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| F 000 ✓ ok/cp | INITIAL COMMENTS<br>Correction date: 10/30/23<br><br>The following deficiencies resulted from the facility's Annual Recertification survey and investigation of Complaints #113991-C, # 114060-C, #114948-C, #115646-C, #116021-C and Facility Reported Incidents #113169-I conducted September 25,2023 to October 5, 2023.<br><br>Complaint #113991-C, #114060-C, #114948-C, #115646-C, and #116021-C were substantiated. Facility reported incident #113169-I was substantiated.<br><br>See Code of Federal Regulations (42CFR) Part 483, Subpart B-C. | F 000 | | |
| F 550 SS=D | Resident Rights/Exercise of Rights<br>CFR(s): 483.10(a)(1)(2)(b)(1)(2)<br><br>§483.10(a) Resident Rights.<br>The resident has a right to a dignified existence, self-determination, and communication with and access to persons and services inside and outside the facility, including those specified in this section.<br><br>§483.10(a)(1) A facility must treat each resident with respect and dignity and care for each resident in a manner and in an environment that promotes maintenance or enhancement of his or her quality of life, recognizing each resident's individuality. The facility must protect and promote the rights of the resident.<br><br>§483.10(a)(2) The facility must provide equal access to quality care regardless of diagnosis, | F 550 | | |

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Angela Lopes, RN HA — TITLE: Executive Director — (X6) DATE: 11/9/23

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

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severity of condition, or payment source. A facility must establish and maintain identical policies and practices regarding transfer, discharge, and the provision of services under the State plan for all residents regardless of payment source.

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

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

§483.10(b)(2) The resident has the right to be free of interference, coercion, discrimination, and reprisal from the facility in exercising his or her rights and to be supported by the facility in the exercise of his or her rights as required under this subpart.
This REQUIREMENT is not met as evidenced by:
Based on observation, resident interview, and staff interviews the facility failed to protect and value resident's private space when they entered a resident room with a closed door without knocking and waiting for permission to enter and failed to ensure residents were treated in a dignified manner for two of four resident's reviewed for dignity (Resident #8, Resident #56). The facility reported a census of 140.

Findings included:

1. The Admission Minimum Data Set (MDS) dated 9/21/23 for Resident #56 listed diagnoses of heart failure, anxiety, and depression. The

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MDS documented the resident scored 15 on a Brief Interview for Mental Status (BIMS) exam, which indicated intact cognition.

On 09/25/23 at 11:18 AM Staff C, Certified Nurses Aid (CNA), opened resident's door and started to come into the resident's room without knocking or announcing herself. She retreated when she saw the resident had company.

On 09/25/23 at 11:18 AM the resident stated staff entered the room without knocking or announcing themselves often and it was a generation thing. She stated she would not say anything about it because they do what they want to do. She clarified that staff came in without knocking or waiting all of the time. The resident shrugged her shoulders and frowned, and added comments that they all do it, what can I do, and I am not going to change anything. The resident stated respecting her space wasn't just walking in. Another staff person brought her food when she was sleeping, took it away, and recorded that she declined the meal. At 8:30 PM when the resident asked why she did not get her dinner, the staff told her she declined it and then said well, you were sleeping. The resident asked how a meal could be declined by a sleeping person. The staff person could not answer. The resident indicated that some staff are respectful and some are not.

On 9/27/23 at 10:21 AM the Director of Nursing stated that she expected staff to knock, introduce themselves, and wash hands or sanitize before entering. She stated that one agency attended training before working with residents. Another agency chose if they wanted to attend training.

On 9/27/23 at 10:48 AM the Administrator stated

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she expected staff to knock and wait for a response.

A policy entitled Resident Rights, revised January 2023, revealed that residents had the right to be treated with dignity and respect in full recognition of the resident's individuality and to be treated in a manner that enhanced the resident ' s quality of life.

2. The Quarterly Minimum Data Set (MDS) assessment dated 9/5/23 revealed Resident #8 scored 15 out of 15 on a Brief Interview for Mental Status (BIMS) exam, which indicated cognition intact. The MDS revealed an indwelling catheter. The MDS revealed medical diagnosis of neurogenic bladder and renal failure.

The Care Plan revealed a focus area dated 6/13/23 of bowel/bladder: resident with a Foley catheter with a diagnosis of neurogenic bladder. The interventions directed staff to follow doctor's order for the catheter changes; and to follow facility policy for catheter cares.

The Electronic Medical Record (EMR) revealed medical diagnosis of Stage 3 B chronic kidney disease and neuromuscular dysfunction of bladder, unspecified.

The Physician Orders revealed the following orders:
a. ordered 6/6/23: Record output of catheter every shift.
b. ordered 7/18/23: Flush Foley every week with 60 cc milliliters every day shift every 7 day(s)

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| F 550 | Continued From page 4<br>c. ordered 8/8/23: Change catheter every 30 days every day shift every 30 day(s) for urinary retention, BPH (benign prostate hyperplasia)<br><br>During an observation on 9/26/23 at 9:38 AM, Resident #8 sat in his recliner feet elevated. The catheter tubing laid on recliner and the drainage bag attached to the side of the recliner and touched the floor with no dignity bag.<br><br>During an observation on 9/27/23 at 11:36 AM, Resident #8 catheter bag hooked to the bottom of the wheelchair under the seat with no dignity bag.<br><br>During an observation on 9/27/23 at 7:54 AM, catheter bag hooked to the bottom of the wheelchair, no dignity bag covering the catheter bag.<br><br>During an observation on 9/27/23 at 9:52 AM, the resident sat in chair with his feet elevated, catheter bag hooked under the recliner foot stool and touched the floor with no dignity bag.<br><br>During an observation on 9/27/23 at 3:06 PM, the resident sat in recliner and slept with his feet propped up and catheter bag hooked to the metal part of the recliner with no dignity bag covering the catheter bag.<br><br>During an observation on 9/27/23 at 4:59 PM, the resident sat in his wheelchair and escorted out of the room and his catheter bag hung under the chair with no dignity bag.<br><br>During an interview on 9/28/23 at 1:09 PM, Staff P, Licensed Practical Nurse (LPN) queried if a catheter bag could touch the floor and she stated | F 550 | | |

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no, they should put something under it so it didn't touch the floor. Staff P asked if a catheter bag needed placed in a dignity bag and she stated yes.

During an interview on 9/28/23 at 1:35 PM, Staff L, Certified Nurse Aide (CNA) queried if catheter bags could touch the floor and she stated no, they shouldn't.

During an interview on 10/2/23 at 11:49 AM, Staff N, CNA asked if catheter bags needed placed in a dignity bag and she stated some residents used dignity bags.

During an interview on 10/2/23 at 11:56 AM, Staff O, LPN confirmed the urinary catheter bags needed dignity bags over them.

During an interview on 10/2/23 at 12:10 PM, Staff K, Assistant Director of Nursing (ADON) queried if dignity bags needed used for urinary catheter bags and she stated yes, they all should.

During an interview on 10/2/23 at 12:55 PM, Staff J, ADON queried if catheters bag could touch the floor and she stated no because of infection control. Staff J queried if catheter bags needed dignity bags and she stated yes, they needed to be used at all times.

During an interview on 10/03/23 at 11:45 AM, the Director of Nursing (DON) queried on if dignity needed used all the time and she stated yes anytime they are visible to anyone else, the catheter bag needed a dignity bag.

The Facility Foley Catheter Care Policy dated 10/22 documented the following information:

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| F 550 | Continued From page 6<br>a. the Foley bag should be hooked to the metal bed frame when resident in bed and covered with a privacy bag. | F 550 | | |
| F 578 SS=E | Request/Refuse/Dscntnue Trmnt;Formlte Adv Dir<br>CFR(s): 483.10(c)(6)(8)(g)(12)(i)-(v)<br><br>§483.10(c)(6) The right to request, refuse, and/or discontinue treatment, to participate in or refuse to participate in experimental research, and to formulate an advance directive.<br><br>§483.10(c)(8) Nothing in this paragraph should be construed as the right of the resident to receive the provision of medical treatment or medical services deemed medically unnecessary or inappropriate.<br><br>§483.10(g)(12) The facility must comply with the requirements specified in 42 CFR part 489, subpart I (Advance Directives).<br>(i) These requirements include provisions to inform and provide written information to all adult residents concerning the right to accept or refuse medical or surgical treatment and, at the resident's option, formulate an advance directive.<br>(ii) This includes a written description of the facility's policies to implement advance directives and applicable State law.<br>(iii) Facilities are permitted to contract with other entities to furnish this information but are still legally responsible for ensuring that the requirements of this section are met.<br>(iv) If an adult individual is incapacitated at the time of admission and is unable to receive information or articulate whether or not he or she has executed an advance directive, the facility may give advance directive information to the individual's resident representative in accordance | F 578 | | |

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with State law.
(v) The facility is not relieved of its obligation to provide this information to the individual once he or she is able to receive such information.
Follow-up procedures must be in place to provide the information to the individual directly at the appropriate time.
This REQUIREMENT is not met as evidenced by:
Based on interviews, record review, and facility policy review, the facility failed to ensure consistent documentation of code status to direct staff clearly on Cardiopulmonary Resuscitation (CPR) and Do Not Resuscitate (DNR) orders for 4 of 5 residents reviewed for Advance Directives (Resident #48, #118, #128, #438). The facility reported a census of 140 residents.

Findings include:

1. The Quarterly Minimum Data Set (MDS) assessment dated 8/8/23 revealed Resident #118 scored 08 out of 15 on a Brief Interview for Mental Status (BIMS) exam, which indicated moderate cognitive impairment. Diagnoses for Resident #118 included Cerebrovascular Accident (stroke), hemiplegia (paralysis) and aphasia (language disorder).

The Care Plan initiated 5/19/23 documented focus, Advance Directives, I am a full code.

The Code status book at the nurse's station included a document titled CPR Preference indicated wanted CPR, signed by Resident #118 responsible party on 5/15/23 and signed by the physician on 5/17/23. The document was also included in the electronic record, miscellaneous file, labeled CPR Preference 5/15/2023.

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The electronic record, face sheet viewed 9/26/23 documented Code Status: Do not Resuscitate (DNR)

09/26/23 4:30 PM Interview with the Director of Nursing (DON) acknowledged inconsistency with records and would need to check if there was a revised document not found in the records indicating a change from CPR to DNR.

2. The Quarterly Minimum Data Set (MDS) assessment dated 8/1/23 revealed Resident #48 scored 15 out of 15 on a Brief Interview for Mental Status (BIMS) exam, indicated intact cognition. Diagnoses for Resident #47 included traumatic spinal cord dysfunction and quadriplegia.

The Care Plan updated 3/21/23 documented focus, Advance Directives, Do not Resuscitate (DNR).

The electronic face sheet record viewed 9/26/23 documented Code Status: Cardiopulmonary Resuscitation (CPR).

The electronic file titled miscellaneous included document labeled DNR order, Admit papers. The document titled, Out of Hospital, Do not Resuscitate, order dated 11/11/22 signed by a physician.

The electronic file titled miscellaneous included document labeled IPOST referring to Iowa Physician orders for scope of treatment dated 5/1/20. The Advance directive dated 5/1/20 directed DNR signed by resident and physician.

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On 09/26/23 at 04:53 PM in an interview with the DON, acknowledged documents in residents records direct DNR yet the electronic face sheet directs CPR. The Assistant Director or Nursing (ADON) present, voiced she recalled a change of Resident #48 choice directing CPR and relayed that documentation is missing from the electronic file. The DON relayed they are working on improved systems with record management and acknowledged need for consistency.

The facility policy titled Cardiopulmonary Resuscitation (CPR) policy revised July 2018 relayed emergency care to be provided in accordance with residents advance directives. Each resident's choice regarding CPR or DNR code status to be readily available for quick identification

3. The Admission Minimum Data Set (MDS) for Resident #128 dated 8/13/23 revealed diagnoses of Parkinson's disease, fracture, and legal blindness. The MDS documented the resident scored 15 on a Brief Interview for Mental Status (BIMS) exam, which indicated intact cognition.

On 09/26/23 at 4:01 PM the miscellaneous tab of Resident #128's Point Click Care (PCC) electronic health record revealed a cardiopulmonary resuscitation (CPR) preference document dated 8/17/23 which requested CPR.

On 09/26/23 at 3:05 PM observed the resident's name plate did not have a green dot.

On 09/26/23 at 03:11 PM Staff A, Assistant Director of Nursing (ADON) transitional care center (TCC), stated that green stickers on a resident's name plate meant full code, and that

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she thought staff looked up code status in the document tab of PCC if there was no sticker in place.

On 09/26/23 at 04:50 PM Staff B stated that code status records were found in PCC and in a binder in the nursing office.

On 09/26/23 at 04:53 PM reviewed the binder in the nursing office. It contained 4 resuscitation related documents and Resident#128 was a current resident. The binder lacked the CPR preference document for this resident.

On 09/26/23 at 04:55 PM Staff A confirmed she was not aware that the binder had not been updated.

On 09/27/23 at 10:21 AM the Director of Nursing (DON) stated that code status is in PCC and books at each nurses station. She was not aware of the issue with the TCC binder and stated they would fix it. She expected documentation for code status to be on the main screen of PCC, in orders, in the Karkex for CNAs, and in the binder. The DON stated that agency staff from Grapetree have an hour of training before working with residents, and agency staff from Clipboard have the choice if they want to come in early for training.

4. The Admission Minimum Data Set (MDS) for Resident #438 dated 9/18/23 revealed diagnoses of coronary artery disease, diabetes, and depression. The MDS documented the resident scored 15 on a Brief Interview for Mental Status (BIMS) exam, which indicated intact cognition.

On 09/26/23 at 3:05 PM observed the resident's

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name plate did not have a green dot.

On 09/26/23 at 03:11 PM Staff A, Assistant Director of Nursing (ADON) transitional care center (TCC), stated that green stickers on a resident's name plate meant full code, and that she thought staff looked up code status in the document tab of PCC if there was no sticker in place.

On 09/26/23 at 04:50 PM Staff B stated that code status records were found in PCC and in a binder in the nursing office.

On 09/26/23 at 04:53 PM reviewed the binder in the nursing office. It contained 4 resuscitation related documents and Resident #438 was a current resident. The binder lacked a CPR preference document for this resident.

On 09/26/23 at 04:55 PM Staff A confirmed she was not aware that the binder had not been updated.

On 09/27/23 at 10:21 AM the Director of Nursing (DON) stated that code status is in PCC and books at each nurses station. She was not aware of the issue with the TCC binder and stated they would fix it. She expected documentation for code status to be on the main screen of PCC, in orders, in the Karkex for CNAs, and in the binder. The DON stated that agency staff from Grapetree have an hour of training before working with residents, and agency staff from Clipboard have the choice if they want to come in early for training.

On 09/27/23 at 1:28 PM the miscellaneous tab of Resident #438's Point Click Care (PCC)

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| F 578 | Continued From page 12<br>electronic health record revealed a cardiopulmonary resuscitation (CPR) preference document dated 9/11/23 which requested CPR.<br><br>On 09/27/23 at 01:31 PM the PCC main screen indicated that resident does not want resuscitation.<br><br>On 09/27/23 at 01:32 PM the resident's orders indicated that the resident does not want resuscitation. | F 578 | | |
| 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-<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 | F 580 | | |

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physician.
(iii) The facility must also promptly notify the resident and the resident representative, if any, when there is-
(A) A change in room or roommate assignment as specified in §483.10(e)(6); or
(B) A change in resident rights under Federal or State law or regulations as specified in paragraph (e)(10) of this section.
(iv) The facility must record and periodically update the address (mailing and email) and phone number of the resident representative(s).

§483.10(g)(15)
Admission to a composite distinct part. A facility that is a composite distinct part (as defined in §483.5) must disclose in its admission agreement its physical configuration, including the various locations that comprise the composite distinct part, and must specify the policies that apply to room changes between its different locations under §483.15(c)(9).
This REQUIREMENT is not met as evidenced by:
Based on clinical record review, staff interview, Facility Investigation Review and facility policy review the facility failed to notify the Power of Attorney or family members regarding allegations of mean and aggressive treatment by a facility staff member resulting in a possible injury to her knee and involuntary seclusion, for one of three residents review for notification. (Resident#385). The facility failed to protect resident during the facility investigation. The facility reported a resident census of 140.

Findings Include:

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The Quarterly Minimum Data Set (MDS) assessment for Resident #385 dated 07/05/2023 revealed the resident scored 8 out of 15 on a Brief Interview for Mental Status exam, which indicated the resident was severally cognitively impaired.

Grievance Form dated 5/16/23 documented that Resident#385 voiced concerns to Director of Social Services, therapy staff, and activities staff. The statement of concerns documented as follows; Staff V, Certified Nurses Aid (CNA) was very mean to the resident. Put her in her room and told her not to come out. Pushed her into her room aggressively with no foot rest so her foot was caught and drug back under her chair hurting her knee. Resident stated the CNA was very mean and unfriendly.

On 09/28/2023 7:35 AM, the Executive Director, (ED), reported the resident had talked with the Director of Social Services,(DSS), about her concerns with CNA Staff V. The ED advised the resident had approached the DSS and told her she was afraid of the CNA. Resident reported she felt safe at the facility but not around that specific staff member. The Resident reported the CNA had abruptly pushed her wheelchair into her room and told her she couldn't come out of her room. A facility investigation was completed by the Executive Director.

An undated facility report titled Investigation Summary provided and narrated by the Executive Director/Administrator (ED) revealed the following; On 5/17/2023 Social Services gave grievance to the Executive Director. The report summarized an alleged incident with Resident #385 and Staff member V Certified Nursing

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Assistant (CNA), pushed her into her room aggressively with no foot rest so her foot was caught and drug back under her chair hurting her knee. R states CNA is mean and unfriendly. Corrective Action by facility: Staff V CNA, date of hire is 12/29/2022. The alleged perpetrator is currently suspended pending investigation. The report also advised the ED met with the Resident. The Resident reported yesterday a CNA got on my case. The Resident advised she "threw me in my room" The Resident reported she was not hurt and she does not have any injuries. She does not remember the name of the staff person. She advised she feels safe here and says she hopes it doesn't happen again. Conclusion-Per recommendation of the Executive Director, employee will be terminated.

On 10/02/2023 11:58 AM, the ED stated there was not a time specified on the grievance filed by the resident as the facility felt the incident rose to the level of an abuse allegation and was treated it as such.

On 10/02/23 05:55 PM.,the Director of Social Services (DSS), reported she was given the information for the grievance from another staff member. The DSS did not directly speak with or observe the Resident on the day of the incident. The DSS advised she wrote the information on a grievance form and put it in one of the Assistant Director of Nursing's (ADON) mailbox. The ADON brought the grievance and concern up the following morning in their daily meeting.

On 10/03/2023 8:45 AM, the ED reported there are cameras near the lobby and front door but she is not aware if there are any cameras in the area where the incident occurred. The ED will

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follow up with this Surveyor. The ED reported no cameras were reviewed during the facility investigation. The ED reviewed the resident's records and was unable to locate any documentation regarding any nursing assessment completed. The ED advised she talked to the resident the following day and asked the resident about the incident and she reported she was not in pain. The ED advised she does not believe she documented this anywhere. The Facility investigation also lacked interviews with other residents and other staff members. The Facility Assessment also lacked nursing assessment or documentation regarding the incident. There was no documentation that the Power of Attorney, family, or medical staff were notified of the incident.

The Facility Policy dated April 2008 with the most current revised version dated January 2023 advised the staff as follows:

It is policy of this community to take appropriate steps to prevent the occurrence of Abuse, Neglect and Misappropriation of resident property. It is also the policy of this community to take appropriate steps to ensure that all alleged violations of federal or state laws which involve mistreatment, neglect, abuse, injuries of unknown source, and misappropriation of resident property ("alleged violations") are reported immediately.
7. Reporting:
a. Any employee who suspects an alleged violation immediately notifies the administrator. The administrator notifies the appropriate state agency of allegations of neglect, exploitation, misappropriation of resident property or mistreatment that do not result in serious bodily injury in no later than 24 hours. Allegations of

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| F 580 | Continued From page 17<br>abuse resulting in serious bodily injury must report immediately, but no later than 2 hours after the allegation is made. Initial reports must include sufficient information to describe the alleged violation with as much information as possible based on the knowledge at the time of the submission and indicate how resident(s) are being protected.<br>b. The results of all investigations are reported to the administrator and to the appropriate state agency, as required by state law and/ or within five (5) working days of the alleged violation.<br>c. The community reports to the State Nurse Aide Registry and licensure authorities any knowiedge it has of any actions by a court of law which would indicate an employee does not or may not meet the requirements to work in a skilled nursing facility.<br>d. The administrator, or his / her designee, notifies the resident's representative regarding the alleged violation and assessment findings and reassures the resident's representative that an investigation has been initiated and appropriate action will be taken. | F 580 | | |
| F 600 SS=D | Free from Abuse and Neglect<br>CFR(s): 483.12(a)(1)<br><br>§483.12 Freedom from Abuse, Neglect, and Exploitation<br>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. | F 600 | | |

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| F 600 | Continued From page 18<br>§483.12(a) The facility must-<br><br>§483.12(a)(1) Not use verbal, mental, sexual, or physical abuse, corporal punishment, or involuntary seclusion;<br>This REQUIREMENT is not met as evidenced by:<br>Based on observation, interview, and record review, the facility failed to protect the resident's right to be free from physical abuse by a resident for two of four residents reviewed for abuse. (Resident #64, Resident #84). The facility reported a census of 140 residents.<br><br>Findings include:<br><br>1. The Quarterly Minimum Data Set (MDS) assessment for Resident #84 dated 9/12/23 revealed the resident scored 8 out of 15 on a Brief Interview for Mental Status (BIMS) exam, which indicated moderate cognitive impairment.<br><br>The Care Plan identified a focus area as Mood/Behavior; resident at risk for potential complications with mood/behavior due to anxiety and depression. The resident often became agitated and aggressive towards staff and other residents with initiated date of 3/24/23.<br><br>The Nurse Progress Note dated 7/31/23 at 8:59 AM documented as follows; Called to telehealth this morning and given behavior problem this morning, resident was disruptive, combative with cares, mocking staff when conversing, argumentative and repeating the words, kicking and uncooperative with cares. Resident refused shower at this time. Resident also hit one of the other residents during breakfast accusing resident that she took her place at the dining | F 600 | | |

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table. Redirected behaviors but still shaking the table, resident was separated during breakfast.

The Behavior Progress Note dated 8/2/23 at 8:57 AM documented, Nurse called [Name Redacted] from [Name Redacted] to let her know that she was trying to run into a lady with her wheelchair. She was anxious when nurse was pulling her away and she ran into the nurse who went between her and the other resident. CNA reported she had also hit this other resident on the head on Monday. The other resident remarked I am nice to everyone and I do not understand why she is doing this to me. Nurse will inform the Assisted Director of Nursing (ADN) and give her a copy of this note to send to phsych and also notify her family of her behaviors.

The Behavior Progress Note dated 8/8/23 at 1:28 PM documented, this nurse was in the process of doing a treatment for a resident when the aide informed nurse that [Resident #84] had become physically aggressive with another resident. [Resident #84] wheeled herself around the dining table and grabbed the other resident's right arm and pinched and also pulled resident's hair.

The Incident Report dated 8/8/23 for Resident #84 documented the following per the Description of Action Taken: Resident was removed from dining area and provided a place to eat away from other residents while agitated.

Review of the Psych Progress Note dated 8/8/23 documented, in part, per facility: in between appts she was agitated, aggressive this AM, hitting staff, at breakfast table this AM patient pulled hair and pinched another resident.

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Observation on 9/28/23 at 10:29 AM revealed Resident #84 present in their wheelchair at a table in the dining room. The resident was the only resident present at the dining table.

On 9/28/23 at 11:15 AM when queried about actions taken for resident to resident incidents, Staff G, Registered Nurse (RN) explained she would immediately separate the two, and depending on the situation she would have one staff with one person and the other with the other til she got the situation diffused. Staff G explained she would immediately notify a supervisor and wait for further direction. Staff G explained she knew it needed to be reported in a very limited time frame. Per Staff G, she would ensure safety and notify a supervisor.

On 10/2/23 at 1:10 PM, when queried about resident to resident incidents, Staff J, Assistant Director of Nursing (ADON) explained immediate safety would be of concern, they would be separated, and if one resident continually abusive they would be separated from everyone else. Staff J further explained an incident report would be done for each resident, and then the family and doctor would be notified for both residents. When queried as to Resident #84, Staff J explained she knew of a situation where Resident #84 had a co-resident she seemed to not like, and would go for this certain person. Staff J explained this had been when the resident lived on a different neighborhood. When queried as to the identity of the other resident, Staff J could not recall. Per Staff J, it was another resident who resided on the neighborhood where Resident #84 lived, and they shared a dining room together.

On 10/2/23 at 2:34PM, when queried about

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resident to resident incidents for Resident #84, Staff K, ADON explained Resident #84 and another lady at the dining table had an incident, and she couldn't remember what Resident #84 had done, pushed her or hit her, she did not remember. Per Staff K, it had been the lady who sat across the table from her. When queried as to the identity of the other resident, Staff K identified the other resident as Resident #64. Staff K explained they had not witnessed the events. Staff L explained the Director of Nursing (DON) at the time, noted to not be the current DON, had handled most of it. Following the interview, an incident report for 7/31/23 was requested from Staff K.

On 10/2/23 at approximately 2:45 PM, Staff K explained she did not see an incident report for 7/31/23.

The incident report for Resident #84 dated 8/8/23 at 7:30 AM for Physical Aggression documented, this nurse was in the process of doing a treatment for a resident when the aide informed nurse that [Resident #84] had become physically aggressive with another resident. [Resident #84] wheeled herself around the dining table and grabbed the other resident's right arm and pinched and also pulled resident's hair. The Description of Action Taken section documented, Resident was removed from dining area and provided a place to eat away from other residents while agitated.

2. The Quarterly Minimum Data Set (MDS) assessment for Resident #64 dated 7/5/23 revealed the resident scored 8 out of 15 on a BIMS exam, which indicated moderately impaired cognition.

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Review of Progress Notes for Resident #84 documented the following:

a. The Nurse Progress Note dated 7/31/23 at 1:23 PM documented, [Name Redacted] was notified over the phone r/t (related to) one of resident hitting her mother on the shoulder during breakfast this morning, and no redness or bruise was noted and denies having pain.

The resident's Progress Notes lacked further documentation dated 7/31/23.

b. The Communication-with Resident note dated 8/1/23 at 11:19 AM documented, Met with resident to discuss an incident that happened yesterday. Discussed with resident, and she does recall an incident yesterday. She states she was eating, and one of her table mates got a stern look on her face and hit her in the shoulder. Resident states she does not think the other resident was in her right mind. She states she did not sustain any injuries. She denies any pain. She denies any emotional concerns, and is not afraid of the other resident. She feels safe in the building, and denies need for any other interventions.

c. The Behavior Progress Note dated 8/8/23 at 2:02 PM documented, this nurse was doing a treatment in another resident room when the CNA (Certified Nurse Assistant) approached and said that resident was sitting at the dining room table eating her breakfast when table mate wheeled around the table and grabbed resident. table mate pinched resident right arm and pulled her hair. resident visibly upset.

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On 10/2/23 at 3:30 PM Staff Q, CNA, who was listed as a witness to the incident on 8/8/23 per the incident report, was queried about resident to resident incident for Resident #84. Staff Q explained maybe a month or so ago the resident moved to [different area in the facility], explained the resident had started to become more combative, and further explained there were two incidents where Resident #84 had "attacked" two residents. Staff Q explained for one resident one day pulling on her (later identified as Resident #64), hitting her, and explained she had caught the aftermanth and moved her out of the way. Per Staff Q, the next day the resident had attacked another resident who sat at the table. When queried as to Resident #64's response, Staff Q explained she knew Resident #64 was very upset about it. When asked how she knew the resident was very upset, Staff Q explained she went to do cares later, and the resident kept repeating she hit me, pulled the back of my sweater. Staff Q explained she had not caught the beginning of the incident, the resident wheeled themselves around the table, and the kitchen called for Staff Q. Per Staff Q, Resident #84 had ahold of Resident #64 and was hitting her.

On 10/2/23 at approximately 3:20 AM, the Administrator explained she had done four staff meetings about abuse reporting. The Administrator explained she had spoken to Resident #64, and the intervention had been to move Resident #84. When queried as to the date discussed, the Administrator explained 8/1. When queried how she found out about it, the Administrator explained she did not know, and someone had mentioned it. When queried if it should have been reported to her, the Administrator explained she should have been

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called immediately, and further explained it was not reportable because did not suffer emotional distress or injury. When queried about the incident which occurred 8/8, the Administrator explained that they did not remember.

Observation of Resident #64 on 10/03/23 at approximately 11:40 AM revealed the resident present in their wheelchair at the dining table eating lunch.

On 10/5/23 at 12:34 PM, the Director of Nursing (DON) explained if had a resident to resident incident, she would report every incident whether culpable or not, would investigate and make sure they were separated, investigate the incident, interview staff, and if the resident interviewable interview them, check for any marks, let the family and doctor know.

The Facility Policy titled Freedom From Abuse, Neglect, and Exploitation dated 4/1/08 documented, in part, the following: It is the policy of this facility to take appropriate steps to prevent the occurrence of:
a. abuse
b. neglect
c. misappropriation of resident property

During an interview on 10/4/23 at 10:21 AM, Resident #64 queried if remembered any incidents with other staff and she stated that happened a while back. She stated she sat in the dining room, and a lady pulled the hair on another lady and then came over pulled my hair and shook my chair. She stated she doesn't remember how long ago it happened and she forgot the resident's name. She stated they moved her out of the dining room. Resident #64

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| F 600 | Continued From page 25<br>asked how that made her feel and she stated she was kind of shook up afterwards but I am okay. She stated when it happened she was minding her own business and then the resident came around. | F 600 | | |
| F 603 SS=J | Free from Involuntary Seclusion<br>CFR(s): 483.12(a)(1)<br><br>§483.12<br>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.<br><br>§483.12(a) The facility must-<br><br>§483.12(a)(1) Not use verbal, mental, sexual, or physical abuse, corporal punishment, or involuntary seclusion;<br>This REQUIREMENT is not met as evidenced by:<br>Based on interviews, clinical record review, facility policy review and facility investigation review, the facility failed to ensure a resident was not subjected to involuntary seclusion when a staff member had used verbal threats to impose the understanding to a resident that she was not allowed to leave her room. This deficient practice resulted in Resident #385 displaying behaviors of anxiety, tearfulness, and fear of the staff member that imposed the involuntary seclusion to the residents room for one of four residents reviewed for abuse (Resident #385). This deficient practice resulted in an Immediate Jeopardy (IJ) to the health and safety of a resident who resided at the | F 603 | | |

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facility. The facility reported a census of 140 residents.

Findings Include:

On 10/4/23, the Iowa Department of Inspections and Appeals staff contacted the facility staff to notify them the Department staff determined an Immediate Jeopardy situation existed at the facility. The Immediate Jeopardy had a start date of 5/16/23. The facility staff removed the immediacy on 10/5/23 at 2:55 PM, and decreased the scope from a J to a D level after the facility staff completed the following;

a. All staff have been trained on June 23, 2023, August 9, 2023 and September 6, 2023 about how to report abuse
b. Building administrator has her personal cell phone number listed on PCC to alert any staff working in the building to call Administrator immediately with any concern of abuse
c. Grievances are reviewed in a timely manner, and any resident concerns are immediately followed up on, to prevent any abuse from occurring
d. Involuntary seclusion is identified in the abuse policy, and staff have been trained. If a resident is crying, or told they should stay in their room by a staff person, another staff member should immediately intervene, ensure the resident's safety and notify the Executive Director or designee immediately.

The Quarterly Minimum Data Set (MDS) assessment for Resident #385 dated 07/05/2023 revealed the resident scored 15 out of 15 on a Brief Interview for Mental Status exam, which indicated the resident was cognitively intact.

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The Investigation Summary, undated, and unsigned, revealed the following allegation: [Resident #385] filed a grievance with Social Services stating Certified Nursing Assistant (CNA) [Staff V] was mean to her. Stated she put her in room and told her not to come out. Stated she pushed her into her room aggressively with no foot rest so her foot was caught and drug back under her chair hurting her knee. She stated the CNA was very mean and unfriendly.

The Section of the Investigation Summary dated 5/17/23 documented as follows; Went to meet with Resident#385. She states that yesterday a CNA "got on my case". She states she "threw me in my room." She states she was not hurt and has no injures. She does not remember the name of the CNA. When asked if she feels safe here she says she does, but she just hopes it doesn't happen again Encouraged Resident (R) to let me know if there are any other concerns. She agreed.

Grievance Form dated 5/16/23 documented a grievance reported to the Director of Social Services was voiced from Resident#385, therapy and activities as follows; Staff V, CNA, was very mean to resident. Put her in her room and told her not to come out. Pushed her into her room aggressively with no foot rest so her foot was caught and drug back under her chair hurting her knee. Resident stated the CNA was very mean and unfriendly. The action plan resolution and date of resolution were left blank.

On 09/28/2023 at 7:35 AM, the Executive Director, (ED), stated the resident had talked with the Director of Social Services,(DSS), about her

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concerns with CNA Staff V. The ED reported the resident had approached the DSS and told her she was afraid of the CNA. Resident#385 reported she felt safe at the facility but not around that specific staff member. The Resident stated the CNA had abruptly pushed her wheelchair into her room and told her she couldn't come out of her room.

On 10/02/2023 at 11:58 AM, the ED advised there is not a time specified on the grievance filed by the resident as the facility felt the incident rose to the level of an abuse allegation and was treated it as such.

On 10/02/23 5:55 PM, the Director of Social Services (DSS), reported she was given the information for the grievance from another staff member. The DSS did not directly speak with or observe the Resident on the day of the incident. The DSS advised she wrote the information on a grievance form and put it in one of the ADON's mailbox. The ADON brought the grievance and concern up the following morning in their daily meeting.

On 10/03/2023 8:45 AM, ED reported there were cameras near the lobby and the front door but she was not aware if there were any cameras in the area where the incident occurred. The ED would follow up with this and get back. The ED reported no cameras were reviewed during the facility investigation. The ED reviewed the resident's records and was unable to locate any documentation regarding any nursing assessment completed. The ED advised she talked to the resident the following day and asked the resident about the incident and she reported she was not in pain. The ED stated she did not

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believe she documented this anywhere. There was no documentation that the Power of Attorney, family, or medical staff were notified of the incident.

During an interview on 10/03/2023 at 10:08 AM., Staff X, Activities Assistant stated she and a co-worker were gathering residents for an activity and went to the Resident #385's room where they found the resident in her wheelchair. The resident looked confused and almost teary eyed, like a kid who got in trouble. The resident advised she needed to use the restroom and the CNA just pushed her into her room and left. That day and the next day the resident seemed to be looking over her shoulder. Staff K interpreted this as she was watching for the CNA that had put her in her room. That same day the resident stated she is mean to me-she told me I needed to stay in my room.

During an interview on 10/03/23 at 10:56 AM., Staff HH Director of People and Culture (previously the Activities Director ) reported, the resident told one of my staff, either Staff X or Staff II and one of them came to me and reported that the resident shared she was pushed into her room and told her she couldn't leave. The resident was not coming out her room.

On 10/03/23, review of Email documentation received from The Director of People and Culture and formerly the Activities Director revealed the following:

a. 5/17/2023 11:16 AM Email from the Director of Life and Community Enrichment sent to the Director of Social Services-Did you write a grievance up for Resident #385? Staff X

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mentioned she thought you did. She is still very upset about Staff V (CNA) being mean to her. The resident literally never complains or anything so it seem legit.

b. 5/17/2023 1:21 PM Email from the Director of Social Services sent to the Director of Life and Community Enrichment-I have not. I will today though. Unfortunately this seems like a very common occurrence.

c. 5/17/2023 1:22 PM Email from the Director of Life and Community Enrichment to the Director of Social Services-With the staff member or Resident #385?

d. 5/17/2023 1:22 PM Email from the Director of Social Services sent to the Director of Life and Community Enrichment-Staff member

e .5/17/2023 Email from the Director of Life and Community Enrichment to the Director of Social Services-That is a shame. When she was Agency working here she seemed great, but I have definitely seen a change.

f. 5/17/2023 1:24 PM Email from the Director of Social Services sent to the Director of Life and Community Enrichment-Did the resident mention to you what Staff V did/said? I'm trying to recall what she told me yesterday. Something about she put her in her room and told her not to come out. Then something else.

g. 5/17/2023 2:26 PM Director of Life and Community Enrichment sent to the Director of Social Services- Staff II and Staff X said she mentioned that she was "bullying" her and "being mean" to her and that this wasn't this first

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instance and that it happens every time she works. She mentioned she pushed her into her room and told her she couldn't come out.

During an interview on 10/03/23 at 2:05 PM., Staff II the current Activities Director advised she was involved with this incident with the resident. It was right before an activity event so it was between one and 1:00 and 1:30 pm. She was getting the residents from their rooms before the activity and Resident #385 was in her room and she wasn't acting normal. She appeared to be upset and when asked the resident said she had to stay in her room. When Staff II inquired about this the resident said the staff member got mad at her and said she had to stay in her room. The resident was able to point out the staff member that reportedly told her she had to stay in her room. Staff II reported this information to her supervisor at the time.

The Facility Policy titled Abuse, Neglect, and Exploitation dated April 2008 with the most current revised version dated January 2023 advised the following:

It is policy of this community to take appropriate steps to prevent the occurrence of Abuse, Neglect and Misappropriation of resident property. It is also the policy of this community to take appropriate steps to ensure that all alleged violations of federal or state laws which involve mistreatment, neglect, abuse, injuries of unknown source, and misappropriation of resident property ("alleged violations") 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 a serious bodily injuring, or not later than 24 hours if the events that cause

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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 jurisdiction in long-term are facilities), in accordance with State law through established procedures. Further, The Community investigates each such alleged violation thoroughly and reports 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.

The facility policy documented under the sub title Definitions as follows;
Abuse: The willful infliction of injury, unreasonable confinement, intimidation, or punishment with resulting physical harm, pain or mental anguish.

On 10/4/23 at 2:25 PM, when queried whether Resident #385 could self propel in her wheelchair, Staff BB, Certified Nursing Assistant (CNA) responded she did not think so, and further explained she had never seen the resident do it. Staff BB explained she would always push her back to her room when she came in.

During an interview on 10/4/23 at 2:46 PM, Staff DD, CNA (Certified Nurse Aide) queried if she knew Resident #385 and she stated yes. Staff DD asked if the resident self propelled or if she

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| F 603 | Continued From page 33<br>needed push in her wheelchair throughout the building and she stated they always pushed her everywhere.<br><br>During an interview on 10/4/23 at 3:09 PM, Staff EE, CNA queried if she knew Resident #385 and she stated yes, the resident was really nice and didn't really talk much. Staff EE asked if they resident moved around herself and she stated the resident was heavy and really weak and she had trouble when she rolled her. Staff EE asked if the resident self propelled herself in the wheelchair and she stated she didn't recall the resident ever moving her feet by herself and never self propelled. Staff EE asked if the resident ever stated issues with other CNAs and how they treated her and she stated no, she didn't remember that, she stated the resident quiet and didn't talk much, and mainly smiled.<br><br>During an interview on 10/4/23 3:43 PM, Staff FF, CNA queried if she knew Resident #385 and she stated yes. Staff FF asked if the resident ever self propelled in her wheelchair and she stated she couldn't remember but they always took her to supper in her wheelchair. Staff FF stated the resident used a stand lift and she assumed she didn't move herself around too much.<br><br>During an interview on 10/04/23 at 07:30 PM, Staff E, CNA queried if she knew Resident #385 and she stated yes. Staff E asked if she propelled herself in the wheelchair and she stated Resident #385 used a stand lift and they always pushed her in the wheelchair. | F 603 | | |
| F 609 SS=D | Reporting of Alleged Violations<br>CFR(s): 483.12(b)(5)(i)(A)(B)(c)(1)(4) | F 609 | | |

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§483.12(c) In response to allegations of abuse, neglect, exploitation, or mistreatment, the facility must:

§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.

§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.
This REQUIREMENT is not met as evidenced by:
Based on observation, interview, and record review the facility failed to ensure allegations of abuse were reported within required regulatory timeframe for three of four residents reviewed for abuse (Resident #64, Resident #84, Resident #385). The facility reported a census of 140 residents.

Findings include:

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1. The Quarterly Minimum Data Set (MDS) assessment for Resident #84 dated 9/12/23 revealed the resident scored 8 out of 15 on a Brief Interview for Mental Status (BIMS) exam, which indicated moderate cognitive impairment.

The Care Plan with initiated dated 3/24/23 identified a focus area for Resident #84 as follows: MOOD/BEHAVIOR: At Risk or Potential for Complications with Mood/Behavior due to anxiety and depression. I often become agitated and aggressive towards staff and other residents.

The Nurse Progress Note dated 7/31/23 at 8:59 AM documented as follows; Called to Telehealth this morning and given behavior problem this morning, resident was disruptive, combative with cares, mocking staffs when conversing , argumentative and repeating the words, kicking and uncooperative with cares. Resident refused shower at this time. Resident also hit one of resident during breakfast accusing resident that she took her place in the dining room. Redirected behaviors but still shaking the table, resident was separated during breakfast.

The Behavior Progress Note dated 8/2/23 at 8:57 AM documented, Nurse called [Name Redacted] from [Name Redacted] to let her know that she was trying to run into a lady with her wheelchair. She was anxious when nurse was pulling her away and she ran into the nurse who went between her and the other resident. CNA reported she had also hit this other resident on the head on Monday. The other resident remarked I am nice to everyone and I do not understand why she is doing this to me. Nurse will inform the ADN and give her a copy of this

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note to send to psych and also notify her family of her behaviors.

The Behavior Progress Note dated 8/8/23 at 1:28 PM documented, this nurse was in the process of doing a treatment for a resident when the aide informed nurse that [Resident #84] had become physically aggressive with another resident. [Resident #84] wheeled herself around the dining table and grabbed the other resident's right arm and pinched and also pulled resident's hair.

Observation on 9/28/23 at 10:29 AM revealed Resident #84 present in their wheelchair at a table in the dining room. The resident was the only resident present at the dining table.

On 9/28/23 at 11:15 AM when queried about actions taken for resident to resident incidents, Staff G, Registered Nurse (RN) explained she would immediately separate the two, and depending on the situation she would have one staff with one person and the other with the other til she got the situation diffused. Staff G explained she would immediately notify a supervisor and wait for further direction. Staff G explained she knew it needed to be reported in a very limited time frame. Per Staff G, she would ensure safety and notify a supervisor.

On 10/2/23 at approximately 3:20 AM, the Administrator explained she had done four staff meetings about abuse reporting. The Administrator explained she had spoken to Resident #64, and the intervention had been to move Resident #84. When queried as to the date discussed, the Administrator explained 8/1. When queried how she found out about it, the Administrator explained she did not know, and

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someone had mentioned it. When queried if it should have been reported to her, the Administrator explained she should have been called immediately, and further explained it was not reportable because did not suffer emotional distress or injury. When queried about the incident which occurred 8/8, the Administrator explained she did not remember.

On 10/5/23 at 12:34 PM, the Director of Nursing (DON) explained if had a resident to resident incident, she would report every incident whether culpable or not, would investigate and make sure they were separated, investigate the incident, interview staff, and if the resident interviewable interview them, check for any marks, let the family and doctor know.

The Facility Policy titled Freedom From Abuse, Neglect, and Exploitation dated 4/1/08 documented, in part, the following: It is also the policy of this community to take appropriate steps to ensure that all alleged violations of federal or state laws which involve mistreatment, neglect, abuse, injuries of unknown source, and misappropriation of resident property ("alleged violations") 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.

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2. The Quarterly Minimum Data Set (MDS) assessment for Resident #385 dated 07/05/2023 revealed the resident scored 8 out of 15 on a Brief Interview for Mental Status exam, which indicated the resident was severally cognitively impaired.

On 09/28/2023 a document titled, Lutheran Living Grievance documented as follows:
Resident # 385 Today's date 5/16/2023
Grievance heard by the Director of Social Services. Voiced by individual resident, therapy and activities. The grievance advised: Staff V, CNA, was very mean to resident. Put her in her room and told her not to come out. Pushed her into her room aggressively with no foot rest so her foot was caught and drug back under her chair hurting her knee. Resident stated the CNA was very mean and unfriendly.

On 09/28/2023 7:35 AM, the Executive Director, (ED), stated that the resident had talked with the Director of Social Services,(DSS), about her concerns with CNA Staff V. The ED advised the resident had approached the DSS and told her she was afraid of the CNA. Resident reported she felt safe at the facility but not around that specific staff member. The Resident reported the CNA had abruptly pushed her wheelchair into her room and told her she couldn't come out of her room. A

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Facility Investigation was completed by the Executive Director.

On 09/28/2023 at 8:00 AM an undated facility report titled Investigation Summary provided and narrated by the Executive Director/Administrator (ED), was reviewed. On 5/17/2023 Social Services gave grievance to the Executive Director. The report summarized an alleged incident with Resident #385 and Staff member V Certified Nursing Assistant (CNA), pushed her into her room aggressively with no foot rest so her foot was caught and drug back under her chair hurting her knee. R states CNA is mean and unfriendly. Corrective Action by facility: Staff V CNA, date of hire is 12/29/2022. The alleged perpetrator is currently suspended pending investigation. The report also advised the ED met with the Resident. The Resident reported yesterday a CNA got on my case. The Resident advised she "threw me in my room" The Resident reported she was not hurt and she does not have any injuries. She does not remember the name of the staff person. She advised she feels safe here and says she hopes it doesn't happen again. Conclusion-Per recommendation of the Executive Director, employee will be terminated.

On 10/02/2023 11:58 AM, the ED advised there is not a time specified on the grievance filed by the resident as the facility felt the incident rose to the level of an abuse allegation and was treated it as such.

On 10/02/23 at 1:05 PM Staff J, ADON confirmed being aware that there was a report made that a staff member pushed her just inside her room and the staff member and the resident had words. Staff J knows the incident was

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reported and stated, "(It might have been reported later" but did not elaborate. Staff J advised the incident should have been reported right away. When an incident occurs the facility should gather all the information and investigate the incident. The facility conducts abuse training at least once a year and maybe every six months with staff. The DON and ED facilitate the abuse trainings.

On 10/02/2023 at 2:35 PM Staff K reported the ED now expects all concerns of abuse to be called to her attention immediately. After that the DON and ADONs are then notified. The facility has two hours to report any abuse concerns to the State.

On 10/02/23 at 05:55 PM.,the Director of Social Services (DSS), advised she was given the information for the grievance from another staff member. The DSS did not directly speak with or observe the Resident on the day of the incident. The DSS advised she wrote the information on a grievance form and put it in one of the Assistant Director of Nursing's (ADON) mailbox. The ADON brought the grievance and concern up the following morning in their daily meeting.

On 10/03/2023 at 8:45 AM the ED confirmed there are cameras near the lobby and front door but she is not aware if there are any cameras in the area where the incident occurred. The ED will follow up with this and get back with this Surveyor. The ED reported no cameras were reviewed during the facility investigation. The ED reviewed the resident's records and was unable to locate any documentation regarding any nursing assessment completed. The ED advised she talked to the resident the following day and

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asked the resident about the incident and she reported she was not in pain. The ED stated she does not believe she documented this anywhere. The Facility investigation also lacked interviews with other residents and other staff members. The Facility Assessment also lacked nursing assessment or documentation regarding the incident. There was no documentation that the Power of Attorney, family, or medical staff were notified of the incident.

On 10/03/2023 at 10:08 AM., Staff X Activities Assistant stated she and a co-worker were gathering residents for an activity and went to the resident's room where they found the resident in her wheelchair. The resident looked confused and almost teary eyed, like a kid who got in trouble. The resident advised she needed to use the restroom and the CNA just pushed her into her room and left. That day and the next day the resident seemed to be looking over her shoulder. Staff X interpreted this as she was watching for the CNA that had put her in her room. That same day the resident stated she is mean to me, she told me I needed to stay in my room.

On 10/03/23 at 10:56 AM., Staff HH Director of People and Culture (previously the Activities Director ) stated, what she could remember was the resident told one of my staff, either Staff X or Staff II and one of them came to me and reported that the resident shared she was pushed into her room and told her she couldn't leave. The resident was not coming out her room.

10/03/23 11:20 AM Email documentation was received from The Director of People and Culture and formerly the Activities Director. That email correspondence reads as follows;

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a. 5/17/2023 11:16 AM Email from the Director of Life and Community Enrichment sent to the Director of Social Services-Did you write a grievance up for Resident #385? Staff X mentioned she thought you did. She is still very upset about Staff V (CNA) being mean to her. The resident literally never complains or anything so it seem legit.

b. 5/17/2023 1:21 PM Email from the Director of Social Services sent to the Director of Life and Community Enrichment-I have not. I will today though. Unfortunately this seems like a very common occurrence.

c. 5/17/2023 1:22 PM Email from the Director of Life and Community Enrichment to the Director of Social Services-With the staff member or Resident #385?

d. 5/17/2023 1:22 PM Email from the Director of Social Services sent to the Director of Life and Community Enrichment-Staff member

e. 5/17/2023 Email from the Director of Life and Community Enrichment to the Director of Social Services-That is a shame. When she was Agency working here she seemed great, but I have definitely seen a change.

f. 5/17/2023 1:24 PM Email from the Director of Social Services sent to the Director of Life and Community Enrichment-Did the resident mention to you what Staff V did/said? I'm trying to recall what she told me yesterday. Something about she put her in her room and told her not to come out. Then something else.

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| F 609 | Continued From page 43<br>g. 5/17/2023 2:26 PM Director of Life and Community Enrichment sent to the Director of Social Services- Staff II and Staff X said she mentioned that she was "bullying" her and "being mean" to her and that this wasn't this first instance and that it happens every time she works. She mentioned she pushed her into her room and told her she couldn't come out.<br><br>On 10/03/23 at 2:05 PM., with Staff II (the current Activities Director) reported she was involved with this incident with the resident. It was right before an activity event so it was between 1:00 and 1:30 pm. She was getting the residents from their rooms before the activity and Resident #385 was in her room and she wasn't acting normal. She appeared to be upset and when asked the resident said she had to stay in her room. When Staff II inquired about this the resident said the staff member got mad at her and said she had to stay in her room. The resident was able to point out the staff member that reportedly told her she had to stay in her room. Staff II reported this information to her supervisor at the time. | F 609 | | |
| F 610 SS=J | Investigate/Prevent/Correct Alleged Violation CFR(s): 483.12(c)(2)-(4)<br><br>§483.12(c) In response to allegations of abuse, neglect, exploitation, or mistreatment, the facility must:<br><br>§483.12(c)(2) Have evidence that all alleged violations are thoroughly investigated.<br><br>§483.12(c)(3) Prevent further potential abuse, neglect, exploitation, or mistreatment while the investigation is in progress. | F 610 | | |

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§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.
This REQUIREMENT is not met as evidenced by:
Based on clinical record review, staff interview, Facility Investigation Review and facility policy review the facility failed to thoroughly and timely investigate a resident's allegations of mean/aggressive treatment and involuntary seclusion by a facility staff member, failed to separate residents from an alleged perpetrator after staff had become aware of allegations, and failed to maintain thorough documentation regarding investigation into the resident's allegations for one of four residents reviewed for abuse (Resident #385). This deficient practice resulted in an Immediate Jeopardy to the health and safety of a resident who resided at the facility. The Facility had a census of 140.

Findings Include:

On 10/4/23 at 3:55 PM, the Iowa Department of Inspections, Appeals, and Licensing staff contacted the facility staff to notify them the Department staff determined an Immediate Jeopardy situation existed at the facility. The Immediate Jeopardy had a start date of 5/16/23. The facility staff removed the immediacy on 10/5/23 at 2:55 PM, and decreased the scope J to D level after the facility staff completed the following:

1. Staff member was immediately suspended,

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and terminated after investigation
2. All staff have been in-serviced on the abuse policies on the following dates: June 23, 2023, August 9, 2023, September 6, 2023
3. I have attached sign in sheets
4. All new hires are required to complete Iowa Dependent Adult Abuse training prior to working on the floor
5. HR audits employee files to ensure all staff are compliant with renewing adult dependent abuse training.
6. All resident admitted prior to 5/16/23 will be interviewed to determine if they have any concerns about abuse, and any negative findings will be investigated thoroughly.
7. All staff the that worked with employee will be interviewed to determine if they ever witnessed any abuse towards a resident from this employee.
8. Staff will be re-inserviced on abuse, abuse reporting, identifying abuse, beginning 10/4/23.
9. Staff will be in-serviced on actions to take until administrator/designee arrives including ensuring resident ' s safety, separate staff/residents, collect any evidence, calling 9-1-1 if appropriate.
10. The nurse is responsible for ensuring safety until administrator/designee can arrive.
11. The executive Director/Administrator, or designee conducts a thorough investigation which includes interviewing the resident, alleged perpetrator, any witnesses, residents that may have also been affected or witnessed, and staff that may have witnessed.
12. The Executive Director/Administrator is on-call 24/7 for any allegations of abuse. If the Executive Director is unable to be available a designee is responsible for any allegations of abuse.
13. All reports will be submitted within the timeframes outlined in the regulations regardless

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of time of day.
14. Please see attached training, on September 6, 2023, all staff were trained on grievances and abuse.

The Quarterly Minimum Data Set (MDS) assessment for Resident #385 dated 07/05/2023 revealed the resident scored 8 out of 15 on a Brief Interview for Mental Status exam, which indicated the resident was severally cognitively impaired.

The Investigation Summary, undated, and unsigned, revealed the following allegation: [Resident #385] filed a grievance with Social Services stating CNA (Certified Nursing Assistant) [Staff V] was mean to her. Stated she put her in room and told her not to come out. Stated she pushed her into her room aggressively with no foot rest so her foot was caught and drug back under her chair hurting her knee. She stated the CNA was very mean and unfriendly.

The Section of the Investigation Summary dated 5/17/23 documented, Went to meet with resident. She states that yesterday a CNA "got on my case". She states she "threw me in my room." She states she was not hurt and has no injures. She does not remember the name of the CNA. When asked if she feels safe here she says she does, but she just hopes it doesn't happen again Encouraged R (resident) to let me know if there are any other concerns. She agreed.

On 09/28/2023 a document titled, [Facility Name Redacted] Grievance was reviewed. It provided the following information: Resident # 385 Today's date 5/16/2023 Grievance heard by the Director of Social Services. Voiced by individual resident,

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therapy and activities. The grievance advised: Staff V, CNA, was very mean to resident. Put her in her room and told her not to come out. Pushed her into her room aggressively with no foot rest so her foot was caught and drug back under her chair hurting her knee. Resident stated the CNA was very mean and unfriendly.

Review of the investigation provided by the facility lacked the schedule of employees who worked the same date and or shift as the alleged event, interview with other residents regarding Staff V interview with the resident's roommate, and information regarding availability of cameras in the area. The Investigation file lacked time cards to verify when Staff V had worked, as staff interviews conducted by the State Agency revealed conflicting dates of incident and when further action was taken.

Interviews conducted by the State Agency regarding the alleged incident revealed staff members were aware of the resident's allegations prior to the DSS becoming aware (Staff X, Activities Assistant, Staff II, Activities Assistant at time of incident, Staff HH, Director of People and Culture). The Investigation Summary provided by the facility lacked interviews with Staff X, Staff II, and Staff HH who had been aware of the allegations prior to the Director of Social Services.

On 09/28/2023 7:35 AM, the Executive Director, (ED), was interviewed. The resident had talked with the Director of Social Services,(DSS), about her concerns with CNA Staff V. The ED advised the resident had approached the DSS and told her she was afraid of the CNA. Resident reported she felt safe at the facility but not around that

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specific staff member. The Resident reported the CNA had abruptly pushed her wheelchair into her room and told her she couldn't come out of her room. A Facility Investigation was completed by the Executive Director.

On 09/28/2023 at 8:00 AM an undated facility report titled Investigation Summary provided and narrated by the Executive Director/Administrator (ED), was reviewed. On 5/17/2023 Social Services gave grievance to the Executive Director. The report summarized an alleged incident with Resident #385 and Staff member V Certified Nursing Assistant (CNA), pushed her into her room aggressively with no foot rest so her foot was caught and drug back under her chair hurting her knee. R states CNA is mean and unfriendly. Corrective Action by facility: Staff V CNA, date of hire is 12/29/2022. The alleged perpetrator is currently suspended pending investigation. The report also advised the ED met with the Resident. The Resident reported yesterday a CNA got on my case. The Resident advised she "threw me in my room" The Resident reported she was not hurt and she does not have any injuries. She does not remember the name of the staff person. She advised she feels safe here and says she hopes it doesn't happen again. Conclusion-Per recommendation of the Executive Director, employee will be terminated.

On 10/02/2023 11:58 AM, the ED reported there is not a time specified on the grievance filed by the resident as the facility felt the incident rose to the level of an abuse allegation and was treated it as such.

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information for the grievance from another staff member. The DSS did not directly speak with or observe the Resident on the day of the incident. The DSS advised she wrote the information on a grievance form and put it in one of the Assistant Director of Nursing's (ADON) mailbox. The ADON brought the grievance and concern up the following morning in their daily meeting.

On 10/03/2023 8:45 AM, the ED reported there are cameras near the lobby and front door but she is not aware if there are any cameras in the area where the incident occurred. The ED will follow up with this and get back with this Surveyor. The ED reported no cameras were reviewed during the facility investigation. The ED reviewed the resident's records and was unable to locate any documentation regarding any nursing assessment completed. The ED advised she talked to the resident the following day and asked the resident about the incident and she reported she was not in pain. The ED advised she does not believe she documented this anywhere. The Facility investigation also lacked interviews with other residents and other staff members. The Facility Assessment also lacked nursing assessment or documentation regarding the incident. There was no documentation that the Power of Attorney, family, or medical staff were notified of the incident.

On 10/03/2023 at 10:08 AM., Staff X Activities Assistant stated she and a co-worker were gathering residents for an activity and went to the resident's room where they found the resident in her wheelchair. The resident looked confused and almost teary eyed, like a kid who got in trouble. The resident advised she needed to use the restroom and the CNA just pushed her into

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her room and left. That day and the next day the resident seemed to be looking over her shoulder. Staff X interpreted this as she was watching for the CNA that had put her in her room. That same day the resident stated she is mean to me, she told me I needed to stay in my room.

On 10/03/23 at 10:56 AM., Staff HH Director of People and Culture (previously the Activities Director ) reported, what she could remember was the resident told one of my staff, either Staff X or Staff II and one of them came to me and reported that the resident shared she was pushed into her room and told her she couldn't leave. The resident was not coming out her room.

10/03/23 11:20 AM Email documentation was received from The Director of People and Culture and formerly the Activities Director. That email correspondence reads as follows:

a. 5/17/2023 11:16 AM Email from the Director of Life and Community Enrichment sent to the Director of Social Services-Did you write a grievance up for Resident #385? Staff X mentioned she thought you did. She is still very upset about Staff V (CNA) being mean to her. The resident literally never complains or anything so it seem legit.

b. 5/17/2023 1:21 PM Email from the Director of Social Services sent to the Director of Life and Community Enrichment-I have not. I will today though. Unfortunately this seems like a very common occurrence.

c. 5/17/2023 1:22 PM Email from the Director of Life and Community Enrichment to the Director of Social Services-With the staff member or

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Resident #385?

d. 5/17/2023 1:22 PM Email from the Director of Social Services sent to the Director of Life and Community Enrichment-Staff member

e. 5/17/2023 Email from the Director of Life and Community Enrichment to the Director of Social Services-That is a shame. When she was Agency working here she seemed great, but I have definitely seen a change.

f. 5/17/2023 1:24 PM Email from the Director of Social Services sent to the Director of Life and Community Enrichment-Did the resident mention to you what Staff V did/said? I'm trying to recall what she told me yesterday. Something about she put her in her room and told her not to come out. Then something else.

g. 5/17/2023 2:26 PM Director of Life and Community Enrichment sent to the Director of Social Services- Staff II and Staff X said she mentioned that she was "bullying" her and "being mean" to her and that this wasn't this first instance and that it happens every time she works. She mentioned she pushed her into her room and told her she couldn't come out.

During an interview on 10/03/23 at 2:05 PM., with Staff II the current Activities Director reported she was involved with this incident with the resident. It was right before an activity event so it was between 1:00 and 1:30 pm. She was getting the residents from their rooms before the activity and Resident #385 was in her room and she wasn't acting normal. She appeared to be upset and when asked the resident said she had to stay in her room. When Staff II inquired about this the

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resident said the staff member got mad at her and said she had to stay in her room. The resident was able to point out the staff member the following day that reportedly told her she had to stay in her room. Staff II reported this information to her supervisor at the time.

The Facility Policy titled Abuse, Neglect, and Exploitation dated April 2008 with the most current revised version dated January 2023 advised the following:

It is policy of this community to take appropriate steps to prevent the occurrence of Abuse, Neglect and Misappropriation of resident property. It is also the policy of this community to take appropriate steps to ensure that all alleged violations of federal or state laws which involve mistreatment, neglect, abuse, injuries of unknown source, and misappropriation of resident property ("alleged violations") are reported immediately.
5. Investigation:
a. Any person who knows or has reasonable cause to suspect that a resident has been or is being abused, neglected, or exploited shall immediately report such knowledge or suspicion to the administrator.
b. The administrator, director of nursing, or designee will notify the appropriate regulatory. investigative, or law enforcement agencies immediately, in accordance with state regulations.
c. Allegations of abuse, neglect, or exploitation will be thoroughly investigated. The investigation will be initiated upon receipt of the allegation. The administrator, or designee, will complete the investigation process.
d. The investigation can include, but is not limited to:
i. The name(s) of the resident(s) involved

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| F 610 | Continued From page 53<br>ii. The date and time the incident occurred<br>i. The circumstances surrounding the incident<br>iv. Where the incident took place<br>V The names of any witnesses<br>vi. The name of the person(s) alleged with committing the act | F 610 | | |
| F 622 SS=D | Transfer and Discharge Requirements<br>CFR(s): 483.15(c)(1)(i)(ii)(2)(i)-(iii)<br><br>§483.15(c) Transfer and discharge-<br>§483.15(c)(1) Facility requirements-<br>(i) The facility must permit each resident to remain in the facility, and not transfer or discharge the resident from the facility unless-<br>(A) The transfer or discharge is necessary for the resident's welfare and the resident's needs cannot be met in the facility;<br>(B) The transfer or discharge is appropriate because the resident's health has improved sufficiently so the resident no longer needs the services provided by the facility;<br>(C) The safety of individuals in the facility is endangered due to the clinical or behavioral status of the resident;<br>(D) The health of individuals in the facility would otherwise be endangered;<br>(E) The resident has failed, after reasonable and appropriate notice, to pay for (or to have paid under Medicare or Medicaid) a stay at the facility. Nonpayment applies if the resident does not submit the necessary paperwork for third party payment or after the third party, including Medicare or Medicaid, denies the claim and the resident refuses to pay for his or her stay. For a resident who becomes eligible for Medicaid after admission to a facility, the facility may charge a resident only allowable charges under Medicaid; or | F 622 | | |

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(F) The facility ceases to operate.
(ii) The facility may not transfer or discharge the resident while the appeal is pending, pursuant to § 431.230 of this chapter, when a resident exercises his or her right to appeal a transfer or discharge notice from the facility pursuant to § 431.220(a)(3) of this chapter, unless the failure to discharge or transfer would endanger the health or safety of the resident or other individuals in the facility. The facility must document the danger that failure to transfer or discharge would pose.

§483.15(c)(2) Documentation.
When the facility transfers or discharges a resident under any of the circumstances specified in paragraphs (c)(1)(i)(A) through (F) of this section, the facility must ensure that the transfer or discharge is documented in the resident's medical record and appropriate information is communicated to the receiving health care institution or provider.
(i) Documentation in the resident's medical record must include:
(A) The basis for the transfer per paragraph (c)(1)(i) of this section.
(B) In the case of paragraph (c)(1)(i)(A) of this section, the specific resident need(s) that cannot be met, facility attempts to meet the resident needs, and the service available at the receiving facility to meet the need(s).
(ii) The documentation required by paragraph (c)(2)(i) of this section must be made by-
(A) The resident's physician when transfer or discharge is necessary under paragraph (c)(1)(A) or (B) of this section; and
(B) A physician when transfer or discharge is necessary under paragraph (c)(1)(i)(C) or (D) of this section.

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(iii) Information provided to the receiving provider must include a minimum of the following:
(A) Contact information of the practitioner responsible for the care of the resident.
(B) Resident representative information including contact information
(C) Advance Directive information
(D) All special instructions or precautions for ongoing care, as appropriate.
(E) Comprehensive care plan goals;
(F) All other necessary information, including a copy of the resident's discharge summary, consistent with §483.21(c)(2) as applicable, and any other documentation, as applicable, to ensure a safe and effective transition of care.
This REQUIREMENT is not met as evidenced by:
Based on observation, interview, and record review, the facility failed to ensure thorough documentation in the clinical record for a resident's transfer to the hospital for three of seven residents reviewed for hospitalization (Resident #7, Resident #60, Resident #124). The facility reported a census of 140 residents.

Findings include:

1. The Quarterly Minimum Data Set (MDS) assessment for Resident #124 dated 9/11/23 revealed the resident had severely impaired cognitive skills for daily decision making. Per the MDS, Resident #124's diagnoses included anxiety disorder and depression.

The Nurse Progress Note dated 9/13/23 at 3:23 PM documented, [Name Redacted], Physician Assistant- Certified (PAC) in facility and assessed [Resident #124]. [Resident #124] has not been bearing weight to right lower extremity (RLE) and

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has been transferred with the stand lift and Hoyer lift recently. NOR: Send to ED (Emergency Department) once brother, [Name Redacted], arrives d/t (due to) not bearing weight to RLE. [Name Redacted], [Name Redacted's] nurse, phoned [Name Redacted] - he stated he would be at facility within 1.5 hours and is aware of new order.

Review of the clinical record lacked documentation of what information was shared with the receiving provider for Resident #124.

2. The Quarterly MDS assessment dated 8/8/23 revealed Resident #60 scored 15 out of 15 on a Brief Interview for Mental Status (BIMS) exam, which indicated cognition intact. The MDS revealed the resident needed extensive assistance with two plus person physical assist for bed mobility, transfers, and dressing. The MDS revealed medical diagnosis of heart failure, hypertension, and hemiplegia/hemiparesis.

The Progress Note dated 7/27/23 at 1:44 PM, revealed the resident complained of shortness of breath (SOB) and contacted Physician Assistant (PA) and provided today's weight and new orders as followed:
a. Metolazone 5 milligrams (mg) PO (oral) now and then 2.5 mg daily.
b. CXR (Chest X-ray) AP (Anterior/Posterior) and lateral (mobile ok), CBC (complete blood count), probnp (pro b-type natriuretic peptide), and BMP (basic metabolic panel), please draw today.

The Progress Note dated 7/27/23 at 2:47 PM, revealed CBC with diff, pro-BNP and BMP drawn

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from left hand at 2:20 PM, spun, then sent to lab per order.

The Progress Note dated 7/27/23 at 5:46 PM, revealed received a call from PA's nurse, who gave order from PA to send Resident #60 to emergency room (ER), if she agreeable, as her WBC (White blood count) elevated along with Congestive Heart Failure (CHF) exacerbation symptoms. Resident #60 agreeable and will go when she finished eating.

The Progress Note dated 7/27/23 at 6:32 PM documented Resident #60 left the facility via ambulance. She was on her way to the ER.

During an interview on 10/2/23 at 1:50 PM, Staff J, Assistant Director of Nursing (ADON) stated she couldn't find a bed hold for Resident #60.

3. The 5-Day MDS assessment dated 8/25/23 revealed Resident #7 scored 15 out of 15 on a Brief Interview for Mental Status (BIMS) exam, which indicated cognition intact.

The Progress Note dated 7/23/2023 at 10:00 AM, documented as follows; the resident's dressing changed to lower left leg and noted foot and leg to mid calf red and warm to touch. Edema present. resident complained of discomfort to area. Resident #7 stated continued to feel cold and noted upper extremity shaky. The PA (Physician Assistant) paged to transport to ER (Emergency Room).

The Progress Note dated 7/23/2023 at 10:35 AM, revealed the PA returned called and info given with order to send to ER. The daughter present and notified of transfer. Called report to nurse at

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ER. Ambulance called for transfer of patient to ER.

The Progress Note dated 8/18/2023 at 7:30 AM, revealed the resident reported in a loud voice, at the same time cried "my hands are so cold, I am so cold, I am very thirsty, I'm afraid of infection in my ankle, I can't stop drinking, I want plain water, I am just so thirsty & cold". During assessment, resident noted tachycardia, with chills, hands and both feet cold to touch, and the rest of body are warm. Resident with runny nose, reported arms hurt. VS (vital signs) obtained, BP (Blood pressure) elevated 168/95, Temperature 99, pulse runs from 114 to 107, O2 (oxygen) on RA (room air) ranged between 82% to 92%. Resident continued to deny SOB (shortness of breath), phones PA, gave advised to test for COVID 19 and negative. BG (blood glucose) checked 112 fasting. Resident then reported feeling nauseous and refused to eat due to nausea. Resident did not progress to feeling better after warm blankets, and repositioning. Refused to take medications. Phoned PA for advised.

The Progress Note dated 8/18/23 at 12:06 PM, documented verbal order received today following advised from PA to send resident to ER due to resident's condition that worsened overtime and similar symptoms seen with resident in the past that progressed to sepsis. Resident taken to ED (emergency department) via EMT (Emergency Medical Technician) on a stretcher, at approximately 9:00 AM, no belongings with resident, POA (Power of Attorney) will meet that the ER. ADON (Assistant Director of Nursing) notified via voicemail. Verbal order: Send to ED for re-evaluation.

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The Progress Note dated 9/30/2023 at 12:33 PM, documented Resident #7 at beginning of this shift at her baseline, calm, did not report any concerns of health. As the day progressed, resident observed to be in tears, crying out loud stating "I can feel it, I have infection again" sobbing with tears and runny nose. When assessed, low fever noted, Acetaminophen (APAP) 650 milligrams (mg) administered. Resident educated and reassured, resident offered no concerns then after warm blankets offered. During reassessment, resident appeared lethargic, clammy, warm to the touch above extremities and cold on distal areas of the body. Temp on 101 to 102 to 103, pulse 110, BP 168/90, respirations 16, O2 with difficulties obtaining it and only reached 85% on RA. When on-call Doctor paged, order then obtained to be sent to ER for further evaluation. Nurse to nurse report were given, 911 called, resident transferred via stretcher without any personal belongings (on nightgowns & covered with blankets). POA will meet resident at the ER. Received a call back from ER nurse that resident admitted with the diagnosis of sepsis with acute renal failure, & cellulitis of lower extremities.

During an interview on 10/02/23 at 11:56 AM, Staff O, LPN queried what she completed when a resident transferred to the hospital and she stated when someone transferred to the hospital they made sure all assessments are completed, contact provider, family, power of attorney (POA), and make sure we have all the orders, contact the ADON, if someone got hurt I will let the Administrator know. She stated she documented nursing documentation, make sure IPOST (Iowa Physician Orders for Scope of Treatment), medication sheets, demographic sheets, bed hold

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policy and verbal or in writing doctor's order. Staff O asked where she documented all the information and she stated the nurse's notes.

During an interview on 10/02/23 at 12:10 PM, Staff K, ADON queried on what the nurses completed and documented when a resident transferred to the hospital and she stated usually the nurse's note and sent a copy of the orders, Medication Administration Record (MAR), face sheet, code status, IPOST and the nurse notes that covered the whole event. Staff K asked where they documented the information and she stated it would be in the nurse's notes. Staff K asked about Resident #60 transfer and she looked up her notes and stated she didn't see a bed hold and they needed to put in the bed hold and what paperwork they sent and that they called report to the ER. Staff K asked about the transfer documentation for Resident #7 for dates 7/23/23; 8/18/23; and 9/30/23 and she stated the bed hold not found in the documentation and she stated she hoped they chart what paperwork they gave to the EMT.

On 10/02/23 at 12:55 PM, Staff J, ADON queried on what the nurses documented when residents transferred to the hospital and she stated the doctor's order, nurse assessment, bed hold, family notification, nurse to nurse report, time called ambulance and when the resident left the facility and where they went. Staff J stated the nurses sent the face sheet, medications, MAR, IPOST, and order to send to the hospital.

During an interview on 10/03/23 at 11:45 PM, the Director of Nursing (DON) queried on what the nurses documented when a resident transferred and she stated with emergency transfers the

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nurses needed to use the e-interact in the assessment guide for them use. The nurse notes needed to document what the symptoms of the resident, bed hold policy, progress note, family notification, IPOST, MAR, Treatment Administration Record (TAR) and they needed to document the paperwork they sent with the EMT and to show proof of what they sent.

The Admission, Transfer, and Discharge Policy dated 10/22 documented the following information:
Transfer to alternative provider will include documentation of the following:
a. History of present illness;
b. Reason for transfer and past medical history:
c. Contact information of the practitioner responsible for care of the resident:
d. Resident representative information, including contact information;
e. Advanced Directive Information;
f. All Special instructions or precautions for ongoing care as appropriate;
g. Comprehensive care plan goals;
h. All other necessary information, including a copy of the resident's discharge summary including the following information: "A recapitulation of the resident's stay that includes, but not limited to,
diagnoses, course of illness/treatment or therapy, and pertinent lab, radiology, and consultation results." A final summary of the resident's status to include identification and demographic information, customary routine, cognitive patterns, communication, vision, mood and behavior patterns, psychosocial well being, functioning and structural problems, continence, disease diagnoses and health conditions, dental and nutritional status, skin condition, activity

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| F 622 | Continued From page 62<br>pursuit, medications, special treatments and procedures and discharge potential at the time of the discharge, that was available for release to authorized persons and agencies, with the consent of the resident or resident's representative. " Reconciliation of all pre-discharge medications with the resident's post discharge medications (both prescribed and over-the-counter). | F 622 | | |
| F 644 SS=D | Coordination of PASARR and Assessments<br>CFR(s): 483.20(e)(1)(2)<br><br>§483.20(e) Coordination.<br>A facility must coordinate assessments with the pre-admission screening and resident review (PASARR) program under Medicaid in subpart C of this part to the maximum extent practicable to avoid duplicative testing and effort. Coordination includes:<br><br>§483.20(e)(1)Incorporating the recommendations from the PASARR level II determination and the PASARR evaluation report into a resident's assessment, care planning, and transitions of care.<br><br>§483.20(e)(2) Referring all level II residents and all residents with newly evident or possible serious mental disorder, intellectual disability, or a related condition for level II resident review upon a significant change in status assessment.<br>This REQUIREMENT is not met as evidenced by:<br>Based on clinical record review and staff interviews the facility failed to ensure resubmission of the Preadmission Screening and Resident Review (PASARR) following change in medical diagnoses for one of two residents | F 644 | | |

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| F 644 | Continued From page 63 | F 644 | | |

reviewed for PASARR (Resident #47). The facility reported a census of 140 residents.

Findings include:

The Annual Minimum Data Set (MDS), dated 7/25/2023 documented Resident #47 did not receive antipsychotic medications and there was no indication of mood/behavioral instability. The resident scored 15 out of 15 on a Brief Interview for Mental Status (BIMS) exam, which indicated the resident was cognitively intact.

Care Plan dated 10/22/2020 and Initiated on 10/22/2020 documented the following;

The Resident has psychotropic medications (antidepressant) with a diagnosis of PTSD, generalized anxiety disorder and hallucinations. The following are the facility interventions;
a) Administer my medications as ordered. Monitor me for and document side effects and effectiveness.
b) Monitor me for and record occurrence of for target behavior symptoms-hallucinations-and document per facility protocol.
c) Monitor me for, record, and report to me MD prn 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.

Document dated 10/14/20 titled Notice of PASRR Level I Screen Outcome reported; PASRR Level I

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Determination: No level II Required-No SMI/ID/RC including No mental health diagnosis is known or suspected.

A document titled Medical Diagnosis indicated Resident#47 had the diagnoses including. Post-Traumatic Stress Disorder, Chronic with the date of 11/10/2020.

On 09/27/23 9:45 AM., the Director of Nursing (DON), reported a Level II PASRR for Resident #47. The DON advised a Level II PASRR has not been submitted for this resident although the resident had a change in mental health status.

On 09/28/23 02:02 PM the Director of Social Services (DSS) was queried in which instances a level one assessment would be resubmitted, and advised this would occur if there was a new diagnosis or a significant change in status. Diagnoses for Resident #47 and the Level 1 PASARR form were reviewed with the SSD, who confirmed it should have been resubmitted. The SSD advised after admission the Resident was diagnosed with PTSD and a Level II PASRR was not submitted although it should have been completed.

The Facility Policy titled Pre-Admission Screening and Resident Review (PASRR) dated April 2008 and revised January 2017 documented, The resident or resident representative will receive notice (copy of Level 1 Screen) if the resident is suspected of having a serious mental illness or a developmental disability, and therefore will require a Level II Screen. The facility must incorporate communication from PASRR Level II determination into a resident's assessment, care planning, and to his/her level of care.

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| F 645 SS=D | PASARR Screening for MD & ID<br>CFR(s): 483.20(k)(1)-(3)<br><br>§483.20(k) Preadmission Screening for individuals with a mental disorder and individuals with intellectual disability.<br><br>§483.20(k)(1) A nursing facility must not admit, on or after January 1, 1989, any new residents with:<br>(i) Mental disorder as defined in paragraph (k)(3)(i) of this section, unless the State mental health authority has determined, based on an independent physical and mental evaluation performed by a person or entity other than the State mental health authority, prior to admission,<br>(A) That, because of the physical and mental condition of the individual, the individual requires the level of services provided by a nursing facility; and<br>(B) If the individual requires such level of services, whether the individual requires specialized services; or<br>(ii) Intellectual disability, as defined in paragraph (k)(3)(ii) of this section, unless the State intellectual disability or developmental disability authority has determined prior to admission-<br>(A) That, because of the physical and mental condition of the individual, the individual requires the level of services provided by a nursing facility; and<br>(B) If the individual requires such level of services, whether the individual requires specialized services for intellectual disability.<br><br>§483.20(k)(2) Exceptions. For purposes of this section-<br>(i)The preadmission screening program under paragraph(k)(1) of this section need not provide for determinations in the case of the readmission to a nursing facility of an individual who, after | F 645 | | |

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being admitted to the nursing facility, was transferred for care in a hospital.
(ii) The State may choose not to apply the preadmission screening program under paragraph (k)(1) of this section to the admission to a nursing facility of an individual-
(A) Who is admitted to the facility directly from a hospital after receiving acute inpatient care at the hospital,
(B) Who requires nursing facility services for the condition for which the individual received care in the hospital, and
(C) Whose attending physician has certified, before admission to the facility that the individual is likely to require less than 30 days of nursing facility services.

§483.20(k)(3) Definition. For purposes of this section-
(i) An individual is considered to have a mental disorder if the individual has a serious mental disorder defined in 483.102(b)(1).
(ii) An individual is considered to have an intellectual disability if the individual has an intellectual disability as defined in §483.102(b)(3) or is a person with a related condition as described in 435.1010 of this chapter.
This REQUIREMENT is not met as evidenced by:
Based on record review, staff interview and facility policy review the facility failed to complete a Preadmission Screening and Resident Review on 1 out of 1 residents reviewed (Resident #69). The facility reported a census of 140 residents.

Findings include:

The Significant Change Minimum Data Set (MDS) dated 9/7/23 revealed Resident #69 had a

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Brief Interview for Mental Status (BIMS) score of 15 which indicates cognitively intact. Resident #69 MDS listed a diagnosis of Anxiety Disorder, Depression and Bipolar Disorder.

Review of the Preadmission Screening and Resident Review (PASARR) dated 7/20/2023 revealed level I outcome exempted hospital discharge. Exempted hospital discharge 30 day approval. - A 30 day or less stay in the nursing facility is authorized. Re-screening must occur by or before the 30th day if the individual is expected to remain in the nursing facility beyond the authorization timeframe.

The residents clinical record lacked a PASARR review after the 30 approval expired.

On 09/27/23 at 3:17 PM Director of Social Services states the marketing director previously had been completing the PASARR and after she left the interim was doing it for a while. She will be responsible for it going forward.

On 09/28/23 at 1:58 PM the Director of Social Services stated 7/21/23 PASARR rescreen must occur by the 30th day. It should have been done on Resident # 69 or been done when she was readmitted.

On 09/28/23 at 2:28 PM the Social Services Director stated she verified Resident # 69 should have had an updated PASARR done on 8/20/23 and it was not completed. She will do it today.

The facility provided a policy Pre-Admission Screening and Resident Review (PASARR) with a revision dated January 2017 the policy failed to direct staff on exempted hospital discharge

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| F 645 | Continued From page 68<br>PASARR and need for resubmission on or before day 30. | F 645 | | |
| F 655 SS=D | Baseline Care Plan<br>CFR(s): 483.21(a)(1)-(3)<br><br>§483.21 Comprehensive Person-Centered Care Planning<br>§483.21(a) Baseline Care Plans<br>§483.21(a)(1) The facility must develop and implement a baseline care plan for each resident that includes the instructions needed to provide effective and person-centered care of the resident that meet professional standards of quality care. The baseline care plan must-<br>(i) Be developed within 48 hours of a resident's admission.<br>(ii) Include the minimum healthcare information necessary to properly care for a resident including, but not limited to-<br>(A) Initial goals based on admission orders.<br>(B) Physician orders.<br>(C) Dietary orders.<br>(D) Therapy services.<br>(E) Social services.<br>(F) PASARR recommendation, if applicable.<br><br>§483.21(a)(2) The facility may develop a comprehensive care plan in place of the baseline care plan if the comprehensive care plan-<br>(i) Is developed within 48 hours of the resident's admission.<br>(ii) Meets the requirements set forth in paragraph (b) of this section (excepting paragraph (b)(2)(i) of this section).<br><br>§483.21(a)(3) The facility must provide the resident and their representative with a summary of the baseline care plan that includes but is not | F 655 | | |

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limited to:
(i) The initial goals of the resident.
(ii) A summary of the resident's medications and dietary instructions.
(iii) Any services and treatments to be administered by the facility and personnel acting on behalf of the facility.
(iv) Any updated information based on the details of the comprehensive care plan, as necessary.
This REQUIREMENT is not met as evidenced by:
Based on observation, interview, and record review the facility failed to ensure timely completion of a baseline Careplan for two of twenty-eight residents reviewed for baseline Careplan (Resident #7, Resident #124). The facility reported a census of 140 residents.

Findings include:

1. The Quarterly Minimum Data Set (MDS) assessment for Resident #124 dated 9/11/23 revealed the resident had severely impaired cognition.

Review of Resident #124's clinical census documentation documented the resident was admitted to the facility on 7/18/23.

On 9/27/23 at 11:10 AM, review of Resident #124's Baseline Care Plan dated 7/18/23 revealed the assessment marked as incomplete, and in progress.

2. The 5-Day MDS assessment dated 8/25/23 revealed Resident #7 scored 15 out of 15 on a Brief Interview for Mental Status (BIMS) exam, which indicated cognition intact.

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The Progress Note dated 8/22/2023 at 3:30 PM revealed transfer in hospital summary: resident returned from hospital by ambulance.

The Electronic Medical Record (EMR) lacked documentation the Baseline Care Plan completed when Resident #7 returned from hospital on 8/22/23.

During an interview on 10/02/23 at 11:56 AM, Staff O, Licensed Practical Nurse (LPN) queried on how completed the baseline care plan and she stated she didn't do care plans and completed every 3 months. Staff O asked who completed the admissions and she stated the nurse and if they were too busy the ADON (Assistant Director of Nursing) would do them.

During an interview on 10/02/23 at 12:10 PM, Staff K, ADON queried when a baseline care plan needed completed and she stated within 24 hours of an admission/readmission. Staff K asked who completed the baseline care plans and she stated recently the admitting nurse completed them. Staff K confirmed Resident #7 didn't have a baseline care plan on 8/22/23. Staff K informed Resident #124 had 2 incomplete baseline care plans dated 7/18/23 and 8/10/23. She stated she didn't know what happened and to ask another ADON but she guessed they needed completed.

During an interview on 10/02/23 at 12:55 PM, Staff J, ADON queried when they completed baseline care plans and she stated within the first 24 hours when admitted to the facility. Staff J asked who completed the baseline care plan and she stated the admitting nurse. Staff J informed Resident #124 baseline plans on 7/18/23 and

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| F 655 | Continued From page 71<br>8/22/23 not completed and she stated the facility had a horrible problem where too many staff got into the care plan and then it didn't get locked.<br><br>During an interview on 10/03/23 at 11:45 AM, the DON (Director of Nursing) queried on when baseline care plans needed completed and she stated within 48 hours and its been a struggle because they do them different and one person opened it and then dietary opened it. She stated she checked and one person needed to complete it within 48 hours.<br><br>The Facility Baseline Resident Centered Care Plan dated 10/22 revealed the following information:<br>a. Baseline care plans developed and implemented for each resident within 48 hours of admission and include, at a minimum, the following information:<br>1. Initial goals based on admission orders<br>2. Physician orders<br>3. Dietary Orders<br>4. Therapy Services<br>5. Social Services | F 655 | | |
| F 657 SS=E | Care Plan Timing and Revision<br>CFR(s): 483.21(b)(2)(i)-(iii)<br><br>§483.21(b) Comprehensive Care Plans<br>§483.21(b)(2) A comprehensive care plan must be-<br>(i) Developed within 7 days after completion of the comprehensive assessment.<br>(ii) Prepared by an interdisciplinary team, that includes but is not limited to--<br>(A) The attending physician.<br>(B) A registered nurse with responsibility for the resident. | F 657 | | |

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(C) A nurse aide with responsibility for the 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, policy review, and staff interview the facility failed to complete comprehensive care plans to reflect care given and failed to consistently provide care conferences on a quarterly basis for 4 of 7 residents reviewed for care plan conferences and care plan revision (Resident #101, Resident #5, Resident #7, Resident #24). The care plan for Resident #101 did not include goals and interventions for 12 focus areas identified. The care plan for Resident #5 did not include interventions for activities of daily living (ADL). The facility reported a census of 140 residents.

Findings included:

1. The Admission Minimum Data Set (MDS) assessment dated 8/28/23 for Resident #101 listed diagnoses of heart failure, obstructive uropathy, and muscle wasting and atrophy. The

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MDS identified a BIMS score of 15 which indicated intact cognition. Section G revealed limited assistance of 1 for bed mobility, locomotion on and off of the unit, and personal hygiene and extensive assistance of 1 for transfers, dressing, and toileting.

The Daily Skilled Comprehensive Note, dated 9/26/23, revealed the resident had impaired vision with glasses, an indwelling catheter, urostomy, received antibiotics, and was unsteady on her feet.

The Comprehensive Care Plan (CCP) for Resident #101, with focus areas dated 8/25/23, included sections for COVID 19 psychosocial well being, communication, advanced directives, abuse prevention, safety/falls, skin integrity, pain, vision, ADLs, bowel and bladder care, dental, and discharge plan that failed to include goals or interventions.

On 09/25/23 at 10:41 AM Resident #101 stated she remembered talking about her care plan with staff but did not recall getting a copy of the plan.

2. The Admission Minimum Data Set (MDS) assessment dated 09/08/23 for Resident #5 listed diagnoses of right hip abscess of bursa, weakness, and difficulty walking. Section G revealed bed mobility, transfers, walking, dressing, and toileting had only occurred once or twice at the time of the assessment. Locomotion and personal hygiene had not occurred or family/non-facility staff provided care.

The Comprehensive Care Plan (CCP) for Resident #5, focus area for ADL dated 9/18/23, failed to include interventions for ambulation,

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bathing, bed mobility, dressing, eating, hygiene, locomotion, toilet use, and transfers.

On 09/27/23 at 10:48 AM the Administrator stated that the nurses and the MDS coordinator are responsible for care plans and associated time frames for completion.

A policy entitled Care Plan Reviews and Conferences, revised 10/2022, indicated the community would conduct a care plan review/conference at least quarterly, and as needed, that was interdisciplinary, and provided an in-depth review of the resident ' s plan of care. It did not address initial care plans. It did not address transitional center care plans for skilled care and short term stays.

3. The Quarterly Minimum Data Set (MDS) assessment dated 7/11/23 revealed Resident #24 scored 15 out of 15 on a Brief Interview for Mental Status (BIMS) exam, which indicated cognition intact.

The last documented Skilled Nursing Facility (SNF) - Interdisciplinary Team (IDT)- Care Conference Summary for Resident#24 had the documented date of 10/14/22 at 12:27 PM and locked on 11/1/22 at 5:40 PM.

On 9/25/23 at 2:41 PM, Resident #24 stated the facility just hired an assistant social services and his last care conference been past the last 3 or 4

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| F 657 | Continued From page 75 | F 657 | | |

months.

During an interview on 10/2/23 at 12:55 PM, Staff J, ADON (Assistant Director of Nursing) queried how often care conferences needed completed and she stated quarterly. Staff J asked if Resident #24 should of been provided a care conference since October 2022 and she stated oh, absolutely.

During an interview on 10/2/23 at 1:50 PM, Staff J stated she couldn't provide any additional information for his care conferences.

4. The 5-Day MDS assessment dated 8/25/23 revealed Resident #7 scored 15 out of 15 on a Brief Interview for Mental Status (BIMS) exam, which indicated cognition intact.

The last documented SNF - IDT - Care Conference Summary for Resident#7 was dated 10/28/22 at 3:50 PM and locked on 11/8/22 at 2:36 PM.

On 9/25/23 at 11:20 AM, Resident #7 stated she didn't remember when they conducted a care conference with her and she knew she didn't do one in quite awhile.

During an interview on 9/27/23 at 5:44 PM, Resident #7 stated she thought maybe in February or March she had a care conference but didn't know for sure. She stated she didn't remember the facility ever doing care conferences every 3 or 4 months.

During an interview on 10/2/23 at 12:10 PM, Staff K, ADON queried on when care conferences

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| F 657 | Continued From page 76 | F 657 | | |

conducted with residents and she stated her understanding was upon admission and then quarterly and social services set up the appointments.

During an interview on 10/2/23 at 6:08 PM, Staff W, Social Services queried on when care conferences got completed and she stated every 3 months and with any significant change. She stated she knew they were behind but since August she was the only social services personnel for 150 residents. Staff W informed the last care conference documented for Resident #7 dated last October and she stated she didn't realize they were that far behind but it must be right. Staff W stated Resident #24 last documented care conference dated October of last year and she stated he had one scheduled and coming up. She stated he visited her office quite a bit and they conducted care conference that were informal. She confirmed nothing was documented and the meeting were between the two of them.

During an interview on 10/03/23 at 11:45 AM, the Director of Nursing (DON) queried on how often care conferences needed completed and she stated quarterly and as needed. The DON asked if they needed documented when completed and she stated yes.

The Facility Care Plan - Reviews/Conferences dated 10/22 revealed the following information:
a. The community conducted a care plan review/conference at least quarterly, and as needed, that is interdisciplinary, provided an in-depth review of the resident ' s plan of care, and provided an opportunity for resident and resident representative and/or family

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| F 657 | Continued From page 77<br>discussion/input. | F 657 | | |
| F 677 SS=D | ADL Care Provided for Dependent Residents<br>CFR(s): 483.24(a)(2)<br><br>§483.24(a)(2) A resident who is unable to carry out activities of daily living receives the necessary services to maintain good nutrition, grooming, and personal and oral hygiene;<br>This REQUIREMENT is not met as evidenced by:<br>Based on interview, observation, record review, and facility policy review the facility failed to provide showers twice weekly for 1 of 3 residents reviewed for ADLs (Activities of Daily Living) (Resident #7). The facility reported a census of 140.<br><br>Findings include:<br><br>The 5-Day MDS assessment dated 8/25/23 revealed Resident #7 scored 15 out of 15 on a Brief Interview for Mental Status (BIMS) exam, which indicated cognition intact. The MDS documented the resident needed extensive assistance with of one person physical assist with bed mobility and total dependence for bathing performance and two plus person physical assist for bathing support provided.<br><br>The Care Plan revealed a focus area for assistance with ADLs due to impaired mobility dated 8/16/22. The interventions revealed bathing assist of 1.<br><br>The POC (Plan of Care) Bathing Task documented Resident #7 received showers on the following dates:<br>a. 8/31/23 | F 677 | | |

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| F 677 | Continued From page 78<br>b. 9/5/23<br>c. 9/7/23<br>d. 9/14/23<br>e. 9/21/23<br>f. 9/28/23<br><br>The POC Bathing Task documented non applicable for the following dates:<br>a. 9/17/23<br>b. 9/25/23<br><br>The Shower Sheets provided documented the dates the resident received a shower:<br>a. 9/14/23<br>b. 9/25/23 and noted bed bath given due to one aide on hall<br><br>During an interview on 9/25/23 at 10:57 AM, Resident #7 stated she didn't always get her showers on her showers days. She stated her hair got bad so quick. She stated 2 showers a week was better. She stated her showers days scheduled on Monday and Thursday and if they miss on Thursday, they try on Friday, or sometimes Saturday. Resident #7 stated the aide already scheduled other residents above her and so she didn't receive her shower yet today.<br><br>During an observation on 9/25/23 at 11:56 AM, Resident #7 sat in bed in a hospital gown, hair combed, with bangs greasy looking.<br><br>During an interview on 9/27/23 at 10:31 AM, Resident #7 stated she received a bed bath yesterday morning and looked forward to her shower scheduled tomorrow but she would see if they completed it.<br><br>During an interview on 9/27/23 at 10:50 AM, | F 677 | | |

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| F 677 | Continued From page 79 | F 677 | | |

Resident #7 stated she didn't want her hair dried washed because it turned out worse than before they washed it. She stated she wanted her hair washed in the shower.

During an interview on 9/28/23 at 10:07 AM, Staff U, Certified Nurse Assistant (CNA) stated staff gave her a hard time because she worked on Monday and supposed to give showers and she was on the only one on the hall and instead she gave Resident #7 a bed bath.

During an interview on 9/28/23 at 10:36 AM, Staff M, CNA queried how often Resident #7 received a shower and she stated Resident #7 supposed to receive a shower twice a week. Staff M asked when shower sheets completed and she stated they tried to complete them with showers and they charted on the computer.

During an interview on 9/28/23 at 1:09 PM, Staff P, Licensed Practical Nurse (LPN) queried if shower sheets completed with showers and she stated yes, they needed filled out for every shower.

During an interview on 10/2/23 at 12:10 PM, Staff K, Assistant Director of Nursing (ADON) queried how often residents received showers and she stated it should be twice a week on the scheduled shower days. Staff K asked where the CNA documented it and she stated in the EMR (Electronic Medical Record) and a shower sheet. She stated each resident needed a shower sheet when they received a shower or refused a shower.

During an interview on 10/03/23 at 11:45 AM, the Director of Nursing (DON) queried on how often

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| F 677 | Continued From page 80<br>residents received showers and she stated twice a week and if a resident refused and needed documented and offered 3 times by 3 different people.<br><br>The Facility Activities of Daily Living- ADL Policy dated 10/22 documented the following information:<br>a. A resident unable to carry out activities of daily living received the necessary services to maintain good nutrition, grooming, and personal hygiene. | F 677 | | |
| 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 observation, interview, record review, and facility policy review the facility failed to assess the pain in the foot and knee after a reported incident and failed to assess the foot after an incident while transferring a resident in the shower chair for 2 out of 4 residents reviewed for assessment and intervention (Resident #7 and Resident #385). The facility reported a census of 140.<br><br>Findings include:<br><br>1. The 5-Day MDS assessment dated 8/25/23 | F 684 | | |

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revealed Resident #7 scored 15 out of 15 on a Brief Interview for Mental Status (BIMS) exam, which indicated cognition intact. The MDS documented the resident needed extensive assistance with of one person physical assist with bed mobility and total dependence for bathing performance and two plus person physical assist for bathing support provided. The MDS revealed a diagnosis of multiple sclerosis.

The Care Plan revealed a focus problem of risk for impaired skin integrity related to impaired mobility and bowel and bladder incontinence and history of venous area to the LLE (left lower extremity) initiated date 7/31/23. The interventions included as follows; observed skin with AM/PM cares and with toileting for redness, rashes, open areas, pain, swelling and reported them to team leader with weekly skin checks and review skin concerns with Medical Doctor (MD).

The Care Plan revealed a focus area for assistance with Activities of Daily Living (ADL's) due to impaired mobility dated 8/16/22. The interventions documented locomotion needed an assist of one Certified Nurse Aide (CNA); assist of one staff due to impaired mobility for toilet use; and used Hoyer lift for transfers.

Observation 9/25/23 at 11:33 AM revealed, a band-aid placed over the 2nd, 3rd, and 4th toes on the left foot.

During an interview on 9/25/23 at 11:45 AM, Resident #7 stated one of the shower aides cut the corner into the shower room and it scuffed off her skin on her toes and they started to bleed. She stated three of her toes got scuffed off in the shower stall. She stated it was a couple of weeks

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ago, and she didn't know what they looked like under the band-aid. She stated she can't put her feet on the foot of the shower chair because her left leg affected with Multiple Sclerosis (MS) and extra big with no room to bend it and once thigh and calf meet and someone had to bend it, with minimal ability to move it.

During an interview on 9/27/23 at 10:31 AM, Resident #7 stated the wounds on her toes happened a couple of weeks ago when they turned the corner in the shower stall. She stated no one assessed it and they would just put a band-aid on it. She stated anyone who saw, applied the band-aid.

During an observation on 9/27/23 at 10:31 AM, Resident #7, second, third, and fourth toes on her left foot had scabbed over wounds on the top of the toes. Two wounds on the 2nd toe, and one wound on the 3rd and 4th toes.

During an interview on 9/28/23 at 10:36 AM, Staff M, CNA queried on what she did when she saw a new wound or sore on a resident and she stated marked in on the shower sheets and notified the nurse or the Assistant Director of Nursing (ADON). Staff M asked what she would do if an incident occurred with a resident and she stated she reported all incidents. Staff M asked if she knew of any recent incidents with Resident #7 and she stated Resident #7 told her a few times staff ran her feet into the showers. She stated she thought it happened once or twice and it didn't happen when she performed cares, but didn't remember when it happened.

During an interview on 9/28/23 at 3:45 PM, the Director of Nursing (DON) stated the last incident

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report completed on 7/1/22 for Resident #7.

During an interview on 10/02/23 at 11:56 AM, Staff O, Licensed Practical Nurse (LPN) queried if she knew about the wounds on Resident #7 left toes and she stated she didn't work Resident #7 hall for a couple of weeks and she didn't hear about incident with her toes. Staff O asked what she did when an incident occurred with a resident and she stated she wrote out the incident report, contacted provider, Power of Attorney (POA), Assistant Director of Nursing (ADON) She confirmed someone definitely should of reported the incident with Resident #7 toes. She stated even if they didn't know the cause of her wounds, they documented unknown cause. Staff O queried if all nurses filled out Incident reports and she stated she seen both ways.

During an interview on 10/02/23 at 12:10 PM, Staff K, ADON queried when an incident report needed filled out and she stated anything really, any injury or if we didn't know what happened, a skin tear. She stated she informed her staff to do an incident report for anything out of the ordinary for the resident, falls, or skin tears. Staff K asked if she knew about the band-aid on Resident #7 left toes and she stated no she didn't. She stated they never informed her of any incident with Resident #7. She stated she would of expected an incident report especially if the staff moving the resident when incident occurred. She stated she didn't know why staff wouldn't report the incident.

During an interview on 10/02/23 at 12:55 PM, Staff J, ADON queried when an incident report needed filled out and she stated falls, wounds, skin tears and that short of thing, and medication

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errors. Staff J asked who filled out the report and she stated the nurse who found the situation. Staff J asked what happened after an incident report completed and she stated they conducted an investigation and looked into it and requested statements. Staff J queried if she aware of the incident with Resident #60 right great toe and she stated yes she believed it occurred when her toe hit the door frame. She stated she didn't know if the resident transferred during incident or in her chair.

During an interview on 10/03/23 at 11:45 AM, the DON queried on when an Incident Report needed completed and she stated for skin tears, resident to resident interactions, falls, any change skin change like a bruise, and anything out of the ordinary. The DON confirmed her expectation needed to be completed for incident with skin issues from transfers. The DON stated she expected the resident assessed and documented, the family, ADON, herself, and doctor notified and alert charting for at least 72 hours or until healed. The DON stated for an investigation, assessment, measurements, wound document sheet needed documented when the incident happened.

The Facility Nursing Documentation Policy dated 2/23 revealed the following information:
a. The facility will provide documentation in a standardized manner of the care and services provided to a resident.
1. Incident/Risk Management reports completed as appropriate and not part of the medical record and used internally for the facility Quality Assessment Performance Improvement (QAPI) process. Incident/Risk Management reports will not be referenced in the nurse's

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| F 684 | Continued From page 85<br>notes. | F 684 | | |

2. The Quarterly Minimum Data Set (MDS) assessment for Resident #385 dated 07/05/2023 revealed the resident scored 8 out of 15 on a Brief Interview for Mental Status exam, which indicated the resident was severally cognitively impaired.

On 09/28/2023 a document titled, Lutheran Living Grievance was reviewed. It provides the following information:
Resident # 385 Today's date 5/16/2023 Grievance heard by the Director of Social Services. Voiced by individual resident, therapy and activities. The grievance documented as follows; Staff V, CNA, was very mean to the resident. Put her in her room and told her not to come out. Pushed her into her room aggressively with no foot rest so her foot was caught and drug back under her chair hurting her knee. Resident stated the CNA was very mean and unfriendly.

On 09/28/2023 at 7:35 AM, the Executive Director, (ED), reported that the resident had talked with the Director of Social Services,(DSS), about her concerns with CNA Staff V. The ED advised the resident had approached the DSS and told her she was afraid of the CNA. Resident reported she felt safe at the facility but not around that specific staff member. The Resident reported the CNA had abruptly pushed her wheelchair into her room and told her she couldn't come out of her room. A Facility Investigation was completed by the Executive Director.

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| F 684 | Continued From page 86<br><br>On 09/28/2023 at 8:00 AM an undated facility report titled Investigation Summary provided and narrated by the Executive Director/Administrator (ED), documented the following; On 5/17/2023 Social Services gave the grievance to the Executive Director. The report summarized an alleged incident with Resident #385 and Staff member V Certified Nursing Assistant (CNA), pushed her into her room aggressively with no foot rest so her foot was caught and drug back under her chair hurting her knee. R states CNA is mean and unfriendly. Corrective Action by facility: Staff V CNA, date of hire is 12/29/2022. The alleged perpetrator is currently suspended pending investigation. The report also advised the ED met with the Resident. The Resident reported yesterday a CNA got on my case. The Resident advised she "threw me in my room" The Resident reported she was not hurt and she does not have any injuries. She does not remember the name of the staff person. She advised she feels safe here and says she hopes it doesn't happen again. Conclusion-Per recommendation of the Executive Director, employee will be terminated.<br><br>On 10/02/2023 at 11:58 AM, the ED was interviewed for additional information regarding the grievance. The ED advised there is not a time specified on the grievance filed by the resident as the facility felt the incident rose to the level of an abuse allegation and was treated it as such.<br><br>During a phone interview on 10/02/23 at 05:55 PM.,the Director of Social Services (DSS), advised she was given the information for the grievance from another staff member. The DSS did not directly speak with or observe the Resident on the day of the incident. The DSS | F 684 | | |

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| F 684 | Continued From page 87<br>advised she wrote the information on a grievance form and put it in one of the Assistant Director of Nursing's (ADON) mailbox. The ADON brought the grievance and concern up the following morning in their daily meeting.<br><br>On 10/03/2023 8:45 AM, another interview was conducted with the ED. When asked, the ED advised there are cameras near the lobby and front door but she is not aware if there are any cameras in the area where the incident occurred. The ED will follow up with this and get back with this Surveyor. The ED reported no cameras were reviewed during the facility investigation. The ED reviewed the resident's records and was unable to locate any documentation regarding any nursing assessment completed. The ED advised she talked to the resident the following day and asked the resident about the incident and she reported she was not in pain. The ED advised she does not believe she documented this anywhere. The Facility investigation also lacked interviews with other residents and other staff members. The Facility Assessment also lacked nursing assessment or documentation regarding the incident. There was no documentation that the Power of Attorney, family, or medical staff were notified of the incident. | F 684 | | |
| F 689 SS=H | Free of Accident Hazards/Supervision/Devices<br>CFR(s): 483.25(d)(1)(2)<br><br>§483.25(d) Accidents.<br>The facility must ensure that -<br>§483.25(d)(1) The resident environment remains as free of accident hazards as is possible; and<br><br>§483.25(d)(2)Each resident receives adequate supervision and assistance devices to prevent | F 689 | | |

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| LUTHERAN LIVING SENIOR CAMPUS | 2421 LUTHERAN DRIVE MUSCATINE, IA 52761 |

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| F 689 | Continued From page 88 | F 689 | | |

accidents.
This REQUIREMENT is not met as evidenced by:
Based on observation, interview, and record review the facility failed to ensure adequate supervision for residents with a known history of falls, failed to ensure residents were safely transported and transferred via wheelchair and/or Hoyer lift for five of nine residents reviewed for accidents (Resident #26, Resident #48, Resident #60, Resident #84, Resident #99). This deficient practice resulted in increased pain, hospital transfer, staples to the back of the head, surgical repair of a hip, a new wound, and bruising. The facility reported a census of 140 residents.

Findings include

1. The Admission Data Set (MDS) assessment for Resident #26 dated 7/26/23 revealed the resident scored 00 out of 15 on a Brief Interview for Mental Status (BIMS) exam, which indicated severe cognitive impairment. Per this assessment, Resident #26 had falls in the last month prior to admission, entry, or reentry, unable to determine was selected for falls in the last two to six months prior to admission, entry, or reentry, and the resident did have a fracture related to a fall in the six months prior to admission, entry, or reentry.

The Care Plan dated 7/31/23 documented, SAFETY/FALLS: I am at risk for falls AEB (as evidenced by) personal history of a fall resulting in left radial and ulnar fractures.

Interventions per the Care Plan documented the following:

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| F 689 | Continued From page 89<br>a. (Intervention dated 8/8/23): 8/04/23 fall intervention: pillow to be placed along my side when I am in bed.<br>b. (Intervention created 8/14/23): 8/11/23 fall intervention: Do not bring to meals unless food is ready or family is present.<br>c. (Dated 7/31/23):Ensure floor mat is next to my bed when I am in bed.<br>d. (Date 8/15/23):Floor mat to be placed by my bed when in bed.<br>e. (Created date 7/31/23): Bed in low position.<br>f. (Created date 7/31/23): Check for unmet needs: pain, toileting, hunger, thirst, temperature<br>g. (Created date 7/21/23): Do not leave unattended in the Bathroom.<br>h. (Created date 7/31/23): Encourage / Assist with non-skid shoes / socks<br>i. (Created date 7/31/23): Ensure environment is free of clutter.<br>j. (Created date 7/31/23): Fall review per facility protocol.<br>k. (Created date 7/21/23): Have commonly used articles within easy reach.<br><br>The resident's After Visit Summary dated 8/9/23 from the orthopedics department of [Hospital Name Redacted] documented the following, noted to occur prior to the resident's admission to the facility: [Resident #26] is an [age redacted] year old female with a medical history significant for diabetes and dementia who sustained a ground level fall in the bathroom on 07/08/2023. She sustained a traumatic subarachnoid hemorrhage, radius/ulna fracture, and T10 anterior vertebral body compression fracture.<br><br>The Fall Risk Screening Tool dated 7/21/23 revealed Resident #26 had 1-3 falls in the past 3 months, had diabetes, took narcotic, | F 689 | | |

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psychotropic, and antihistamine medication, and documented the following narrative per the Functional Status section: Pt is not steady without help, not able to use call light, is cognitively impaired. The Narrative Summary on the Fall Risk Screening Tool documented, Resident gets up without calling, does not use call light, is not steady without assistance.

The resident's Admit/Readmit Tool dated 7/21/23 documented Resident #26 alert to person only, and included the following narrative: Pt is confused will make weird comments about going home or babies being taken care of.

The Baseline Care Plan dated 7/21/23 locked 7/30/23 identified Resident #26 as a fall risk.

The Comprehensive Nursing Note dated 7/23/23 at 12:05 PM documented, in part, Ability to Express Ideas and Wants / Needs - Rarely / Never Understood Up and down trying to get up out of the chair and than the bed this AM. Back pain so pain medication for pain and anxiety given. Calling out the husband's name multiple time and trying to go search for him multiple time before he arrived.

The Comprehensive Nursing Note dated 7/26/23 at 10:11 AM documented, in part, Ability to Express Ideas and Wants / Needs - Rarely / Never Understood Resident speech unclear and has difficulty communicating wants and needs at this time.

The eMAR-Administration Note dated 7/27/23 at 10:14 PM documented, Anxious all shift, out of bed several times per self and walking in hallway. 1:1 (one to one) most of the evening after her

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husband left.

The Comprehensive Nursing Note dated 7/29/23 at 4:39 PM documented, Ability to Express Ideas and Wants / Needs - Rarely / Never Understood Does not follow instructions or cues. Frequent cueing and assistance provided.

The Late Entry Nurse Progress Note dated 8/4/23 at 11:08 AM documented, CNA (Certified Nurse Assistant) doing rounds around 0740 to get everybody up for breakfast, and found Pt on her knees with RUA (right upper extremity) on the mat as well in Pt's room. Nurse was next door by that time, CNA called nurse says "she's on the mat". Pt transferred to wheelchair, ROM (range of motion) and VS (vital signs) assessed right away. ROM intact on BLE (bilateral lower extremities), RUA intact as well. VS WNL (within normal limits). ADON (Assistant Director of Nursing) notified, POA (Power of Attorney) notified, PCP (Primary Care Provider) faxed to make aware. Pt then taken to nurse's station after getting dress and uses the restroom. Pt continued to be monitored and offered 1:1 for fall intervention.

The Incident Report dated 8/4/23 at 7:50 AM revealed the resident's fall was not witnessed.

The IDT (interdisciplinary team) Post Fall Review dated 8/8/23, locked 8/13/23 for a fall which occurred on 8/4/23 at 7:50 AM documented the following per the new preventative intervention section: Fall discussed with members of IDT. Pillow to be placed along my side while in bed.

The Incident Progress Note dated 8/8/23 at 11:54 PM documented, CNA [Name Redacted] observed Resident on floor in bedroom at 2240

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(10:40 PM), laying supine on fall mat next to bed. [Name Redacted] left room and came to Nurse's station and requested assistance from Nurse. Both staff members returned to [Room Number Redacted] immediately. Nurse able to complete frontal body assessment with no new injuries noted. Resident denied pain initially, however once Resident attempted to sit up, voiced pain 'really bad in my back.' Resident laid back down and with support of staff, cautioned to remain in supine position. Resident frequently moving arms and legs, Nurse notes physical s/s (signs/symptoms) of spasms/pain in back during movement. V/S (vital signs) 98.0 - 179/82 - 92 - 95% RA - 98.0. Nurse notified POA (Power of Attorney) at 2250 (10:50 PM) of fall with possible injury, who requested Resident be seen by the ER(Emergency Room) to see if any further injury occurred since initial fracture. 911 called by Nurse at 2258. Unit CNA sent to front to ensure ambulance is able to enter facility. Nurse in room with Resident and unable to leave room due to there being no other staff in unit. Nurse unable treat initial pain due to lack of staff/Resident not safe to leave alone while still on floor and moving her limbs in ways that are obviously causing her pain. EMTs (Emergency Medical Technicians) arrived to facility at 2210 (10:10 PM). Resident blackboarded at this time. Resident left facilityvia EMTs at 2230. Nurse called report to [Name Redacted Emergency Department] at this time. POA called facility at 2345 and notified that Resident was OOF (out of facility) and en route to hospital. Again Nurse explained that once Resident is out to hospital all updates should come from [Name Redacted] as they will be providing care for Resident.

The Incident Report dated 8/8/23 at 10:40 PM

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revealed the resident's fall was not witnessed.

The IDT Post Fall Review dated 8/9/23, locked 8/13/23 for a fall which occurred on 8/8/23 at 10:40 PM documented, Pt incontinent of bladder. Needs assistance with transfers. Unable to use call light independently. The preventative intervention section documented, Fall discussed with members of IDT. Pt sent to ER (Emergency Room) for evaluation. Contour mattress will be placed on bed.

The Nurse Progress Note dated 8/9/23 at 2:24 AM documented, Resident returned to the facility at this time via EMTs (Emergency Medical Technicians). No new orders noted. Resident resting in bed without s/s (signs/symptoms) of pain at this time. CT of Head completed in ED (emergency department) with clear results, no s/s or concern of head injury from unwitnessed fall on 8/8/23. POA called at this time and notified of return to facility.

The Order Progress Note dated 8/11/23 at 11:58 AM documented, Sustained witnessed fall loc at the dining room. Following order received via verbal order following post fall assessment. POA , Spouse, Assistant Director of Nursing (ADON), PCP aware. Order: Send to ER for further evaluation. And skin laceration.

The Nurse Progress Note dated 8/11/23 at 12:01 PM documented by Staff Z, Registered Nurse (RN), revealed the following: Pt fell on the floor, witnessed by fellow Patients nearby @approx. 1050AM. According to witnessed, pt stood up and tried to make a step when immediately leaned sideway to the right and fall. When CNA came around, Pt already on the floor. Pt assisted on her

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back slowly, with neck sensitively being moved slowly. Some drainage of blood noted on back of head, pressure in placed, VS (vital signs), ROM (range of motion) assessed. No significant findings on ROM, VS BP (blood pressure) 176/91, T 97.7, P 97, R 20, O2 98% RA (room air). Pt alert to self (baseline). Order obtained, 911 then was called. Pt then picked up via emergency medical vehicle on a stretcher. Report given to ER nurse.

The ED Provider Note, date of service 8/11/23 at 1:00 PM, HPI (History of Present Illness) patient is an [age redacted]-year-old female who is a poor historian secondary to her dementia. Patient comes in with a fall neck collar and body brace in her left arm in a cast complaining of a fall that happened when she was trying to get up she fell backwards hitting her head. Patient's other injuries had occurred 2 days prior. She had been transferred to the [Hospital Name Redacted] in [City Name] at that time. Patient does have a small parenchymal hemmhorage to her brain.

The ED Note Addendum dated 8/11/23 at 1:04 PM documented, Three staples placed in laceration in the back of the head by provider.

The Nurse Progress Note dated 8/11/23 at 10:08 PM documented, in part, Pt (patient) returned from ED about 1600 (4:00 PM). Pt alert to self and vitals are stable. Pt had some signs of discomfort this shift and scheduled medication given.

The Health Status Note dated 8/11/23 at 11:10 AM documented, Phoned POA regarding fall incident this AM. POA voiced concerns of brain bleed of Pt that happened in the past, stated "She

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had front brain bleed last July, we need to watch it". When called [Hospital Name] emergency room, Nurse at the ER are aware of the "head bleed" history in the past, ER nurse stated, "her head bleed has not increased in size, it is still there but it has not affected with this fall" and that "no head injury noted other than laceration in the back of head, 3 staples in placed". Phoned POA to f/up (follow up) w (with) any head injury that according to ER report, there is no brain/head injury other than the small laceration on the back of head, and that three staples in placed and that staples will come with an order to be removed in 10 days.POA voiced understanding.

The IDT Post Fall Review dated 8/11/23, locked 8/15/23, for a fall which occurred 8/11/23 at 10:50 AM documented the resident had a fall in the dining room, was sitting in her wheelchair prior to the fall, and sustained a laceration to the back of the head. The Post Fall Findings section documented, Pt was out in dining room sitting in wheelchair. She was witnessed to stand up tried to make step when she immediately leaned sideways to the right and fell. The fall prevention interventions section documented, Fall discussed with members of IDT. Do not bring to dining room unless meal is ready or family member present.

The Nurse Progress Note dated 8/13/23 at 11:24 AM documented, F/up (follow up) fall 8/11/23-VSS 98.6-98-20-142/85. No changes in LOC (level of conciousness) or signs/symptoms of pain. Resident alert to self and family only as per baseline. Staples to posterior scalp laceration intact. No signs of pain. Cast LUE (left upper extremity) dry and in place. CMS intact.

On 10/3/23 at 10: 27 AM, Staff X, Activities

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Assistant, explained Resident #26 had dementia really bad. Per Staff X, the resident was in the wheelchair and she looked lost. Staff X also explained the resident would lay in her bed and would be squirming.

On 10/3/23 at approximately 10:50 AM, when queried about Resident #26's cognition, Staff Y explained the resident was not cognitively intact. Per Staff Y, the resident used a wheelchair. When queried if the resident tried to get up independently, Staff Y explained she did not remember over here (certain part of facility), and explained in a different part of the facility the resident would roll out of bed.

On 10/03/23 at 1:31 PM, Staff Z Registered Nurse (RN), who had authored the resident's note on 8/11/23, explained the following for Resident #26: Staff Z explained the resident could not verbalize needs but could sometimes say she was in pain. Staff Q explained the resident could verbalize needs to use the restroom and could answer questions not accurately. Per Staff Z, the resident had Alzheimer's. Staff Z explained she did remember frequent falls, and did a lot of interventions, did a thick mattress on floor, and resident crawled and wanted to go home. Per Staff Z the resident was very restless when her husband was not around, and always looked for him when not around. Staff Z explained that was when the resident wanted to get out/go home. When queried if she was present when the resident fell, Staff Z explained the resident had falls in [certain section of building], and when had a fall she (Staff Z) was working the resident was gotten up a little late and had fallen the night before. Staff Z explained they had the resident up at the nursing station, it was time for lunch, the

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resident was taken for lunch and stood up and fell. Per Staff Z, she stood up and fell, and all of a sudden happened very very quickly. Per Staff Z, even when staff were around couldn't get to her fast when she stood up, she fell. Staff Z explained she had to send the ER because of a laceration to the back of the skull. Staff Z explained the resident had a skin tar when she had fallen and hit her head. Staff Z explained the resident had stitches done, and returned pretty much back to baseline, very restless.

When queried if she saw the resident fall when she got the head laceration, Staff Z responded yes, she stood up and fell ,and she didn't even make a step. Per Staff Z, the resident stood up, lost her balance, and fell. When queried if she was ever on a 1:1, Staff explained yes. Per Staff Z, when she was a 1:1 someone needed to be with her next to her. Per Staff Z, a lot of the time when there was a 1:1 they had that person supervise 100%, and in Resident #26's case Staff Z explained someone needed to be sitting next to her. When queried if the resident had been on 1:1 before the head laceration, Staff Z responded yes. When queried if the resident was on 1:1 the day she got the head laceration, Staff Z responded yes. Per Staff Z, when the resident was taken to the dining room, everybody needed to be brought in the room, and that is when it happened. Staff Z explained nobody was there next to her (Resident #26), and Staff Z explained the facility was so short staffed that day. Per Staff Z, two aides took turns keeping an eye on her, and for that moment when needed to bring everyone down, the resident got left out for seconds, stood up, and fell. Staff Z explained she was even there as well as she needed to give medication to somebody, and was a little far to

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get to the resident to prevent her from falling. Staff Z explained it would be ideal if enough staff to be a 1:1 with her to be with her the time she was up.

On 10/03/23 at 1:45 PM, Staff Z explained explained it seemed like CNA staff were burnt out, something like that, due to short staffing. Staff Z explained in that situation where she had fallen Staff Z did voice needed another person to be with her. Staff Z explained she was thankful the resident was asleep and wasn't restless. Staff Z explained the resident did not get up until 10. Staff Z explained she needed another staff here to work with her so that she could accommodate restless residents. Per Staff Z, prior to report the aide said the resident had not slept and was up all night until 3 in the morning. Staff Z explained most of the time she worked the resident hadn't slept and was very restless.

On 10/4/23 at 2:52 PM, Staff DD, CNA explained the following about Resident #26: Per Staff DD, the resident always wanted to try to get up our of bed or stand up out of wheelchair. Staff DD explained there were times when herself and [redacted] would visit, and there were times the resident would be put in the dining room unsupervised. Staff DD explained one time the need to hurry up to her side and tell her to sit down as no one was around the resident.

On 10/4/23 at 3:50 PM, Staff FF, CNA explained the following about Resident #26: Per Staff FF, when the resident first moved in she was pretty restless, and was pretty quiet. Staff FF explained towards the end the resident was kind of restless again.

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On 10/5/23 at 12:48 PM when queried about one to one supervision, the DON explained mostly in [dementia area] the facility tried to staff three and an activity aide. Per the DON, if having behaviors, up and down, they tried to get that person with them. The DON explained she had only seen it twice since she started. The DON also explained hospitality aides were utilized sometimes. Per the DON, the hospitality aids were only at the facility certain hours. The DON explained they knew Resident #26 started in a [certain part of the facility], and ended up long term care. Per the DON, Resident #26 had full blown dementia and should have been in the [dementia area]. When queried about stopping 1:1, the DON explained it would not be stopped if they were still a fall risk, unless behaviors adjusted, or a cause was determined.

2. The MDS for Resident #99 dated 4/17/23 revealed the resident scored 4 out of 15 on a BIMS exam, which indicated severe cognitive impairment. Per this assessment, the resident had not had falls since admission, entry, reentry, or the prior assessment.

The Care Plan created 3/31/23 initiated 4/12/23 for Resident #99 documented SAFETY/FALLS: I am at risk for falls AEB (as evidenced by) personal history of a fall resulting in right hip fracture.

Interventions per the Care Plan documented the following:

a. 10/3/23- 10/2/23 fall intervention: implement standing order for bowel regime.
b. 4/02/23 fall intervention: floor mat placed next to bed.

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c. 4/04/23 fall intervention: keep in common area when restless.
d. 5/10/23 0015 fall intervention: Offer to bring me to the common area when I am restless.
e. 5/10/23 0645 fall intervention: request UA.
f. 5/14/23 fall intervention: Third shift staff to offer AM cares in the morning.
g. 6/06/23 fall intervention: request order for UA.
h. 7/18/23 fall intervention: staff will redirect me after family visits.
i. 7/22/23 fall intervention: Contour mattress placed
j. 9/22/23 fall intervention: med review completed.
k. Fall intervention for 7/13/23: Dysem to WC.
l. 3/31/23: Assistive Device (grabber, toilet seat riser, bathroom bars)
m. 3/31/23: Bed in low position.
n. 4/4/23: Call light positioned for easy access.
o. 3/31/21: Check for unmet needs: pain, toileting, hunger, thirst, temperature
p.3/31/23: Do not leave unattended in the Bathroom.
q. 4/4/23: Ensure environment is free of clutter
r. 4/4/23: Fall review per facility protocol
s. 4/4/23: Have commonly used articles within easy reach.

The Admission Summary/Move In Note for Resident #99 dated 3/30/23 at 5:32 PM documented, Admitted from [Hospital Name Redacted] at 1330 (1:30 PM), transferred via ambulance, accompanied by EMT's (Emergency Medical Technicians] Admitting dx:: Right hip fx (fracture) Assessment overview:: See assessment tab.

The Fall Risk Screen for Resident #99 dated 3/30/23 documented the resident had three or

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more falls in the last 6 months, was at risk for falls, and documented, Pt is a 1:1, family at bedside at this time.

The Behavior Progress Note dated 4/1/23 at 10:33 PM documented, [Resident #99] having increase agitation and restlessness this PM, was noted to be up in room transferring self from bed to chair. Repeatedly stating she wants to go home. 1:1 most of the evening. Currently sitting in lounge area looking at magazines.

The Nurse Progress Note dated 4/2/23 at 9:38 AM documented, approx. 0905 (9:05 AM) pt was found on floor next to bed, cna (certified nurse assistant) came and got this nurse, upon arrival, pt was sitting on her buttocks leaned back on bed. Pt R (right) leg was rotated inwards, pt was in extreme pain, pt was two person lifted while supporting leg into bed, bed was in the lowest position. VS (vital signs) were obtained by CNA, nurse immediately called 911 for EMT (emergency medical technician) services. Pt son "[Name Redacted]" arrived while ems (emergency medical services) was assessing pt, he also notified pt husband, they had verbalized that they would not hold room, due to pt possibly having to be readmitted to HOSPITAL for reFX of Rt hip. Ems took pt to [Hospital Name Redacted] left building approx. 0925 (9:25 AM) . Son took pt belongings upon leaving facility. Ed nurse was given full report approx0934 (9:34 AM).

The Incident Report dated 4/2/23 at 9:05 A documented per the Notes section, Pt injury was related to hip fx (fracture), dislocation was a possibility send to ed for further evaluation. The Other Information section documented, pt has dementia is a fall risk.

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The Nurse Progress Note 4/2/23 at 9:51 AM documented, ADON (Assistant Director of Nursing) on call notified. Notified, that this nurse does not suspect pt (patient) rolled out of bed, but possibly attempted to stand up and fell on bottom, due to bed being so low to ground and in locked position. Pt had been restless prior to this nurse arriving for shift. Pt was also attempting to toilet self. Pt has dementia and does not make safe decision, pt is often a one on one due to this.

The Nurse Progress Note dated 4/2/23 at 12:38 PM documented, Called ED (Emergency Department) to check on pt, ed nurse stated that they were able to reduce pt hip and pt will be coming back to facility sometime, Pt is being monitored as she was sedated at hospital. Ed nurse will call when pt is ready for DC (discharge). [Name Redacted] van driver notified that she will need picked up

The Nurse Progress Note dated 4/2/23 at 4:06 PM documented, Pt returned to facility via medical emergency transport, on a stretcher assisted by two EMT guys. Pt's today's visit to ER (emergency room) was d/t (due to) fall that resulted to closed dislocation of right hip. Hematoma of right hip noted...CT hip wo contrast of R hip unilat 2/3 views wo (without) contrast on R pelvis were performed. ED Dr. (doctor) dislocated lower extremity, profolol and zofran given prior. Pt is w family ATM resting in bed. Nurse manager notified of the return of Pt.

The Nurse Progress Note dated 4/2/23 at 9:24 PM documented, [Resident #99] has been very restless and agitated this PM. Noted she did not return from ED (emergency department) with

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Abductor pillow and right foot appears externally rotated. Increased pain noted with repositioning, PRN (as needed) APAP (Tylenol) administered. Floor mat obtained and placed next to bed. Bed in lowest position and frequent checks completed. IV remains in right antecubital area. Attempted to remove and she became irritated and started hitting. Will try again when she calms down.

The Nurse Progress Note dated 4/4/23 at 11:45 PM documented, At 1910 (7:10 PM) CNA informed this nurse patient was on floor. Patient was sitting on floor end of bed. Bed in low position. Medmizer pushed away from bed. Call light within reach. Gripper socks on. Patient unable to give clear description. Alert and oriented x1 per baseline. Was able to communicate she was hot. This nurse asked patient if she needed to use bathroom and patient stated yes. Patient last toileted at 1730 (5:30 PM). Right leg rotating in per normal. Dr. [Name Redacted] aware of this and getting further x-rays tomorrow. Neuro's WNL (within normal limits) and started per facility protocol. Patient denied hitting head. No bumps or bruises noted. Vital B/P (blood pressure) 170/76, pulse 124, respirations 20, temp 97.1. Vitals retaken at 1925 B/P 141/88, P (pulse) 122, resp 18, temp 98.1. Patient denied pain time of fall.Leg immobilizer placed on right leg. Patient was assist x3 with gait belt into wheelchair and then toileted. Patient was brought out to common area for closer monitoring. [Name Redacted] PA-C notified at 1920 (7:20 PM). Family member [Name Redacted] notified at 1925 (7:25PM).

The Incident Report dated 4/4/23 at 7:10 PM documented the following Description of Action

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Taken: Patient assisted to toilet where she urinated. She was then brought out to common area to be monitored. The Notes section documented, Patient denied pain time of fall. Patient then started moaning due to discomfort in right leg. PRN (as needed) Tylenol given with relief.

Review of Hospital Records History and Physical (H and P) for an admission date and time documented as 4/6/23 at 1:00 PM documented, Impression: Persistent dislocated right hip arthroplasty.

Review of Hospital Records, preliminary results dated 4/6/23 at 3:03 PM, at revealed the resident had an xray of the hip unilateral 2/3 view revealed examination: right hip for indication of right hip pain. The Findings documented, There is a right hip hemiarthroplasty with dislocation. The Plan section documented, Dislocation of right hip arthroplasty-failed reduction in the emergency room...Plan is for right hip revision most likely Saturday afternoon.

Review of H and P-Encounter Notes from Hospital Records for date of service 4/7/23 at 7:26 PM documented, This is an [age redacted]-year-old female with past medical history of dementia, atrial fibrillation on Eliquis, CVA, osteoporosis, hypertension who presented to the ED from [Name Redacted] skilled nursing facility with fall found to have dislocated right hip prosthesis. Patient recently underwent right hip hemiarthroplasty on 3/27 with Dr. [Name Redacted] for displaced right femoral neck fracture following a fall. She then represented on 4/2 after a fall and found to have dislocation of prosthesis which was successfully reduced in the

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ED and she was discharged back to [Facility Name Redacted]. Reportedly, patient sustained another fall on 4/4 and was again found to have dislocation of right hip prosthesis, reduction in the ED was unsuccessful. Case was discussed with Dr. [Name Redacted] who recommended transfer to [City Name] for revision.

Review of the Orthopedic Consult present in Hospital Records, filed 4/8/23 at 9:47 PM, documented, in part, the following: She sustained a displaced right femoral neck fracture approximately 2 weeks ago and had an uncomplicated hemiarthroplasty. This was then complicated by dislocation several days later, which was reduced in the emergency department and then complicated by a secondary dislocation which could not be reduced in the emergency department...After waiting 48 hours from her last Eliquis dose, I recommended to the family that the patient return to the operating room and have a revision arthroplasty and conversion to total hip arthroplasty in order to try achieve pain relief as the patient does have significant crying out in pain with any attempt of motion or movement.

The Nurse Progress Note dated 5/10/23 at 12:15 AM documented, CNA's went to do rounds and found patient lying on the floor on her left side next to her bed. Bed in low position, gripper socks on.
Resident unable to tell this nurse what happened. This nurse asked patient what happened and if she was ok and she replied "I'm in heaven." Patient lying next to bed with head by the foot of the bed on her left side. No signs of injury to head, no bumps, redness or bleeding noted to body. Patient denies any pain. Speech is clear. Able to move all extremities without pain. Vitals

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obtained. Patient assisted back in bed. Notified on call ADON (Assistant Director of Nursing) and faxed Dr. [Name Redacted] to notify. Will have dayshift nurse notify family.

The Nurse Progress Note dated 5/10/23 at 6:44 AM documented, CNA alerted the nurse to come to her room. She was sitting on the bathroom floor taking off her brief. Nurse asked her if she was hurt and did she loose her balance and she stated she did not fall. Nurse and CNA assisted her to use the bathroom. She hadno bruising and no injury noted. Vitals were obtained. Nurse will contact MD regarding her falls this am and monitor her neuro.

The Incident Report dated 5/10/23 at 6:45 AM documented the following Incident Description: She was on the bathroom floor trying to take off her brief. The Resident Description section documented, She remarked I did not fall I am just changing this as she was holding a brief. The Description of Action Taken ecion documented, Assisted her to use the bathroom, assessed for injury and checked vitals.

The Incident Report dated 5/10/23 at 12:15 AM documented, Nursing Description: CNA's went to do rounds and found patient lying on the floor on her left side next to he bed. Bed in low position, gripper socks on. The Resident Description section documented, Resident unable to tell this nurse what happened. This nurse asked patient what happened and if she was ok and she replied "Im in heaven." The Description of Incident documented, Patient lying next to bed with head by the foot of the bed on her left side. No signs of injury to head, no bumps, redness or bleeding noted to body. Patient denies any pain. Speech is

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clear. Able to move all extremities without pain. Vitals obtained. Patient assisted back in bed.

The Incident Report dated 5/14/23 at 5:05 AM documented the following Nursing Description: Resident slide off her bed onto floor mat and on to floor. Resident scooted herself toward her bedroom entry door. Nurse found resident sitting on floor at 0505 (5:05 AM). The Resident Description section documented, I wanted to go to the restroom.

The Late Entry Nurse Progress Note dated 5/14/23 at 5:50 AM documented, Resident was found sitting on the floor next to her bedroom door at 0505 by this nurse. Nurse asked resident what she was trying to do. Resident stated she wanted to go to the restroom. Nurse assessed resident, able to move all extremities well, no injuries, no complain of pain. Nueros intact, vitals as follow:117/51, 96.4, 98, 20, 96%. Grips equal and strong. Nurse and CNA assisted resident to w/c (wheelchair) and then toileted and changed resident and placed in a recliner on the lounge. Nurse faxed Dr. [Name Redacted] and texted ADON [Name Redacted] to inform of incident. Nurse notified oncoming nurse that family needs to be notified.

The Nurse Progress Note dated 6/6/23 at 1:55 PM documented, Staff heard a noise, this Nurse notified Res was on floor of bathroom in another Res room. Noted Res on right side in fetal position grabbing back of her head. Res tearful at this time et reports pain to back of her head. Upon assessment noted small area of swelling et (and) redness to back of head. Also redness noted to tailbone area. Res had a previous rt (right) hip fx (fracture), gait appears to be the

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same, no increased pain noted upon standing Res. Neuro's initiated et wnl (within normal limits) at this time. This Nurse notified [Name Redacted Provider] of fall et injuries. Per CNA after getting Res off toilet she did buckle but this is not unusual for Res-reported this to [Name Redacted] also. Per [Name Redacted] since Res is on Eliquis-call family et ask if they want her sent out to be evaluated. This Nurse placed call Husband et he was unsure at this time. Stated he would be in shortly to see Res et will let Nurse know then. Res husband arrived shortly after this, Res is currently denying pain to both this Nurse et husband. This Nurse showed him Res injury to back of head et also explained why she should possibly be evaluated. Res husband has yet to decide at time of this writing.

The Incident Report dated 6/6/23 at 12:10 PM documented the following Resident Description: I had to go to the bathroom. The Description of Action Taken section documented, Res assessed for injuries. V.S (vital signs) obtained. Neuro's initiated per protocol. Res assisted up from floor et onto toilet as she needed to use the BR. Per the Incident Report, the resident had a hematoma to the back of the head and pain score of 5.

The Nurse Progress Note dated 6/7/23 at 2:02 PM documented, No new injuries noted post fall. Continues to have redness/swelling to back of head, Res denies pain. Res did self transfer herself to BR (bathroom) again in another Res room-staff found Res sitting on toilet. Staff explaining to Res again that she should not be transferring herself due to falls/injury to self. Res tearful at this time.

The Nurse Progress Note dated 6/24/23 at 1:44

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PM documented, CNA reported an area of bruising noted to rt side lower spine/back area. It was reported that Res had a fall/found on floor of her room yesterday. No other injuries noted. No signs of discomfort noted. Res able to move extremities per her usual.

The Nurse Progress Note dated 7/13/23 at 5:50 AM documented, This resident had a fall this shift. This nurse was charting in Station 4, and the CNA had called and said that this resident was on the floor, sitting on her bottom facing forward. The CNA had come out of a room, and observed this resident on the floor. She had been in a wheelchair. It appears that she slid herself out of the wheelchair and onto the floor. She can't remember what happened. She was assessed for injuries and none were noted. Vitals were taken, as well as neuros started. She continues to deny pain. Dayshift staff will need to notify her PCP and the ADON when she comes in, as well as family.

The Incident Progress Note dated 7/18/23 at 4:29 PM documented, in part, Pt wheeling self to family lounge, pt attempted to stand up, then fell on buttocks. Pt unable to state what had occurred. Pt assessed for injuries, pt did not hit head nor any injuries noted.

The Incident Report dated 7/22/23 at 4:15 AM documented the following Nursing Description: Resident found sitting her buttocks scooting across the dining area in [specific section of Building].

The Nurse Progress Note dated 7/22/23 at 1:05 PM documented, Res husband [Name Redacted] was notified of Res fall/scooting across floor early am. No apparent injuries noted, Res able to move

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all extremities per her usual. No signs of discomfort this shift. Res slightly anxious at start of shift et was attempting to climb out of her chair, when asked what was wrong she stated she was cold. This Nurse put a blanket over her which helped.

The Nurse Progress Note dated 9/12/23 at 2:12 AM documented, CNA informed this nurse resident was on the floor at 0210 (2:10 AM) . Upon entering room noted resident sitting by the doorway in her room with her legs extended. Resident was wearing slipper socks. No bumps, redness nor bruising noted to head, no other injuries to body noted. No s/s of pain or discomfort noted. Assisted resident up from floor x3. Neuros started per facility protocol and WNL (within normal limits). MD notified of incident. Will have first shift nurse call family in the morning.

The IDT Progress Note dated 9/12/23 at 12:08 PM documented, Fall on 9/12/23 discussed with IDT. Fall intervention is to change night shift rounding to every 4 hours if I am sleeping.

The Nurse Progress Note dated 9/15/23 at 5:10 PM documented, CNA found resident in another residents bathroom on the floor...Resident could move all extremities, no complaints of pain, and stated she didn't hit her head. No injuries noted at this time. Resident was unable to tell me what she was trying to do when asked. CNA's then picked the resident up off the floor and I started a neuro sheet. At this time I contacted the on call doctor he said to call back if resident worsens, hasnausea, vomiting, drowsy, etc.

The Incident Progress Note dated 9/22/23 at 12:40 PM documented, in part, NA informed this

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| LUTHERAN LIVING SENIOR CAMPUS | 2421 LUTHERAN DRIVE MUSCATINE, IA 52761 |

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nurse resident was on the floor. Upon entering room noted resident right outside the bathroom door on the floor with leg extended very tearful (confused) and wanting up from floor. Assessment completed able to move all extremities, no bumps redness nor bruising to head. No s/s of pain or discomfort related to the fall. Resident was wearing gripper socks and was incontinent of bowel. Assisted off the floor to wheel chair with gaitbelt x2.

The Incident Report dated 9/22/23 at 12:40 PM revealed the resident had a pain score of 7.

The Incident Progress Note dated 10/3/23 at 3:28 AM documented, This nurse was at medication cart as she finished counting for oncoming shift. This nurse turned around as she heard resident opening her bedroom door. resident was scooting on her buttocks with legs out in front of her and pushing with her hands towards the back of her. Resident was able to scoot out of the room. resident scooting herself across the floor. Resident unable to give description of what she was doing. Resident was sleeping in bed previous to this with bed in low position and floor mat next to bed. Resident assessed for injuries and no impairments or concerns to BUE (bilateral upper extremities)or BLE (bilateral lower extremities) during assessment. Staff assist of two from floor into wheelchair once assessment finished. Resident observed to have a 1.5cm x 1.5 cm circular abrasion/scratch to mid leftshin. Area cleansed and band aid applied due to minimal bleeding. Resident taken to common area recliner to rest. neuros and vitals started per facility protocol. fax sent to dr [Name Redacted] office. Will have day shift nurse notify family in the morning.

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| F 689 | Continued From page 112<br><br>On 10/4/23 at 2:42 PM, Staff CC, CNA, explained the following about Resident #99: Per Staff CC, the resident was funny, could be very pleasant, and Staff CC explained the resident liked to climb out of bed a lot. When queried if he had ever been at the facility when the resident had fallen, Staff CC explained he had not. When queried about one to one, Staff CC explained the resident was not on one to one that he could remember.<br><br>On 10/4/23 at 3:20 PM, Staff EE, CNA, explained the following about Resident #99: When queried if the reresident was a fall risk, Staff EE acknowledged the resident was. When queried if she had been at the facility when the resident had fallen, Staff EE explained she had. Per Staff EE, the resident thought she was independent and it still took two to get the resident off the floor when she had fallen. Per Staff EE, falls were when the resident rolled out of bed. Per Staff EE, the resident had been found on the mat and tried to transfer self, and thought she was able to and could not. When queried if the resident was on any increased supervision, Staff EE explained there had been for a month or two because the resident wanted to self transfer and behaviors thought had the resident on 1:1 because of her behaviors and wanted to get out of the wheelchair. Staff EE explained once the resident put in her wheelchair, the resident tried to self transfer. Per Staff EE, 1:1 depended on day to day dependent on behaviors day to day.<br><br>3. The Quarterly Minimum Data Set (MDS) assessment for Resident #84 dated 9/12/23 revealed the resident scored 8 out of 15 on a BIMS exam, which indicated moderate cognitive impairment. | F 689 | | |

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The Care Plan dated 6/8/21 documented, I have a self care deficit related to decreased mobility and modified independence.

The Nurse Progress Note authored by Staff R, Licensed Practical Nurse (LPN) dated 9/23/2023 at 8:00 AM documented, Other nurse was pushing this Res. in the w/c (wheelchair) when this nurse heard the Res. yell, " My toes, My toes." Noted that the slipper on this Resident on the R. (right) side had gotten caught ( on the wheel adjuster for height ) when the nurse was pushing her and foot got ran into by the wheel. Took to slipper off to get it released from the w/c. Noted a small circle scratch to the R. side of the foot by the pinky toe. Slight bruising noted at this time. ROM (range of motion) WNL (within normal limits) for this Res. but still having pain.

The Incident Report dated 9/23/23 for Resident #84 documented, Looked at the area and noted very slight bruising to the area with a small scratch ( circle) to the top of the foot towards the pinky toe. The Injuries Observed At Time of Incident section documented abrasion and bruise to the right toe(s). Level of pain documentation dated 9/23/23 at 10:11 AM documented a pain score of 4.

The Nurse Progress Note dated 9/24/23 at 11:00 AM documented, Res. sitting in the w/c and this nurse was able to take off the Res. sock without c/o (complaint of) pain or moving foot away from the nurse. While sitting in the chair and this nurse was looking at the foot noted she was moving all of her toes on the R. foot. Noted bruising purple in color to the top of the foot from toes to the middle of the foot. half of her foot is bruised. No

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| F 689 | Continued From page 114<br>c/o pain with palpation of the area. The foot does have some edema where the bruising is. Slipper reapplied.<br><br>The Weekly Skin Check Tool dated 9/24/23 for Resident #84 documented, abrasion to the R. top of foot, with slight bruising to the top of foot.<br><br>On 10/02/23 at 4:30 PM during an interview with Staff R, LPN, Staff R identified a different nurse who transported the resident, Staff R explained the foot pedals were off, and explained she just got done weighing her. When queried how a resident would be transported if the pedals were off, and Staff R explained you were not supposed to.<br><br>On 10/3/23 at 1:17 PM, Staff J, Assistant Director of Nursing (ADON) acknowledged the resident was pushed in a wheelchair without foot pedals, and acknowledged she should not have been.<br><br>On 10/5/23 at 12:47 PM, the Director of Nursing (DON) explained she educated the staff there was a no pedal no push policy.<br><br>4. The Quarterly Minimum Data Set (MDS) assessment dated 8/1/23 for Resident #48 revealed 15 out of 15 score on a Brief Interview for Mental Status (BIMS) exam, indicating cognition intact. Diagnoses for Resident #48 | F 689 | | |

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included traumatic spinal cord dysfunction and quadriplegia.

The Care Plan initiated 8/28/22 for Resident #48 documented the intervention for transferring required two staff members, Hoyer transfer (mechanical lift) for all transfers using the large sling and directed staff to assist with maneuvering limbs during the transfer.

On 9/25/23 at 11:30 AM Resident #48 in his motorized chair at the nurse station, right great toe has gauze type dressing wrapped around the toe dated today, 9/23/23.

On 9/25/23 at 11:40 PM Nurse Staff D acknowledged wrapping Resident #48 toe that was bleeding after he was transferred out of bed this morning. Staff D acknowledged Resident #48 was assisted up by two staff using the Hoyer lift from bed to the motorized wheel chair.

On 09/26/23 at 07:54 AM Resident #48 in bed waiting for staff to Hoyer transfer. Resident #48 reported yesterday, he was in the transfer sling and staff let me swing, toe hit the metal on the bed rail causing it to bleed during the transfer. Resident #48 stated, staff have let him bang around in the sling more than once, and contracted staff assisted at that time and could not recall the names of the contracted staff that often come and go. Resident #48 stated staff are often rushed and not careful with transferring.

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5. The Quarterly Minimum Data Set (MDS) assessment dated 8/8/23 revealed Resident #60 scored 15 out of 15 on a Brief Interview for Mental Status (BIMS) exam, which indicated cognition intact. The MDS documented the resident needed extensive assistance with two plus person physical assist for bed mobility, transfers, and dressing. The MDS revealed medical diagnosis of heart failure, hypertension, and hemiplegia/hemiparesis.

The Care Plan identified a focus problem of skin integrity for actual complications with impaired skin integrity including skin tears, bruising and pressure related to current medical and physical status with initiated date of 9/13/22. The interventions were listed as follows; documented medications, labs, and treatments as ordered; and observe skin with AM/PM cares and with toileting for redness, rashes, open areas, pain, swelling and report them to team leader with

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weekly skin checks.

The Care Plan identified a focus problem of Activities of Daily Living (ADL's): Potential for complications with deficits with ADLs related to current medical and physical status that resident didn't ambulate with initiated date 9/13/23. The interventions directed staff as follows; resident required the assist of 2 staff members and the Hoyer lift for transfers.

The Electronic Medical Record (EMR) revealed the medical diagnosis of morbid (severe) obesity due to excess calories; and hemiplegia and hemiparesis following cerebral infarction (Stroke) affecting right dominant side.

The Progress Note dated 9/19/23 at 4:50 AM documented nurse noted wound on right great toe, resident stated staff put a protective dressing on it. Nurse to notified 1st shift, with a recommendation that resident be placed on Physician Assistant (PA) list to be seen. Peri-wound area noted reddened. Resident stated pain on touch. PRN (as needed) medication given for general discomfort at 4:30 AM.

The Incident report #9468 dated 9/19/23 at 5:29 AM revealed the following information:
a. Nursing description: Resident had abrasion/scab on right great toe
b. Resident's Description: They put a band-aid on it.
c. Description of Action Taken: Nurse left open to air (OTA) at this time until PAC assessed and advised.

The Skilled Nursing Facility (SNF) - Weekly

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Wound Round Documentation dated 9/19/23 at 12:33 PM revealed the following information:
a. new wound- acquired on 9/15/23
b. type of wound: abrasion
c. wound location: right great toe
d. 100% eschar tissue
e. no drainage
f. surrounding tissue intact
g. treatment plan of care: band-aid applied
h. no odor

The Physician Orders revealed the following orders:
a. ordered 9/19/23 and discontinued 9/21/23: Wound care: right great toe-trauma wound: Apply skin prep to scab and cover with protective dressing twice weekly and as needed every day shift every Tuesday, Friday for trauma wound care and as needed for trauma wound care and if dressing becomes soiled or loose
b. ordered 9/21/23 and discontinued 9/27/23: Maxsorb AS (alginate) to wound Right 1st toe and cover with border gauze, change daily. one time a day for trauma wound care.

The PA Notes dated 9/20/23 revealed Resident #60 sustained an injury to right 1st toe. She stated the injury of the right 1st toe occurred on Saturday, 9/16/23, when the toe got bumped on a door. The resident had an abrasion of the medial aspect of the right 1st toe, moist yellow base. The band-aid saturated with serosanguineous drainage. Peri-wound without erythema, warmth, or induration, no odor. No purulent drainage. Plan: Abrasion right 1st toe: Current treatment per wound specialist is skin prep; however, wound now open and moist. Will discontinue current treatment. Use Maxsorb AG to wound and cover with border gauze. Change daily. The

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resident diabetic and needed watched closely for signs of infection or worsening. Anticipated delayed wound healing with resident's diabetes, immobility, and multiple other comorbidities. Progress report on toe in one week.

During an interview on 9/27/23 at 5:03 PM, Resident #60 stated she had sores on her toes. She stated while in the Hoyer lift they turned her around to get into the shower chair and her toes hit the wall. She stated they hit her right foot. She stated they didn't take vitals but assessed her foot and got the nurse and knew what happened and the PA came in Monday and and decided to dress it.

During an observation on 9/28/23 at 8:15 AM, Resident #60 wound on the medial side of the right great toe. The wound intact and brownish in color.

During an interview on 9/28/23 at 1:09 PM, Staff P, LPN queried on how Resident #60 received the wound on her right foot and she stated it happened over the weekend during a shower. Staff P asked if the accident needed an incident report and she states yes, an incident report would be done and the nurses filled them out. Staff P asked what the documented on the incident report and she stated they described what happened, assessed it, notified the doctor, and requested a treatment, and then notified the Power of Attorney (POA). Staff P asked what she considered incident reports and she stated skin tears, resident fell on the floor, slid out of the recliner, slid out of the wheelchair, aggression towards another resident, any new findings not there before. Staff P stated the incident report went to management. Staff P stated she let the

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Assistant Director of Nursing (ADON) know and they found an intervention depending on the issue. Staff P queried how an accident got reported and she stated the Certified Nurse Aide (CNA) told her and if someone fell they knew better than to get them off the floor.

During an interview dated 9/28/23 at 1:35 PM, Staff L, CNA queried if she knew what happened to Resident #60 and she stated the resident told her the toe got tangled up. Staff L asked what she did when an accident or incident occurred with a resident what would she do and she stated she made sure everything okay and made sure the resident safe and got the charge nurse and let them know what happened. She stated she certainly passed it on to my nurse.

During an observation on 9/28/23 at 1:58 PM, Staff P performed a wound treatment to the right great toe. The wound closed and approximately the size of a dime and brownish in color.

During an interview on 10/02/23 12:55 PM, Staff J, ADON queried when an incident report needed filled out and she stated falls, wounds, skin tears and that short of thing, and medication errors. Staff J asked who filled out the report and she stated the nurse who found the situation. Staff J asked what happened after an incident report completed and she stated they conducted an investigation and looked into it and requested statements. Staff J queried if she aware of the incident with Resident #60 right great toe and she stated yes she believed it occurred when her toe hit the door frame. She stated she didn't know if the resident transferred during incident or in her chair.

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During an interview on 10/02/23 at 1:50 PM, Staff J, ADON queried on her expectation of the incident with Resident #60 and she stated to investigate and find out where for sure the wound came from. She guessed her idea behind it was Resident #60 alert and oriented and she could tell her what happened with the wound. She thought they ran into the bed frame and she wished they would of notified her earlier and the nurse working took care of it right away. She stated she spoke to Resident #60 the day she completed the incident report. Staff J asked if the facility conducted training on transfers and she stated yes, they could always do training.

During an interview on 10/03/23 at 11:45 AM, the DON (Director of Nursing) queried on when an Incident Report needed completed and she stated for skin tears, resident to resident interactions, falls, any change skin change like a bruise, and anything out of the ordinary. The DON confirmed her expectation needed to be completed for incident with skin issues from transfers. The DON stated she expected the resident assessed and documented, the family, ADON, herself, and doctor notified and alert charting for at least 72 hours or until healed. The DON stated for an investigation, assessment, measurements, wound document sheet needed documented when the incident happened.

During an interview on 10/5/23 at 10:40 AM, Staff EE, RN (Registered Nurse) stated one day shift she worked the dementia unit and residents fell and she notified the supervisor and requested a resident be placed on a 1 on 1 and received a text from the DON that the supervisor currently working the floor and would come over when she finished. Staff EE stated she left at 2:00 PM and

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didn't know if the supervisor ever came and helped on the unit after she left.

The Facility Accidents/Hazards/Supervision/Devices Policy dated 8/22 revealed the following information:
a. It is the policy of Health Dimensions Group (HDG) communities to implement a culture of safety and commit to implementing systems that address resident risk and environmental hazards to minimize the likelihood of accidents. Furthermore, HDG communities provides an environment that was free from accident hazards over which the facility has control and provides supervision and assistive devices to each resident to prevent avoidable accidents in a manner that helps promote quality of life. This includes respecting residents' rights to privacy, dignity and self determination, and their right to make choices about significant aspects of their life in the facility. This may include:
a. identified hazard(s) and risk(s)
b. Evaluated and analyzed hazard(s) and risk(s)
c. Implemented interventions to reduce hazard(s) and risk(s);
d. Developed effective communication methods, included a system for reporting resident risks and environmental hazards; and
e. Engaged staff, residents, and families in training on safety, and promoted ongoing discussions about safety with input from staff, as well as residents and families.

The Facility Nursing Documentation Policy dated 2/23 revealed the following information:
a. The facility will provide documentation in a standardized manner of the care and services provided to a resident.
1. Incident/Risk Management reports

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| F 689 | Continued From page 123<br>completed as appropriate and not part of the medical record and used internally for the facility Quality Assessment Performance Improvement (QAPI) process. Incident/Risk Management reports will not be referenced in the nurse's notes. | F 689 | | |
| F 690 SS=D | Bowel/Bladder Incontinence, Catheter, UTI<br>CFR(s): 483.25(e)(1)-(3)<br><br>§483.25(e) Incontinence.<br>§483.25(e)(1) The facility must ensure that resident who is continent of bladder and bowel on admission receives services and assistance to maintain continence unless his or her clinical condition is or becomes such that continence is not possible to maintain.<br><br>§483.25(e)(2)For a resident with urinary incontinence, based on the resident's comprehensive assessment, the facility must ensure that-<br>(i) A resident who enters the facility without an indwelling catheter is not catheterized unless the resident's clinical condition demonstrates that catheterization was necessary;<br>(ii) A resident who enters the facility with an indwelling catheter or subsequently receives one is assessed for removal of the catheter as soon as possible unless the resident's clinical condition demonstrates that catheterization is necessary; and<br>(iii) A resident who is incontinent of bladder receives appropriate treatment and services to prevent urinary tract infections and to restore continence to the extent possible.<br><br>§483.25(e)(3) For a resident with fecal incontinence, based on the resident's | F 690 | | |

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comprehensive assessment, the facility must ensure that a resident who is incontinent of bowel receives appropriate treatment and services to restore as much normal bowel function as possible.
This REQUIREMENT is not met as evidenced by:
Based on observation, interview, record review, and facility policy review the facility failed to prevent the catheter bag from touching the floor for 1 of 3 residents reviewed for urinary catheters (Resident #8). The facility reported a census of 140.

Findings include:

The Minimum Data Set (MDS) assessment dated 9/5/23 revealed Resident #8 scored 15 out of 15 on a Brief Interview for Mental Status (BIMS) exam, which indicated cognition intact. The MDS revealed an indwelling catheter. The MDS revealed medical diagnosis of neurogenic bladder and renal failure.

The Care Plan revealed a focus area dated 6/13/23 of bowel/bladder: resident with a Foley catheter with a diagnosis of neurogenic bladder. The interventions documented followed doctor's order for the catheter changes; and followed facility policy for catheter cares.

The Electronic Medical Record (EMR) revealed medical diagnosis of Stage 3 B chronic kidney disease and neuromuscular dysfunction of bladder, unspecified.

The Physician Orders revealed the following orders:
a. ordered 6/6/23: Record output of catheter

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every shift.
b. ordered 7/18/23: Flush Foley every week with 60 cc (milliliter) every day shift every 7 day(s)
c. ordered 8/8/23: Change catheter every 30 days every day shift every 30 day(s) for urinary retention, BPH (benign prostate hyperplasia)

On 9/26/23 at 9:38 AM, Resident #8 sat in his recliner feet elevated. The catheter tubing laid on recliner and the drainage bag attached to the side of the recliner and touched the floor with no dignity bag.

On 9/27/23 at 9:52 AM, the resident sat in chair with his feet elevated, catheter bag hooked under the recliner foot stool and touched the floor with no dignity bag.

On 9/27/23 at 3:06 PM, the resident sat in recliner and slept with his feet propped up and catheter bag hooked to the metal part of the recliner with no dignity bag covering the catheter bag.

On 9/27/23 at 4:59 PM, the resident sat in his wheelchair and escorted out of the room and his catheter bag hung under the chair with no dignity bag.

On 9/28/23 at 1:09 PM, Staff P, Licensed Practical Nurse (LPN) queried if a catheter bag could touch the floor and she stated no, they should put something under it so it didn't touch the floor.

On 9/28/23 at 1:35 PM, Staff L, Certified Nurse Aide (CNA) queried if catheter bags could touch the floor and she stated no, they shouldn't.

On 10/2/23 at 11:49 AM, Staff N, CNA queried if a

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| F 690 | Continued From page 126<br>catheter bag can touch the floor and she stated no they usually hung beside the bed on a non-movable part and when they transferred the resident the catheter bag hung on the hook on the machine used to transfer them.<br><br>On 10/2/23 at 11:56 AM, Staff O, LPN asked if catheter bags could touch the floor and she stated oh, absolutely not. She stated they needed a bag that covered the urinary catheter bag and it needed hooked below the bladder and not touching the floor.<br><br>On 10/2/23 at 12:10 PM, Staff K, ADON queried if catheter bags could touch the floor and she stated no and if the resident laid in a low bed, she would definitely put a pad or something on the floor under the catheter bag.<br><br>On 10/2/23 at 12:55 PM, Staff J, ADON queried if catheters bag could touch the floor and she stated no because of infection control.<br><br>On 10/03/23 at 11:45 AM, the DON (Director of Nursing) queried if catheter bags touch the floor and she stated no, when a resident sat in a recliner the catheter hook placed on a table next to them below the bladder.<br><br>The Facility Foley Catheter Care Policy dated 10/22 directed staff as follows;<br>a. The Foley bag should not touch the floor. | F 690 | | |
| F 725 SS=E | Sufficient Nursing Staff<br>CFR(s): 483.35(a)(1)(2)<br><br>§483.35(a) Sufficient Staff.<br>The facility must have sufficient nursing staff with the appropriate competencies and skills sets to | F 725 | | |

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provide nursing and related services to assure resident safety and attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident, as determined by resident assessments and individual plans of care and considering the number, acuity and diagnoses of the facility's resident population in accordance with the facility assessment required at §483.70(e).

§483.35(a)(1) The facility must provide services by sufficient numbers of each of the following types of personnel on a 24-hour basis to provide nursing care to all residents in accordance with resident care plans:
(i) Except when waived under paragraph (e) of this section, licensed nurses; and
(ii) Other nursing personnel, including but not limited to nurse aides.

§483.35(a)(2) Except when waived under paragraph (e) of this section, the facility must designate a licensed nurse to serve as a charge nurse on each tour of duty.
This REQUIREMENT is not met as evidenced by:
Based on staff interviews, resident interviews, record review and policy review. The facility failed to ensure sufficient staffing to meet resident's needs for 6 of 29 residents reviewed in the sample (#7, #26, #27, #48, #52, #60). The facility reported a census of 140.

Findings include:

1. The Quarterly Minimum Data Set (MDS) assessment dated 8/1/23 for Resident #48 revealed 15 out of 15 score on a Brief Interview for Mental Status (BIMS) exam, indicating

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cognition intact. Diagnoses included traumatic spinal cord dysfunction and quadriplegia.

The Care Plan initiated 8/28/22 for Resident #48 documented the intervention for transferring required two staff members with Hoyer transfer (mechanical lift) for all transfers using the large sling and directed staff to assist with maneuvering limbs during the transfer.

On 09/26/23 08:05 AM Resident in bed, stated that Certified Nurse Assistant (CNA) reported they must finish feeding and then would help him up for a shower. Resident expressed anger that he had to wait for others to eat before getting up. The Resident stated he wanted to be up before 8:00 AM every morning. and on 9/25/23 it was 10:00 AM before he was assisted out of bed due to short staff.

On 9/26/23 at 8:15 AM Nurse Staff D Relayed Residents that required two-person assistance must wait longer because there is only one aide for the hall. Staff D relayed another CNA expected at 8:30 AM that will share work with two halls. Staff D acknowledged Resident #48 wanted to get up before 8:00 AM but has to wait due to unavailable two person to assist. Nurse D relayed she had medication administration obligations and resident required Hoyer lift transfer, required two people.

On 9/26/23 3:20 PM Nurse staff D relayed there are staffing issues, staff don't come in, we use a lot agency staff and the agency staff do not care.

On 9/26/23 at 03:45 PM Nurse staff D relayed there is supposed to be two CNA staff on hallway 400 and two on hallway 500 and rarely happened.

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Staff D stated usually will have one on each hall and one that shares the two halls. Staff D relayed on Monday (9/25/23) there was only one aide on 400 and one on 500 because staff called in sick. Staff D relayed residents that required assistance of two, waited much longer as a result.

On 9/27/23 at 4:42 PM Resident #48 stated on Monday (9/25/23) it was about 10:00 AM before received help up. Relayed, turned the call light on to get assistance out of bed and felt ignored. Resident #48 relayed short staffing is usual and staff often relay they have to feed people before he can be assisted out of bed.

9/27/23 04:45 PM Nurse staff D relayed I asked the contracted CNA staff to lye a Resident down before the end of their shift, they just left and did not do it, they don't care.

2. The Quarterly Minimum Data Set (MDS) for Resident #52 dated 06/27/23 listed diagnoses included renal disease, disc degeneration, pain and dementia. The MDS section for Brief Interview of Mental Status (BIMS) scored 12 indicated resident cognition is moderately intact. On 9/16/23 a new admission MDS documented resident #52 readmitted to the facility from acute hospital stay.

The care plan was updated 9/16/23 indicated Resident #52 returned from hospital after a left hip fracture surgery. The care plan directed staff to follow physical therapy orders, to provide one or two assistance with bed mobility assistance.

On 9/28/23 at 8:10 AM Observed Resident #52 in bed had taken gown off and was naked and

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incontinent, legs off the bed, in low position, call light on, two aides at end of the hall assisting another resident.

On 9/28/23 at 8:14 AM Staff E,CNA walked by the resident's room with the call light on did not look in the room, did not respond to resident's light, relayed is working on 400 hall and 500 hall, needed to go back to the 500 hall.

On 9/28/23 at 8:18 AM Staff H, CNA responded to resident light, relayed is only one assigned to the hall, relayed does not know the residents only what is on the paper. Relayed resident needs two people to transfer. Relayed is short staff, is the only one for this hall the other girl had to leave to help those in the other hall. Stated resident will have to wait until I can get another person to help me before she can get up.

On 9/23/23 at 8:50 AM Staff F, Registered Nurse (RN-Contracted staff) I don't usually work this hall. Staff F relayed is usually two CNA's per hall and acknowledged several that require two-person transfers must wait. Relayed, was told, today scheduling was done incorrectly, did not know if they can find another person to come in and help. Relayed she had to give medication and residents that need two staff assist, will have to wait.
.
On 9/28/23 at 8:55 AM Staff E, CNA reported breakfast is usually until 9:15 We have residents over there waiting to eat. We can't bring them to the dining room. Relayed they need direct feeding assistance and staff observation. They have to wait until we can get everyone up.

09/28/23 12:50 PM Staff F, RN reported it is

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usual to be short staffed and work over hours.

On 9/26/23 at 05:00 PM Interview with the Administrator and Dietary Director who explained that they are short kitchen staff because two assistant cooks are on medical leave. The Administrator relayed high school kitchen staff often stay for a few years and leave. The Administrator acknowledged staffing problems.
3. The Minimum Data Set (MDS) assessment dated 7/26/23 revealed Resident #26 scored 00 out of 15 on a Brief Interview for Mental Status (BIMS) exam, which indicated severe cogntive impairment. Per this assessment, Resident #26 had falls in the last month prior to admission, entry, or reentry, unable to determine was selected for falls in the last two to six months prior to admission, entry, or reentry, and the resident did have a fracture related to a fall in the six months prior to admission, entry, or reentry.

The Care Plan dated 7/31/23 documented, SAFETY/FALLS: I am at risk for falls AEB (as evidenced by) personal history of a fall resulting in left radial and ulnar fractures.

The Incident Progress Note dated 8/8/23 at 11:54 PM documented, in part, CNA [Name Redacted] observed Resident on floor in bedroom at 2240 (10:40 PM), laying supine on fall mat next to bed. [Name Redacted] left room and came to Nurse's station and requested assistance from Nurse. Both staff members returned to [Room Number Redacted] immediately. Nurse able to complete frontal body assessment with no new injuries noted. Resident denied pain initially, however once Resident attempted to sit up, voiced pain 'really bad in my back.' Resident laid back down and with support of staff, cautioned to remain in

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supine position. Resident frequently moving arms and legs, Nurse notes physical s/s (signs/symptoms) of spasms/pain in back during movement...Nurse notified POA (Power of Attorney) at 2250 (10:50 PM) of fall with possible injury, who requested Resident be seen by the ER(Emergency Room) to see if any further injury occurred since initial fracture. 911 called by Nurse at 2258 (10:58 PM). Unit CNA sent to front to ensure ambulance is able to enter facility. Nurse in room with Resident and unable to leave room due to there being no other staff in unit. Nurse unable to treat initial pain due to lack of staff/Resident not safe to leave alone while still on floor and moving her limbs in ways that are obviously causing her pain. EMTs (Emergency Medical Technicians) arrived to facility at 2210 (10:10 PM).

On 10/3/23 at 12:11 PM, the Director of Nursing (DON) explained she knew staffing had been a big issue, and explained she added [Agency Staffing Company Name] when she started as getting no agency staff from [Another Staffing Company Name].

4. Review of the Quarterly Minimum Data Set for Resident #27 dated 9/5/23 revealed a Brief Interview for Mental Score of 13 indicating the resident is cognitively intact.

On 9/26/23 at 9:19 AM Resident #27 stated she waited over 2 hours one night for assistance with toileting after having a loose stool. She stated a Certified Nursing Assistant came in and turned her light off and then never came back. No one told the next shift and so no one came in to assist for 2 hours.

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On 09/28/23 at 12:25 PM Staff S, Certified Medication Aide (CMA) states I work 1st and 2nd shift staffing has been crazy. It was terrible at one point we were doing a hall by herself then they got more people hired and brought agency in and now the agency have calling in sick also. Typical staff down a wing is 2 certified nurse aides, one medication aide and one nurse. When there is a call in they think we can run with one aide and we really can't because need 2 staff for Hoyer lifts. Not on our shift am I aware On third shift they have to do more than one station if there is a call off.

On 09/28/23 12:33 PM Staff T, Registered Nurse (RN) stated it has been busy because I am trying to cover two halls and it is impossible to get medications and treatments done on two halls. The staffing problems have been happening quite a bit. CNA staffing have been times when there is only one CNA per hall. They changed the Hoyers from one assist to two assist so it makes it difficult to get people up and then everyone gets behind, I try to help but trying to do two halls as a nurse and help CNA out with transfers then that puts me behind even further. When I was working as a CNA the third shift aides were having to cover 3 different halls.

On 09/28/23 12:42 PM Staff U, CNA reported the staffing has been bad. It is to the point where on days we only have one aide on each hall or split halls. Sometimes we don't have a nurse they have to split halls also because they don't have a nurse for every hall. There are times when I can't get showers or bath done due to not enough help.

On 09/28/23 at 12:48 PM Staff M, CNA stated there have been times we are are very short

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staffed we have to split halls and one CNA per wing. Then they will have one other CNA go between halls so there would be 3 aides between the two halls. When there is only one of us here sometimes we can't get all the showers done I have had residents who are Hoyers for 2 person assist so they will have to wait up to an hour to get up while I find help.

On 09/28/23 at 1:10 PM the Director of Nursing stated staffing has been a challenge since I started they use a daily staff sheet and that is what I know from here. I do not feel like it is adequate staffing. Since I started it has been an issue. I actually just mentioned yesterday to get contract staff for 90 days, they also have a recruitment firm they are working with to obtain staff. The assistant director of nursing are required to come in if they are short and the minimum data set nurse. We have moved some people around to help with staffing.

The facility provided a policy titled Nursing Administration Staffing with a revision date of May, 2020 the policy states the facility ensures that services are provided by sufficient numbers of staff 24 hours a day,7 days a week. A registered nurse is on site for a least 8 consecutive hours a day, 7 days a week, except when under a waiver from the state. The facility must designate a registered nurse to serve as the director of nursing on a full-time basis except when under a waiver from the state.
1. Director of nursing oversees the nursing budget, including staffing.
2. The director of nursing may serve as a charge nurse only when the facility has an average daily occupancy of 60 or fewer residents.
3. A PPD for each shift is set for the facility.

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| LUTHERAN LIVING SENIOR CAMPUS | 2421 LUTHERAN DRIVE MUSCATINE, IA 52761 |

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4. Staffing coordinator or designee establishes schedules for the facility, using the staffing ratios.
5. Designated nursing staff is educated on how to fill staffing vacancies when call-ins occur.

5. The Minimum Data Set (MDS) assessment dated 8/8/23 revealed Resident #60 scored 15 out of 15 on a Brief Interview for Mental Status (BIMS) exam, which indicated cognition intact. The MDS revealed the resident needed extensive assistance with two plus person physical assist for bed mobility, transfers, and dressing.

The Progress Note dated 9/18/23 at 6:36 PM revealed Resident #60 requested to be moved from bed to reclining chair this evening. Staff unable to complete request due to staffing. Management aware of staffing on unit.

During an interview on 9/28/23 at 10:07 AM, Staff U, CNA (Certified Nurse Aide) queried about staffing and she stated the facility short staffed. Staff U asked what she considered short staffed and she stated one aide for each hall. She stated it needed to be two. She stated they told her when she was hired they would have 2 CNA for each hall.

During an interview on 9/28/23 at 10:36 AM, Staff M, CNA queried on staffing and she stated this week they were staffed okay because State came. She stated since October she ran the hall with minimal help. She stated she the facility had a scheduling issue. She stated they needed 2 CNAs for each hall due to the Hoyer lifts required 2 staff members. She stated some of the residents waited over an hour to get out of bed because they needed a Hoyer transfer. They

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schedule 3 nurses on midnights and they each covered 3 halls.

During an interview on 9/28/23 at 1:09 PM, Staff P, LPN (Licensed Practical Nurse) queried on staffing and she stated yes, the facility short staffed and the facility tried and provided agency staff but agency staff called off a lot. Staff P stated they should be scheduled 2 CNA and 1 nurse for each hall but when someone called off they will split two halls and have 3 CNA for 2 halls.

During an interview on 9/28/23 at 1:35 PM, Staff L, CNA queried about staffing and she stated hadn't been good around here for a couple of months. She stated in the time she worked here, this was the lowest she seen. She stated she didn't see it getting better and they needed more teamwork in the whole building and not just the CNAs. She stated when state came everyone came out of the office and not now. She stated when short staffed, short cuts happened such as instead of a shower the residents received a bed bath. She stated when 3 CNAs scheduled for 2 halls one goes to lunch at 10:00 AM, then the second one goes at 10:15 AM, and the third one goes at 10:30 AM which leaves one CNA to do both halls for 15 minutes and that can't be done. She stated when she worked the hall by herself and went to the dining room, they didn't have a CNA in the hall to watch for lights.

6. The MDS assessment dated 8/25/23 revealed Resident #7 scored 15 out of 15 on a Brief Interview for Mental Status (BIMS) exam, which indicated cognition intact.

The eMAR (electronic Medication Administration

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Record) Administrations Note dated 9/28/2023 at 3:14 PM
documented for Resident #7- Per wound physician: Cleanse left tibia with NS (normal saline). Apply Xeroform to wound bed. Cover with 4x4/ABD/wrap 2 times per week and PRN. Shower days every day shift every Monday, Thursday on shower days. Worked both halls, did not have time to do treatment.

The eMAR (electronic Medication Administration Record) Administrations Note dated 9/28/2023 at 3:15 PM documented for Resident #7- Per wound physician: Left posterior thigh: Apply skin repair cream with lotrisone and apply to skin BID (twice a day) every shift and PRN x 14 days until 10/5/23 at 11:59 PM. Worked both halls, did not have time to do treatment.

The eMAR (electronic Medication Administration Record) Administrations Note dated 9/28/2023 at 3:15 PM documented for Resident #7- Blood pressure check BID every day and evening shift. Worked both halls, did not have time.
The eMAR (electronic Medication Administration Record) Administrations Note dated 9/28/2023 at 3:15 PM documented for Resident #7- Daily Skilled Comprehensive note assessment to be completed by Nurse daily while receiving skilled services effective 8/22/23. Every day shift for skilled documentation. Worked both halls, did not have time to do.

The eMAR (electronic Medication Administration Record) Administrations Note dated 9/28/23 at 3:16 PM documented for Resident #7 apply Triad hydrophilic to left ankle wound daily and PRN (as needed) one time a day for wound care. Worked both halls, did not have time to do treatment.

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| F 725 | Continued From page 138<br><br>The eMAR (electronic Medication Administration Record) Administrations Note dated 9/28/23 at 3:16 PM documented for Resident #7 clotrimazole-Betamethasone External Cream 1-0.05 %- apply to peri wound on left ankle topically one time a day for wound care. Worked both halls, did not have time to do treatment.<br><br>During an interview 10/5/23 at 10:23 AM, Staff T, RN (Registered Nurse) queried if she ever couldn't complete her work due to staffing and she stated yes, last Thursday she worked two halls and couldn't get all her work done. Staff T asked if she charted she didn't complete the treatments and she stated yes. Staff T asked if her supervisor aware she couldn't complete her duties and she stated she let the ADON know and the nursing supervisor checked on her frequently and aware.<br><br>During an interview on 10/5/23 at 10:40 AM, Staff EE, RN queried if the dementia unit staffed for adequate supervision and she stated no, she stated on one day shift she worked the dementia unit she gave medications on her unit and then went and administered insulin to residents in two other halls because they were staffed with medication aides. She stated when she came on shift, she didn't receive report and the couldn't get into the computer. | F 725 | | |
| F 732 SS=D | Posted Nurse Staffing Information<br>CFR(s): 483.35(g)(1)-(4)<br><br>§483.35(g) Nurse Staffing Information.<br>§483.35(g)(1) Data requirements. The facility must post the following information on a daily basis: | F 732 | | |

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| F 732 | Continued From page 139<br>(i) Facility name.<br>(ii) The current date.<br>(iii) The total number and the actual hours worked by the following categories of licensed and unlicensed nursing staff directly responsible for resident care per shift:<br>(A) Registered nurses.<br>(B) Licensed practical nurses or licensed vocational nurses (as defined under State law).<br>(C) Certified nurse aides.<br>(iv) Resident census.<br><br>§483.35(g)(2) Posting requirements.<br>(i) The facility must post the nurse staffing data specified in paragraph (g)(1) of this section on a daily basis at the beginning of each shift.<br>(ii) Data must be posted as follows:<br>(A) Clear and readable format.<br>(B) In a prominent place readily accessible to residents and visitors.<br><br>§483.35(g)(3) Public access to posted nurse staffing data. The facility must, upon oral or written request, make nurse staffing data available to the public for review at a cost not to exceed the community standard.<br><br>§483.35(g)(4) Facility data retention requirements. The facility must maintain the posted daily nurse staffing data for a minimum of 18 months, or as required by State law, whichever is greater.<br>This REQUIREMENT is not met as evidenced by:<br>Based on observation, staff interview and policy review the facility failed to publicly post the required nursing staff requirements. The facility reported a census of 140 residents. | F 732 | | |

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| F 732 | Continued From page 140<br>Findings include:<br><br>During an observation on 09/26/23 at 4:17 PM surveyor unable to locate nurse staffing posting the receptionist at the front desk states she is not sure where they have this posted.<br><br>During an observation on 9/27/23 at 12:32 PM surveyor attempted to find daily staff posting and not able to locate. The Director of Nursing (DON) is unsure where this is located and she stated she would have to check with someone else.<br><br>During an interview on 09/27/23 at 1:20 PM the DON stated staffing is not posted, they have not done it since the last scheduler left her position. She stated she would expect staff to post it daily at the main entrance and in the transitional care center.<br><br>The facility provided a policy titled Nursing Staff Required Posting with a revised date of 11/2022 which directed the facility will post the following information on a daily basis:<br>· Facility name<br>· Current date<br>· Total number and the actual hours worked by the following categories of licensed and unlicensed nursing staff directly responsible for resident care per shift:<br>1. Registered nurses<br>2. Licensed practical nurses or licensed vocational nurses<br>3. Certified nurse aides<br>· Resident census | F 732 | | |
| F 758 SS=D | Free from Unnec Psychotropic Meds/PRN Use CFR(s): 483.45(c)(3)(e)(1)-(5) | F 758 | | |

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| F 758 | Continued From page 141<br>§483.45(e) Psychotropic Drugs.<br>§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:<br>(i) Anti-psychotic;<br>(ii) Anti-depressant;<br>(iii) Anti-anxiety; and<br>(iv) Hypnotic<br><br>Based on a comprehensive assessment of a resident, the facility must ensure that---<br><br>§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;<br><br>§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;<br><br>§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<br><br>§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 | F 758 | | |

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rationale in the resident's medical record and 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 observation, interview, and record review the facility failed to ensure documented non-pharmacological interventions attempted prior to the administration of anti-anxiety medication for one of five residents reviewed for unnecessary medications (Resident #124). The facility reported a census of 140 residents.

Findings include:

The Quarterly Minimum Data Set (MDS) assessment for Resident #124 dated 9/11/23 revealed the resident had severely impaired cognitive skills for daily decision making. Per the MDS, Resident #124's diagnoses included anxiety disorder and depression.

The Care Plan revised 9/7/23 at 1:07 PM documented, psychotropic drug use: At risk for complications R/T (related to) use of antianxiety-as needed (PRN), antidepressant - Daily Use, antipsychotic - Daily Use. The Intervention dated 9/7/23 documented, Non Pharmacological Interventions: Snack Remove Stimuli Music Distraction Walk 1:1 Interaction Massage Call to brother who speaks Arabic.

The Physician Order dated 8/10/23 at 12:00 PM documented, Lorazepam Oral Tablet 1 MG

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(Lorazepam)
Give 1 tablet by mouth every 4 hours as needed for anxiety/agitation.

The Physician Order dated 8/14/23 documented, Lorazepam Oral Concentrate 2 MG/ML (milligram/milliliter)
with directions to give 0.5 ml by mouth every 4 hours as needed for anxiety/agitation.

Review of Resident #124's Medication Administration Record (MAR) documented the resident received 0.5 mg of PRN Ativan twice on 9/11/23 (documented at 1:00 PM and 7:30 PM) and received one dose on 9/17/23 (documented at 8:33 AM).

Review of Progress Notes revealed non-pharmacological interventions attempted were documented via an eMAR-Administration Note date 9/11/23 at 1:00 PM, however Progress Notes lacked documentation of non-pharmacological interventions attempted for the dose administered on 9/11/23 at 7:30 PM.

Review of the eMAR-Administration Note dated 9/17/23 at 8:33 AM documented, Lorazepam Oral Concentrate 2 MG/ML Give 0.5 ml by mouth every 4 hours as needed for anxiety/agitation Very agitated et aggressive et combative-Res hit CNA in the face leaving a red mark across her face et knocking her glasses off her face. The note lacked non-pharmacological interventions attempted prior to medication administration.

Review of Resident #124's MAR documented the resident received 1 mg of PRN Ativan on 9/18/23 and 9/25/23.

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The electronic medication record (EMAR)-Administration Note dated 9/18/23 at 3:56 PM documented, Lorazepam Oral Tablet 1 MG Give 1 tablet by mouth every 4 hours as needed for anxiety/agitation increase anxiety. The note lacked documentation of non-pharmacological interventions attempted prior to medication administration.

The EMAR-Administration Note dated 9/25/23 8:27 PM documented, Lorazepam Oral Tablet 1 MG
Give 1 tablet by mouth every 4 hours as needed for anxiety/agitation res hit the meds out of this nurse hand when attempted to administer at 1930 (7:30 PM), second attempt. The note lacked documentation of non-pharmacological interventions attempted prior to medication administration.

On 10/2/23 at 1:13 PM when queried about administration of PRN anti-anxiety medication, Staff J, Assistant Director of Nursing (ADON) explained non-pharmacological interventions, music, toileting, food, water, etc. should be documented under the PRN medication, and what interventions were done prior to giving the mediations should be in the MAR. When queried if this would flow to the progress notes, Staff J explained she believed they did.

On 10/3/23 at 12:13 PM when queried about non-pharmacological interventions and PRN antianxiety medication, the Director of Nursing (DON) acknowledged staff were supposed to put at three at least for non-pharmacological interventions. The DON explained this would be in the progress notes, and explained usually under a behavior note would be where she would

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| F 758 | Continued From page 145<br>have put it.<br><br>The Facility Policy titled Unnecessary Medication-Psychotropic Medication dated 4/1/08, revised 9/22/17, documented, 6. Prior to the administration of a PRN antipsychotic, an evaluation of the justification for use of the medication must be documented in the resident's record. It should include:<br>a. Specific reasons why the medication was to be given<br>b. What other non-pharmaceutical interventions were tried prior<br>c. What other clinical conditions were ruled out, such as pain, urinary tract infection (UTI), etc. | F 758 | | |
| F 839 SS=D | Staff Qualifications<br>CFR(s): 483.70(f)(1)(2)<br><br>§483.70(f) Staff qualifications.<br>§483.70(f)(1) The facility must employ on a full-time, part-time or consultant basis those professionals necessary to carry out the provisions of these requirements.<br><br>§483.70(f)(2) Professional staff must be licensed, certified, or registered in accordance with applicable State laws.<br>This REQUIREMENT is not met as evidenced by:<br>Based on staff interview, human resources file review, and document review, the facility failed to ensure a staff member held needed certification and current educational requirements to pass medications in long term care setting for one of three employee files reviewed (Staff JJ). The facility reported a census of 140 residents.<br><br>Findings include: | F 839 | | |

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| F 839 | Continued From page 146<br><br>On 10/5/23 at approximately 2:30 PM, the human resources file for Staff JJ lacked documentation of direct care worker (DCW) verification or medication aide certificate.<br><br>During an interview with Staff HH, Director of People and Culture completed 10/5/23 at 3:00 PM, Staff HH acknowledged staff had to be a CNA to be a med aide. Per Staff HH, Staff JJ used to work and pick up in assisting living, and came upstairs to work in long term care but her Certified Nurisng Assistant (CNA) expired and her med aid expired. Documentation was requested for the employee's Direct Care Worker search and medication aide information.<br><br>On 10/5/23 at approximately 3:15 PM during an interview with Staff HH and the facility's Administrator, the following was reported: Staff JJ worked in assisted living, and in the nursing facility section as a med aide. On 9/17/23, it was discovered the CNA aspect was not current, an investigation was done, and the employee was pulled off.<br><br>Review of paperwork pertaining to the situation provided by the facility revealed Staff JJ's Certified Nurse Aide expired on 12/26/19. Handwritten on the DCW form was the following: LTC (long term care) 8/14-9/17. Review of a document dated 9/13/23 revealed, One staff member identified as not having current CNA license. | F 839 | | |
| F 865 SS=C | QAPI Prgm/Plan, Disclosure/Good Faith Attmpt CFR(s): 483.75(a)(1)-(4)(b)(1)-(4)(f)(1)-(6)(h)(i)<br><br>§483.75(a) Quality assurance and performance | F 865 | | |

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improvement (QAPI) program.
Each LTC facility, including a facility that is part of a multiunit chain, must develop, implement, and maintain an effective, comprehensive, data-driven QAPI program that focuses on indicators of the outcomes of care and quality of life. The facility must:

§483.75(a)(1) Maintain documentation and demonstrate evidence of its ongoing QAPI program that meets the requirements of this section. This may include but is not limited to systems and reports demonstrating systematic identification, reporting, investigation, analysis, and prevention of adverse events; and documentation demonstrating the development, implementation, and evaluation of corrective actions or performance improvement activities;

§483.75(a)(2) Present its QAPI plan to the State Survey Agency no later than 1 year after the promulgation of this regulation;

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

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

§483.75(b) Program design and scope.
A facility must design its QAPI program to be ongoing, comprehensive, and to address the full

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range of care and services provided by the facility. It must:

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

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

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

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

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

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

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

§483.75(f)(4) The QAPI program identifies and prioritizes problems and opportunities that reflect

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organizational process, functions, and services provided to residents based on performance indicator data, and resident and staff input, and other information.

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

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

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

§483.75(i) Sanctions.
Good faith attempts by the committee to identify and correct quality deficiencies will not be used as a basis for sanctions.
This REQUIREMENT is not met as evidenced by:
Based on staff interview, review of CMS-2567 reports, and facility QAPI (Quality Assurance and Performance Improvement) Plan, the facility failed to ensure an effective QAPI (Quality Assurance Performance Improvement) process to address previously identified quality deficiencies, resulting in multiple repeat deficiencies identified on the facility's current recertification and complaint survey previously identified during surveys completed in the last fifteen months. The facility reported a census of 38 residents.

Findings include:

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a. The CMS-2567 form from a recertification survey dated 6/6/22 to 6/15/22 revealed the facility issued a deficient practice for no actual harm level citation for reporting of alleged violations; assessment and interventions; free from accidents/hazards/supervision; and urinary catheter care.

b. Review of the facility's CMS-2567 form from a complaint survey which occurred 4/12/23 to 4/26/23 revealed the facility received a no actual harm level citation for notification to physician/family; and free from accidents/hazards/supervision.

The facility's current recertification survey, entrance date 9/25/23, resulted in an Immediate Jeopardy deficient practice for failure to investigate/prevent/correct alleged violation and a harm level deficient practice for free from accidents/hazards/supervision no actual harm citation for assessment and intervention and urinary catheter care.

During an interview on 10/5/23 at 3:22 PM, the Administrator queried how long a QA (Quality Assurance) process kept in process and she stated until the project resolved. Discussed with the Administrator the recurrent citations over the last complaint survey and recertification survey and asked her the steps they took to prevent the issues from reoccurring and she stated they conducted a meeting every Thursday and assigned a representative for financial, people, quality, and clinical and each representative brought concerns to the meeting. She stated they picked a new topic, or brought family concerns, sentinel event, grievances, or QAPI (Quality Assurance and Performance Improvement). She

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| F 865 | Continued From page 151<br>stated they conducted audits and made sure processes still in place, and filled out score cards to see what they tracked.<br><br>The Facility Quality Council - Quality Assurance and Performance Improvement Program Policy Dated 8/29/22 revealed the following information:<br>a. The Quality Council:<br>1. Meets monthly to identify issues with respect to necessary quality assessment, quality assurance, and improvement activities.<br>2. Develops and implements appropriate plans of action to correct identified quality deficiencies. | F 865 | | |
| F 919 SS=D | Resident Call System<br>CFR(s): 483.90(g)(1)(2)<br><br>§483.90(g) Resident Call System<br>The facility must be adequately equipped to allow residents to call for staff assistance through a communication system which relays the call directly to a staff member or to a centralized staff work area from-<br><br>§483.90(g)(1) Each resident's bedside; and<br>§483.90(g)(2) Toilet and bathing facilities.<br>This REQUIREMENT is not met as evidenced by:<br>Based on observation, staff interviews and policy review, the facility failed to provide 1 of 4 residents reviewed with accessibility of a functioning call system device to allow resident to staff communication (Resident #52). The facility reported a census of 140.<br><br>The Quarterly Minimum Data Set (MDS) for Resident #52 dated 06/27/23 listed diagnoses included renal disease, disc degeneration, pain and dementia. The MDS section for Brief | F 919 | | |

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Interview of Mental Status (BIMS) scored 12 indicated resident cognition is moderately intact.

On 9/16/23 a new admission MDS documented resident #52 readmitted from acute hospital stay.

The care plan was updated 9/16/23 indicated Resident #52 returned from hospital stay related to a left hip fracture. The care plan directed staff to follow physical therapy orders, to provide one or two assistance with bed mobility assistance. The Care Plan documented under the focus area of safety and falls an intervention to reinforce need to use the call light to request assistance.

On 09/26/23 at 08:31 AM observed resident #52 lying in her bed, the call light was attached to the chair, out of residents reach. Resident verbalized, I have to pee so bad. Resident acknowledged had no way to summon staff.

On 9/26/23 at 08:45 AM Certified Nursing Aide (CNA) Staff #I, came in the room and relayed would get a bed pan, returned within minutes later with a bed pan to Resident #52 room, shut the door to provide care and exited following services.

09/26/23 08:52 AM approached resident in bed, covered with blankets, Resident #52 relayed is on the bedpan. The call light remained on the resident's chair, was not in reach of resident while she lye in bed on the bed pan.

09/26/23 09:18 AM Resident was assisted up in chair, observed at this time eating donuts, has call light tied on the chair within reach, the call light was not be plugged into the wall, the other end of the cord laid on the floor. The call light

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was inoperable.

On 9/26/23 at 9:19 staff reentered per requested and acknowledged that resident call light was not in reach when she was in the bed and acknowledged resident was placed on the bed pan without ensuring her call light in reach. Staff I also acknowledged the call light attached to Resident #52 chair was not plugged into the wall.

On 9/26/23 at 9:20 AM Staff I reported that when a call light is not plugged into the wall a blinking light outside the door should alert staff that it is not plugged in. Staff I acknowledged the blinking light was not working to alert staff that the call light is not working. Staff I relayed would alert the charge nurse and put in a work order.

On 09/26/23 at 04:53 PM the Director of Nursing, (DON) acknowledged residents should have access to their call light and relayed ensured the work order was addressed to ensure proper functioning.

Facility Policy titled Resident Call system, reviewed dated May 2020 documented all residents have call system access while in bed or sitting at their bedside or in the bathroom.

The facility assessment dated 7/26/23 documented resources to protect and promote the health and safety of residents included a nurse call system.

LUTHERAN LIVING PLAN OF CORRECTION

- **F 550 Resident Rights/Exercise of rights:**

***Corrections for the examples cited:***

- R8 catheter and dignity bag placed on 10/5/23
  *R56 Staff have been educated on dignity/privacy.

***How will you identify other residents who are at risk for being affected by this alleged deficient practice:***

- All resident are considered at risk to be affected by this alleged deficient practice.

***What measures will you put into place or what system changes will you make to ensure that the deficient practice does not recur.***

- Staff education on dignity by Executive Director or designee including use of dignity bags, knocking on the door, and the resident's right for privacy beginning on 10/11/23.
- Resident interviews (5-10) weekly to inquire if staff are upholding dignity until no negative findings.
- ADON or designee to conduct dignity rounds weekly until no negative findings.

***How the corrective action will be monitored to ensure that the deficient practice does not recur?***

Negative findings will be corrected immediately and reported at Quality Assurance and Performance Improvement Meeting monthly and conduct education training as needed. Ongoing random reviews of this system will be incorporated into the monthly Quality Assurance Performance Improvement Program.

*This plan of correction will be accomplished by 11/13/23.*

LUTHERAN LIVING PLAN OF CORRECTION

- **F 578 Request/Refuse/DscntnueTrmnt/Formlt Adv Dir**

***Corrections for the examples cited:***

- R128, 438, 118, 48, have been reviewed and updated.

***How will you identify other residents who are at risk for being affected by this alleged deficient practice****:*

- All residents are considered to be at risk for this deficient practice.

***What measures will you put into place or what system changes will you make to ensure that the deficient practice does not recur.***

- Education to staff on IPOLST and physicians orders by Executive Director or designee
- Education on IPOLST to Social Service (LMSW) by Director of Nursing.
- LMSW or designee will ensure IPOLST are completed upon admission and reviewed quarterly.
- Complete whole house audit to ensure compliance of physician's orders, completed IPOLST and matching care plan by LMSW or designee.
- IDT will review admissions to ensure completed IPOLST, physicians orders and careplan.

***How the corrective action will be monitored to ensure that the deficient practice does not recur?***

- Negative findings will be corrected immediately and reported at Quality Assurance and Performance Improvement Meeting and conduct education training as needed. Ongoing random reviews of this system will be incorporated into the monthly Quality Assurance Performance Improvement Program.

***This plan of correction will be accomplished by 11/13/23.***

LUTHERAN LIVING PLAN OF CORRECTION

- **F 580 Notify of changes**

***Corrections for the examples cited:***

- R385, resident no longer lives at facility. All other residents, if there is an incident/accident the family/decision maker and physician will be notified immediately, and documented.

***How will you identify other residents who are at risk for being affected by this alleged deficient practice:***

- All residents are considered to be at risk for this alleged deficient practice.

***What measures will you put into place or what system changes will you make to ensure that the deficient practice does not recur.***

- Licensed nurses were educated on family and physician notifications, reasons to notify family, how and where to document beginning 10/19/23 by the Director of Nursing or designee.
- Director of Nursing to develop and implement checklist for incidents/accidents to include family and physician notification.
- Director of Nursing or designee to review all incidents/accidents daily (5x week) to ensure family and physician notifications were completed until compliance is achieved.

***How the corrective action will be monitored to ensure that the deficient practice does not recur?***

- Negative findings will be corrected immediately and reported at Quality Assurance and Performance Improvement Meeting and conduct education training as needed. Ongoing random reviews of this system will be incorporated into the monthly Quality Assurance Performance Improvement Program.

***This plan of correction will be accomplished by 11/13/23.***

LUTHERAN LIVING PLAN OF CORRECTION

- **F 600 Free from Abuse and Neglect**

***Corrections for the examples cited****:*

- R64, 84 were separated immediately and safe. R84 transferred to the dementia unit.

***How will you identify other residents who are at risk for being affected by this alleged deficient practice:***

- All residents are considered to be at risk for this deficient practice.

***What measures will you put into place or what system changes will you make to ensure that the deficient practice does not recur****.*

- Education to staff on resident- to -resident altercation by Executive Director.
- Staff was inserviced on abuse, neglect and reporting on 10/4 and 10/5 by Executive Director.
- Staff inserviced on abuse, neglect and grievances on 10/11/23 by Executive Director.
- All new hires are trained on orientation and Relias prior to working a shift.
- All staff complete the IOWA Specific Adult Abuse Training prior to working the Floor.
- HR or designee monitors employee's files for compliance with every 3 year Certification with the Adult Abuse Training Program.

***How the corrective action will be monitored to ensure that the deficient practice does not recur?***

- Negative findings will be corrected immediately and reported at Quality Assurance and Performance Improvement Meeting and conduct education training as needed. Ongoing random reviews of this system will be incorporated into the monthly Quality Assurance Performance Improvement Program.

*This plan of correction will be accomplished by 11/13/23.*

LUTHERAN LIVING PLAN OF CORRECTION

- **F 603 Free from Involuntary seclusion**

***Corrections for the examples cited:***

- R 385 no longer lives here. No involuntary seclusion is used in this facility.

***How will you identify other residents who are at risk for being affected by this alleged deficient practice:***

- All residents are considered to be at risk for being affected by this deficient practice.

***What measures will you put into place or what system changes will you make to ensure that the deficient practice does not recur.***

- Education to all staff on abuse and neglect with emphasis on identifying and reporting by Executive Director.
- All staff have been in-serviced on the abuse policies on the following dates: June 23, 2023, August 9, 2023, September 6, 2023, 10/4/23 to 10/5/23, 10/11/23, and 11/8/23. All new hires are required to complete Iowa Dependent Abuse training prior to working on the floor.
- HR audits employee files to ensure all staff are compliant with renewing Adult Dependent Abuse Training.
- All residents admitted prior to 5/16/23 were interviewed to determine if they have any concerns about abuse, and any negative findings will be reported and investigated immediately by Executive Director.
- All staff that worked with employee involved in the incident will be interviewed to determine if they ever witnessed any abuse towards a resident from this employee by Executive Director or designee.
- Staff will be re-inserviced on abuse, abuse reporting, identifying abuse, beginning 10/4/23.
- The Executive Director or designee will interview 5-10 residents week for concerns on dignity, staffing, care and abuse. Negative findings will be followed up on immediately. Interviews will continue until no negative reports are received.
- The Executive Director or designee will review grievance log daily (5x week) to identify issues that could be considered abuse and follow up appropriately until compliance is achieved.

***How the corrective action will be monitored to ensure that the deficient practice does not recur?***

- Negative findings will be corrected immediately and reported at Quality Assurance and Performance Improvement Meeting and conduct education training as needed. Ongoing random reviews of this system will be incorporated into the monthly Quality Assurance Performance Improvement Program.

***This plan of correction will be accomplished by 10/30/23.***

LUTHERAN LIVING PLAN OF CORRECTION

**F 609 Reporting of Alleged Violations**

***Corrections for the examples cited:***

- (R64,84,385) Staff was trained on reporting requirements by Executive Director and Executive Director educated by Regional Director of Quality and Clinical Services.

***How will you identify other residents who are at risk for being affected by this alleged deficient practice:***

- All residents are at risk to be affected by this alleged deficient practice.

***What measures will you put into place or what system changes will you make to ensure that the deficient practice does not recur.***

- All staff have been trained on June 23, 2023, August 9, 2023, and September 6, 2023, 10/4/23 to 10/5/23, 10/11/23, and 11/8/23, about how to report abuse.
- Executive Director has her personal cell phone number listed on PCC to alert any staff working in the building to call Administrator immediately with any concerns of abuse.
- Grievances are reviewed daily (5xweek) by Executive Director or designee to identify potential abuse and are followed up on immediately and reported if applicable.
- Education to staff on resident- to -resident altercation by Executive Director or designee.
- The Executive Director or designee will interview 5-10 residents week for concerns on dignity, staffing, care and abuse. Negative findings will be followed up on immediately. Interviews will continue until no negative reports are received.

***How the corrective action will be monitored to ensure that the deficient practice does not recur:***

- Negative findings will be corrected immediately and reported at Quality Assurance and Performance Improvement Meeting and conduct education training as needed. Ongoing random reviews of this system will be incorporated into the monthly Quality Assurance Performance Improvement Program

***This plan of correction will be accomplished by 11/13/23.***

LUTHERAN LIVING PLAN OF CORRECTION

**F 610 Investigate/Prevent/Correct Alleged Violation**

***Correction for the examples cited:***

- R385 all allegations are investigated immediately. Staff have been re-educated on reporting.

***How will you identify other residents who are at risk for being affected by this alleged deficient practice:***

- All residents will be considered at risk of being affected by this alleged deficient practice.

***What measures will you put into place or what system changes will you make to ensure that the deficient practice does not recur.***

- Staff was inserviced on abuse, neglect and reporting on June 23, 2023, August 9, 2023, September 6, 2023, 10/4/23 to 10/5/23, 10/11/23.
- Staff inserviced on abuse, neglect and grievances on June 23, 2023, August 9, 2023, September 6, 2023, 10/4/23 to 10/5/23, 10/11/23.
- All new hires are trained on orientation and Relias prior to working a shift.
- All staff complete the IOWA Specific Adult Abuse Training prior to working the Floor.
- HR or designee monitors employee's files for compliance with every 3 year Certification with the Adult Abuse Training Program.
- Staff will be re-inserviced on abuse, abuse reporting, identifying abuse, beginning 10/4/23.
- Executive Director is interviewing 5-10 residents weekly for identification of care issues, dignity, staffing concerns and potential abuse and will act immediately on negative findings related to abuse until substantial compliance is achieved.
- The Executive Director or designee is reviewing the Grievance logs for any concerns that could be identified as abuse daily (5x week) and following up immediately if potential abuse identified until substantial compliance is achieved.
- Education to ED, DON, ADON's and SS on Investigative process by RDQCS.

***How the corrective action will be monitored to ensure that the deficient practice does not recur?***

- Negative findings will be corrected immediately and reported at Quality Assurance and Performance Improvement Meeting and conduct education training as needed. Ongoing random reviews of this system will be incorporated into the monthly Quality Assurance Performance Improvement Program

***This plan of correction will be accomplished by 10/30/23.***

LUTHERAN LIVING PLAN OF CORRECTION

**F 622 Transfer and Discharge Requirements**

***Corrections for the examples cited:***

- (R7, 60, 124) Licensed nurses trained on the following: all residents will have documentation of transfer to hospital or appropriate facility, reason for transfer, with documentation of family notification, nurse to nurse report, and appropriate paperwork sent.

***How will you identify other residents who are at risk for being affected by this alleged deficient practice:***

- All residents who are transferred are considered to be at risk for the deficient practice.

***What measures will you put into place or what system changes will you make to ensure that the deficient practice does not recur.***

- Education on bed hold process to all Licensed Nurses by DON or designee.
- Facility to develop and train on a transfer guide to utilize when transferring a Resident. This process will be ongoing.
- ADON or designee will review each transfer chart daily (5x week) for appropriate documentation and bed hold process until compliance is achieved.

***How the corrective action will be monitored to ensure that the deficient practice does not recur?***

- Negative findings will be corrected immediately and reported at Quality Assurance and Performance Improvement Meeting and conduct education training as needed. Ongoing random reviews of this system will be incorporated into the monthly Quality Assurance Performance Improvement Program.

***This plan of correction will be accomplished by 11/13/23.***

LUTHERAN LIVING PLAN OF CORRECTION

**F 644 Coordination of PASARR and Assessments**

***Corrections for the examples cited:***

- R47 and R69 PASSAR's were resubmitted on 10/5/23.

***How will you identify other residents who are at risk for being affected by this alleged deficient practice:***

- All residents are considered at risk to be affected by this alleged deficient practice.

***What measures will you put into place or what system changes will you make to ensure that the deficient practice does not recur.***

- Education to SSD and Admission Coordinator by Director of Nursing on PASSAR process.
- Education on utilizing Maximus Assessment Pro Ascend for auditing and monitoring process to LMSW by Director of Nursing or designee.
- LMSW or designee will audit all current residents for PASSAR and any negative findings will be corrected immediately.
- LMSW or designee will audit PAASAR's for every admission and ensure completion as appropriate. This will be an ongoing process.

***How the corrective action will be monitored to ensure that the deficient practice does not recur?***

- Negative findings will be corrected immediately and reported at Quality Assurance and Performance Improvement Meeting and conduct education training as needed. Ongoing random reviews of this system will be incorporated into the monthly Quality Assurance Performance Improvement Program.

***This plan of correction will be accomplished by 11/13/23.***

LUTHERAN LIVING PLAN OF CORRECTION

**F645 PASARR Screening for MD &ID**

***Corrections for the examples cited:***

- R47 Had their PASARR resubmitted 10/6/23.

***The facility will identify other residents at risk to be affected by this deficient practice:***

- All residents are considered at risk to be affected by this alleged deficient practice.

***What measures will you put into place or what system changes will you make to ensure that the deficient practice does not recur.***

- LMSW or designee will attend Clinical Meeting daily (5 x week) and any changes in diagnosis and /or psychotropic addition/change will be identified and followed up at that time as applicable to the PASSAR process. This is an ongoing process.
- Director of Nursing or designee will educate LMSW and Assistant on Point Click Care dashboard to identify diagnosis and medication changes.
- LMSW or designee will review current resident diagnosis for new psychiatric diagnosis and submit new PASSAR if applicable.

***How the corrective action will be monitored to ensure that the deficient practice does not recur***

- Negative findings will be corrected immediately and reported at Quality Assurance and Performance Improvement Meeting and conduct education training as needed.

***This plan of correction will be accomplished by 11/13/23.***

**F 655 Baseline Care plan**

- ***Corrections for the examples cited:***
  All baseline careplans including R7, 124, are completed within 48 hours of admission.

***How will you identify other residents who are at risk for being affected by this alleged deficient practice:***

- All residents are considered to be at risk for this alleged deficient practice.

***What measures will you put into place or what system changes will you make to ensure that the deficient practice does not recur.***

- Regional MDS Educator provided education to MDS Coordinators and DON on 10/9/23.
- Education will be provided to licensed nurses regarding baseline care plans by Director of Nursing or designee.
- Reviews of baseline careplans by MDS Coordinator or designee will be completed weekly to ensure timely completion.

***How the corrective action will be monitored to ensure that the deficient practice does not recur?***

- Negative findings will be corrected immediately and reported at Quality Assurance and Performance Improvement Meeting and conduct education training as needed. Ongoing random reviews of this system will be incorporated into the monthly Quality Assurance Performance Improvement Program

***This plan of correction will be accomplished by 11/13/23***

LUTHERAN LIVING PLAN OF CORRECTION

- **F 657 Care Plan Timing and Revision**

***Corrections for the examples cited:***

- Careplan conferences will be completed for all residents including R5, 7, 24, 101, per Federal and State regulations, at least quarterly, and as needed.

***How will you identify other residents who are at risk for being affected by this alleged deficient practice:***

- All residents are considered at risk to be affected by this deficient practice.

***What measures will you put into place or what system changes will you make to ensure that the deficient practice does not recur.***

- Education to LMSW provided by MDS Regional MDS on sending letters and Careplan Conference requirements.
- Social Service Assistant pr designee will send letters to responsible party and Resident regarding care with change of condition and quarterly.
- LMSW or designee will ensure care plan conferences occur.
- LMSW or designee will audit IDT care plan conference summary weekly to ensure timely completion of meeting.

***How the corrective action will be monitored to ensure that the deficient practice does not recur?***

- Negative findings will be corrected immediately and reported at Quality Assurance and Performance Improvement Meeting and conduct education training as needed. Ongoing random reviews of this system will be incorporated into the monthly Quality Assurance Performance Improvement Program

***This plan of correction will be accomplished by 11/13/23.***

LUTHERAN LIVING PLAN OF CORRECTION

**F 677 ADL Care Provided for Dependent Residents**

***Corrections for the examples cited*:**

- All residents, including R7 are offered two showers weekly.

***How will you identify other residents who are at risk for being affected by this alleged deficient practice:***

- All residents are considered to be at risk for this alleged deficient practice.

***What measures will you put into place or what system changes will you make to ensure that the deficient practice does not recur.***

- Education to staff on shower system and completion by Executive Director or designee.
- Resident shower schedules will be entered into PCC.
- ADON or designee will monitor showers daily (5x week) to ensure completion until substantial compliance is achieved, then randomly weekly.

***How the corrective action will be monitored to ensure that the deficient practice does not recur?***

- Negative findings will be corrected immediately and reported at Quality Assurance and Performance Improvement Meeting and conduct education training as needed. Ongoing random reviews of this system will be incorporated into the monthly Quality Assurance Performance Improvement Program

***This plan of correction will be accomplished by 11/13/23***

LUTHERAN LIVING PLAN OF CORRECTION

**F 684 Quality of Care**

***Corrections for the examples cited:***

- R7, and all other residents that have any accident or incident will have correct documentation and family notification. R 385 no longer lives here.

***How will you identify other residents who are at risk for being affected by this alleged deficient practice:***

- All residents will be at risk to be affected by this deficient practice.

***What measures will you put into place or what system changes will you make to ensure that the deficient practice does not recur.***

- Education on nurse documentation by the Director of Nursing or designee.
- Daily review of nursing notes by the Director of Nursing (5x week) for problems identified and to ensure follow-up. This is an ongoing process.

***How the corrective action will be monitored to ensure that the deficient practice does not recur?***

Negative findings will be corrected immediately and reported at Quality Assurance and Performance Improvement Meeting and conduct education training as needed. Ongoing random reviews of this system will be incorporated into the monthly Quality Assurance Performance Improvement Program.

***This plan of correction will be accomplished by 11/13/23.***

LUTHERAN LIVING PLAN OF CORRECTION

**F 689 Free of Accident Hazards/Supervision/Devices**

***Corrections for the examples cited:***

- All residents including R26, 48, 84, 60, 99, will receive correct protocol for care, which will include documentation, notification, and any MD orders, as well as fall and incident interventions.

***How will you identify other residents who are at risk for being affected by this alleged deficient practice****:*

- All residents are considered to be at risk for this deficient practice*.*

***What measures will you put into place or what system changes will you make to ensure that the deficient practice does not recur****.*

- Director of Nursing to develop and implement a checklist for incidents/accidents to include family and physician notification, documentation and interventions.
- Education to licensed staff on accident/incident checklist by Director of Nursing or designee.
- Director of Nursing or designee to review all incidents/accidents daily to ensure family and physician notifications were completed as well as appropriate interventions to prevent reoccurrence and documentation of incident/accident.

***How the corrective action will be monitored to ensure that the deficient practice does not recur?***

- Negative findings will be corrected immediately and reported at Quality Assurance and Performance Improvement Meeting and conduct education training as needed. Ongoing reviews of this system will be incorporated into the monthly Quality Assurance Performance Improvement Program

***This plan of correction will be accomplished by 10/30/23.***

LUTHERAN LIVING PLAN OF CORRECTION

**F 690 Bowel/Bladder Incontinence, Catheter, UTI**

***Corrections for the examples cited:***

- All residents including R8, will not have catheter bag/tubing on the floor. Bag will be in protective sleeve, and at the correct height attached to a secure area.

***How will you identify other residents who are at risk for being affected by this alleged deficient practice:***

- All residents will be considered at risk for this alleged deficient practice.

***What measures will you put into place or what system changes will you make to ensure that the deficient practice does not recur.***

- Education on infection control and dignity related to catheter bag handling by Executive Director or designee.
- ADON or designee will audit all residents with catheters for proper positioning and dignity covers by 10/10/23.
  ADON or designee will make rounds at least weekly ongoing and document findings.

***How the corrective action will be monitored to ensure that the deficient practice does not recur?***

- Negative findings will be corrected immediately and reported at Quality Assurance and Performance Improvement Meeting and conduct education training as needed. Ongoing random reviews of this system will be incorporated into the monthly Quality Assurance Performance Improvement Program

***This plan of correction will be accomplished by 11/13/23***

LUTHERAN LIVING PLAN OF CORRECTION

**F 725 Sufficient Nursing Staff**

***Corrections for the examples cited:***

- R26, 48, 52, 41, 27, 7, 60, all resident will be provided the safe amount of staffing needing to provide quality of care.

***How will you identify other residents who are at risk for being affected by this alleged deficient practice****:*

- All residents are considered to be at risk of this alleged deficient practice.

***What measures will you put into place or what system changes will you make to ensure that the deficient practice does not recur****.*

- Education on PPD's and staff responsibility to notify managers when they need assistance and staff accountability to Nursing staff by Executive Director or designee.
- Labor meeting daily Monday thru Friday to review previous days PPD's and anticipate staffing needs with Executive Director, Director of Nursing, Staffing Coordinator and other applicable staff.
- Resident interviews (5 to 10) regarding satisfaction with staffing ratios will be conducted by the Executive Director or designee weekly.
- Staff interviews (5 to 10) regarding satisfaction with staffing ratios will be conducted by the Executive Director or designee weekly.

***How the corrective action will be monitored to ensure that the deficient practice does not recur?***

- Negative findings will be corrected immediately and reported at Quality Assurance and Performance Improvement Meeting and conduct education training as needed. Ongoing random reviews of this system will be incorporated into the monthly Quality Assurance Performance Improvement Program.

***This plan of correction will be accomplished by 11/13/23.***

LUTHERAN LIVING PLAN OF CORRECTION

**F 732 Posted Nurse Staffing Information**

***Corrections for the examples cited:***

- No examples cited.

***How will you identify other residents who are at risk for being affected by this alleged deficient practice:***

- All residents have potential to be affected by this alleged deficient practice.

***What measures will you put into place or what system changes will you make to ensure that the deficient practice does not recur.***

- Education to licensed nursing on Staff Posting Requirements.
- DON or designee will audit daily (5 x week) for accurate completion.

***How the corrective action will be monitored to ensure that the deficient practice does not recur?***

- Negative findings will be corrected immediately and reported at Quality Assurance and Performance Improvement Meeting and conduct education training as needed. Ongoing random reviews of this system will be incorporated into the monthly Quality Assurance Performance Improvement Program.

**This plan of correction will be accomplished by 11/13/23.**

LUTHERAN LIVING PLAN OF CORRECTION

**F 758 Free from Unnec Psychotropic Meds/PRN use**

***Corrections for the examples cited:***

- R124 and all other residents that are prescribed psychotropic and/or pain medication will be given three non-pharmacological interventions, prior to administering the medication.

***How will you identify other residents who are at risk for being affected by this alleged deficient practice:***

- All residents on prn pain and/or psychotropic medications will be considered at risk to be affected by this alleged deficient practice.

***What measures will you put into place or what system changes will you make to ensure that the deficient practice does not recur.***

- Education to licensed staff on non-pharmacological interventions by Director of Nursing or designee.
- Whole house audit of physicians orders for prn pain medications and prn psychotropic medications and ensure non-pharmacological interventions are in place for the orders and will be documented on prior to medication administration by ADON or designee.
- New admissions/readmissions will have physician orders reviewed for appropriate interventions daily (5x week) by ADON or designee until compliance achieved.
- ADON or designee will randomly review physician orders and/or medication administration weekly to ensure non-pharmacological interventions are in place and are being documented prior to medication administration until compliance is achieved.

***How the corrective action will be monitored to ensure that the deficient practice does not recur?***

- Negative findings will be corrected immediately and reported at Quality Assurance and Performance Improvement Meeting and conduct education training as needed. Ongoing random reviews of this system will be incorporated into the monthly Quality Assurance Performance Improvement Program

***This plan of correction will be accomplished by 11/13/23.***

LUTHERAN LIVING PLAN OF CORRECTION

**F 839 Staff Qualifications**

***Corrections for the examples cited:***

- Staff cited had been removed from the schedule at the time the facility identified the issue.

***How will you identify other residents who are at risk for being affected by this deficient practice.***

- All residents are at risk to be affected by this alleged deficient practice.

***What measures will you put into place or what system changes will you make to ensure that the deficient practice does not recur.***

- All staff audit by HR of all current employees to ensure licensure is current has been conducted and documented.
- HR or designee will audit all new employees prior to working the floor to ensure licensure verification has been completed.

***How the corrective action will be monitored to ensure that the deficient practice does not recur?***

- Negative findings will be corrected immediately and reported at Quality Assurance and Performance Improvement Meeting and conduct education training as needed.

***This plan of correction will be accomplished by 11/13/23.***

LUTHERAN LIVING PLAN OF CORRECTION

**F865 QAPI Prgm/Plan**

***Corrections for the examples cited:***

- All concerns identified at annual survey were brought to the next monthly Quality Assurance and Performance Improvement Training.

***How will you identify other residents who are at risk for being affected by this alleged deficient practice:***

- All residents have the potential to be affected by this alleged deficient practice.

***What measures will you put into place or what system changes will you make to ensure that the deficient practice does not recur.***

- Education to Interdisciplinary Quality Assurance and Performance Improvement Team by the RDQCS or designee, on the QAPI process.
- System failures resulting in citations will remain Performance Improvement Plans until compliance is achieved. Formal QAPI meeting held 10/24/23.

***How the corrective action will be monitored to ensure that the deficient practice does not recur?***

- Negative findings will be corrected immediately and reported at Quality Assurance and Performance Improvement Meeting and conduct education training as needed. Ongoing survey issues will remain a Performance Improvement Plan until compliance is achieved and then random reviews of this system will be incorporated into the monthly Quality Assurance Performance Improvement Program.

***This plan of correction will be accomplished by 11/13/23.***

LUTHERAN LIVING PLAN OF CORRECTION

**F 919 Resident Call System**

***Corrections for the examples cited:***

- R52's call light was immediately repaired. A whole house call light audit was performed to ensure all call lights were operative.

***How will you identify other residents who are at risk for being affected by this alleged deficient practice:***

- All residents are considered to be at risk for this alleged deficient practice.

***What measures will you put into place or what system changes will you make to ensure that the deficient practice does not recur.***

- Education to all staff on procedure if call light is not working and to immediately notify Manager.
- The facility will purchase and distribute handheld bells for emergency use.
- Maintenance will test all call lights for function and document finding every 2 weeks.

***How the corrective action will be monitored to ensure that the deficient practice does not recur?***

- Negative findings will be corrected immediately and reported at Quality Assurance and Performance Improvement Meeting and conduct education training as needed.

***This plan of correction will be accomplished by 11/13/23.***