STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	165284	A. Building B. Wing	09/05/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Sunny Knoll Care Centre	135 Warner Street Rockwell City, IA 50579

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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 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured. 49628 Based on clinical record review, staff interviews, and policy reviews the facility failed to develop and implement a Comprehensive Care Plans for 2 of 17 residents reviewed (Resident #6 and #13). The facility reported a census of 25 residents. Findings include: 1. The Minimum Data Set (MDS) for Resident #6 dated 6/20/24 identified a Brief Interview for Mental Status (BIMS) score of 10 which indicated moderate cognitive impairment. The MDS documented diagnoses that included: coronary artery disease, heart failure, asthma, and respiratory failure. Resident #6 received oxygen therapy while a resident in the facility and during the last 14 days of the assessment reference period. The Baseline Care Plan dated 6/14/24 revealed the resident had a specialized service/treatment for oxygen at 2L via nasal cannula (NC). The Care Plan printed on 9/5/24 revealed there was not a focus area or interventions for staff to follow until 9/4/24 regarding the resident ' s use of oxygen. On 9/4/24 a new focus area for oxygen therapy was initiated with directions for staff to follow regarding Resident #6's need for oxygen. Resident #6's Clinical Physician Orders revealed the resident used 1.5 L per nasal cannula continuously to keep O2 saturations above 90%. 2. The MDS for Resident #13 dated 6/18/24 identified a BIMS score of 14 which indicated intact cognition. The MDS documented diagnoses that included: arthritis, cerebrovascular accident, and tobacco use. The document revealed Resident #13 used tobacco. The Baseline Care Plan date 6/12/24 revealed smoking safety as a potential education need for the resident. The Care Plan printed 9/5/24 revealed there had not been a focus area or interventions for smoking until 9/4/24. On 9/4/24 the care plan was updated to include a focus area of smoking and the directions staff were to follow with the resident regarding smoking. (continued on next page)

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 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The Smoking Data Collection documents dated 6/12/24 and 9/4/24 revealed the resident had impaired decision making ability, required a smokers apron, and may only smoke with staff supervision. On 9/4/24 at 2:20 PM the Director of Nursing (DON) expected the supports the residents needed regarding oxygen and smoking would be reflected on the care plans. The DON acknowledged the care plans need to have revisions and be current with a resident's needs. On 9/4/24 at 3:00 PM the Administrator stated she did not know a lot about care plans, but expected the supports the residents required would be reflected on the documents. The facility provided document, Oxygen Administration, revised 6/15/21, revealed the treatment plan be reviewed, revised as indicated and per physician order. The facility provided document, Smoking: Resident/Patient Overview, revised 9/19, revealed the resident should have an individualized smoking plan and the smoking plan of care be implemented. The facility provided document, Care Plan Development 5.4, with an original date of 8/15, revealed the care plan is integral to the provision of resident care. The document further revealed the care plan is derived from the MDS and identified the resident needs, strengths, risk factors, and abilities.

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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** 41785 Based on observation, interviews and record review the facility staff failed to follow physician's orders for 2 of 15 residents reviewed, (Resident #15 and #14). Resident #15 had a brief hospitalization , when he returned to the facility his antipsychotic medication had been entered incorrectly and was administered at the wrong dose for 6 days. Resident #14 had a diagnosis of diabetes and the physician communicated to staff when to contact him/her regarding blood glucose levels outside the parameters. Staff failed to contact the doctor when the resident had a high glucose. The facility reported a census of 25 residents. Findings include: 1) According to the Minimum Data Set (MDS) dated [DATE], Resident #15 had a Brief Interview for Mental Status (BIMS) score of 15, cognitively intact. The resident used a walker and a wheelchair, and required substantial assistance with dressing, hygiene and toilet transferring. His diagnoses included anemia, hypertension, diabetes mellitus, anxiety, depression, bipolar disorder, syncope and narcolepsy. The Care Plan updated on 8/13/24, showed Resident #15 had an actual fall due to poor balance, and he had self-care performance deficit related to an amputation below the left knee. The resident used antidepressant medication and the psychotropic medications; aripiprazole (Abilify) and quetiapine related to behavior management. Staff were directed to administer medications as ordered and document side effects. On 9/3/24 at 9:34 AM, Resident #15 was in his room in bed and just waking up for the day. He said that he had shoulder pain after a recent fall. Resident #15 said that since the fall he is supposed to wait for someone to help transfer, he had been independent. The Clinical Physician Orders showed an order dated 8/3/24 at 7:30 AM, for Aripiprazole 20 milligrams (mg) one time a day. According to an Incident Report dated 8/14/24 at 3:05 AM, Resident #15 fell in his room and was taken to the hospital. The Hospital Patient Discharge Instructions dated 8/21/24 at 4:10 PM, showed the following medication orders: a. Aripiprazole 2 mg. 1 tab once a day b. Aripiprazole 20 mg. 1 tab once a day. The List of Medications was initialed on 8/21/24, by Staff B Licensed Practical Nurse (LPN), indicating the Medication Administration Record (MAR) was updated, the clinical contact was notified and a Progress Note was entered. The list was noted on 8/22/24 by the Director of Nursing (DON). (continued on next page)

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The August MAR showed that the Aripiprazole 2 mg was entered into the electronic chart on 8/21/24 at 11:33 PM. The previous Aripiprazole 20 mg. order was still active, so Resident #15 received 22 mg. daily from 8/22 - 8/27. On 9/4/24 at 10:20 AM, Staff C, Registered Nurse (RN) looked at the August MAR for Resident #15. She acknowledged that she signed off on both orders on 2 of the 6 days but she did not remember if there was a separate card and did not question the order. On 9/4/24 at 12:44 PM, Staff B, Licensed Practical Nurse (LPN) said that the nurses have been taught to double note medication lists after they are entered so a second person checks for accuracy. He said the DON would also look it over the list so they practiced triple checking. Staff B said that he would not sign the document until he knew the medications were accurate. Staff D didn't remember the hospital orders for Resident #15, but he thought there had been some changes when he came back from the hospital. On 9/4/24 at 8:31 AM, the DON acknowledged that she signed off on the medication list from the hospital. She said that some of the medications had been entered incorrectly and some were later discontinued. She acknowledged that by initialing the medication list, the nurse was saying that the list was entered correctly, and a second signature was saying it was checked and it was correct. 2) According to the MDS dated [DATE], Resident #14 was admitted to the facility on [DATE] with a BIMS score of 12 (moderate cognitive deficits). He required substantial assistance with dressing, hygiene and transfers. He had a diagnosis of hypertension, diabetes mellitus, muscle wasting and atrophy. The Care Plan revised on 3/13/24, showed Resident #14 had diabetes mellitus and was insulin dependent. Staff were directed to monitor and document for side effects and effectiveness of medication. An order dated 8/5/24 at 7:30 AM, directed staff to use the Accu-Chek (glucometer, measures BG levels), 4 times a day, and to call the provider for Blood Glucose (BG) level less than 70 and/or over 400. Normal blood glucose levels for diabetics tend to run around 80-180 mg/dL (milligrams per deciliters). A Nursing Note dated 8/22/24 at 1:38 PM, showed the residents BG levels had been unstable and the provider was monitoring. The Vitals tab in the electronic chart showed on 8/19/24 at 11:04 PM, Resident #14 had a blood glucose level of 489. The documentation was signed by Staff A, LPN. The chart lacked evidence that the BG had been rechecked, and lacked any nursing note for the overnight shift on 8/19/24. On 9/4/24 at 1:35 PM Staff A, LPN said Resident #15 had unstable blood glucose. She worked the overnight shifts and would check the BG before he went to bed. She did not remember a time when his were out of parameters and if it had ever been high or low, she said that she would have taken it again before contacting the doctor. She didn't know of time when it was over 400 mg/dl during her shift. (continued on next page)

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 9/5/24 at 8:25 AM, the DON said that she had done some education with Staff A on the high glucose level and expectations. She said she would have wanted her to retake the BG, add a nursing note and if it was still high, to contact the primary care physician. On 8/5/24 at 10:05 AM, the Administrator said that they did not have policies specific to blood glucose parameters or medication order entry, but they follow the standards of care. She agreed that it was standard of care to double check a BG outside of norms and then call the doctor if it was still abnormal. She also agreed that medication orders should be double checked for accuracy.

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide care and assistance to perform activities of daily living for any resident who is unable. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 41785 Based on observations, interviews and record review, the facility failed to ensure that vulnerable residents were repositioned to ensure comfort and prevent ulcers for 1 of 2 residents reviewed, (Resident #21). The facility reported a census of 25 residents. Findings include: According to the Minimum Data Set (MDS) dated [DATE], Resident #21 was unable to participate with a Brief Interview for Mental Status (BIMS) assessment (severe cognitive deficits) She was admitted to the facility on [DATE] on Hospice services, and was totally dependent on staff for eating, hygiene, toileting, and dressing. She was always incontinent of bowel and urine. Her diagnoses included renal insufficiency, Alzheimer's Disease, cognitive communication deficit, muscle weakness and dysphagia. The Care Plan updated on 7/23/24, showed Resident #21 had limited neck movement and she was non-verbal due to diagnosis of Alzheimer's disease. She was admitted to the facility with three pressure ulcers; one on each hip and one on the coccyx. Staff were directed to follow facility policies/protocols for the prevention/treatment of skin breakdown. Resident #21 needed monitoring assistance to turn and reposition and she required skin inspection with all cares and weekly by nursing. Staff were to observe for redness, open areas, scratches, cuts, bruises and to report changes. The following was an ongoing observation of Resident #21 on 9/3/24: 12:00 PM, the resident was at the lunch table in her Wheel Chair (WC) and was sleeping. 1:04 PM in the WC in her room, sleeping. Her head hangs down far on the right side. 1:22 PM, still in the WC sleeping, head hanging low to the right side. 1:58 PM, still sleeping in the WC, head hanging to the right. 2:30 PM, the resident was awake, still in the WC with head hanging to side 2:46 PM, 2 unidentified aides went room to room passing ice water. 2:47 PM one of the aides went into the room of Resident #21 and walked back out. 2:56 PM in the WC sleeping. Her legs are crossed. 3:16 PM sleeping in the WC, her left leg bent with foot on the seat of the WC. 3:33 PM resident's feet were back down on the foot pedals of the WC and she was sleeping. 3:48 PM, 2 aides exited the resident's room and she was in bed on her right side. (continued on next page)

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 9/5/24 at 8:21 AM, the Director of Nursing (DON) said the aide that was caring for Resident #21 on 9/3/24 realized at the end of the day that she had forgotten to put the resident in bed after lunch. The DON said that she educated staff, and acknowledged that 4 hours was too long for the resident to be sitting the chair and she should have been put into bed. On 8/5/24 at 10:05 AM, the Administrator said that they did not have a policy specific to how often staff should reposition vulnerable residents. She acknowledged that 4 hours was too long for a resident to be left in the wheel chair. According to a facility policy titled: Skin Care and Wound Management dated 6/2015. The interdisciplinary team would work with the resident and responsible party to identify and implement interventions to prevent and treat potential skin integrity issues. Risk factors include: impaired mobility and decreased activity.

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate treatment and care according to orders, resident's preferences and goals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 41785 Based on observation, interview and record review the facility failed to monitor and follow up on skin issues for 2 of 2 residents reviewed, (Residents #21 and #11). At the time of survey, Residents #21 and #11 were found to have skin issues that were not being monitored or documented. The facility reported a census of 25 residents. Findings include: 1) According to the Minimum Data Set (MDS) dated [DATE], Resident #21 was unable to participate with a Brief Interview for Mental Status (BIMS) assessment (severe cognitive deficits) She was admitted to the facility on [DATE] on Hospice services and was totally dependent on staff for eating, hygiene, toileting, and dressing. Her diagnoses included renal insufficiency, Alzheimer's Disease, cognitive communication deficit, muscle weakness and dysphagia. The Care Plan updated on 7/23/24, showed Resident #21 had limited neck movement and she was non-verbal due to diagnosis of Alzheimer's disease. She was admitted to the facility with three pressure ulcers; one on each hip and one on the coccyx. Staff were directed to follow facility policies/protocols for the prevention/treatment of skin breakdown. Resident #21 needed monitoring assistance to turn and reposition and she required skin inspection with all cares and weekly by nursing. Staff were to observe for redness, open areas, scratches, cuts, bruises and to report changes. On 9/3/24 at 9:47 AM, Staff E, Certified Nurse Aide (CNA) and Staff D, CNA, provided incontinence cares to Resident #21. The resident was very thin with many boney prominences (vulnerable to pressure sores) throughout. She had protective patches on the right and left hip dated 9/2/24 and an uncovered scab, partially open, on her right knee. Staff D and Staff E were not aware of what caused the sore on her knee or if the nurses were aware. The most recent Weekly Skin assessment dated [DATE] at 9:41 AM, showed the resident had two identified sites; one on the left hip and one on the right hip that was healed. The clinical record lacked documentation of the spot on her knee or any physician's order for treatment of that area. On 9/4/24 at 6:30 AM, Staff D, CNA provided a shower to Resident #21. The left hip had a pinpoint area that was open, and the right hip had a reddened area with no open spots. Staff D said that yesterday was the first time that she had seen the scab on the right knee. On 9/4/24 at 3:35 PM the Director of Nursing (DON) said the CNA's are expected to document a new skin issue and to notify nursing. She suspected that Resident #21 had hit her knee on the table or wall because she does bend her legs a lot. A facility policy titled: Skin Care and Wound Management dated 6/2015, showed that the interdisciplinary team would evaluate and documented identified skin impairments and description of impairment to determine appropriate treatment. Staff would provide weekly monitoring of resident skin status and daily monitoring of existing wounds. 26527 (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	2) According to the MDS assessment dated [DATE], Resident #11 scored 10 on the BIMS indicating moderate cognitive impairment. The resident depended on staff for activities of daily living except eating. The resident had diagnoses including non-Alzheimer's dementia and multiple sclerosis. The MDS indicated the resident was at risk for developing pressure ulcers, but had no ulcers, wounds or skin problems. The Care plan revised 4/14/19 identified Resident #11 had the potential for pressure ulcer development related to disease process. Interventions included following facility policies/protocols for the prevention of skin breakdown, informing Resident #11 caregivers of any new area of skin breakdown, and monitoring/documenting/reporting to the physician as needed for changes in skin status, appearance, and color. On 9/3/24 at 11:09 a.m. Resident #11 sat in the common area with noted scabs on her right ear. On 9/4/24 at 10:42 a.m. the scabs on the resident's right ear were clearly visible from across the room (dining room/common area). On 9/4/24 at 4:32 p.m. the resident sat in the common area. Her right ear appeared red. The resident stated it itched and she had scratched it. The resident's clinical record lacked any documentation of the areas to her right ear. On 9/4/24 at 3:26 p.m. the DON stated she thought the resident had an area on her ear that had resolved. If she had developed another area staff should have assessed the area and intervened as necessary.

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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. 49628 Based on clinical record review, staff interviews, and policy review the facility failed to protect a resident from possible accidents and injuries for 1 of 17 residents reviewed, (Resident #13). The facility reported a census of 25 residents. Findings include: The MDS for Resident #13 dated 6/18/24 identified a BIMS score of 14 which indicated intact cognition. The MDS documented diagnoses that included: arthritis, cerebrovascular accident, and tobacco use. The document revealed Resident #13 used tobacco. The Baseline Care Plan date 6/12/24 revealed smoking safety as a potential education need for the resident. The Care Plan printed 9/5/24 revealed there had not been a focus area or interventions for smoking until 9/4/24. Resident #13's Clinical Physician Orders did not reveal physician's orders for smoking. Review of the Electronic Health Record (EHR) revealed an order for nicotine patches for 14 mg x14 days, 7 mg x14 days and discontinue. Resident #13's Medication Administration Review (MAR) 7/24 revealed a Nicotine Transdermal Patch 24 hour (hr) 14 mg/24 hr patch initiated on 7/3 and discontinued on 7/7/24. An order for the Nicotine Transdermal Patch 24 hr 14 mg/24 hr patch initiated on 7/7/24, held from 7/8 to 7/12 and ended on 7/17/24. An order for Nicotine Transdermal Patch 24 hr 7 mg/24 hr patch with a hold from 7/3 to 7/22 with the first patch on 7/22/24 and the last patch on 7/31/24 for a total of 8 patches. Resident #13's 8/24 MAR revealed the order for Nicotine Transdermal Patch 24 hr 7 mg/24 hr patch present with no further dates marked as given. The 9/24 MAR did not reveal the Nicotine Transdermal Patch 24 hr 7 mg/24 hr patch. The Smoking Data Collection documents dated 6/12/24 and 9/4/24 revealed the resident had impaired decision making ability, required a smokers apron, and may only smoke with staff supervision. On 9/4/24 at 1:50 PM Staff E, Certified Medication Aide, stated she had not taken Resident #13 out to smoke. On 9/4/24 at 2:15 PM Staff C, Registered Nurse (RN), stated she had never taken the resident out to smoke. The staff stated the resident goes out periodically with no set schedule. Staff C stated the resident typically smoked in the evenings. The staff stated the nicotine patches were stopped and started due to the resident wanting to smoke and then wanting to quit. The staff stated she did not know when they were stopped last. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 9/5/24 at 7:13 AM the Director of Nursing (DON) reviewed Resident #13's orders and confirmed the resident did not have an order for smoking. The DON reviewed the MARS and concurred the resident had started and stopped the nicotine patch several times with the 7 mg dose that started on 7/22 and continued through the end of the month for a total of 8 patches. The DON agreed the patch should have continued into August as reflected on the MAR, but could not explain why the patch was not documented as to whether provided or discontinued. On 9/5/24 at 7:25 AM the Administrator stated she expected there would be orders in Resident #13's chart for smoking. The facility provided document, Smoking: Resident/Patient Overview, revised 9/19, revealed a resident who wanted to smoke would have an evaluation/assessment for smoking safety. A component of that assessment would include physician orders.

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F 0851 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Electronically submit to CMS complete and accurate direct care staffing information, based on payroll and other verifiable and auditable data. 49628 Based on the Center for Medicare and Medicaid Services (CMS) Payroll Based Journal (PBJ) Staffing Data Report (January 1 - March 31) review, facility staffing reports review, employee time cards review, and staff interviews, the facility failed to submit accurate staff reports for the PBJ Staffing Data Report. The facility reported a census of 25 residents. Findings include: The PBJ Staffing Data Report run date 8/29/24 triggered for failing to have licensed nursing coverage 24 hours/day - 4 or more days within the quarter with <24 hours/day licensed nursing coverage with specific infraction dates. The report reflected 7 dates with failure to provide 24 hour/day nursing coverage during February and March. Review of the Nurse Schedule for the infraction dates revealed nursing shifts covered by Staff F, previous Director of Nursing (DON), for 5/7 dates. Review of time cards for the remaining 2 infraction dates revealed nursing services were provided for 24 hours/day. On 9/4/24 at 1:30 PM the Business Office Manager (BOM) stated she submitted the staff hours worked to their corporate office for PBJ final submission. The staff indicated 5/7 dates Staff F had worked as a floor nurse. The staff stated Staff F was a salaried position and did not clock in/out when working. The staff stated that one date was a week day which was a normal shift for Staff F. The staff commented that the 4 dates in March were weekend dates, and she provided an Adjusted Hours document reflecting Staff F worked the weekends to the corporate office for PBJ report submission. The staff could not explain why the additional 2/7 dates had flagged as insufficient licensed nurse coverage. On 9/4/24 at 1:40 PM the Payroll Coordinator for Arboreta Healthcare stated if he was aware of salaried staff working as floor staff, it would be reflected on the report. The staff stated he had not received notification Staff F worked as a floor nurse on 3/16, 3/17, 3/23, 3/24 and therefore was not reflected in the submitted report. The staff could not answer when Staff F worked as a staff during the week whether it would show on the report unless specifically noted. On 9/4/24 at 2:00 PM the Administrator stated she was not aware of the PBJ report with triggers for failing to have licensed nursing coverage 24 hours/day for the second quarter. The Administrator acknowledged she knew Staff F had worked as a floor nurse and the hours may not have been submitted correctly.