STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	165252	A. Building B. Wing	07/25/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Westview Acres Care Center	203 S W Lorraine Leon, IA 50144

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(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 - Some	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. 50471 Based on clinical record review, facility policy, and staff interview, the facility failed to have the Doctor signature on the Iowa Physician Orders for Scope of Treatment (IPOST) for 1 of 16 residents reviewed for Advance Directives (Resident # 17). The facility reported a census of 40 residents. Findings include: The Iowa Physician Orders for Scope of Treatment (IPOST) dated 12/11/23 revealed no Doctor signature for a code status of Do Not Resuscitate. On 7/23/24 at 10:05 AM the Social Worker (SW) revealed the IPOST did not get signed by the Doctor. The facility policy titled Advance Directives revised 7/18/24 instructed staff the residents attending Physician will clarify and present any relevant medical issues and decisions to the resident or legal representative as the residents condition changes in an effort to clarify and adhere to the residents wishes. The Interdisciplinary Team will conduct ongoing review of the residents decision-making capacity and communicate significant changes to the residents legal representative. Such changes will be documented in the care plan and medical record. The Interdisciplinary Team will review annually with the resident his or her advance directives to ensure that such directives are still the wishes of the resident. Such reviews will be made during the annual assessment process and recorded on the resident assessment instrument (MDS).

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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

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F 0607 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop and implement policies and procedures to prevent abuse, neglect, and theft. 46873 Based on employee file review, staff interview, and facility policy, the facility failed to ensure 1 of 5 staff members reviewed (Staff A, Certified Nurse Aide) completed the two hour Dependent Adult Abuse training within 6 months of their hire date. The facility reported a census of 40 residents. Findings include: Review of the employee file of Staff A, conducted on 7/24/24, revealed a hire date of 10/6/23. The employee file documented the Iowa Department of Public Health (IDPH) approved Dependent Adult Abuse Mandatory Reporter training was completed on 7/23/24. On 7/24/24 at 10:50 am, the Director of Nursing (DON) stated Staff A had done the training in February but failed to finalize it until 7/23/24. She stated the facility is conducting an audit of all employee files for current training. The facility policy titled Nursing Facility Abuse Prevention, Identification, Investigation and Reporting Policy, dated July 2019, documented the following: - Within six months of hire each employee shall be required to complete an initial 2-hour training course provided by the Iowa Department of Human Services relating to the identification and reporting of dependent adult abuse. Each employee will take a 1-hour recertification training within 3 years of the initial training and every three years thereafter.

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop the complete care plan within 7 days of the comprehensive assessment; and prepared, reviewed, and revised by a team of health professionals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 50471 Based on clinical record review, staff interview, and facility policy review, the facility failed to revise the care plan for 1 of 16 residents reviewed for revision of care plan (Resident #23). The facility reported a census of 40 residents. Findings include: The Minimum Data Sheet (MDS) assessment dated [DATE] identified a BIMS score of 14 which indicated cognition intact. The MDS revealed the resident independent with bed mobility, personal care, transfers, toileting, eating, and dressing. The MDS revealed the resident frequently incontinent of urine and occasional incontinent of bowel. The MDS documented diagnoses that included: other and unspecified nontraumatic intracranial hemorrhage, hypertension, diabetes mellitus, cerebrovascular accident, asthma, chronic obstructive pulmonary disease (COPD), morbid (Severe) obesity, unspecified mental disorder due to known physiological condition, restless legs syndrome, and atrial fibrillation. The MDS revealed antidepressant, insulin, and diuretic. The Care Plan revised 7/18/24 revealed no documentation for tubi grip related to right lower leg pain. The care plan revealed no documentation for depression, including the resident started on antidepressant medication 3/21/24. The care plan revealed no personalized interventions or assessment for asthma and COPD. On 07/25/24 at 10:18 AM the Minimum Data Set Coordinator (MDS) stated the Doctor does their rounds at the facility Thursday, the Progress Note from visit arrived on Monday or Tuesday, orders are left on paper the day of the visit. The floor nurse documented the order(s), the management nurses processed the order(s), staff uploaded the order(s). The nurse that documented the order(s) updated the care plan and diagnosis if applicable, the management nurses verified the care plan and diagnosis are updated. The care plan should be personalized for the resident updated with depression, antidepressant medication, tubi grip, assessment and personalized interventions for asthma and COPD. The facility policy title Comprehensive Care Plan Policy reviewed 7/18/24 instructed staff to: Assessment: conduct a thorough assessment of the resident's current health status, including any changes in their condition, medications, or treatments. This assessment should be performed by a qualified healthcare provider, such as a nurse or physician. Review the resident's current care plan to determine if any revisions are needed. This review should include input from the resident, their family members, and any other healthcare providers who are involved in the resident's care. Based on the assessment and review of the current care plan, revise the care plan as needed to reflect any changes in the resident's health status or care needs. The revised care plan should include specific goals and interventions to address the resident's physical, emotional, and social needs. (continued on next page)

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review and revise the comprehensive care plan at least quarterly or as needed based on changes in the resident's health status or care needs. Revising a comprehensive care plan is an important part of the resident care in skilled nursing facility. It allows community staff to adapt the care plan to meet the resident's changing needs and improve their overall quality of life. It is important for nursing staff to follow this policy and procedure to ensure that all residents receive appropriate and timely revisions to their care plan.

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F 0725 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide enough nursing staff every day to meet the needs of every resident; and have a licensed nurse in charge on each shift. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 47079 Based on observations, resident interview, and policy review, the facility failed to respond to resident call lights in a timely manner for 5 of 5 residents reviewed (#1, #7, #13, #30, & #32). The facility reported a census of 40. Findings include: 1. The quarterly Minimum Data Set (MDS) assessment dated [DATE] revealed a Brief Interview for Mental Status (BIMS) score of 12 out of 15 which indicated moderately impaired cognition. It included diagnoses of hypertension, Non-Alzheimer's dementia, anxiety, depression, and bipolar disorder. It indicated the resident was independent in all activities of daily living (ADLs) but required moderate assistance with bathing. The Care Plan revised 12/28/23 documented Resident #13 is at moderate risk for falls and directed staff to encourage her to wear her shoes with all transfers and gripper socks when not wearing shoes. The Care Plan also directed staff to encourage her to get out of her bed and out of her room every day due to anxiety and tends to isolate herself. On 7/22/24 a continuous observation revealed Resident #13's call light was activated at 2:53 PM and staff responded at 3:16 PM. 46873 2. The MDS for Resident #1 dated 7/11/24 documented a BIMS score of 15 indicating intact cognition. On 7/22/24 at 2:21 pm, Resident #1 reported she waits a long time for her call light to be answered. She stated she looks at the clock in her room and it is often a 45 minute wait. 3. The MDS for Resident #7 dated 4/4/24 documented a BIMS score of 12 indicating mildly impaired cognition. On 7/22/24 at 2:43 pm, Resident #7 stated she felt call lights generally were a 15-20 minute response time. 4. The MDS for Resident #30 dated 5/9/24 documented a BIMS score of 14 indicating intact cognition. (continued on next page)

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F 0725 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During observation on 7/22/24 beginning at 2:48 pm the call light of Resident #30 was noted to be triggered. At 2:53 pm, a staff member was observed exiting the room next door to Resident #30's room. The staff member looked to her left, the direction of the call light illuminated above the door, turned and walked the opposite direction. At 2:56 pm, another staff member was observed walking down the hallway and past the room of Resident #30 without stopping to answer the call light. At 3:04 pm another staff member was observed walking past the room without answering the call light. At 3:06 pm a fourth staff member walked by the room and entered another room briefly. This staff member then returned and answered the call light. The call light was answered 18 minutes into observation. On 7/22/24 at 3:57 pm, a family member of Resident #30 stated he feels the facility is low staffed. He spoke very highly of the nursing staff and stated they provide good care but he feels there are not enough CNAs. 5. On 7/22/24 at 3:13 pm, Resident #32 reported she considers the care she receives to be good but stated there are long wait times to receive help when she rings her call light. On 7/25/24 at 3:20 PM, the Director of Nursing stated staff were expected to answer resident call lights within the 15 minute requirement. The undated facility policy titled Call Light System documented the following: -Upon receiving an alert from the call light system, staff members at the nurse station shall acknowledge the call promptly. -If responding staff is unable to meet the resident needs independently they shall promptly seek assistance from appropriate healthcare providers or supervisors.

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F 0758 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Implement gradual dose reductions(GDR) and non-pharmacological interventions, unless contraindicated, prior to initiating or instead of continuing psychotropic medication; and PRN orders for psychotropic medications are only used when the medication is necessary and PRN use is limited. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 47079 Based on clinical record review, staff interviews, and policy review, the facility failed to ensure a psychotropic medication (a medication that affects a person's mental state) gradual dose reduction (GDR) was appropriately attempted for 1 of 1 resident (#13) reviewed. The facility reported a census of 40. Findings include: On 7/22/24 at 4:19 PM, Resident #13 stated she slept about 5 hours during the daytime after sleeping at night. She did not know what medications she was prescribed. The quarterly Minimum Data Set (MDS) assessment dated [DATE] revealed a Brief Interview for Mental Status (BIMS) score of 12 out of 15 which indicated moderately impaired cognition. It included diagnoses of hypertension, Non-Alzheimer's dementia, anxiety, depression, and bipolar disorder. It indicated the resident received an antidepressant and antianxiety medication but had not exhibited a crying episode during the previous 7-day look-back period. The Electronic Health Record (EHR) included an order dated 12/07/23 for Buspirone Hydrochloride (HCL) oral tablet 5 mg; two (2) tablets by mouth every morning and at bedtime related to generalized anxiety disorder. It also included an order dated 12/08/23 for Celexa (antidepressant) oral tablet 40 mg; one (1) tablet by mouth one time a day related to major depressive disorder. A Gradual Dose Reduction for Celexa was implemented 3/16/24 with an updated order Celexa oral tablet 20 mg; one (1) tablet by mouth one time a day related to major depressive disorder. On 5/05/24, the pharmacist recommended a GDR for Buspirone to 7.5 mg twice daily. It indicated the resident lacked documentation of signs and symptoms of anxiety during the previous 30-day look-back period. On 5/16/24, the provider response indicated continue since a decrease was likely to worsen anxiety. A Progress Note dated 5/20/24 documented a pharmacy recommendation of possible reduction in Buspar. It included a physician response to Continue since decrease likely to worsen anxiety. The Care Plan dated 12/11/23 revealed the resident had a diagnosis of anxiety and directed staff to assess for side effects related to anxiety med 1- dizziness 2-disturbed sleep 3-irritability every shift per eMAR (Electronic Medication Administration Record). A Behavior Documentation Record review revealed the resident had not experienced crying in the last six (6) months. (continued on next page)

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F 0758 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 7/25/24 at 1:30 PM, the Director of Nursing (DON) and the Social Worker stated behavior documentation would be located in progress notes or behavior documentation sheet in the EHR. An undated policy titled Drug Regimen Review indicated if evidence of a valid clinical reason for rejecting the recommendation is provided and the attending physician is the medical director (MD), the consultant pharmacist and DON arrange a meeting with the MD to discuss the issues. The DON or designated licensed nurse address and document recommendations that do not require a physician intervention.

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Provide and implement an infection prevention and control program. 47079 Based on observations, staff interviews, document reviews, and policy review, the facility failed to implement a comprehensive water management program and identify areas or devices in the building to reduce the risk and prevent the growth of Legionella or other waterborne pathogens. The facility also failed to implement appropriate hand hygiene practices during resident care. The facility reported a census of 40 residents. Findings include: 1. On 7/25/24 at 11:00 AM, the Maintenance Director stated the facility did not have a current water flow diagram, a water management plan, or a process in place to identify areas in the building to reduce the risk or growth of Legionella or other waterborne pathogens. On 7/25/24 at 11:20 AM, the Environmental Services Director stated she flushed every resident toilet and turned on the water in every resident room sink for 30 seconds every day. She also stated she wasn't able to provide documentation of the completed task. During an interview on 7/25/24 at 11:20 AM, the Director of Nursing (DON) stated there hadn't been a resident room vacant for more than one month. A policy titled Legionella Water Management Program revised 7/2017 indicated the water management program included the following elements: a) A detailed description and diagram of the water system in the facility kept by maintenance. b) The identification of areas in the water system that could encourage the growth and spread of Legionella or other waterborne bacteria. c) The identification of situations that can lead to Legionella growth. At 1:30 PM, the DON stated the Maintenance Director reported to the Administrator and she was not certain whether the Maintenance Director was responsible for implementing the water management plan. 50471 (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	2. On 7/24/24 at 11:22 AM observed Staff B, RN grab gloves from the medication cart, don gloves, pick up the accu check monitor, test strip, cotton ball, lancet, alcohol swab, and barrier. Staff failed to clean hands prior to donning gloves. Staff B carried items to the room of Resident #22, knocked on the residents door, waited for permission, entered when the resident voiced permission. Staff B placed the barrier on the side table realized the side table was wet from beverages, moved items off the recliner, placed barrier on the recliner, placed the accu check monitor, test strip, lancet, and alcohol swab on the recliner. Staff failed to clean hands or change gloves after moving items from wet table. Staff B realized the cotton ball was not there, Staff B obtained a Kleenex. Staff B cleansed the residents finger, used the lancet, obtained a drop of blood, placed the blood on the test strip, and covered the finger with the Kleenex. Results revealed, disposed the Kleenex, disposed the used lancet in the sharp container in the bathroom, removed soiled gloves, and hand washing completed. On 7/24/24 at 11:30 AM observed Staff B, RN grab gloves from the medication cart, don gloves, pick up medication cup with medications, pre-set insulin flex pen, and alcohol swab. The staff failed to clean hands prior to donning gloves. Staff B carried items to the room of the Resident #22, knocked on the residents door, waited for permission, and entered when the resident voiced permission. Staff B handed the resident the cup of medications, grabbed the cup of water, handed the cup of water to the resident, received the cup of water from the resident when the resident took the medications, and Staff B placed the cup of water onto the side table. Staff failed to clean hands after med administration and before insulin administration. Staff B then informed the resident about the insulin, the resident gave permission, Staff B lifted the shirt of the resident, cleansed the abdominal area, placed the insulin flex pen into the abdomen and pushed the button, administered the insulin, waited about 10 seconds removed the insulin flex pen, covered the resident with the shirt, disposed the flex pen needle into the sharp container in the bathroom, removed soiled gloves, and completed hand washing. 3. On 7/24/24 at 11:45 AM observed Staff B, RN grab gloves from the medication cart, donned gloves, picked up medication cup with medications, pre-set insulin flex pen, alcohol swab, cup of powder stool laxative, pain relief patch-12 hour, pain patch-72 hour, and pulse ox monitor. The staff failed to clean hands prior to donning gloves. Staff B carried items to the room of the Resident #18, knocked on the residents door, waited for permission, entered when the resident voiced permission. Staff B set down the cup of medications on the resident food tray, placed the pre-set insulin flex pen on barrier by the sink, poured juice into the cup of powder stool laxative, stirred with spoon, and placed the spoon back onto tray. Staff attempted to obtain a pulse ox reading, the monitor did not provide a result, picked up the cup of medications, resident took cup of medications and picked out the tablets as she prefers, Staff B provided the juice as the resident needed, the resident voiced when she completed. Staff B removed the pain relief patch-72 hour from right chest and placed new patch on left side of chest. Staff B asked the resident to lift up her dress, placed the pain relief patch-12 hour on the right hip. Staff B asked the resident where the resident preferred the insulin, the resident informed Staff B, staff administered the insulin flex pen, removed the needle disposed in the sharp container in the bathroom. The Staff B removed soiled gloves and performed hand washing. The staff failed to clean hands or change gloves between any of the different administrations. On 7/25/24 at 2:45 PM Director of Nursing (DON) stated that hand hygiene should be completed before, after, and during a procedure if needed. Including when using gloves. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	The facility policy titled Handwashing Policy reviewed 5/10/24 instructed staff to perform hand washing before applying gloves and after removing gloves or other PPE, or alcohol based hand gel, after contact with blood, body fluids, secretions, mucous membranes, or non-intact skin, before moving from a contaminated body site to a clean body site during resident care, after providing direct resident care. The facility policy titled Implementation of Personal Protective Equipment (PPE) Use in Nursing Homes to Prevent Spread of Multidrug-resistant Organisms (MDROs) reviewed 7/10/24 instructed staff to Use of PPE is based on the staff interaction with residents and the potential for exposure to blood, body fluids, or pathogens (e.g., gloves are worn when contact with blood, body fluids, mucous membranes, non-intact skin, or potentially contaminated surfaces or equipment are anticipated).