

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 165381	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 09/26/2024
NAME OF PROVIDER OR SUPPLIER Windsor Place Senior Living Campus		STREET ADDRESS, CITY, STATE, ZIP CODE 900 South Stone Street Sigourney, IA 52591	

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 0606</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Not hire anyone with a finding of abuse, neglect, exploitation, or theft.</p> <p>35434</p> <p>Based on employee file review, policy review and staff interviews, the facility failed to conduct a record check evaluation prior to employment to indicate clearance for work for 1 of 5 employee files reviewed. The facility reported a census of 22 residents.</p> <p>Findings include:</p> <p>The untitled facility staff roster listed a hire date for Staff B Registered Nurse(RN) as 9/11/23.</p> <p>An 8/30/23 Single Contact License and Background Check(SING) stated a Criminal History(CCH) record was found and the results would be faxed. The facility lacked further documentation regarding Staff B's CCH and lacked documentation of a record check evaluation completed to indicate she could work at the facility.</p> <p>On 9/25/24 at 2:22 p.m., the Business Office Manager(BOM) stated the facility could not locate the record check evaluation for Staff B and stated she thought they would receive a citation for this. She stated this should be completed prior to hire.</p> <p>On 9/25/24 at 3:30 p.m. the Administrator stated they initiated a background check for Staff B and she was off the schedule until Friday. She stated background checks should be completed prior to the start of work.</p> <p>On 9/26/24 at approximately 2:30 p.m., the Director of Nursing(DON) stated if Staff B's record check evaluation was not complete by Friday, she would work her shifts in place of her.</p> <p>The undated facility Abuse Policy stated the facility would follow protocols for conducting employment background checks.</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 0657</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Develop the complete care plan within 7 days of the comprehensive assessment; and prepared, reviewed, and revised by a team of health professionals.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 35434</p> <p>Based on clinical record review, staff interview, and policy review the facility failed to include fall interventions for 1 of 2 residents reviewed with a history of falls (Resident #21), failed to address nutrition needs for 1 of 2 residents reviewed for weight loss (Resident #21), and failed to address a resident's history of sexual behaviors toward other residents/staff for 1 of 2 residents reviewed for resident-to-resident interactions (Resident #12). The facility reported a census of 22 residents.</p> <p>Findings include:</p> <p>1. The 5-Day Minimum Data Set (MDS) assessment tool, dated 7/17/24, listed Resident #21's admitted as 7/10/24 with the diagnoses of stroke, shortness of breath, and diabetes. The MDS stated the resident had a fall within the last month prior to admission and stated the resident required substantial/maximal assistance for chair transfers, toilet transfers. The MDS listed the resident's Brief Interview for Mental Status(BIMS) score as 9 out of 15, which indicated moderately impaired cognition.</p> <p>a. A 9/2/24 Fall report stated the resident sat on his bottom on the floor in front of the sink holding his stool riser. He stated that he had to go to the bathroom and went without his walker.</p> <p>A 9/8/24 Fall report stated the resident laid near his bathroom door and said he had to urinate.</p> <p>A 9/16/24 Fall report stated the resident fell in his room. The report stated the resident did not state the reason he got out of bed.</p> <p>The resident's Care Plan did not address the resident's falls nor include interventions to prevent additional falls.</p> <p>On 9/26/24 at 11:36 a.m., the Director of Nursing(DON) stated the Care Plan should address falls.</p> <p>2. The facility policy Nutrition (Impaired)/Unplanned Weight Loss-Clinical Protocol, revised September 2017, stated the nursing staff would monitor and document weights of residents and would report significant weight loses to the physician. The staff and physician identified pertinent interventions based on identified causes.</p> <p>A 7/9/24 hospital Registered Dietician note documentd Resident#21 had inadequate energy intake due to a decreased ability to consume sufficient energy evidenced by weight loss and insufficient energy intake from diet compared to estimated needs.</p> <p>The Weight Summary included the following weights.</p> <p>7/12/24 182.8 lbs</p> <p>7/17/24 197.2 lbs</p> <p>(continued on next page)</p>		

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<p>F 0657</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>7/23/24 200 lbs</p> <p>8/1/24 191.0 lbs</p> <p>8/6/24 178.6 lbs</p> <p>9/1/24 184.6 lbs</p> <p>9/5/24 181.8 lbs</p> <p>The resident's weight loss between 7/23/24(200 lbs) and 8/6/24(178.6 lbs) calculated as a 10.7% loss.</p> <p>The resident's Care Plan did not address the resident's above weight fluctuations or history of inadequate energy intake and did not include interventions to ensure the resident did not lose additional weight.</p> <p>The resident's clinical record lacked documentation of physician notification of the above weight fluctuations.</p> <p>A 7/20/24 Nutrition/Dietary Note listed the resident's weight as 197.2 lbs and stated the resident was at increased risk of altered nutrition.</p> <p>On 9/25/24 at 1:23 p.m., the DON stated staff should reweigh a resident if there was more than a 3 pound increase or decrease. She stated the facility process was that the dietician evaluated the weights and sent a note to the physician. If the physician thought the weight loss was concerning, he sent orders.</p> <p>On 9/26/24 at 11:36 a.m., the DON stated the Care Plan should address weight loss.</p> <p>47336</p> <p>2. The MDS dated [DATE] revealed Resident #12 scored a 12 out of 15 on the BIMS exam, which indicated cognition moderately impaired. The MDS revealed the resident display physical behavioral symptoms such as hitting, kicking, pushing, scratching, grabbing, and abusing others sexually 1 to 3 days of the 14 day look back period.</p> <p>The Care Plan revealed a focus area on 7/9/24 for resident had potential to be verbally aggressive and had ineffective coping skills. The interventions dated 7/9/24 revealed to anticipate his needs; assess his coping skills and support system; and when resident became agitated to intervene before the agitation escalated.</p> <p>The Care Plan did not reveal a focus area for the resident's verbal or physical sexual aggression towards others.</p> <p>(continued on next page)</p>		

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<p>F 0657</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>The Progress Note dated 7/3/24 at 8:47 PM, revealed a (Certified Nurse Aide) CNA went into resident's room and commented on resident's haircut. Resident held up his middle finger and made a sexually vulgar comment regarding employee's genitalia. CNA told resident that that was not appropriate and walked out of resident's room.</p> <p>The Progress Note dated 7/11/24 at 2:18 PM, revealed the resident noted joking with staff and he may have taken it too far, he squeezed staff arms too hard and left imprint of fingernails in her arm. Resident instructed to let go several times and did not. Finally, after about 5 times of telling him, he let go of staff member's arm.</p> <p>The Progress Note dated 7/14/24 at 10:57 PM, revealed resident tried to tell staff about the 3 women at the next table to him in the doctor tried to say their names and got them wrong and the resident described one of the resident as the one with the breasts like yours (to the CNA) from Texas. The resident then poked at staff's belly and asked her is she was pregnant. The resident then tried to get staff to go into an empty room with him so he could tell her something and the staff told the resident no.</p> <p>The Progress Note dated 7/19/24 at 5:35 PM, revealed resident continued to be sexually inappropriate to staff.</p> <p>The Progress Note dated 8/2/24 at 4:09 PM, revealed the resident out of room flirting with female staff and making inappropriate comments.</p> <p>The Progress Note dated 8/3/24 at 3:26 PM, revealed the resident rude and argumentative with staff. resident enjoyed calling the telephone line and reporting false occurrences. Then came out of room and laughed at staff. The resident frequently butts in and started yelling out numbers during narcotic count and frequently made sexual comments to nursing staff.</p> <p>The Progress Note dated 8/3/24 at 5:01 PM, revealed this Registered Nurse (RN) gave resident his PM meds and asked the resident if he would like water. The resident stated yes, or a vodka and orange juice or vodka on the rocks or vodka and sour, that makes you horny. Then the resident got up from the chair and walked back and forth behind this RN and stated Why don't you scratch my back, it itches or you could scratch somewhere else. Then the resident walked down the hall.</p> <p>The Progress Note dated 8/6/24 at 3:45 PM, revealed this nurse notified by [name redacted] in dietary that there was an incident between this resident and Resident #3. This resident came down the hallway by dining room and grabbed Resident #3 butt and pulled her hair. He then returned to his room. Interview with Resident #3 and she reported he grabbed her ass. She was visibly and verbalized she was upset and now scared of the other resident. Director of Nursing (DON) and Administrator notified.</p> <p>The Progress Note dated 8/7/24 at 1:28 PM, revealed the resident's daughter in to visit today; shortly after resident moved rooms to the opposite hallway. The resident's daughter in his room and a short while later noted to be leaving upset; stated he put his hands on me, I'm leaving. The resident remained in his room after this.</p> <p>The Progress Note dated 8/7/24 at 11:39 PM, revealed no behaviors toward any other resident. Told nurse you really got me good busted all my teeth out resident then sticks his teeth out and starts laughing and grabbed at nurse. Speech fast and garbled per usual.</p> <p>(continued on next page)</p>		

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<p>F 0657</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>The Progress Note dated 8/8/24 at 5:46 AM, revealed resident continued to swear and make sexual comment to staff.</p> <p>The Progress Note dated 8/17/24 at 5:10 AM, revealed the resident continued to make sexually inappropriate comments. Speech often hard to understand.</p> <p>The Progress Note dated 8/22/24 at 11:51 PM, revealed a CNA was in resident's room and he asked her to apply some Icy Hot to his back. As she leaned to the side to reach his back, he stuck his arm out, putting it between her legs. CNA said she quickly moved before he grabbed her. As she leaned over to turn his call light over, she said he grabbed her breasts. Resident reminded that it was inappropriate to touch other people like that. He had also made a comment about wanting to fight that tall girl with the glasses. But he did not give a name.</p> <p>The Progress Note dated 9/15/24 at 11:42 PM, revealed two staff went to get resident to tell him it was time for lunch and he was yelling and told them to help him out of the chair. When staff went to help him, he grabbed one of the CNA's arms and tried pulling her on top of him. The resident threw himself back into the chair and continued to yell.</p> <p>The Progress Note dated 9/16/24 at 12:33 AM, revealed a CNA told this nurse that she was in the stock room putting away supplies when resident entered the room. She stated that she had the door closed but that it had not latched. Resident walked in and began slowly closing the door while saying, Fuck, fuck me, fuck me. I'm horny. Come on fuck me. CNA told resident that he needed to leave the stock room immediately and that he was being very inappropriate. Resident then left without any arguments. Approximately 5 minutes later, resident walked up to the common area and asked where the CNA was. He said that he needed her to rub cream on my leg. Will you send her down to my room. He then turned around and went into his room. Resident had always applied his Icy Hot himself (per his request/Dr. order), so this nurse reminded him that it was in his room and that it would be best if he applied it to his leg.</p> <p>During an interview on 9/25/24 at 4:43 PM, Staff C, CNA stated last Sunday, she filled the back storage room and the resident poked his head in the door and mumbled something and then it became more clear. She stated Resident #12 stated fuck me, fuck me and went to grab the door to enclose us in the room and Staff C told him to get out of the room and he did. Staff C queried on any interventions they did with Resident #12 and she stated they do care with 2 staff members in the room and try to redirect him.</p> <p>During an interview on 9/25/24 at 5:04 PM, Staff D, LPN (Licensed Practical Nurse) queried on Resident #12 behaviors and she stated he was volatile, and when he got mad, it was explosive. Staff D stated she knew of two incidents with the resident making inappropriate comments to the staff. Staff D stated she knew the resident had a meltdown when his daughter came.</p> <p>During an interview on 9/26/24 at 10:03 AM, the DON confirmed Resident #12 made inappropriate comments to staff and it needed care planned. The DON stated the resident currently on 15 minute checks. The DON stated she was shocked with the incident with Resident #12 and Resident #3 and then nothing happened for awhile until the incident with the CNA. The DON stated the resident had raised his hand to her and the Administrator.</p> <p>(continued on next page)</p>		

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<p>F 0657</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>The Facility Care Plan, Comprehensive Person-Centered Policy revised on November 2019 revealed the following:</p> <ul style="list-style-type: none"> a. Incorporate identified problem areas b. Incorporate risk factors associated with identified problems c. Reflect treatment goals, timetables, and objective in measurable outcomes d. Areas of concern identified during the resident assessment would be evaluated before interventions added to the care plan. e. Assessment of residents ongoing and care plans revised as information about the residents and the resident's conditions change.

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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>Ensure services provided by the nursing facility meet professional standards of quality.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 47336</p> <p>Based on observation, record review, staff interview, and the facility policy, the facility failed to ensure an insulin vial discarded after it was opened past 28 days for 1 of 1 residents reviewed for insulin administration (Resident #5). The facility reported a census of 22 residents.</p> <p>Findings include:</p> <p>The Minimum Data Set (MDS) assessment dated [DATE] revealed Resident #5 revealed 15 out of 15 on the Brief Interview for Mental Status (BIMS), which indicated cognition intact. The MDS revealed a diagnosis of diabetes mellitus (DM). The MDS revealed the resident received insulin for 7 out of 7 days.</p> <p>The Care Plan revealed a focus area dated 12/13/24 for DM I/II and at risk for frequent infections, alternation of skin, visual impairment, hyper/hypoglycemia, renal failure and cognitive/physical impairments.</p> <p>The EMR (Electronic Medical Record) revealed a Medical Diagnosis for Type II DM without complications</p> <p>The EMR revealed the following Physician Orders:</p> <p>a. Lantus Subcutaneous Solution 100 units/ml (milliliters)- inject 18 units subcutaneously one time a day</p> <p>During an observation on 09/25/24 at 7:37 AM, Staff A, RN (Registered Nurse) administered 18 units of insulin into Resident #5 left upper arm. Staff A asked to look at the insulin bottle she used and Staff A pulled a medication bottle with the resident's name and the insulin vial inside the bottle. The medication bottle had a label which revealed the bottle changed on 8/20/24. The vial revealed no visible date it was opened.</p> <p>During an observation on 9/25/24 at 7:44 AM Staff A asked again to see the insulin bottle and then asked if the 8/20/24 was the correct date and she stated she didn't think that was right and placed the insulin back into the resident's cubbie in the medication cart.</p> <p>During an interview on 9/25/24 at 12:43 PM, Staff A queried when opened insulin vials needed discarded and she stated 45 days, or was it 30 days.</p> <p>During an interview on 9/26/24 at 10:16 AM, the Director of Nursing (DON) informed of the date on the insulin bottle container and she stated she hoped the date was for another bottle and a fresh bottle put in it. The DON stated the nurses were supposed to use permanent markers and mark the bottle itself. The DON stated the opened vials needed discarded in 30 days.</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>During an observation on 09/26/24 at 10:18 AM, the DON asked to look at Resident #5 insulin vial and the nurse pulled out a bag with an insulin vial with the date 8/23/24 under the date the vial opened. The nurse then pulled out the medication bottle with another bottle of the resident's insulin with the date of 8/20/24. The DON queried on her expectation of the opened insulin the DON responded that it was pulled in 30 days.</p> <p>The Insulin Administration Policy dated September 2014 revealed the following:</p> <p>a. Steps in Procedure (Insulin Injections via Syringe)</p> <p>1. check expiration date, if drawn from an opened multi-dose vial. If opened a new vial, record expiration date and time on the vial (follow manufacturer recommendations for expiration after opening.)</p> <p>The GoodRX website dated February 5, 2024 (provided by the facility) revealed the following:</p> <p>a. Unused Lantus vials stored at room temperature last for up to 28 days.</p>

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<p>F 0692</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide enough food/fluids to maintain a resident's health.</p> <p>35434</p> <p>Based on clinical record review, policy review, and staff interviews, the facility failed to recognize and address weight fluctuations for a resident at risk of impaired nutrition for 1 of 2 residents reviewed for weight loss(Resident #21). The facility reported a census of 22 residents.</p> <p>Findings include:</p> <p>The Minimum Data Set (MDS) assessment tool, dated 7/17/24, listed diagnoses for Resident #21 which included stroke, shortness of breath, and diabetes and listed the resident's Brief Interview for Mental Status(BIMS) score as 9 out of 15, indicating moderately impaired cognition.</p> <p>The facility policy Nutrition (Impaired)/Unplanned Weight Loss-Clinical Protocol, revised September 2017, stated nursing staff would monitor and document weights of residents and would report significant weight losses to the physician. The staff and physician identified pertinent interventions based on identified causes.</p> <p>A 7/9/24 hospital Registered Dietician note stated the resident had inadequate energy intake due to a decreased ability to consume sufficient energy evidenced by weight loss and insufficient energy intake from diet compared to estimated needs.</p> <p>The Weight Summary included the following weights.</p> <p>7/12/24 182.8 lbs</p> <p>7/17/24 197.2 lbs</p> <p>7/23/24 200 lbs</p> <p>8/1/24 191.0 lbs</p> <p>8/6/24 178.6 lbs</p> <p>9/1/24 184.6 lbs</p> <p>9/5/24 181.8 lbs</p> <p>The resident's weight loss between 7/23/24(200 lbs) and 8/6/24(178.6 lbs) calculated as a 10.7% loss.</p> <p>The resident's Care Plan did not address the resident's above weight fluctuations or history of inadequate energy intake and did not include interventions to ensure the resident did not lose additional weight.</p> <p>The resident's clinical record lacked documentation of physician notification of the above weight fluctuations.</p> <p>(continued on next page)</p>		

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<p>F 0692</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>A 7/20/24 Nutrition/Dietary Note listed the resident's weight as 197.2 lbs and stated the resident was at increased risk of altered nutrition.</p> <p>On 9/25/24 at 1:23 p.m., the Director of Nursing (DON) stated staff should reweigh a resident if there was more than a 3 pound increase or decrease. She stated the facility process was that the dietician evaluated the weights and sent a note to the physician. If the physician thought the weight loss was concerning, he sent orders.</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>Provide safe and appropriate respiratory care for a resident when needed.</p> <p>35434</p> <p>Based on observation, clinical record review, policy review, and staff and resident interviews, the facility failed to ensure a resident's oxygen tank was available for use for 1 of 1 residents reviewed receiving oxygen therapy (Resident #3). The facility reported a census of 22 residents.</p> <p>Findings include:</p> <p>The Quarterly Minimum Data Set (MDS) assessment tool, dated 6/27/24, listed diagnoses for Resident #3 which included chronic obstructive pulmonary disease (COPD, a disease of the lungs which caused shortness of breath and difficulty breathing), diabetes, and pain in an unspecified joint. The MDS stated the resident had shortness of breath with exertion (such as walking) and when lying flat. The MDS listed the resident's Brief Interview for Mental Status(BIMS) score as 10 out of 15, which indicated moderately impaired cognition.</p> <p>The facility policy Oxygen Administration, revised October 2010, directed staff to set up oxygen for residents who received oxygen therapy.</p> <p>A 4/12/24 Order Details report listed an order for oxygen 1 liter as needed to keep oxygen greater than 90%.</p> <p>Care Plan entries, dated 7/9/24, stated the resident had COPD, was at risk for shortness of breath, and utilized oxygen as needed. The Care Plan directed staff to administer supplemental oxygen as ordered per the physician.</p> <p>On 9/24/24 at 8:35 a.m., Resident #3 walked down the hall pushing her oxygen concentrator. The oxygen tubing went under the resident's feet multiple times as she tried to push the concentrator down the hall to her room.</p> <p>Observations on 9/25/24 revealed the following:</p> <p>At 7:22 a.m. the resident was in her bathroom. Her oxygen concentrator was in the dining room near her table.</p> <p>At 7:37 a.m., the Administrator went into the bathroom to check on the resident and she said she was fine.</p> <p>At 7:44 a.m. the resident walked out of her room with her walker. The resident wheezed and appeared short of breath. She walked to the dining room and had a cough.</p> <p>At 8:07 a.m., the resident ate breakfast while utilizing oxygen via the concentrator.</p> <p>At 8:21 a.m., the resident stood up from the table with her walker and spoke to Staff G Certified Nursing Assistant(CNA). Staff G assisted another resident out of the dining room. Resident #3 walked to her room and her oxygen concentrator remained in the dining room. The concentrator remained in the dining room until Staff H brought it to the resident' room at 8:43 a.m.</p> <p>(continued on next page)</p>		

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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 0695</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>At 8:46 a.m., the resident stated she would like her oxygen as soon as possible after meals.</p> <p>On 9/26/24 at 9:44 a.m., Staff I CNA stated staff should take the resident's concentrator back to her room right away after meals. She stated she observed it not taken back right away in the past. She stated the resident should not wheel it back herself as it was not safe.</p> <p>On 9/26/24 at 9:53 a.m. Staff G CNA stated recently she needed her oxygen more. She stated they would bring the oxygen to the dining room when she started heading there. She stated after meals, if she stood up, they would take it back to her room. She stated she should not push it herself.</p> <p>On 9/26/24 at approximately 10:20 a.m., Staff F Licensed Practical Nurse (LPN) stated the resident needed her oxygen and staff should take it to her right away. She stated she should never push it herself.</p> <p>On 9/26/24 at 11:36 a.m., the Director of Nursing (DON) stated recently the resident needed her oxygen more during the day. She stated she should not push it by herself and if she was using it, needed it right away.</p>		

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<p>F 0697</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide safe, appropriate pain management for a resident who requires such services.</p> <p>35434</p> <p>Based on clinical record review, policy review, and resident and staff interviews, the facility failed to ensure that 1 of 1 resident reviewed for pain (Resident #15) received treatment and care related to pain management. The facility reported a census of 22 residents.</p> <p>Findings include:</p> <p>The Quarterly Minimum Data Set (MDS) assessment tool, dated 6/20/24, listed diagnoses for Resident #15 which included non-Alzheimer's dementia, diabetes, and hypertension. The MDS stated the resident had frequent pain over the last 5 days and listed the resident's Brief Interview for Mental Status (BIMS) score as 12 out of 15, which indicated moderately impaired cognition. The MDS documented that for the 5 day MDS look back period the resident did not receive any as needed (PRN) pain medication, or non-medication intervention for pain, only scheduled pain medication.</p> <p>The facility policy Pain Management revised 2015, stated pain management was an essential component of health care and directed staff to recognize when the resident was experiencing pain and manage or prevent pain. The policy directed staff to carry out interventions to address pain including medications.</p> <p>Care Plan entries, dated 2/14/24, stated the resident had chronic pain and directed staff to evaluate the effectiveness of pain interventions/medications and notify the physician if interventions were unsuccessful.</p> <p>On 9/23/24 at 1:56 p.m., Resident #15 stated his foot hurt and staff did not care. During the interview, Staff B Registered Nurse (RN) came into the room to ask the resident if he would like to go to his care conference. The resident stated in front of Staff B that his leg was really bad this morning.</p> <p>The September 2024 Medication Administration Record(MAR) listed the following:</p> <ul style="list-style-type: none"> a. A 6/26/22 order for Acetaminophen (a non-narcotic pain medication) 325 milligrams(mg) three times daily as needed for pain. b. A 7/12/24 order for Tramadol (a narcotic pain medication) 50 mg every 12 hours as needed for pain. <p>The MAR lacked documentation the resident received the above as needed medications on 9/23/24.</p> <p>The resident's Progress Notes lacked documentation of a pain assessment completed on 9/23/24.</p> <p>On 9/25/24 at 6:40 a.m., the resident stated his hip hurts like hell.</p> <p>On 9/25/24 at 12:34 p.m., Staff B stated she did not hear Resident #15 say that he was in pain. She stated he received Tylenol (Acetaminophen) and therapy services.</p> <p>(continued on next page)</p>		

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<p>F 0697</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>On 9/26/24 at approximately 10:20 a.m., Staff F Licensed Practical Nurse (LPN) stated Resident #15 did have some pain in his hips from time to time. She stated if he complained of pain and it was outside of the timeframe of his scheduled Tramadol, she would administer his as needed Tylenol. She stated if this did not work, she would contact the physician.</p> <p>On 9/26/24 at 11:36 a.m., the Director of Nursing(DON) stated if a resident reported he had pain, the nurse should evaluate the resident and look on the MAR to see if there was a medication he could have.</p>

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<p>F 0801</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Many</p>	<p>Employ sufficient staff with the appropriate competencies and skills sets to carry out the functions of the food and nutrition service, including a qualified dietician.</p> <p>35434</p> <p>Based on document review, policy review, and staff interviews, the facility failed to employ a qualified person to serve as the Director of Food and Nutrition Services in the absence of a full-time dietitian. The facility reported a census of 22 residents.</p> <p>Findings include:</p> <p>The facility policy Dietary Services Administration effective 3/2015, stated if a dietician was not employed full time, the facility would designate a person to serve as the Director of Food Service who received frequently scheduled consultations from a qualified dietician. The facility would designate a person to serve as the Food Services Director who was a qualified dietitian, a graduate of dietetic technician or dietetic assistant training program or, a graduate of a state-approved course that provided 90 or more hours of classroom instruction in food service supervision and who had experience as a Food Service Supervisor in a health care institution.</p> <p>On 9/23/24 at 9:29 a.m. the Dietary Manager stated she was not a Certified Dietary Manager (CDM), but stated she was in the course. She stated she could not work on it a lot though because she worked every day.</p> <p>On 9/26/24 at 12:04 p.m., the Dietary Manager stated she turned in a few assignments for her CDM course. She stated she could call the dietician anytime she needed her. She stated she did not have consultations with the former dietician.</p> <p>On 9/26/24 at 12:35 p.m., the Administrator stated the Dietary Manager was in the CDM course now and had a year to complete this.</p>

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<p>F 0812</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Many</p>	<p>Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 35434</p> <p>Based on observation, policy review, and staff interview, the facility failed to maintain adequate sanitation for 2 of 2 kitchen observations and failed to carry out sanitary food handling during 1 of 1 meal service observation. The facility reported a census of 22 residents.</p> <p>Findings:</p> <p>The initial kitchen tour, conducted on 9/23/24 at 9:29 a.m., revealed the following concerns:</p> <p>a. Dust particles hung from the 3 spigots of the fire suppression system over the stove.</p> <p>An observation of the noon meal service on 9/24/24 at 11:30 a.m. revealed the following concerns:</p> <p>a. Dust remained on the spigots of the fire suppression systems. A long dust string extended from the bottom of one of the spigots to the horizontal fire suppression pipe.</p> <p>b. [NAME] splatters on the inside floor of the microwave with brown solid food debris on the inside of the door. Yellow and brown solid food debris was present on the front of the microwave near the door opener. The outside of the microwave was sticky to the touch.</p> <p>c. Thick dust particles were present between the air conditioning unit in the corner of the kitchen and the wall. Buns and crackers were on the counter below the unit.</p> <p>d. A floor fan with heavy black dust particles sat on the floor between the white refrigerator in the corner of the kitchen and the cupboards.</p> <p>e. The Dietary Manager opened a bread bag with her bare hands and touched two slices of bread with her bare hands while she spread peanut butter on one of the slices and placed it on a plate. She then squeezed jelly onto the bread. After she finished making the sandwich, she pushed it down with her bare palm. She then placed the plate with the sandwich on a cart. Staff A took the cart out of the kitchen and the Dietary Manager stated the sandwich was for Resident #1.</p> <p>f. [NAME] splatters and crumbs covered the floor of the cupboard under the sink near the coffee maker. A container full of pot holders sat in the crumbs.</p> <p>g. A spray bottle containing a blue substance sat on a metal cart within 1 inch of a [NAME] tub. The Dietary Manager stated the bottle contained glass cleaner.</p> <p>h. An air conditioner to the left of the dish washer blew air toward clean dishes including silverware and water jugs. The flaps of the air conditioner were covered with brown spatters and contained dust particles.</p> <p>(continued on next page)</p>		

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<p>F 0812</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Many</p>	<p>On 9/26/24 at 12:04 p.m., the Dietary Manager stated surfaces in the kitchen and spigots should be kept clean. She stated she had a cleaning list for the cook and the dietary aide to follow. She stated she should have worn gloves prior to making the sandwich.</p> <p>On 9/26/24 at 12:55 p.m. the facility ice machine had build-up of a white crusty-appearing substance on both sides of the machine. Flecks of a dark substance were present on the ceiling of the interior ice compartment. A bucket with a scrub brush sat on top of the ice machine. An ice scoop sat directly on the top of the machine not contained in an ice scoop holder.</p> <p>The facility policy Cleaning and Sanitation of Food Service Areas, stated the food service staff would maintain the sanitation of the dining areas. The policy directed staff to clean surfaces to include small equipment, microwaves, hoods, and ice machines.</p>		

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<p>F 0865</p> <p>Level of Harm - Potential for minimal harm</p> <p>Residents Affected - Many</p>	<p>Have a plan that describes the process for conducting QAPI and QAA activities.</p> <p>47336</p> <p>Based on staff interview, review of CMS-2567 reports, and facility QAPI (Quality Assurance and Performance Improvement) Plan, the facility failed to ensure an effective QAPI (Quality Assurance and Performance Improvement) process to address previously identified quality deficiencies, resulting in multiple repeat deficiencies identified on the facility's current recertification and complaint survey previously identified during surveys completed in the last 17 months. The facility reported a census of 22 residents.</p> <p>Findings include:</p> <p>Review of the facility's CMS-2567 form from the last recertification's survey which occurred on 6/26/23 to 6/29/24 revealed the facility received no actual harm level citations for care plan revision and food procurement, and QAPI good faith.</p> <p>Review of the facility's CMS-2567 form from a complaint survey which occurred 12/28/23 to 1/10/24 revealed the facility received a no actual harm level citation for food procurement.</p> <p>During an interview on 9/26/24 at 1:03 PM, the Administrator queried on how the facility made sure it stayed in substantial compliance after a plan of care completed for previous surveys and she stated the facility conducted mock surveys on a monthly basis. The Administrator asked what her expectation for substantial compliance and she stated for the facility to do be and continue to have things brought to her attention. The Administrator stated they would keep monitoring.</p> <p>The QAPI Plan 2023 revealed the following information:</p> <p>a. The goals of the QAPI Committee included</p> <ol style="list-style-type: none"> 1. to promote consistently facility systems and processes and appropriate practices in resident care 2. to help identify negative outcomes relative to resident care and resolve them appropriately. 3. to help departments, consultants and ancillary services implement plans to correct identified issues in quality of care 4. to coordinate the development, implementation, monitoring, and evaluation of action plans to achieve specified quality goals 		

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<p>F 0883</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Develop and implement policies and procedures for flu and pneumonia vaccinations.</p> <p>47336</p> <p>Based on record review, staff interview, and facility policy review, the facility failed to screen residents for eligibility and/or failed to document refusals for the pneumococcal vaccines for 3 of 5 residents reviewed. (Resident #5, Resident #7, and Resident #12). The facility reported a census of 22 residents.</p> <p>Findings include:</p> <p>1. The Review of Resident #5 EMR (Electronic Medical Record) Immunization Record revealed no documentation of the resident receiving a pneumococcal vaccine.</p> <p>The Review of Iowa Registry Immunization System (IRIS) revealed the resident received the pneumococcal 13-valent conjugate vaccine (PCV13) on 10/27/15.</p> <p>The facility lacked documentation the resident received/offered/declined any other pneumococcal vaccines.</p> <p>2. The Review of Resident #7 EMR Immunization Record revealed the resident received PCV13 on 11/13/15.</p> <p>The Review of IRIS revealed the resident received the pneumococcal 23 vaccine on 9/2/14.</p> <p>The facility lacked documentation the resident offered/declined any additional pneumococcal vaccines.</p> <p>3. The Review of Resident #12 EMR Immunization Record revealed the resident lacked documentation for the past history or current vaccinations.</p> <p>The Review of IRIS revealed the resident didn't receive any pneumococcal vaccines.</p> <p>The facility lacked documentation the resident offered/declined/received any pneumococcal vaccines.</p> <p>During an interview on 9/24/24 at 11:41 AM, the Director of Nursing (DON) queried on Resident #5, #7, and #12 pneumococcal vaccine status and the DON stated she didn't have access to IRIS, but was working on it. The DON stated she tried to speak to Resident #12 on his vaccine status and he would not tell her. The DON stated Resident #7 received her vaccines outside of the facility.</p> <p>During an interview on 09/26/24 9:08 AM, the Director of Nursing (DON) stated she didn't realize she needed to have the residents sign a consent or declination for the pneumococcal vaccines. The DON stated if Resident #5 wanted the pneumococcal vaccine, they would get them done and would order the vaccine through pharmacy. The DON stated she didn't put in a progress note either for the declination. The DON stated she didn't have any declination forms for Resident #12.</p> <p>The Facility Pneumococcal Vaccine dated 8/16 revealed the following:</p> <p>(continued on next page)</p>		

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<p>F 0883</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>a. All residents were offered pneumococcal vaccines to aid in preventing pneumonia/pneumococcal infections.</p>

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<p>F 0887</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Educate residents and staff on COVID-19 vaccination, offer the COVID-19 vaccine to eligible residents and staff after education, and properly document each resident and staff member's vaccination status.</p> <p>47336</p> <p>Based on record review, staff interview, and facility policy review the facility failed to screen residents for eligibility of the COVID-19 vaccines and/or failed to document refusal or acceptance of the COVID-19 vaccines for three of five residents reviewed. (Resident #5, Resident #7, and Resident #12)) The facility reported a census of 22 residents.</p> <p>Findings include:</p> <p>1. The Review of Resident #5 EMR (Electronic Medical Record) Immunization Record revealed the resident refused a COVID-19 vaccine (no date documented).</p> <p>The Review of Iowa Registry Immunization System (IRIS) revealed the resident received the Pfizer COVID-19 vaccine on 12/29/22.</p> <p>The facility lacked documentation the resident received/offered/declined any other COVID-19 vaccines.</p> <p>2. The Review of Resident #7 EMR Immunization Record revealed the resident received Moderna COVID-19 booster on 10/11/23.</p> <p>The Review of IRIS revealed the resident received the Moderna COVID-19 on 10/11/23.</p> <p>The facility lacked documentation the resident offered/declined any additional COVID-19 vaccines.</p> <p>During an interview on 9/26/24 08:30 AM, Resident #7 stated she wanted to ask the facility if they offered the COVID vaccine. She stated she usually got them at her doctor's office, but the ride to the office was rough.</p> <p>3. The Review of Resident #12 EMR Immunization Record revealed the resident lacked documentation for the past history or current vaccinations.</p> <p>The Review of IRIS revealed the resident didn't receive any COVID-19 vaccines.</p> <p>The facility lacked documentation the resident offered/declined/received any COVID vaccines.</p> <p>During an interview on 9/24/24 at 11:41 AM, the Director of Nursing (DON) queried on Resident #5, #7, and #12 COVID-19 vaccine status and she stated Resident #12 was not at the facility during the COVID clinic. The DON stated she didn't have access to IRIS, but was working on it. The DON stated she tried to speak to Resident #12 on his vaccine status and he would not tell her. The DON stated Resident #7 received her vaccines outside of the facility.</p> <p>(continued on next page)</p>		

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<p>F 0887</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>During an interview on 09/26/24 09:08 AM, the DON stated she didn't realize she needed to have the residents sign a consent or declination for the COVID-19 vaccines. The DON stated she spoke with Resident #5 and she declined the vaccine, but she didn't sign a declination. The DON stated she didn't put in a progress note either for the declination. The DON stated she didn't have any declination forms for Resident #12.</p> <p>The Coronavirus (COVID-19) and COVID-19 Vaccine Policy revised on 2/18/22 revealed the following:</p> <p>a. Residents</p> <p>1. The vaccine would be offered and administered to residents per the most current Manufacturer's, CDC (Centers for Disease Center), Federal, State, and/or local guidance.</p>		