STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	165460	A. Building B. Wing	07/07/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Karen Acres Care Center	3605 Elm Drive Urbandale, IA 50322

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to a dignified existence, self-determination, communication, and to exercise his or her rights. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 44512 Based on resident clinical record, staff and family interviews, policy review and video evidence, the facility failed to protect a resident from abuse when a certified nursing assistant utilized a personal smartphone to video record a resident (Resident #4) and distribute the recording on a social media site and labeled the video with the resident's name. The facility reported a census of 28 residents. Findings include: The Quarterly Minimum Data Set (MDS) dated [DATE] for Resident#4 revealed a diagnosis of dementia, depression, anxiety and chronic kidney disease and required the assistance of staff for personal hygiene, toileting and dressing needs. The Brief Interview for Mental Status (BIMS) score of 10 which suggested a moderate cognitive impairment and disorganized thinking with difficulty keeping track of what is being said. The Care Plan directed staff to monitor, document, and report a change in behavior, mood and cognition to include hallucinations and delusions, social isolation, suicidal thoughts, withdrawal and to encourage social interaction or leisure activity. The Progress Note dated 3/22/24 at 9:56 am documented, the facility staff notified the resident's family of the self-report to the Department of Inspection of Appeals (DIA) that involved a staff member who posted a video to social media that had her mother in the video. The Incident Summary dated 3/21/24 revealed: a. Staff G, Certified Nursing Assistant (CNA) posted a video involving Resident #4 to social media. b. The video appeared benign but does include Resident#4's face, Staff G's face and text that read say hi to (Resident #4's first name). c. Interview with Staff G whom stated he didn't really think about it. d. Corrective action: Staff G, CNA terminated immediately per company's zero tolerance policy related to posting videos/images of residents to personal social media. (continued on next page)

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F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Nursing Facility Abuse Prevention, Identification, Investigation, and Reporting Policy (dated 10/2022) included documentation that prohibited nursing staff from taking part in acts that result in personal degradation, including taking or using photographs or using recording devices in any manner that would demean or humiliate a resident and prohibits using any type of equipment (cameras, smart phones, or other electronic devices) to take, keep or distribute photographs or recordings on social media or through social media messages. Signed by Staff G, CNA, dated 8/9/23. A Cell Phone Policy that prohibited cell phone use while on duty except when on break to make a call. Any use of photographs or recordings for use on social media will lead to disciplinary action and/or termination of the employee. Signed by Staff G, CNA, dated 8/9/23. During an interview on 7/7/24 at 1:48 pm, Staff H, CNA stated Staff G, CNA had an Instagram account that she was on and Staff G posted a video with Resident#4 in it. Staff H stated she saw the phone recording 8 hours after it was posted. Staff H stated Resident#4 was dressed, lying in bed, which contained her face, her voice talking random words and Staff G posted Say Hi to (Resident#4's first name) everyone. Staff H stated all of Staff G's followers could see the video. Staff H stated she was aware of the cell phone policy and reported the video to Staff D, Licensed Practical Nurse (LPN) and Staff I, Director of Nursing (DON). Staff H stated after the video was turned over to the administration, she deleted it off her phone. Staff H stated Resident#4 was confused 90% of the time, will repeat stuff on the news repeatedly, but will say yes or no for showering or eating. During an interview on 7/7/24 at 12:26 pm, Staff D, LPN stated Staff H, CNA revealed the video, Staff G, CNA was in the video, Resident#4 was in the bed covered and dressed, and rambling. Staff D stated it was hard to say what she was talking about, I didn't get it, she was rambling. Staff D stated she reported the video to the DON. During an interview on 7/7/24 at 12:04 pm, Staff B, CNA stated he had worked for this facility for [AGE] years. Staff B stated he was aware of the cell phone, no video recording, and no pictures. Staff B stated he had taken pictures of residents with his personal phone, uploaded to the Administrator so the pictures could be processed for resident records or on the facility web site. Staff B stated the staff are not allowed to take videos yet it had happened in the past twice, 2 people have made that mistake. During an interview on 7/8/24 at 12:30 pm, Staff G, CNA stated that in March 2024 (unable to remember the exact date) he was provided care for Resident #4. Staff G stated he had his cell phone and was in Resident#4's room, Just me and (first name of Resident #4), chilling and talking, she was giving me advice. Staff G stated I videoed it (Resident #4) and put it on my Instagram and left it out there, in 24 hours it will delete itself but this was up for 3 hours. Staff G stated he thought about the post and took it down. Staff G stated the person who knew about the video (Staff H) turned it in, She waited days to report it. Staff G stated he had worked 3-4 days after taking the video, then the administration instructed him to not report to work until further notice, then terminated his employment the next day. Staff G stated, They confused me because they said if I make a mistake, I get 3 strikes before termination, and this was my mistake. Staff G stated he had completed the Dependent Adult Abuse class (DAA) and he had witnessed other people posting pictures and thought it was ok. Staff G denied signing a form instructing him not to video. (continued on next page)

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F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The facility provided 8 seconds of video evidence of Staff G, CNA wearing a hoodie, rubbing his chin and rolling his eyes while Resident#4's voice rambling in the background. The text read, everyone say hi to (Resident#4's first name), then the video switched to Resident#4 talking randomly, not looking at the camera, appeared to be clothed and in bed. During an interview on 7/9/24 at 10:26 am The Power of Attorney (POA) stated the facility had notified her that there was a video involving her mother posted on social media. The POA stated the information that she received was vague and a few days after the facility administration were made aware of it since the staff member was fired. The POA stated she asked to see the video but the administration told her that it was not available. The POA stated My mom has had Dementia for some time now and why would he video her, was he trying to embarrass her? The POA stated she didn't know what the CNA was trying to do but had to trust that the facility staff was going to do the right thing. During an interview 7/8/24 at 1:322 pm The DON stated his expectation, that the nurses need to hold the CNA's accountable. During an interview on 7/7/24 at 12:42 pm The Administrator stated the incident was reported, an investigation was completed, they terminated the employee and reported it to the DIA. The Administrator stated she provided training immediately and took the information to the management team. The Administrator stated the nursing staff implemented the cell phone policy.

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F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Honor the resident's right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 46873 Based on observations, staff interviews and facility policy review, the facility failed to maintain uncluttered hallways to promote a safe and homelike environment for one of three hallways. The facility also used a shower room for equipment storage. The facility reported a resident census of twenty eight. Findings include: On 7/5/24 at 9:50 am, the 300 Hallway was noted to be very cluttered. One full side of the hallway had multiple wheelchairs, full body and standing mechanical lifts and a dining chair. On the opposite side of the hall, one room had an isolation cart outside of the doorway. The doorway to room [ROOM NUMBER], room of Resident #22, was noted to be partially obstructed by the wheels of a wheelchair. The Minimum Data Set of Resident #22, dated 6/19/24 documented the resident needed supervision or touching assistance for wheelchair locomotion up to 150 feet. On 7/7/24 at 9:22 am, the Director of Therapy stated Resident #22 generally had a staff member assist him when propelling his wheelchair but he can self propel out of his room if he desires. On 7/5/24 at 9:59 am, Staff B, Certified Nurse Aide (CNA) stated the mechanical lifts are generally left in the hallway near the rooms of the residents who use them. He noted the wheelchair which was obstructing room [ROOM NUMBER] and stated the doorway should not be blocked. He moved the wheelchair from that area and placed it further down the hall. On 7/5/24 at 10:24 am, Staff B, CNA was observed removing a wheelchair from the hallway. He stated he was taking it to the garage for storage. He also said it had belonged to a resident who was no longer in the facility. On 7/6/24 at 8:56 am, all wheelchairs had been removed from the 300 hallway. Full body mechanical lifts were still stored on the hallway. Staff C, Licensed Practical Nurse was observed performing medication pass. She was observed moving a mechanical lift out of the way to obtain access to place her medication cart to administer medications for room [ROOM NUMBER]. On 7/6/24 at 9:00 am, Staff D, LPN was observed removing a full body lift from the 300 hallway and moving it into the shower room and leaving it in the shower room. On 7/6/24 at 9:12 am, Staff B, CNA was observed removing a second full body mechanical lift from the 300 hallway and taking it to a different hallway. On 7/7/24 at 10:08 am, The Administrator stated resident equipment storage, including mechanical lifts, should be limited to one side of the hall. She stated the building is older and storage space is extremely limited. (continued on next page)

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F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	The undated Facility Policy Accommodation of Needs and Preferences and Homelike Environment policy included in the Policy statement The facility will provide a safe, clean, comfortable, and homelike environment, allowing the resident to use his or her personal belongings to the extent possible. The Objective statement read The objective of the accommodation of resident needs and preferences is to create an individualized, home-like environment to maintain and/or achieve independent functioning, dignity, and well-being to the extent possible in accordance with the resident's own needs and preference. On 7/7/24 at 11:01 am, the Administrator stated the facility does not have a policy for equipment storage.

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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** 50471 Based on observations, menu review, and staff interview, the facility failed to serve the appropriate menu for two of two meals observed. The facility also failed to follow a standard pureed process for two of two pureed food prep observations. Findings include: The facility's menu for lunch on 7/6/24 identified the following items to be served to diets. #6 Scoop (sc) Tator tot casserole 8 ounces (oz) Serving Toss salad/dressing 4 oz Serving chilled fruit 1 each bread/[NAME] 1 Square (SQ) Smores Brownies 8 oz Milk Continuous observation of lunch preparation and service began on 7/6/24 at 10:50 AM. Staff E, Cook, placed two 4 oz servings of tator tot casserole into the blender. She blended the casserole. When done with the puree process, Staff used spatula, placed servings into clean pan, and placed into oven. No measurement of the volume of pureed casserole was done. Staff E stated she placed two servings of peaches in bowl which was prepared prior to observation beginning. She placed the peaches in the blender. She blended the peaches. When done with the puree process, Staff used spatula, placed servings into two separate bowls, covered them, and placed them in the refrigerator. No measurement of the volume of peaches was done. The peaches for regular diet, prepared prior to observation beginning. Staff E placed two 4 oz servings of coleslaw into the blender. She blended the coleslaw. When done with the puree process, Staff used the spatula, placed servings into two separate bowls, covered them, and placed them in the refrigerator. No measurement of the volume of coleslaw was done. The coleslaw for regular diet, prepared prior to observation beginning. Staff E stated she prepared the bread and butter which was prepared prior to observation beginning. She placed two servings into blender. She added milk and pureed the bread and butter. When done with the puree process, Staff used the spatula, placed the servings into two separate bowls, covered them, and placed them on the counter next to the prepared bread and butter. No measurement of the volume of bread and butter was done. (continued on next page)

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F 0803 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Staff E removed tator tat casserole from oven, placed in steam cart, placed coleslaw on ice, peaches were pulled out last and placed on cart. On 7/6/24 at 11:31 AM Staff E, Staff F, Dietary Aide, began to serve the meal. Staff E used a #8 sc to serve the Tator tot casserole for mechanical and puree diet, and 4 oz ladle to serve the regular diet, a 4 oz draining ladle to serve the coleslaw, peaches in fruit dish prepared prior, and used thongs placed bread and butter on plate. Staff E did not prepare or serve smores brownies, no dessert provided. The facility's menu for breakfast on 7/7/24 identified the following items to be served to diets. 1 serving Choice of Cereal 1 each Egg 1 each Muffin 1 each Sausage Patty 8 oz Milk 4 oz Choice of Juice On 7/7/24 at 7:25 AM Staff E prepared cinnamon roll, oatmeal, cream of wheat, prior to observations. Noted Staff E used #8 scoop (sc) for oatmeal and cream of wheat, and used thongs to serve 1 cinnamon roll each. Staff E used 4 ounce (oz) ladle, scooped liquid egg, 3-4 times placed on grill, added cheese, onion, peppers, folded and flipped egg, cut into 2-3 servings, placed on plate, served. No sausage patty was prepared or served. On 7/6/24 1:45 PM Staff K, Executive Chef reported #6 scoop (sc) holds 51/3 ounce (oz) and a #8 scoop holds 4 oz, also observed a 4 oz ladle and 5 oz ladle. Menu was reviewed with serving sizes. Staff K described the pureed process as follows; - Put the serving size it in the blender, if needed add milk/water, blend, measure it in measuring cup, look at chart and note what scoop to use, put the food in appropriate container and put where it needs to be. Staff K instructed use of Food Portion Chart as follows: -You look at how much is in the cup (total volume) and how many servings you put need and then it tells you what scoop to use. Staff K reported that the menus have what amount of food to provide each resident no matter what dies the resident is on. The Executive Chef (EC) agreed that the cook needs more education about serving size/utensils. (continued on next page)

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F 0803 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	The EC also commented that he wants to review with new Registered Dietician as he thinks serving size appears larger than it should be.

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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. 47079 Based on observations, staff interviews, and facility policy review, the facility failed to maintain sanitary practices by improperly storing resident food. The facility reported a census of 27 residents. Findings include: On 7/05/24 at 7:30 AM, a kitchen observation identified the following findings: A True refrigerator contained: 1) An undated, previously opened jar of mayonnaise. 2) An unlabeled bowl of meat and vegetables. 3) An unlabeled, undated tub of a chopped orange item. 4) An unlabeled, undated, and partially uncovered bowl of chopped cantaloupe. 5) An unlabeled, undated tub of a shredded orange item. A True freezer contained: 1) An unlabeled, undated bag of meat. 2) An unlabeled, undated block of meat wrapped in Saran wrap. A shelf located in the kitchen contained an undated, previously opened jar of peanut butter. On 7/07/24 at 10:08 AM, the Administrator stated food should be labeled, dated, and covered when stored. A policy titled Dining Services Storage dated June 2018 indicated foods held in refrigerator or other storage areas shall be appropriately covered, labeled, and dated.

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide and implement an infection prevention and control program. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 47079 Based on observations, record review, staff interview, and policy review, the facility failed to implement infection control practices to prevent cross contamination of invasive medical equipment for one of one blood glucose test observations. Facility staff also failed to decrease possible spread of infection for one of one resident reviewed for a urinary catheter (Resident#28) . The facility reported a census of 27 residents. Findings include: 1. On 7/05/24 at 7:22 AM, Resident #28 was observed sitting in her wheelchair with her indwelling catheter drainage bag hanging on the underside wheelchair frame and the tubing lying on the floor. On 7/5/24 at 8:31 AM, a second observation revealed the resident's indwelling catheter tubing was still lying on the floor. The Admission Minimum Data Set (MDS) dated [DATE] revealed the resident had a Brief Interview for Mental Status (BIMS) score of 14 out of 15 which indicated completely intact cognition. It included diagnoses of Cancer, hemiparesis (one-sided muscle weakness), and Chronic Kidney Disease. It also indicated the resident had an indwelling catheter, and required maximum assistance with toileting hygiene. The Care Plan revised 6/24/24 indicated the resident had an indwelling catheter and indicated the resident would remain free from catheter-related trauma through the 9/15/24 review date. On 7/07/24 at 10:08 AM, the Administrator stated Foley catheter tubing should not contact the ground. An undated policy titled Routine Catheter Care indicated the rationale for the policy was for the prevention of infections to the residents who are at risk due to the use of an indwelling Foley catheter. 50471 (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	2. On 7/5/24 at 8:51 am, Staff A, Registered Nurse (RN), Director of Nursing (DON), was observed obtaining the blood glucose of Resident #19. After obtaining the blood glucose, Staff A stated there are no sharps containers in the resident rooms and he would dispose of the used lancet (a small needle used to prick the skin and draw a small drop of blood for blood sugar testing) in the sharps container at the medication cart. Staff A placed the used lancet in a container which also had a blood sugar monitor, a bottle of blood sugar test strips, and an insulin pen in it. Staff A, RN, carried the container out of Resident #19's room and walked down the hall to the medication cart. He placed the container in the bottom drawer of the medication cart and shut the drawer and then prepared the medications for Resident #19. He then removed the blood glucose container to obtain the insulin pen. He was not observed wearing gloves. He noted the used lancet in the container and picked it up and disposed of it in the sharps container. He obtained the insulin pen and placed the container back in the medication cart and closed the drawer. Staff A was not observed cleaning or sanitizing the container or any of the equipment in the container which contained the used lancet during the observation. On 7/07/24 at 10:08 AM, the Administrator stated staff should have immediately placed the lancet in the sharps container and should not have transported the lancet in the resident's supply container. The undated policy title Finger Stick for Blood Glucose directed staff to dispose of lancet in container for sharps, return equipment to storage area, and clean as needed.