STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	165251	A. Building B. Wing	10/24/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Ravenwood Specialty Care	2651 St Francis Drive Waterloo, IA 50702

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 0578 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to request, refuse, and/or discontinue treatment, to participate in or refuse to participate in experimental research, and to formulate an advance directive. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 42441 Based on clinical record review, policy review, and staff interviews, the facility failed to have a consistent code status between the physician orders, the electronic health record (EHR), and the Care Plan for 1 of 1 resident reviewed for Advanced Directives (Resident #101). The facility reported a census of 116 residents. Findings include: Resident #101's Minimum Data Set (MDS) assessment dated [DATE] identified a Brief Interview of Mental Status (BIMS) score of 14, indicating intact cognition. Resident #101's Clinical Physician Orders included an order dated [DATE] for cardiopulmonary resuscitation (CPR). Review of the facility form titled, Cardiopulmonary Resuscitation and DNR order Declaration Form, signed by Resident #101 on [DATE], indicated he desired to have CPR initiated to prolong his life when biological death (final death) is not imminent. The Care Plan Focus initiated [DATE] reflected Resident #101 had an Advanced Directives code status of do not resuscitate (DNR). The Care Plan documented the goal was for Advanced Directives to be followed per resident/family request. The Care Plan further directed staff to perform CPR, honor the resident's wishes and review the resident's wishes quarterly and as needed. Review of facility policy titled, Advanced Directives, revised [DATE] directed to have consistent Plans of Care for each resident with their documented treatment preferences and/or Advanced Directive. The staff will inform the Care Plan Team of such changes and/or revocations so that appropriate changes can be made in the resident assessment (MDS) and Care Plan. During an interview on [DATE] at 8:12 AM, the Director of Nursing (DON) reported they expected consistent Advanced Directives between the resident's physician orders, the EHR, and the Care Plan. During an interview on [DATE] at 8:37 AM, Staff A, Registered Nurse (RN), explained the facility kept the Advanced Directives on the resident's Medication Administration Record (MAR), in the EHR, in a book at the nurse's station, and on the Care Plan. (continued on next page)

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

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F 0578 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on [DATE] at 1:15 PM, the DON acknowledged Resident #101's Care Plan Focus had DNR documented and the rest of his clinical record listed he desired CPR.

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F 0582 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Give residents notice of Medicaid/Medicare coverage and potential liability for services not covered. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 50874 Based on clinical record review and staff interviews the facility failed to provide the Skilled Nursing Facility Advance Beneficiary Notice of Non coverage form CMS 10055 (SNF ABN) for 1 of 3 residents (Resident #372) reviewed. The facility reported a census of 116. Findings include: Resident #372 Minimum Data set (MDS) assessment dated [DATE] identified a Brief Interview for Mental Status (BIMs) score of 11, indicating moderately impaired cognition. The MDS indicated Resident #372 required supervision or touching assistance (helper provides verbal cues and/or contact guard assistance as resident completes activity. Assistance may be provided throughout the activity or intermittently) for sit to stand, chair/bed to chair transfer, toileting, and walking. Resident #372's MDS included diagnoses of cancer, coronary artery disease (impaired blood vessels), heart failure, diabetes mellitus, cerebrovascular accident (stroke), wound infection, non traumatic ischemic (dead tissue) infarction (inadequate blood supply) of the muscle (right lower leg), and non Alzheimer's dementia. The Notice of Non Coverage form CMS 10123 (NOMNC) dated 9/10/24 at 3:27 PM indicated the Social Worker contacted Resident #372's Power of Attorney (POA) and explained the NOMNC. The POC indicated they would sign it on 9/11/24. An addendum added on 9/11/24 at 10:42 AM indicated the Social Worker spoke with the POA and notified him Resident #372 knew about his discharge from skilled services and he understood, he didn't wish to appeal. The POA signed the form on 9/11/24. The Social Service Progress Note dated 9/11/24 at 4:20 PM indicated Resident #372 would remain in the facility at an intermediate care facility (ICF) level of care after his Medicare A skilled stay ended. Resident #372 Clinical Census listed an admitted [DATE] as Medicare Part A skilled stay. The Clinical Census documented on 9/13/24, Resident #372 continued to reside in the facility after his Medicare Part A skilled services ended. Resident #372's clinical record lacked a SNF ABN. On 10/22/24 at 1:42 PM Staff B, Social Worker, declared themselves as the person responsible for reviewing the SNF ABN and the NOMNC with the resident/responsible family. Staff B verified they didn't provide Resident #372 with the SNF ABN. On 10/22/24 at 2:16 PM the Administrator said they expected all required notifications be completed as required. The facility failed to provide a policy for providing Medicare required notices.

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F 0644 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Coordinate assessments with the pre-admission screening and resident review program; and referring for services as needed. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 48003 Based on clinical record review and staff interview, the facility failed to submit a Preadmission Screening and Resident Review (PASRR) evaluation for 1 of 2 residents reviewed with a new mental health diagnosis (Resident #63). The facility reported a census of 116 residents. Findings include: Resident #63's Minimum Data Set (MDS) assessment dated [DATE] identified a Brief Interview for Mental Status (BIMS) score of 12, indicating moderately impaired cognition. The MDS included diagnoses of anxiety, depression, psychotic disorder, post-traumatic stress disorder (PTSD). In addition, Resident #63 received antipsychotic and depression medications during the lookback period. The Care Plan Focus initiated 1/18/23 reflected Resident #63 had the potential for psychosocial well-being problems related to anxiety, depression, PTSD, psychosis, delusions, and hallucinations, due to his loss of independence and being away from family following his recent admission to the facility. The Psychological Service Progress Note dated 3/6/23 listed a diagnosis of PTSD. Resident #63's Level 1 PASRR dated 11/20/23 lacked a diagnosis of PTSD. Resident #63's clinical record lacked a PASRR after 11/20/23. During an interview on 10/23/24 at 11:24 AM, the Social Services Coordinator reported they missed PTSD on the PASRR and they should have completed a new one. In an interview on 10/23/24 at 11:32 AM, the Director of Nursing (DON) reported the facility didn't have a policy for PASRR, as the facility followed the regulations.

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 42133 Based on clinical record review, policy review and staff interview the facility failed to ensure staff use the assistance of two certified nursing assistants (CNA) when using the full body mechanical lift (transferring a person using a sling that are dependent upon staff to move from the bed and/or chair) to transfer for 2 of 3 residents sampled (Resident #12 and #34). The facility reported a census of 116 residents. Findings include: 1. Resident #12's Minimum Data Set (MDS) assessment dated [DATE] identified a Brief Interview for Mental Status (BIMS) score of 15, indicating intact cognition. Resident #12 had a functional limitation of both lower extremities. They required the use of a wheelchair and total staff assistance for chair to bed/chair to chair transfers. The MDS included a diagnosis of a cerebrovascular accident (stroke). The Care Plan Focus dated 11/14/23 related to Activities of Daily Living (ADLs) directed the following: a. Resident #12 didn't walk b. Resident #12 required the use of two staff members to transfer with the full-body mechanical lift. During an interview on 10/21/24 at 12:11 PM Resident #12 reported once they knew how to use the full-body mechanical lift, they just used one person to operate it. They only use one person to lay him down in the afternoon with the full-body mechanical lift. Resident #12 pointed a finger at Staff C, CNA, who stood in the upper part of the hallway and said he's a good one. He'll put him in bed with the full-body mechanical lift by himself. When they had two staff, that usually meant they didn't know what they were doing. A review of Resident #12's weight record on 10/22/24 documented a weight on 10/2/24 of 165 pounds. During an interview on 10/23/24 at 1:10 PM Resident #12 sat in his wheelchair in the doorway of his room. Resident #12 waited for someone to lay him down in bed. He stated now they have to get another CNA to run the full-body mechanical lift so he had to wait. On 10/23/24 at 1:14 PM observed Staff F, CNA, and Staff M, CNA, bring the full-body mechanical lift to Resident #12's room and assisted him from the wheelchair to his bed with two staff and the full-body mechanical lift. 2. Resident #34 MDS assessment dated [DATE] identified a BIMS score of 13, indicating intact cognition. Resident #34 required total staff assistance with transfers from the chair to bed or from the bed to chair. Resident #34 had functional impairment of both lower extremities. The MDS included diagnoses of stroke with hemiparesis (half body weakness), anxiety, and morbid obesity. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The Care Plan Focus dated 11/14/23 related to ADLs directed she needed two CNAs present for all cares, she couldn't walk, relied on a wheelchair, and required a full-body mechanical lift with two aides for transfers. On 10/21/24 at 12:37 PM Resident #34 reported most of the time they use two people with the full-body mechanical lift to get her from the wheelchair back to bed. However, last night they only had 1 aide available. They used only 1 aide to operate the full-body mechanical lift to put her to bed. Resident #34 voiced she felt safer when they had two staff with the full-body mechanical lift, but she didn't feel unsafe when they only had 1 aide run the full-body mechanical lift. Interview completed on 10/21/24 at 12:43 Staff O, CNA, reported sometimes they had to find another staff member to help do the 2-assist full-body mechanical lift transfers. The staff are not to use the full-body mechanical lifts by themselves. The review of Resident #34's weight record on 10/22/24 documented a weight on 10/8/24 of 242.8 pounds. On 10/22/24 at 12:09 PM Staff F verbalized she wouldn't do a full-body mechanical lift by herself, as they had residents that weighed more than 200 pounds. She add it is not safe to do it alone. Interview completed on 10/22/24 at 12:18 PM Staff L, CNA, verbalized if they needed help with a full-body mechanical lift transfer, they are to ask the nurse or another aide from another hallway. She didn't transfer anyone with a full-body mechanical lift by herself. During an interview on 10/22/24 at 12:25 Staff M voiced you have to find another staff member to help use the full-body mechanical lift. Staff M added she wouldn't do a full-body mechanical lift without a second person. If no one is available, they couldn't lift them. Staff M said they can't operate a full-body mechanical lift with 1 person. On 10/22/24 at 12:47 PM Staff H, CNA, reported the facility had some residents that required 2 assist for care. He voiced people from different wings help out, or they have a float aide who assists. When he can't find a second aide to transfer resident with a full-body mechanical lift transfer, he did transfer the resident by himself with the full-body mechanical lift transfer. He voiced he reported the issue to the Director of Nursing (DON), approximately a month before. During an interview on 10/23/24 at 8:11 AM Staff I, CNA, reported call ins it makes it tough, but they get the care done. She had to go ask if someone can help her. Depending on the nurse, and which nurse worked, they may or may not help. She refused to use a full-body mechanical lift by herself and wouldn't risk her certification. She didn't see other aides running the full-body mechanical lift by themselves, but she wouldn't put it past the aides on the other side (hallways C and D). She wouldn't have a resident fall out of a lift sling on her watch. During an interview on 10/23/24 at 11:35 AM Staff J, Licensed Practical Nurse (LPN), reported the facility policy required 2 staff members operate the full-body mechanical lift. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 10/23/24 at 3:21 PM the DON reported the staff shouldn't operate the full-body mechanical lift without a second staff person. She stressed to the staff to come get her if they needed help with the full-body mechanical lift. They staffed two aides or at least a float aide that is to assist when a resident required the assistance of 2 staff. She expected the staff to ask the float CNA, Certified Medication Aide (CMA), or the nurse to assist with transfers. The DON voiced no staff informed her they did full-body mechanical lifts by themselves. A full-body mechanical lift transfer required absolutely 2 staff members. She reported they didn't have any resident incident reports or injuries regarding the full-body mechanical lifts. On 10/23/24 at 3:35 PM the DON reported being upset that staff said they reported the issue to her. She always goes out to the floor and stressed to the staff that full-body mechanical lifts required 2 staff. On 10/24/24 at 9:00 AM the DON submitted the In Service Education they provided on 10/23/24 to the staff that directed full-body mechanical lift transfers must have 2 staff members to with no exceptions. On 10/24/24 at 10:40 AM the DON reported the facility used their full-body mechanical lift Operator's Instruction Manual Competency Checklist. The facility didn't have a full-body mechanical lift policy. The EZ Way Smart Lift Operator's Instructions revised 6/14/23 directed depending on the situation, facility policy, and the patient's condition, 2 caregivers may be necessary, with some patients it is best to use two people. On Page 7, figure 6 the manual included a picture of 2 staff with the patient ready to be lifted from the bed. On Page 8, figure 9 included 2 staff attaching the lift sling to lift a person out of the wheelchair.

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide and implement an infection prevention and control program. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 42133 Based on observation, clinical record review, policy review and staff interview, the facility failed to provide clean peri care per the standards of practice for 1 of 2 residents sampled (Resident #65). As the staff provided peri-care to Resident #65, they failed to wipe front to back, change their gloves as completing a dirty task, complete hand hygiene prior to applying gloves, and removing their gloves. The facility identified a census of 116 residents. Findings include: Resident #65's Minimum Data Set (MDS) assessment dated [DATE] identified a Brief Interview for Mental Status (BIMS) score of 3, indicating severely impaired cognition. Resident #65 required total staff assistance for toileting hygiene. The MDS listed Resident #65 as always incontinent of urine and frequently incontinent of bowel. The MDS included diagnoses of Alzheimer's disease and non Alzheimer's dementia. The Care Plan Focus revised 7/12/24 indicated Resident #65 had bowel and bladder incontinence related to her Alzheimer's disease. The Interventions directed the following: a. Assist her to the bathroom or commode as needed. b. Assist her with perineal cleansing as needed. c. Provide her with incontinence pads. On 10/23/24 at 11:04 AM observed Staff C, Certified Nursing Assistant (CNA), push Resident #65 in the wheelchair into the spa room, as Staff D, CNA, held the door. Without performing hand hygiene, Staff C and Staff D donned (put on) gloves. With their gloved hands, Staff C touched the wheelchair to lock the brakes and Staff applied the gait belt around Resident #65's waist. Staff D removed her brief with a visible solid blue line revealing the brief as wet. Staff D walked over to the trash can and disposed of the dirty brief. After Resident #65 used the toilet, they stood her up from the toilet. Staff D cleansed her front peri area with a disposable wipe. She cleansed the right vaginal fold, the left vaginal fold, and down the middle without changing the wipe or folding the disposable wipe. Staff D then cleansed the left of Resident #65's gluteal fold, then the right of the gluteal fold, and then down the gluteal fold with the same disposable wipe without changing or folding the wipe. Staff D threw away the disposable wipe. While still wearing their gloves or completing hand hygiene, Staff D obtained and applied a clean brief through the back of Resident #65's legs. Staff D pulled the brief from the back to the front, then attached the brief. Afterwards without removing their gloves or completing hand hygiene, Staff D pulled up Resident #65's pants, placed the gait belt under her left arm, and then removed her dirty gloves. Without completing hand hygiene after removing his gloves, Staff C assisted Resident #65 out of the spa room to her wheelchair. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 10/23/24 at 1:19 PM Staff E, CNA, reported they should complete peri care by wiping front to back with one swipe on each side of the cloth, unless the resident had a bowel movement. If the resident had a bowel movement, then she cleansed the bottom first and then cleansed the front peri-area (low abdomen, vaginal folds, and thighs) of the resident. Staff E didn't know of any needed special precautions when cleansing from back to front. During an interview completed on 10/23/24 at 1:25 PM Staff F, CNA, said she would perform peri cares by cleansing the front peri area and work towards the back. She stated she got trained in the one wipe, one swipe method. She would only use one wipe to clean one area. Then she would perform hand hygiene and change gloves when she touched something soiled before touching clean supplies. On 10/23/24 at 1:35 PM Staff G, Assistant Director of Nursing (ADON), reported the facility followed a peri care policy. She expected the CNAs to clean from front to back, using a one wipe, one swipe method. If the CNAs have to go from dirty to touching clean supplies, they are to change their gloves and perform hand hygiene. During an interview on 10/23/24 at 3:21 PM the DON reported she expected the staff to clean the entire peri area, change the fold on the cleansing wipe with each swipe and change gloves before handling clean peri care supplies. The Perineal Care policy revised February 2018 directed the following care: a. Wash perineal area, wiping from front to back. b. Separate labia and wash area downward from front to back. c. Continue to wash the perineum moving from inside outward to the thighs, rinse perineum thoroughly in same direction, using fresh water and a clean washcloth. d. Gently dry perineum. e. Remove gloves and sanitize and wash hands. f. Put on gloves. g. Ask the resident to turn on their side with their top leg slightly bent, if able. h. Use new wash cloth and apply soap or skin cleansing agent, or use cleansing wipes i. Wash the rectal area thoroughly, wiping from the base of the labia towards and extending over the buttocks. j. Rinse and dry thoroughly. k. Wash perineal area, wiping from front to back. l. Use a new wash cloth and apply soap or skin cleansing agent, or use cleansing wipes.