STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	165178	A. Building B. Wing	12/09/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Aase Haugen Home	Four Ohio Street Decorah, IA 52101

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0684 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Provide appropriate treatment and care according to orders, resident's preferences and goals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 48003 Based on record review, staff and medical professional interviews the facility failed to promptly identify and intervene for an acute change in a resident's condition related to dehydration for 1 of 3 residents reviewed (Resident#2), resulting in Resident #2 being transported and admitted to the hospital via ambulance [DATE] with severe dehydration and sepsis. Resident #2 died on [DATE]. Resident #2's Electronic Health Record (EHR) documented he had acute changes in condition noted as follows with lack of follow up assessments and notification to the physician with the condition changes: [DATE] increased blood pressure [DATE] No assessment completed [DATE] slightly elevated pulse [DATE] increase in pulse, blood pressure and mental status change. [DATE] No assessment completed [DATE] prior to being seen by psych via telecare in the early afternoon no assessment completed. On [DATE] at 4:45 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. This Immediate Jeopardy situation started on [DATE], the day Resident #2's documentation noted an acute change in condition with no physician notification and no follow up assessment completed. The facility staff removed the immediacy on [DATE] after the facility staff completed the following: Corrective Action: a. Immediate in-service for nurses on identifying acute changes in resident conditions, conducting complete assessments, and notification of providers of changes in condition in a timely manner. b. Attestation of these procedures for all shifts prior to caring for the residents c. Immediate review of all resident documentation going back 72 hours to ensure there were no current changes of condition that may require follow-up, further assessment, or provider notification. (continued on next page)

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

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F 0684 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	d. Any identified concerns will be assessed and the proper notifications made prior to clinical leadership leaving for the day. e. Started Daily auditing of all resident records to ensure that there are no current changes of condition that may require follow-up, further assessment, or provider notification. The scope lowered from a J to G (harm that is not immediate) on [DATE] after ensuring the facility implemented education and their policy and procedures. The facility reported a census of 57 residents. Findings include: The Minimum Data Set (MDS) assessment dated [DATE] documented Resident #2 had moderate impaired cognition. The MDS further revealed during the 7 day look back period he had not exhibited any rejection of care. The MDS documented he needed Supervision or touch assistance (Helper provides verbal cues and/or touching/steadying and/or contact guard assistance as resident completes activity. Assistance may be provided throughout the activity or intermittently) with eating. The MDS documented diagnoses of diabetes, hip fracture, Alzheimer's disease and hypertension. Resident #2's Care Plan with a focus for potential for unplanned weight changes related to variable oral intake of meals and fluids, diabetes mellitus, Alzheimer's Disease with confusion, history of hip fracture and hospitalization . The interventions for the focus were to provide and serve diet as ordered, he needs assistance with feeding, and weight weekly and as needed. Review of the EHR for Resident #2 documented the following: Resident #2's discharge summary from the hospital on [DATE] documented he was initially taken to the local ER where imaging revealed a right displaced femur fracture. He had a hip replacement on that side in 2022. Workup aside from hip fracture was unremarkable aside from mild thrombocytopenia. The resident was medically stable for discharge. Review of the skilled assessments documented the following findings: [DATE] increased blood pressure with no follow up or notification to the physician. [DATE] No assessment completed that 24 hour time period last completed on 5:27 AM on [DATE]. [DATE] slightly elevated pulse with no follow up or notification to the physician. [DATE] increase in pulse, blood pressure, and mental status change. with no follow up or notification to the physician. [DATE] No assessment completed since assessment completed since 10:42 AM on [DATE] [DATE] prior to being seen by psych provider via telecare in the early afternoon no assessment completed. (continued on next page)

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F 0684 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Review of Resident #2's Progress Notes document the following: [DATE] 10:38 PM : The resident was sleepy during supper. It is noted that resident is pocketing food, Licensed Practical Nurse (LPN) attempted to offer resident Ensure and it ran out of resident's mouth. Pain medication and other medications were administered prior to supper with no issues. We will continue to monitor. [DATE] 6:35 PM : The resident returned, from supper, clammy, not very active, eyes closed, drooling. The resident had been like this at the start of shift although not clammy until after supper. vitals taken, BS 196. afebrile. was reported that he attempted to hit the Certified Nursing Assistant (CNA) as she was trying to feed him. Will continue to monitor him. [DATE] 7:05 PM CNA's alerted this nurse to bloody drainage noted on sweatpants, when laying resident in bed, right side along the incision site. This nurse did not see any openings along the incision, no fluids were noted after palpating the incision area. Drainage is a serosanguinous (watery fluid and blood), moderate amount. Positioned resident on the right side, pillow between his legs to keep hip aligned. [DATE] 5:15 AM The resident has a fever of 100.1 Fahrenheit (F), Tramadol was given earlier and at this time cool compress to forehead temp 99.2 F at beginning of shift. [DATE] 1:32 PM Resident is lethargic, responds to verbal stimuli, when asked a question he is not able to answer, he is noted to be grimacing occasionally, and occasionally makes jerking movements. The writer called the resident's Power of Attorney (POA) with an update and voicemail left on the ARNP's nurse phone. We will continue to monitor. [DATE] 3:43 PM Resident transferred to ED via ambulance. Review of the Psych Telehealth note written on [DATE] documented: Today, staff report Resident #2 has had a change in mental status over the past 24 hours, blood pressure is slightly elevated, and running a low-grade temperature. Resident #2 is brought into a private office for an exam. He appears in distress - grimacing and respirations mildly elevated. He does not open his eyes or engage in conversation. Appointment concluded. Nursing staff instructed to notify PCP immediately as he appears to need urgent medical evaluation. During an interview on [DATE] at 2:36 PM Staff A, Registered Nurse (RN) reported for the [DATE] change in condition she passed it on in report to the next shift nurse to monitor. She reported at that time she did not notify the physician of changes. She reported she should have. For the change of condition on [DATE] she left a voicemail on the Advanced Nurse Practitioner's nurse phone on the condition change at 1 PM. She reported she then got a call back at 2:55 PM that recommended sending to the ED if the family was okay. She called the Power of Attorney and she didn't answer so called the second emergency contact which is a daughter and she wanted him sent to the ED. She then called the ambulance and the resident was sent out. During an interview on [DATE] at 10:20 AM, the Nurse Consultant reported the Nurse Practitioner reported she was not aware of any condition change or concerns with Resident #2 until [DATE] when the nurse called after he was seen by Psych. She reviewed the chart and no one was notified in the office. He reported staff should have notified the physician or the Nurse Practitioner. (continued on next page)

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F 0684 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	During an interview on [DATE] at 12:52 PM the Psychiatric-Mental Health Nurse Practitioner (PMHNP) reported she had been following Resident #2 for a year and a half via telehealth (the use of digital technology to access health care services remotely via video) for psych care and so she knows the resident. She reported on his appointment on [DATE] he was slumped over and not responding to her questions like he normally would. He would answer yes/no questions in the past. She noted he had been grimacing and respirations were mildly elevated. She noted the mental status change and staff reported he had this change for 24 hours, that he was running a low-grade fever and that his blood pressure was slightly evaluated. She immediately stopped the visit and told the nurse to notify his primary care physician and as he appeared to need urgent medical evaluation. During an interview on [DATE] at 3:55 PM Resident #2's Advanced Registered Nurse Practitioner (ARNP) reported her and her office were not aware of any change in condition prior to the notification on the afternoon of [DATE]. Resident #2's emergency room (ED) Notes dated [DATE] at 4:14 PM: Resident #2 with significant dementia and a recent right femur surgical repair on ,d+[DATE] who is a resident at [NAME] home. Presents today from the nursing home with fever, tachycardia (elevated heart rate), and decreased responsiveness. History is per nursing staff who spoke with nursing home staff as well as Emergency Medical Staff providers. Staff report he started to have a fever today which was controlled with Tylenol. They report his mental state has not been the same since he was hospitalized for his femur fracture. He appears profoundly dehydrated in the bed, dry mucus membranes and dry skin, and opens his eyes to voice. He is not verbally responsive. IV was established by EMS and Normal Saline was started. admitted with sepsis and dehydration. Hospital Physician Progress Note dated [DATE] documented Resident #2 discharged from the hospital on [DATE] after sustaining a femur fracture and Sodium level was 143 upon discharge. He was transferred to the nursing home after discharge from the hospital. - Per chart review, it was noted that Resident #2 was having mental status changes, fever, and minimal urine output with possible 1 episode of urination per shift for a week prior to this admission. Nurse Practitioner documented conversation on [DATE] he was admitted on [DATE] with a 7 Liter water deficit. Resident #2's Progress Notes documented the following: [DATE] 11:11 AM The resident returned from hospital stay. [DATE] 11:31 AM The resident admitted to hospice level of care. [DATE] 12:29 AM The resident passed. Resident #2's Death Record documented immediate cause of death was dehydration due to or as a consequence of sepsis.