

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 165350	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 06/19/2024
NAME OF PROVIDER OR SUPPLIER Pine Acres Rehabilitation and Care Center		STREET ADDRESS, CITY, STATE, ZIP CODE 1501 Office Park Road West Des Moines, IA 50265	

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
<p>F 0658</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Ensure services provided by the nursing facility meet professional standards of quality.</p> <p>46875</p> <p>Based on clinical record review, staff interviews and laboratory interview, the facility failed to provide care and services according to accepted standards of clinical practice for 2 of 3 residents reviewed (Residents #2, #3). The facility failed to obtain labs per Physician orders. The facility reported a census of 55 residents.</p> <p>Findings include:</p> <p>1. The Minimum Data Set (MDS) assessment for Resident #2 dated 1/13/24 identified a Brief Interview for Mental Status (BIMS) score of 11, which indicated moderately impaired cognition. The MDS included diagnoses of coronary artery disease, heart failure (inability for the heart to pump enough blood), hypertension (high blood pressure), end stage renal disease (kidney), diabetes mellitus, acute and chronic respiratory failure with hypoxia (low level of oxygen in body tissue), pulmonary hypertension (type of high blood pressure that affects the arteries in the lungs and right side of the heart), and chronic obstructive pulmonary disease(COPD)(chronic inflammatory lung disease that causes obstructive air flow from the lungs).</p> <p>The February 2024 Medication Administration Record (MAR) directed staff to administer Warfarin Sodium (Coumadin/blood thinner) 2.5 mg (milligrams) by mouth in the afternoon (start date 1/25/24) related to atherosclerotic heart disease (hardening of the arteries from plaque buildup).</p> <p>A Progress Note dated 2/1/24 at 10:26 PM documented Resident #2's INR lab result (international normalized ratio) (how long it takes for blood to clot) was 3.2. The note documented new orders were received to continue the same dose of Coumadin and recheck INR in one week.</p> <p>A facility form titled MD/Nursing Communications form dated 2/1/24 directed staff to continue the same dose of Coumadin and recheck an INR in one week. The form was signed by NP (Nurse Practitioner) on 2/2/24.</p> <p>A facility form titled MD/Nursing Communications form dated 2/6/24 directed staff to obtain a straight catheter for urinalysis culture and sensitivity (UA C&S) as recent UA's x 2 have been contaminated and repeat a CBC with differential (complete blood count).</p> <p>An Encounter Note dated and signed by the NP on 2/8/24 directed staff to repeat CBC and refer to GI (Gastrointestinal) as previously ordered and if unable to obtain UA via straight catheter to send through Vikor.</p> <p>(continued on next page)</p>

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

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
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<p>F 0658</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>A Progress Note on 2/8/24 at 11:00 AM documented staff was unable to collect INR this morning.</p> <p>A facility form titled MD/Nursing Communications form dated and signed by NP on 2/9/24 documented previously requested that if unable to obtain UA via straight catheter, then please send via Vikor. Also requested repeat CBC. Please ensure this lab has been drawn.</p> <p>An Encounter Note dated and signed by NP on 2/12/24 documented repeat CBC ordered and awaiting UA results.</p> <p>The Clinical record lacked any follow up or documentation that the INR was obtained on 2/8/24 or after. The clinical record lacked any lab results for the UA and CBC ordered 2/6/24 to 2/12/24.</p> <p>On 6/17/24 at 4:30 PM, the DON (Director of Nursing) verified she could not locate Resident #2's UA and CBC results in the clinical record that were ordered 2/6 to 2/12/24. She stated she would call the laboratory to see if the results were not faxed to the facility.</p> <p>On 6/17/24 at 5:15 PM, the DON reported the facility was to send a UA through Vikor and no one currently knows how to use it or log into the portal.</p> <p>On 6/17/24 at 11:34 AM, the laboratory verified a UA and CBC for Resident #2 was not received from 2/6/24 to 2/12/24. The lab reported they received a lab (CBC with diff) on 2/19/24.</p> <p>On 6/18/24 at 2:10 PM, the DON reported the facility had an INR machine and did the INR labs in house. The DON acknowledged and verified she could not locate that an INR was completed for Resident #2 on 2/8/24 or after. She stated it was an expectation to obtain labs per physician orders.</p> <p>On 6/18/24 at 8:56 AM, Staff B, LPN reported Vikor was a way to take a urine specimen out of a soiled brief. She said she had not used one and was not familiar with how it worked. She stated she thought it was a last resort and not a common practice.</p> <p>On 6/18/24 at 3:57 PM, The DON reported she heard back from Vikor. She stated Vikor had an order for a UA for Resident #2 but nothing was ever sent in.</p> <p>2. The Quarterly MDS assessment for Resident #3 dated 5/24/24, BIMS assessment was not completed. The Staff Assessment for Mental Status which indicated severely impaired decision making. The MDS included diagnoses of anemia, coronary artery disease, hypertension, hip fracture, Alzheimer's disease and Non-Alzheimer's disease.</p> <p>A Physician Order dated 5/29/24 directed staff to obtain UA C&S, clean catch, and send the UA specimen to the facility preferred lab. The order directed to fax the results to hospice.</p> <p>The Progress Notes lacked documentation regarding the Physician order from 5/29/24 and lacked follow up documentation regarding obtaining the UA.</p> <p>The May 2024 Medication Administration Record (MAR) directed staff to obtain UA C&S, clean catch and send it to the facility's preferred lab. The MAR directed staff to fax the UA results to hospice. The UA was signed off with a check mark and staff initials on 5/30/24 indicating the UA was obtained.</p> <p>(continued on next page)</p>		

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<p>F 0658</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>The Clinical record lacked UA results from 5/30/24.</p> <p>On 6/19/24 at 1:50 PM, the DON reported she called the laboratory and there was no UA specimen sent in for 5/30/24. The DON reported she does not believe the UA was obtained.</p> <p>A facility policy titled Laboratory Services and Reporting reviewed/ revised on 4/2024 documented the facility must provide or obtain laboratory services when ordered by a Physician, Physician Assistant, Nurse Practitioner, or Clinical Nurse Specialist in accordance with state law. The policy compliance guidelines document that the facility must provide or obtain laboratory services to meet the needs of its resident and is responsible for the timeliness of services.</p>

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<p>F 0689</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 46875</p> <p>Based on clinical record reviews, observations, staff interviews and policy review, the facility failed to provide adequate nursing supervision to prevent accident and injuries for 1 of 3 residents reviewed (Resident #3) for falls. The facility reported a census of 55 residents.</p> <p>Findings include:</p> <p>The Quarterly MDS assessment for Resident #3 dated 5/24/24, BIMS assessment was not completed. The Staff Assessment for Mental Status indicated severely impaired decision making. The MDS identified Resident #3 was independent with bed mobility and transfers. The MDS documented Resident #3 used a walker, and had impairment on both lower extremities. The MDS documented diagnoses of anemia, coronary artery disease, hypertension, hip fracture, Alzheimer's disease and Non-Alzheimer's disease.</p> <p>An Incident Report dated 5/17/24 at 9:15 PM documented staff found Resident #3 laying on the floor at the end of hall 3. Resident stated, I was walking around and I fell . Resident #3 was laying on his back with his legs stretched out in front of him. Resident #3 complained of acute pain to the left leg and hip with limited range of motion. The left leg was rotated outwards. The incident report documented a phone call placed to the power of attorney(POA) and hospice. The POA and Hospice requested Resident #3 be transferred to the hospital for an evaluation and 911 was called for transport.</p> <p>A Progress note dated 5/18/24 at 1:15 PM documented Resident #3 had been admitted to hospital for a left hip fracture.</p> <p>A Physician Discharge Summary dated 5/20/24 documented Resident #3 diagnosis was a closed left hip fracture. The summary documented discharge orders included:</p> <ul style="list-style-type: none"> -Activity as tolerated with posterior hip precautions for 6 weeks. -Weight bearing as tolerated -Leave dressing on the left hip, keep it clean, dry and intact until clinic visit. <p>A Progress Note dated 5/20/24 at 1:06 PM documented Resident #3 had a left hip displaced femoral neck fracture status post hemiarthroplasty posterior approach left hip. The note documented Resident #3 returned back to the facility at approximately 11 AM. Resident #3 had an order for weight bearing as tolerated. New intervention documented in progress note was for Resident #3 to require assistance of one with transfers and ambulation and to use a wheelchair for long distances.</p> <p>A Fall Risk assessment dated [DATE] documented a score of 18 which indicated Resident #3 was at high risk for falls.</p> <p>(continued on next page)</p>		

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<p>F 0689</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>The Fall Care Plan revised on 5/20/24 documented Resident #3 was at risk for falls related to impaired balance, poor safety awareness, neuromuscular/functional impairment and/or the use of medications that may increase fall risks related to diagnosis of Alzheimer, convulsions, epilepsy, and orthostatic hypotension. The Care Plan documented Resident #3 had a fall on 5/17/24 that resulted in a left hip displaced posterior neck fracture status post hemiarthroplasty posterior approach of the left hip.</p> <p>The Fall Care Plan documented the following new interventions:</p> <p>Posterior hip precautions for 6 weeks. Date Initiated: 05/20/2024</p> <p>Stop sign up on 300 Hall to detour Resident #3 from entering the empty hall. Date Initiated: 05/17/2024</p> <p>W/C for long distances due to left hip fracture Date Initiated: 05/20/2024</p> <p>Weight bearing as tolerated. Staff assistance X 1 with ambulation and transfers. Date Initiated: 05/20/2024</p> <p>A Progress Note dated 6/4/24 at 6:09 PM documented therapy recommended Resident #3 to receive assistance of one staff member with four wheeled walker for gait outside of room and to and from meals. Resident #3 may transfer and gait with a four wheeled walker independently in the room.</p> <p>A Physical Therapy evaluation note dated 6/4/24 documented Resident #3 will benefit from assistance of one for safety with gait outside of his room long distances and with pain however demonstrates safety with modified independence in room using FWW (front wheeled walker).</p> <p>On 6/18/24 at 8:10 AM, observed Resident #3 ambulate independently from his room to the dining room table in the dining room with a four wheeled walk with a steady gait.</p> <p>On 6/19/24 at 11:15 AM, Staff H, LPN (Licensed Practical Nurse) reported Resident #3 walks with his FWW by himself. She stated he is not supposed to but he does.</p> <p>On 6/19/24 at 11:22 AM, Staff I, CMA (Certified Medication Aide) reported Resident #3 was supposed to be the assistance of one. She stated Resident #3 does walk independently with a walker in the hallway. She stated he does get up by himself. She stated if she sees Resident #3 walking by himself she does try to walk with him.</p> <p>On 6/19/24 at 11:35 AM, Staff J, CNA (Certified Nursing Assistant) reported Resident #3 was independent with his walker and he walked around the building by himself.</p> <p>6/19/24 at 11:46 AM, Staff D, CNA reported Resident #3 walks independently inside and outside of his room with this walker. She stated he needs some cueing on when to go to meals and activities but he goes on his own.</p> <p>(continued on next page)</p>		

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<p>F 0689</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>On 6/19/24 at 12:25 PM, the DON (Director of Nursing) reported Resident #3 was supposed to be assist of one outside of his room but he refuses to let staff help him. She stated he gets up and goes on his own. She stated therapy evaluated Resident #3 and recommended assistance of one outside of his room. She stated IDT (interdisciplinary care team) needs to review Resident #3's level of assistance. The DON stated Resident #3 was receiving Hospice but she could look into getting a one time Physical therapy evaluation to reevaluate him. She stated he was unsteady and does trip in the hallways at times.</p> <p>The facility policy titled Accidents and Supervision reviewed/revised 2/2024 documented the resident environment to remain free of accident hazards as is possible. Each resident to receive adequate supervision and assistive devices to prevent accidents.</p> <p>The policy further documented supervision as an intervention and a means of mitigating accident risk. The facility will provide adequate supervision to prevent accidents.</p>

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<p>F 0690</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide appropriate care for residents who are continent or incontinent of bowel/bladder, appropriate catheter care, and appropriate care to prevent urinary tract infections.</p> <p>46875</p> <p>Based on observation, clinical record review, staff interviews, and policy review the facility failed to provide appropriate incontinence care for 1 of 3 residents reviewed (Resident #4). The facility reported a census of 55 residents.</p> <p>Findings include:</p> <p>The Quarterly Minimum Data Set (MDS) assessment for Resident #4 dated 3/4/24 identified a Brief Interview for Mental Status (BIMS) score of 14, which indicated intact cognition. The MDS identified Resident #4 was dependent on staff for toileting hygiene and transfers. The MDS included diagnoses of heart failure (inability for the heart to pump enough blood), hypertension (high blood pressure), renal disease (kidney), diabetes mellitus, and overactive bladder. The MDS identified Resident #4 was always incontinent of bowel and bladder.</p> <p>The Care Plan with target date 9/1/24 revealed Resident #4 had the potential for infection related to history of UTIs and pneumonia with initiated date of 6/7/2022. The Care Plan directed staff to monitor/document/report to the physician signs and symptoms of a urinary tract infection. The Care Plan also directed staff to check and change Resident #4 four times per shift and as needed.</p> <p>The Clinical Census revealed Resident #4 hospitalized from 5/26/24 to 5/30/24.</p> <p>A Progress Note dated 5/26/24 at 1:39 PM documented Resident #4 was admitted to the hospital for Sepsis (a serious condition when the body responds improperly to an infection) and Urinary Tract Infection (UTI).</p> <p>A Hospital History and Physical (H&P) dated 5/26/24 revealed Resident #4 was hospitalized due to acute toxic/metabolic encephalopathy (alterations in mental status), acute hypoxemic respiratory failure (not enough oxygen in the blood), severe sepsis and UTI.</p> <p>(continued on next page)</p>		

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<p>F 0690</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>On 6/18/24 at 9:07 AM, observed staff D, CNA (Certified Nursing Assistant) and Staff F, CNA complete Resident #4's incontinence cares with the DON (Director of Nursing) present in the room. Observed a package of incontinence wipes, tube of cream and an incontinence brief laying on the end of the bed with no barrier. Staff D and Staff F applied gloves from their shirt pockets. The bed sheet was pulled back and Staff F checked the incontinence brief (Observed the incontinence brief was wet as the line on the pad was blue). Staff D assisted with holding up Resident #4's abdominal fold while Staff F completed peri care in the front. Staff F with her dirty gloves assisted with turning Resident #4 to her right side, touching the bedding. Staff F removed the wet incontinence brief by pulling it out from underneath Resident #4. Staff F placed a clean incontinence brief underneath Resident #4 and touched the package of incontinence wipes with her dirty gloves. Staff F proceeded to cleanse the buttocks with the same pair of dirty gloves, wiping back to front three times, then switched and wiped front to back. Staff F did not cleanse or wipe the lower back or bilateral hips. Staff F applied cream to Resident #4's buttocks with the same pair of dirty gloves. Staff F then removed the gloves, applied hand sanitizer from Staff D and applied new gloves. Staff F applied cream to the front peri area and reported to the DON that there was some redness from Resident #4's brief. Surveyor observed a red linear line on Resident #4's right upper thigh/leg. After applying cream, Staff F did not remove her gloves and pulled up the incontinent brief, fasten it and pulled down Resident #4's shirt. Staff F then removed her gloves, did not sanitize her hands, and pulled up Resident #4's blanket. Staff F proceeded to sack up the garbage and left the room without washing or sanitizing her hands.</p> <p>On 6/18/24 at 9:20 AM, the DON acknowledged and verified concerns with the incontinence care she observed. She reported Staff F was a newer CNA and that she would provide education regarding the peri care process, hand hygiene and gloving.</p> <p>On 6/18/24 at 3:57 PM, the DON said she expected staff to complete hand hygiene when changing gloves, change gloves between dirty and clean tasks, have clean gloves on when applying cream and perform complete peri care that would include the lower back and hips.</p> <p>A facility policy titled Perineal Care reviewed/revised 2/2024 documented it is the practice of the facility to provide perineal care to all incontinent residents during routine bath and as needed in order to promote cleanliness and comfort, prevent infection to the extent possible, and to prevent and assess for skin breakdown.</p> <p>A facility policy titled Hand Hygiene reviewed/revised 12/2023 documented that all staff will perform proper hand hygiene procedures to prevent the spread of infection to other personnel, residents, and visitors. Staff will perform hand hygiene when indicated, using proper technique consistent with accepted standard of practice. The policy further documented the use of gloves does not replace hand hygiene. If the tasks required gloves, perform hand hygiene prior to donning gloves, and immediately after removing gloves.</p> <p>A facility policy titled Personal Protective Equipment reviewed/revised 5/2024 documented the following regarding glove usage:</p> <ol style="list-style-type: none"> a. Perform hand hygiene before donning gloves and after removal. Gloves are not a substitute for hand hygiene. b. Change gloves and perform hand hygiene between clean and dirty tasks, when moving from one body part to another, when heavily contaminated or when torn. 		

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<p>F 0695</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide safe and appropriate respiratory care for a resident when needed.</p> <p>46875</p> <p>Based on observations, record review, staff interviews, and policy review, the facility failed to provide oxygen according to physician orders for 3 of 4 residents reviewed (Residents #2, #6, and #7) for respiratory services. The facility reported a census of 55 residents.</p> <p>Findings Include:</p> <p>1. The Annual Minimum Data Set (MDS) assessment for Resident #2 dated 12/4/23 identified a Brief Interview for Mental Status (BIMS) score of 15, which indicated intact cognition. The MDS included diagnoses of coronary artery disease, heart failure (inability for the heart to pump enough blood), hypertension (high blood pressure), end stage renal disease (kidney), diabetes mellitus, acute and chronic respiratory failure with hypoxia (low level of oxygen in body tissue), pulmonary hypertension (type of high blood pressure that affects the arteries in the lungs and right side of the heart), and chronic obstructive pulmonary disease(COPD)(chronic inflammatory lung disease that causes obstructive air flow from the lungs).The MDS documented Resident #2 was on oxygen therapy while a resident at the facility.</p> <p>The Care Plan initiated on 4/14/23 revealed Resident #2 had oxygen therapy related to ineffective gas exchange. The Care Plan directed staff to administer oxygen via nasal cannula at 5 liters.</p> <p>The December 2023 Medication Administration Record (MAR) directed staff to administer oxygen via nasal cannula at 5 liters to keep oxygen levels above 90% every shift.</p> <p>A Progress Note dated 12/4/23 at 6:57 PM documented a nurse responded to Resident #2's bathroom call light. Resident was noted to be incontinent of urine and bowel. Peri care was given and incontinent brief changed. Resident #2 was short of breath and the portable oxygen tank was empty. Resident #2's incontinent brief was pulled up but Resident #2 was not able to stand long enough to get the underpants and outer pants up. Resident #2 refused to stand up again. Resident #2 was wheeled in a wheelchair from bathroom to bedroom quickly due to an empty portable oxygen tank. Resident #2 was switched from a portable tank to an oxygen concentrator in the room.</p> <p>On 6/17/24 at 1:27 PM, Staff A, LPN (Licensed Practical Nurse) reported on 12/4/23 Resident #2 had either been to an activity or supper and needed to go to the bathroom. Staff A stated Resident #2 was super short of breath and when troubleshooting she realized the portable oxygen tank was empty. Staff A stated she put the call light on to get a new tank but that did not happen quickly so she switched Resident #2 to the oxygen concentrator in her room. Staff A reported she was not sure how long the oxygen tank was empty for. Staff A reported she did not think the facility had a process for checking the portable oxygen tanks.</p> <p>2. The MDS assessment for Resident #6 dated 3/24/24 identified a BIMS score of 5, which indicated severely impaired cognition. The MDS included diagnoses of heart failure, hypertension, diabetes mellitus, and chronic atrial fibrillation (irregular heart beat).</p> <p>(continued on next page)</p>		

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<p>F 0695</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>The Care Plan with a target date of 9/12/24 revealed Resident #6 had altered cardiovascular status and was at risk for shortness of breath, chest discomfort/pain/tightness, pain/numbness/weakness in extremities and diagnosis of atrial fibrillation and congestive heart failure. The care plan directed staff to administer oxygen via nasal cannula as ordered.</p> <p>The June 2024 Treatment Administration Record (TAR) directed staff to administer oxygen at 3 liters per minute via nasal cannula continuously.</p> <p>On 6/18/24 at 7:27 AM, observed Resident #6 was sitting in the hallway in her wheelchair with a portable oxygen tank in a bag hanging on the back of the wheelchair. The portable oxygen tank was set at 2 liters and the dial on the tank was on red which indicated the tank was empty. Staff B, LPN verified the portable tank was empty and that Resident #6 needed a new tank. Staff B yelled down the hallway and requested a new oxygen tank. Staff C, MDS Coordinator changed out the portable oxygen tank and reported he set the tank to 2 Liters. Observation revealed the new portable oxygen tank was set at 2 liters.</p> <p>On 6/18/24 at 7:38 AM, Staff D, CNA (Certified Nursing Assistant) reported she assisted getting Resident #6 up this morning. She stated she did not check the portable tank as she was all over assisting with the residents.</p> <p>On 6/18/24 at 8:11 AM, Resident #6 was sitting in the dining room in a wheelchair with portable oxygen on at 2 liters per nasal cannula.</p> <p>On 6/19/24 at 7:34 AM, Resident #6 was sitting in the dining room in a wheelchair with portable oxygen on at 2 liters per nasal cannula.</p> <p>3. The MDS assessment for Resident #7 dated 5/14/24 identified a BIMS score of 7, which indicated severely impaired cognition. The MDS included diagnoses of hypertension, acute and chronic respiratory failure, COPD, anxiety and depression. The MDS documented Resident #7 was on oxygen therapy while a resident at the facility</p> <p>The Care Plan with a target date of 7/2/24 revealed Resident #7 had COPD. The Care Plan lacked information or interventions related to oxygen therapy.</p> <p>The June 2024 Treatment Administration Record (TAR) directed staff to administer supplemental oxygen at 2 liters at all times every shift for shortness of breath.</p> <p>On 6/18/24 at 7:42 AM, observed Resident #7 sitting at the dining room table with a nasal cannula in her nose and a portable oxygen tank on the back of the wheelchair. The portable oxygen tank was set at 2 liters and the dial on the tank was on red which indicated the tank was empty. Staff E, PTA (Physical Therapy Assistant) verified Resident #7's tank needed to be changed and stated she would take care of it.</p> <p>On 6/18/24 at 8:10 AM, Resident #7 returned to dining with PTA. The portable oxygen tank was changed and set at 2 liters per nasal cannula.</p> <p>(continued on next page)</p>		

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NAME OF PROVIDER OR SUPPLIER Pine Acres Rehabilitation and Care Center		STREET ADDRESS, CITY, STATE, ZIP CODE 1501 Office Park Road West Des Moines, IA 50265	

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<p>F 0695</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>On 6/18/24 at 2:10 PM, the DON (Director of Nursing) stated she expected the staff to check the portable oxygen tanks when putting the resident on the portable tank. She stated the staff should check to make sure the portable tank was full or had enough oxygen in it. She verified the CNAs are to get a nurse to change the tank if it is low or empty. She stated the staff need to make sure when they switch the portable oxygen to a concentrator that the portable tank is turned off. The DON reported she expected staff to follow physician orders related to oxygen administration.</p> <p>A facility policy titled Oxygen Administration revises/reviewed 4/2024 documented oxygen to be administered to residents who need it, consistent with professional standards of practice, the comprehensive person-centered care plans, and the resident's goals and preferences. The policy further documented oxygen to be administered under orders of a physician. The policy directed the resident's care plan shall identify the interventions for oxygen therapy, based on the resident's assessment and orders.</p>

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<p>F 0778</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Help the resident make transportation arrangements to and from radiology services.</p> <p>46875</p> <p>Based on clinical record review, hospital record review, staff interview and policy review, the facility failed to arrange and/or provide transportation services to Physician appointments for 2 out of 3 resident reviewed (Residents #2, #3). The facility reported a census of 55 residents.</p> <p>Findings include:</p> <p>1. The Quarterly Minimum Data Set (MDS) assessment for Resident #2 dated 1/13/24 identified a Brief Interview for Mental Status (BIMS) score of 11, which indicated moderately impaired cognition. The MDS identified Resident #2 was dependent on staff for bed mobility and chair/bed to chair transfers. The MDS documented Resident #2 used a wheelchair. The MDS included diagnoses of coronary artery disease, heart failure (inability for the heart to pump enough blood), hypertension (high blood pressure), end stage renal disease (kidney), diabetes mellitus, acute and chronic respiratory failure with hypoxia (low level of oxygen in body tissue), pulmonary hypertension (type of high blood pressure that affects the arteries in the lungs and right side of the heart), and chronic obstructive pulmonary disease(COPD)(chronic inflammatory lung disease that causes obstructive air flow from the lungs).</p> <p>A Hospital Physician Transfer Report dated 1/8/24 documented Resident #2 had an appointment for a Carotid Complete Test scheduled for 1/16/24 at 3:00 PM with Cardiology and a follow up appointment on 2/1/24 at 4:30 PM with Cardiology. The report documented Resident #2 was hospitalized for Urinary Tract Infection (UTI), Sepsis(a serious condition when the body responds improperly to an infection), Acute Kidney Injury, Influenza A and Chronic Respiratory failure with hypoxia (not enough oxygen in the blood).</p> <p>Resident #2's Clinical record lacked documentation Resident #2 went to the cardiology appointments scheduled on 1/16/24 and 2/1/24.</p> <p>A Hospital note titled Appointment dated 1/16/24 documented Resident #2 was a no show for her appointment scheduled for 1/16/24 at 3:00 PM.</p> <p>A Hospital note titled Appointment dated for 2/1/24 documented Resident #2 was a no show for her appointment schedule for 2/1/24 at 4:30 PM.</p> <p>A Hospital note titled Telephone dated for 2/9/24 at 11:19 AM documented Hospital RN (Registered Nurse) spoke to facility nurse and facility nurse reported she was not sure why Resident #2 was a no show for appointment on 2/1/24. The note documented Resident #2 was rescheduled for 2/12 and provided information to the facility nurse. The facility nurse was to check with transportation to ensure they are able to bring Resident #2 and to call back if unable to transport.</p> <p>A Hospital note dated for 2/12/24 documented Resident #2 was a no show for her appointment schedule for 2/12/24 at 1:00 PM.</p> <p>(continued on next page)</p>		

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<p>F 0778</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>A Hospital note titled Telephone dated for 2/16/24 at 3:11 PM documented Hospital RN called facility to check on Resident #2. Hospital RN reported Resident #2 was a no show again on 2/12 and voiced frustration with missing appointments. The note documented Hospital RN rescheduled Resident #2's appointment for 2/22/24.</p> <p>On 6/18/24 at 2:45 PM, the Administrator reported Resident #2 used an outside transportation service for bariatric residents to get to and from appointments.</p> <p>On 6/19/24 at 1:08 PM, Senior Manager for the outside transportation company reported Resident #2 was not scheduled for transportation services on 1/16/24, 2/1/24 and 2/12/24.</p> <p>2. The Quarterly MDS assessment for Resident #3 dated 5/24/24, BIMS assessment was not completed. The Staff Assessment for Mental Status indicated severely impaired decision making. The MDS identified Resident #3 was independent with bed mobility and transfers. The MDS documented Resident #3 used a walker. The MDS included diagnoses of anemia, coronary artery disease, hypertension, hip fracture, Alzheimer's disease and Non-Alzheimer's disease.</p> <p>A Hospital Physician Transfer Report dated 5/20/24 documented Resident #3 had a follow up appointment scheduled with orthopedic surgery on 5/30/24 at 10:00 AM. The report documented Resident #3 had a closed fracture of the left hip. The discharge instructions documented to leave dressing on the left hip, keep the dressing clean, dry and intact until clinic visit.</p> <p>The Clinical record revealed Resident #3 went to the follow up appointment on 6/4/24 instead of 5/30/24.</p> <p>The Progress note dated 6/4/24 at 11:04 AM documented Resident #3 returned from a follow up appointment with Orthopedics.</p> <p>On 6/19/24 at 10:23 AM, Staff G, Transportation Aide reported she had rescheduled Resident #3's appointment for 5/30/24 to 6/4/24 due to two residents scheduled at the same time. She stated the other resident needed to be seen as it was an appointment for a surgery. She stated she took Resident #3 on June 4th and met his family there. She stated they did not try to schedule with an outside transportation company as the facility normally handles transportation in house. Staff G reported she did not find out about Resident #3 's appointment until the day of.</p> <p>On 6/19/24 at 10:30 AM, the DON (Director of Nursing) stated the nurse should have filled out a transportation form for Resident #3's appointment to be added to the transportation calendar. She stated the transportation aide should not have been notified the day off the appointment. She said she was not sure what happened.</p> <p>On 6/19/24 at 12:00 PM, the Provisional Administrator reported she was not aware Resident #3's appointment on May 30th was rescheduled. She stated she would expect the transportation aide to let her know so they could look at other options to accommodate both appointments. She reported the facility does not have any contracts with outside transportation companies.</p> <p>(continued on next page)</p>		

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<p>F 0778</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>A facility policy titled Transportation Services reviewed/revised 4/2024 documented the facility will assist and/or provide resident/patient transportation services when needed to ensure that each resident/patient receives a full continuum of services. The policy further documented the facility is to schedule transportation as soon as a date and time of appointment is known.</p>