

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 165411	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 03/03/2025
NAME OF PROVIDER OR SUPPLIER Southfield Wellness Community		STREET ADDRESS, CITY, STATE, ZIP CODE 2416 Des Moines Street Webster City, IA 50595	

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 0550</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Honor the resident's right to a dignified existence, self-determination, communication, and to exercise his or her rights.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 46875</p> <p>Based on resident interviews, staff interview and policy review, the facility failed to provide care for 1 out of 21 residents reviewed (Resident #24) in a manner to promote dignity and respect. The facility reported a census of 54 residents.</p> <p>Findings include:</p> <p>Resident #24's Minimum Data Set (MDS) assessment dated [DATE] identified a Brief Interview for Mental Status (BIMS) score of 14, indicating intact cognition.</p> <p>On 2/24/25 at 11:22 AM, Resident #24 said she became incontinent of BM (bowel movement) a couple of times since she admitted to the facility, due to not having enough staff. She reported she felt like a baby when she became incontinent.</p> <p>On 2/26/25 at 4:00 PM, the Administrator reported she expected staff to treat residents with respect, dignity, and provide them care as soon as possible.</p> <p>On 2/27/25 at 8:30 AM, Resident #24 reported she knew when she needed to have a BM and became incontinent of BM a couple times recently as she waited for someone to help her.</p> <p>The facility policy titled Resident Rights - Dignity and Respect revised April 2024 defined the purpose of the policy as to lay the foundation for treating all residents with dignity, respect, and maintaining and enhancing his or her self esteem and self worth. In addition, the policy directed that each resident has the right to considerate, respectful care, treated with honesty, dignity and with reasonable accommodation of individual needs except where the health, safety, or rights of the resident or other individuals in the facility would be endangered.</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 0656</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 46875</p> <p>Based on clinical record review, staff interview and policy review the facility failed to develop a Care Plan to address risk factors and interventions for 1 of 21 residents reviewed (Resident #25) for comprehensive Care Plans. The facility reported a census of 54 residents.</p> <p>Findings include:</p> <p>Resident #13's Minimum Data Set (MDS) assessment dated [DATE] identified a Brief Interview for Mental Status (BIMS) score of 15, indicating intact cognition. The MDS included diagnoses of diabetes mellitus, non Alzheimer's dementia, depression and post-traumatic stress disorder (PTSD). The MDS documented Resident #13 received anti anxiety medication and a hypoglycemic medication during the lookback period.</p> <p>Resident #13's February 2025 Medication Administration Record listed the following orders:</p> <ul style="list-style-type: none"> a. Metformin HCL 1000 mg (milligrams) - give 1 tablet 2 times a day for type 2 diabetes mellitus. b. Sitagliptin 100mg - give 1 tablet 1 time a day for type 2 diabetes mellitus. c. Buspirone HCL (anti anxiety medication) 10 mg - give 1 tablet 3 times a day related to dementia. d. Freestyle Libre 14-day reader device (continuous glucose system receiver) - inject 1 device intramuscularly (IM) every 14 days related to type 2 diabetes mellitus. e. Insulin Glargine 100 unit/ml (milliliter) dated 2/25/25 - inject 22 units subcutaneously (fatty tissue under the skin) 1 time a day for 3 days. The MAR directed staff to increase insulin by 3 units every 72 hours until fasting glucose was less than 150 mg/dl (milligrams per deciliter). f. Insulin Lispro 100 unit/ml - inject per sliding scale listed on MAR at breakfast, lunch, supper and at hour of sleep. g. Insulin Lispro 100 unit/ml - inject 17 units subcutaneously 3 times a day related to type 2 diabetes mellitus. <p>The Care Plan with a target date 5/20/25 lacked direction regarding the treatment and management of type 2 diabetes mellitus and insulin usage. The Care Plan lacked risk factors and interventions regarding blood sugar monitoring and parameters on when to report to the Physician, signs/symptoms to monitor for related to hyper/hypoglycemia (high/low blood sugars), and potential adverse reactions/complications. In addition, the Care Plan did not address the ant anxiety medication, potential side effects and what to monitor for while taking the high-risk medication.</p> <p>(continued on next page)</p>		

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<p>F 0656</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>On 2/25/25 at 2:35 PM, Staff A, Nurse Consultant, verified the current Care Plan didn't address the insulin and antianxiety medications. The nurse consultant reported she expected the Care Plan include high risk medications.</p> <p>The facility policy titled Care Plan Policy revised July 2023 described the purpose of the policy as to ensure all Care Plans including the Baseline Care Plan are in conjunction with federal regulations including the completion of the Baseline Care Plan within 48 hours of admission and a comprehensive Care Plan developed after the comprehensive assessment of a resident. The policy added Interdisciplinary Team would review and revise the Care Plan after the completion of the MDS assessments when applicable and with changes that warrant a Care Plan revision.</p>		

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<p>F 0676</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Ensure residents do not lose the ability to perform activities of daily living unless there is a medical reason.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 44512</p> <p>Based on observations, record review, resident and staff interviews and policy review, the facility failed to provide restorative care for 2 of 2 residents reviewed (Residents #43 and #46). The facility failed to initiate a restorative program for Resident #43 for 18 days after the Physical Therapist (PT) recommended restorative care. In addition, they failed to provide restorative care as (PT) recommended for Resident #46. The facility reported a census of 54 residents.</p> <p>Findings include</p> <p>1. Resident #43's Minimum Data Set (MDS) assessment dated [DATE] included diagnoses of a stable fracture of the thoracic spine and muscle weakness. The MDS listed Resident #43 received Physical Therapy (PT) and Occupational Therapy (OT).</p> <p>Resident #43's Clinical Physician Orders reviewed 2/25/25 included an order dated 1/14/25 for physical therapy to evaluate and treat.</p> <p>Resident #43's MDS assessment dated [DATE] a Medicare part A stay from 1/14/25 - 2/12/25. Resident #43 received 489 minutes of PT and 317 minutes of OT.</p> <p>A document titled Therapy Discharge Notification to Nursing dated 2/7/25 indicated Resident #43 reached her potential and they set-up a restorative maintenance program. The PT and the Director of Nursing (DON) signed the document on 2/7/25.</p> <p>Resident #43's Care Plan lacked the restorative program recommended by PT on 2/7/25.</p> <p>An e mail sent from the Administrator on 2/25/25 at 4:39 PM detailed Resident #43 discharged from PT. They indicated Resident #43 have a restorative nursing program setup but it didn't get completed.</p> <p>2. Resident #46's MDS assessment dated [DATE] identified brief interview for mental status (BIMS) score of 15, indicating intact cognition. Resident #46 required substantial assistance of 2 staff for transfers and toileting. The MDS included a diagnosis of hemiplegia (paralysis of one side of the body).</p> <p>The Point of Care (POC) Response History reviewed 2/25/25 for the previous 30 days listed a task for a restorative program to include active assist range of motion (AAROM) for bilateral upper extremities (BUE) with the left upper extremity supported with a brace and bilateral lower extremities (BLE) for 15 minutes, 2 to 3 times a week and as tolerated (PRN). A standing activity in steady stand for duration as tolerated. The documentation reflected Resident #46 received restorative on:</p> <p>a. 1/27/25 completed 0 minutes.</p> <p>b. 1/29/25 completed 10 minutes.</p> <p>(continued on next page)</p>		

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<p>F 0676</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>c. 1/31/25 completed 0 minutes.</p> <p>d. 2/1/25 completed 25 minutes.</p> <p>e. 2/2/25 completed for 10 minutes</p> <p>f. 2/3/25 completed 0 minutes.</p> <p>g. 2/5/25 completed 0 minutes.</p> <p>h. 2/7/25 completed for 15 minutes.</p> <p>i. 2/8/25 completed 0 minutes.</p> <p>j. 2/9/25 completed 0 minutes.</p> <p>k. 2/12/25 completed for 15 minutes.</p> <p>l. 2/15/25 completed 0 minutes.</p> <p>m. 2/17/25 completed for 10 minutes.</p> <p>n. 2/20/25 completed for 35 minutes.</p> <p>o. 2/24/25 completed 0 minutes.</p> <p>h. 2/25/25 completed for 20 minutes.</p> <p>The documentation reflected a response not required on 1/30/25, 2/4/25, 2/10/25, 2/11/25, 2/16/25, 2/23/25.</p> <p>Resident #46's GG Assessment - V3 dated 2/10/25 by the DON included an assessment of the Activities of Daily Living (ADL) functional goals.</p> <p>Resident #46's Progress Notes lacked documentation by the restorative nurse to evaluate his restorative care progress.</p> <p>During an interview on 2/24/25 at 1:56 PM, Resident #46 said he thought he should have his restorative program for daily exercises but he only received restorative care one time a week due to Staff C, Restorative Aide, get pulled to do certified nursing aide (CNA) work instead.</p> <p>During an interview on 2/25/25 at 10:21 AM Staff C stated she got pulled to do CNA duties often and verified she was the only restorative aide. Staff C stated she completed the restorative work due to the residents only needing it two times a week and documented the completion in POC Response History restorative task.</p> <p>(continued on next page)</p>

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<p>F 0676</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>During an interview on 2/27/25 at 9:02 AM, the DON reported being responsible for the restorative program since December 2024. The DON stated the PT communicated every Thursday in a case load meeting with nursing and discussed which residents would discharge from therapy with a communication form, it included if they provided recommendations. The DON stated the restorative nurse duties were to oversee the restorative aide and to document progress in the nurse's notes. The DON stated she didn't document nor evaluate the progress of residents in the restorative program. The DON stated she didn't know why Resident #43 did not have their restorative care program set up yet. The DON added Resident #46 didn't address concerns about not receiving his restorative care as ordered.</p> <p>A policy titled Restorative Care revised 1/20/11 directed the following:</p> <ul style="list-style-type: none"> a. Residents who are candidates for restorative nursing care shall be appropriately assessed, Care Planned and evaluated for progress. b. Measurable objectives and interventions documented in the Care Plan. c. Evidence of periodic evaluation by a licensed nurse in the clinical record. d. Nursing assistants trained in the techniques that promote resident function. e. These activities are carried out or supervised by members of the nursing staff. f. The technique, procedure, or activity is practiced for a total of at least 15 minutes over a 24-hour time period. g. A licensed nurse should evaluate the resident's program for appropriateness. h. The rehabilitation/restorative summary will be documented according to the following schedule: <ul style="list-style-type: none"> i. With each assessment admission, annual, change of condition, and/or quarterly. ii. When the resident is discharged from the rehabilitation/restorative program. 		

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<p>F 0677</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Provide care and assistance to perform activities of daily living for any resident who is unable.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 48886</p> <p>Based on clinical record review, resident interview, staff interview and policy review, the facility failed to provide resident bathing to maintain good personal hygiene and personal choice for residents unable to carry out the activity of daily living (ADL) independently, for four of four residents reviewed (#6, #24, #27 and #48). The facility reported a census of 54 residents.</p> <p>Findings include:</p> <p>1. Resident #6's Minimum Data Set (MDS) assessment dated [DATE] identified a Brief Interview for Mental Status (BIMS) score of 15, indicating intact cognition. The MDS indicated Resident #6 used a wheelchair and required total assistance from staff to shower/bathe. The MDS included diagnoses of progressive neurological conditions, diabetes mellitus and multiple sclerosis.</p> <p>The Care Plan Focus with a target date of 3/11/25 indicated Resident #6 required assistance with ADL's. The Interventions instructed the staff with the following:</p> <p>a. Assist Resident #6 with shower/bathing per schedule.</p> <p>b. Resident #6 needed total assistance of 1 with bathing.</p> <p>During an interview 2/24/25 at 1:30 PM, Resident #6 stated she is to receive a shower daily, however in the last few months she is only receiving a shower approximately every other day.</p> <p>The POC Response History reviewed 2/25/25 related to the task of bathing, asked if Resident #6 received a shower or bath daily.</p> <p>Resident #6's December 2024 Documentation Survey Report (DSR) related to bathing indicated they didn't receive a bath / shower on the following days: Sunday, 12/1/24, Saturday, 12/14/24, Sunday, 12/15/24</p> <p>Resident #6's January 2025 DSR related to bathing reflected they didn't receive a bath on Sunday, 1/12/25.</p> <p>Resident #6's February 2025 DSR lacked documentation for Thursday 2/13/25 that they received a bath.</p> <p>During an interview 2/25/25 at 10:30 AM, Staff C, Certified Nursing Aide (CNA), stated the facility had days when they have agency staff, usually on the weekends. The agency staff sometimes call in and don't show up for work. When this happens, the facility don't replace the agency staff and then they pull the bath aides to help on the floor. They can't get baths done on those days for all of the residents who have a bath scheduled for that day, usually on a weekend, but it could happen during the week as well.</p> <p>(continued on next page)</p>		

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<p>F 0677</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>During an interview 2/25/25 at 10:40 AM, Staff D, CNA, stated they have times when agency staff don't show up for work, and then they have to pull the bath aides to work on the floor. When this happens, they are not able to give all residents scheduled that day, their baths.</p> <p>During an interview 2/25/25 at 3:54 PM, the Director of Nursing (DON) stated they expected residents receive their shower on their scheduled bath days, or as many times a week they request a shower. The DON acknowledged Resident #6 is scheduled to receive a bath/shower daily and the task section didn't indicate she received them daily. The DON stated the staff only document the baths/showers in the task locations.</p> <p>2. Resident #27's MDS assessment dated [DATE] identified a BIMS score of 15, indicating intact cognition. Resident #27 required substantial/maximal assistance from staff to shower/bathe. The MDS documented Resident #27 used a walker and a wheelchair. The MDS included diagnoses of medically complex conditions and paraplegia (the loss or impairment of motor and sensory functions in the lower half of the body).</p> <p>The Care Plan Focus with a target date of 4/8/25, indicated Resident #27 required assistance with ADL's. The Interventions instructed the following:</p> <ul style="list-style-type: none"> a. Assist Resident #27 with their shower/bathing per schedule. b. Resident #27 required substantial/maximal with assist of 1 staff member(s) to complete bathing. <p>Resident #27's December 2024 DSR related to bathing indicated a schedule for Monday and Thursdays. The documentation reflected (N), indicating Resident #27 didn't receive a bath on 12/11/24. The documentation reflected RR, indicating Resident #27 refused a bath on 12/4/24, 12/8/24, 12/18/24, and 12/25/24.</p> <p>Resident #27's January 2025 DSR related to bathing reflected a schedule for Mondays and Thursdays. The documentation listed RR for 1/5/25 and 1/8/25. The Documentation reflected an N for 1/22/25 and 1/29/25. The record indicated Resident #27 only received a shower on 1/27/25 and 1/30/25.</p> <p>The POC Response History reviewed on 3/3/25 for bathing regarding the previous 30 days, listed Resident #27 as scheduled for Mondays and Thursdays for bathing. The task documented Resident #27 only received a bath on 2/17/25 and 2/20/25.</p> <p>During an interview 2/24/25 at 11:17 AM, Resident #27 stated he didn't get his shower 2 times a week. He added he wanted it twice a week on Mondays and Wednesdays, but sometimes it is just once a week. They say they are busy to shower him. Resident #27 stated on some Mondays they say they are too busy and he is only showered once a week.</p> <p>During an interview 2/25/25 at 3:54 PM, the DON stated she expected residents receive their shower on the days they are scheduled, or as many times a week they request a shower. The DON acknowledged Resident #27 didn't receive his showers on all of his scheduled days.</p> <p>(continued on next page)</p>

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<p>F 0677</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>3. Resident #48's MDS assessment dated [DATE] identified a BIMS score of 15, indicating intact cognition. The MDS indicated Resident #48 used a walker and a wheelchair. The MDS listed Resident #48 required partial/moderate assistance to shower/bathe. The MDS included diagnoses of debility, cardiorespiratory conditions, heart failure, diabetes mellitus, and chronic kidney disease.</p> <p>The Care Plan Focus with a target date of 5/20/25, indicated Resident #48 required assistance with ADL's. The Interventions instructed the following</p> <p>a. Assist Resident #48 with shower/bathing per schedule.</p> <p>b. Resident #48 required substantial/maximal with assist of 1 staff member(s) to complete this ADL.</p> <p>Resident #48's December 2024 DSR reflected a schedule for Monday, Wednesday, and Saturdays for him to get a bath. The Documentation reflected the following:</p> <p>a. N - No bath: 12/2/24, 12/14/24</p> <p>b. RR - Resident Refused: 12/4/24</p> <p>c. Y, S - Yes, Shower: 12/7/24, 12/16/24, 12/23/24, 12/25/24, and 12/28/24.</p> <p>Resident #48's January 2025 DSR reflected a schedule for Monday, Wednesday, and Saturdays for him to get a bath. The Documentation reflected the following:</p> <p>a. Y, S - Yes, Shower: 1/1/25, 1/6/25, 1/13/25, 1/18/25, 1/22/25, 1/25/25, 1/29/25.</p> <p>b. N - No bath: 1/11/25, 1/20/25.</p> <p>During an interview 2/24/25 at 3:09 PM, Resident #48 stated in the past 3 months he only got 10 showers. He stated he is supposed to get them 3x's a week, on Monday, Wednesday, and Saturday. Resident #48 stated they are shorthanded. He usually didn't get his bath on Saturdays. Resident #48 stated he wanted a shower 3 times a week.</p> <p>During an interview 2/25/25 at 3:54 PM, the DON said she expected the residents receive their shower on their scheduled days, or as many times a week they request a shower. The DON stated Resident #48 has talked to her about he didn't receive his showers as often as he would like them during the week. The DON acknowledged Resident #48 didn't receive all of his scheduled showers.</p> <p>46875</p> <p>4. Resident #24's Minimum Data Set (MDS) assessment dated [DATE] identified a Brief Interview for Mental Status (BIMS) score of 14, indicating intact cognition. The MDS identified Resident #24 as dependent on staff members for showering/bathing. The MDS included diagnoses of cancer, multiple sclerosis, and pathological fracture of the right femur.</p> <p>Resident #24's Clinical Census listed an admitted [DATE].</p> <p>(continued on next page)</p>		

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<p>F 0677</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>The Care Plan with a target date of 5/20/25 identified Resident #24 required assistance of two staff members to complete the bathing task. The Care Plan directed staff to assist Resident #24 with shower/bathing per schedule.</p> <p>The POC Response History reviewed 2/25/25 for the previous 30 days related to as needed bathing. The documentation reflected they received a bath on 2/14/25. On 2/7/25 and 2/8/25 reflected she didn't receive a bath.</p> <p>The POC Response History reviewed 2/25/25 for the previous 30 days related to scheduled baths reflected Resident #24 preferred a bath 2 times a week. The documentation reflected they received a bath on 2/24/25 and didn't receive one on 2/20/25. The document lacked any other documentation.</p> <p>The forms lacked documentation that Resident #24 had refused any showers or baths. According to the documentation Resident #24 received two baths since admission on 2/6/25.</p> <p>The Clinical Record lacked documentation of any attempts to offer or encourage Resident #24 to shower or bathe.</p> <p>On 2/25/25 at 11:22 AM, Staff G, RN (Registered Nurse), reported the only place she knew the staff documented bathing was in the computer. When asked who had the responsibility to give baths when they didn't have a bath aide scheduled, Staff G referred the question to the DON.</p> <p>On 2/25/25 at 11:25 AM, the DON reported the facility attempted to schedule a bath aide daily. The DON described the bath aide position as not essential. At times they pulled the bath aide to the floor to work as a CNA (certified nursing assistant). The DON reported she expected the CNAs to complete the baths as much as possible when they didn't have a bath aide. She reported the facility faced staffing issues and were bringing agency staff in the building. When asked if there were concerns with getting baths done, she said yes, they had a problem sometimes.</p> <p>On 2/25/25 at 11:50 AM, Staff H, RN, reported they documented baths under tasks in the electronic health record. She reported Resident #24 had their baths scheduled for Monday and Thursday. She verified Resident #24 had two baths documented since admission. When asked if there were concerns with getting baths done, she said yes. She reported the facility attempted to schedule two bath aides one for the front and one for the back of the building but then the bath aides are pulled to work the floor due to staffing concerns and then baths don't get done. Staff H said the staff try to work in the missed baths but there are 7 12 baths scheduled every day so it is hard to fit more baths in. Staff H reported that usually if a resident missed a bath, the bath was not done again until the next scheduled bath day.</p> <p>On 2/25/25 at 12:22 PM, the DON reported she expected the staff to offer residents a bath at a minimum 2 times per week and if a resident refused a bath that the staff reproach and reoffer the bath that day. The DON reported she expected the nurses to document refusals in the progress notes.</p> <p>On 2/25/25 at 3:11 PM, the Administrator reported the facility didn't have a bathing policy and they follow the standard of care.</p>		

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NAME OF PROVIDER OR SUPPLIER Southfield Wellness Community		STREET ADDRESS, CITY, STATE, ZIP CODE 2416 Des Moines Street Webster City, IA 50595	
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 0684</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide appropriate treatment and care according to orders, resident's preferences and goals.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 46875</p> <p>Based on clinical record review, staff interviews, and policy review the facility failed to provide assessment and interventions necessary for the care and services, to maintain the residents' highest practical physical well being for 3 of 21 residents reviewed (Residents #55, #20, and #27). The facility reported a census of 54 residents.</p> <p>Findings include:</p> <ol style="list-style-type: none"> 1. Resident #55's MDS (Minimum Data Set) assessment dated [DATE] identified a BIMS (Brief Interview for Mental Status) score of 11, indicating moderately impaired cognition. Resident #55 required substantial to maximal assistance with bed mobility and all transfers. The MDS included diagnosis of heart failure (inability for the heart to pump blood), hypertension (high blood pressure), atrial fibrillation (irregular heart beat), diabetes mellitus and acute kidney failure. The MDS documented Resident #55 received diuretic medication during the lookback period. <p>The Care Plan Focus with a target date of [DATE] documented Resident #55 had a risk for altered cardiovascular functioning related to CHF (congestive heart failure). The Care Plan directed the following interventions:</p> <ol style="list-style-type: none"> a. Encourage/assist Resident #55 to elevate his legs when sitting. b. Encourage/assist Resident #55 with changing position slowly when going from lying, standing and sitting. c. Administer medication as ordered. d. Monitor and report to Practitioner any signs or symptoms of cardiac complications. e. Monitor for increased edema and report to the Practitioner. f. Monitor vital signs, weight and labs as ordered. <p>A Progress Note dated [DATE] documented the ARNP (Advanced Registered Nurse Practitioner) saw Resident #55 and gave the following new Physician orders:</p> <ol style="list-style-type: none"> a. Give Lasix (diuretic medication) 40 mg (milligrams) now and then daily. b. Start Aspirin 81 mg daily. c. Discontinue empagliflozin (diabetic medication). d. Obtain daily weights and if weight is greater than 3 lbs. (pounds) in 24 hours give additional 20 mg of Lasix. e. Increase Spironolactone (diuretic medication) to 25 mg daily. <p>(continued on next page)</p>		

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<p>F 0684</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>f. Obtain the following labs and x ray</p> <ul style="list-style-type: none"> i. CMP (complete metabolic panel) ii. BNP (brain natriuretic peptide) iii. CBC with differential (complete blood count) iv. portable chest x ray. <p>g. Resident #55 may benefit from evaluation by Hospice.</p> <p>Resident #55's [DATE] TAR (Treatment Administration Record) included an order started [DATE] to complete a 5-minute respiratory assessment every shift for CHF which included auscultation (listen) of lung sounds, pulse, respirations and oxygen saturation monitoring. Review of the respiratory assessments on the TAR lacked documentation of Resident #55's lung sounds. The TAR lacked documentation of daily weights on [DATE], [DATE], [DATE] and [DATE].</p> <p>The Weight Summary lacked daily weights for the same dates.</p> <p>Due to the lack of documentation of the daily weights resulted in the lack of documentation regarding the need or administration of Lasix 20 mg if Resident #55's weight was greater than 3 lbs. in 24 hours.</p> <p>A Progress Note dated [DATE] (Sunday) at 1:08 AM documented the facility received Resident #55's lab results for the CBC with differential, CMP and BNP. The progress note documented the following abnormalities:</p> <ul style="list-style-type: none"> a. Auto hematology <ul style="list-style-type: none"> - Auto monocyte percent - 14.8(H) (expected equal to or under 12, may indicate infection), - RBC (Red blood cells) - 3.87(L) (expected 4.6 - 6.20), - Hemoglobin (Hgb) - 9.6 (L) (expected 13.5 - 18), Hematocrit (Hct) - 32.6(L) (expected 37 - 47) - MCH (a measure of the average Hgb in the RBCs) - 24.8(L) (expected 29 - 35), - RDW (measures the size of the RBC) - 20.2(H) (expected 11.5 - 14.5). b. General Chemistry <ul style="list-style-type: none"> - Glucose - 151(H) (expected 70 - 99) - BUN (measures kidney function) - 35(H) (expected ,d+[DATE]) - Creatinine (measures kidney function) - 1.42(H) (expected 0.6 - 1.3) <p>(continued on next page)</p>		

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<p>F 0684</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>- BUN/Creat ratio - 25(H) (expected 10 - 20)</p> <p>- eGFR CKD EPI (measure kidney disease stages) - 47(L) (expected greater than 90, 47 indicated moderate impairment)</p> <p>- AST (measures liver function) - 9(L) (expected ,d+[DATE]),</p> <p>- Total protein - 6.3(L) (expected 6.4 - 8.2)</p> <p>- Albumin (measures the liver and kidney function) - 2.6(L) (expected 3.4 - 5)</p> <p>- Globulin (measures kidney and liver function) - 3.7(H) (expected 2.3 - 3.5)</p> <p>- A/G ratio (measures nutritional status, immune function, and overall health) - 0.7(L) (expected 1.1 - 2).</p> <p>c. Cardiac Isoenzymes (checks heart function)</p> <p>- NT proBNP (checks heart function) - 7919(H) (expected ,d+[DATE]).</p> <p>The Progress Note on [DATE] at 1:08 AM reflected Resident #55 had a BNP result of7,919 pg/ml (picograms per milliliter), with a reference range of 0 450. (A high BNP level may indicate heart failure, kidney failure, pulmonary embolism or other conditions).The progress note documented they faxed the lab results to the ARNP for review.</p> <p>A Progress Note dated [DATE] at 2:29 PM documented Resident #55 continued to have increased weight gain with pitting edema noted to hands, arms and back.</p> <p>A Progress Note dated [DATE] at 6:28 PM documented Resident #55's abnormal chest x ray results. The chest x ray impression showed an enlarged cardiac silhouette (impaired heart function), mild pulmonary vascular congestion (fluid in the lungs) and small bilateral pleural effusions with bibasilar atelectasis (partial collapse of the lungs due to buildup of fluid between the lung and the tissue lining) and or consolidation (buildup of fluid inside the lung). The noted documented they faxed the abnormal results to the ARNP for review.</p> <p>Review of the clinical record lacked documentation that staff monitored Resident #55's lung sounds from [DATE] to [DATE] after the increase in diuretic medications and the abnormal labs/chest x ray results.</p> <p>Review of the clinical record lacked documentation of an assessment or monitoring of Resident #55's edema after [DATE].</p> <p>A Progress Note dated [DATE] at 1:45 PM revealed Resident #55 expired (died) at 11:07 AM.</p> <p>Review of the clinical record lacked documentation that the ARNP addressed the abnormal lab results the facility faxed on [DATE].</p> <p>(continued on next page)</p>		

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<p>F 0684</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Review of the Progress Notes lacked documentation that the ARNP addressed the abnormal chest x ray results the facility faxed on [DATE].</p> <p>Review of Resident #55's chest x ray results dated [DATE] revealed the ARNP signed/noted the x ray on [DATE] after Resident #55 expired.</p> <p>A communication form titled Reminders provided by the facility on [DATE] for Resident #55 revealed on [DATE] at 1:49 PM the ARNP reviewed the abnormal lab results and directed her nurse to call the facility with the results and inquire how Resident #55's shortness of breath was. The form documented the ARNP's nurse spoke to a facility nurse on [DATE] at 4:52 PM. The form documented the facility nurse reported Resident #55 was down 2 lbs. and was doing okay. The form lacked any further direction or Physician orders regarding the abnormal lab results.</p> <p>On [DATE] at 2:43 PM, the Administrator reported the facility didn't have a policy for obtaining daily weights. In addition, the Administrator reported the facility didn't have a policy about following Physician orders. The Administrator reported the facility followed the standard of care.</p> <p>On [DATE] at 5:50 PM, Staff A, Nurse Consultant, verified the lack of documentation for daily weights. Staff A reported she expected the facility to follow the physician order. Staff A verified the facility faxed the lab results on [DATE] (Sunday) and the Provider didn't review them until [DATE] (Wednesday). Staff A verified a lack of follow up regarding the lab results. In addition, Staff A verified the Provider didn't follow-up or review the chest x ray results until [DATE]. The Nurse Consultant reported the facility worked with the ARNP on her timeliness of addressing concerns and had multiple meetings to discuss this.</p> <p>A facility policy titled Alert Charting Guidelines revised [DATE] defined the purpose as to provide guidelines for monitoring documentation that may be needed following a change in patient condition or status. The guidelines indicated patients are entered on the Alert Charting Log when they are identified as requiring continued follow up and documentation. Patients should remain on the log for a minimum period of 72 hours unless their condition improved. Patients are removed from the Alert Charting Log when the patient's status stabilized or the condition or symptoms prompting the initial placement on the log has resolved or stabilized. The guidelines directed documentation in the electronic clinical record may include, but is not limited to patient evaluation findings, physician notifications/responses, family notification, and any new orders or instructions received. The licensed nurse can reference the alert charting log at the start of each shift to identify patients requiring continued follow up and documentation.</p> <p>2. Resident #20's MDS assessment dated [DATE] identified a BIMS score of 6, indicating severely impaired cognition. The MDS identified Resident #55 required substantial to maximal assistance with bed mobility and all transfers. The MDS included diagnosis of anemia (low blood iron level), heart failure (inability for the heart to pump blood), hypertension (high blood pressure), diabetes mellitus, malnutrition (inadequate intake of nutrition) and non Alzheimer's disease.</p> <p>The Care Plan Focus with a target date [DATE] documented Resident #20 had a risk for altered skin integrity related to fragile skin. The Care Plan directed the following interventions:</p> <p>a. Administer treatment per physician orders.</p> <p>(continued on next page)</p>		

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<p>F 0684</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>b. Apply barrier cream to the peri area/buttocks as needed.</p> <p>c. Encourage good nutrition and hydration in order to promote healthier skin.</p> <p>d. Encourage Resident #20 to reposition.</p> <p>e. Keep nails trimmed to reduce risk of scratch/injury.</p> <p>f. Observe skin condition with ADL (Activities of Daily Living) care.</p> <p>g. Pressure reducing device on bed and chair.</p> <p>h. Resident #20 to have ice cubes to her hot drinks.</p> <p>Resident #20's February 2025 Medication Administration Record (MAR) included the following orders:</p> <p>a. Aspirin 81 mg (milligrams) daily started [DATE]. Give 1 tablet by mouth 1 time a day related to cerebral infarction (stroke).</p> <p>b. Plavix 75 mg daily (both antiplatelet medications) started [DATE]. Give 1 tablet by mouth 1 time a day related to cerebral infarction.</p> <p>On [DATE] at 3:30 PM, observed bruises to Resident #20's right hand and arm. During an interview, Resident #20 couldn't say how the bruises occurred. The bruises appeared the following:</p> <p>a. Dark colored (red/purple) bruise between the first two knuckles on the right hand</p> <p>b. Dark colored (black/red) circular bruise to the right hand below the thumb.</p> <p>c. Bruise (yellow, red, purple in color) below the wrist on the right arm</p> <p>d. Bruise (red/purple in color) on the right forearm below the elbow.</p> <p>Review of the clinical record lacked any documentation, assessments or notifications of the bruises to the right knuckle, hand or right arm.</p> <p>On [DATE] at 9:30 AM, Staff B, LPN (Licensed Practical Nurse), reported staff are to observe for new skin areas during care and baths. She reported if they observed a new skin area, they need to assess the area for causative factors, complete a skin sheet, notify the Physician and family, then follow the skin area weekly until healed. Staff B observed the bruises to Resident #20's right hand and arm, then reported she would look into the areas.</p> <p>On [DATE] at 10:10 AM, Staff B verified the clinical record lacked documentation of Resident #20's bruises to her right hand and arm. She said she would assess and document the areas.</p> <p>(continued on next page)</p>		

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<p>F 0684</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>On [DATE] at 4:00 PM, Staff A reported she expected staff to monitor Resident #20's skin with cares and baths, then report any new areas to the nurse. Staff A reported the facility was working on implementing weekly skin assessments for the residents but not all residents had assessments in place at the time.</p> <p>A facility policy titled Skin Management Guide revised [DATE] defined the purpose of the policy as to describe the process steps required for identification of patients at risk for the development of skin alteration, identify prevention techniques and interventions to assist with the management of pressure injuries and skin alterations. The policy directed staff to do the following in the event a patient experience a new non pressure injury:</p> <ol style="list-style-type: none"> a. Complete the skin evaluation b. Notify the attending Physician and obtain treatment orders c. Notify the family/responsible party d. Communicate findings to interdisciplinary team for additional evaluation needed e. Enter the event in the electronic Risk Management System if applicable (bruises of unknown origin). Determine the root cause and initiate modifications in the patient's plan of care as indicated. f. Document in the patient's electronic health record <p>48886</p> <p>3. Resident #27's MDS assessment dated [DATE] identified a BIMS score of 15, indicating intact cognition. The MDS included diagnoses of medically complex conditions, anemia, hypertension, hyperlipidemia (elevated cholesterol levels increasing the risk for stroke or heart attacks) and paraplegia (the loss or impairment of motor and sensory functions in the lower half of the body). The MDS identified Resident #27 received a diuretic during the lookback period.</p> <p>The Care Plan Focus with a target date of [DATE], indicated Resident #27 had a risk for altered cardiovascular functioning related to hypertension. The Interventions directed the following:</p> <ol style="list-style-type: none"> a. Monitor vital signs, weight and labs as ordered. b. Knee high TED hose (specialized stocking to prevent blood clots). <p>The Care Plan Focus with a target date of [DATE] indicated Resident #27 required the use of diuretic medication related to edema. The Interventions instructed to monitor weights.</p> <p>The POC Response History reviewed [DATE] listed a task to apply compression stockings (thigh high to his right and left leg, apply in the morning and remove as bedtime). The documentation indicated the staff applied the stockings on [DATE], then removed his stockings on [DATE] and [DATE].</p> <p>Resident #27's TAR included an order dated [DATE] and discontinued on [DATE] to apply thigh high compression socks on in the morning and off in the evening.</p> <p>(continued on next page)</p>		

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<p>F 0684</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Resident #27's clinical record lacked documentation of the compression socks after [DATE].</p> <p>Resident #27's Clinical Physician Orders reviewed [DATE] included the following orders.</p> <p>a. [DATE]: Furosemide oral tablet (a diuretic) 20 mg, two tablets by mouth in the morning related to localized edema and essential (primary) hypertension</p> <p>b. [DATE]: Hydrochlorothiazide oral tablet (a diuretic) 1.5 tablet by mouth one time a day related to essential (primary) hypertension.</p> <p>The clinical record lacked documentation of an order for weights.</p> <p>Resident #27's Weights and Vitals reviewed on [DATE] reflected the following weights:</p> <p>a. Admission weight [DATE]: 210.6 pounds (lbs.)</p> <p>b. [DATE]: 221.2 lbs.</p> <p>c. [DATE]: 218.2 lbs.</p> <p>d. [DATE]: 219.4 lbs.</p> <p>e. [DATE]: 220.6 lbs.</p> <p>f. [DATE]: 219.8 lbs.</p> <p>g. [DATE]: 238.0 lbs.</p> <p>h. [DATE], [DATE], and [DATE]: 240.2 lbs.</p> <p>i. [DATE]: 240.9 lbs.</p> <p>j. [DATE]: 253.8 lbs.</p> <p>k. [DATE]: 255.6 lbs.</p> <p>From [DATE] to [DATE], Resident #27 gained 18.2 lbs. in approximately 2 weeks, indicating a significant weight gain of 8.28%.</p> <p>From [DATE] until [DATE], Resident #27 gained 34.4 lbs. in less than 6 months' time, indicating a 15.55% weight gain.</p> <p>During an observation of Resident #27 on [DATE], saw Resident #27 wearing thigh high compression socks on both legs.</p> <p>(continued on next page)</p>

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<p>F 0684</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>During an interview [DATE] at 8:21 AM, the Director of Nursing (DON) stated Resident #27's ARNP ordered to apply thigh high compression stockings in the morning and remove in the evening back in September of 2024 at admission and he still had the order in place. The DON didn't know why the order didn't exist in his clinical record. The DON said the staff should document the compression stockings (ted hose) in tasks. The order didn't get added to tasks because the system didn't auto generate it, but it has been generated as of [DATE]. The DON acknowledged the order didn't get documented in Resident #27's clinical record for the months of January and February 2025. She expected the staff document the compression stockings they put on and took off at the correct times. The DON added she expected an order is in place and in his clinical record. Resident #27 wore the compression stockings daily in January and February of 2025.</p> <p>During an interview [DATE] at 9:00 AM, Resident #27's ARNP stated he had chronic edema since 2019. He wore thigh high compression stockings since his admission to the facility in September of 2024. She briefly had the facility hold off on the compression stockings at the end of December when due to his hospitalization , then he went back to needing to wear them daily on [DATE]. The ARNP stated due to Resident #27 being on more than one diuretic and having chronic edema, he should have daily weights taken. The ARNP expected the facility to notify her of a 3-pound weight gain in a day and a 5-pound weight gain in a week. The ARNP stated she didn't see someone notified her of any concerning weight gains, or of a 3 - or 5-pound weight gain. The ARNP stated Resident #27's weight gain since admission could be related to having consistent meals and eating more regularly. In December, around Christmas time, Resident #27 had a normal fluid overload test completed. The ARNP stated she last saw Resident #27 in the facility on [DATE]. She didn't have any concerns for Resident #27 at the time, however stated the facility should weigh him daily and he should wear the thigh high compression stockings daily.</p> <p>During an interview [DATE] at 11:43 AM, the DON stated she couldn't find an order for Resident #27's weights. She added they follow the standard practice for weights, if they didn't have an order and they should follow the standard practice for the resident's diagnoses and medications. If a resident had chronic edema and used a diuretic such as Resident #27, they should weigh the resident more than the standard once a month. The DON stated if a resident with chronic edema taking a diuretic didn't have an order for weights, they should follow up with the physician to determine how often the resident should be weighed. The DON stated they didn't follow up with the physician on weights and didn't track daily weights or consistent weights for Resident #27.</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 review, staff interviews, and policy review the facility failed to provide adequate nursing supervision to prevent accidents and injuries for 1 of 2 residents reviewed (Resident #20) for falls. The facility failed to complete a thorough root cause analysis and implement a fall intervention after a fall occurred. The facility reported a census of 54 residents.</p> <p>Findings include:</p> <p>Resident #20's Minimum Data Set (MDS) assessment dated [DATE] identified a Brief Interview for Mental Status (BIMS) score of 6, indicating severely impaired cognition. Resident #20 required substantial to maximal assistance with bed mobility and all transfers. The MDS included diagnoses of anemia (low iron levels in the blood), heart failure (inability for the heart to pump blood), hypertension (high blood pressure), diabetes mellitus, malnutrition (inadequate intake of nutrition) and non Alzheimer's disease. The MDS documented Resident #20 had one fall with injury since last assessment.</p> <p>The Care Plan Focus with a target date 5/12/25 documented Resident #20 had a risk for falls and required assistance with ADLs (activities of daily living). The Care Plan directed the following interventions:</p> <ul style="list-style-type: none"> a. Assist Resident #20 with ambulation and transfers using a gait belt, standard walker and substantial/maximal assistance of 1 staff member. Staff may use an EZ stand (standing mechanical lift) as needed. b. Call light within reach. c. Dycem (nonskid pad) to wheelchair. d. Nonskid footwear. e. Therapy evaluation and treatment as needed. <p>A Progress Note titled Incident Report dated 11/21/24 at 4:54 PM documented a CNA (certified nursing assistant) called the nurse to Resident #20's room. Upon arrival, the nurse noted Resident #20 lying on the floor in her bedroom. Resident #20 laid positioned on her right side, propped up on her right arm with her legs stretched straight out. Resident #20 and the CNA reported as they came from the bathroom to sit in the wheelchair and Resident #20 tripped over her own feet. The carpet looked dry and free of clutter. The note documented Resident #20 wore tennis shoes, along with a gait belt and had her walker. The note revealed Resident #20 obtained skin tears from the fall to the right elbow that measured 4.5 x 3.5 and right knee that measured 2 x 1.5. The note documented the preliminary recommendation for further preventive measures as an OT (occupational therapy) evaluation and treatment for ambulation.</p> <p>The Clinical Record lacked documentation of obtaining a physician order for the OT evaluation and treatment for Resident #20 after the fall.</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>Review of a facility form titled Risk Management dated 11/21/24 documented the root cause analysis described Resident #20 as weak and lost her footing. The note recommended a PT (Physical Therapy) evaluation and treatment. The root cause analysis lacked documentation on why Resident #20 lost her footing or tripped causing her to fall.</p> <p>The clinical record lacked documentation the facility obtained a physician order for PT evaluation and treatment.</p> <p>Resident #20's Care Plan lacked documentation of a fall intervention for 11/21/24.</p> <p>On 2/26/25 at 11:35 AM, the Administrator reported an OT evaluation and treat as the preliminary recommendation and upon further investigation by the former DON (Director of Nursing) she determined that PT (Physical Therapy) should be ordered and it did not happen.</p> <p>On 2/26/25 at 4:00 PM, Staff A, Nurse Consultant reported the facility completed a root cause analysis under risk management but it wasn't good. She reported the previous DON planned to get PT orders due to weakness but did not follow through.</p> <p>The facility policy titled Fall Risk Assessment and Intervention revised 6/25/12 instructed the facility to assess residents upon admission, readmission, and change in condition for potential risk factors associated with falls. Initial interventions specific to the resident would be implemented at the time of the assessment. The policy directed to complete an incident report and quality assurance investigation form should a resident experience a fall. Assess each fall to try to determine the cause. Review the Care Plan with each occurrence and add new/different approach relative to the assessed cause of the fall.</p>		

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<p>F 0698</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide safe, appropriate dialysis care/services for a resident who requires such services.</p> <p>48886</p> <p>Based on clinical record review and staff interview, the facility failed to provide dialysis care to meet the needs of a resident for 1 of 1 residents reviewed (Resident #34). The facility failed to notify the primary care physician (PCP) of weight gain according to the parameters ordered by the PCP. The facility reported a census of 54 residents.</p> <p>Findings include:</p> <p>Resident #34's Minimum Data Set (MDS) assessment, dated 12/6/24, identified a Brief Interview for Mental Status (BIMS) score of 15, indicating intact cognition. The MDS included diagnoses of medically complex conditions, heart failure, hyperlipidemia (elevated cholesterol increasing the risk of stroke or heart attack) and end stage renal (kidney) disease (ESRD). The MDS indicated Resident #34 received dialysis.</p> <p>The Care Plan with a target date of 3/16/25 included the following Focuses:</p> <ul style="list-style-type: none"> a. Resident #34 required dialysis related to a diagnosis of end stage renal disease. <ul style="list-style-type: none"> i. The Intervention directed to monitor weights. b. Resident #34 required the use of diuretic (medication used to reduce the amount of fluid) medication related to ESRD. <ul style="list-style-type: none"> i. The Intervention instructed to monitor weights and report abnormal findings to the practitioner. <p>Resident #34's Order Details dated 9/11/22 directed to complete daily weights related to chronic kidney disease. The order directed to notify the physician of a weight gain of 2 3 pounds in 24 hours or 5 pounds in 5 days.</p> <p>The POC Response History related to weights reviewed 2/27/25 for the previous 30 days reflected the following weights that required physician notification:</p> <ul style="list-style-type: none"> a. 4-pound gain between 12/1 to 12/2 b. 4-pound gain between 12/4 to 12/5 c. 6-pound gain between 12/5 to 12/6 d. 5-pound gain between 12/7 to 12/8 e. 6-pound gain between 12/16 to 12/17 f. 5-pound gain between 12/19 to 12/20 <p>(continued on next page)</p>

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<p>F 0698</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>g. 5-pound gain between 12/21 to 12/22</p> <p>h. 5-pound gain between 12/22 to 12/23</p> <p>i. 5-pound gain between 12/25 to 12/26</p> <p>j. 5-pound gain between 12/28 to 12/29</p> <p>k. 8.4-pound gain between 12/29 to 12/30</p> <p>l. 4-pound gain between 12/31 to 1/1/25</p> <p>m. 5-pound gain between 1/2 to 1/3</p> <p>n. 6-pound gain between 1/16 to 1/17</p> <p>o. 8-pound gain between 1/18 to 1/19</p> <p>p. 4-pound gain between 1/21 to 1/22</p> <p>q. 7-pound gain between 1/26 to 1/27</p> <p>r. 4-pound gain between 1/28 to 1/29</p> <p>s. 4-pound gain between 1/30 to 1/31</p> <p>t. 5-pound gain between 2/2 to 2/3</p> <p>u. 5-pound gain between 2/4 to 2/5</p> <p>v. 8-pound gain between 2/6 to 2/7</p> <p>w. 6-pound gain between 2/8 to 2/9</p> <p>x. 4-pound gain between 2/19 to 2/20</p> <p>y. 6-pound gain between 2/20 to 2/21</p> <p>z. 4-pound gain between 2/22 to 2/23</p> <p>The clinical record lack documentation of notification to the physician regarding Resident #34's weight gains under the parameters of the physician order.</p> <p>During an interview 2/27/25 at 1:50 PM, the Director of Nursing (DON) reported she couldn't locate the physician notifications related to Resident #34's weight gains. The DON acknowledged no one notified the physician about Resident #34's weight changes as ordered.</p> <p>(continued on next page)</p>

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<p>F 0698</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>During an interview 2/27/25 at 3:25 PM, the Administrator said she expected the staff to follow physician's orders. The Administrator stated the facility didn't have a policy regarding this, as they use the standard of care.</p>

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<p>F 0713</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide or arrange emergency care by a doctor 24 hours a day.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 46875</p> <p>Based on clinical record review, staff interviews and policy review, the facility failed to ensure the Physician responded promptly to a notification of abnormal laboratory results and chest x ray results for 1 of 21 residents (Resident #55) reviewed. See F684 for additional information regarding Resident #55. The facility reported a census of 54 residents.</p> <p>Findings include:</p> <p>Resident #55's MDS (Minimum Data Set) assessment dated [DATE] identified a BIMS (Brief Interview for Mental Status) score of 11, indicating moderately impaired cognition. Resident #55 required substantial to maximal assistance with bed mobility and all transfers. The MDS included diagnosis of heart failure (inability for the heart to pump blood), hypertension (high blood pressure), atrial fibrillation (irregular heart beat), diabetes mellitus and acute kidney failure. The MDS documented Resident #55 received diuretic medication during the lookback period.</p> <p>A Progress Note dated [DATE] documented the ARNP (Advanced Registered Nurse Practitioner) saw Resident #55 and ordered the following:</p> <p>a. Obtain the following labs and x ray</p> <p>i. CMP (complete metabolic panel)</p> <p>ii. BNP (brain natriuretic peptide)</p> <p>iii. CBC with differential (complete blood count)</p> <p>iv. portable chest x ray.</p> <p>b. Resident #55 may benefit from evaluation by Hospice.</p> <p>A Progress Note dated [DATE] (Sunday) at 1:08 AM documented the facility received Resident #55's lab results for the CBC with differential, CMP and BNP. The progress note documented the following abnormalities:</p> <p>a. Auto hematology</p> <p>- Auto monocyte percent - 14.8(H) (expected equal to or under 12, may indicate infection),</p> <p>- RBC (Red blood cells) - 3.87(L) (expected 4.6 - 6.20),</p> <p>- Hemoglobin (Hgb) - 9.6 (L) (expected 13.5 - 18), Hematocrit (Hct) - 32.6(L) (expected 37 - 47)</p> <p>- MCH (a measure of the average Hgb in the RBCs) - 24.8(L) (expected 29 - 35),</p> <p>- RDW (measures the size of the RBC) - 20.2(H) (expected 11.5 - 14.5).</p> <p>(continued on next page)</p>		

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<p>F 0713</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>b. General Chemistry</p> <ul style="list-style-type: none"> - Glucose - 151(H) (expected 70 - 99) - BUN (measures kidney function) - 35(H) (expected ,d+[DATE]) - Creatinine (measures kidney function) - 1.42(H) (expected 0.6 - 1.3) - BUN/Creat ratio - 25(H) (expected 10 - 20) - eGFR CKD EPI (measure kidney disease stages) - 47(L) (expected greater than 90, 47 indicated moderate impairment) - AST (measures liver function) - 9(L) (expected ,d+[DATE]), - Total protein - 6.3(L) (expected 6.4 - 8.2) - Albumin (measures the liver and kidney function) - 2.6(L) (expected 3.4 - 5) - Globulin (measures kidney and liver function) - 3.7(H) (expected 2.3 - 3.5) - A/G ratio (measures nutritional status, immune function, and overall health) - 0.7(L) (expected 1.1 - 2). <p>c. Cardiac Isoenzymes (checks heart function)</p> <ul style="list-style-type: none"> - NT proBNP (checks heart function) - 7919(H) (expected ,d+[DATE]). <p>The Progress Note on [DATE] at 1:08 AM reflected Resident #55 had a BNP result of 7,919 pg/ml (picograms per milliliter), with a reference range of 0 450. (A high BNP level may indicate heart failure, kidney failure, pulmonary embolism or other conditions).The progress note documented they faxed the lab results to the ARNP for review.</p> <p>A Progress Note dated [DATE] at 2:29 PM documented Resident #55 continued to have increased weight gain with pitting edema noted to hands, arms and back.</p> <p>A Progress Note dated [DATE] documented Resident #55's abnormal chest x ray results. The chest x ray impression showed the cardiac silhouette was enlarged, mild pulmonary vascular congestion and small bilateral pleural effusions with bibasilar atelectasis and or consolidation. The note documented the abnormal results were faxed to the ARNP for review.</p> <p>Review of the clinical record lacked documentation that the ARNP addressed the abnormal lab results faxed on [DATE]. The progress notes lacked any follow up or other means of communication with the ARNP regarding the abnormal lab results.</p> <p>Review of the Progress Notes lacked documentation the ARNP addressed the abnormal chest x ray results faxed on [DATE]. The progress notes lacked any follow up or other means of communication with the ARNP regarding the abnormal chest x ray results.</p> <p>(continued on next page)</p>		

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<p>F 0713</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>The Progress Note dated [DATE] at 1:45 PM revealed Resident #55 expired at 11:07 AM.</p> <p>Review of Resident #55's chest x ray results dated [DATE] revealed the ARNP signed/noted the x ray on [DATE] after Resident #55 has expired.</p> <p>A communication form titled Reminders provided by the facility on [DATE] for Resident #55 revealed on [DATE] at 1:49 PM the ARNP reviewed the abnormal lab results and directed her nurse to call the facility with the results and inquired about Resident #55's shortness of breath. The form documented the ARNP's nurse spoke to a facility nurse on [DATE] at 4:52 PM. The form documented the facility nurse reported Resident #55 lost 2 lbs. and was doing okay. The form lacked additional direction or Physician orders regarding the abnormal lab results.</p> <p>On [DATE] at 5:50 PM, Staff A, Nurse Consultant, verified the facility faxed the lab results on [DATE] (Sunday) and the Provider didn't review them until [DATE]. Staff A verified a lack of follow up regarding the lab results. In addition, Staff A verified the Provider didn't follow-up or review Resident #55's chest x ray results until [DATE]. The Nurse Consultant reported the facility was working with the ARNP on her timeliness of addressing concerns and had multiple meetings to discuss this.</p> <p>On [DATE] at 11:27 AM, the ARNP reported she didn't provide coverage over the weekend ([DATE]) and that a hospitalist covered for her. The ARNP reported she not being in work status on ,d+[DATE] and , d+[DATE]. She said she returned to work status on ,d+[DATE] and reviewed the labs then. She said she had her nurse call the facility to follow up on Resident #55 and the facility nurse reported him as doing ok. When asked if he had a BNP lab completed prior, she reported Resident #55 as a new patient for her starting in [DATE]. She explained she didn't have a baseline BNP. When asked about the chest x ray results, the ARNP reported she didn't review the results the week of [DATE]. She reported she looked for the chest x ray results in the chart last night ([DATE]) and the next morning ([DATE]), but she couldn't locate the results. She said usually an outside provider sent a copy of the results and then someone scanned the results in the chart. She said she didn't work [DATE] or [DATE]. She said the following week she had clinic day on Thursday, [DATE] and her clinic folder would have the fax with the chest x ray results inside. She reported she noted the chest x ray report on that day which was consistent with the date on the chest x ray form in the facility chart. She reported she didn't know of the facility's policy but if the patient's condition changed or if they had a concern, the facility generally reached out to her.</p> <p>On [DATE] at 12:53 PM, Staff A reported she expected the staff to follow up on the lab and chest x ray results with another means of communication if the Provider didn't respond in a timely manner. Staff A reported critical lab values should be reported immediately and non critical abnormal labs reported within 24 hours.</p> <p>(continued on next page)</p>		

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<p>F 0713</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>A facility policy titled Laboratory/Diagnostic Value Reporting revised [DATE] directed to promptly notify the ordering physician, physician assistant, nurse practitioner or clinical nurse specialist of laboratory, radiology and other diagnostic services with results that are in a critical reference range. The policy directed the facility would promptly notify the resident's attending physician, when STAT (immediate) laboratory results are available or when lab results are clinically considered critical. When the laboratory received any critical laboratory result or detected by the nursing staff, the result would be communicated to the physician/ordering clinician promptly. If the resident didn't have their attending physician available, then they should contact the Medical Director or appropriate facility practitioner for notifications and orders. Radiology reports with findings conclusive of acute abnormalities or significant changes in conditions would be communicated to the resident's attending physician promptly. If the resident's attending physician was not available, the Medical Director or appropriate facility practitioner would be contacted for notifications or orders.</p>		

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<p>F 0725</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide enough nursing staff every day to meet the needs of every resident; and have a licensed nurse in charge on each shift.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 44512</p> <p>Based on observation, clinical record review, resident, and staff interviews, the facility staff failed to consistently answer call lights within a reasonable amount of time (15 minutes). Residents reported having to wait thirty to forty five minutes for someone to answer their call light numerous times during the week. The facility reported a census of 54 residents.</p> <p>Findings include:</p> <p>1. Resident #46's Minimum Data Set (MDS) assessment dated [DATE] identified a Brief Interview for Mental Status (BIMS) score of 15, indicating intact cognition. Resident #46 required substantial assistance of 2 staff for transfers and toileting. The MDS included a diagnosis of hemiplegia (paralysis of one side of the body).</p> <p>During an interview on 2/24/25 at 12:41 PM, Resident #46 stated the staff took a long time to answer their call light. Observed Resident #46 in a wheelchair, with his left leg and left arm secured to the wheelchair arm rest. Resident #46 stated it took 30 minutes to an hour in the afternoon and evening shifts. Resident #46 stated, he didn't have accidents but squirmed, it made him feel low on the priority list. Resident #46 stated when his call light pendant broke, it didn't get replaced, he couldn't reach the call light and had to yell for help.</p> <p>A call light response document for Resident #46 revealed:</p> <ol style="list-style-type: none"> a. On 2/18/25 at 7:36 AM a call response time of 37 minutes. b. On 2/29/25 at 6:04 PM a call response time of 18 minutes. c. On 2/19/25 at 6:44 PM a call response time of 37 minutes. d. On 2/20/25 at 12:10 PM a call response time of 32 minutes. e. On 2/21/25 at 11:48 AM a call response of 1 hour and 5 minutes. f. On 2/25/25 at 6:39 AM using pendent, a call response time of 36 minutes. <p>48886</p> <p>2. Resident #6's Minimum Data Set (MDS) assessment dated [DATE] identified a Brief Interview for Mental Status (BIMS) score of 15, indicating intact cognition. Resident #6 required total assistance from staff toileting hygiene and lower body dressing. Resident #6 used a wheelchair for mobility. The MDS included diagnoses of progressive neurological conditions, diabetes mellitus and multiple sclerosis.</p> <p>(continued on next page)</p>		

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<p>F 0725</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>During an interview 2/24/25 at 1:16 PM, Resident #6 stated over the past weekend she waited for 2 hours in the bathroom for staff to help her. Resident #6 stated she needed help getting dressed and in the bathroom for toileting hygiene. Resident #6 stated she had times at night when the facility only had 1 nurse and 1 CNA for the whole building, then someone would come in later sometimes to help. The facility used agency staff sometimes and did the past weekend. Resident #6 described herself as partially clothed, while she sat on the toilet for 2 hours waiting for someone to help. She reported her legs and butt hurt after sitting on the toilet for 2 hours. Resident #6 reported it as frustrating. They came in to help her get on the toilet, and then left, saying they would be back in a few minutes, but they didn't come back in a few minutes. Resident #6 said after waiting several minutes for staff to return to help her off the toilet and help with toileting hygiene, she turned her call light on again. Someone came back, saying they needed another person and would be back again. Resident #6 stated she waited for 2 hours for someone to come back to assist her off the toilet, with toileting hygiene, and lower body dressing. Resident #6 stated she had other times she waited longer than 15 minutes for a call light response.</p> <p>The facility call light report for the past 30 days for Resident #6, from 1/29/25 to 2/25/25, listed 12 instances where Resident #6 waited longer than 20 minutes for a call light response:</p> <ul style="list-style-type: none"> a. 1/30/25 at 7:18 PM, 20:54 minutes b. 1/31/25 at 9:34 AM, 21:58 minutes c. 1/31/25 at 1:26 PM, 32:01 minutes d. 2/4/25 at 8:33 AM, 39:29 minutes e. 2/7/25 at 5:07 PM, 43:08 minutes f. 2/8/25 at 10:39 AM, 34:11 minutes g. 2/9/25 at 7:41 AM, 30:03 minutes h. 2/13/25 at 12:41 PM, 30:20 minutes i. 2/16/25 at 11:05 AM, 26:18 minutes j. 2/17/25 at 12:44 PM, 20:20 minutes k. 2/24/25 at 8:21 AM, 47:21 minutes l. 2/25/25 at 7:21 PM, 24:57 minutes <p>46875</p> <p>3. Resident #24's Minimum Data Set (MDS) assessment dated [DATE] identified a Brief Interview for Mental Status (BIMS) score of 14, indicating intact cognition.</p> <p>Resident #24's Clinical Census listed an admitted [DATE], into Room A7 1.</p> <p>(continued on next page)</p>		

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<p>F 0725</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>On 2/24/25 at 11:22 AM, Resident #24 said she became incontinent of BM (bowel movement) a couple of times since she admitted to the facility, due to not having enough staff. She reported she felt like a baby when she became incontinent. She said the staff might answer her call light in 5 minutes but then took 40 minutes to come back and help her. She reported last night (2/23/25) she put her call light on at 1:15 AM and asked for some Tylenol and she didn't get it until that morning around 7:30 AM. She reported the staff are nice but they didn't have enough people. She described 2 staff members for 3 hallways as not enough.</p> <p>A facility form titled Past Events for dates 2/6/25 to 2/26/25 for Room A 7 reflected the following call light elapsed times greater than 15 minutes:</p> <ul style="list-style-type: none"> a. 2/6/25 - 8:48 PM = 1 hour 30 minutes b. 2/7/25 - 10:15 PM = 25 minutes c. 2/8/25 8:44 PM = 23 minutes d. 2/10/25 - 8:42 AM = 25 minutes e. 2/12/25 - 4:44 AM = 20 minutes f. 2/14/25 - 7:33 AM = 30 minutes g. 2/15/25 - 7:43 AM = 46 minutes h. 2/15/25 - 9:15 PM = 20 minutes i. 2/16/25 - 10:02 PM = 21 minutes j. 2/18/25 - 6:56 AM = 26 minutes k. 2/18/25 - 7:57 AM = 28 minutes l. 2/19/25 - 8:32 AM = 25 minutes m. 2/20/25 - 8:39 AM = 20 minutes n. 2/21/25 - 7:16 AM = 28 minutes o. 2/21/25 - 9:06 AM = 24 minutes p. 2/22/25 - 7:58 AM = 29 minutes q. 2/23/25 - 7:36 AM = 20 minutes r. 2/24/25 - 1:31 AM = 27 minutes s. 2/24/25 - 7:43 AM = 34 minutes <p>(continued on next page)</p>

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 165411	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 03/03/2025
NAME OF PROVIDER OR SUPPLIER Southfield Wellness Community		STREET ADDRESS, CITY, STATE, ZIP CODE 2416 Des Moines Street Webster City, IA 50595	

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<p>F 0725</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>4. dated 2/3/25 Resident #13 identified a BIMS score of 15, indicating intact cognition.</p> <p>The Clinical Census revealed Resident #13 was admitted to the facility on [DATE] and resided in Room B45 1.</p> <p>On 2/24/25 1:33 PM, Resident #13 said he can wait up to 30 minutes for his call light to be answered. He explained he pooped his pants before waiting for someone to answer his call light, he added it made him feel embarrassed. He reported he used his phone to time the call light response.</p> <p>A facility form titled Past Events for dates 1/25/25 to 2/26/25 for Room B 45 revealed the following call light elapsed times greater than 15 minutes:</p> <ul style="list-style-type: none"> a. 1/27/25 - 9:48 PM = 26 minutes b. 1/29/25 - 9:43 AM = 28 minutes c. 1/29/25 - 12:49 PM = 24 minutes d. 1/31/25 - 5:44 PM = 25 minutes e. 1/31/25 - 6:46 PM = 58 minutes f. 2/1/25 - 11:11 AM = 25 minutes g. 2/1/25 - 5:25 PM = 29 minutes h. 2/1/25 - 6:42 PM = 27 minutes i. 2/4/25 - 1:12 AM = 23 minutes j. 2/4/25 - 5:37 PM = 23 minutes k. 2/5/25 - 9:05 PM = 1 hour 4 minutes l. 2/6/25 - 4:20 PM = 21 minutes m. 2/6/25 - 5:42 PM = 26 minutes n. 2/6/25 - 6:24 PM = 27 minutes o. 2/7/25 - 11:08 AM = 39 minutes p. 2/7/25 - 10:14 PM = 27 minutes q. 2/8/25 - 12:09 AM = 21 minutes r. 2/8/25 - 2:57 PM = 20 minutes <p>(continued on next page)</p>

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<p>F 0725</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>s. 2/8/25 - 6:24 PM = 20 minutes</p> <p>t. 2/8/25 - 7:08 PM = 45 minutes</p> <p>u. 2/10/25 - 7:14 PM = 33 minutes</p> <p>v. 2/12/25 - 12:37 PM = 42 minutes</p> <p>w. 2/12/25 - 4:32 PM = 21 minutes</p> <p>x. 2/12/25 - 9:14 PM = 30 minutes</p> <p>y. 2/13/25 - 11:42 AM = 21 minutes</p> <p>z. 2/13/25 - 5:06 PM = 22 minutes</p> <p>aa. 2/14/25 - 1:49 PM = 20 minutes</p> <p>bb. 2/15/25 - 8:14 AM = 39 minutes</p> <p>cc. 2/15/25 - 12:17 PM = 31 minutes</p> <p>dd. 2/16/25 - 7:56 PM = 28 minutes</p> <p>ee. 2/19/25 - 9:59 AM = 27 minutes</p> <p>ff. 2/19/25 - 4:22 PM = 22 minutes</p> <p>gg. 2/19/25 - 7:54 PM = 32 minutes</p> <p>hh. 2/20/25 - 8:23 AM = 37 minutes</p> <p>ii. 2/21/25 - 8:40 PM = 21 minutes</p> <p>jj. 2/22/25 - 7:52 PM = 21 minutes</p> <p>kk. 2/24/25 - 7:15 PM = 26 minutes</p> <p>On 2/26/25 at 11:30 AM, Staff F, CNA (certified nursing assistant), reported Resident #13 had times when he requested to go to the bathroom, but the staff were busy and not available to take him. Staff F confirmed Resident #13 had incontinence of bowel and bladder while waiting for staff to assist him.</p> <p>On 2/26/25 at 10:15 AM, the Administrator reported she expected the staff to answer call lights within 15 minutes.</p> <p>(continued on next page)</p>		

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<p>F 0725</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>The facility policy titled Call Light Policy revised September 2023 instructed to ensure a prompt response to a resident's call for assistance and to ensure the call system properly worked. The policy included the facility should answer call lights in a timely manner and when answering a call light, respond to the request. If they couldn't provide immediate assistance and the resident didn't have an emergent need, they can turn the call light off and inform the resident a staff member would be back to assist them shortly.</p>		

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<p>F 0726</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Ensure that nurses and nurse aides have the appropriate competencies to care for every resident in a way that maximizes each resident's well being.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 48886</p> <p>Based on clinical record review, resident and staff interviews and policy review, the facility failed to adequately trained staff to perform a treatment for 1 of 1 resident reviewed (Resident #6). The facility failed to have a nurse flush Resident #6's catheter as ordered. Instead of the nurse, a Certified Nursing Aide (CNA) the irrigated/flushed Resident #6's catheter. The facility reported a census of 54 residents.</p> <p>Findings include:</p> <p>Resident #6's Minimum Data Set (MDS) assessment dated [DATE] identified a Brief Interview for Mental Status (BIMS) score of 15, indicating intact cognition. The MDS included diagnoses of progressive neurological conditions, diabetes mellitus, neurogenic bladder (a condition that affects the bladder's ability to function properly due to damage to the nerves that control it), and multiple sclerosis. The MDS identified the resident had an indwelling catheter.</p> <p>The Care Plan Focus with a target date of 3/11/25, indicated Resident #6 required the use of a suprapubic catheter (a thin, flexible tube inserted through a small incision in the lower abdomen directly into the bladder) related to a neurogenic bladder. The Interventions instructed to irrigate/flush Resident #6's catheter as ordered.</p> <p>During an interview 2/24/25 at 1:18 PM, Resident #6 stated on the previous Saturday (2/22/25), the nurse didn't know how to flush her catheter. The nurse said she did, but then said she didn't. Resident #6 stated she flushed her catheter herself with the help of a CNA.</p> <p>During an interview 2/27/25 at 1:26 PM, Resident #6 stated an agency nurse worked the Saturday night of 2/22/25. The agency nurse said she didn't know how to flush the catheter. Resident #6 reported the flush as an antibiotic flush, that the agency nurse didn't know how to do. Resident #6 stated Staff E, CNA, and her did the flush together. Resident #6 reported the flush as her gentamicin bladder irrigation flush. Resident #6 stated they didn't have complications. In addition, Staff E wore a gown and gloves.</p> <p>Resident #6's Order Details directed to irrigate the bladder with gentamicin bladder irrigation (a procedure that involved instilling a solution of the antibiotic gentamicin directly into the bladder to treat or prevent urinary tract infections) 240 milligrams (mg) / 500 milliliters (ml) normal saline, one time a day for infection prevention. The Order instructed to instill 30 ml into bladder daily, clamp for 30 minutes then drain. The order listed a start date of 10/17/24 and scheduled for Resident #6's hour of sleep (HS).</p> <p>(continued on next page)</p>		

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<p>F 0726</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>During an interview 2/27/25 at 2:15 PM, Staff E stated she worked at the facility for 6 years, full time hours as a CNA. She explained she didn't train for any other job duty other than a CNA. She worked primarily in the back hall, where Resident #6 resides. Staff E stated she worked the last Saturday, 2/22/25, on the 2:00 PM to 10:00 PM shift with an agency nurse that night. That night, around 9:15 PM, Staff E went and told the agency nurse that Resident #6 was ready for her flush. The agency nurse said what is that? Staff E stated she explained the flush to the agency nurse and the agency nurse said they didn't know what they were doing. The agency nurse thought the CNA's could do more than what they could and asked throughout the night for the CNA's help. Staff E stated she told the agency nurse CNA's couldn't do certain cares, including the flush. The agency nurse told Staff E to do the flush for Resident #6. Staff E stated she went into Resident #6's room by herself, the agency nurse didn't go with her at all, and she performed Resident #6's flush/irrigation, with Resident #6 telling her what to do. Staff E stated she admits she did this, that she didn't have the training to do this, and shouldn't done the treatment. She stated Resident #6 walked her through what to do. Staff E stated she clamped where Resident #6 told her to clamp, unhooked the bag, put the flush/antibiotic fluid in, unclamped and pushed the flush in and then put the resident's catheter back together. Staff E stated she felt it went okay and Resident #6 told her it went okay. Staff E stated she wore a gown and gloves. Staff E stated she left a note for the Director of Nursing (DON) about what she did. Staff E stated the DON talked to her and told her not to do it again, she said nothing else happened as far as discipline. Staff E stated an awareness she is not trained or qualified to perform this task, a licensed nurse should have performed it.</p> <p>During an interview 2/27/25 at 2:35 PM, the DON stated she didn't know anything about Staff E performing a flush/irrigation with Resident #6 over the weekend. She added Staff E didn't leave her a note and she didn't talk to Staff E about the situation. The DON stated a CNA didn't have training to perform this type of care and Staff E knew she shouldn't perform the care, as it wasn't within her scope of practice. The DON stated they did have an agency nurse work the past Saturday night, 2/22/25. The Administrator was present during the interview and stated she didn't know about this taking place either. The DON and the Administrator stated they expected the staff to not perform cares beyond their scope of practice and training.</p> <p>A review of the facility CNA job description document, revised December 2014, documented in the general summary, a CNA helps with activities of daily living and effectively implements, communicates and documents resident care.</p>		

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<p>F 0865</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Many</p>	<p>Have a plan that describes the process for conducting QAPI and QAA activities.</p> <p>46875</p> <p>Based on review of the facility's Quality Assurance Performance Improvement (QAPI) plan, the facility's past surveys, and staff interviews, the facility failed to correct their own deficiencies for 7 of 12 areas of concern. The facility reported a census of 54 residents.</p> <p>Findings include:</p> <p>The facility QAPI Plan reviewed 1/14/24 defined the mission as to provide resident centered healthcare services, excellence in clinical care, and to promote care giver engagement and empowerment to better serve the resident, family and the community. The guiding principles consisted of the following:</p> <p>QAPI has a prominent role in our management and board functions on par with monitoring reimbursement and maximizing revenue.</p> <p>QAPI outcomes are directly related to the quality of care and the quality of life of the residents.</p> <p>- The organization uses QAPI to make decisions and guide the day to day operations.</p> <p>QAPI included all employees, all departments and all services provided.</p> <p>The QAPI program focuses on our organization's systems and processes and the facility strives to continually identify and make changes to the systems/processes in order to improve outcomes.</p> <p>The organization makes QAPI decisions based on data gathered from the input and experience of the caregivers, residents, health care practitioners, families, and other stakeholders.</p> <p>The organization sets goals for performance and measures progress towards those goals.</p> <p>The organization supports performance improvement by encouraging the employees to support each other as well as to be accountable for their own professional performance and practice.</p> <p>The organization maintains a culture that encourages, rather than punishes, employees who identify errors or system breakdowns.</p> <p>The survey identified the following concerns during the current survey, that were also cited at surveys in the past year:</p> <ol style="list-style-type: none"> a. Development/Implement comprehensive Care Plan b. ADL (activity of daily living) care provided for dependent residents c. Quality of care <p>(continued on next page)</p>

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<p>F 0865</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Many</p>	<p>d. Free of accident hazards/supervision/devices</p> <p>e. Dialysis</p> <p>f. Sufficient Nursing Staff</p> <p>g. QAPI program/plan, disclosure/good faith attempt</p> <p>On 3/3/25 at 11:02 AM, the Administrator acknowledged the repeated concerns and reported she thought the facility had a better plan in place to address the concerns. The Administrator voiced the importance of having the right people in the right position and that several administration nurses are no longer in the building. She reported the facility was working on culture change and voiced change didn't happen overnight. The Administrator reported the facility worked on accountability factors with the staff, working on building an effective nursing administration team, and working on replacing agency staff members. She reported the Corporation assigned the Regional Nurse Consultant to the facility in November and they helped provide support to the facility including training the DON (Director of Nursing).</p>

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<p>F 0881</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Many</p>	<p>Implement a program that monitors antibiotic use.</p> <p>44512</p> <p>Based on observation, antibiotic stewardship policy, clinical record review, and staff interview, the facility failed to follow policies with all residents. The Infection Preventionist (IP) identified residents with an infection using a facility map, but couldn't provide evidence of when the antibiotic began, the monitoring of laboratory data, and the evaluation of the treated infections. The facility had 2 residents (Residents #43 and #37) with active urinary tract infections (UTIs) and 1 resident (Resident #35) who completed an antibiotic for a methicillin resistant staphylococcus aureus (MRSA) infection (a contagious infection that requires treatment with specific medication due to the infection not responding to other medications). The facility reported a census of 54 residents.</p> <p>Findings include:</p> <p>1. The Health Status Note dated 1/16/25 at 7:50 AM reflected Resident #37 returned from an appointment with the following new orders:</p> <p>a. Start Bactrim DS (antibiotic) 800 - 160 MG 1 tablet by his g-tube (tube inserted in the stomach to bypass the esophagus to prevent issues with swallowing or increase nutritional intake) for 14 days for a UTI.</p> <p>The New Order Note dated 1/27/25 at 11:51 AM indicated Resident #37 returned from the Urologist appointment with new orders for the following:</p> <p>a. Increase urinary catheter changes to every 3 weeks or 21 days.</p> <p>b. Start nitrofurantoin (antibiotic) 100 milligrams (MG) nightly for 90 days.</p> <p>c. Start D-Mannose (a sugar that may help treat and prevent UTIs by blocking E. coli bacteria) 1000 MG twice a day</p> <p>2. Resident #43's Clinical Physician's Order reviewed 2/25/25 listed an order for Cipro oral tablet 250 MG from 2/18/25 - 2/25/25.</p> <p>3. The Nutrition/Dietary Note dated 2/24/25 at 10:50 AM indicated Resident #35 used an antibiotic due to a diagnosis of MRSA.</p> <p>During an interview on 2/24/25 at 3:04 PM Staff F reported Resident #35 needed quarantined the previous week but no longer needed.</p> <p>During an interview on 2/27/25 at 2:17 PM, the Director of Nursing (DON) reported being the current infection Preventionist (IP) and having the responsibility for the infection prevention and antibiotic stewardship program. The DON provided a monthly map of the facility with color coding of infections. The map failed to provide evidence of the antibiotic used for the infections, or the monitoring of the lab data or evidence-based criteria for the evaluation of the treated infections. The DON stated the facility would soon start using a system on the computer that would track the infections.</p> <p>(continued on next page)</p>		

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<p>F 0881</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Many</p>	<p>During an interview on 2/27/25 at 2:29 PM, the Administrator explained she had to get permission before she could provide the infection tracking process due to it being Quality Assurance (QA) material.</p> <p>During an interview on 2/27/25 at 3:02 PM, the Administrator couldn't provide evidence of an active antibiotic stewardship program.</p> <p>A policy titled Antibiotic Stewardship Program dated 1/23/25 revealed:</p> <p>a. The antibiotic stewardship program committee included the DON and the Infection Prevention Program Coordinator.</p> <p>b. The DON was accountable to educate and implement antibiotic stewardship protocol for nursing staff, assess, monitor and communicate changes in the resident's condition by monitoring laboratory/x ray reports associated with the disease. The DON was responsible to communicate results/effectiveness of the antibiotic therapy to the medical provider.</p> <p>c. The infection Preventionist (IP) gathers data and tracks when antibiotics start, monitoring adherence to evidenced based published criteria during the evaluation and management of the treated infections. The IP reviews the antibiotic resistance patterns and understands which infections are caused by resistant organisms, presents the collected data to the monthly Quality Assurance committee meeting and assists with antibiotic stewardship education to staff, residents and families.</p>		