

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 165198	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 07/18/2024
NAME OF PROVIDER OR SUPPLIER Iowa City Rehab & Health Care		STREET ADDRESS, CITY, STATE, ZIP CODE 3661 Rochester Avenue Iowa City, IA 52245	

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 0550</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Honor the resident's right to a dignified existence, self-determination, communication, and to exercise his or her rights.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 42133</p> <p>Based on observation, interview, policy review, and staff interview the facility failed to uphold resident rights and dignity for 1 of 1 residents reviewed on hospice care. The facility identified a census of 46 residents.</p> <p>Findings include:</p> <p>Resident #17 Minimum Data Set (MDS) assessment dated [DATE] showed a Brief Interview for Mental Status (BIMS) score of 1 out of 15 indicating severe cognitive loss. The Resident required substantial to maximal assistance (the helper does more than half the effort. The helper lifts or holds trunk or limbs and provides more than half the effort) for eating (ability to use suitable utensils to bring food and/or liquid to the mouth and swallow food and/or liquid one the meal is placed before the resident). The MDS documented diagnoses of cerebrovascular accident (CVA) with hemiparesis (a condition that causes partial paralysis or weakness on one side of the body), generalized muscle weakness, cognitive communication deficit, and the presence of hospice care services.</p> <p>The Care Plan revised 6/03/24 documented Resident #17 with a terminal prognosis related to muscular dystrophy, prostate cancer, and chronic comorbidities. The Care Plan directed the staff to adjust the provision of activities of daily living (ADL's) to compensate for the Resident's changing abilities. The Care Plan noted Resident #17 as alert and oriented with a high risk for altered nutrition related to multiple comorbidities.</p> <p>A 7/16/24 review of Resident #17's Kardex directed the following:</p> <ol style="list-style-type: none"> a. Resident #17 could eat independently and occasionally needed assist with containers or set up. b. Encourage the Resident to drink fluids of choice. c. Provide a carbohydrate-controlled diet, regular texture, thin liquid diet as ordered. Monitor intake, record every meal and ensure the Resident is sitting upright for meal intake. <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 0550</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>d. Use communication techniques which enhance interaction: allow adequate time to respond, repeat as necessary; do not rush; request feedback; clarification from the resident to ensure understanding; face when speaking and make eye contact; turn off the television/radio as needed to reduce environmental noise; ask yes/no questions if appropriate; use simple, brief, consistent words/cues; use alternative communication tools as needed such as a communication book/board, writing pad, gestures, signs and pictures; use task segmentation to support short term memory deficits.</p> <p>e. Provide a homelike environment and maintain his comfort.</p> <p>During an observation on 7/16/24 at 11:44 AM the Surveyor watched from the resident's open doorway as Staff L Certified Nursing Assistant (CNA) talked on her personal cell phone as she assisted Resident #17 with his lunch meal. Staff L immediately tried to conceal her cell phone when the surveyor knocked on the door. Staff L verbalized she was sorry for being on her cell phone, but it was a family emergency. Her mother was ill and she had only worked at the facility a few days. Staff L did not express any emotion or crying only startled and tried to hide her phone. Resident #17 observed eating each bite of food without choking or swallowing issues.</p> <p>On 7/17/24 at 3:59 PM Staff M, CNA reported personal cell phones are to be used only at break-time.</p> <p>On 7/17/24 at 4:01 PM Staff C, RN reported personal cell phones for personal phone calls should only be used at break-time per the facility policy.</p> <p>A 7/18/24 review of Staff L's New Hire Task List showed she electronically submitted a signed copy of the Wireless Device Policy on 6/28/24 at 4:51 PM to the facility.</p> <p>During an interview on 7/17/24 at 4:05 PM the DON reported staff are not supposed to use their personal phones for personal calls unless they are on break.</p> <p>The Resident Rights and Responsibilities Policy, dated 2/15, provided by the facility directed the facility strives to assure that each resident/patient has a dignified existence, self-determination, and communication with, and access to, persons and services inside and outside the center. Each resident/patient and/or family/responsible party will be presented with a copy of the Federal and State-Specific Resident Rights upon admission and as requested during stay.</p> <p>The Nursing Home Resident's Rights documented Residents of nursing homes have rights that are guaranteed by the federal Nursing Home Reform Law. The Law requires nursing homes to promote the rights of each resident and stresses individual dignity and self-determination. The Document stated residents have the right to a dignified existence to be treated with consideration, respect, and dignity recognizing each resident's individuality.</p> <p>The Wireless Mobile Device Policy dated 7/1/15 directed personal use of internal communication system is only permitted during non-working time (i.e. breaks, lunch periods, etc.) and should be kept to a minimum.</p>		

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<p>F 0658</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Ensure services provided by the nursing facility meet professional standards of quality.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 44972</p> <p>Based on observation, record review, staff and resident interviews, and policy review, the facility failed to provide services that met professional standard regarding medication administration and following physician orders for 2 of 9 residents reviewed (Resident #31 and #32). Staff failed to monitor and stay with residents who did not have an order for self-medications to ensure the medications were taken as ordered. The facility reported a census of 46 residents.</p> <p>Findings include:</p> <p>1. The Minimum Data Set (MDS) assessment dated [DATE] documented Resident #31 had a Brief Interview for Mental Status (BIMS) score of 8 indicating moderate cognitive impairment. The MDS further documented the resident had diagnoses including cerebral infarction, cognitive communication deficit, and dysphagia.</p> <p>In an observation on 7/15/24 at 11:35 AM, a medication cup with 2 white tablets was noted on Resident #31's bedside table. Resident #31 reported the medication was Tylenol. Resident #31 reported the staff thought she was going to take them, but she planned to hold on to them and take them later.</p> <p>A review of Resident #31 medication administration record (MAR), noted the resident had an order for acetaminophen (Tylenol) 325 milligrams (mg) tablets, give 650 mg three times a day for pain. The lunch dose of medication was signed as given for 7/15/24 by Staff I, Licensed Practical Nurse (LPN).</p> <p>In an interview on 7/17/24 at 9:58 AM, Staff J, Certified Medication Aide (CMA), reported on 7/16/24 shortly after getting to work at 6:00 AM, she noted a medication cup with several pills in it setting on Resident #31's bedside table unattended. She reported the medications were removed from the resident's room and discarded.</p> <p>Review of the physician orders did not indicate an order for self-medication administration for Resident #31.</p> <p>2. The MDS assessment dated [DATE] documented Resident #32 had a BIMS score of 9 indicating moderate cognitive impairment. The MDS further documented the resident had diagnoses including obstructive hypertrophic cardiomyopathy, psychoactive substance dependence, cognitive communication deficit, dysphagia, major depressive disorder, anxiety disorder, opioid dependence, Type II diabetes mellitus, and cerebral infarction.</p> <p>In an interview on 7/17/24 at 9:58 AM, Staff J, CMA reported on 7/16/24 shortly after getting to work at 6:00 AM, she noted a medication cup with several pills in it setting on Resident #32's bedside table unattended. She reported she knew one of the medications in the cup was Gabapentin but could not identify any of the other medications. She reported the medications were removed from the room and discarded.</p> <p>Review of the physician orders did not indicate an order for self-medication administration for Resident #32.</p> <p>(continued on next page)</p>		

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<p>F 0658</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>In an interview on 7/17/24 at 3:48 PM, the Acting Director of Nursing (DON) stated it was the expectation medications not be left in a resident's room unattended. The medication staff were to watch the resident take the medications and if the resident declined the medication at the time, the staff were to remove the medications from the room.</p> <p>A facility provided policy titled Medication Administration dated 1/13, stated the medication staff were to remain with the resident/patient until all medication were taken.</p>

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<p>F 0689</p> <p>Level of Harm - Minimal harm or potential for 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>**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 protect a resident from hazards in the environment for 1 of 1 resident sampled when Resident #4 acquired first degree burns from spilt coffee and failed to ensure a resident was properly assessed to be independent to smoke, followed the facility smoking policy and discarded cigarette butts into a proper receptacle (Resident #28). The facility identified a census of 46 residents.</p> <p>Findings include:</p> <p>1. Resident #4 Minimum Data Set (MDS) assessment dated [DATE] showed a Brief Interview for Mental Status (BIMS) score of 2 indicating a severe cognitive impairment. The resident exhibited inattention (being easily distractible/difficulty keeping on track of what is said) that fluctuated; continuously present disorganized thinking (rambling or irrelevant conversation, unclear, illogical flow of ideas, or unpredictable switching from subject to subject); delusions; physical behavioral symptoms directed toward others (e.g., hitting, kicking, pushing, scratching, grabbing) 1-3 days per week. The MDS documented diagnoses of Non-Alzheimer's dementia, muscle weakness, and directed the resident required supervision/touch assistance (the helper provides verbal cues and/or touching/steadying and/or contact guard assistance as resident completes the activity. Assistance may be provided throughout the activity or intermittently) with eating (the ability to use suitable utensils to bring food and/or liquid to the mouth and swallow food and/or liquid once the meal is placed before the resident).</p> <p>The Care Plan dated 3/04/24 documented Resident #4 with a potential for a nutritional problem related to a past medical history of dementia. The Care Plan also noted Resident #4 with a behavior problem and a history of being physically aggressive toward other residents. The Care Plan lacked direction to the staff on the amount of meal assistance and supervision the resident required.</p> <p>A 7/11/24 7:03 AM Incident Report documented Resident #4 was rushed back to her room from the dining room. The aide reported the resident had poured a cup of hot coffee on her chest. The resident wore a shirt and sweater at the time. The (chest) area is red, warm to touch, dry smooth and even. No swelling noted. The Immediate Action Taken showed the nurse and aide took off the resident's clothes, washed the area with cold water and placed cold wash clothes to the area. Vital signs were assessed. Tylenol was administered. The Incident Report documented the injury type as a burn to the chest. The Incident Report noted confusion as a predisposing physiological factor to the incident.</p> <p>On 7/15/24 at 11:27 AM Dietary Staff provided the lunch meal to Resident #4 on a bedside table set up by the South nurse station. Four staff members were in the areas, (three certified nursing assistants (CNAs) and a nurse who sat behind the nurse's desk. The staff went up and down the hallways delivering the room trays and periodically came back to encouraged Resident #4 to eat, but did not actually sit down with the resident to provide any supervision/touch assistance. The resident did not have any liquids in lidded mugs.</p> <p>A 7/16/24 7:00 AM review of the Care Plan and the Kardex lacked any updates on meal assistance, supervision or any new interventions to prevent the resident from spilling hot coffee again.</p> <p>(continued on next page)</p>		

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<p>F 0689</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Observation on 7/16/24 at approximately 7:30 AM revealed the Administrator asked Resident #4 if she would like to come spend time with her. Resident #4 responded yes and started to propel her wheelchair following the Administrator. The Administrator asked her if she would like to have a cup of coffee.</p> <p>Observation the morning of 7/16/24 revealed Resident #4 eating breakfast in the Administrator's office under the supervision of the nurse consultant. The resident did not have any of her fluids in cups with lids.</p> <p>During an observation on 7/16/24 at 11:39 AM Resident #4 sat in the wheelchair eating lunch in the Assistant Director of Nursing (ADON) Office with the ADON. Resident #4 had lemonade and milk provided on her meal tray.</p> <p>During an interview on 7/16/24 at 1:36 PM, Staff G, Certified Medication Aide (CMA) reported she was passing medications on the morning of 7/11/24. She explained Resident #4 always has the shakes and jerking type movements in her arms/hands when she first gets up in the morning for about 30 minutes. She just jerks and spasms. Staff G didn't know if her brain needed to catch up after she wakes up or something. Everyone knows she has these shaking movements. Resident #4 sat in her wheelchair with her stuffed animal cat and started to propel her wheelchair up the hallway by the medication room. Staff H, Certified Nursing Assessment (CNA) came up the hallway from the kitchen carrying a cup of coffee in a brown plastic coffee mug. She saw Staff H give Resident #4 the cup of coffee and Resident #4 had the shakes and the hot coffee went all over her chest. Resident #4 started screaming bloody murder four times. She assumed there was no lid on it or if there was a lid it came off and spilled all over her chest. Staff H tried dabbing the resident's shirt and held the resident's shirt away from her skin. Staff H took the resident back to her room and reported the incident to Staff C, Registered Nurse (RN). Staff G verbalized if she is on the resident's hallway, she always makes sure not to give her anything to drink first think in the morning as the Resident will spill it all over herself. Staff G didn't feel the resident needed supervision to eat and drink. She needed more eyes on her for her behaviors. The resident had always been able to eat and drink herself but had recently been to the hospital for a urinary tract infection (UTI).</p> <p>On 7/16/24 at 2:13 PM Staff H, explained that Resident #4 had Alzheimer's Disease. Her synopsis (brain) doesn't fire right in the morning and she is very jerky before she gets her medications. Staff H recalled she got the resident up and transferred to the wheelchair that morning. She convinced her to come out of her room to the area where she usually eats breakfast. Usually by the time she gets up she can have breakfast and drink her coffee. She reported she went to the kitchen and got a cup of coffee for Resident #4. She handed the cup of coffee to Resident #4 and told her to steady the cup, almost immediately the resident's arm/hand twitched and she dumped the hot coffee down the front of her shirt. Staff H reported she tried to pull the resident's shirt out away from her skin and tuck her own uniform top under the Resident's shirt to try to pad between the resident's shirt and body. She took the Resident back to her room. She removed the Resident's shirt and placed cool wash clothes to her chest and went to get the nurse. She placed cool compresses on the Resident three times and then the Resident finally calmed down. She reported she didn't think the resident had spilled liquids prior to the incident. There were always people around. She eats in a hot spot of traffic so there are always eyes on her. Staff H verbalized she definitely would not give her hot coffee again. Since that time, she learned other aides put ice in the Resident's coffee to cool her coffee prior to giving the coffee to the Resident. As far as she knew the Resident ate and drank on her own since she returned from the hospital. She reported there was no lid on the cup of coffee that morning.</p> <p>(continued on next page)</p>		

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<p>F 0689</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>On 7/16/24 at 2:47 PM Staff C reported Resident #4 received burns from spilling hot coffee on herself. Staff H got the resident ready for the day and brought her out to the kitchen to get her some coffee. She did not see the incident. Resident #4 would start shaking her arms and then would just stop. Staff H told her the Resident had poured coffee on herself. She had burns on her right upper chest and below the sternum. The skin was reddened with no blisters. She had contacted the Provider and got an order to start Silvadene cream. Staff C commented she had not seen Resident #4 spilling liquids prior to this incident, but the resident did have behaviors and would throw liquids at staff and potentially other residents.</p> <p>During an interview on 7/17/24 at 7:20 AM the ADON reported the team had discussed providing a coffee cup with a lid for Resident #4. She stated the Dietary Supervisor was going to check to see if they had the lidded two handled cups and if not, he would order the cups in. She verbalized she needed to follow up with the Dietary Supervisor regarding the cups.</p> <p>On 7/17/24 at 7:21 AM the Surveyor followed the ADON to the kitchen. The Dietary Supervisor reported he had not been told that Resident #4 needed a covered cup for her coffee. The Dietary Supervisor reported they did have the two handled lidded mugs for Resident #4 to use and he would have to update her dining slip as the covered mugs were not on her Dietary Slip.</p> <p>A 7/17/24 7:30 AM review of Resident #4 Dietary Slip on her breakfast tray, reviewed with the ADON, lacked documentation or direction to the staff to utilize a cup with a lid for hot liquids.</p> <p>On 7/17/24 at 7:26 AM Staff G reported Resident #4 was noted to have the shaking and jerky movements when she gets up in the morning. She verbalized she has never seen Resident #4 use a covered mug for her coffee. She reported it would be a good idea to use a covered mug for her safety.</p> <p>During an observation on 7/17/24 at 7:30 AM the ADON served the resident her breakfast tray in the Social Service office with the coffee in a two handled cup with a lid.</p> <p>On 7/17/24 at 7:49 AM the Dietary Supervisor reported he felt bad but he had not been notified that Resident #4 needed covered mug for her coffee. She had not used any covered mugs up until today (7/17/24).</p> <p>On 7/17/24 at 7:32 AM the ADON reported Resident #3, #10, #17, #23, and #42 all require similar assistance to Resident #4.</p> <p>During an interview on 7/17/24 at 7:37 AM Staff C, RN reported Resident #4 had behaviors all the time. She has dumped fluids on herself and thrown fluids at others when she had been mad. She reported she does shake first thing in the morning. She has not been using a cup with a lid on it since the incident with the coffee. She verbalized the use of a lidded up would make it safer for her.</p> <p>(continued on next page)</p>

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<p>F 0689</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>On 7/17/24 at 1:49 PM Staff H reported Resident #4 takes about a half hour to get dressed and up into the wheelchair. She is usually pretty good by that time of the morning. When she spilled the coffee that morning, she spilled the entire full cup of coffee down the right side of her shirt. The right side of her shirt was saturated with the hot coffee. She reported when the nurse came in to assess her, Resident #4 had a 4 inch by 1.5 inch area of redness on her chest above her right breast. Staff H explained the Resident had been seated in her wheel chair across from the medication room. She had gone to the kitchen to get her a cup of coffee (approximately 25 feet to the kitchen and back). She took Resident #4's stuffed cat from her and handed her the brown coffee cup and told her to steady it. The Surveyor recreated the scenario walking 25 feet to the kitchen, getting a cup of coffee and walking 25 feet back to where the resident was sitting. At that time the cups of coffee from the kitchen temped at 156.5 degrees.</p> <p>During an interview on 7/17/24 at 4:10 PM the Administrator and DON reported they had not reviewed any other residents that could be at a risk of spilling hot fluids as part of the review of Resident #4's incident. The Administrator reported she expects staff will report in any change of condition that could result in an unsafe situation so therapy services can be set up.</p> <p>The facility failed to identify Resident #4 could be at risk of burning herself with hot liquids, posed a risk to other residents, and failed to timely place an intervention to ensure her safety and the safety of other residents.</p> <p>The Dining Services Policy, dated 6/2015, directed the staff to provide the residents with assistive devices as required.</p> <p>The Incident/Accident Management Policy, reviewed 11/19, included directed incident/accident identification and reporting are the responsibility of all employees of the facility.</p> <p>2. Resident #28 MDS assessment dated [DATE] showed a BIMS score of 14 indicating intact cognition. The MDS documented Resident #28 with functional impairment of the bilateral upper and lower extremities and utilized a wheelchair. The MDS further documented Resident #28 as dependent upon staff for bed to chair transfers and independent in propelling his wheelchair. The MDS listed diagnoses of traumatic brain injury, paraplegia, muscle wasting, and atrophy. The MDS noted the use of tobacco and listed a diagnosis of nicotine dependence.</p> <p>A review of the Smoking: Resident/Patient Overview Policy, revised 2019 documented the facility provides safe, designated smoking areas for residents who smoke. Smoking is prohibited in any resident rooms, or outside the designated smoking areas. Approved, non-combustible ashtrays are provided in the designated smoking areas. Smoking may not occur within 20 feet of an exit or entrance to the facility (or as specified by state requirements). Residents who smoke will be evaluated for smoking and level of independence. Smoking materials will be secured by the facility. Residents that are assessed as unsafe to smoke with reasonable accommodations or those who fail to adhere to the smoking policy, will not be allowed to smoke. Residents that fail to follow the smoking policy will be re-educated. Review showed Resident #28 refused to sign the Smoking Overview Policy on 2/08/24.</p> <p>The Smoking Data Collection assessment dated [DATE] documented the following:</p> <p>a. Does the resident have impaired decision making/judgement? Yes.</p> <p>(continued on next page)</p>		

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<p>F 0689</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>b. Does the resident have impaired short/long term memory? Yes.</p> <p>c. Is the resident aware of safety needs of self/others, i.e. communicate the need for help if lit material falls on them? No.</p> <p>d. Can resident light his own cigarette safely? Yes.</p> <p>e. Does the resident consistently and appropriately use an ashtray to manage ashes and self-extinguish cigarettes? Yes.</p> <p>f. Identify any history of smoking related incident. Resident smoked in bed/room.</p> <p>g. No accommodation required for resident to smoke.</p> <p>h. Resident instructed in facility policies including areas, times and storage of smoking supplies. State understanding? Yes.</p> <p>i. Based on the collected data, does the resident demonstrate safe smoking? Yes.</p> <p>j. Based on the data collected, the resident is granted smoking privileges under the following circumstances: independent, does not require staff supervision.</p> <p>k. Smoking policy has been reviewed with the resident and/or resident representative and understanding has been verbalized? Yes.</p> <p>The Care Plan revised 3/19/24 directed the resident had behavior problems related to hallucinations (a sensory experience that occurs when someone senses something that isn't there, such as a sight, sound, smell, touch, or taste) and delusions (fixed false beliefs that are not based in reality and are not shared by others in the same culture, religion, or social group) and directed the staff to provide 1:1 with staff when he was out of bed as of 3/18/24. The Care Plan also documented Resident #28 as a smoker and directed staff in the following:</p> <p>a. Know that the resident has a history of smoking in his room. Staff to intervene and remind resident that it is not allowed.</p> <p>b. Know that the resident is often non-compliant with the smoking policy and has been seen smoking in undesignated smoking areas during undesignated smoking times. Staff to attempt to intervene, redirect and educate.</p> <p>c. Know that the resident smokes out in front of the building. Remind the resident to sign out prior to going outside to smoke.</p> <p>d. Observe the resident for evidence of safe smoking compliance.</p> <p>e. Provide resident education on the facility policy and procedure related to smoking materials.</p> <p>f. Remind the resident of smoking times and location.</p> <p>(continued on next page)</p>

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NAME OF PROVIDER OR SUPPLIER Iowa City Rehab & Health Care		STREET ADDRESS, CITY, STATE, ZIP CODE 3661 Rochester Avenue Iowa City, IA 52245	
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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<p>F 0689</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>g. Smoking materials are to be kept inside his smoking material compartment that he has a key to within the smoking material locker.</p> <p>h. The Resident is able to safely smoke independently.</p> <p>On 7/15/24 at 1:18 PM Staff G assisted the resident via wheelchair out the front doors of the facility to sit in his wheelchair to smoke. Resident #28 removed a cigarette from the box and lit the cigarette himself. Staff G and the hospice nurse supervised the resident while outside the facility. Further observation revealed cigarette butts in the driveway in the area the resident sat in the wheelchair approximately 6-8 feet from the front entrance of the facility.</p> <p>During an interview on 7/15/24 at 1:22 PM Staff F reported Resident #28 is supposed to sign himself out before he goes out front to smoke, but he is to be on 1:1 due to behaviors. She reported he is outside with the hospice nurse right now.</p> <p>A 7/15/24 review of the Release of Responsibility for Leave of Absence Sheet for Resident #28 showed he had not signed out of the facility since 7/12/24 at 12:50 PM.</p> <p>Observation on 7/15/24 at 1:38 PM revealed Resident #28 seated in the wheelchair approximately three feet in the drive way to the right of the entrance doors under the facility canopy smoking, 10 feet from where an ambulance pulled in at approximately 1:30 PM. Staff had to assist the resident to move for the ambulance to pull through.</p> <p>On 7/15/24 at 4:09 PM Resident #28 reported he had made some colorful remarks to another resident out in the pavilion (designated smoking area), so now he is to go out front to smoke.</p> <p>On 7/16/24 at 10:15 AM Staff M, Physical Therapy explained that the independent smokers have keys on lanyards and they store their cigarettes in a clear locked bin on the wall in the East dining room. They can access their cigarettes to smoke at their leisure and then they are to return them to the lock box when they are finished. The designated smoking area is right outside the East dining room.</p> <p>A 7/16/24 review of the Kardex directed the staff to ensure he wore appropriate clothing outside to smoke; remind of smoking times and locations; assist the resident in his wheelchair out to take smoke breaks and smoking materials were to be kept inside his smoking material compartment that he has a key to within the smoking material locker.</p> <p>During an interview on 7/16/24 at 1:44 PM Staff G, CNA verbalized Resident #28 keeps his cigarettes in his locked backpack. He does not put his cigarettes back in the required lock box even though he has his own key and lockbox that is supposed to put his cigarettes in. She has seen his cigarettes in his backpack. He does what he wants to do. It is not fair that other residents have to follow the rules and he just gets to do whatever he wants. He has the Administrator wound around his finger. He doesn't get along with other residents, so he goes out front of the building to smoke. It is not a designated smoking area, but according to the Long-Term Care Ombudsman, he has the right to go outside and smoke wherever he wants to. He will keep doing what he does until someone puts their foot down. When he is with a staff member, he does not have to sign out of the facility to go smoke, but if he goes out alone he has to sign out of the facility. He is 1:1 supervision now due to behaviors.</p> <p>(continued on next page)</p>		

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<p>F 0689</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>On 7/16/24 at 2:24 PM Staff H, CNA reported he is his own person, if he goes out front and he is not around other residents then he doesn't need to be 1:1 (supervision). If he goes back to the smoking area he has to be more 1:1 as he argues with other residents. He stated he can sign himself out and go smoke out front on his own so he just started doing that. She reported she thought the front area was a designated smoking area as there is a covered ash tray receptacle out front.</p> <p>During an observation at 7/16/24 at 4:45 PM Resident #28 sat in the wheelchair approximately six feet off the front door under the canopy smoking with staff present.</p> <p>During an interview on 7/17/24 at 8:31 AM Staff F, CNA reported the front area under the canopy is not a designated smoking area where Resident #28 smokes. She stated Resident #28 doesn't get along with anyone which is why he goes out front to smoke.</p> <p>On 7/17/24 at approximately 8:45 AM Staff G voiced Resident #28 cannot put out his own cigarettes when he is done smoking. Resident #28 throws his cigarette butts on the ground out front. She reported his legs don't work and he physically can't move them to put out his cigarette butt once he thrown it on the ground so she has to stomp on the cigarette butt to distinguish it and then she picks it up and bring the cigarette butt inside and throws in the regular garbage. Surveyor asked for clarification again if it was the regular garbage or the cigarette butt receptacle. Staff G repeated she brings the cigarette butt in and throws it away in the regular facility garbage can. Staff G further reported not all staff dispose of the cigarette butts after the butts are thrown on the ground and Resident #28 does not dispose of the cigarette butts in the receptacle.</p> <p>Observation on 7/17/24 at 8:02 AM revealed 10 cigarette butts laying in the front drive way under the front canopy. Six of the cigarette butts were approximately 6 feet off the front door where Resident #28 had been observed smoking with staff between 7/15/24 and 7/17/24.</p> <p>During an observation on 7/17/24 at 11:17 AM the Administrator reported she was the supervision for Resident #28. She assisted Resident #28 out the front double doors and then Resident #28 propelled his wheelchair approximately 10 feet out from the front doors to the right side of the front entrance canopy. He opened his box of cigarettes, put one in his mouth. The Administrator lit his cigarette for him. At 11:20 AM Staff K, housekeeper observed outside sweeping up the cigarette butts from the outside of the canopy.</p> <p>On 7/17/24 at 11:27 AM Staff K reported she is not out in the front when Resident #28 goes out to smoke, so she couldn't say if he used the cigarette receptacle, but she does sweep up a lot of cigarette butts from the front area. At 11:33 AM the Administrator picked up two cigarette butts from the ground approximately 10 inches from the resident right side of his wheelchair and put in the cigarette butt receptacle. The resident made no attempt to use put his own cigarette butt in the receptacle when he was done smoking.</p> <p>During an on-site visit to the facility on [DATE] at 2:35 PM the Long-Term Care Ombudsman verbalized she has never told the facility that the residents' have the right to smoke on the premises wherever they choose. The facility still has to follow the smoking policies.</p> <p>(continued on next page)</p>

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<p>F 0689</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>During an interview on 7/17/24 at 4:20 PM the Administrator reported Resident #28 is supervised due to behaviors when he is out of his room whether it be smoking or whatever he is doing. He is to be independent with his smoking. Even though the resident is independent, he is still being provided with 1:1 supervision. She expects that if he flicks a cigarette butt on the ground, the staff will put it out and dispose of it properly in the cigarette receptacle. Staff should still follow the smoking policies.</p> <p>The Smoking Policy Procedure, revised September 2019, directed the following:</p> <ol style="list-style-type: none"> 1. Identify the resident/patient who requests to smoke. Instruct resident/patient on smoking policy and document education in the Medical Record. 2. Evaluate/Assess the resident/patient for smoking safety. 3. Determine level of independence or supervision and reasonable accommodations the resident/patient would require to smoke safely per the smoking evaluation. Accommodations may include, but are not limited to, set up assistance, staff supervision, staff assistance, and adaptive or protective equipment. 4. Implement the individualized smoking plan of care.

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<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>44972</p> <p>Based on observation, staff interview and policy review, the facility failed to ensure proper personal hygiene practices to prevent contamination of food when staff failed to wear beard guards while in the kitchen area. The facility reported a census of 46 residents.</p> <p>Findings include:</p> <p>In an observation on 7/16/24 at 2:45 PM, 2 male dietary employees were noted to be working in the kitchen area with hair nets on but no beard guards in place to cover their facial hair.</p> <p>In an interview on 7/16/24 at 2:55 PM, the Dietary Manager stated it was the expectation that facial hair be covered. He reported he hadn't noticed the staff were not wearing the beard guards. They have the beard guards available and he would have the staff start wearing them. He stated they had worn them in the past.</p> <p>A facility provided policy titled Sanitation - Personal Hygiene, stated the staff were to wear hair restraints at all times and beard guards were to be worn by all male employees with facial hair.</p>

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<p>F 0880</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide and implement an infection prevention and control program.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 42133</p> <p>Based on observation, clinical record review, and staff interview the facility failed to provide appropriate catheter care to prevent potential cross contamination that could lead to a urinary tract infection (UTI) for 2 of 2 residents sampled (Resident #17 and #41). The facility identified a census of 46 residents.</p> <p>Findings include:</p> <ol style="list-style-type: none"> 1. Resident #17 Minimum Data Set (MDS) assessment dated [DATE] showed a Brief Interview for Mental Status (BIMS) Score of 1 indicating severe cognitive impairment with a diagnosis of cerebrovascular accident (CVA) with hemiplegia (a symptom that causes paralysis or severe weakness on one side of the body). The MDS documented Resident #17 as dependent upon staff for managing his urinary catheter for a diagnosis of neurogenic bladder. <p>The Care Plan revised 2/20/23 documented the use of a suprapubic catheter and directed the staff in the following:</p> <ol style="list-style-type: none"> a. The Resident's suprapubic catheter changed at the urology clinic monthly. Date Initiated 3/06/2024. b. The Resident has an 18 French catheter with a 10 cubic centimeter (CC) bulb. Position the catheter bag and tubing below the level of the bladder and away from the entrance door. c. Monitor/record/report to the Medical Doctor for signs and symptoms of UTI: pain, burning, blood tinged urine, cloudiness, no output, deepening of urine color, increased pulse, increased temperature, urinary frequency, foul smelling urine, fever, chills, altered mental status, change in behavior, change in eating pattern. d. Wear a gown and gloves during high contact care of the catheter. <p>A review of the Order Summary Report signed by the Provider on 6/04/24 showed the following orders:</p> <ol style="list-style-type: none"> a. Clean the suprapubic site with saline and gauze. Cover the site with split gauze two times a day. b. Utilize an 18 French 5 CC bulb catheter connected to straight drainage (use 10 cc in the bulb). Change the catheter every 4 weeks and as needed at the urology clinic. c. Monitor for decrease urine output, bladder distension, or pain. For suspected blockage, try gently milking the catheter tubing. If unsuccessful, may irrigate using the following method: pour 60 milliliters (ML) of saline into the top of the syringe. Raise the syringe and tub straight up to let the saline go through the tube. Notify the Medical Doctor/Nurse Practitioner if unsuccessful in clearing as needed for obstruction. Active date 8/10/23. <p>(continued on next page)</p>

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<p>F 0880</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>A 7/15/24 review of Resident #17 Kardex directed the staff to:</p> <ul style="list-style-type: none"> a. Wear a gown and gloves during high-contact care for the resident including care of the urinary catheter. b. Position the catheter bag and tubing below the level of the bladder and away from the entrance door. c. Provide Foley catheter care. d. Monitor/record/report to the Medical Doctor for signs and symptoms of UTI: pain, burning, blood tinged urine, cloudiness, no output, deepening of urine color, increased pulse, increased temperature, urinary frequency, foul smelling urine, fever, chills, altered mental status, change in behavior, change in eating pattern. <p>The Kardex lacked direction to keep the urinary drainage bag and tubing off the floor.</p> <p>On 7/15/24 at 11:34 AM Resident #17 lay in bed on his left side with the urinary drainage bag hanging off the right side of the bed in direct contact with the floor. The urinary drainage bag tubing had yellow cloudy urine present.</p> <p>On 7/15/24 at 1:16 PM Resident #17 lay in bed with the urinary drainage bag and three inches of the catheter tubing lay directly on the floor to the right side of the bed frame.</p> <p>During an observation on 7/15/24 at 2:41 PM Resident #17 lay supine in bed. The urinary drainage bag lay completely flat on the floor with the drain tube in direct contact with the floor under the right side of the bed.</p> <p>During an interview on 7/15/24 at 4:08 PM a Family Representative reported the urinary drainage bag is on the floor when she visits a lot. She stated she feels this has contributed to his past UTI's and hospitalizations.</p> <p>On 7/16/24 at 1:51 PM Staff G, Certified Nursing Assistant (CNA) explained the urinary drainage bags should be hooked to the metal bed frame, below the level of the bladder so the bags drain. The urinary drainage bag should never be on the floor, that is how the bags get torn. The bags should be inside a dignity bag.</p> <p>During an interview on 7/16/24 at 3:06 PM Staff C, Registered Nurse (RN) reported the CNA's are expected to position the urinary drainage bags and tubing up off the floor by hanging the bags off of the metal part of the bed frame.</p> <p>During an interview on 7/17/24 at 4:00 PM the Assistant Director of Nursing (ADON) reported she expects the staff to secure the urinary drainage bag and tubing to the bed frame so that it doesn't touch the floor. When queried about the low beds, the Administrator verbalize the staff should utilize a wash basin under the urinary drainage bag and tubing to keep off the floor.</p> <p>(continued on next page)</p>		

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<p>F 0880</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>On 7/18/24 at 6:45 AM the Administrator responded the facility didn't have a policy for the handling of urinary drainage bags or infection control policies that pertain to the handling of urinary drainage bags. The facility only had a general infection control policy.</p> <p>The Infection Control Overview Policy, reviewed 3/2020, documented the facility strives to prevent transmission of infections, development of nosocomial (health care acquired infection that developed while in a long-term care facility) infections, and effectively treat and manage nosocomial infections. The goal of the program is to identify and reduce the risks of acquiring and transmitting infections among the residents. The infection prevention and control process is directed at lowering risk, and improving trends and rates of epidemiologically significant infections.</p> <p>44972</p> <p>2. The MDS dated [DATE] documented Resident #41 had diagnoses that included acute cholecystitis, infection due to indwelling catheter, diabetes mellitus, benign prostatic hyperplasia, atrial fibrillation, chronic kidney disease, and obstructive and reflux uropathy. The resident had a BIMS score of 15 indicating intact cognition. Resident #41 required total staff assistance with bathing, toileting, personal hygiene and transfers and had an indwelling catheter.</p> <p>The Care Plan dated 10/9/23 revealed a focus area for the Foley catheter related to a neurogenic bladder with a goal that Resident #41 would remain free from catheter related trauma and a focus area for the urinary catheter related to obstructive uropathy with a goal the resident would not develop complications associated with catheter use.</p> <p>In an observation on 7/17/24 at 8:27 AM, Resident #41's catheter bag was noted to be lying on the floor beside the bed.</p>		