STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	165443	A. Building B. Wing	04/09/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Grand Ji Vante	502 Butler Street Ackley, IA 50601

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)
F 0578 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to request, refuse, and/or discontinue treatment, to participate in or refuse to participate in experimental research, and to formulate an advance directive. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 42441 Based on clinical record review, policy review and staff interviews, the facility failed to ensure code status between the facility and hospice were congruent for 1 of 2 residents reviewed for advanced directives (Resident #10). The facility reported a census of 34 residents. Findings include: Resident #10's Clinical Census listed an admitted [DATE]. Per the Census, Resident #10 discharged to the hospital on [DATE] and returned on [DATE]. The Cardiopulmonary Resuscitation (CPR)/NO CPR Directives, dated [DATE] and signed by the physician revealed Resident #10 desired CPR. The Contracted Hospice form dated [DATE], signed by Resident #10's Power of Attorney (POA) directed to provide no resuscitation for Resident #10. The form lacked a physician's signature. Resident #10's Progress Note dated [DATE] at 11:06 AM documented by Staff B, Registered Nurse (RN), the facility noted a full code status with no signed copy of the Do Not Resuscitate(DNR) form located. The nurse spoke with the family who reported Resident #10 didn't want to be resuscitated. Staff B called Resident #10's Hospice provider for clarification. Resident #10's Progress Note dated [DATE] at 11:06 AM documented by Staff M, Licensed Practical Nurse (LPN), they received a DNR status from her Hospice provider. The Care Plan Active Problem revised [DATE] reviewed [DATE] at 2:58 PM reflected Resident #10 wished to receive CPR. Resident #10's Physician Orders reviewed on [DATE] at 11:09 AM listed an order for full code order dated [DATE] and an open-ended end date. Resident #10's Face Sheet reviewed [DATE] at 11:16 AM revealed a diagnosis of an encounter for palliative care dated [DATE]. (continued on next page)

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE

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F 0578 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On [DATE] at 4:26 PM, the Assistant Director of Nursing (ADON) said she believed Resident #10 returned from the hospital on a Friday. She would typically make the changes but thought she didn't work that day. The ADON explained the Director of Nursing (DON) could have made changes and so could have the nurses but couldn't confirm all the nurses knew how to do it. On [DATE] at 5:05 PM, the ADON reported she spoke to the Hospice nurse and they were waiting for the provider to sign the DNR order. On [DATE] at 9:02 AM, the ADON explained if a resident went on hospice they technically change to a DNR and would get the Iowa Physician Orders for Scope of Treatment (IPOST). The ADON added Resident #10 came from the hospital with Hospice orders and the facility typically would get an IPOST with DNR at that time. The ADON confirmed the facility didn't receive an IPOST when Resident #10 returned from the hospital. On [DATE] at 9:35 AM, the ADON said when Resident #10 admitted to the facility she had a full code order. The ADON further stated when Resident #10 went to the hospital and then returned to the facility she had a DNR code status according to the Hospice form. The ADON stated Resident #10 admitted to the hospital on [DATE] and returned to the facility on hospice on [DATE], a Friday. The ADON stated she assumed someone else could have changed it or taken care of the Hospice order. The Nursing Facility CPR/DNR policy dated [DATE] instructed when a resident is a no code or DNR in the facility, Cardio Pulmonary Resuscitation or CPR will not be initiated in the event that a resident experienced a lifeless condition. When a resident is coded or CPR in the facility, Cardio Pulmonary Resuscitation or CPR will be initiated by the staff when a lifeless condition is observed and someone will call 911. In the event that a resident and/or responsible party member (as appropriate) decide to change to the CPR/DNR designation, they may do so at any time by speaking to a nursing staff member. That nursing staff member will be responsible for ensuring the appropriate facility CPR/No CPR directives form is completed and physician's signature is obtained (if required) with the physician orders updated. On [DATE] at 8:30 AM, the Regional Director of Quality and Clinical Services reported the facility expected the code status between Hospice and the facility match. In addition, the nurses receive an updated IPOST.

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F 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Immediately tell the resident, the resident's doctor, and a family member of situations (injury/decline/room, etc.) that affect the resident. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 47079 Based on clinical record review, staff and family interviews, and policy review, the facility failed to provide family notification in a timely manner when changes occurred in the resident's physical or mental condition for 1of 1 resident reviewed (Resident #23). The facility reported a census of 34 residents. Findings include: Resident #23's Minimum Data Set (MDS) assessment dated [DATE] identified a Brief Interview for Mental Status (BIMS) score of 7, indicating severely impaired cognition. The MDS indicated Resident #23 required setup assistance with eating and moderate assistance with all other activities of daily living (ADLs). In addition, the MDS listed Resident #23 as independent or required supervision with mobility, used a walker for ambulation, and didn't use a wheelchair for mobility. The MDS included diagnoses of coronary artery disease, bipolar disorder, asthma, and depression. On 4/2/24 at 7:50 AM, Resident #23's Family Member stated the facility didn't notify them until 2 1/2 to 3 weeks after Resident #23's decline in physical condition. On 4/2/24 at 1:52 PM, Staff B, Registered Nurse (RN), stated family notifications are documented in Progress Notes but if it wasn't documented, it didn't mean it wasn't done, it just meant the staff didn't documented it. On 4/4/24 at 9:14 AM, Staff G, RN, stated any change in status warrants a notification to the family and physician. A Progress Note dated 2/21/24 at 3:49 PM indicated Resident #23 requested to use a wheelchair because she believed she never been able to walk. A Progress Note dated 2/23/24 at 10:03 AM recorded the staff assisted Resident #24 to a wheelchair and brought her to the dining room for breakfast. No subsequent Progress Note indicated the resident ambulated with her walker. A Progress Note dated 3/13/24 at 11:59 AM indicated the facility notified the family of Resident #23's mobility decline and her need for a wheelchair. The Care Plan Problem revised 3/16/24 reflected Resident #23 required assistance from 1-2 with ADLs, and used a wheelchair propelled by staff for mobility. On 4/9/24 at 11:15 AM, the Chief Clinical Officer stated the facility should notify the family within 24 hours of a resident's nonurgent, significant change of condition. The Resident Representative & PCP Notification (primary care physician) policy dated 11/16/23 directed the staff to notify the resident's representative as soon as possible for any significant change of condition; unless specified otherwise.

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F 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure each resident receives an accurate assessment. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 42441 Based on clinical record review and staff interview, the facility failed to transmit a discharge Minimum Data Set (MDS) assessment in a timely manner for 1 of 1 resident reviewed for resident assessment (Resident #32). The facility reported a census of 34 residents. Findings include: The MDS assessment dated [DATE] indicated Resident #32 discharged from the facility to home on 2/2/24. Section Z of the MDS listed the completion date 4/8/24 and lacked a signature for the RN verification of completion. The MDS 3.0 Resident Assessment page listed under Assessments Due Discharge Assessment with a Due Status listed as late. The due date reflected 2/2/24 with a completion due date of 2/16/24. The Resident Census form reviewed on 4/6/24 at 12:08 PM indicated Resident #32 admitted to the facility on [DATE] and discharged on [DATE]. During an interview 4/8/24 at 8:30 AM, the Assistant Director of Nursing (ADON) acknowledged Resident #32's discharge MDS assessment didn't get completed. On 4/8/24 at 12:52 PM, the Administrator reported the facility didn't have a current policy regarding MDS completion. They expected the staff to follow the most recent Resident Assessment Instrument (RAI). During an interview 4/9/24 at 8:30 AM, the Regional Director of Quality and Clinical Services reported they expected accurate MDS assessments and for the staff to follow the RAI process. The Long-Term Care Facility Resident Assessment Instrument 3.0 User's Manual Version 1.18.11 revised October 2023 reflected a discharge assessment return not anticipated or return anticipated needed completed 14 dates after the discharge date and transmitted with 14 days of the completion date.

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop the complete care plan within 7 days of the comprehensive assessment; and prepared, reviewed, and revised by a team of health professionals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 42441 Based on resident interview, clinical record review, policy review and staff interview, the facility failed to invite a resident or a resident's representative to an initial Care Conference for one of one (Residents #38). The facility reported a census of 34 residents. Findings include: Resident #38's Minimum Data Set (MDS) assessment dated [DATE] listed an admitted [DATE]. The MDS identified a Brief Interview for Mental Status (BIMS) of 14, indicating intact cognition. During an interview 4/1/23 at 2:03 PM, Resident #38 reported the facility didn't invite her to a Care Conference since she admitted to the facility. Resident #38's clinical record review lacked documentation related to the completion of an initial Care Conference. During an interview 4/2/24 at 11:11 AM, the Regional Director of Quality and Clinical Services revealed Resident #38's quarterly Care Conference needed rescheduled due to Resident #38 admission to the hospital at the time. She added she would ask about an initial Care Conference for Resident #38 and let the surveyor know if she found the information. During an interview 4/4/24 at 2:30 PM, the Assistant Director of Nursing (ADON) denied knowing that Resident #38 required an initial Care Conference. The Comprehensive Care Plan policy, effective March 2024 instructed to prepare an interdisciplinary person centered comprehensive Care Plan for each resident following their most current standards of care. Residents and resident representatives, if the resident wishes, will be invited to participate in the interdisciplinary Care Conference. The facility will document the participation and invitations of the Care Conference. On 4/9/24 at 8:30 AM, the Regional Director of Clinical Services said they expected the facility to invite the resident and their representative to all Care Conferences including the initial Care Conference.

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F 0690 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate care for residents who are continent or incontinent of bowel/bladder, appropriate catheter care, and appropriate care to prevent urinary tract infections. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 47079 Based on observation, staff interviews, record review, and policy review, the facility failed to provide appropriate treatment and services to prevent a urinary tract infection for 1 of 3 residents (Resident #23). The facility reported a census of 34 residents. Findings include: Resident #23's Minimum Data Set (MDS) assessment dated [DATE] identified a Brief Interview for Mental Status (BIMS) score of 7, indicating severely impaired cognition. The MDS indicated Resident #23 required setup assistance with eating and moderate assistance with all other activities of daily living (ADLs). In addition, the MDS listed Resident #23 as independent or required supervision with mobility, used a walker for ambulation, and didn't use a wheelchair for mobility. The MDS described Resident #23 as frequently incontinent of bowel and bladder. The MDS included diagnoses of coronary artery disease, bipolar disorder, asthma, and depression. On 4/2/24 at 7:50 AM observed Resident #23's bathroom soap dispensers didn't have soap in them. On 4/2/24 at 11:33 AM, Staff L, Certified Nursing Aide (CNA), and Staff B, Registered Nurse (RN), checked Resident #23 for incontinence care need. Staff L and Staff B donned gloves and removed the covers from Resident #23. While Resident #23 laid on her right side, Staff L removed her gloves, entered Resident #10's bathroom, rinsed her hands in the sink with water, and attempted to get soap from the empty soap dispenser three (3) times. She rinsed her hands again, dried them off with paper towels, and turned off the water. She donned gloves and returned to the left side of Resident #23. Staff B rubbed body wash on Resident #23's back, that she mistook for lotion. Upon being told of her mistake, she removed her gloves and tossed them over Resident #23 toward the trash can. She entered Resident #23's bathroom, grabbed the box of gloves, and placed them on Resident #23's table. In addition, she gathered several sheets of toilet paper for Staff L to use to complete the perineal care. Staff B handed Staff L a wad of toilet paper. Staff L sprayed cleanser on the toilet paper wad and wiped Resident #23's left inner gluteal area. She sprayed a separate toilet paper wad with the cleanser and wiped Resident #23's right inner gluteal area. She then sprayed cleanser on the last toilet paper wad and wiped Resident #23's vaginal area from front to rear. Staff L removed the soiled brief from under Resident #23, rolled it in a tube like fashion, and threw it away. She then grabbed the replacement brief and positioned it under Resident #23's right hip. Staff L and Staff B changed their gloves and repositioned Resident #23 on her back. Staff L finished putting the brief on Resident #23, they turned her on her left side and covered Resident #23 with a sheet and blanket. Staff B entered the bathroom, rinsed her hands with water, donned new gloves, wet an oral hygiene sponge, and wiped the interior of resident's mouth. After finishing, the staff removed their gloves and exited Resident #23's room. The Care Plan Problem dated 1/16/24 included a goal that Resident #23 wouldn't exhibit a urinary tract infection (UTI) secondary to incontinence. The Progress Note dated 1/25/24 at 5:53 PM reflected Resident #23 received a new order for cephalexin (antibiotic) 500 milligrams (MG) twice a day for 10 days. (continued on next page)

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F 0690 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The Progress Note dated 1/26/24 at 5:01 AM identified Resident #23 didn't have any adverse side effects due to the use of cephalexin for a UTI. The Progress Note dated 2/3/24 at 12:06 PM indicated the staff encouraged Resident #23 to drink fluids due to her current UTI. the resident received antibiotics for a UTI. On 4/4/24 at 9:22 AM, Staff L stated she didn't know the facility's hand hygiene policy but verbalized hand hygiene should be performed (a) upon entering a resident's room, (b) when providing care between clean to dirty areas, (c) when providing care between dirty to clean areas, and (d) prior to exiting the resident's room. The Handwashing policy dated 2/29/24 directed the staff to perform hand hygiene (a) after handling soiled or used linens, dressings, bedpans, catheters and urinals, (b) before and after assisting a resident with toileting (hand washing with soap and water), (c) before and after assisting a resident with personal care (e.g., oral care, bathing), and (d) after removing gloves or aprons. On 4/9/24 at 11:15 AM, the Chief Clinical Officer stated hand hygiene should occur between glove changes and should include soap, water, or sanitizer when staff provide incontinence care to a resident.

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F 0757 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Ensure each resident's drug regimen must be free from unnecessary drugs. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 42441 Based on clinical record review, policy review and staff interview, the facility failed to have a system in place to ensure residents who use Coumadin (blood thinner) received their therapeutic monitoring as ordered by the physician for 3 of 3 residents reviewed (Residents #5, #13, #16). The facility failed to get Resident #5 and Resident #13's lab draws completed for at least 6 days. Resident #13 had an elevated lab level that required the facility to hold his medication for 2 doses. When Resident #5 missed her lab draw, the facility failed to get her lab draw completed resulting in her missing 8 days of her coumadin. The facility failed to follow the Physician's order for Resident #16 and drew their lab early resulting in a low therapeutic level for their convenience. When interviewed the Assistant Director of Nursing (ADON), and the Director of Nursing (DON) reported someone else had the responsibility for ensuring the labs got completed. The DON showed the survey team her desk and said the orders might be on there, with her hand on a 4-inch pile of papers with orders. The facility didn't know they had a problem until the surveyor questioned an order. The facility failed to ensure orders got implemented. The survey team notified the facility of the immediate jeopardy (IJ) on 4/3/24 at 4:45 PM, that began on 3/27/24. The facility removed the immediacy on 4/4/24. a. On 4/2/24 the facility reviewed all 3 residents and ensure each resident received the correct Coumadin dose and completed a lab requisition slip for each resident for their next lab draw. b. The facility developed a new lab order process that involved the use of a lab log and lab requisition order. c. On 4/3/24 the facility educated the nurses regarding the new processes for lab orders, prothrombin time (PT)/ international normalized ratio(INR) orders tracking and residents on anticoagulants that receive an order for an antibiotic. The facility lowered the scope and severity from a level J to a D after ensuring the facility implemented their removal plan. Findings include: 1. Resident #13's Minimum Data Set (MDS) assessment dated [DATE] listed an admitted [DATE]. The MDS identified a Brief Interview for Mental Status (BIMS) of 7, indicating severely impaired cognition. The MDS indicated Resident #13 received an anticoagulant (Coumadin) within the previous 7 days or since admission. Resident #13's Resident Profile reviewed on 4/9/24 at 10:54 AM included diagnoses of an acute embolism (blood vessel blockage), thrombosis (limited blood flow) of unspecified deep veins of the lower left extremity, and long term (current) use of anticoagulants. The Care Plan Problem revised 2/26/24 identified Resident #13 had long term use of anticoagulant therapy related to an acute embolism and thrombosis of unspecified deep vein of distal lower extremity and another pulmonary embolism. The Care Plan documented a goal of no active bleeding. (continued on next page)

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F 0757 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Resident #13's Active Orders reviewed on 4/3/24 included the following blood thinner orders effective 2/14/24: a. Warfarin 2.5 milligrams (MG) once a day on Monday, Wednesday, Friday 4:00 PM 7:00 PM. b. Warfarin 5 MG once a day on Tuesday, Thursday, Saturday 4:00 PM 7:00 PM. The Progress Notes dated 4/2/24 at 5:01 PM written by the Director of Nursing (DON) indicated they discovered Resident #13 missed their INR following the discovery of another resident with a missed INR. Each person who received Coumadin had their medical chart reviewed, revealing Resident #13 had an order for an INR lab draw scheduled for 3/28/24. The nurse failed to enter the lab draw into the Medication Administration Record (MAR), therefore causing no completion of the lab. The DON added Resident #13 continued to take the current dose of Coumadin during that time. The facility received an order to draw a stat (immediate) PT/INR lab. Review of untitled hospital form with current Coumadin dosage and next INR lab draws for Resident #13 listed his INR goal as 2.3, with a diagnosis of history of deep vein thrombosis (DVT). On 2/28/24 documentation revealed an INR level of 2.63 with the next INR draw for 1 month and to continue the current dose. The form lacked documentation of an INR drawn on 3/28/24. On 4/2/24 documentation revealed an INR of 3.52 and with an order to hold 2 doses of Coumadin and then change the order to 5 MG for 4 days and 2.5 MG for 3 days. On 4/3/24 at 12:05PM, the DON reported the Assistant Director of Nursing (ADON) conducted a monthly audit to monitor INR and Coumadin orders. The DON added she didn't have a process in place to ensure INR labs are completed as ordered. The DON then proceeded to place her hand on top of a stack of papers on her desk measuring approximately 4 inches, reporting it as orders. She reported being behind and that the orders for the INRs could be in the stack of papers. The DON again confirmed they didn't have a process in place to monitor INRs except a monthly audit that is completed by the ADON. On 4/3/24 at 12:17 PM, the ADON explained she completed an audit once a month regarding INRs and confirmed the facility didn't have a process in place to ensure the completion of INRs. According to undated information from the Coumadin manufacturer Bristol [NAME] Squibb Pharma Company, patients [AGE] years or older appear to exhibit greater than expected PT/INR response to the anticoagulant effects of warfarin (Coumadin). The cause of the increased sensitivity is unknown. The most serious risks associated with anticoagulant therapy with Coumadin are hemorrhage in any tissue or organ. Coumadin is a narrow therapeutic range drug and may be affected by factors such as other drugs. Periodic determination of PT/INR is essential. The Anticoagulant Therapy policy dated March 2024, instructed the resident response to warfarin therapy will be evaluated on the basis of International Normalized Ratio (INR). The physician will direct how often the lab values are drawn and monitored. The most current copy of the resident's PT/INR will be kept in the resident's chart. During an interview 4/9/24 at 8:30 AM, the Director of Quality and Clinical Services remarked they expected the staff to follow INR orders as ordered. 47079 (continued on next page)

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F 0757 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	2. Resident #5's Minimum Data Set (MDS) assessment dated [DATE] identified a Brief Interview for Mental Status (BIMS) score of 9, indicating moderately impaired cognition. The MDS included diagnoses of diabetes mellitus, anemia (low iron blood level), venous insufficiency (a vein condition that allows blood to flow backward and pool in the legs), a cardiac pacemaker, prosthetic heart valve, and long term current use of anticoagulants (blood thinners). Resident #5 received an anticoagulant within the 7 day lookback period. The Care Plan Problem revised 1/13/24 indicated Resident #5 received anticoagulant therapy. The Intervention directed the staff to adjust the medication dosage per facility protocol, monitor labs, flowsheets as ordered. Resident #5's Order History reviewed on 4/9/24 at 10:18 AM included the following warfarin (anticoagulant) orders a. Started 3/6/24: 2.5 MG once a day on Sunday. The order discontinued on 3/13/24. - Laboratory order for a Prothrombin Time/International normalized ratio (PT/INR - blood test used to determine how long it takes blood to clot) dated 3/13/24. b. Started 3/13/24: 5 MG once a day on Sunday, Monday, Tuesday, Wednesday, Thursday, Friday, and Saturday. Resident #5's Medication Administration Record (MAR) dated 3/6/24 - 4/4/24 reflected she received warfarin continuously from 3/6/24 to 3/26/24. Resident #5's MAR dated 3/15/24 - 4/11/24 included an order regarding Coumadin Use interactions. The order contained special instructions that a recheck of the PT/INR may be warranted within 7-14 days of a medication change. Monitor for signs or symptoms of bleeding. Notify the Physician of any change in condition. A Progress Note dated 3/13/24 at 2:04 PM identified Resident #5's INR lab result as 1.67. On 4/2/24 at 3:49 PM, the Director of Nursing (DON) reported Resident #5 didn't receive their warfarin since 3/26/24. She stated an agency nurse received an order on 3/13/24 to collect a new INR on 3/26/24 but didn't enter the lab order in Resident #5's electronic health record (EHR). She confirmed they didn't collect the lab because it didn't appear on the DON's lab list and the pharmacy didn't send future warfarin due to the facility not sending a follow up order. The Coagulation Report (Lab Result) dated 4/2/24 at 7:14 PM listed the INR as 1.02. The Phone Message/Call *Final Report* dated 4/3/24 indicated the provider learned Resident #5 accidentally had her warfarin held for the previous week. The provider gave an order to resume warfarin at the current dose and recheck the INR in 1 week. (continued on next page)

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F 0757 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	3. Resident #16's Minimum Data Set (MDS) assessment dated [DATE] identified a Brief Interview for Mental Status (BIMS) score of 12, indicating moderately impaired cognition. The MDS included diagnoses of diabetes mellitus, atrial fibrillation (improper heart function that allows blood to pool inside the chambers), cerebral vascular accident (stroke), long term use of anticoagulants (blood thinners), a cardiac pacemaker (machine used to help pump blood in the heart effectively), and endocarditis (inflammation of the inner lining of the heart chambers and valves usually caused by a bacterial infection). It also indicated Resident #16 received an anticoagulant and an antibiotic within the 7 day lookback period. The Care Plan Problem dated 11/5/19 indicated Resident #16 received anticoagulant therapy. The Interventions directed the staff to be aware of possible drug interactions, such as antibiotics. The Order History report reviewed on 4/9/24 at 8:34 AM included the following orders: a. Dated 2/29/24: Warfarin 3 MG give 1.5 MG (0.5 tablet) once an evening. b. Vancomycin (antibiotic) 1 gram (200 milliliters ML). Give 1250 MG per 250 ML. - Dated 2/29/24: Once a day. Discontinued 3/9/24. - Dated 3/11/24: Once a day every other day. Discontinued 3/21/24. - Dated 3/21/24: Once a day on Saturday, Monday and Wednesday. Discontinued 3/29/24. - Dated 3/29/24: Give 1250 MG on 3/31/24 and 4/2/24 after Vancomycin draw. Discontinued 4/3/24. - Dated 4/5/24: Give 1250 MG on Friday. - Dated 4/8/24: Per 4/3/24 order, last dose scheduled. c. Dated 3/4/24: PT/INR. No documentation of subsequent PT/INR lab orders. The untitled hospital form with Coumadin dosages and next lab draw reflected Resident #16's INR goal as 2-3. The INR on 3/4/24 had a result of 4.3, with the next INR due in 2 weeks. The form lacked documentation of completed labs after 3/4/24. The Phone Message/Call *Final Report* dated 4/4/24 at 8:11 AM listed Resident #16's INR lab result as 3. 11. The provider said to continue her warfarin at the current dose and recheck in one week. The Anticoagulant Therapy effective May 2024 directed the staff to minimize the adverse effects of anticoagulant therapy through laboratory monitoring ordered by the resident's physician and follow up. (continued on next page)

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F 0757 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Warfarin and Antibiotics: Drug Interactions and Clinical Considerations published online 7/30/23 to the National Library of Medicine indicated due to its narrow therapeutic index, warfarin necessitates frequent monitoring and dose adjustments to maintain the delicate balance between adequate anticoagulation and the risk of bleeding or thrombotic (blood clot) complications. Monitoring is typically conducted by assessing a PT/INR, with diligent surveillance of any elevations in PT/INR levels to prevent adverse outcomes. However, one common complication associated with warfarin therapy is the heightened risk of major bleeding, particularly when co-administered with medications capable of influencing its metabolism. In particular, antibiotics have the potential to interfere with warfarin's anticoagulant effect through various mechanisms. Antibiotics can induce or inhibit the activity of cytochrome P450-2C9, an enzyme crucial for warfarin metabolism. Additionally, some antibiotics can disrupt the population of vitamin K-producing bacteria in the intestines, further modulating warfarin's pharmacological response. As a result, these drug interactions can either enhance or diminish warfarin's efficacy, with potential clinical consequences. The importance of managing these interactions becomes evident when considering the narrow therapeutic index of warfarin. Increased warfarin levels can have detrimental effects, while subtherapeutic levels may lead to inadequate anticoagulation. And while some antibiotic classes carry a higher risk of bleeding events than others, a comprehensive understanding of the potential interactions between different antibiotics, including penicillin derivatives, fluoroquinolones, cephalosporins, sulfa drugs, anti-mycobacterial agents, macrolides, and metronidazole and warfarin, is necessary.

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F 0758 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Implement gradual dose reductions(GDR) and non-pharmacological interventions, unless contraindicated, prior to initiating or instead of continuing psychotropic medication; and PRN orders for psychotropic medications are only used when the medication is necessary and PRN use is limited. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 47079 Based on record review, staff interview, and policy review, the facility failed to evaluate and manage an as needed psychotropic medications between fourteen days of use for 1 of 1 resident sampled (Resident #34). The facility reported a census of 34. Findings included Resident #34's Minimum Data Set (MDS) assessment dated [DATE] identified a Brief Interview for Mental Status (BIMS) score of 8, indicating moderately impaired cognition. The MDS included diagnoses of Parkinson's disease, dementia, and hallucinations. The MDS reflected Resident #34 used an antidepressant. The Order History Report included an order for Trazodone tablet dated 11/9/23. Give 25 MG by mouth at bedtime as needed (PRN) for restlessness or insomnia. Order got discontinued on 12/7/23 (28 days after the start date). An Observation Detail List Report dated 11/9/23 reflected Resident #34's spouse signed the consent for Resident #34's psychotropic medication use. Resident #34's Medication Administration Record (MAR) dated 11/9/23 - 12/9/23 indicated Resident #34 received trazodone for insomnia (trouble sleeping) on 11/10/23; 11/15/23; 11/22/23; 11/27/23; 11/28/23; 11/29/23; 11/30/23; and 12/1/23; and for restlessness on 12/3/23. The Care Plan Problem revised 2/16/24 identified Resident #34 received psychotropic medication for insomnia. The Interventions directed the a. Trazodone order got changed from PRN to a scheduled regimen. b. The pharmacist review per protocol and would perform recommended drug reductions. A Pharmacist's Recommendation to Provider document dated 12/8/23 indicated the pharmacist requested a clinical rationale for continued use of PRN trazodone for a 90 day duration or for the provider to discontinue PRN Trazodone. The document included the provider's response to discontinue the use of PRN Trazodone. On 4/2/24 at 3:49 PM, the Director of Nursing (DON) stated the resident received Trazadone at home prior to admission but the facility didn't know his administration schedule nor duration. The Antipsychotic/GDR (gradual dose reduction) policy dated April 2024 indicated PRN orders for psychotropic medications are limited to 14 days. Except if the attending physician or prescribing practitioner believes that it is appropriate for the PRN order to be extended beyond 14 days, he/she should document their rationale in the resident's medical record and indicate the duration for the PRN order. (continued on next page)

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F 0758 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 4/9/24 at 11:15 AM, the Chief Clinical Officer stated PRN psychotropic medications should be canceled after 14 days or the provider should be notified for clarification.

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F 0801 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	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. 47079 Based on document review and staff interview, the facility failed to employ sufficient staff with the appropriate competencies and skills sets to carry out the functions of the food and nutrition service by not having a certified dietary manager. The facility reported a census of 34 residents. Findings include: On 4/1/24 at 9:50 AM, Staff A, Dining Services Manager, described herself as the facility Dining Services Manager, but added she didn't have a certification in nutrition and food service management. She stated the facility had a contract dietician who provided monthly dietary service consultation. On 4/1/24 at 10:00 AM, a course completion certificate revealed Staff A didn't have a certification in nutrition and food service management. On 4/3/24 at 7:06 AM, Staff A stated she didn't have formal training other than course completed on 9/11/23. She stated worked as a dining manager since 12/22/22 but had no other dietary management experience. The Staffing Licensed Dietitian policy dated September 2019 indicated the licensed Dietitian along with the facility staff will assure that State and Federal regulatory requirements are met.

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F 0803 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure menus must meet the nutritional needs of residents, be prepared in advance, be followed, be updated, be reviewed by dietician, and meet the needs of the resident. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 47079 Based on observation, staff interviews, and policy review, the facility failed to follow the approved diet menu and failed to measure accurate servings for residents who received pureed diets. The facility reported a census of 34 residents. Findings include: The facility's menu for lunch for 4/3/24 identified the following items to be served as part of the planned pureed textured diet. a) Roast Turkey b) Stuffing c) Chicken Gravy d) [NAME] Vegetables e) Bread/Margarine f) Coffee Cream dessert On 4/3/24 at 11:30 AM, a kitchen observation revealed the Dietitian approved Week 4 menu items didn't get prepared for lunch. The staff served the following menu items for lunch on 4/3/24. a) Tater Tot casserole b) [NAME] vegetables c) Salad, chef and regular On 4/3/24 at 11:30 AM, watched Staff A, Dining Services Manager (DSM), prepare the pureed diets. She used a spatula and placed two (2) unmeasured amounts of tater tot casserole into a blender. She added an unmeasured amount of low fat milk to the blender and mixed the contents. She checked the consistency and added an unmeasured amount of milk two (2) more times. She blended the contents then poured it into two (2) small bowls. She stated each bowl contained 1 serving of pureed for each resident. She told the kitchen server to use the black, #4 serving scoop for the beans (vegetables). On 4/3/24 at 11:35 AM, witnessed the kitchen didn't have a pureed conversion chart to determine pureed diet serving size. A policy titled Pureed Diet dated January 2021 directed staff to use the following pureed diet procedure. (continued on next page)

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F 0803 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	a) Measure out desired number of servings into container for pureeing. b) Puree food. c) Add any necessary liquid/fats/stabilizers etc. to obtain mashed potato/pudding consistency. d) Measure the volume of food after it has been pureed. e) Divide the total volume of the pureed food by the original number of portions. This is the NEW PORTION size. On 4/9/24 at 11:15 AM, the Chief Clinical Officer stated pureed preparation should use the volume method that involves measuring.

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F 0804 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure food and drink is palatable, attractive, and at a safe and appetizing temperature. 47079 Based on observation, staff interview, and policy review, the facility failed to provide food served by a method to maintain a safe and appetizing temperature. The facility reported a census of 34. Findings include: During a continuous dining observation on 4/3/24 beginning at 12:05 PM, Staff E, Dietary Aide (DA), took the temperature of two (2) foods. The temperatures measured outside the acceptable holding temperature. The pureed tater tot casserole had a temperature of 133.1 Fahrenheit (F) and the chef salads temperature measured 52.1 F. At 12:08 PM, Staff E said she didn't normally check the temperature of a salad, she just served them. She reported she didn't even know how to check their temperature. At 12:12 PM, Staff A, Dining Services Manager (DSM), instructed Staff E to put the salads in ice the next time she brought salads to the dining area to they stayed cold. The facility served the residents the salads after checking their temperature. At 12:32 PM, Staff C prepared a resident plate containing the mechanical soft turkey. When asked to verify the temperature, Staff C measured the mechanical soft turkey temperature as 129 F. The staff reheated the turkey to 190 F before they served it to a resident. The staff served the pureed turkey to a resident without rechecking the temperature or being reheated. The Food Preparation and Service policy revised October 2018 directed food held at temperatures between 41 F and 135 F promoted the rapid growth of pathogenic organisms that cause foodborne illness. The policy instructed to maintain the temperature above 135 F. At 12:43 PM, Staff E checked the holding temperature of the pureed serving and noted it measured 133.1 F. Staff E continued to serve the pureed serving. The Food Temperature/Food Safety policy dated 3/4/24 instructed the cooks to measure temperatures before food is served to ensure the temperatures of the food maintained below 41 F and above 135 F. If foods are not at the proper temperature, the food will be reheated to 165 F for 15 seconds or cooled to the proper temperature. It also indicated cold foods will be placed in a pan with the item over a deeper pan of ice to assure cold foods are kept at 41 F or below. On 4/9/24 at 11:15 AM, the Chief Clinical Officer reported the staff should follow the food temperature policy.

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 47079 Based on observations, staff interviews, and facility policy review, the facility failed to maintain sanitary practices by (a) improperly storing food, (b) failing to maintain correct dishwasher operation, and (c) failing to prevent cross contamination during food service. The facility reported a census of 34 residents. Findings include: On [DATE] at 4:30 PM, Staff D, Dietary Server, picked up a stack of plates and placed both thumbs on the food surface side, then they placed them in the serving plate dispenser. On [DATE] at 11:35 AM, a kitchen observation identified (a) an unlabeled, bag of red substance with an expiration date of [DATE], (b) an unlabeled, undated bag of meat chunks, and (c) an undated, opened bag of pasta. On [DATE] at 11:45 AM, Staff A, Dining Services Manager (DSM), described the dishwasher as a low temp, chemical appliance. She cycled the dishwasher and rubbed a chlorine test strip against the inside of the dishwasher cover. The test strip did not change color, indicating a lack of sanitizer. She repeated the process four (4) times and yielded the same results. She changed the empty sanitizer supply jug and repeated the dishwasher sanitizer test which again indicated a lack of sanitizer. On [DATE] at 12:00 PM, Staff E, Dietary Server, placed three (3) sheets of wax paper on the steam table serving counter. She leaned forward over the steam table serving counter and her abdomen directly contacted the top of the center piece of wax paper. - At 12:15 PM, Staff E raised a steam table pan lid with her ungloved hand. She put the lid back down on the pan, put on gloves, and used tongs to remove the steam table pan lid. She placed the tongs on a separate sheet of wax paper. She sorted the dietary tickets with her gloved hand then grabbed a plate with the thumb of the same hand directly on the food surface side of the plate where food was placed. - At 12:28 PM, Staff E used the same tongs to remove a steam table pan lid and placed the tongs beside the gray serving scoop on the middle wax paper where her abdomen touched. - At 12:30 PM, a staff member handed the DSM a pair of gloves over the glass divider and one fell behind the sink faucet. The DSM grabbed the glove from behind the faucet and gave the pair of gloves to Staff F, Dining assistant who used the gloves while buttering bread. - At 12:33 PM, Staff E used the tongs to remove and replace a steam table pan lid and laid the tongs on the first sheet of wax paper and came in direct contact with the exterior side of a serving scoop. - At 12:40 PM, Staff E grabbed a slice of buttered bread from Staff F with the gloved hand used to touch non food surfaces. (continued on next page)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	- At 12:47 PM, Staff E grabbed a stack of the dessert plates and her right thumb touched the food surface side of the plate within the buffered rim area. On [DATE] at 12:52 PM, Staff E reported they used the dishwasher to wash the breakfast dishes after finishing the breakfast service. On [DATE] at 1:05 PM, the DSM cycled the dishwasher and rubbed a chlorine test strip against the inside of the dishwasher cover. The test strip again didn't change color, indicating a lack of sanitizer. She repeated the process three (3) times and yielded the same results. She requested maintenance to troubleshoot the dishwasher. The maintenance staff stated the actuating device was probably worn out and needed replaced. After multiple attempts, the DSM performed a sanitizing strip test that reflected present sanitizer. The Storage policy dated [DATE] instructed foods held in refrigerators or other storage areas shall be appropriately covered, labeled and dated. The Sanitation policy dated [DATE] directed if the dish machine required a chemical sanitizer, proper levels of the chemical will be checked at each meal's dish run. The Food Production and Service policy dated [DATE] indicated all food is prepared following proper sanitary practices including adequate temperatures, good hygiene, infection control, and protection from contamination. It also indicated bare hands should never touch ready to eat foods directly bread, sandwiches, fresh fruit etc. Disposable gloves are required or foods will be served with clean tongs, scoops, forks, spoodles, spatulas, or other suitable utensils to avoid bare contact of foods. On [DATE] at 11:15 AM, the Chief Clinical Officer stated (a) all food should have a label and a date when opened, while expired food should be discarded, (b) staff should follow sanitizing regulations, (c) dishes should be handled by the edges, and (d) utensils used to handle non food items should not be placed with food serving utensils; tongs should not be put with ladles.

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F 0836 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure the facility is licensed under applicable State and local law and operates and provides services in compliance with all applicable Federal, State, and local laws, regulations, and codes, and with accepted professional standards. 42441 481-58.20(135C) Duties of health service supervisor. Every nursing facility shall have a health service supervisor who shall: 58.20(13) Evaluate in writing the performance of each individual on the health care staff on at least an annual basis. This evaluation shall be available for review in the facility to the department; (III) Based on personnel record review and staff interview, the facility failed to conduct annual staff evaluations for 5 of 5 employee records reviewed (Staff B, Registered Nurse (RN); Staff C, Maintenance Supervisor; Staff G, RN; Staff H, Licensed Practical Nurse (LPN); Staff I, RN). The facility reported a census of 34 residents. Findings include: 1. Staff B's personnel record review included the following: a. Hire date of 6/2/17 b. Most recent annual evaluation 7/8/21. Staff B's personnel record lacked an evaluation after 7/8/21. 2. Staff C's personnel record review included the following: a. Hire date of 9/8/20. b. Most recent annual evaluation 3/4/22. Staff C's personnel record lacked an evaluation after 3/4/22. 3. Staff G's personnel record review included the following: a. Hire date of 9/9/19. b. Most recent annual evaluation 10/11/21. Staff G's personnel record lacked an evaluation after 10/11/21. 4. Staff's personnel record review included the following: a. Hire date of 3/1/23. (continued on next page)

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F 0836 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	b. No annual evaluation. 5. Staff I's personnel record review included the following: a. Hire date of 8/19/19. b. Most recent annual evaluation 2/17/20. Staff I's personnel record lacked an evaluation after 2/17/20. On 4/8/24 at 3:23 PM, the Administrator revealed the facility didn't have a policy regarding staff evaluations. During an interview 4/9/24 at 8:30 AM, the Regional Director of Quality and Clinical Services acknowledged the facility didn't do staff evaluations as expected. They expected the staff receive an evaluation annually.

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F 0849 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Arrange for the provision of hospice services or assist the resident in transferring to a facility that will arrange for the provision of hospice services. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 47079 Based on interviews, record reviews, and policy review the facility failed to update a resident's Care Plan following their admission to Hospice Services for 1 of 1 resident reviewed for hospice services (Resident #23). The facility reported a census of 34 residents. Findings include: Resident #23's Minimum Data Set (MDS) assessment dated [DATE] identified a Brief Interview for Mental Status (BIMS) score of 7, indicating severely impaired cognition. The MDS indicated Resident #23 required setup assistance with eating and moderate assistance with all other activities of daily living (ADLs). In addition, the MDS listed Resident #23 as independent or required supervision with mobility, used a walker for ambulation, and didn't use a wheelchair for mobility. The MDS included diagnoses of coronary artery disease, bipolar disorder, asthma, and depression. It further identified the resident had not received hospice services. On 4/2/24 at 7:50 AM, Resident #23's family member stated the resident was recently admitted under hospice care. The Electronic Health Record (EHR) Census page and hospice documents revealed the resident was admitted to hospice services on 3/20/24. A Progress Note dated 3/21/24 at 5:19 AM indicated the resident was under the care of hospice services. The Care Plan revised 3/22/24 did not include hospice services or hospice related interventions. The EHR did not include hospice Care Plan documents. On 4/9/24 at 11:15 AM, the Chief Clinical Officer stated Care Plans should be revised with significant change timelines; currently 14 days from the date of recognition. A policy titled Comprehensive Care Plan dated March 2024 indicated the resident's comprehensive plan of care will be updated when a significant change occurs, goals are met, interventions are no longer appropriate or have been identified to be ineffective or new nutrition diagnosis is identified.

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0868 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Have the Quality Assessment and Assurance group have the required members and meet at least quarterly 42441 Based on record review, policy review and staff interview, the facility failed to ensure the required members were present at quarterly Quality Assurance Performance Improvement (QAPI) meetings. The facility reported a census of 34 residents. Findings include: Record review revealed the facility had QAPI meetings on the following dates: a. 2/13/23 b. 3/14/23 c. 6/13/23 d. 8/21/23 e. 10/17/23 f. 1/30/24 Record review revealed the required QAPI members were not present for the following meetings: a. 2/13/23 No Administrator or Medical Director b. 3/14/23 No Administrator or Medical Director c. 6/13/23 No Director of Nursing or Administrator d. 8/21/23 No Director of Nursing, Administrator or Medical Director The Quality Assurance & Performance Improvement policy revised December 2022 instructed the quality assurance performance programs and activities will be established utilizing a systemic approach to assure compliance with State and Federal regulations. On 4/4/24 at 1:10 PM, the Administrator acknowledged the quarterly QAPI meetings didn't have the required staff members present as expected prior to January 2024. On 4/9/23 at 8:30 AM, the Regional Director of Quality and Clinical Services explained they expected the facility to follow the QAPI meetings regulations.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	165443	A. Building B. Wing	04/09/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Grand Ji Vante	502 Butler Street Ackley, IA 50601

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)
F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide and implement an infection prevention and control program. 47079 Based on observation, staff interviews, document reviews, and policy review, the facility failed to develop a comprehensive water management program and identify areas or devices in the building to reduce the risk and prevent the growth of Legionella or other waterborne pathogens. The facility also failed to evaluate where hazardous conditions may occur in the water systems and implement measures to prevent waterborne pathogens. In addition, the facility failed to provide hand hygiene supplies for each resident and/or visitor. The facility reported a census of 34 residents. Findings include: An observation on 4/2/24 at 7:50 AM revealed empty soap dispensers in Resident #23's bathroom and in the visitors' main hall men's bathroom. An observation on 4/2/24 at 2:57 PM revealed an empty hand sanitizer dispenser located on a pillar between the Assistant Director of Nursing's office and the food serving area. Follow up observations on 4/3/24 at 7:02 AM and 4/4/24 at 7:37 AM revealed the aforementioned dispensers remained empty. On 4/4/24 at 8:14 AM, Staff K, Environmental Services (EVS), stated she tried to check each room for hand hygiene supplies but some resident rooms don't have a soap dispenser or had an old dispenser that needed replaced. She stated the facility had been transitioning dispensers and she helped maintenance replace some dispensers but couldn't help due to being busy. She didn't know of any room that didn't have soap. On 4/4/24 at 8:43 AM, Staff C, Maintenance Supervisor, reported trying to get dial auto dispensers because the supplier for the old dispensers discontinued the soap refill cartridges. He asked if each room needed a soap dispenser. The Infection Prevention and Control Program policy, revised December 2023, states an Infection Prevention and Control Program (IPCP) is established and maintained to provide a safe, sanitary, and comfortable environment and to help prevent the development and transmission of communicable diseases and infections. On 4/4/24 at 10:55 AM, Staff C, Maintenance Supervisor stated a third party company tested the water but he couldn't access the prior water testing results. In addition, he couldn't locate the water management control policy. During an interview on 4/4/24 at 11:30 AM with the Administrator, the third party representative, Staff C, and Staff J, Maintenance Assistant; the third party representative stated he didn't test the facility's water supply for anything other than chlorine levels which included free chlorine. He added he didn't test the facility's water on a routine, monthly basis. Staff C and Staff J stated they didn't perform the resident water temperature checks and they didn't have system measures to identify or prevent the growth of Legionella and other opportunistic waterborne pathogens. The facility didn't have a water flow diagram available for review. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	165443	A. Building B. Wing	04/09/2024

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Grand Ji Vante	502 Butler Street Ackley, IA 50601

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	The Handwashing policy dated 2/29/24 indicated hand hygiene continues to be the primary means of preventing the transmission of infection and directed staff to perform hand hygiene with soap and water before and after direct resident contact. An undated policy titled Water Management Control Policy indicated the Water Management Program Team would (a) identify building water systems using a flow diagram, (b) identify areas of potential concern, (c) identify areas of potential exposure to residents via water droplets or aspiration, (d) apply control measures as a corrective action, (e) determine whether control measures produce effective limits, (f) continue to monitor results, and (g) document results. On 4/9/24 at 11:15 AM, the Chief Clinical Officer stated hand hygiene should occur between glove changes and should include soap and water or sanitizer.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	165443	A. Building B. Wing	04/09/2024

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Grand Ji Vante	502 Butler Street Ackley, IA 50601

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F 0943 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Give their staff education on dementia care, and what abuse, neglect, and exploitation are; and how to report abuse, neglect, and exploitation. 42441 Based on clinical record review, policy review and staff interview, the facility failed to ensure Dependent Adult Abuse Mandatory Training recertification training was completed timely for 2 of 5 staff personnel files reviewed (Staff B, Registered Nurse (RN) and Staff C, Maintenance Supervisor). The facility reported a census of 34 residents. Findings include: Personnel record review revealed Staff B, RN last completed the 2-hour Dependent Adult Abuse Mandatory Training 3/31/21. Personnel record review revealed Staff C, Maintenance Supervisor last completed 2-hour Dependent Adult Abuse Mandatory Training 1/4/21. Review of facility policy revised November 2023 and titled, Abuse Prevention, Identification, Investigation and Reporting Policy, revealed within 6 months of hire each employee shall be required to complete an initial 2 hour training course provided by the Iowa Department of Human Services relating to the identification and reporting of dependent adult abuse. Each employee will take a 1 hour recertification training within 3 years of the initial training and every three years thereafter. During an interview 4/9/24 at 8:30 AM, the Regional Director of Quality and Clinical Services acknowledged Staff B and Staff C didn't complete the recertification training. They reported they expected them to follow the regulations regarding mandatory dependent adult abuse training.