| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 165158 | A. Building<br>B. Wing | 06/13/2024 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| Azria Health Clarinda | 600 Manor Drive<br>Clarinda, IA 51632 |

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

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| F 0657<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Develop the complete care plan within 7 days of the comprehensive assessment; and prepared, reviewed, and revised by a team of health professionals.<br><br>47673<br><br>Based on electronic health record (EHR) review, resident interview, staff interviews and facility policy review the facility failed to provide an opportunity for a comprehensive care plan to be reviewed and revised by an interdisciplinary team composed of a resident and/or resident representative to allow developing the care plan and making decisions about his or her care to 1 of 5 residents reviewed (Resident #6). The facility reported a census of 66 residents.<br><br>Finding include:<br><br>The Minimum Data Set (MDS) assessment for Resident #5 dated 5/13/24 documented a Brief Interview for Mental Status (BIMS) score of 14 indicating no cognitive impairment.<br><br>On 6/10/24 at 1:25 PM Resident #5 stated she had not been to a care plan meeting. Resident #5 stated her Power Of Attorney had not been invited either.<br><br>Review of EHR titled, AZH Multidisciplinary Care Conference V1.0 revealed the last care conference was completed 2/8/24.<br><br>On 6/11/24 at 11:51 AM Staff I stated normally she was on top of care conferences meetings, but had doubled the census at the facility in the last month. Staff I stated she spoke with the MDS coordinator about how to get caught back up and they had developed a plan. Staff I stated care conferences should be completed at least quarterly every 90 days with resident and/or resident representatives allowed to participate. Staff I stated Resident #5 was due for a care conference. Staff I stated Resident #5's care conference should have been completed in May but was not.<br><br>On 6/11/24 at 12:22 PM the DON stated the facility's expectation was care conferences would have been completed with the resident and/or resident representative every 90 days.<br><br>Review of Policy titled, Care Planning - Interdisciplinary Team revised 3/22 documented that comprehensive, person-centered care plans are based on resident assessments and developed by an interdisciplinary team. The IDT was to include but was not limited to the resident and/or the resident's representative. |

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.

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

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| F 0676<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Ensure residents do not lose the ability to perform activities of daily living unless there is a medical reason.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 47079<br><br>Based on clinical record review, observation, staff interviews, and policy review, the facility failed to maintain Activities of Daily Living (ADLs) by failing to provide restorative aid for 1 of 1 resident reviewed (#46). The facility reported a census of 66 residents.<br><br>Findings include:<br><br>The 5-day Medicare Minimum Data Set (MDS) assessment dated [DATE] indicated the resident had a Brief Interview for Mental Status (BIMS) score of 0 out of 15 which indicated severely impaired cognition. It revealed the resident required supervision or touching assistance with eating; moderate assistance with oral hygiene, toileting hygiene, and upper body dressing; and maximal assistance with bathing, lower body dressing, and putting on and removing footwear.<br><br>The quarterly MDS assessment dated [DATE] indicated the resident still had a BIMS score of 0 out of 15. It revealed the resident required supervision or touching assistance with eating; maximal assistance with lower body dressing; and was dependent with all other aspects of ADLs.<br><br>On 6/11/24 at 12:56 PM, Resident #46 observed having difficulty eating lunch in the dining room.<br><br>The Electronic Health Record (EHR) included a restorative therapy progress note that revealed the resident not able to participate in restorative therapy due to a lack of available staff to help him ambulate.<br><br>On 6/12/24 at 9:36 AM, Staff A, Certified Nursing Assistant (CNA) stated the resident required a second staff member to assist with ambulation by following the resident with a wheelchair. She stated Staff B, CNA used to assist but hasn't been available due to a change in residents' shower schedules. She stated resident restorative therapy is documented in the resident's EHR.<br><br>A document titled Restorative list indicated the resident was to be walked to the dining room for one (1) meal.<br><br>On 6/12/24 at 9:49 AM, Staff C, Physical Therapy Assistant (PTA) stated the resident discharged from Occupational Therapy on 4/01/24 and from Physical Therapy (PT) on 4/02/24.<br><br>A document titled Therapy to Nursing Restorative Nursing Program Communication dated 4/02/24 directed staff to ambulate the resident 60 - 90 feet. Staff C stated staff was to ambulate the resident to the dining room for one (1) meal every day.<br><br>On 6/12/24 at 10:02 AM, Staff D, CNA stated resident walking would be documented under 150 feet walking task in the EHR.<br><br>The Review of the 150-feet walking task list indicated the resident was ambulated 11 times since 4/03/24 and 3 times between 5/01/24 and 5/31/24.<br><br>(continued on next page) |

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| F 0676<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | On 6/12/24 at 10:51 AM, the Director of Nursing (DON) stated the resident would sometimes refuse to allow anyone to ambulate him. She also stated if the resident had been ambulated, it would appear in the response section of the 150-feet walking task report. She stated a not applicable response indicated the task was not done.<br><br>A policy titled Restorative Nursing Services revised 7/2017 revealed residents would receive restorative nursing care as needed to help promote optimal safety and independence. It indicated residents may be started on a restorative nursing program upon admission, during the course of stay or when discharged from rehabilitative care and included restorative goals and objectives are individualized and resident-centered, and are outlined in the resident's plan of care.<br><br>On 6/13/23 at 7:32 AM, the DON stated the staff should have documented the resident's refusal to participate in restorative therapy. |

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| F 0755<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Provide pharmaceutical services to meet the needs of each resident and employ or obtain the services of a licensed pharmacist.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 47079<br><br>Based on clinical record review, resident interview, staff interviews, and policy review, the facility failed to document an administered medication into the resident's medical record for 1 of 1 resident reviewed (Resident # 53). The facility reported a census of 66 residents.<br><br>Findings include:<br><br>The quarterly Minimum Data Set (MDS) assessment dated [DATE] indicated the resident had a Brief Interview for Mental Status (BIMS) score of 15 out of 15 which indicated completely intact cognition. It included diagnoses of Diabetes Mellitus, hypertension, anxiety, and depression. It also indicated the resident had not vomited during the 7-day look-back period.<br><br>On 6/10/24 at 3:12 PM, Resident #53 stated she was sent to the hospital on 4/15/24 due to a Urinary Tract Infection (UTI) and Clostridium Difficile (C-Diff) infection.<br><br>The Electronic Health Record (EHR) Progress Notes dated 4/15/24 at 11:43 PM revealed the resident complained of nausea at 6:00 PM and had emesis at 7:00 PM. It also revealed the resident was sent to the Emergency Department (ED).<br><br>The Care Plan included a history of Gastroesophageal Reflux Disease (GERD).<br><br>The EHR included orders for the resident to take one (1) 4 milligram (mg) Ondansetron tablet by mouth every six (6) hours as needed for nausea.<br><br>On 6/12/24 at 8:03 AM, Staff G, Licensed Practical Nurse (LPN) stated she was told during shift report the resident complained of not feeling well all day and the resident already received medication for nausea.<br><br>On 6/12/24 at 8:22 AM, Staff H, Registered Nurse (RN) stated she didn't remember the resident complaining during her shift. She stated as-needed (PRN) medications are usually documented on the Medication Administration Record (MAR) accompanied by a progress note that would include attempted, non-pharmacological interventions.<br><br>The MAR lacked documented administration of Ondansetron medication on 4/15/24.<br><br>The hospital medical record indicated the resident admitted she received Zofran at 7:00 PM.<br><br>A document titled Administering Medications revised 4/2019 directed staff to initial the resident's MAR on the appropriate line after giving each medication and before administering the next ones.<br><br>On 6/13/24 at 7:32 AM, the DON stated Staff G contacted her and stated that she gave the resident Zofran shortly after 6:00 PM when the resident complained of nausea. The DON stated the staff should have documented the medication administration. |

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| F 0880<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Provide and implement an infection prevention and control program.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 47079<br><br>Based on clinical record review, resident interview, observation, staff interview, and policy review the facility failed to implement appropriate infection control practices to prevent cross contamination by failing to perform hand hygiene during resident care. The facility reported a census of 66 residents.<br><br>Findings include:<br><br>The quarterly Minimum Data Set (MDS) assessment dated [DATE] indicated the resident had a Brief Interview for Mental Status (BIMS) score of 15 out of 15 which indicated completely intact cognition. It included diagnoses of Diabetes Mellitus, anxiety, depression, and the need for assistance with personal care. It also revealed the resident required set-up assistance with eating; moderate assistance with oral hygiene; maximal assistance with upper body dressing and personal hygiene; and was dependent with toileting hygiene, bathing, lower body dressing, and putting on and removing footwear.<br><br>The Care Plan initiated 5/16/24 revealed the resident was dependent on two staff assistance with toileting. It also directed staff to provide pericare after each incontinent episode and observe enhanced barrier precautions for infection control.<br><br>On 6/10/24 at 3:12 PM, Resident #53 stated she was sent to the hospital on 4/15/24 due to a Urinary Tract Infection (UTI) and Clostridium Difficile (C-Diff) infection.<br><br>On 6/12/24 at 10:45 AM, Staff E, Certified Nurse Aide (CNA) and Staff F, CNA performed incontinence care for Resident #53. An observation of the incontinence care revealed the resident was sitting on the bedside commode with her pants and disposable brief pulled down to her mid-thigh level and a blanket covered her lower abdomen and mid-thighs. Staff E, CNA already had gloves on and removed the blanket and repositioned the resident's pants and briefs. Staff F, CNA raised the resident with an E-Z stand transfer device. Staff E, CNA took a hygiene wipe and wiped the resident from behind and used a front-to-back method to perform urinary incontinence care. No hand hygiene was performed while she performed the resident's incontinence care.<br><br>A policy titled Standard Precautions revised 10/2022 indicated hand hygiene refers to handwashing with soap (anti-microbial or non-antimicrobial) or the use of alcohol-based hand rub (ABHR), which does not require access to water and directed staff to perform hand-hygiene after contact with items in the resident's room. It also indicated gloves are changed as necessary, during the care of a resident to prevent cross-contamination from one body site to another.<br><br>On 6/13/24 at 7:32 AM, the Director of Nursing (DON) stated the staff should not have touched anything else after gloving their hands. |