

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 165446	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 04/18/2024
NAME OF PROVIDER OR SUPPLIER Westbrook Acres		STREET ADDRESS, CITY, STATE, ZIP CODE 605 Garfield Street Gladbrook, IA 50635	

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 0625</p> <p>Level of Harm - Potential for minimal harm</p> <p>Residents Affected - Some</p>	<p>Notify the resident or the resident's representative in writing how long the nursing home will hold the resident's bed in cases of transfer to a hospital or therapeutic leave.</p> <p>40907</p> <p>Based on interviews and record reviews, the facility failed to provide the bed hold policy for 1 of 2 residents reviewed (Resident #39). On 12/8/23 Resident #39 was sent to the hospital for seizures. A bed hold policy was not discussed/given to Resident #39's representative. The facility reported a census of 51 Residents.</p> <p>Findings include:</p> <p>A Census page for Resident #39 documented to stop billing on 12/8/23.</p> <p>A Progress Note dated 12/8/23 at 1:00 p.m., documented that this resident was loaded into the ambulance for seizure activity.</p> <p>A Progress Note dated 12/11/23 at 2:35 p.m., documented that this resident returned to the facility on a stretcher after an acute hospital stay.</p> <p>On 4/16/24 at 1:46 p.m., the Licensed Nursing Home Administrator (LHNA), stated they do not have a bed hold for 12/8-11/23 hospital stay for Resident #39. She stated that the nurse working was an agency nurse and must have missed it.</p> <p>An undated Bed Hold Policy, directed staff that the charge nurse would notify the resident's power of attorney, guardian or next of kin of transfer and the Bed Hold form.</p>

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

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
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<p>F 0658</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Ensure services provided by the nursing facility meet professional standards of quality.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 40907</p> <p>Based on observations, interviews, and record review, the facility failed to follow a physician's order for 1 of 1 residents reviewed with a tube feeding (Resident #39). Resident #39 was ordered to have water every 2 hours through her PEG (percutaneous endoscopic gastrostomy) tube (a flexible feeding tube inserted through the abdominal wall and into the stomach for nutritional support). This resident received the water every hour. The facility reported a census of 51 residents.</p> <p>Findings include:</p> <p>A Minimum Data Set, dated dated dated [DATE], documented that Resident #39's diagnoses included Cerebral Palsy, seizure disorder and gastrostomy status. It documented that Resident #39 had a feeding tube.</p> <p>A Routine Medication record dated 4/1/24 to 4/30/24, directed staff that Resident #39 was to have her PEG tube flushed every 2 hours. It documented to auto flush through the pump.</p> <p>Admission Orders dated 2/25/24, directed staff to flush PEG tube with 30 cc (cubic centimeters) every 2 hours. Auto flush with pump.</p> <p>A Progress Note dated 4/6/24 at 3:00 p.m., documented that the pump was switched out and the recently used pump was sent to the supplier to be recalibrated.</p> <p>On 4/16/24 at 11:38 AM, Staff A Registered Nurse (RN), stated they are supposed to run water after the tube feeding at 30 cc (cubic centimeters) an hour. She was unable to find the order on the Routine Medication record.</p> <p>On 4/16/24 at 12:00 PM, Staff A stated the machine is calibrated to automatically run the flush. Staff A pointed out in the Medication Record the resident was to receive a 30 cc flush every 2 hours. Visualization of the machine at this time revealed the machine was running the flush at 30 cc every hour instead of every 2 hours. Staff A acknowledged that the rate should be every 2 hours instead of every 1 hour.</p> <p>On 4/16/24 at 12:02 PM, the Director of Nursing (DON), stated the pump was changed last week and it was sent to be recalibrated. This DON stated that the new pump may have been set up incorrectly when the facility calibrated the new pump.</p> <p>On 4/16/24 at 12:21 PM, the Licensed Nursing Home Administrator (LNHA), stated that they had taken care of the pump issue. She stated that they recalibrated the pump to reflect the current order. This LNHA acknowledged that they had calibrated the pump wrong.</p> <p>An undated Physician Order Policy and Procedure, directed that all physician's orders must be accurately transcribed.</p>		

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<p>F 0727</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Have a registered nurse on duty 8 hours a day; and select a registered nurse to be the director of nurses on a full time basis.</p> <p>40907</p> <p>Based on interview and record review, the facility failed to provide 8 consecutive hours of Registered Nurse (RN) coverage daily (in a 24 hour period). The facility reported a census of 51 residents.</p> <p>Findings include:</p> <p>On 4/17/24 at 12:42 p.m., reviewed March 2024 and April 1-19/2024 schedules. Noted 3 days (4/6/24, 4/13/24 and 4/14/24) did not have 8 consecutive hours of RN coverage.</p> <p>On 4/17/24 at 12:50 p.m., the Licensed Nursing Home Administrator (LNHA), stated that the RN scheduled for 8 hours on 4/6/24, had to leave at 11:00 a.m., and was relieved by a Licensed Practical Nurse (LPN). The LNHA stated that the RN worked from 6:00 a.m. to 11:00 a.m. which left the facility short of the 8 hour RN coverage for that day. The LNHA stated that on 4/12/24 an agency nurse came in at 10:00 p.m. and worked through the night until 6:00 a.m. on 4/13/24. She stated the agency RN worked 6 hours from midnight (12:00 a.m.) on 4/13/24 to 6:00 a.m (6 hours), but that still left them short of the required 8 hours of RN coverage on 4/13/24. On 4/14/24, the LNHA stated there was no RN coverage for this day. The LNHA stated that LPN's covered the rest of the shifts in the 24 hour periods on 4/6/24 and 4/13/24. She stated LPN's covered all of the shifts on 4/14/24.</p> <p>Punch detail on 4/6/24, documented that Staff A, RN punched in at 5:58 a.m. and punched out at 11:41 a.m.</p> <p>An undated print out provided by the LNHA, documented that an agency RN worked from 9:00 p.m. to 6:00 a. m. The LNHA identified that this is the agency RN that came in on 4/12/24 p.m. and clocked out on 4/13/24 a. m.</p> <p>An undated RN Staffing Policy directed that: As per Medicare standard, (this facility) will maintain RN staffing hours for 8 consecutive hours per 24 hour period. The 24 hour period starts at midnight each calendar day.</p>		