| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
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| F 000 | INITIAL COMMENTS<br><br>Correction date: 8.26.22<br><br>✓ DC<br>The following deficiencies resulted from the facility's annual recertification survey and investigation of complaints #97840-C, #102408-C, 102421-C, 103334-C, #105497-C and facility reported incidents #104467-I, #104468-I, #104470-I, #105273-I, #106597-I conducted August 01, 2022 to August 04, 2022.<br><br>Complaint #97840-C not substantiated.<br>Complaint #102408-C substantiated.<br>Complaint #102421-C not substantiated.<br>Complaint #103334-C substantiated.<br>Complaint #105497-C not substantiated.<br>Facility reported incident #104467-I not substantiated.<br>Facility reported incident #104468-I not substantiated.<br>Facility reported incident #104470-I not substantiated.<br>Facility reported incident #105273-I not substantiated.<br>Facility reported incident #106597-I substantiated.<br><br>See Code of Federal Regulations (42CFR) Part 483, Subpart B-C. | F 000 | | |
| F 580 SS=D | Notify of Changes (Injury/Decline/Room, etc.)<br>CFR(s): 483.10(g)(14)(i)-(iv)(15)<br><br>§483.10(g)(14) Notification of Changes.<br>(i) A facility must immediately inform the resident; consult with the resident's physician; and notify, consistent with his or her authority, the resident representative(s) when there is- | F 580 | | |

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

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 580 | Continued From page 1<br>(A) An accident involving the resident which results in injury and has the potential for requiring physician intervention;<br>(B) A significant change in the resident's physical, mental, or psychosocial status (that is, a deterioration in health, mental, or psychosocial status in either life-threatening conditions or clinical complications);<br>(C) A need to alter treatment significantly (that is, a need to discontinue an existing form of treatment due to adverse consequences, or to commence a new form of treatment); or<br>(D) A decision to transfer or discharge the resident from the facility as specified in §483.15(c)(1)(ii).<br>(ii) When making notification under paragraph (g)(14)(i) of this section, the facility must ensure that all pertinent information specified in §483.15(c)(2) is available and provided upon request to the physician.<br>(iii) The facility must also promptly notify the resident and the resident representative, if any, when there is-<br>(A) A change in room or roommate assignment as specified in §483.10(e)(6); or<br>(B) A change in resident rights under Federal or State law or regulations as specified in paragraph (e)(10) of this section.<br>(iv) The facility must record and periodically update the address (mailing and email) and phone number of the resident representative(s).<br><br>§483.10(g)(15)<br>Admission to a composite distinct part. A facility that is a composite distinct part (as defined in §483.5) must disclose in its admission agreement its physical configuration, including the various | F 580 | | |

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| F 580 | Continued From page 2<br>locations that comprise the composite distinct part, and must specify the policies that apply to room changes between its different locations under §483.15(c)(9).<br>This REQUIREMENT is not met as evidenced by:<br>Based on clinical record review, facility document review and staff interview, the facility failed to notify the physician of a missing Fentanyl patch for 1 of 4 resident (Resident #11) reviewed. The facility identified a census of 38 residents.<br><br>Findings include:<br><br>The Minimum Data Set (MDS) assessment dated 7/14/22 showed Resident #11 with a Brief Interview for Mental Status (BIMS) score of 99, with long/short term memory loss and severely impaired daily decision making. The Resident required extensive assistance with bed mobility, transfer, dressing, toileting and personal hygiene. The MDS documented a diagnosis of unspecified dementia without behavioral disturbance, hospice care and use of opioid medication.<br><br>A Physician Order signed on 7/19/22 listed an order for Fentanyl 12 microgram (mcg) transdermal patch, apply to meaty part of body every 3 days for pain.<br><br>A Medication Administration Record (MAR), July 2022, documented on 7/23/22 at 6:57 p.m. Staff D, Registered Nurse (RN) placed a new Fentanyl Patch 12 mcg/hour topically on Resident #11. The MAR documented on 7/23/22 Staff E, RN, 10:00 p.m. to 6:00 a.m. charge nurse documented a placement check on the Fentanyl Patch present on the Resident's "left." The MAR documented a new Fentanyl Patch 12 mcg/her | F 580 | | |

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| F 580 | Continued From page 3<br>applied as ordered on 7/26/22 at 6:33 p.m.<br><br>A Health Status Note dated 7/24/2022 at 10:04 a.m. documented by Staff A, RN documented she checked Resident #11 for a Fentanyl (Patch) placement and no patch noted on her left lateral deltoid; patch was changed last evening. Torso checked and no patch noted. Staff A checked the resident's clothing that she wore; no patch. She asked the Resident Care Technician (RCT) if she saw a Fentanyl patch on resident left upper arm when doing morning cares and she says she did not see a patch. Staff A checked the resident's bedding and found no patch. Staff A documented she spoke to Staff B, RCT, in laundry to see if she had seen a patch and Staff B responded no, but she would monitor the laundry and let her know. Staff A called the on-call nurse and informed her of missing Fentanyl patch as well as the Assistant Director of Nursing (ADON).<br><br>The July 2022 MAR lacked documentation that a new Fentanyl Patch had been applied as physician ordered for Resident #11. The MAR documented the resident received Morphine Sulfate (Concentrate) Solution 20 Milligrams (mg)/Milliliter (ml). Give 0.25 ml by mouth every 2 hours as needed for shortness of breath or pain. Administered:<br>a. 7/25/22 at 00:03 a.m., pain level 9 on 1-10 scale;<br>b. 7/25/22 at 5:41 p.m., pain level 5 on 1-10 scale;<br>c. 7/26/22 at 8:05 a.m., pain level 9 on 1-10 scale;<br>d. 7/26/22 at 5:55 p.m., pain level 4 on 1-10 scale;<br><br>The July 2022 MAR also documented the | F 580 | | |

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| F 580 | Continued From page 4 | F 580 | | |

following medication administered to Resident #11: Lorazepam Tablet 1 mg. Give 1 mg by mouth every 2 hours as needed for restlessness. The MAR documented the resident received the medication as follows:
a. 7/24/22 at 8:54 a.m.
b. 7/24/22 at 3:06 p.m.
c. 7/25/22 at 00:001 a.m.
d. 7/25/22 at 11:38 a.m.
e. 7/25/22 at 5: 41 p.m.

A review of the Progress Notes from 7/24/22 thru 8/03/22 and a review of the Resident's paper medical chart lacked documentation of notification to the physician via call or facsimile regarding the missing Fentanyl Patch.

During an interview on 9/04/22 at 9:27 a.m. the Hospice Nurse reported Staff A notified her the same day the Fentanyl Patch went missing. She stated she had been in the facility for another resident; she didn't actually see Resident #11 that day and did not contact any physician on the missing pain medication. The Hospice Nurse stated she assumed the facility put on another Fentanyl patch for pain and did not address it with the facility; Staff A never asked her about additional pain medication.

During an interview on 9/04/22 at 9:33 a.m. Staff A reported the Hospice Nurse had been in the facility to see another resident and she had informed her of Resident #11's missing Fentanyl patch. Staff A reported she had been really busy addressing the care of another resident and she did not notify Resident #11's physician or address if another Fentanyl Patch should have been applied. She stated that Resident #11 did have as needed (PRN) Morphine for pain and she

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| F 580 | Continued From page 5<br>remembered giving the PRN Morphine for pain that day and probably should have notified the physician.<br><br>During an interview on 8/04/22 at 10:57 a.m. the Assistant Director of Nursing (ADON) reported she didn't know the facility's policy on physician notification regarding to missing medications, but she would have expected someone, either the charge nurse or the Hospice nurse to notify the physician of the missing Fentanyl patch and address pain medication needs if another patch needed to be applied. It should have been addressed with the physician by someone.<br><br>The Physician Notification Policy, undated, provided by the facility listed a Procedure that included:<br>1. Physicians will be notified promptly of the following:<br>A. Any accident or unusual incident.<br>B. Any accident or incident which results injury which may require physician intervention.<br>C. A significant change in resident condition which is life threatening.<br>D. A significant change in resident condition which has potential for clinical complication.<br>E. A change in condition which requires a significant alteration in treatment.<br>F. Death of a resident.<br>G. Discharge or transfer of a resident.<br>2. Same Day Fax notification may be utilized for condition changes, transfer, discharges, accident and incidents, and other events which do not require immediate attention. | F 580 | | |
| F 609 SS=D | Reporting of Alleged Violations<br>CFR(s): 483.12(c)(1)(4) | F 609 | | |

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| F 609 | Continued From page 6<br>§483.12(c) In response to allegations of abuse, neglect, exploitation, or mistreatment, the facility must:<br><br>§483.12(c)(1) Ensure that all alleged violations involving abuse, neglect, exploitation or mistreatment, including injuries of unknown source and misappropriation of resident property, are reported immediately, but not later than 2 hours after the allegation is made, if the events that cause the allegation involve abuse or result in serious bodily injury, or not later than 24 hours if the events that cause the allegation do not involve abuse and do not result in serious bodily injury, to the administrator of the facility and to other officials (including to the State Survey Agency and adult protective services where state law provides for jurisdiction in long-term care facilities) in accordance with State law through established procedures.<br><br>§483.12(c)(4) Report the results of all investigations to the administrator or his or her designated representative and to other officials in accordance with State law, including to the State Survey Agency, within 5 working days of the incident, and if the alleged violation is verified appropriate corrective action must be taken.<br>This REQUIREMENT is not met as evidenced by:<br>Based on clinical record review, facility document review, staff interviews and facility policy review, facility staff failed to report to the Department of Inspection and Appeals a missing Fentanyl patch for one resident (#11) and failed to report an allegation of verbal and physical abuse in a timely manner for another resident (#14) of five residents reviewed for abuse prevention. The facility identified a census of 38 residents. | F 609 | | |

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| F 609 | Continued From page 7<br><br>Findings include:<br><br>1. The Minimum Data Set (MDS) assessment dated 7/14/22 showed Resident #11 with a Brief Interview for Mental Status (BIMS) score of 99, with long/short term memory loss and severely impaired daily decision making. The resident required extensive assistance with bed mobility, transfer, dressing, toileting and personal hygiene. The MDS documented a diagnosis of unspecified dementia without behavioral disturbance and that she received hospice care and opioid medication.<br><br>A Medication Administration Record (MAR), dated July 2022, documented on 7/23/22 at 6:57 p.m. Staff D, Registered Nurse (RN) placed a new Fentanyl Patch 12 mcg/hr (microgram/hour) topically on Resident #11. The MAR documented on 7/23/22 Staff E, RN, 10:00 p.m. to 6:00 a.m. charge nurse documented a placement check on the Fentanyl Patch present on the resident's "left."<br><br>A Health Status Note dated 7/24/2022 at 10:04 a.m. documented by Staff A, RN documented she checked Resident #11 for a Fentanyl (Patch) placement and no patch noted on her left lateral deltoid; patch was changed last evening. Torso checked and no patch noted. Staff A checked the resident's clothing that she wore; no patch. She asked the Resident Care Technician (RCT) if she saw a Fentanyl patch on resident left upper arm when doing morning cares and she says she did not see a patch. Staff A checked the resident's bedding and found no patch. Staff A documented she spoke to Staff B, RCT, in laundry to see if she had seen a patch and Staff B responded no, but she would monitor the laundry and let her | F 609 | | |

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| F 609 | Continued From page 8 | F 609 | | |

know. Staff A called the on-call nurse and informed her of missing Fentanyl patch as well as the Assistant Director of Nursing (ADON).

During an interview on 8/02/22 at 2:18 p.m. the Administrator reported the missing patch was not reported into the Department of Inspection and Appeals (DIA) as she had not known about it. The Administrator learned of the incident that day. The Administrator stated she had not been able to get into the DIA on-line reporting system and would have expected the incident to have been reported to DIA.

During an interview on 8/02/22 at 2:35 p.m. the Assistant Director of Nursing (DON) reported she received a call from Staff A when the Fentanyl Patch went missing. She had inquired if Staff A had informed the on-call nurse and told her to follow what the on-call nurse had informed her to do what the on-call nurse, Staff C, Licensed Practical Nurse (LPN) said to do. The ADON reported it was a Sunday and she and the DON were both off on Monday so she texted the MDS Coordinator and told her to check and be sure that everything had been followed up on Monday.

During an interview on 8/2/22 at 3:09 p.m. the MDS Coordinator reported when she came in on Monday she pulled the schedules, face sheet, and medication sheets for the investigation. She did not know if the incident was reported to DIA, but she did not report it. The MDS Coordinator stated the Administrator was usually the one that reported incidents into DIA. Usually someone will text the Administrator when something occurs that needed to be reported, but there was so many hand in the pot that she didn't ask any questions. The MDS Coordinator didn't ask if

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| F 609 | Continued From page 9<br>anyone had reported the incident.<br><br>During an interview on 8/02/22 at 3:44 p.m. the DON reported she completed an investigation on Resident #11's missing patch when she had returned to work on Tuesday 7/26/22. The DON stated she did not report the missing Fentanyl Patch to DIA and had not thought about reporting. She reported she would have to check the facility policy as to what it directed on reporting.<br><br>During an interview on 8/03/22 at 12:30 p.m. the Administrator stated she had not reported the incident into DIA since the surveyors were already on site and looking at the incident.<br><br>A Missing Narcotic (Patch/tab/liquid) Protocol, dated 7/27/22, provided by the facility and signed by the DON listed the following steps:<br>1. The staff will notify the nurse manager on call.<br>2. No staff leave the facility until statements are taken and search is completed.<br>3. The DON/Administrator must be notified.<br>4. Pull schedules to see who worked the shift before as staff members not at the facility at the time of the missing narcotic noticed may also need to be questioned. All staff being interviewed must be asked the same questions. It is easier to go with yes/no questions.<br>5. When instructing staff, please make sure you have dates/times on the statements of when the questioning is being done but also when last time seen, etc.<br>6. Make sure the physician is being notified.<br>7. Instruct the nurse to not enter anything into the nurses notes. The note will be entered after all information is gathered/investigation completed.<br>8. If any questions please call DON or if not available contact the corporate nurse. | F 609 | | |

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The protocol lacked any direction on reporting to DIA.

The Nursing Facility Abuse Prevention, Identification, Investigating and Reporting Policy, dated July 2019, provided by the facility, defined abuse of "Misappropriation of Resident property" means the deliberate misplacement, exploitation, or wrongful temporary or permanent use of a Resident's belongings or money without the Resident's consent. This includes misappropriation or diversion of resident medications. The Policy Reporting requirements state allegations of Resident abuse, neglect, exploitation, mistreatment, injuries of unknown origin and misappropriation should be reported immediately to the charge nurse. The charge nurse is responsible for immediately reporting the allegation of abuse to the Administrator, or designated representative. All allegations of Resident abuse shall be reported to the Iowa Department of Inspection and Appeals not later than two (2) hours after the allegation is made. All allegations of Resident neglect, exploitation, mistreatment, injuries of unknown origin and misappropriation shall be reported to the Iowa Department of Inspection and Appeals, not later than two (2) hours after the allegation is made, if the events that cause the allegation result in serious bodily injury, or not later than twenty-four (24) hours if the events that cause the allegation involve neglect, exploitation, mistreatment, injuries of unknown origin and misappropriation, but do not result in serious bodily injury.

2. The MDS assessment dated 5/16/22 documented Resident #14 had diagnoses that included heart failure, high blood pressure, stroke, malnutrition and depression. The

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| F 609 | Continued From page 11<br>assessment documented the resident possessed severely impaired memory and cognition, as evidenced by a BIMS score of six. The assessment documented the resident required the assistance of two staff with transfers, walking in her room and toilet use and the assistance of one staff with personal hygiene. The MDS documented Resident #14 had no behavioral symptoms or refusal of care during the assessment period.<br><br>Review of Resident #14's Confidential Incident Report documented an incident of alleged abuse that occurred on 05/22/2022 at 12:30 PM.<br><br>The DIA Intake Submission time documented Resident #14's allegation of abuse as submitted on 05/23/22 at 11:08 AM.<br><br>During an interview on 08/03/22 at 10:55 AM, the prior Administer stated he worked as the Administrator of the facility at the time of the incident on 05/22/22 with Resident #14. He stated he was informed right way by the DON on a Sunday and believed he reported it to DIA first thing on Monday.<br><br>During an interview on 08/04/22 at 11:12 AM with the Administrator revealed she was not working at the facility during the incident with Resident #14 on 05/22/22 but would have reported the alleged abuse to DIA within two (2) hours. | F 609 | | |
| F 623 SS=D | Notice Requirements Before Transfer/Discharge<br>CFR(s): 483.15(c)(3)-(6)(8)<br><br>§483.15(c)(3) Notice before transfer.<br>Before a facility transfers or discharges a resident, the facility must- | F 623 | | |

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| F 623 | Continued From page 12<br>(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.<br>(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<br>(iii) Include in the notice the items described in paragraph (c)(5) of this section.<br><br>§483.15(c)(4) Timing of the notice.<br>(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.<br>(ii) Notice must be made as soon as practicable before transfer or discharge when-<br>(A) The safety of individuals in the facility would be endangered under paragraph (c)(1)(i)(C) of this section;<br>(B) The health of individuals in the facility would be endangered, under paragraph (c)(1)(i)(D) of this section;<br>(C) The resident's health improves sufficiently to allow a more immediate transfer or discharge, under paragraph (c)(1)(i)(B) of this section;<br>(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<br>(E) A resident has not resided in the facility for 30 days.<br><br>§483.15(c)(5) Contents of the notice. The written | F 623 | | |

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| F 623 | Continued From page 13<br>notice specified in paragraph (c)(3) of this section must include the following:<br>(i) The reason for transfer or discharge;<br>(ii) The effective date of transfer or discharge;<br>(iii) The location to which the resident is transferred or discharged;<br>(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;<br>(v) The name, address (mailing and email) and telephone number of the Office of the State Long-Term Care Ombudsman;<br>(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<br>(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 advocacy of individuals with a mental disorder established under the Protection and Advocacy for Mentally Ill Individuals Act.<br><br>§483.15(c)(6) Changes to the notice.<br>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 | F 623 | | |

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| F 623 | Continued From page 14<br>becomes available.<br><br>§483.15(c)(8) Notice in advance of facility closure<br>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).<br>This REQUIREMENT is not met as evidenced by:<br>Based on clinical record review and staff interview, the facility failed to notify the Long-Term Care Ombudsman of residents discharging the facility for one of four residents reviewed (Resident #14). The facility reported a census of 38 residents.<br><br>Findings include<br><br>1. Record review of Resident #14's Minimum Data Set (MDS) log documented a discharge on 05/04/2022.<br><br>Record review of Resident #14's MDS log documented a reentry to the facility on 05/09/22.<br><br>Record review of the facility's May 2022 Ombudsman Notification logs revealed no notification to the Ombudsman that Resident #14 discharged on 05/04/22.<br><br>During an interview 8/2/22 at 3:15 PM the facility Administrator verified that the LTC Ombudsman office had not been notified of the transfer to the hospital for Residents #14 and there had been a | F 623 | | |

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| F 623 | Continued From page 15<br>miscommunication about this requirement but it has been corrected and will be done going forward. | F 623 | | |
| F 684 SS=D | Quality of Care<br>CFR(s): 483.25<br><br>§ 483.25 Quality of care<br>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.<br>This REQUIREMENT is not met as evidenced by:<br>Based on record review, staff interviews, and policy review the facility failed to provide as needed (PRN) diuretic medication as directed by the physician for 1 of 1 residents reviewed for diuretic PRN medication (Resident #36). The facility reported a census of 38 residents.<br><br>Findings include:<br><br>The Five Day Scheduled Minimum Data Set (MDS) dated 3/14/22 documented that Resident#36 had diagnoses including coronary artery disease, and congestive heart failure. The MDS documented that the resident had taken diuretic medication the last seven days.<br><br>The Medication Administration Record (MAR) for Resident#36 dated 5/1/22 to 5/31/22 documented the following order with start date of 3/7/22; Torsemide (diuretic medication) tablet 20 MG, give 1 tablet by mouth every 24 hours as needed | F 684 | | |

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| F 684 | Continued From page 16<br>for weight gain PRN in addition to daily dose for three pounds (lbs). weight gain, continue until weight back to normal.<br><br>Record review of a document titled Weights and Vitals Summary for Resident #36 documented:<br>05/15/22 weight 206 lbs.<br>05/16/22 weight 207 lbs. and 210 lbs.<br><br>Record review of Resident #36 May 2022 MAR lacked administration of Torsemide Tablet 20 MG, give 1 tablet by mouth every 24 hours as needed from 05/15/22 to 05/16/22.<br><br>Record review of a document titled Weights and Vitals Summary for Resident #36 documented:<br>Record review of Resident #36<br>07/15/22 wight 195 lbs.<br>07/16/22 no weight documented<br>07/17/22 weight 203 lbs.<br><br>Record review of Resident #36 July 2022 MAR lacked administration of Torsemide Tablet 20 MG, give 1 tablet by mouth every 24 hours as needed from 07/15/22 to 07/17/22<br><br>Record review of Resident #36 current Care Plan instructed staff on the following:<br>Focus: Resident receives diuretic therapy related to Heart Failure, date initiated: 01/26/22<br>Goal: Resident will receive diuretic as ordered and be free from medication side effects, revised on: 01/26/22<br>Intervention: Administer diuretic as ordered, date initiated: 01/26/22<br><br>During an interview on 08/04/22 at 11:14 AM with the Administrator revealed she would expect for PRN diuretic medication to be given if it met the | F 684 | | |

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| F 684 | Continued From page 17<br>order criteria and did not constitute a reweigh.<br><br>Record review of a policy titled, Medication Administration, dated 10/10/2019 instructed the facility on the following:<br>Whenever medications are administered on an "as needed" (PRN) basis, the staff administering the dose is responsible for documenting the administration. The nurse will be responsible for assessing the need and effectiveness of the PRN medication. | F 684 | | |
| F 808 SS=D | Therapeutic Diet Prescribed by Physician<br>CFR(s): 483.60(e)(1)(2)<br><br>§483.60(e) Therapeutic Diets<br>§483.60(e)(1) Therapeutic diets must be prescribed by the attending physician.<br><br>§483.60(e)(2) The attending physician may delegate to a registered or licensed dietitian the task of prescribing a resident's diet, including a therapeutic diet, to the extent allowed by State law.<br>This REQUIREMENT is not met as evidenced by:<br>Based on observation, staff interviews and record review the facility failed to provide 1 of 38 residents (Resident #9) with their physician prescribed diet. The facility reported a census of 38 residents.<br><br>Findings include<br><br>The Quarterly Minimum Data Set (MDS) dated 5/26/22 documented that Resident#9 had diagnoses including stroke, and gastro-esophageal reflux disease. The MDS documented that the resident had impairment of | F 808 | | |

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| F 808 | Continued From page 18<br>one upper extremity, and required meal set up assist of one staff member.<br><br>Record review of a document titled Diet Type Report, dated 08/01/2022 documented Resident #9 is to received a mechanical soft diet.<br><br>Record review of Resident #9 current Care Plan documented and intervention of; provide with diet as ordered, initiated on 11/24/2015 and last revised on 12/15/2016.<br><br>Record review of Resident #9 Orders documented a diet of: General diet, Mechanical Soft texture, Regular consistency, with a start date of 10/07/2019.<br><br>During an observation on 08/03/22 at 12:38 PM of a Certified Nursing Assistant (CNA) providing regular diet to Resident #9.<br><br>During an observation on 08/03/22 at 12:42 PM the Dietary Manger realized Resident #9 received the wrong diet. Observed Resident #9 consumed approximately 1/4 of the regular. The Dietary Manager removed the regular diet plate of food and provided the correct diet of mechanical soft to Resident #9.<br><br>During an interview on 08/04/22 at 10:45 AM with the Assistant Director of Nursing (ADON) revealed she would expect residents to receive the correct diets. | F 808 | | |
| F 812 SS=E | Food Procurement,Store/Prepare/Serve-Sanitary CFR(s): 483.60(i)(1)(2)<br><br>§483.60(i) Food safety requirements.<br>The facility must - | F 812 | | |

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| F 812 | Continued From page 19<br><br>§483.60(i)(1) - Procure food from sources approved or considered satisfactory by federal, state or local authorities.<br>(i) This may include food items obtained directly from local producers, subject to applicable State and local laws or regulations.<br>(ii) This provision does not prohibit or prevent facilities from using produce grown in facility gardens, subject to compliance with applicable safe growing and food-handling practices.<br>(iii) This provision does not preclude residents from consuming foods not procured by the facility.<br><br>§483.60(i)(2) - Store, prepare, distribute and serve food in accordance with professional standards for food service safety.<br>This REQUIREMENT is not met as evidenced by:<br>Based on observation, staff interviews and policy review the facility failed to keep the facilities oven and convection oven free of black and brown buildup. The facility reported a census of 38 residents.<br><br>Findings include<br><br>During an observation on 08/01/22 from 9:20-9:40 AM revealed the facilities kitchen oven with black build up noted to stove. The facilities convection oven also observed with black buildup and brown exterior buildup.<br><br>During an interview on 08/01/22 from 9:20-9:40 AM with the Dietary Manager revealed she would like the ovens cleaner, but unable to with staffing levels right now.<br><br>Record review of a undated kitchen cleaning | F 812 | | |

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| F 812 | Continued From page 20<br>policy, titled Cleaning of Kitchen Items documented the following instructions:<br>a. Stove<br>1. Daily, wipe up any spills with warm soapy water.<br>2. If large spill occurs pray with oven cleaner, allow time to sit and scrub clean.<br>3. Some spill may clean up by sending through dish machine: do at the end of doing dishes<br>4. Weekly: The grates must be scrubbed clean and put through dish machine. Also while grates are off stove remove burners and place upside down on another burner. Turn flame on to burn carbon off for 5-10 minutes, remove burner, handle with potholders (to prevent burning yourself), replace. Monthly: The pipes should be scrubbed/clean. You can spray with oven cleaner if needed. Remember to use personal protective equipment.<br><br>b. Oven<br>1. Remove racks and place in large sinks.<br>2. Spray oven cleaner on racks and inside the oven.<br>3. Allow time to sit and soak.<br>4. wipe with wet rag.<br>5. Wipe with rag twice and use clean rag second time.<br>6. Recipe with wet rag if white spots remain, wipe dry. | F 812 | | |
| F 868 SS=C | QAA Committee<br>CFR(s): 483.75(g)(1)(i)-(iii)(2)(i)<br><br>§483.75(g) Quality assessment and assurance.<br>§483.75(g)(1) A facility must maintain a quality assessment and assurance committee consisting at a minimum of:<br>(i) The director of nursing services; | F 868 | | |

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| F 868 | Continued From page 21<br>(ii) The Medical Director or his/her designee;<br>(iii) At least three other members of the facility's staff, at least one of who must be the administrator, owner, a board member or other individual in a leadership role;<br><br>§483.75(g)(2) The quality assessment and assurance committee must:<br>(i) Meet at least quarterly and as needed to identifying issues with respect to which quality assessment and assurance activities are necessary.<br>This REQUIREMENT is not met as evidenced by:<br>Based on document review, policy review and staff interview the facility failed to have the Medical Director in attendance at least quarterly for the Quality Assurance and Performance Improvement (QAPI) meetings. The facility identified a census of 38 residents.<br><br>Findings include:<br><br>A review on 8/03/22 of the QAPI Meeting Attendance Signature Sheets, provided by the facility, showed from October 1, 2021 thru June 30th, 2022 the Medical Director had not signed in and attended any of the QAPI meetings. The July 2022 QAPI Meeting Attendance Signature Sheet showed the Medical Director did attend the July 2022 meeting.<br><br>During an interview on 8/03/22 at approximately 12:27 PM the Administrator reported they had switched Medical Directors and the previous Medical Director had not attended the QAPI Meetings. She stated they are working to correct that. Her expectation is that the Medical Director would attend and participate in the QAPI | F 868 | | |

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| F 868 | Continued From page 22<br>meetings.<br><br>The QAPI Plan, undated, provided by the facility documented all department managers, the administrator, the director of nursing, infection control and prevention officer, medical director, consulting pharmacist and up to three additional staff members will provide QAPI leadership by being on the Quality Assurance Assessment (QAA) Committee.<br><br>The New Hampton Nursing and Rehab Center QAPI meeting schedule, provided by the facility documented the facility planned to have QAPI meetings for the following dates with the Medical Director in attendance:<br>1. July 21, 2022<br>2. August 18, 2022<br>3. September 15, 2022<br>4. October 20th 2022<br>5. November 17, 2022<br>6. December 15, 2022 | F 868 | | |
| F 908 SS=F | Essential Equipment, Safe Operating Condition<br>CFR(s): 483.90(d)(2)<br><br>§483.90(d)(2) Maintain all mechanical, electrical, and patient care equipment in safe operating condition.<br>This REQUIREMENT is not met as evidenced by:<br>Based on observation, interviews, and dryer manual review the facility failed to keep access panels to two (2) dryers closed when running the dryers to dry clothing and linens. The facility reported a census of 38 residents.<br><br>Findings include | F 908 | | |

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| F 908 | Continued From page 23<br>During an observation on 08/03/22 at 08:45 AM of the facilities laundry room revealed two (2) dryers one (1) running with a very well contained orange fire inside the machines. The access panel open with the keys in the lock.<br><br>During an interview on 08/03/22 at 08:45 AM with the Laundry Supervisor revealed the access panels to the dryers are closable by lock and key but the heat goes out when they are closed, so they are kept open for air flow. She then revealed the lint traps are cleaned after every load with a broom and also cleaned with a shop vac monthly.<br><br>During an interview on 08/03/22 at 10:12 AM with the facilities dryer servicing company revealed the following information.<br>The whole point of the dryer access panel lock is for it to be locked when the dryer is in use. The access panel is used for maintenance purposes only. If they are having issues with airflow then they need to have that looked at and get adjusted or we would fix the switch. The access panel should be shut to keep the air flow coming in from the bottom of the machine and working up, keeping the panel open affects that. The dryers could get too and potentially not trip the three (3) safety's built into the machine. The flames should be blue in color. If the flames are orange the flame could ignite the burners causing a serious dryer fryer. The orange flame is concerning because its getting to much air flow and those safety's would not trip.<br><br>During an interview on 08/03/22 at 12:40 PM with the Maintenance Supervisor revealed last month he completed cleaning of the lint vent/trap with a shop vac on the underneath inside the dryer, backside if the dryer, and vents. | F 908 | | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 165297 | A. BUILDING _____ B. WING _____ | 08/04/2022 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| NEW HAMPTON NURSING & REHAB CE | 703 SOUTH FOURTH AVENUE NEW HAMPTON, IA 50659 |

| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) | (X5) COMPLETION DATE |
|---|---|---|---|---|
| F 908 | Continued From page 24<br><br>During interview and observation on 08/03/22 01:08 PM with Laundry Supervisor revealed the dryers typically have orange flames that stay on and once it gets hot enough they turn blue. Flames were observed by the Laundry Supervisor as orange in color during the observation while the machine was running<br><br>During an interview on 08/03/22 at 01:11 PM with the Laundry Supervisor revealed the access panels have been vented since she has been working here and that is greater than 9 years. Dryers were observed running with access panels open.<br><br>During an interview on 08/04/22 at 11:14 AM with the facilities Administrator revealed the dryers are not serviced on a regular basis just when needed.<br><br>During an interview on 08/04/22 at 11:17 AM with the facilities Administrator revealed they have closed the access paned and they will stay stay closed now.<br><br>Record review of and undated laundry cleaning check list instructed the facility to daily:<br>a. Clean dryers after each use<br>b. clean dryer lint traps after each load<br><br>Record review of the facilities dryer manual provided by the facility dated December 2016 instructed the facility to:<br>a. WARNING: Never start the tumbler with any guards/panels removed.<br>b. Control panel and access panel MUST be reinstalled after inspection or servicing of the tumble dryer is completed | F 908 | | |

8/20/2022

Preparation and/or execution of this Plan of Correction does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The Plan of Correction is prepared and/or executed solely because it is required by the provisions of Federal and Sate laws. Without waiving the foregoing statement, the facility states as follow:

F580 Notify of Changes

Resident #1's physician was notified of the missing fentanyl patch on 8/11/22. Nurses were re-educated on physician notification policy by the Director of Nursing. The Director of Nursing or Designee will audit physician notifications randomly for completion. This will be on going.

F609 Reporting of Alleged Violations

Resident #11 missing fentanyl patch was reported to the Department of Inspections and Appeals on 8/02/22 by this Administrator. Resident #14 alleged abuse allegations were reported to the Department of Inspections and Appeals on 5/23/22 by the former administrator. Nursing staff were educated on the requirement to notify DIA of missing medications by the Administrator. The alleged abuse reporting timelines were re-educated to staff by the Administrator. The Director of Nursing or designee will review all missing medication incidents daily. The administrator will be notified and review all allegations of abuse for timely report. This will be ongoing.

F623 Notice Requirements of Transfer/Discharge

Resident #14 notice of transfer was reported to the State Ombudsman on 8/22/22 by the Administrative Assistance. Education was provided on reporting requirements by the Administrator. This will be audited monthly by the Administrative Assistant or designee. This will be ongoing.

F684 Quality of Care

Resident #36 PRN order was reviewed by nursing staff on 8/23/22. Nursing staff were educated on following physician orders by the Director of Nursing. PRN medication orders will be audited for appropriateness and proper complication randomly weekly by the Director of Nursing or designee. This will be ongoing.

F808 Therapeutic Diets

Resident #9's diet was reviewed with dietary staff on 8/3/22. All dietary staff were educated on resident's therapeutic diet policy by the dietitian. Resident diet orders will be audited randomly by the Dietitian or designee. This will be ongoing.

F812 Food Procurement Store/Prepare/Serve Sanitary

The oven and convection oven were cleaned on 8/26/22 by dietary staff. Dietary staff were educated on the cleanliness of the dietary equipment by the Administrator. The dietary supervisor or designee will audit the oven and convection oven will be audited for cleanliness weekly for 6 months. This will be ongoing.

F868 QAA Committee

A new medical director started April 2022. The QA committee was educated on the requirements of the medical director attendance by the Administrator. This will be reviewed quarterly by the Administrator or designee. This will be ongoing.

F908 Essential Equipment in working condition

The laundry vents were closed and locked on 8/3/22 by the maintenance director. The laundry staff and maintenance were educated on keeping the vent closed by the Administrator. The maintenance director or designee will audit the closure of the vents weekly. This will be on going.