

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 165481	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 07/11/2024
NAME OF PROVIDER OR SUPPLIER Mayflower Home		STREET ADDRESS, CITY, STATE, ZIP CODE 616 Broad Street Grinnell, IA 50112	

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** 40907</p> <p>Based on observations, interviews and record review, the facility failed to recognize and respect the psychosocial feedback and responses for 2 of 3 residents reviewed (Residents #4 and #10). Resident #4 and Resident #10 both had alarms that sounded when standing. Resident #4 reported the alarm made her anxious and like she needed to move when her alarm sounded. Resident #10 reported the alarm as jarring and it frightened her. The facility had a census of 27 residents.</p> <p>Findings include:</p> <p>1. Resident #4's Minimum Data Set (MDS) assessment dated [DATE], identified a Brief Interview for Mental Status (BIMS) score of 15, indicating intact cognition. Resident #4 required supervision or touching assistance with transfers, standing, and ambulation. The MDS included diagnoses of anxiety, depression, COPD (chronic obstructive pulmonary disease) and osteoarthritis. The MDS documented Resident #4 used a bed alarm daily.</p> <p>The Care Plan Focus revised 7/9/24 indicated Resident #4 had a risk for falls and fall related injuries due to her history of falls, increased weakness, use of oxygen per nasal cannula (O2/NC), contributing diagnoses, balance and gait deficits. Resident #4 continued to self-transfer, removed, or hid her alarms. The facility discontinued her chair alarm on 4/24/24. On 7/9/24, the facility placed a new alarm due to her noncompliance with requesting assistance with transfers resulting in falls and/or increased risk for falls. The Interventions directed the following:</p> <p>a. 1/9/24: Resident #4 needed an assistance from 1 staff with transfers, ambulation in room, and throughout the facility with use of a gait belt and walker.</p> <p>b. 12/1/23: Place a body pillow to the left side of Resident #4's bed to define edge of bed for Resident #4.</p> <p>c. 12/1/23: Check with Resident #4 between 9:00 a.m. and 9:30 a.m., to see if she is ready to get out of bed.</p> <p>d. 5/21/24: Educated Resident #4 that she was at risk for falls. Re-educate/remind further as needed.</p> <p>(continued on next page)</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 0550</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>e. 5/21/24: Educated Resident #4 on the need for calling for assistance, questions, medications and/or concerns. The staff must assess Resident #4's compliance of the use of her call light to assist with above needs.</p> <p>f. 1/9/24: Ensure proper bed alarm placement and functioning while in bed. Resident #4 did remove her alarm at times. The staff should provide education on the importance of placement and the importance of requesting assistance prior to trying to self-transfer. Resolved 6/20/24.</p> <p>g. 1/9/24: Ensure chair alarm is in place when up and proper functioning. Resident #4 did remove chair alarm at times, Staff should educate on the importance of placement and need for requesting assistance prior to attempting to self-transfer. Resolved 4/24/24.</p> <p>h. 6/17/24: Listed the fall intervention as of 6/15/24: Ensure the use of the assistive device. Consult therapy as needed (PRN) to help with transfers and use of assisted devices.</p> <p>i. 6/20/24: Ensure placement and functioning of the floor alarm due to Resident #4 hiding the bed alarm (discontinued bed alarm due to noncompliant use). Cancelled 7/9/24.</p> <p>j. 7/9/24: Laser motion sensor alarm placed in room to alert staff when Resident #4 self-transferred.</p> <p>k. 6/11/24: Provide and encourage use of a reacher to pick up items off the floor.</p> <p>l. Revised 7/9/24: Provide education and counseling on the importance of using her call light for assistance. Keep Resident #4's door open. Resident #4 refused to use bedside commode attempted for safety.</p> <p>m. 6/13/24: Refer to Physical Therapy to evaluate and treat if indicated due to right lower knee weakness.</p> <p>n. 12/1/23: Remind Resident #4 to use call light and wait for staff assistance prior to attempting to self-transfer.</p> <p>o. 2/28/24: Remind Resident #4 to use the call light for assistance for all transfers and toilet use.</p> <p>The Care Plan Focus revised 2/16/24 identified Resident #4 had a risk for problems related to psychosocial wellbeing and participation due to her short-stay admission, but determined unsafe to return home. Resident #4 reported feeling isolated with diagnoses of depression and anxiety. The related Goal reflected she would participate in activities of daily living (ADLs), activities of her choice, her mood will not result in an overall decline through the next review date. The Interventions directed the staff the following:</p> <p>a. 11/24/23: Monitor and document Resident #4's for impact of medical problems on activity level.</p> <p>b. 11/24/23: Observe Resident #4 for changes in mood and participation, intervene and report if indicated.</p> <p>(continued on next page)</p>		

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<p>F 0550</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>On 7/10/24 at 12:47 p.m., the Physical Therapist stated Resident #4 already had a floor alarm the first time this Physical Therapist saw Resident #4. The rest of the therapy team agreed that they did not make recommendations for Resident #4 to have alarms.</p> <p>On 7/10/24 at 12:56 p.m., when questioned about how the wall alarm made her feel, Resident #4 responded it made her anxious. Resident #4 described it as loud and made her feel like she needed to get up and move or something. She reported it as defective. When asked if anyone talked to her about it being an alarm to alert staff about her moving in her room, Resident #4 replied no one talked to her about that. She stated she can move around herself. When asked if staff talked to her about their concern of her falling, she stated no one talked to her about falling.</p> <p>On 7/11/24 at 9:11 a.m., Resident #4's Daughter (RR#4) stated she didn't love the alarms and didn't think the alarms prevented her mother from falling. RR#4 stated when the alarms sound, the staff come to her mom's room check on her and see that she fell . RR#4 stated in her opinion the alarm went off so often, that it could slow the staff's response to the alarm. RR#4 stated the alarms are loud, hard to turn off, and they end up waiting for the staff a while to respond to the alarm to turn them off. RR#4 said as they wait, they sit in the room waiting with a loud alarm sounding. When asked if she felt the alarms caused her mother any distress, RR#4 responded yes when an alarm went off, it caused her mom anxiety. RR#4 stated her mom did have short-term memory loss.</p> <p>2. Resident #10's MDS assessment dated [DATE], identified a BIMS score of 15, indicating intact cognition. Resident #10 required supervision or touching assistance with chair/bed and toilet transfers, standing, and ambulation. The MDS included diagnoses of Parkinson's disease and cerebral infarction (stroke). The MDS documented that Resident #10 used a floor mat alarm daily.</p> <p>The Care Plan Focus revised 7/2/24 reflected Resident #10 had a potential to fall or have fall related injuries due to her needing assistance with self-care and mobility tasks due to admitting with impaired range of motion to her right lower extremity due to a previous fall with hip fracture that required repair. The connected Goal revised 7/1/24, indicated Resident #10 wouldn't sustain any additional falls related injuries by utilizing fall precautions through the next review date. The Interventions instructed the staff the following:</p> <p>a. 1/8/24: Anticipate and meet Resident #10's needs.</p> <p>b. 1/8/24: Be sure Resident #10's call light is within reach and encourage Resident #10 to use it for assistance as needed. Resident #10 needs prompt response to all requests for assistance.</p> <p>c. 5/19/24: Place chair alarm arm in wheelchair and recline. Observe placement and functioning. Cancelled 7/10/24.</p> <p>d. 1/8/24: Educate Resident #10, family, and caregivers about safety reminders and what to do if a fall occurred.</p> <p>e. 5/19/24: Encourage and remind Resident #10 to use her call light for assistance prior to attempting to self-transfers.</p> <p>f. 3/14/24: Ensure bed alarm placement and proper functioning.</p> <p>(continued on next page)</p>		

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<p>F 0550</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>i. Revised 4/24/24: Will follow up with continued need of alarm on 5/7/24 if Resident #10 returned to full weightbearing status.</p> <p>iii. Intervention resolved 7/2/24.</p> <p>g. 1/8/24: Ensure Resident #10 wore appropriate footwear when ambulating or mobilizing in her wheelchair (w/c).</p> <p>h. 5/30/24: Floor alarm in front of chair (while up in chair) and at bedside (while in bed).</p> <p>i. 1/8/24: Physical Therapy to evaluate and treat as ordered or PRN.</p> <p>j. 6/14/24: Visual Reminder Note on closet to remind Resident #10 to not transfer without staff assistance.</p> <p>Resident #10's list of Fall Incident Reports listed she fell on [DATE].</p> <p>A Progress Note dated 5/30/24 at 10:05 a.m., documented the staff discussed with Resident #10 about safety and need for staff to be by her when she is up with her walker. Staff found Resident #10 in the hall independently with her walker, no call light on, and no alarm sounding. Upon investigation, discovered alarm placed in different chair. Took a long walk with Resident #10, who visited with therapy about plans to do restorative exercises. Resident #10 reported a concern that no one would work with her anymore. Reassured Resident #10 that she would continue to get exercises with Occupational Therapy and she could ambulate with staff. When they returned to Resident #10's room, she avoided sitting in chair with alarm and asked, is it going to beep when I move my butt? In addition, Resident #10 avoided sleeping in her bed due to the bed alarm. When visited about an alternative option of a floor alarm, Resident #10 appeared more agreeable to that. Resident #10 stated what do I have to do to get rid of that?. Staff advised that Resident #10 would have to use her call light consistently for staff to be with her during ambulation and transfers. Resident #10 stated well I am done with therapy and at my best level so I can do whatever I want now. Advised that the staff's job required them to keep the residents safe from injury or otherwise. Additionally, the staff had facility rules they need to follow. Floor alarm placed, bed and chair alarms taken out.</p> <p>A Progress Note dated 5/30/24 at 10:18 a.m., documented a staff member reported Resident #10 crying in her room. The nurse visited with Resident #10 again and asked why she was upset. Resident #10 stated she couldn't go to a birthday party. The nurse explained the staff would make sure she could go to the birthday party. Resident #10 added she did not like the floor alarm and wanted to go home. Resident #10 stated What is the use of having legs if they won't let me use them? The nurse advised Resident #10 that she could ambulate with staff, they just needed to know when she would like to, as well as being able to walk to dining area and back to room for meals. Reiterated that staff needed to be present while she does so. Resident stopped crying, but continued to display some anxiousness about various things.</p> <p>On 7/8/24 at 2:57 p.m., observed an alarm mat at the foot of Resident #10's recliner. Resident #10 reported she HATES it. Resident #10 voiced she never fell and the staff wanted to make sure she called them before trying to take herself to the bathroom.</p> <p>(continued on next page)</p>		

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<p>F 0550</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>On 7/10/24 at 10:47 a.m., Resident #10 looked asleep in her recliner, with the mat on the floor. The Director of Nursing (DON) and Staff D stated Resident #10 never refused the floor mat. They said Resident #10 told the staff she wanted the chair alarm removed and the bed alarm removed, so they removed those alarms. They acknowledged Resident #10 told staff she hated the mat, however they stated Resident #10 didn't refuse letting the staff to place it under her feet. They added that Resident #10 now refused to sleep in her bed, and slept in her recliner. They stated that Resident #10 got up to try to help her husband, she had slow gait and walked on her tip toes. The DON and Staff D described Resident #10 as a high fall risk. The DON stated Resident #10 currently worked in physical therapy (PT) as Resident #10 and her husband wanted to discharge back to their home. The DON stated Resident #10's children believed Resident #10 could take care of their father. The DON stated that Resident #10 and her husband had alarms at home and when/if they discharge they will take the alarm with them.</p> <p>On 7/10/24 at 12:46 p.m., the Physical Therapy Aide (PTA), stated she remembered having a conversation with nursing when Resident #10 ended therapy that maybe they could try a floor mat since she did not like the bed alarm or the chair alarm. Resident #10 didn't consistently use her call light but would go ahead and transfer herself. She needed to have 1 assist with a gait belt and walker for safety reasons.</p> <p>On 7/10/24 at 1:01 p.m., When asked how the floor alarm made her feel, Resident #10 reported the alarm as jarring and frightened her. When asked if she knew why she had the floor alarm, she stated it is there to keep a person in one place but that can't be good for the body. When asked if they had talked to her about their concern for her falling, she shook her head no.</p> <p>On 7/10/24 at 1:37 p.m., the DON, acknowledged the concern regarding psycho-social well-being for Resident #4 and Resident #10. This DON stated she would like the facility to be alarm free.</p> <p>On 7/10/24 at 4:01 p.m., the Executive Director acknowledged concerns with alarms. Stated she had a conversation with their call light company regarding other options that would send a signal to a phone instead without the loud noise sounding from the alarm.</p> <p>On 7/11/24 at 11:56 a.m., the DON stated each resident's alarm sounded differently and the staff could hear the alarms from all halls. The DON explained she expected the staff to answer the alarms immediately.</p> <p>A Facility assessment dated [DATE], directed the staff to do the following:</p> <ol style="list-style-type: none"> a. Build relationship with resident/get to know him/her; engage resident in conversation b. Find out what resident's preferences and routines are; what makes a good day for Resident #10; what upsets him/her and incorporate this information into the care planning process. Make sure staff caring for Resident #10 have this information c. Record and discuss treatment and care preferences d. Support emotional and mental well-being; support helpful coping mechanisms <p>(continued on next page)</p>		

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<p>F 0550</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>e. Offer and assist resident and family caregivers (or other proxy as appropriate) to be involved in person-centered care planning and advance care planning.</p> <p>The Resident Alarms policy revised June 2024, directed the staff to utilize resident alarms in limited circumstances, in accordance with the resident's needs, goals, and preferences, so Resident #10 will be able to attain or maintain his or her highest practicable level of physical, mental, and psychosocial well-being. An alarm is any physical or electronic device that monitors the resident's movement and alerts the staff, by either audible or inaudible means, it detects when movement.</p> <p>a. The use of alarms does not eliminate the need for adequate supervision of the resident. Types of alarms include:</p> <ul style="list-style-type: none"> i. Bed alarms - including devices such as a sensor pad on the bed or a device that clips to the resident's clothing ii. Chair alarms - including devices such as a sensor pad placed on the chair or wheelchair or a device that clips to the resident's clothing iii. Floor mat alarms - including devices such as a sensor pad placed on the floor beside the bed iv. Motion sensor alarms - includes infrared beam motion detectors. v. Other - includes devices such as alarms on Resident #10's bathroom and/or bedroom door, toilet seat alarms, or seatbelt alarms. <p>b. The facility shall establish and utilize a systematic approach for the safe and appropriate use of resident alarms, including efforts to identify risk; evaluate and analyze risk; implement interventions to reduce risk; and monitor for effectiveness of the interventions and modifying interventions when necessary.</p> <p>c. Identification of risk: The facility should assess each resident for fall and elopement risk upon admission and periodically thereafter as part of the comprehensive assessment process.</p> <ul style="list-style-type: none"> i. The medical record should have the medical symptoms identified and documented. The information may come from the resident's medical history, physical exam, or individual observation. ii. The facility should identify the adverse consequences related to alarm when using or considering the use of alarms. <p>d. Evaluation and analysis of risk: The interdisciplinary team shall analyze each resident's unique risks and medical symptoms to determine the root cause(s) of each risk.</p> <ul style="list-style-type: none"> i. The interdisciplinary team shall consider the severity of risks/symptoms, the immediacy of risks, and trends such as time of day, location, or stated reasons for the behavior/fall. ii. The facility should develop interventions to address the root cause(s) of each risk. <p>e. Implementation of interventions</p> <p>(continued on next page)</p>		

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<p>F 0658</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Ensure services provided by the nursing facility meet professional standards of quality.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 42441</p> <p>Based on observation, policy reviews and staff interviews, the facility failed to follow manufacturer's recommendations while administering insulin utilizing an insulin KwikPen for 1 of 1 resident reviewed for insulin administration with an insulin pen (Resident #16). The facility reported a census of 28 residents.</p> <p>Findings include:</p> <p>Resident #16's Minimum Data Set (MDS) assessment dated [DATE] identified a Brief Interview for Mental Status (BIMS) score of 4, indicating severely impaired cognition. The MDS included a diagnosis of diabetes mellitus.</p> <p>Resident #16's July 2024 Medication Administration Record (MAR) listed an order dated 5/30/24 for Basaglar KwikPen Solution Pen injector 100 UNIT/milliliter (ML) (insulin glargine). Inject 45 units subcutaneously in the morning for diabetes mellitus type 2.</p> <p>On 7/10/24 at 7:10 AM, observed Staff A, Licensed Practical Nurse (LPN), administer glargine insulin subcutaneously to Resident #16 utilizing the Basaglar KwikPen. Following administration, Staff A immediately removed the insulin pen from Resident #10.</p> <p>Review of the manufacturer's recommendation for Basaglar Temp Pen insulin glargine injection directed to insert the needle into the skin. Push the Dose Knob all the way in, continue to hold the dose knob in and slowly count to 5 before removing the needle.</p> <p>During an interview 7/10/24 at 12:09 PM Staff A reported she didn't receive training to keep the insulin KwikPen in place for a period of time following administration.</p> <p>During an interview 7/10/24 at 12:20 PM, Staff A acknowledged the manufacturer's recommendation is to hold the pen in place following administration and slowly count to 5 before removing the needle. In addition, Staff A explained she previously pulled the insulin pen out immediately after she heard the pen click following administration.</p> <p>The Insulin Pen policy, revised February 2023 instructed while still pressing the plunger, keep the needle in the skin following the manufacturer's protocol, then remove the needle.</p> <p>The Medication Administration policy, revised 10/19/23 directed the staff to administer medications as ordered in accordance with manufacturer specifications.</p> <p>During an interview 7/10/24 at 1:38 PM, the Director of Nursing (DON) reported they expected the staff follow manufacturer's recommendations when administering insulin.</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 165481	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 07/11/2024
NAME OF PROVIDER OR SUPPLIER Mayflower Home		STREET ADDRESS, CITY, STATE, ZIP CODE 616 Broad Street Grinnell, IA 50112	

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 0727</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</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>42441</p> <p>Based on daily staffing sheets, punch detail, policy review and staff interviews, the facility failed to have 8 hours Registered Nurse (RN) coverage. The facility reported a census of 28 residents.</p> <p>Findings include:</p> <p>The Daily Healthcare (HC) Schedule, dated 6/16/24, revealed Staff B, Registered Nurse, worked the night shift on 6/16/24.</p> <p>The review of the facility punch detail reflected on 6/16/24 Staff B clocked in at 10:07 PM and clocked out 6/17/24 at 6:37 AM. The facility couldn't provide additional information including Daily HC schedules or punch detail regarding RN coverage on 6/16/24.</p> <p>The Nursing Services and Sufficient Staff policy, revised 10/10/23 revealed except when waived, the facility must use the services of a registered nurse for at least 8 consecutive hours a day, 7 days a week.</p> <p>During an interview 7/10/24 at 2:00 PM the Director of Nursing acknowledged an RN didn't work 8 consecutive hours on 6/16/24 as expected.</p>