STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	165278	A. Building B. Wing	06/06/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Living Center West	1050 4th Avenue SE Cedar Rapids, IA 52403

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 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Honor the resident's right to a dignified existence, self-determination, communication, and to exercise his or her rights. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 48452 Based on observation, staff interview, resident interview, clinical record review, and policy review the facility failed to treat residents with dignity and respect while providing cares for 5 of 7 residents reviewed for resident rights (Residents #3, #6, #7, #8, #9). The facility reported a census of 83 residents. Findings include: 1. Resident #3's Minimum Data Set (MDS) assessment dated [DATE] identified a Brief Interview for Mental Status (BIMS) score of 15, indicating intact cognition. The MDS indicated Resident #3 required total assistance with toilet use, transfers, and sitting up in bed. The MDS reflected diagnoses of anxiety and depression, obesity, and respiratory failure. The Care Plan Focus dated 2/27/23 reflected Resident #3 had a decline in activities of daily living (ADL). The Intervention directed to not rush the resident and allow extra time for ADLs. On 5/23/24 at 2:36 PM observed Resident #3 laying on her left side in bed with her right arm over her forehead. As she slowly rolled to her right to lay on her back, her face reflected a slight grimace. She stated she had a leg that didn't work very well anymore. Resident #3 described Staff A, Certified Nurse Aide (CNA), as rough when providing care on the overnight shift from 5/21/24 to 5/22/24. Resident #3 elaborated rough meant rushed and maybe angry. In addition, if she didn't move fast enough Staff A pulled on her leg to position her. Resident #3 said she couldn't report the CNA as mean, but just in a hurry. She shouldn't have to fear putting the call light on at night because she didn't know who was going to answer. Resident #3 stated the CNA 'runs hot and cold' and she never knew what she was going to get. On 5/28/24 at 4:45 PM Staff D, Certified Nursing Assistant (CNA), stated that some CNAs can be 'stern.' She reported resident needs were extensive and the CNAs had to do their work to move on to assist other residents. Staff D stated Resident #3 reported Staff A rolled her too hard or too rough. On 5/28/24 at 5:00 PM Staff E, Registered Nurse (RN), stated she observed some CNAs work in a way resident might feel is too fast. She stated residents had complained to her about 3rd shift working with them too fast. (continued on next page)

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

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F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 5/29/24 at 5:24 AM Staff B, CNA, stated maybe some staff do work too fast. Residents want staff to spend a lot of time with them, but they had to get to the next resident to provide care. Staff B stated some staff approaches were hard for residents. She heard residents complain about rude attitudes. That included Staff A. On 5/29/24 at 6:25 AM Staff C, RN, said the facility staffed by budget, not acuity, and some residents didn't sleep through the night. On 5/29/24 at 1:29 PM the Assistant Director of Nursing (ADON) stated residents at night reported they didn't get the care they deserved. On 6/4/24 at 9:50 AM Staff G, CNA, reported Resident #3 told her she tried to be nice to Staff A because she knew she got upset. An interview with Staff A, CNA, on 6/4/24 at 1:09 PM revealed she would go to the nurse if Resident #3 reported pain. She said she didn't think she was rough providing cares. Staff A thought residents might view rough as carelessness, moving too fast, or rushed cares. She stated she could tell maybe by the look on their face or what they said. Staff A confirmed she told other CNAs not to go in the resident's room unless her call light was on. She thought Resident #3 didn't want anyone in there because she was upset when she first arrived that they woke her up multiple times at night. Staff A didn't ask the resident if this was what she wanted. A document titled Resident's [NAME] of Rights, revised 12/2023, documented the resident had a right to a dignified existence and self determination. A facility must treat each resident with respect and dignity and care for each resident in a manner and in an environment that promotes maintenance or enhancement of quality of life. The facility must protect and promote the rights of the resident. The Nursing Facility Abuse Prevention, Identification, Investigation, and Reporting Policy, dated October 2022, indicated the facility would provide a supportive and safe environment for all residents. 2. Resident #6's Minimum Data Set (MDS) assessment dated [DATE] identified a Brief Interview for Mental Status (BIMS) score of 15, indicating intact cognition. Resident #6 required total staff assistance with sitting up in bed and all transfers. The MDS reflected diagnoses of morbid obesity, anxiety and depression, and need for assistance with personal care. The Care Plan Focus dated 4/8/24 indicated Resident #6 had chronic pain and ADL deterioration. The Interventions directed the following: a. Assess the effects of pain b. Monitor for complaints and non verbal signs of pain c. Don't rush the resident allowing for extra time to complete ADLs. An interview with Resident #6 on 5/23/24 at 2:50 PM stated on or around the week of 5/19/24 Staff A was going too fast and grabbed her arm to turn her. Resident #6 further stated there have been other times Staff A has been rude or rushed during care. That included: (continued on next page)

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F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	1. Yelling from the doorway when the call light was on 'what do you want' even though she had to come in to turn the light off 2. Ignoring her when coming in to assist her roommate 3. Making her feel like a nuisance if she needed her, like she shouldn't be here 4. Moving her too fast and rolling her on her arm 5. Making rough, growling sounds while turning her, 'bullish like a drill sergeant ' 6. Telling other CNAs not to come in her room unless the call light was on An interview with Resident #6's roommate on 6/3/24 at 10:00 AM revealed that Staff A is 'hard on' Resident #6. She was 'pretty rough' on her, she heard it. She explained she heard Resident #6 groan and Staff A said she had to roll over and just moved her fast. The resident asked for pillows and Staff A dropped them on the bed without helping her use them as support. Resident #6's roommate added Staff A regularly worked 16 hour shifts, it affected her mood and the way she treated them. On 6/5/24 at 10:19 AM Staff H, Licensed Practical Nurse (LPN), stated he couldn't deny if residents described Staff A as rushed or frustrated, she had a routine and didn't want it messed with. It wouldn't surprise him if there was a complaint; if they called her and she helped. Then they called again, changing her routine and she didn't like that. On 6/5/24 at 2:23 Staff I, CNA, stated residents can misinterpret Staff A and she can misinterpret them. She didn't think that happened with the other staff. Staff A could get anxious and was matter of fact. She had a routine that she stuck to. Some of the residents missed that when she was not there, some didn't. 3. Resident #7's Minimum Data Set (MDS) assessment dated [DATE] identified a Brief Interview for Mental Status (BIMS) score of 15, indicating intact cognition. Resident #7 required substantial to maximal assistance with bed mobility and total assistance from staff to stand from sitting and chair to bed transfers. The MDS reflected diagnoses of chronic pain, obesity, and polyneuropathy. On 5/28/24 at 4:14 PM Resident #7 revealed he felt some of the staff on the overnight shift were 'not so good. ' He stated around 9:00 PM or 10:00 PM he didn't like to put his call light on because of who might walk through the door. He said there were 7nights a week that he lived there and he knew all of them were not going to be good because of certain staff. 'It isn't right.' He mentioned his medications needed to be on time and staff should not talk down to residents. He should not have to worry about who was coming to take care of him. Resident #7 explained joking back and forth with two CNAs who told him he was the boss because he was the resident. When he shared that visit with a nurse and another CNA who came in, he said the nurse told him she was the boss around here and he felt she wasn't joking. This made him feel more anxious. 4. Resident #8's Care Plan listed an admitted [DATE] and diagnoses of diabetes mellitus, Parkinson's disease, and unsteadiness on feet. The Care Plan Focus dated 5/30/24 reflected Resident #8 had a deterioration in ability to complete ADLs. The Interventions instructed to not rush Resident #8, allow extra time, help with morning and evening cares. (continued on next page)

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F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	The Admission Record listed Resident #8 as his own responsible party. A progress note dated 5/29/24 at 13:04 documented Resident #8 reported to the facility's nurse practitioner about a CNA being rough with him last night. On 5/30/24 at 1:50 PM observed Resident #8 resting on his back in bed, on the top of his sheets. Resident #8 described himself as tired due to having difficulty sleeping the night before. He couldn't find his call light and had to get up to use the bathroom. He stated one of the facility's staff came into his room and told him to get back in bed. Resident #8 demonstrated how the CNA put her hands on his back, pushed him, and then he indicated he stumbled. He said he felt helpless and scared because it was dark, and he didn't know who it as he was new to the facility. He asked me to leave the door open so someone could see him. A document titled interview with (Staff J, RN) on 5/29/24 described Resident #8 got up and down a lot that night, used his call light a lot, and that she didn't have concerns with his care. An interview with Staff J on 6/4/24 at 11:39 AM revealed that she didn't know who the CNA was and therefore not able to discuss the care provided. On 6/4/24 at 8:12 AM Staff B recalled working with Resident #8. That night she checked in on the residents at least every 2 hours, completed check and change as needed, and assisted with toileting. She stated this resident was up and down all night and she redirected him to bed, offered the recliner, offered the common area, and took him to the bathroom or provided his urinal at least 4 times. She believed a resident who was being very vocal that night triggered and upset him. She denied physical contact other than putting her hand on his shoulder to guide him back to bed. Staff B indicated he also needed assistance with pivoting and that could be what he was thinking of. She stated there were no other staff in the room while she provided redirection, and they could have prevented this situation if they had enough staff at night to calm the other resident and Resident #8 at the same time. A follow up interview with Resident #8 on 6/3/24 at 10:20 AM determined the resident didn't have concerns over the weekend other than help being slow to come Sunday night. He reported that he remained worried, and watched the hallway outside of his room during the interview. 5. Resident #9's Minimum Data Set (MDS) assessment dated [DATE] identified a Brief Interview for Mental Status (BIMS) score of 15, indicating intact cognition. Resident #9 required partial to moderate assistance with bed mobility and needed total assistance from staff for transfers. The MDS reflected diagnoses of benign prostatic hyperplasia, chronic pain, and a fracture. A progress note dated 4/26/24 at 14:31 labeled Behavior Note documented Resident #9 complained 3 times that week of staff rolling him too rough during cares and being rude. He didn't think they were trying to hurt him but did say they needed to be gentler. The Progress Notes lacked follow-up documentation with Resident #9 about the status of the situation. (continued on next page)

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F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 6/3/24 at 3:12 PM Resident #9 reported he didn't think staff were rough any more, but mostly too fast. They could still slow down a little and talk to him. He said some staff are more respectful than others.

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure services provided by the nursing facility meet professional standards of quality. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 48452 Based on clinical record review, interviews, and policy review the facility failed to ensure catheter care orders were in place for 1 of 3 residents reviewed for catheter care (Resident #1). The facility reported a census of 83 residents. Findings include: Resident #1's Minimum Data Set (MDS) assessment dated [DATE] identified a Brief Interview for Mental Status (BIMS) score of 15, indicating intact cognition. Resident #1 required supervision or touch assistance with transfers, standing up from bed, and mobility. The MDS reflected diagnoses of benign prostatic hyperplasia, chronic kidney disease, and respiratory failure. The Care Plan Focus dated 4/29/24 indicated Resident #1 had a urinary catheter. The Focus lacked interventions for cleaning the catheter site, changing the catheter bag, or changing the catheter. Neither the Medication Administration Record (MAR) or the Treatment Administration Record (TAR) documented an order to change the indwelling urinary catheter on a schedule or as needed before 5/13/24, (27 days after admission). The MAR and TAR printed at 9:58 AM on 5/28/24 lacked documentation of orders to change the catheter bag. The Order Note dated 5/13/24 at 2:42 PM indicated Resident #1 didn't have orders entered for care of the indwelling urinary catheter. The nurse contacted the Nurse Practitioner for orders at that time. On 5/28/24 at 5:59 PM the Administrator stated the only time the facility monitored fluid intake or urine output for residents with a catheter was if there was a provider's order. On 5/29/24 at 1:55 PM the Director of Nursing stated the facility entered orders at admission and found an RN to do the admission assessment. Sometimes that was her or the Assistant Director of Nursing, or the charge nurse. She further stated that there was no documentation of emptying the bags, tracking fluid intake, or measuring urine output that might have caught missing orders. An interview with Staff K, Licensed Practical Nurse (LPN) on 5/30/24 at 10:18 AM revealed there were no orders in place for catheter care or maintenance when the resident began complaining of pain on 5/13/24, so he had to call the nurse practitioner to establish care. He had to find supplies, put together a makeshift catheter kit, and was able to get it changed later that day. He stated someone dropped the ball on making sure the orders were in place at admission. A policy titled Catheter Care effective 10/1/18 documented the procedure for catheter site care. It lacked policy or procedure regarding catheter orders, bag replacement, catheter replacement, assessment for care or removal, or documentation of input/output.

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate pressure ulcer care and prevent new ulcers from developing. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 48452 Based on clinical record review, interviews, and policy review the facility failed to provide wound care as ordered for 1 of 3 residents (Resident #2) In addition, the facility failed to complete skin assessments for 1 of 3 residents reviewed (Resident #6). The facility reported a census of 83 residents. Findings include: 1. Resident #2's Minimum Data Set (MDS) assessment dated [DATE] identified a Brief Interview for Mental Status (BIMS) score of 15, indicating intact cognition. Resident #2 required substantial to maximal assistance with rolling in bed, they required total assistance with sitting up and transfers. The MDS included diagnoses of diabetes mellitus, paraplegia (inability to move from the waist down), stage IV (4) pressure ulcer of unspecified buttock, and non pressure chronic ulcer of skin of sites with fat layer exposed. The Care Plan Focus initiated 3/6/23 reflected Resident #2 had skin breakdown. The Interventions directed the following: a. Assess Resident #2 for risk factors b. Assist with repositioning, keeping skin as clean and dry as possible c. Minimize skin exposure to moisture d. Monitor skin during care e. Skin treatments as ordered for areas of impaired skin integrity. A document titled Treatment Administration Record (TAR) listed the following treatments as not completed in May 2024: a. 5/1/24: i. Gentamicin 480mg in Saline Solution Use 60 ml via irrigation every evening shift for Bladder irrigation Instill 60mL into bladder via catheter. Clamp for 30min, then drain. ii. Calamine External Lotion 8 8 % Apply to Affected Area topically every day and evening shift for Itching due to shingles. iii. Calmoseptine External Ointment 0.44 20.6 % Apply to Left groin topically every day and evening shift for MASD wound until healed. iv. Dakin's (1/4 strength) External Solution 0.125 % (Sodium Hypochlorite) Apply to Coccyx topically every day and evening shift for Coccyx/sacral wound Dampen kerlix with Dakin's solution and pack into wound base. Cover with dry ABD and secure with Medipore tape. (continued on next page)

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	v. Dakin's (1/4 strength) External Solution 0.125 % (Sodium Hypochlorite) Apply to right ischium topically every day and evening shift for right ischium pressure ulcer Cleanse wound, pat dry. Apply skin prep to the intact skin around the wound (peri wound) and at the location of the adhesive application. Lightly moisten gauze, pack lightly into wound bed, cover with silicone border or ABD PAD & paper tape (DUODERM ANCHORS IN PLACE FOR TAPE) BID and PRN vi. Miconazole Powder (Miconazole) Apply to ABDOMINAL SKIN FOLDS topically every day and evening shift for MASD Cleanse skin with soap and water, rinse well, pat dry, sprinkle powder lightly until healed vii. Miconazole Powder (Miconazole) Apply to Bilateral groin topically every day and evening shift for MASD Cleanse skin with soap and water, rinse well, pat dry, sprinkle powder lightly until healed viii. Miconazole Powder (Miconazole) Apply to Neck folds topically every day and evening shift for MASD Cleanse skin with soap and water, rinse well, pat dry, sprinkle powder lightly until healed ix. Triad Hydrophilic Wound Dress External Paste (Wound Dressings) Apply to penis topically every day and evening shift for Pressure ulcer, penis Cleanse open area, pat dry. Apply triad paste and cover w/ gauze. BID and PRN x. Triad Hydrophilic Wound Dress External Paste (Wound Dressings) Apply to Right Posterior Thigh topically every day and evening shift for Shearing b. 5/6/24: i. Mepilex Border Flex External Pad Apply to Umbilicus topically every day shift for Hernia Change mepilex dressing daily and as needed. ii. Mepilex External Pad Apply to Bilateral Heels topically every day shift for Bilateral heal callous A document titled Medication Administration Audit Report documented that in the week prior to Resident #2's discharge to the hospital, the facility provided 101 out of 113 treatments outside of their scheduled time frames. A progress note dated 5/20/24 at 10:34 AM titled SBAR Summary for Providers documented a change of condition for the resident. It included respiratory changes, abdominal pain and tenderness, pain, and pressure ulcer/injury wound. The recommendation was to send Resident #2 to the emergency department (ED) for further investigation, recommendation, treatment. A document titled ED Triage Notes dated 5/20/24 at 12:50 PM documented Resident #2 transferred to a different healthcare facility with a pressure injury to the sacral region with necrotizing fasciitis (bacterial infection causing soft tissue death). On 5/28/24 at 5:00 PM Staff E, Registered Nurse (RN), stated she was very aware of residents complaining about missing wound treatments and indicated management was aware of it as well. She stated the problem was inconsistency in staffing and heavy levels of care along with poor communication. (continued on next page)

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 5/29/24 at 1:29 PM the Assistant Director of Nursing confirmed she was aware of 3 residents with concerns about missing wound treatments, including Resident #2. She stated it was the Director of Nursing's (DON) responsibility to order supplies and she did that monthly. There was a way to order emergency supplies if needed. On 5/29/24 at 1:55 PM the DON stated she was not aware of any resident complaints about missing wound treatments. She tried to figure out the resident's needs and ordered supplies once a month. The DON stated a lot of high acuity had put a strain on their supplies. She indicated that insurance only allowed for specific amounts so she tried to order more stock supplies. On 6/5/24 at 10:19 AM Staff H, Licensed Practical Nurse (LPN), explained they had difficulty making sure the facility had enough dressings in place for Resident #2. He stated he planned 5 days ahead for catheter care to make sure he had all of the supplies, but sometimes, the dressings just ran out. Staff take things from an area they shouldn't without telling someone. He said they just need to know the supplies are available to do their job. Staff H also reported that Resident #2 told him the weekend agency staff were not completing all of the treatments they marked. On 6/6/24 at 2:06 PM the Administrator stated that if a box didn't have documentation on the TAR, ideally the nurse did the treatment, but missed documenting it happening. However, nursing 101 is that if no one documented it, it didn't happen. She didn't know the TAR reflected time of the completed treatments. The Pressure Ulcer Prevention Program policy, effective 6/7/17, instructed to complete assessments in a timely manner; implement interventions, monitor, and revise as appropriate; and recognize, evaluate, and report changes in condition to the resident's attending practitioner. The program shall include implementing individualized comprehensive plans of care (interventions). The procedure included following physician's orders for treatment. 2. Resident #6's Minimum Data Set (MDS) assessment dated [DATE] identified a Brief Interview for Mental Status (BIMS) score of 15, indicating intact cognition. Resident #6 required total staff assistance with sitting up in bed and all transfers. The MDS reflected diagnoses of morbid obesity, anxiety and depression, and need for assistance with personal care. The Care Plan Focus dated 4/8/24 indicated Resident #6 had chronic pain and ADL deterioration. The Interventions directed the following: a. Assess the effects of pain b. Monitor for complaints and non verbal signs of pain c. Don't rush the resident allowing for extra time to complete ADLs. On 5/23/24 at 2:50 PM observed Resident #6 lying in her bed, covers on, propped up with pillows, watching television. She stated that on or around the week of 5/19/24, as Staff A went too fast with her cares, she grabbed her right arm to turn her. Resident #6 showed a bruise on the inside of her arm and reported it as a result of that repositioning. The observation revealed no additional bruises next to or on the other side of her arm. (continued on next page)

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Resident #6's progress notes lacked documentation of a skin assessment or the origin of the original bruise. The facility lacked documentation of completed skin assessments with Resident #6's showers on 5/9/24, 5/13/24, 5/16/24, 5/20/24, 5/23/24, 5/27/24, or 5/30/24. On 5/31/24 at 4:29 PM the Administrator provided an incomplete Daily Bath Tracking Log by email. She wrote CNAs/Bath Aides completed the bath sheets that identified new skin areas, and then gave the sheets to the nurse to address if the resident had any areas noted. If no areas noted they gave the sheets to the DON to file. On 6/3/24 at 8:17 AM in a follow-up email, the Administrator reported they recently implemented the tracking logs and they didn't have any available for the month of May. On 6/5/24 at 10:19 AM Staff H, Licensed Practical Nurse (LPN), reported he didn't know of Resident #6's bruise until the Assistant DON came to investigate the cause.

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F 0690 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide appropriate care for residents who are continent or incontinent of bowel/bladder, appropriate catheter care, and appropriate care to prevent urinary tract infections. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 48452 Based on clinical record review, observations, interviews, and policy review the facility failed to accurately and thoroughly assess patterns in fluid intake, voiding patterns, cleaning care, or symptoms associated with long term catheter use for 3 of 3 residents reviewed for catheters and for 12 of 12 residents in the facility using catheters as part of their care. The facility reported a census of 83 residents. Findings include: 1. Resident #1's Minimum Data Set (MDS) assessment dated [DATE] identified a Brief Interview for Mental Status (BIMS) score of 15, indicating intact cognition. Resident #1 required supervision or touch assistance with transfers, standing up from bed, and mobility. The MDS reflected diagnoses of benign prostatic hyperplasia, chronic kidney disease, and respiratory failure. Resident #1's Care Plan included a focus area dated 4/29/24 documenting the use of the indwelling catheter related to urinary retention and a failed voiding trial. Interventions included catheter care BID and PRN (twice a day and as needed), reporting urinary tract infection symptoms, labs as ordered, and assessing for continued need of the catheter quarterly. The Care Plan lacked interventions regarding resident specific catheter site cleaning and care, changing the catheter bag, changing the catheter, fluid intake or urinary output guidelines, or symptoms to monitor for a change in condition. The MDS Observation Tasks documented continence for 29 of 41 possible shifts from 5/1/24 to 5/14/24 with 12 shifts not documented. 2 of 29 reflected Resident as continent, 11 of 29 as incontinent, 2 of 29 not rated due to a condom catheter, and the remaining 14 identified Resident #1's indwelling catheter. The document lacked evidence the staff provided catheter or catheter bag care on any shift. Progress notes, task sheets, electronic health records, and paper charts lacked documentation regarding patterns in fluid intake, voiding patterns, cleaning care, or symptoms associated with long term catheter use. 2. Resident #2's Minimum Data Set (MDS) assessment dated [DATE] identified a Brief Interview for Mental Status (BIMS) score of 15, indicating intact cognition. Resident #2 required substantial to maximal assistance with rolling in bed, they required total assistance with sitting up and transfers. The MDS included diagnoses of diabetes mellitus, paraplegia (inability to move from the waist down), stage IV (4) pressure ulcer of unspecified buttock, and non-pressure chronic ulcer of skin of sites with fat layer exposed. Resident #2's Progress notes, task sheets, electronic health records, and paper charts lacked documentation regarding patterns in fluid intake, voiding patterns, cleaning care, or symptoms associated with long term catheter use. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	165278	A. Building B. Wing	06/06/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Living Center West	1050 4th Avenue SE Cedar Rapids, IA 52403

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F 0690 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	3. Resident #9's Minimum Data Set (MDS) assessment dated [DATE] identified a Brief Interview for Mental Status (BIMS) score of 15, indicating intact cognition. Resident #9 required partial to moderate assistance with bed mobility and needed total assistance from staff for transfers. The MDS reflected diagnoses of benign prostatic hyperplasia, chronic pain, and a fracture. Progress notes, task sheets, electronic health records, and paper charts lacked documentation regarding patterns in fluid intake, voiding patterns, cleaning care, or symptoms associated with long term catheter use. Observation of catheter bag care for Resident #9 on 6/3/24 at 1:49 PM revealed staff pulled the curtain, practiced hand hygiene, wore appropriate PPE, and cleaned the tubing. Staff didn't discuss fluid intake with the resident, ask about catheter associated pain, or document urine output. An interview with Staff L, Licensed Practical Nurse (LPN) on 5/28/24 at 4:34 PM revealed orders for changing bags and the catheter should be in the electronic health record. She stated sometimes she doesn't have the right supplies for catheter care. She didn't think the facility measured fluid intake or urine output for any residents unless there was a specific order. On 5/28/24 at 4:45 PM Staff D, Certified Nursing Assistant (CNA) stated they have never had to document catheter care, input, or output for. They told the nurse what they observed and the nurse documented. On 5/28/24 at 5:00 PM Staff E, Registered Nurse (RN), stated they didn't document outputs at the facility. The CNAs emptied catheter bags at the end of every shift, but, didn't document either. She indicated there were residents currently in the facility on fluid restrictions and dialysis who should have this monitored. She thought it should be in the electronic health record under the task section. During an interview at 5:59 PM on 5/28/24 the Administrator stated the only time the facility monitored intake and output for catheters was if the doctor wrote an order for it. During an interview on 5/29/24 at 6:25 AM Staff C, RN stated she experienced poor communication in the facility. She indicated there was information she felt she should have about residents that she didn't get. She didn't know about documenting urine output, as the CNAs didn't have a place to record quantity or quality. She said notifying the providers of decreased output is difficult, because they don't have data to report. On 5/29/24 at 1:29 PM the Assistant Director of Nursing (ADON) stated the facility didn't currently document fluid intake or urine output unless they had an order from the provider. The order from the provider only included fluid restriction, not how much input to allow or to monitor for output. She reported she expected the staff to document the information. On 5/29/24 at 1:55 PM the DON explained they didn't have catheter care documentation. A follow up interview on 6/6/24 at 12:01 verified catheter care didn't get documented. The DON couldn't report how they verified the completion of catheter care. (continued on next page)

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F 0690 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	A policy titled Comprehensive Assessment and Reassessment, effective 5/10/17, documented the assessment of the care or treatment required to meet the needs of the resident shall be ongoing throughout the resident's stay, with the assessment process individualized to meet the needs of the resident population. It listed symptoms that might be associated with a disease, condition, or treatment, continence, and special treatments and procedures as factors in this process. A policy titled Catheter Care, effective 10/1/18, provided the procedure for emptying the catheter bag. It didn't address the other components of catheter care, assessments, monitoring, communication with providers, patterns in fluid intake, voiding patterns, interventions, cleaning care, or symptoms associated with short or long term catheter use.

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F 0835 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Administer the facility in a manner that enables it to use its resources effectively and efficiently. 48452 Based on observation, record review, and interviews the facility failed to maintain an adequate number of supplies to provide for the daily needs of all residents in the facility. The facility reported a census of 83 residents. Findings include: The Treatment Administration Record for Resident #2 lacked documentation of completion of 12 treatments between 5/1/24 and 5/6/24. During an interview with Staff L, Licensed Practical Nurse (LPN) on 5/28/24 at 4:34 PM she stated sometimes she didn't have the supplies she needed for catheter care. On 5/28/24 at 4:45 PM Staff D, Certified Nursing Assistant (CNA) stated 3 different residents complained of missed wound care treatments. She provided that information to the nurse on duty. On 5/28/24 at 5:00 PM Staff E, Registered Nurse (RN) stated there were not enough supplies to complete care. She gave the example of a need the week before to use pudding cups instead of medication cups because they ran out. At 6:25 AM on 5/29/24 Staff C, RN, stated supplies were an issue in the facility. She felt they didn't keep track of the used items and the acuity of the residents admitted . Staff C mentioned running out of medication cups, cups used to measure 30 cc when flushing catheters, blood glucose test strips when there were 11 diabetic residents on one floor, alcohol squares which required them to order some from the pharmacy to ensure they could continue to provide care, tissues, and gloves. She also reported the facility had to ask a family member to bring in colostomy supplies from home for a new resident because they were not properly prepared for her arrival. On 5/29/24 at 1:29 PM the Assistant Director of Nursing (ADON) stated the Director of Nursing (DON) ordered supplies. She would order once a month and could ask for emergency orders if needed. The ADON stated she had heard multiple instances of running out of supplies including medication cups. She stated she put multiple notes under the DON's door and added that the Administrator had to come in on a Saturday to help get supplies so staff could complete their work. On 5/29/24 at 1:55 PM the DON confirmed she was responsible for supplies and ordered them once per month. She stated she tried her best to figure out the supplies needed and noted high acuity put a strain on their supply. The DON stated she started ordering more stock supplies because insurance only allowed specific amounts. On 6/4/24 at 11:50 AM observed the lower level storage room. A white plastic organizer held drawers labeled with different sizes of Mepilex wound dressings. All of the drawers were empty except the one labeled with the 6 inch by 6 inch size which held two of the dressings. The Director of Nursing (DON) stated she was placing an order that day. (continued on next page)

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F 0835 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 6/4/24 at 12:00 PM observed a second floor medication cart. There was one 2 inch by 2 inch Mepilex in the second drawer, with 3 more in a box in the 3rd drawer. The double-locked bottom drawer of the cart contained approximately 3, 6x6 Mepilex. Staff H reported they locked those dressings so they didn't disappear when he needed them to provide treatment. He stated people took them and didn't tell anyone so he would run out when he needed to complete treatments.