

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 165178	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 07/25/2024
NAME OF PROVIDER OR SUPPLIER Aase Haugen Home		STREET ADDRESS, CITY, STATE, ZIP CODE 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)
<p>F 0644</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Coordinate assessments with the pre-admission screening and resident review program; and referring for services as needed.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 50874</p> <p>Based on observation, resident, family, and staff interviews the facility staff failed to submit a new Preadmission Screening and Resident Review (PASRR) for 2 of 2 residents sampled (Residents #29 and #56). The facility reported a census of 62 residents.</p> <p>Findings include:</p> <p>1. Resident #29 Minimum Data Set (MDS) assessment dated [DATE] identified a Brief Interview for Mental Status (BIMS) score of 3 indicating severe cognitive impairment. The MDS included diagnoses of bipolar disorder, anemia, orthostatic hypotension, and non-Alzheimer's dementia.</p> <p>Resident #29 current PASRR Level 1 Screening Outcome dated 3/12/2021 reflected a PASRR Level 1 Determination, No Level II required. The bipolar disorder diagnosis was not listed on the submitted form.</p> <p>A Monthly Medication Therapy Review - Prescriber Notification Form for GDR (Gradual Dose Reduction) signed by the Nurse Practitioner on 6/27/23, listed diagnoses of bipolar disorder, anxiety, dementia with behavioral disturbance, and major depressive disorder.</p> <p>During an interview on 7/24/24 at 10:15 AM, Staff H social worker, stated the clinical team reviews referral packets and the clinical nursing team advises him when a PASRR for Level II determination will be required.</p> <p>During an interview on 7/24/24 at 10:21 AM, Staff I DON indicated that diagnoses are reviewed and the MDS nurse will advise the social worker when a PASRR will need to be submitted.</p> <p>The Maximus PASRR manual dated 2/8/23 directs PASRR evaluations are referred to as Level II evaluations to distinguish them from their counterpart Level I screens; the Level I screen is a brief screen used to identify persons applying to or residing in Medicaid certified nursing homes that are subject to the Level II process. Once a person with a suspected or known diagnosis is identified through that screen, a Level II evaluation must be performed to determine whether the individual has special treatment needs associated with the MI and/ or ID/RC.</p> <p>(continued on next page)</p>

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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<p>F 0644</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>2. Resident #56 MDS assessment dated [DATE] identified a BIMS score of 2 indicating severe cognitive impairment. The MDS included diagnoses of atherosclerotic heart disease, coronary artery disease, hypertension, non-Alzheimer's dementia, and post-traumatic stress disorder.</p> <p>Resident #56 current PASRR Level 1 Screening Outcome dated 7/21/23 reflected a PASRR Level 1 Determination, No Level II required. The post-traumatic stress disorder diagnosis was not listed on the submitted form, which would trigger the need for a Level II PASRR to be submitted.</p> <p>A 7/24/24 review of the Point Click Care medical diagnosis list documented a diagnosis of post-traumatic stress disorder with an active diagnosis on 7/25/23.</p>		

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<p>F 0684</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide appropriate treatment and care according to orders, resident's preferences and goals.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 42133</p> <p>Based on observation, clinical record review, policy review and staff interview, the facility failed to properly secure medication and assess resident safety for medication administration for 1 of 1 residents sampled (Resident #53). The facility identified a census of 62 residents.</p> <p>Findings include:</p> <p>The Minimum Data Set (MDS) assessment dated [DATE] showed a Brief Interview for Mental Status (BIMS) score of 11 indicating moderate cognitive loss. The MDS listed a diagnosis of mild cognitive impairment of uncertain/unknown etiology.</p> <p>A review of the Order History Report signed by the Provider on 7/02/24 lacked physician orders to self-administer medications or orders for Pepto Bismol or vitamin D.</p> <p>A 7/23/24 review of Resident #53 Care Plan and Kardex lacked documentation Resident #53 could store and self-administer medications.</p> <p>During an observation on 7/23/24 at 10:23 AM Resident #53 lay in a low bed watching television. Observation at this time revealed, a half full bottle of Pepto Bismol and a half full bottle of vitamin D, 1000 international units (IU) on the second shelf of the residents double mirrored cabinet above his dresser. He reported he didn't think he had used the vitamin D in a while, but he verbalized when he has an upset stomach after eating, he comes back to his room and takes a few swigs of the Pepto and that does the trick. Resident #53 reported he needs that often.</p> <p>A 7/23/24 10:48 AM review of Resident #53 Point Click Care (PCC) Assessment tab in the electronic health record for the past 6-9 months lacked documentation of an assessment to self-administer medications.</p> <p>On 7/23/24 at 7/23/24 at 1:18 PM observed Resident #53 leave his room with the door open approximately one foot and walk up toward the dining room out of sight.</p> <p>During an observation on 7/23/24 at 1:31 PM the half full bottle of Pepto Bismol and the half full bottle of vitamin D remained on Resident #53 second shelf of his cabinet above his dresser.</p> <p>On 7/24/24 at 9:47 AM Staff B Licensed Practical Nurse (LPN) verbalized she hadn't seen any physician orders for any resident's to self-medicate on the electronic medication administration record. If she had any questions about medication in resident rooms, she would ask the Assistant Director of Nursing (ADON).</p> <p>On 7/24/24 at 9:57 AM Staff C CMA reported there are no residents that self-administer medications on the Woodlands hallway. If she found medication in a room, she would report to the Director of Nursing (DON) as she thought it would need to be assessed.</p> <p>(continued on next page)</p>		

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<p>F 0684</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Interview completed on 7/24/24 at 9:59 AM revealed Staff D Registered Nurse (RN) voiced the facility has an assessment form they complete. All bedside stands have a locked drawer on them. The resident, cognition wise, has to know when to take the medication, how often to take the medication, be able to write down when they take the medication, and how to keep the medication locked up. They get a physician order for the resident to have the medication at the bedside and the resident is assessed and has to demonstrate proper medication administration. Staff D verbalized she did not know where the medication self administration form was kept. After thinking further, she voiced she thought the assessment form was in PCC under assessments. Staff D checked and the Medication self-administration safety screen assessment form came up in PCC.</p> <p>During an observation on 7/24/24 at 10:02 AM Resident #53 room door observed open all the way approximately four feet. A half full bottle of Pepto Bismol and half bottle of vitamin D 1000 IU sat on the second shelf of his cabinet above his dresser. The sliding glass door of the cabinet was completely open. Staff D stood at the medication cart approximately 28 feet from Resident #53 room.</p> <p>On 7/24/24 at 10:11 AM Staff E ADON entered Resident #53 room to look for another resident and walked out of the room. Resident #53's room door remained wide open.</p> <p>During an interview on 7/24/24 at 10:27 AM Staff D reported Resident #53 went on a bus trip this morning and would be back a little later. Resident #53's room door remained wide open. The half full bottle of Pepto Bismol and half-full bottle of vitamin D 1000 IU sat on the second shelf of the cabinet above the dresser. The sliding glass door to the cabinet was wide open.</p> <p>Observation on 7/24/24 at approximately 11:05 AM revealed the facility bus returning from the morning outing. Resident #53 returned to his room.</p> <p>During an interview on 7/24/24 at 10:36 AM the DON reported they have not run into the situation where a resident wanted to self administer their own medications. She would have to look into what the facility policy entailed. She reported from her past experience, usually they have to get a physician order for the resident to keep the medications at their bedside, ensure the resident can keep the medication locked up and do assessments to ensure the resident is safe to administer the medication.</p> <p>On 7/24/24 at 12:22 PM Resident #53 door remained open approximately 10 inches. The half bottles of Pepto Bismol and vitamin D3 1000 IU remained on the second shelf of the residents cabinet above his dresser in clear view with the sliding glass door open. Resident #53 was out to lunch in the main dining room at this time.</p> <p>On 7/24/24 at 1:57 PM Staff G Certified Nursing Assistant (CNA) voiced she had never seen any medications in resident rooms that should not be there.</p> <p>During an interview on 7/25/24 at 8:41 AM the DON reported She didn't think Resident #53 would be safe to administer his own medication. The DON further verbalized it is typically more highlighted in the memory unit for residents not to have medications at the bedside. They don't do any formal training for staff to recognize and report on medications in resident rooms, but she would expect staff to report to the charge nurse if they saw medications in the resident's room (that was not administered by the nurse).</p> <p>(continued on next page)</p>		

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<p>F 0684</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>The Self-Administration of Medication Policy, revised 1/14/24 directed the following:</p> <ol style="list-style-type: none"> 1. As part of their overall evaluation, the staff and practitioner will assess the resident's mental and physical abilities to determine whether self-administering medications is clinically appropriate for the resident. 2. In addition to general evaluation of decision-making capacity, the staff and practitioner will perform a more specific skill assessment, including (but not limited to) the resident's: <ol style="list-style-type: none"> a. Ability to read and understand medication labels; b. Comprehension of the purpose and proper dosage and administration time for the medications. c. Ability to remove medications from container and to ingest and swallow (or otherwise administer) the medication; and d. Ability to recognize risks and major adverse consequences of the medications. 3. Self-Administered medications must be stored in a safe and secure place, which is not accessible by other residents. 4. Staff shall identify and give to the charge nurse any medications found at the bedside that are not authorized for self-administration, for return to the family or responsible party.

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<p>F 0689</p> <p>Level of Harm - Actual harm</p> <p>Residents Affected - Few</p>	<p>Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents.</p> <p>49698</p> <p>Based on clinical record review, facility documents, and staff interviews the facility failed to prevent accidents and hazards for 1 of 3 residents reviewed (Resident #41). The facility reported a census of 62 residents.</p> <p>Findings include:</p> <p>Review of the MDS (minimum data set) dated 5/2/24 revealed Resident #41, was non-verbal, had a BIMS (Brief Interview for Mental Status) score of 0, indicating the resident is rarely understood, and a cognitive pattern of 2, indicating moderately impaired (decisions poor; cues/supervision required). Resident #41 had diagnoses of Dementia with other behavioral disturbance, mood disturbance, and anxiety disturbance.</p> <p>Review of Resident #41's Care Plan, revision date 7/9/24, indicated resident had limited physical mobility, Resident #41 did not ambulate, ADL self-care performance deficit required two staff for all transfers and may use mechanical lift at nurses discretion.</p> <p>Review of a Progress Note dated 7/17/24 at 4:05 PM, Staff K, LPN, was called down to resident's room, on arrival he was found lying flat on the floor underneath the mechanical lift sling, which was still attached to the lift. Staff stated that he fell out of the sling backwards, the strap that goes on his left shoulder was off of the metal bars. Staff also stated that he had hit his head. Neurological assessment started, range of motion with in normal limits, skin was assessed and noted to have a skin tear to his left elbow. Resident was assisted x 3 with lift into bed. The doctor was notified and Nurse K was informed as long as there was no active bleeding, continue to monitor and send Resident #41 to ER if symptoms worsen. Resident's family and DON (Director of Nursing) were notified.</p> <p>Progress Note date 7/17/24 at 9:26 PM revealed, at 5:48 PM, Staff L, LPN, called the on call provider to informed them, Resident #41 was not using his left hand as he normally would, he was not able to feed self and he had a red spot on the back of his head. Resident #41's right pupil was reactive and sluggish measuring 3 mm and left pupil reactive and brisk measuring 3 mm. Per the provider, if the family agreed, the Staff L was to send Resident #41 the ER (emergency room) to be evaluated. At 5:55 PM, Staff L contacted Resident #41's family who indicated due to insurance and financial concerns not to send and make him comfortable, if any changes to his condition to notify the family. Staff L, notified the DON and Provider that Resident's family did not want him sent to ER at this time.</p> <p>Progress Note dated 7/18/24 at 3:33 PM, revealed Resident #41 was seen by Facility provider per nursing request following the incident 7/17/24. Resident #41 noted to have a hematoma on left side of his head and upper extremity discomfort. Facility provider was notified of family request not to send to ER. As needed order for ice received and continued with neuro assessments, pupils equal and reactive to light.</p> <p>(continued on next page)</p>		

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<p>F 0689</p> <p>Level of Harm - Actual harm</p> <p>Residents Affected - Few</p>	<p>Facility Provider Clinic Note, dated 7/18/24, revealed Resident #41 was reported to have an episode of emesis after breakfast this morning and was taken back to his room. He is resting quietly in his bed at the time of my assessment. I did press on all of his extremities and he cried out in pain with palpation to the left should and distal clavicle. He was also crying out in pain when I palpated left side of his head, with a moderate hematoma noted. Pupils equal, reactive. No active bleeding, no other significant bruising noted. No signs of increased discomfort in the lower extremities, hips, or pelvis. Would recommend further evaluation in the ER if any new changes or worsening in condition although this has been previously declined by Resident #41's Power Of Attorney as she prefers to monitor him and just keep him comfortable in the facility as able. I did also order a cold compress to be applied to the left shoulder and left scalp as needed three times daily for 20 minutes at a time.</p> <p>Progress Note dated 7/18/24 8:50 PM revealed, the author, DON, was updated on Resident #41's general demeanor change, he was difficult to arouse from waking, and screams out in pain with light palpation to left shoulder. He had emesis this AM and had been lethargic this shift, difficult to arouse and generally appears off his baseline cognitively, however difficult to assess due to resident being non-verbal. He was evaluated by Facility Provider with recommendation to evaluate at the ER, family declined ER evaluation at that time. This author (DON) called and Resident #41's family on 7/18/24 at 8:30 PM to update on Resident #41's current change in level of consciousness and intense pain to left shoulder. DON explained to family the indication to be seen in ER to qualify for hospice for palliative care support for pain management. Family confirms concerns with insurance and financial burden, DON assured family further financial burden will not occur due to ER visit. Family verbally gave consent to sent Resident #41 via ambulance to ER to be evaluated.</p> <p>Progress Note dated 7/18/2024 at 9:46 PM revealed, family was in agreement to send Resident #41 out to ER due to resident noted to be sluggish when responding to this nurse and yelling out in pain when touched on left side. Paper work completed and ambulance called at 9:43 PM for ambulance. Ambulance arrived at 10:05 PM, resident was assisted to stretcher and left accompanied with 2 EMT's.</p> <p>Progress Note dated 7/19/2024 12:00 AM, indicated call was received from ER, Resident #41 was discharged , X-ray of left should revealed no fracture, some separation of the ac joint.</p> <p>Review of Incident Report dated 7/17/24 at 1:15 PM, revealed the following:</p> <p>A.) On 7/17/24 the mechanical lift and sling was inspected by DON without issues. Root cause determined the left shoulder strap was not hooked into mechanism completely and gave away.</p> <p>B.) On 7/17/24 Education was provided to staff, competencies performed with no concerns.</p> <p>C.) On 7/19/24 Resident #41 was evaluated in ER, diagnosed with AC separation.</p> <p>Witness Statement dated 7/17/24, Staff N, CNA, stated Staff M, CMA and I hooked up mechanical lift to transfer Resident #41 as Staff N controlled the lift, I, Staff N, CNA, was behind Resident #41's chair. Once Resident #41 was lifted to clear the chair, I (Staff N, CNA) proceeded to pull the chair back and in the process of doing so, Resident #41 began to fall from the sling onto the floor, that's when I (Staff N, CNA) stepped out of the room and called for the nurse.</p> <p>(continued on next page)</p>		

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<p>F 0689</p> <p>Level of Harm - Actual harm</p> <p>Residents Affected - Few</p>	<p>Witness Statement dated 7/17/24, Staff M, CMA, stated Staff N, CNA and I went and hooked up Resident #41 to transfer into bed, I (Staff M, CMA) was operating the lift, as the lift was going up in the air I checked to make sure the straps were still attached and getting tight, went to turn him around and Staff N, CNA, moved the chair out of the way and I saw the strap dropped down and he fell to his left side, hitting his head on the floor and right leg was still in the lift when he landed. I (Staff M, CMA) yelled for the nurse to come to room and sit next to Resident #41 and try to reassure him it was going to be okay.</p> <p>Review of Major Injury Determination Form dated and signed 7/17/24 at 1:15 PM, indicated by Facility Provider, after reviewing circumstances, injury and prognosis of patient, the injury Resident #41 sustained was not a major injury.</p> <p>Hoyer lift Transfer Training Education, signed by attended staff, dated 4/12/24 at 2:00 PM, indicated the following:</p> <ol style="list-style-type: none"> 1.) Inspect mechanical lift prior to use- any concerns? [NAME] tip guards in place? Report to DON and maintenance if missing. 2.) Inspect lift sling prior to use- correct size per resident's weight? Any wear on straps? Report to DON and maintenance if so. 3.) 2 nursing staff must be present at all times during mechanical lift transfers: CNAs, Med Aides, LPNs, RNs only- no dietary/housekeeping/maintenance staff. 4.) 1 nursing staff to run lift, while paying attention to resident's arms (inside sling at all times) and legs to prevent feet from bumping mechanical lift. 5.) 2nd staff to have at least 1 hand on resident at all times, guiding body and pulling back/adjusting as necessary to prevent foot contact with mechanical lift. 6.) 2nd staff must not be preparing bed/room/linens etc. during transfer. 7.) When in wheelchair, remove mechanical lift sling and tuck away to prevent skin breakdown on appropriate residents. (per care plans) Those unable to completely remove, tuck leg straps in and pull top straps around to maintain dignity. 8.) Our current fall protocol states to use the mechanical lift whenever a resident has fallen and need assist up. If resident is able to get up on own, mechanical lift not needed, but they must be able to do 100% themselves. <p>Competency Testing of Hoyer (mechanical lift) completed by Staff M, CMA, Staff N, CNA, and other nursing staff on 7/17/24 indicated the following steps during mechanical lift transfer procedure:</p> <p>Step 10: The caregiver ensure loops to be hooked up to the lift are uniform.</p> <p>Step 11: Both caregivers agree the clips and loops are secured to the lift and in proper position prior to moving the resident and the resident is safely positioned in the sling.</p> <p>(continued on next page)</p>		

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<p>F 0689</p> <p>Level of Harm - Actual harm</p> <p>Residents Affected - Few</p>	<p>Step 12: The lead uses the controls to raise the resident. The helper assures the sling is secured and may need to hold the resident's head.</p> <p>Interview with Staff M, CMA on 7/25/24 at 9:34 AM, revealed Staff M, CMA, hooked up Resident #41 to mechanical lift, as the operator, she always watches as the residents go up, watching that all straps go up together, guiding Resident #41's legs to rotate into the right position, then she noticed the top strap slipped off and resident fell down to his left side, hitting his head on the floor. Staff M, CMA stated there are always two staff when transferring residents by mechanical lift. Training was received for mechanical lift transfers following the incident.</p> <p>Interview with Staff O, CNA, on 7/25/24 at 9:37 AM, indicated CNAs/CMAs had received mechanical lift training and competency testing a week ago.</p> <p>Interview with Staff J, RN Supervisor on 7/25/24 at 10:47 AM, revealed Staff J would expect to have 2 staff members during mechanical lift transfer and perform the set up and transfer according to the training guidelines including making sure straps are secured. One staff is to run controls and watch the sling and mechanical lift while the other is to guide and move the resident as little as possible while moving the mechanical lift to the transfer location.</p>		

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<p>F 0800</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Provide each resident with a nourishing, palatable, well-balanced diet that meets his or her daily nutritional and special dietary needs.</p> <p>41537</p> <p>Based on observation, staff interview, and policy review the facility failed to ensure 10 of 10 residents received a well-balanced diet that met their nutritional needs. The facility reported a census of 62 residents.</p> <p>Findings include:</p> <p>During an observation on 7/24/23 at 11:00 AM - 11:45 AM of the puree process for chicken sandwiches revealed the following:</p> <p>Staff F, Cook, had ten (10) cooked and breaded chicken patties in a large mixer that was being ground, Staff F added in chicken broth and milk to get to proper consistency. Staff F, decided the consistency was about correct and was going to transfer into a serving dish to serve. The Surveyor intervened and asked if the buns have been added to the pureed chicken and Staff F informed they had not been and went and proceeded to add three (3) buns to the pureed chicken, and continued the process, Staff F was checking consistency and about ready to remove to serve and the Surveyor intervened again and informed that if there are ten (10) servings of chicken there would need to also be ten (10) buns to ensure residents get the same amount of calories as a non-pureed diet would get one (1) patty and one (1) bun to make a sandwich. Staff F then proceeded to add seven (7) more buns. Staff F, finished mixing and was going to transfer into the serving dish without measuring the pureed food. The Surveyor intervened asking what their process was for measuring to ensure correct portions are served for all ten (10) residents and Staff F was not sure, Staff F then utilized resources found in the kitchen to ensure accurate portions were given to all ten (10) residents</p> <p>During non meal food service observation on 7/24/23. The facility provided accurate portions to puree residents.</p> <p>During an interview with Staff J, Registered Nurse (RN) Supervisor on 7/25/24 at 10:15 AM revealed he would expect puree diets to get the same amount of food as non pureed diet residents.</p> <p>Review of the facility policy, Therapeutic Diets, dated 7/1/24 lacked instruction to staff on the process of how to complete the puree process and ensure, puree diet residents get the same portions as regular diets.</p>		

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
<p>F 0801</p> <p>Level of Harm - Potential for minimal harm</p> <p>Residents Affected - Many</p>	<p>Employ sufficient staff with the appropriate competencies and skills sets to carry out the functions of the food and nutrition service, including a qualified dietician.</p> <p>41537</p> <p>Based on record review, staff interviews, and job description review the facility failed to have a qualified professional serve as the Dietary Manager. The facility reported a census of 62 residents.</p> <p>Findings include:</p> <p>Record review of the Dietary Managers employee file on 7/23/24 lacked documentation they had completed a state approved food service supervisor's course as required.</p> <p>During an interview with Staff J, Registered Nurse (RN) Supervisor on 7/25/24 at 10:15 AM revealed the Dietary Manager had been employed by the facility since roughly February, 2024 and did not have a state approved food service supervisor's course completed.</p> <p>Record review of the the facilities Job Description for Dietary Managers updated 7/24/24 instructed they are to complete a state approved food service supervisor's course.</p>

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 165178	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 07/25/2024
NAME OF PROVIDER OR SUPPLIER Aase Haugen Home		STREET ADDRESS, CITY, STATE, ZIP CODE Four Ohio Street Decorah, IA 52101	
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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)		
<p>F 0802</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Provide sufficient support personnel to safely and effectively carry out the functions of the food and nutrition service.</p> <p>41537</p> <p>Based on record review, staff interviews, and policy review the facility failed to have a qualified and educated dietary staff provide food service to residents. The facility reported a census of 62 residents.</p> <p>Findings include:</p> <p>Record review of an untitled and undated document provided by the facility instructed meal times are:</p> <p>Breakfast 7:30 AM</p> <p>Lunch 11:30 AM</p> <p>Supper 5:00 PM</p> <p>During an observation on 7/22/24, noon meal service started in the dinning room at 12:04 PM and was completed at 12:40 PM.</p> <p>During an observation on 7/24/24, noon meal service in the dinning room started at 12:02 PM and completed at 12:45 PM.</p> <p>Record review of the the facilities Job Description for [NAME] updated 7/24/24 instructed requirements for completion of a state approved safety and sanitation, and modified diet courses.</p> <p>Record review of the the facilities Job Description for [NAME] updated 7/24/24 instructed requirements for completion of a state approved safety and sanitation course.</p> <p>During an interview on 7/24/23 at 11:45 PM with Staff F, Cook, revealed he has been trained on different types of diets and how to prepare them.</p> <p>During an interview with Staff J, Registered Nurse (RN) Supervisor on 7/25/24 at 10:15 AM revealed no Dietary staff have food service training completed for safety and sanitization course or modified diets.</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 165178	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 07/25/2024
NAME OF PROVIDER OR SUPPLIER Aase Haugen Home		STREET ADDRESS, CITY, STATE, ZIP CODE Four Ohio Street Decorah, IA 52101	
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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)		
<p>F 0812</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards.</p> <p>41537</p> <p>Based on observation, staff interviews, and policy review the facility failed to ensure during meal service, ready to eat food was not touched by contaminated gloves for multiple residents that were served chicken sandwiches. The facility reported a census of 62 residents.</p> <p>Findings include:</p> <p>During intermittent observations of meal service on 7/24/24 at 12:05 PM to 12:32 PM revealed Staff F, [NAME] put on gloves and touched multiple surface items including handles, trays, counter tops, his clothing, his arm, serving utensils, exterior portion of bread bags and would precede to touch sandwich buns with the same gloves.</p> <p>The facility provided an undated policy, Dietary Sanitary Conditions that lacked instruction to staff on when gloves should be worn, but did instruct staff to complete good hand washing prior to preparing, serving, and distributing food.</p> <p>During an interview with Staff J, Registered Nurse (RN) Supervisor on 7/25/24 at 10:15 AM revealed he had instructed staff to remove gloves and wash their hands when in doubt.</p>		