 AM Resident #22 told the police officer that he had hit Staff G because he needed a cigarette. The Emergency Medical Service (EMS) personnel arrived and started to assess the Resident. Resident #22 cooperated with the Police and EMS personnel.

During an interview on 12/6/22 at 10:05 AM Staff G stated she needed to go stand outside until Resident #22 went out, then she left the area.

On 12/6/22 at 10:11 AM observed EMS personnel taking Resident #22 out of the facility to the local emergency department (ED).

During an interview on 12/6/22 at 11:38 AM Staff K, CNA, said that Resident #22 wanted to be

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called by his middle name for the last two days. He always called her by a shortened version of her name, but right before he hit her, he used her full first name stating he wanted a cigarette then he hit her so hard it knocked her dentures to the other side of her mouth. She then reported she went behind the nurses' station behind the other staff. She had been scared and reported she is now scared of Resident #22. She hadn't always been afraid of him but she verbalized she is now afraid of Resident #22. She stated Resident #22 has hit other residents. Staff K verbalized fear that Resident #22 will come back to the facility.

During an interview on 12/6/22 at approximately 2:30 PM the Administrator reported if Resident #22 returns, he will be put on one to one observation by the staff.

The Health Status Note dated 12/7/22 at 3:05 PM labeled as Late Entry indicated that Resident #22 returned to the facility after an overnight observation stay at the ED. While at the ED, Resident #22 received a new order of Seroquel 12.5 milligrams (MG).

During an observation on 12/8/22 at 7:02 AM Resident #22 ambulated from his room at the end of D wing, all the way through the hallway, through the dining room, through the C wing, and up to the front nurses' station with no staff present. The Administrator saw him at the front double doors and asked him how his night was. He responded that it had been all right. The Administrator walked away from Resident #22 back into her office. Resident #22 then walked back through the double doors into the C wing out of the supervision of the Administrator or other staff and back to the D hallway. No staff were

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present in the D hallway. An empty chair sat outside Resident #22's room.

During an observation on 12/8/22 at 7:53 AM Resident #22 sat on the seat of his walker eating breakfast in his room. Staff P, CNA, observed going in and out of room D 34. Staff P went out and performed hand hygiene, then entered Resident #22's room to check on him. Staff P then exited Resident #22's room and went into room D 35. Staff L, LPN, stood at the medication cart at the front of the D hallway going in and out of rooms passing medications. Staff L never looked down the hall towards the direction of Resident #22's room. At 7:55 PM Staff P came out of room D 35 and exited out of the D hallway through the double doors to the dining room. At this time Resident #22 observed yelling from his room, "God damn it, stay out."

During an observation on 12/8/22 at 7:57 AM the Housekeeping Supervisor came into the D hallway walking down to the shower room to obtain supplies, then left the D hallway. Staff L continued to go into random resident rooms to pass medications leaving no staff present in the D hallway. Staff L did not look down towards Resident #22's room when she returned to the hallway.

On 12/8/22 at 7:59 AM observed Staff P reenter the D hallway then enter room D 35. Resident #22 started to yell loudly random words. At 8:00 AM Staff P donned personal protective equipment (PPE) to enter room D 39. Staff P entered Room D 39. Resident #22 started to yell even louder, "I get no respect," repeatedly. Staff P came out of Room D 39 removing her PPE and peaked in on Resident #22. Staff P informed the surveyor that

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she didn't think that Resident #22 could have a roommate. Staff P then left to go into another Resident's room. Staff L not observed in the hallway at this time.

On 12/8/22 at 8:02 AM witnessed Resident #22 yelling, "I get no respect. You make me so nervous. I am fucking pissed at you, you fucking bitch. Fuck you. Last time..... God damn nuts."

On 12/8/22 at 8:04 AM watched Staff P exit the D hallway through the double doors out to the dining room with the double doors closed behind her. Staff L not observed in the hallway. At 8:05 AM Resident #22 continued to ramp up screaming and yelling. At 8:05 AM Staff L came back to the hallway. Resident #22 observed walking in the room, no supervision outside of the doorway. At 8:06 AM Staff L left the hallway to enter room D 31 leaving no supervision in the hallway for Resident #22. Resident #22 continued to scream and yell from his room. At 8:09 AM Resident #22 observed sitting in front of the mirror in his room yelling into the mirror.

On 12/8/22 at 8:10 AM observed Staff L return to the hallway to the medication cart to prepare medication. At 8:11 AM the Housekeeping Supervisor entered the D hallway going to the shower room to obtain supplies as Staff L went into another resident's room to pass medications. At 8:12 AM Staff P came back to the D hallway and walked to the shower room, then exited the D hallway. At 8:13 AM witnessed Staff F, CNA, entered the D hallway.

During an interview on 12/8/22 at 8:14 AM Staff F stated they are to provide Resident #22 with one to one supervision. She stated she did not know

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who had been assigned to provide one to one supervision to Resident #22 from 6:00 AM to 8:00 AM

On 12/8/22 at 8:15 AM observed Staff A, nurse aide (NA), enter the hallway carrying her purse and coat which she sat down on the chair outside of Resident #22's room. She stated she had to sit with Resident #22 to make sure that he didn't have any physical contact with anyone.

During an interview on 12/8/22 at 11:26 AM Staff X, LPN, reported that Resident #22 assaulted a 100-pound lady at another nursing facility, really badly. They couldn't get him off of her. They had put the female resident in the same hallway as him and he assaulted her again. That facility sent him to the hospital and then he was admitted to Cedar Falls Health Care Center. Staff X reported being pretty upset when Resident #22 admitted to the facility. They were not given much history on Resident #22 with his admission. Staff X stated "to be honest, they gave us zero guidance." He read the paperwork and he tried to give the staff guidance. He told the staff to keep an eye on him and if he got worked up to not push him, not escalate the situation, and to come get him if they needed him. Typically, they do not have issues until 5 AM then Resident #22 will get up and start hearing voices.

In an email from the Administrator on 12/19/22 at 11:24 AM, the Administrator responded the expectation is that the staff keep residents safe from abuse by intervening when needed, following policy, reporting to the charge nurse, DON, and/or Administrator as needed.

The Facility abated the Immediate Jeopardy on

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F 689	Continued From page 60 12/12/22, decreasing the citation to a "D" level by ensuring the staff received education and provide a plan for one to one supervision for Resident #22. On 12/8/22 the Iowa Department of Inspection and Appeals determined an immediate jeopardy for the facility failing to provide supervision to prevent potential abuse for all other residents and staff. A Plan of Correction for removal of immediate jeopardy submitted by the facility on 12/8/22 detailed the following information: 1. Resident #22 Care Plan has been reviewed and updated by the DON/Designee on 12/8/22 with interventions regarding his history of physically aggressive behavior to ensure protection of residents and staff from physical abuse. 2. An audit was completed by the DON/Designee on 12/8/22 to identify residents with known violent behaviors to ensure their Care Plan has interventions regarding aggressive behavior to ensure protection of residents and staff from physical abuse. 3. The Regional Director of Clinical Services educated the Social Service Designee and Director of Nursing on 12/8/22 related to the requirements of implementing a plan of care that includes interventions for residents with aggressive behavior. 4. DON/Designee will complete audits of 24-hour reports including progress notes daily for 4 weeks then 5 times weekly for 8 weeks to ensure residents that present with aggressive behaviors continue to have Care Plan interventions implemented to address the aggressive behaviors. Results of these audits will be	F 689		

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presented to the QAPI meeting monthly for 3 months for review and recommendations as needed. The DON is responsible for monitoring and following up as needed.

An undated Staff Roster with the Administrator's initials handwritten by each employee's name titled Staff Education on how to handle agitated/aggressive behaviors was submitted to the Iowa Department of Inspection and Appeals on 12/8/22 at 9:56 PM. The document included Guidance for increased supervision during periods of aggression.
a. Talk in a calm voice
b. Make slow transitions or movements
c. Do not engage in arguments
d. Allow resident to have false allusions - do not tell them they do not exist
e. Do not leave the resident unattended
f. Provide a barrier between the upset resident and other residents (ex. Placing yourself between the upset resident and another resident that may be passing by.
g. Try to redirect the resident to a quiet area with less people
h. If warranted, use a personal device to call the facility for assistance (reminder you are not to leave the resident unattended).

The Administrator notified the State Bureau Chief on 12/8/22 at 9:08 PM that Resident #22 went out to the emergency department per his request as he felt an increase in agitation. Resident #22 had a psychiatric appointment set up for the next week and the Administrator communicated that he would be one-on-one till further medical assistance is provided and he feels balanced out or the facility finds other placement. All staff were educated on how to handle behaviors of

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aggression on 12/8/22.

During an interview on 12/12/22 at 10:12 AM Staff CC, Housekeeping/Laundry, reported that she did not get the behavioral training from the previous week. She thought they didn't have her correct phone number so they weren't able to get in touch with her, but she assumed she would get the training that day at some point.

During an interview on 12/12/22 at 10:18 AM Staff R, CNA, reported that she did not receive any behavioral training from the previous week by the facility.

During an interview on 12/12/22 at approximately 11:00 PM the Administrator reported she had educated all the employees on the Staff Roster or she had texted out the education on handling agitated/aggressive behaviors to the employees. She had not followed up with the employee to see if they actually received the education or understood the education that she sent out. The Nurse consultant stated to the Administrator that it is not enough to text the education out. She needs to provide follow-up to ensure the education was received and the staff understood the information. The Administrator reported she would provide further follow-up.

During an interview on 12/12/22 at 12:30 PM Staff T, CNA, reported they worked 10 PM to 6 AM the past weekend Friday (12/9/22) and Saturday (12/10/22). She reported that she did not do 1:1 supervision for Resident #22 during those shifts, as the schedule indicated she worked as a regular CNA/Certified Medication Aide (CMA). She had been assigned to the D wing but technically they work everywhere in the facility.

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Friday night Resident #22 roamed around the first hour out to the front lounge, then to the dining room for about an hour. She reported they had four staff Friday night and only 2 sides on Saturday night.

During an interview on 12/12/22 at 2:08 PM Staff U, CNA, reported they had not been able to do one to one supervision for Resident #22 on Friday (12/9/22) and Saturday (12/10/22) night. They checked on Resident #22 every 15 - 20 minutes. Staff T, CNA, went back to check the D wing. She stayed up front and watched the A and B hallways. The nurse did their regular job. They have residents that require two staff for their cares so they (Staff U and Staff T) worked together to complete rounds. Staff W, RN, watched the call lights to make sure that no one got up out of bed. Resident #22 sat up in the front lounge area for a few hours, then he got up, walked back to his room, and went to bed around midnight. Staff U explained that they did the best they could.

On 12/12/22 at 2:14 PM Staff W reported they had someone call in that Sunday night at 9:10 PM. She explained that she reached out to several staffing agencies trying to get that staff replaced. She talked to the DON who gave her a list of staff to call. She talked to numerous people and could not get anyone to come in. She stated Resident #22 had been in the front lobby. They gave him food and fluids. Then he wanted to go back to the bathroom. They took him to the bathroom and they stayed with him until he went to sleep. They alternated checking on him but could not stay at his bedside 24/7. She reported she did not have a checklist to sign off, but they checked on him frequently. She reported that

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when the aides did rounds, she would go back, and check on him but she also had a mountain of orders to get through so she did sit at the desk to do orders. He slept the rest of the night. It wasn't easy but they worked as a team to watch him.

On 12/12/22 at 3:48 PM the Administrator provided additional documentation of staff education for 1:1 supervision to all staff and updated the education on handling agitated/aggressive behaviors to ensure staff had received the required information. The Administrator or her Designees provided staff education on-site and via telephone to employees regarding the requirements of 1:1 supervision. The facility implemented the use of walkie talkies to communicate if someone needed to come takeover 1:1 supervision for Resident #22. They revised the daily wing schedules to assign the employee responsible for providing the 1:1 supervision and implemented the use of a sign in/out sheet for those staff providing the 1:1 supervision. The 1:1 supervision education specified Resident #22 to be under supervision at all times. When the Resident is in his room staff may remain outside of the room door. If the Resident is in the hallway, they must be within arms-length of the Resident. The Plan was submitted to the Surveyor via email at 3:48 PM.

During an interview on 12/13/22 at 6:03 AM Staff Z, CNA, reported that she had been assigned to do one to one supervision for Resident #22. She reported she had been with him from 11:00 PM until 6:00 AM that morning. He had been in the front lounge until around midnight, then he went back to his room, and went to bed. Resident #22 slept from midnight to 5 AM, when she reported at 5 AM she got him up and brought him out to

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the dining room for coffee and cookies. Resident #22 observed at this time sitting at the dining room table drinking coffee and eating cookies, under 1:1 supervision.

During an interview on 12/13/22 at 6:13 AM Staff X reported they were able to monitor Resident #22 with 1:1 for supervision during the night. He reported the resident had a good night sleeping from midnight to 5 AM which is his normal routine. He reported he planned to talk with the Director of Nursing (DON) and Administrator about covering the resident's mirror or taking the mirrors out of the room since the mirror seems to trigger his screaming and yelling.

During an interview on 12/13/22 at 9:35 AM the Director of Nursing (DON) reported if a resident is aggressive the resident should be separated back to a different room. The physician should be contacted to give direction on what to do. She would probably put the resident on one to one supervision. When Resident #22 was at the hospital. They had done medication management on him and he didn't have behaviors and had been pleasant. He had bouts in front of the mirror but did not have physical aggression with anyone. She said there were no changes in the Care Plan after the staff observed him air punching, punching the back of the couches, and the door. She told the staff that his sister-in-law was very adamant that he has to get his medications to stay stable for his mental condition. If he didn't take his medications, they would re-approach him, and find a different staff member to try to get his medication administered. If that was unsuccessful, the staff were to try to call the sister-in-law to see if she could convince him to take his medications. The last resort is to call the

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DON to come give his medication. He has a delusional thought process. Some employees state they will not intervene as they do not want to get hit, but she has educated if any other residents come within the vicinity of Resident #22 they need to try to keep the other resident out of Resident #22's space.

The Behavioral Management, Care Management Reference Anger and Aggression Policy dated 5/15 provided by the facility as a policy for accident/supervision documented the following approaches to be utilized:
Dementia and/or related disorders:
1. Rule out potential causes of delirium or infection
2. Respond to cues of stress
3. Evaluate for pain, hunger and need to toilet
4. Reduce potential for injury
5. Plan for regular exercise
6. Be consistent

Psychiatric Disorder:
1. Maintain a safe distance for caregivers and other resident/patients and visitors
2. Remove dangerous objects as able
3. Evaluate for depression and/or psychosis
4. Utilize behavior tracking records to determine time, place, possible triggers and meanings of behavior
5. Listen and validate feelings related to loss and grief
6. Acknowledge anger
7. Avoid rationalization and arguments
8. Include resident/patient and family/responsible party in planning the day and associated cares as much as possible; allow the resident/patient to have control over decisions as much as possible

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F 689	Continued From page 67 The Facility abated the immediate jeopardy on 12/12/22, decreasing the scope and severity to a "D" level deficiency.	F 689		
F 726 SS=D	Competent Nursing Staff CFR(s): 483.35(a)(3)(4)(c) §483.35 Nursing Services The facility must have sufficient nursing staff with the appropriate competencies and skills sets to provide nursing and related services to assure resident safety and attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident, as determined by resident assessments and individual plans of care and considering the number, acuity and diagnoses of the facility's resident population in accordance with the facility assessment required at §483.70(e). §483.35(a)(3) The facility must ensure that licensed nurses have the specific competencies and skill sets necessary to care for residents' needs, as identified through resident assessments, and described in the plan of care. §483.35(a)(4) Providing care includes but is not limited to assessing, evaluating, planning and implementing resident care plans and responding to resident's needs. §483.35(c) Proficiency of nurse aides. The facility must ensure that nurse aides are able to demonstrate competency in skills and techniques necessary to care for residents' needs, as identified through resident assessments, and described in the plan of care. This REQUIREMENT is not met as evidenced by:	F 726	F 726 1. On or before 02/01/23 the DON or designee will conduct an interview with resident #15 relating to how her showers are being given to ensure staff are providing showers per plan of care. 2. On or before 02/01/23 the DON or designee will conduct an audit of how showers are provided to ensure staff are informed and follow resident's plan of care. 3. By 02/01/23 the DON or designee will re-educate CNAs regarding process for showering including following resident's plan of care regarding showers. 4. The DON or designee will complete audits weekly for 4 weeks then monthly for 2 months to ensure staff continue to understand the process of showering and following the residents plan of care. Results of these audits will be taken to the QAPI meeting monthly for 3 months for review and recommendations as needed. The DON is responsible for monitoring and follow-up as needed.	2/1/23

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Based on observations, record review, staff and resident interviews and policy review, the facility failed to provide qualified nursing staff to provide a safe shower to 1 of 3 resident's reviewed for cares (Res #15). The facility reported a census of 55.

Findings include:

The Minimum Data Set (MDS) dated 10/1/22 for Resident #15 revealed a Brief Interview for Mental Status (BIMS) score of 15 indicating intact cognition. The MDS revealed a diagnosis of morbid obesity, arthritis, inability to walk due to both lower extremities being amputated and needed 2 persons to assist with transfers from bed to wheelchair using a mechanical lift.

The Care Plan dated 4/3/22 revealed Resident #15 was not to be left alone in shower chair.

During an interview on 12/6/22 at 10:22 AM Resident #15 stated Staff A, Nurse Assistant (NA) had left her in the sling on the mechanical lift during her shower 3 weeks ago, and Staff B, NA was assisting but walked out of shower and left her in the sling. Resident #15 stated she used a shower chair usually.

During an interview on 12/6/22 at 2:25 PM Staff A, NA stated Resident #15 requested to receive the shower up in the air and told her it was not safe. Staff A stated Resident #15 required 2 persons for transfer in the mechanical lift but did not identify the 2nd assistant. Staff A stated she was a Certified Nurse Assistant in 2001, but it expired and was to take the State testing to become certified on December 13th, 2022.

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F 726	Continued From page 69 During an interview on 12/6/22 at 2:55 PM Staff B, NA stated Resident #15 was a 2 person assist for transfer and shower, and assisted Staff A to the shower room with Resident #15. Staff B stated that Staff A asked how to do this, mechanical lift to the shower chair, and Resident #15 stated to give her a shower in the sling. Staff B stated Staff A was giving the shower to Resident #15 in the sling, and Staff B stated she said that this is not safe and left the shower room. Staff B stated she told the Administrator the next day. A review of Admission Packet Section B Facility Services Care and Treatment revealed a statement; You have a right to: (6 bullet points down) receive services with reasonable accomidation of individual needs and preferences except when the health or safety of you or other residents would be endangered. During an interview on 12/7/22 at 9:02 AM the Director of Nursing (DON) stated she was not aware of the shower given to Resident #15 while in the mechanical lift sling and stated Staff A is not a certified nurse assistant. During an interview on 12/7/22 at 12:15 PM, the Administrator stated both Staff A and Staff B were hired under the waiver and did not know they had to be certified by 11/1/22. The Administrator stated she had both NA's set to challenge the State testing on 12/13/22.	F 726		
F 758 SS=D	Free from Unnec Psychotropic Meds/PRN Use CFR(s): 483.45(c)(3)(e)(1)-(5) §483.45(e) Psychotropic Drugs.	F 758		

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F 758	Continued From page 70 §483.45(c)(3) A psychotropic drug is any drug that affects brain activities associated with mental processes and behavior. These drugs include, but are not limited to, drugs in the following categories: (i) Anti-psychotic; (ii) Anti-depressant; (iii) Anti-anxiety; and (iv) Hypnotic Based on a comprehensive assessment of a resident, the facility must ensure that--- §483.45(e)(1) Residents who have not used psychotropic drugs are not given these drugs unless the medication is necessary to treat a specific condition as diagnosed and documented in the clinical record; §483.45(e)(2) Residents who use psychotropic drugs receive gradual dose reductions, and behavioral interventions, unless clinically contraindicated, in an effort to discontinue these drugs; §483.45(e)(3) Residents do not receive psychotropic drugs pursuant to a PRN order unless that medication is necessary to treat a diagnosed specific condition that is documented in the clinical record; and §483.45(e)(4) PRN orders for psychotropic drugs are limited to 14 days. Except as provided in §483.45(e)(5), if the attending physician or prescribing practitioner believes that it is appropriate for the PRN order to be extended beyond 14 days, he or she should document their rationale in the resident's medical record and	F 758	F 758 1. On 1/19/2023 the RDCS conducted an audit of resident # 37 medication orders to validate there are currently no active prn psychotropic medications orders. 2. On or before 02/01/23 the DON or designee will conduct an audit of resident's orders for prn psychotropic medication and obtain appropriate documentation or discontinue orders from physician as needed. 3. On or before 02/01/23 the DON or designee will re-educate the licensed nurses regarding the requirements of prn psychotropic medications. 4. DON or designee will complete audits weekly for 4 weeks then monthly for 2 months to validate prn psychotropic medication orders continue to have stop dates or appropriate documentation from physician. Results of audits will be taken to the monthly QAPI meeting for 3 months for review and recommendations as needed. The DON is responsible for monitoring and follow-up.	2/1/23

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indicate the duration for the PRN order.

§483.45(e)(5) PRN orders for anti-psychotic drugs are limited to 14 days and cannot be renewed unless the attending physician or prescribing practitioner evaluates the resident for the appropriateness of that medication.
This REQUIREMENT is not met as evidenced by:
Based on record review and staff interview, the facility failed to limit an as needed (PRN) psychotropic medication order to 14 days without a rational and failed to limit a PRN antipsychotic medication to 14 days without an evaluation from the prescribing provider for 1 of 3 residents reviewed in the sample (Resident #37). The facility reported a census of 55 residents.

Findings include:

The quarterly Minimum Data Set (MDS) for Resident #37 dated 10/26/22 documented the resident had diagnoses including traumatic brain injury (TBI), anxiety and depression. The MDS further documented the resident had severely impaired cognitive skills for daily decision making and required assistance of 1 for activities of daily living.

Review of the Care Plan initiated 7/7/22 documented Resident #37 used psychotropic medication related to behaviors and TBI with a goal the resident will remain free of drug related complications. The Care Plan directed staff to:

a. Administer medications as ordered, monitor/document for side effects and effectiveness
b. Consult with pharmacy and Medical Director

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(MD) to consider dosage reduction when clinically appropriate.
c .Gradual dose reduction (GDR) per protocol.
d. Monitor/record/report to MD as needed side effects and adverse reactions of psychoactive medications: unsteady gait, tardive dyskinesia, EPS (shuffling gait, rigid muscles, shaking), frequent falls, refusal to eat, difficulty swallowing, dry mouth, depression, suicidal ideations, social isolation, blurred vision, diarrhea, fatigue, insomnia, loss of appetite, weight loss, muscle cramps nausea, vomiting, behavior symptoms not usual to the person.

Review of pharmacy progress notes dated 6/24/22 revealed a comment was sent to the provider indicating as needed (PRN) haloperidol (antipsychotic) and quetiapine (antipsychotic) cannot exceed 14 days.

Review of pharmacy progress notes dated 7/21/22 revealed a comment was sent to the provider indicating PRN haloperidol and quetiapine cannot exceed 14 days.

Review of pharmacy progress notes dated 8/22/22 revealed a comment was sent to the provider indicating PRN lorazepam (antianxiety) needed a stop date.

Review of August 2022 Medication Administration Record for Resident #37 revealed she received PRN lorazepam 14 days after the order was initiated as follows:
a. 8/25/22 at 3:57 PM
b. 8/27/22 at 3:23 PM
c. 8/28/22 at 8:53 AM
d. 8/28/22 at 2:29 PM

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F 758	Continued From page 73 e. 8/30/22 at 4:51 PM Review of pharmacy progress notes dated 9/20/22 revealed a comment was sent to the provider indicating PRN lorazepam needed a stop date. Review of September 2022 Medication Administration Record for Resident #37 revealed she received PRN lorazepam 14 days after the order was initiated as follows: a. 9/2/22 at 3:43 PM b. 9/22/22 at 2:05 AM c. 9/30/22 at 11:00 PM Review of pharmacy progress notes dated 10/21/22 revealed a comment was sent to the provider indicating PRN lorazepam needed a stop date. Review of October 2022 Medication Administration Record for Resident #37 revealed she received PRN lorazepam 14 days after the order was initiated as follows: a. 10/15/22 at 12:01 AM b. 10/18/22 at 10:12 PM c. 10/23/22 at 1:39 PM d. 10/31/22 at 4:00 AM Record review revealed PRN quetiapine was ordered 6/23/22-7/30/22 for Resident #37 without an evaluation from the provider 14 days after ordered. Record review revealed PRN haloperidol was ordered 6/23/22-7/30/22 for Resident #37 without an evaluation from the provider 14 days after ordered.	F 758		

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F 758	Continued From page 74 Record review revealed PRN lorazepam was ordered 8/10/22-11/4/22 without a rational from the provider 14 days after ordered. Review of facility policy titled Behavior Management: Psychoactive Medication Management/Antipsychotic Medication Management dated May 2014 lacked direction in regards to limiting PRN psychotropic medication to 14 days without a rationale and limiting PRN antipsychotic medication to 14 days without an evaluation from the prescribing provider. During an interview 12/13/22 at 10:36 AM the Director of Nursing acknowledged the facility failed to limit PRN lorazepam to 14 days without a rational to continue and PRN Seroquel and Haldol orders were not limited to 14 days without an evaluation from the provider as expected.	F 758		
F 838 SS=B	Facility Assessment CFR(s): 483.70(e)(1)-(3) §483.70(e) Facility assessment. The facility must conduct and document a facility-wide assessment to determine what resources are necessary to care for its residents competently during both day-to-day operations and emergencies. The facility must review and update that assessment, as necessary, and at least annually. The facility must also review and update this assessment whenever there is, or the facility plans for, any change that would require a substantial modification to any part of this assessment. The facility assessment must address or include: §483.70(e)(1) The facility's resident population, including, but not limited to,	F 838	F 838 1. Administrator completed an update of the facility assessment on or before 02/01/23 to include the acuity needs of the residents in the facility. 2. The IDT team reviewed the facility assessment on or before 02/01/2023 with the administration and updates completed as needed. 3. Regional Director of Clinical Services educated the Administrator on or before 02/01/2023 on the requirement of updating the facility assessment to include the acuity needs of the residents. 4. Administrator/Designee will conduct audits weekly for 4 weeks and then monthly for 2 months to ensure facility assessment continues continues to be updated to included the current acuity needs of the residents. Results of these audits will be presented to the QAPI meeting monthly for 3 months for review and	

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F 838	Continued From page 75 (i) Both the number of residents and the facility's resident capacity; (ii) The care required by the resident population considering the types of diseases, conditions, physical and cognitive disabilities, overall acuity, and other pertinent facts that are present within that population; (iii) The staff competencies that are necessary to provide the level and types of care needed for the resident population; (iv) The physical environment, equipment, services, and other physical plant considerations that are necessary to care for this population; and (v) Any ethnic, cultural, or religious factors that may potentially affect the care provided by the facility, including, but not limited to, activities and food and nutrition services. §483.70(e)(2) The facility's resources, including but not limited to, (i) All buildings and/or other physical structures and vehicles; (ii) Equipment (medical and non- medical); (iii) Services provided, such as physical therapy, pharmacy, and specific rehabilitation therapies; (iv) All personnel, including managers, staff (both employees and those who provide services under contract), and volunteers, as well as their education and/or training and any competencies related to resident care; (v) Contracts, memorandums of understanding, or other agreements with third parties to provide services or equipment to the facility during both normal operations and emergencies; and (vi) Health information technology resources, such as systems for electronically managing patient records and electronically sharing information with other organizations.	F 838	recommendations as needed. Administrator is responsible for monitoring and follow-up	2/1/23

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§483.70(e)(3) A facility-based and community-based risk assessment, utilizing an all-hazards approach.
This REQUIREMENT is not met as evidenced by:
Based on document review and interview, the facility failed to fully address the resident acuity needs in the facility assessment. The facility identified a census of 55 residents.

Findings include:

During an interview on 12/14/22 at approximately 8:00 a.m. the surveyor inquired about the Facility Assessment from survey entrance on 12/05/22. The Administrator reported she still had to update portions of the Facility Assessment.

A review of the Facility Assessment on 12/14/22 at 8:20 a.m. revealed the Facility Assessment lacked documentation of an assessment of resident acuity assistance levels (independent, 1-2 assistance or dependent) for dressing, bathing, transfers, and eating. The Facility Assessment lacked documentation of the resident base for mobility. The Facility Assessment documented it had been reviewed by the Quality Assurance and Performance Improvement (QAPI) committee on 10/04/22.

During an interview on 12/14/22 at 9:30 a.m. the Administrator reported she had started working on the Facility Assessment after she came on board in April 2022. The only Facility Assessment she could find had been the one from 2019 so she worked on getting it updated. She reported she had planned to update the facility assessment this morning (12/14/22) to include

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F 838	Continued From page 77 the percentages on the activities of daily living (ADL) part as she had not understood how to do that. She reported the document had not been completed when it had been reviewed by the quality analysis committee in October 4, 2022.	F 838		
F 880 SS=E	Infection Prevention & Control CFR(s): 483.80(a)(1)(2)(4)(e)(f) §483.80 Infection Control The facility must establish and maintain an infection prevention and control program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of communicable diseases and infections. §483.80(a) Infection prevention and control program. The facility must establish an infection prevention and control program (IPCP) that must include, at a minimum, the following elements: §483.80(a)(1) A system for preventing, identifying, reporting, investigating, and controlling infections and communicable diseases for all residents, staff, volunteers, visitors, and other individuals providing services under a contractual arrangement based upon the facility assessment conducted according to §483.70(e) and following 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;	F 880	F 880 1. On 1/19/2023 the RDCS audited residents # 16, # 38 & # 49 noting they have recovered from COVID 19 and no longer require isolation precautions. 2. On 1/19/2023 the RDCS audited residents with no residents currently requiring isolation for COVID or other infectious disease. 3. The DON or designee will re-educate staff regarding the requirements of infection control including staff viewing the “Clean Hands” video, the “Keep COVID Out” video, the “Sparkling Surfaces” video and the “PPE Lessons” video on or before 02/01/23. A Root Cause Analysis (RCA) was completed by the facility QAPI team on or before 02/01/23/2023 with copy of RCA provided to QIO on or before 02/01/2023. 4. The DON or designee will complere audits weekly for 4 weeks then monthly for 2 months to ensure staff continue to following isolation infection control protocol as required. Results of audits will be taken to the monthly QAPI meeting for 3 months for review and recommendations. The DON is responsible for ongoing monitoring and follow-up.	2/1/23

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(ii) When and to whom possible incidents of communicable disease or infections should be reported;
(iii) Standard and transmission-based precautions to be followed to prevent spread of infections;
(iv)When and how isolation should be used for a resident; including but not limited to:
(A) The type and duration of the isolation, depending upon the infectious agent or organism involved, and
(B) A requirement that the isolation should be the least restrictive possible for the resident under the circumstances.
(v) The circumstances under which the facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease; and
(vi)The hand hygiene procedures to be followed by staff involved in direct resident contact.

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

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

§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, clinical record review and staff interview the facility failed to wear appropriate personal protective equipment for isolation precautions for care of residents positive

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for COVID 19 for 3 of 3 Resident (Resident #16, #38 and #49) sampled for infection control. The facility identified a census of 55 residents.

Findings include:

1. The Minimum Data Set (MDS) assessment dated 10/25/22 showed a Brief Interview for Mental Status (BIMS) score of 15 indicating intact cognition. The Resident required extensive assistance for bed mobility, transfer, dressing, toileting and personal hygiene. The MDS listed a diagnosis of manic depression and anxiety.

A COVID 19 Tracking Excel Spreadsheet provided by the facility documented Resident #49 with an onset of COVID 19 symptoms of body aches and positive COVID 19 test on 12/02/22.

An observation of Resident #49's Room on 12/05/22 at 11:00 revealed a plastic bin positioned outside of the room door containing hand sanitizer, germicidal wipes, isolation gowns, face shields, N95 masks (An N95 respirator is a respiratory protective device designed to achieve a very close facial fit and very efficient filtration of airborne particles) and gloves. The Resident's room door and the isolation bin contained no signage as to the type of isolation, type of personal protective equipment (PPE) to be worn or when the PPE should be worn.

During an observation on 12/05/22 at 11:18 a.m. Staff J, Occupational Therapy Assistant, came out of Resident #49's room. Staff J had a gait belt around her neck touching her isolation gown. She removed the gait belt from around her neck and placed on the hallway handrail outside of Resident #49's door while she removed her gown

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and threw in the isolation trash. She failed to remove and change out her N95 mask after she left the room. She went across the hallway by the fire extinguisher to sanitizer her hands and the hand sanitizer unit did not work. She grabbed the gait belt from the hand rail, went to the hand sanitizer unit by the double doors to sanitized her hands, grabbed the gait belt which had been in the COVID 19 room and placed around her neck and exited the D wing double doors out into the main dining area. She failed to sanitize the gait belt and and change her N95 mask after being in a COVID 19 positive room.

During an observation on 12/05/22 at 11:26 a.m. Staff K, Certified Nursing Assistant, (C.N.A.) wearing only a N95 mask and goggles entered into Resident #49's room without donning an isolation gown. At 11:28 a.m. Staff K left Resident #49's room and went directly across the hallway to room D 32 without performing hand hygiene and without changing her N95 mask or sanitizing her goggles.

During an observation on 12/05/22 at 11:34 a.m. Resident #49 propelled the wheelchair out of room D 29 down the hallway towards room D 34 guiding Staff K to go in the room to get some items out of her regular room. Staff K entered room D 34 without performing hand hygiene still wearing the same N95 mask and goggles she had worn into Resident #49's room to get some items for Resident #49. Resident #49 then went and sat in her wheelchair outside of the hallway to the shower room. Staff k left the D hallway.

During an observation on 12/05/22 at 11:36 a.m. Resident #49 sat in her wheelchair in the D hallway in front of the hallway to the shower

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room. Resident #49 looked at the Surveyor and state, "I'm COVID positive."

During an observation on 12/05/22 at approximately 11:40 a.m. Staff K returned to the D hallway carrying a large pile of clean linens (bed linens, soaker pad and a gown). She proceeded to place the pile of clean linens on top of the isolation bin outside of Resident #49's room. Staff K went up to Resident #49 and informed her due to having COVID she could not use the shower room and to return to her room. Resident #49 returned to her room and left the door open to her room.

During an observation on 12/05/22 at approximately 11:43 a.m. Resident #25 in the next room yelled out of her room to Staff K, "that Resident's (Resident #49) door is supposed to be shut!" Staff K stated, "okay, give me a minute." Then a random resident in room D 32 across the hall, not included in the survey sample, yelled, "am I going to get my coffee." Staff K stated she would get his coffee and exited the D hallway without closing Resident #49's room door. At 11:46 a.m. Staff K returned to the D wing with a cup of coffee and delivered it to room D 32.

During an observation on 12/05/22 at 11:47 a.m. Staff K proceeded to don an isolation gown, face shield and gloves in front of Resident #49's open doorway. A staff member entered the hallway with several covered food trays on a food cart and state, "you're letting the COVID out" motioning to Resident #49's door. Staff K then shut Resident #49's door and waited for Staff F, C.N.A., to bring the Resident's food tray so that she could take it into the room. Staff F returned to the D hallway and handed Resident #49's

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lunch meal items into Staff K to take into Resident #49's room.

During an interview on 12/06/22 at 11:40 a.m. Resident #49 reported the staff are pretty good about having a gown, gloves, N95 mask and face shield on when they come into her room. She did acknowledge that Staff had not had on a gown when she entered her room to get her ready to go for her bath on 12/05/22.

During an observation on 12/06/22 at 11:45 a.m. Resident #49 did not have a garbage receptacle in the room to doff personal protective equipment prior to exiting the room. The resident stated she had a tiny trash can by her bed. Further observation revealed a small trash can by the resident's bedside with no PPE disposed of. Further observation revealed no garbage receptacle outside of Resident #49's room to doff PPE. Staff going down to room D 33 (COVID room) to doff PPE in a garbage receptacle outside of that room. The D wing had not been designated as a COVID only wing.

2. A COVID 19 Tracking Excel Spreadsheet provided by the facility documented Resident #16 tested positive for COVID 19 on 12/09/22.

During an observation on 12/12/22 at 8:34 a.m. Staff AA C.N.A. entered Resident #16's room D 31 wearing an N95 mask that had been worn in other rooms and eye goggles. Room D 31 lacked signage on the outside of the room door to indicate any transmission-based precautions were indicated. Staff AA failed to don a gown or gloves prior to enter Rm D 31. Further observation revealed Staff AA exited room D 31 without performing hand hygiene and changing

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out the N95 mask or disinfecting her eyewear before proceeding to another resident room.

During an interview on 12/15/22 at 2:50 p.m. the DON reported Resident #16 and #49 tested positive for COVID 19 on 12/09/22. She stated the nurses had tested them again in error a second time that week and should not have done so. She stated they use the rapid COVID test and do not do PCR (PCR means polymerase chain reaction. It's a test to detect genetic material from a specific organism, such as a virus) COVID 19 testing. She reported they had purchased more isolation bins, trash cans this week and the Social Service Designee had put the isolation signs up this week on the room door and had missed a few rooms but all of the isolation signs were now up. She confirmed the facility isolates residents that test positive for COVID 19 for 10 days.

3. During an observation on 12/06/22 at 12:36 p.m. Staff N, LPN entered Resident #50's room to perform enteral tube care. Staff N wore her KN95 (KN95 masks have many of the same protective properties of N95 masks) mask below her nose. She set up to flush Resident #50's enteral tube (enteral feeding tubes allow liquid food to enter your stomach or intestine through a tube) with 30 milliliters of water. The syringe wouldn't work to be able to complete the flush. Staff N left Resident #50's room to obtain the correct syringe. At 12:48 p.m. Staff N re-entered Resident #50's room wearing her KN95 mas below her nose. Staff N could not get the syringe to work to complete the flush so she left the room again to obtain another syringe. At 12:51 p.m. Staff N re-entered Resident #50's room wearing her KN95 mask below her nose. She couldn't not

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get the syringe to work to complete the flush. Staff G, Registered Nurse (RN) came into the room and stated she knew exactly what syringe the resident needed for the enteral tube flush. Staff G left the room and then re-entered wearing her KN 95 mask appropriately and handed the correct syringe to Staff N to complete the flush for Resident #50's enteral tube.

4. During an observation on 12/8/22 at 8:00 a.m. Staff L, Licensed Practical Nurse (LPN) had her KN95 mask sitting below her nose when passing medications on D hallway. At 8:15 a.m. she entered room D31-2 to administer medications and resided in the room approximately 15 minutes.

5. During an observation on 12/08/22 at 11:43 a.m. Staff M, C.N.A., assisted Staff F to transfer Resident #32 with a mechanical standing transfer. Staff M wore her N95 mask down below her nose coming within 2 foot of the resident during the standing lift transfer which took approximately 15 minutes.

During an interview 12/13/22 at 9:40 a.m. the DON revealed it would be an expectation staff wear PPE for droplet isolation when working with a resident that is Covid positive.

During an interview on 12/19/22 at 1:57 p.m.the DON reported if the facility is covid positive, she expects teh staff to wear eye protection and an N95 while providing care to residents with the mask placed over the mouth and nose. If staff is in an office or in the break room and not within 6 feet of a resident, they can remove the mask and eye protection.

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The Infection Prevention Two-Tier Transmission Based Precautions Policy dated 03/2015 provided by the facility documented the facility would utilized a Two-Tier Transmission Based Precautions as approved by the Center for Disease Control and Prevention (CDC). Standard Precautions, first-tier, will be utilized on all resident/patients. The Transmission Based Precautions (Contact, Droplet, Airborne), second-tier, will be utilized as applicable. The nurse will have the authority to initiate precautions without a physician's order in an emergency. The Procedure directed the staff in the following:

The Standard Precautions Policy reviewed 3/2022 provided by the facility documented Standard Precautions, first-tier, will be utilized on all residents. The Transmission-Based Precautions (Contact, Droplet, Airborne), second-tier, will be utilized as applicable. The nurse will have the authority to initiate precautions without a physician's order in an emergency. The facility will utilize the Two-Tier Transmission Based Precautions as recommended by the CDC.

Hand Hygiene
1. Perform hand hygiene:
a. After contact with blood, body fluids or surfaces that could be contaminated
b. After removing PPE, including gloves
c. Between resident contact
d. Between tasks and procedures on the same resident to prevent cross contamination of different body sites
e. Immediately after removal of gloves and other PPE
f. Assist resident with hand hygiene after staff assists with toileting tasks

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F 880	Continued From page 86 g. Assist resident with hand hygiene before meals 2. Wash hands promptly: a. After gloves are removed b. Between resident/patient contact c. As indicated to avoid transfer of microorganisms to other resident/patient or environments d. Between tasks and procedures on the same resident/patient to prevention cross contamination of different body sites. Personal Protective Equipment (PPE) Gloves 1. Gloves must be donned before contact of equipment/clothing/exposed skin with blood/body fluids, secretions, and excretions. Clean gloves should also be donned before touching mucous membranes or non-intact skin. 2. Remove gloves after contact with blood, body fluids, mucous membranes, nonintact skin or contaminated surfaces. 3. Change gloves and perform hand hygiene between tasks and procedures on the same resident before moving from a contaminated body site to a clean body site. 4. Remove gloves immediately after use, before touching non-contaminated items and environmental surfaces, and before going to another resident. 5. Perform hand hygiene promptly to avoid transfer of microorganisms to other residents or environment. Mask, Eye Protection, Face Shield 1. Wear a mask and eye protection or a face	F 880		

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shield to protect mucous membranes of the eyes, nose, and mouth
during procedures and resident/patient care activities that are likely to generate splashes or sprays of blood, body
fluids, secretions and excretions.
2. During aerosol-generating procedures on patients suspected or proven infections transmitted by respiratory
aerosols wear a fit-tested N95 or higher respirator in addition to gloves, gown, and face/eye protection.

Gown
1. Wear a gown (clean, non-sterile gown is adequate) to protect skin and to prevent soiling clothing during
procedures and resident/patient care activities that are likely to generate splashes or sprays of blood, body fluids,
secretions, and excretions. Select a gown that is appropriate for the activity and amount of fluid likely to be
encountered.
2. Remove a soiled gown as promptly as possible, and wash hands to avoid transfer of microorganisms to other
resident/patients or environments.

Resident/Patient Placement
1. Place an infectious resident/patient who contaminates the environment in a private room.

Resident/Patient Care Equipment
1. Bag or cover used resident/patient care equipment with blood, body fluids, secretions, and excretions to prevent
skin and mucous membranes exposures, contamination of clothing, or transfer of

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microorganisms to other
resident/patients or environment.
2. Ensure that reusable equipment is not used for the care of another resident until it has been cleaned and
disinfected per manufacturer's instructions. Single use items are to be properly discarded.

The Center for Disease Control and Prevention (CDC) retrieved from https://www.cdc.gov/coronavirus/2019-ncov/hcp/infection-control-recommendations.html directs patients placed in empiric Transmission-Based Precautions based on close contact with someone with SARS-CoV-2 infection should be maintained in Transmission-Based Precautions for the following time periods:
1. Patients can be removed from Transmission-Based Precautions after day 7 following the exposure (count the day
of exposure as day 0) if they do not develop symptoms and all viral testing as described for asymptomatic
individuals following close contact is negative.
2. If viral testing is not performed, patients can be removed from Transmission-Based Precautions after day 10
following the exposure (count the day of exposure as day 0) if they do not develop symptoms.

The CDC Recommended infection prevention and control (IPC) practices when caring for a patient with suspected or confirmed SARS-CoV-2 infection retrieved from https://www.cdc.gov/coronavirus/2019-ncov/hcp/infection-control-recommendations.html specifies the following.

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F 880	Continued From page 89 1. Health Care Personnel who enter the room of a patient with suspected or confirmed SARS-CoV-2 infection should adhere to Standard Precautions and use a NIOSH-approved particulate respirator with N95 filters or higher , gown, gloves, and eye protection (i.e., goggles or a face shield that covers the front and sides of the face). As community transmission levels increase, the potential for encountering asymptomatic or pre-symptomatic patients with SARS-CoV-2 infection also likely increases. In these circumstances, healthcare facilities should consider implementing broader use of respirators and eye protection by health care personnel (HCP) during patient care encounters. For example, facilities located in counties where Community Transmission is high should also consider having HCP use PPE as described below: The National Institute for Occupational Safety and Health (NIOSH) approved particulate respirators with N95 filters or higher can also be used by HCP working in other situations where additional risk factors for transmission are present, such as the patient is unable to use source control and the area is poorly ventilated. They may also be considered if healthcare-associated SARS-CoV-2 transmission is identified and universal respirator use by HCP working in affected areas is not already in place. Eye protection (i.e., goggles or a face shield that covers the front and sides of the face) worn during all patient care encounters.	F 880		

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6. The quarterly MDS dated 11/23/22 revealed Resident #38 had a BIMS score of 15 indicating intact cognition. The MDS documented the resident had diagnoses including Parkinson's disease, renal (kidney) failure and schizophrenia and was independent with most activities of daily living.

Review of progress notes revealed the resident tested positive for Covid on 12/2/22.

Observation 12/2/22 at 2:34 PM revealed a cart with PPE supplies outside of Resident #38's room however signage was not on the resident's door indicating he was in isolation.

On 12/2/22 at 2:34 PM observed Staff V, CNA go into Resident #38's room A01-1 to answer his light wearing an N95 mask and no other personal protective equipment (PPE).

On 12/5/22 at 2:42 PM, observed Staff V go back into Resident #38's room to deliver milk to him that he had requested wearing only an N95 mask and no other PPE staff V remained in the room with him for approximately 1 minute discussing how he was feeling.

On 12/5/22 at 2:52 PM, observed Staff V return to Resident #38's room wearing only an N95 and no other PPE after he had requested to talk to her. Staff V remained in his room for approximately 10 seconds.

During an interview at 2:53 PM, Staff V revealed

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F 880	Continued From page 91 she was agency staff and it was her first time working in the A hallway when asked about not wearing the PPE required in Resident #38's room. During an interview 12/13/22 at 9:40 AM the DON revealed it would be an expectation staff wear PPE for droplet isolation when working with a resident that is Covid positive and signage would be in place indicating the resident was in isolation. 7. On 12/14/22 at 1:25 PM, observed Staff AA, CNA after exiting the door to the resident's designated smoking area immediately pull her mask down below her mouth and put her face shield backwards on top of her head with 6 residents present that had their face masks below their mouths in order to smoke. Staff AA continued to talk with the residents and did not maintain 6 feet distance while her face mask and face shield were not in place. During an interview 12/14/22 at 1:31 PM while the DON was present and also observing Staff AA outside with the residents and not wearing her PPE appropriately, revealed the expectation is for staff to be masked at all times and wear PPE appropriately while they are with the residents.	F 880		
F 943 SS=D	Abuse, Neglect, and Exploitation Training CFR(s): 483.95(c)(1)-(3) §483.95(c) Abuse, neglect, and exploitation. In addition to the freedom from abuse, neglect, and exploitation requirements in § 483.12, facilities must also provide training to their staff that at a minimum educates staff on-	F 943	F 943 1. On or before 02/01/23 the Administrator or designee will review Dependent Adult Certification for staff Q, R, S & T to validate education has been completed. 2. On or before 02/01/23 the Administrator or designee will audit employee records to validate Dependent Adult Abuse training is completed within 6 months of hire. 3. On or before 02/01/23 the Administrator re-educated the BOM regarding tracking when	

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F 943	Continued From page 92 §483.95(c)(1) Activities that constitute abuse, neglect, exploitation, and misappropriation of resident property as set forth at § 483.12. §483.95(c)(2) Procedures for reporting incidents of abuse, neglect, exploitation, or the misappropriation of resident property §483.95(c)(3) Dementia management and resident abuse prevention. This REQUIREMENT is not met as evidenced by: Based on personnel file review, staff interview and policy review, the facility failed to assure 4 of 6 staff reviewed met the requirement for Mandatory Adult Abuse training (Staff Q, Staff R, Staff S, Staff T). The facility reported a census of 55 residents. Findings include: Staff Q, Dietary Aide, had a start date of 9/7/21. Record review revealed Staff Q had not completed the 2 hour Dependent Adult Abuse training until 9/21/22. Staff R, Certified Medication Aide (CMA) had a start date of 10/18/21. Record review revealed she had not completed the 2 hour Dependent Adult Abuse training. Staff S, Housekeeper, had a start date of 12/8/21. Record review revealed she had not completed the 2 hour Dependent Adult Abuse training. Staff T, Certified Nursing Aide (CNA), had a start date of 12/1/21. Record review revealed she had not completed the 2 hour Dependent Adult Abuse training.	F 943	Dependent Adult Abuse training is needed/ completed. 4. Administrator or designee will audit Dependent Adult Abuse training monthly for 3 months to ensure training continues to be completed as required. Results of audits will be taken to the monthly QAPI meeting for 3 months for review and discussion. The DON is responsible for ongoing monitoring and follow-up.	2/1/23

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F 943	Continued From page 93 Facility policy titled, Abuse Prevention and Reporting, revised August 2019 revealed each employee shall be required to complete two hours of training relating to the identification and reporting of dependent adult abuse within six months of initial employment. During an interview 12/14/22 at 2:50 PM, the Administrator revealed it is an expectation Dependent Adult Abuse training is completed within 6 months of employment per policy and acknowledged it had not been.	F 943		