STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	165358	A. Building B. Wing	10/17/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Thomas Rest Haven	217 Main Street Coon Rapids, IA 50058

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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 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	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** 41785 Based on observation, interview, and record review the facility failed to ensure that residents were treated with dignity and respect for 2 of 13 residents reviewed. Resident's #238 and #1 reported that a staff member instructed them to urinate in their adult briefs if/when they couldn't assist them to the restroom in a timely manner. The facility reported a census of 37 residents. Findings include: 1) According to the Minimum Data Set (MDS) dated [DATE], Resident #238 had a Brief Interview for Mental Status (BIMS) score of 7 (moderate cognitive deficit). He had diagnoses that included heart failure, hypertension, diabetes, cerebrovascular accident, and traumatic brain injury. Resident #238 was admitted to the facility on [DATE]. The Care Plan for Resident #238, dated 10/8/24, showed that he had self-care deficits and required assistance with activities of daily living. He was unable to ambulate, used a wheelchair and required assistance of 2 staff with the sit to stand mechanical lift for transfers. The resident had bladder incontinence and staff were to clean him after each incontinence episode. On 10/14/24 at 11:00 AM, Resident #238 stated that the facility was under staffed and it often took over 20 minutes to get someone to help him to the toilet. He said that staff would tell him to go ahead and urinate in his brief and they would come and clean him up later. It was on the overnight shift that he was told this, and he didn't get cleaned up until the next morning. The resident said that initially, the staff had set a commode in the middle of the room for him to use, and then they stood back and kept asking if he was done. He said that he was unable to go when someone was watching or in the room, so he asked them to change that arrangement. They tried a couple of different things, such as using a urinal. At one point, the staff member that stood and held the urinal told him to hurry up, I ain't got all night Resident #238 indicated that this had been a stressful and degrading experience for him. A care conference note dated 10/15/24 at 10:45 AM, showed that Resident #238 expressed that it was taking the staff a long time to help him to the toilet. On 10/16/24 at 7:27 AM, Staff C, Certified Med Aide (CMA) said that she overheard staff members saying that a resident had been told to just pee in his brief, but she did not know a specific staff member but that is was an overnight staff. (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 - Few	2) According to the Minimum Data Set (MDS) dated [DATE], Resident #1 had a BIMS score of 15 (intact cognitive ability). The resident was totally dependent for dressing, and required partial assistance with toileting, sit to stand and transfers. He was frequently incontinent of urine, and always continent of bowel. The Care Plan updated on 9/11/24, showed that Resident #1 had self-care deficits and required assistance with Activities of Daily Living (ADL's). He had impaired balance and Parkinson's Disease. They required assists of one for toileting and had constipation related to decreased mobility. On 10/17/24 at 7:18 AM, Resident #1 was in his room in the recliner. When asked if anyone had ever told him to urinate in his brief, the resident said that's happened to me. When the resident became hesitant and it seemed that the conversation was making him nervous. He said that he didn't remember any details. On 10/16/24 at 3:18 PM, Staff A, Licensed Practical Nurse (LPN) said that she knew that Staff B, Certified Nurse Aide (CNA) told Resident #1 that he was on his call light too often and that he should pee in his brief. The resident then told Staff A that he wanted to get a urinary catheter so he wasn't bothering the night staff so much. Staff A said that she had a conversation with Staff B about this and Staff B responded that he was always on his call light. They have since he started using a urinal at night with him so they didn't have to transfer him. On 10/17/24 at 11:58 AM, Staff B, CNA said that Resident #238 had trouble urinating when someone was in the room. They tried the commode, and when he couldn't go she told him that if he has to go in his brief, it's okay and they could just clean him up later. She said that they had him on the commode one night and he couldn't so they put him back to bed and then he pooped his pants. Someone cleaned him up later. She said that they tried using a urinal, but he couldn't go when someone was there holding the urinal. They put a brief on him at night to help hold the urinal in place so he could hold onto it himself. She denied having told him just to go in his brief but said that if the staff weren't able to get to him in time and he has an accident, it's okay, and they would just clean him up later. Staff B said that Resident #1 always talked wanting to get a catheter and she denied telling him that he should urinate in brief. When asked if the staff were taught how to maintain a resident's dignity regarding incontinence cares, she said that she just tells the residents it's not a big deal when they have to clean them up. On 10/17/24 at 10:17 AM, the Administrator denied having any knowledge of staff telling residents to urinate in their brief and she said that this was intolerable. She acknowledged that Resident #1 had requested a catheter and she told him that there must be a medical need. She said they provide regular education with staff on dignity issues and incontinence issues were addressed. According to the Resident [NAME] of Rights, residents had a right to be treated with respect and dignity, including; the right to reside and receive services in the facility with reasonable accommodation of resident needs and presences except when to do so would endanger the health or safety of the resident or other residents. An undated grievances policy indicated that the facility would encouraged residents to resolve concerns with management and administer without fear of reprisal or intimidation.

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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 0640 Level of Harm - Potential for minimal harm Residents Affected - Some	Encode each resident's assessment data and transmit these data to the State within 7 days of assessment. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 49990 Based on clinical record review, staff interview, facility policy review, and the Resident Assessment Instrument (RAI) Manual, and policy review, the facility failed to complete and transmit a resident Minimum Data Set assessment upon a resident's discharge within the required time-frame for one of fourteen residents reviewed (Resident #10). The facility reported a census of 37 residents. Findings include: The Minimum Data Set (MDS) assessment tool dated 07/24/24 revealed the Assistant Director of Nursing (ADON) signed the assessment as completed on 08/01/24. The MDS assessment dated [DATE], revealed Resident #10 admitted to the facility on [DATE], and discharged from the facility on 07/24/24. The MDS assessment revealed the DON signed the assessment as completed on 08/01/24. It further documented Staff J, MDS Consultant, signed and submitted the discharge, return not anticipated MDS on 10/17/2024. The Electronic Health Record (EHR) revealed the discharge return not anticipated MDS assessment dated [DATE] was completed on 08/01/24 but was not submitted to CMS. In an interview on 10/17/2024 at 09:16 AM with the Director of Nursing, she acknowledged that they had experienced issues with MDS, with the former MDS coordinator not really fitting in the position. She acknowledged the facility had not submitted the MDS for resident #10 within the required timeframe. The RAI Manual Version 3.0 revealed the discharge return not anticipated MDS assessment must be completed when the resident discharged from the facility and the resident not expected to return to the facility within 30 days. The discharge return not anticipated MDS must be completed within 14 days after the discharge date , and submitted within 14 days after the MDS completion date.

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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 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 41785 Based on observation, interview, and record review the facility failed to provide adequate nursing supervision to prevent falls for 1 of 4 residents reviewed (Resident #24). Resident #24 had a fall that caused injury after he got up from the chair without assistance. The facility reported a census of 37 residents. Findings include: According to the Minimum Data Set (MDS) dated [DATE], Resident #24 had a Brief Interview for Mental Status (BIMS) score of 0 (severe cognitive deficit). The resident had verbal and physical behavioral symptoms directed toward others 1-3 days a week. The resident used a wheel chair and a walker for mobility. He was totally dependent on staff for hygiene and dressing and required partial assistance with chair to bed transfers and toilet transfers. The Care Plan for Resident #24, dated 4/6/24, showed that he was at risk for falls due to impaired balance during transitions. He often slept in the recliner and staff were to monitor and assist him in getting out of the chair. The resident had increased anxiety when he was in his room, and this increased the risk of falls. A pressure alarm was used to the bed, recliner, and wheelchair to alert staff to when the resident was getting up. He was unable to utilize his call light, or to ask for assistance due to his cognitive impairment. Staff were to place a floor mat in front of the resident's bed when he was in bed. A Nursing Note dated 4/26/2024 at 6:50 PM, showed that Resident #24 had an unwitnessed fall in the dining room when he got up from the dining room chair and tried to walk back to the living room area. He was sent to the emergency room due to severe left hip pain. The personal alarm was not on the chair at the time. A hospital report dated 4/27/24 at 9:56 AM, showed the active admitting problem diagnosis included; fall as cause of accidental injury in residential institution as place of occurrence, and a closed fracture of neck of left femur. The plan of care included surgery for the following day to include 3 screws across the fracture to stabilize. According to a Nursing Note dated 4/30/24 at 3:11 PM, Resident #24 was readmitted to the facility after left hip repair. He was partial weight bearing for transfers only and staff provided a personal alarm. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 10/16/24 at 11:30 AM, Staff F, Certified Nurse Aide (CNA) said that she was present when Resident #24 fell in the dining room. She didn't see him fall, but remembered that he had tried several times prior to get up and they redirected him to stay seated. Two other CNAs had been in the dining room at the time, one was transferring another resident and one CNA had been assisting a resident with her meal. Staff F said that Resident #24 was easily agitated and they tried to keep him in the recliner out by the TV to keep an eye on him. She said that he'd had some medication changes that had helped keep him calmer. Staff F said that the resident would normally stay in his wheel chair during meals rather than the dining room chair. She didn't remember for sure if he was in his wheel chair on the evening of 4/29/24. She couldn't say for sure if there had been an alarm on his chair, but the resident would stand up very quickly and she didn't know if an alarm would have made a difference because it happened so fast. On 10/16/24 at 11:21 AM, Staff E, CNA, said that she was in the dining room on the evening when Resident #24 got up from his chair and fell . She did not see him get up on his own because she was assisting another resident with a meal. Staff E said that the resident often attempted to get up on his own. She did not know if he had the alarm on or remember hearing the alarm. On 10/15/24 at 1:49 PM, Staff D, Dietary Aide (DA) remembered that he was working the evening that Resident #24 fell in the dining room. He didn't see it happened but heard the commotion. He came out of the kitchen and saw a couple of CNA's with the resident after the fall. The resident was agitated and trying to get up off the floor. Staff D said that Resident #24 was constantly trying to get up from the chair on his own. He didn't know if he had an alarm on, and didn't remember hearing an alarm. In an observation on 10/16/24 at 8:30 AM, Staff G, Certified Medication Aide (CMA) went to the room of Resident #24 to get him up for the morning. The resident was very sleepy, and said no many times while the CNA applied his support hose and sat him on the side of the bed. The motion sensor alarm was turned on and placed under the fitted sheet. Staff G used a gait belt to assist him to stand and he used a walker to ambulate into the bathroom. Staff G assisted the resident to sit on the toilet and he became more agitated and continued to say no. While Staff G turned her back to gather clothing from his closet, the resident stood up from the toilet with the use of his walker. Staff G turned back around to see him standing and quickly got him to sit back down on the toilet. At 8:45 AM, Staff G called for assistance and Staff I, CMA came in the room within a couple of minutes. Staff I stated that she had been present for one of the falls that Resident #24 had. She said the resident fell when he got up from the recliner and tried to walk to the kitchen. She said that he had taken the batteries out of the sensor alarm in the chair. Staff I stayed in the room briefly, then Staff G told her she felt that she could finish up okay without her help, and at 8:52 AM, Staff I left the room. While Resident #24 was sitting on the toilet, Staff G washed his legs and then slipped on a pair of sweat pants just to his ankles. The resident became increasingly agitated and continued to say no and moaned. Staff G stepped out of the bathroom and pulled the wheelchair closer to the bathroom door but failed to lock the wheels. At 9:00 AM, Staff G had the resident stand and hold onto the walker as she wiped his bottom and started to apply a clean brief. While she tried to secure the brief, Resident #24 started walking out of the bathroom with the brief partially attached and his pants still around his ankles. Staff G encouraged him to stop so she could pull up his pants but he kept walking out of the bathroom. She was finally able to secured the brief and pull up his pants just before he got to the wheelchair. She had him turn around with his bottom toward the seat of the wheel chair and he plopped down into the seat. Because the wheels were not locked, the wheel chair moved back slightly. Staff G immediately acknowledged that she should have engaged the brakes. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 10/16/24 at 11:10 AM, the Administrator said that they recently implemented team meetings to brainstorm root causes and possible interventions to decrease falls at the facility. On 10/17/24 at 10:24 AM, the Administrator said that Resident #24 had been a challenge with his impulsiveness and fall risk. She said they had tried many different interventions and she would expect staff to follow through with the Care Plan interventions such as use of motion alarms. She said staff were instructed to get help if/when the resident became agitated. She said that the resident had gotten much better since he had some medication changes. According to policy titled: Falls Assessment, last revised on 5/24/24, residents that were identified as high risk for falls would have fall interventions implemented. The interventions for reducing the residents' risk for fall would be resident specific and based on assessment findings.

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure drugs and biologicals used in the facility are labeled in accordance with currently accepted professional principles; and all drugs and biologicals must be stored in locked compartments, separately locked, compartments for controlled drugs. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 41785 Based on observation, interview, and record review the facility failed to ensure that staff were aware of the date that a stock supplement had been opened before administering it to a resident for 1 of 4 residents reviewed (Resident #17). The facility reported a census of 37 residents. Findings include: According to the Minimum Data Set (MDS) dated [DATE], Resident #17 had a Brief Interview for Mental Status (BIMS) score of 15. He was independent with sit to lying, sit to stand, and toilet transfers. His diagnoses included hypertension, diabetes, Alzheimer's, anxiety, depression. The Care Plan last updated on 10/10/24 showed that Resident #17 had self-care deficits and required assistance with Activities of Daily Living (ADL). In an observation of the medication administration for Resident #17, on 10/15/24 at 7:18 AM, Staff H, Licensed Practical Nurse (LPN) prepared Vitamin B-12 500 micrograms (mcg). When asked about a documented open date on the bottle, Staff H acknowledged that there was not an open date, put a pill in with the rest of the medications and administered them to the resident. She then set the bottle aside and said that she would ask the Administrator what she should do with the bottle. Staff H later said that after talking to the Administrator she realized that she should not have administered the vitamin supplement to the resident. In the future, if there was a bottle unmarked, she would destroy the pills, get a new bottle, and document with the open date. On 10/17/24 at 10:26 AM, The Administrator said that she has a nurse go through the medication cart on a regular basis to look for open bottles with no opened date. She said that staff were taught to put the open date on as soon as they open the bottle. She looked through the facility policies and said that she did not find a medication policy that addressed open date documentation.