

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 165525	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 06/13/2024
NAME OF PROVIDER OR SUPPLIER The New Homestead Care Center		STREET ADDRESS, CITY, STATE, ZIP CODE 2306 State Street Guthrie Center, IA 50115	

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 0641</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Ensure each resident receives an accurate assessment.</p> <p>46873</p> <p>Based on clinical record review, staff interviews, facility policy review, and guidance from the RAI manual, the facility failed to ensure the Minimum Data Set (MDS) assessment of each resident accurately reflected the resident's status at the time of the assessment for 2 of 15 residents reviewed (Resident #3 and Resident #10) . The facility reported a census of 48 residents.</p> <p>Findings include:</p> <p>1. The Weight Summary for Resident #3 documented the resident had been in the facility in 2019 and on 2/8/19 had a documented weight of 355.0 pounds. The next time a weight was documented was 3/1/24, revealing a weight of 285.0 pounds, a difference of 70 pounds over the approximately 5 years between the recorded weights.</p> <p>The MDS of Resident #3, dated 2/8/24 documented an entry date of the most recent admission as 2/2/24. The MDS recorded the resident's current weight as 355.0 pounds.</p> <p>The Clinical Summary in the resident's hospital records, located in his electronic health record revealed the resident had been weighed at the hospital on 2/2/24 at 5:26 am and documented the resident's weight of 284 pounds, 14.4 oz.</p> <p>On 6/11/24 at 1:32 pm, the MDS Coordinator stated the 355 pounds documented on the MDS of Resident #3 was incorrect. She stated she did not see an admission weight documented anywhere but that the 2019 weight should not have been documented on the MDS.</p> <p>2. The MDS of Resident #10, dated 5/16/24, reflected the resident was administered an anticoagulant medication during the lookback period of the MDS, 5/10/24-5/16/24.</p> <p>The Medication Administration Record (MAR) of Resident #10 for May of 2024 revealed the resident was administered Aspirin and Plavix. Both medications are classified as anti platelet. The MAR failed to reveal the resident was administered any anticoagulant medication. (Anticoagulants slow down blood clotting, while antiplatelet medications prevent platelets from clumping and prevent clots from forming).</p> <p>The MDS of Resident #10 additionally reflected the resident received 0 minutes of Restorative Nursing Walking between 5/10/24 and 5/16/24.</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 0641</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>The Follow Up Question Report documented Walk to Dine was completed three times a day, every day between 5/10/24 and 5/16/24 for Resident #10.</p> <p>On 6/11/24 at 1:30 pm, the MDS Coordinator stated she began her job in the facility in March of 2024. She stated she was instructed when she was hired not to document any restorative nursing on any MDS. She stated the facility does not have a Restorative Nurse, and the Certified Nurse Aides are completing the programs such as walk to dine.</p> <p>On 6/11/24 at 1:37 pm, the MDS Coordinator stated coding Resident #10 being on an anticoagulant medication was an error and she would submit an MDS modification.</p> <p>On 6/11/24 at 2:49 pm, the Director of Nursing stated the facility's management company instructed the facility staff to remove minutes from the Restorative Program charting. She stated the facility no longer records restorative minutes anywhere.</p> <p>The facility document Comprehensive Assessment and Reassessment, effective 5/10/17, documented the assessment must include at least the following:</p> <ul style="list-style-type: none"> - Nutritional Status - Medications; prescription and over-the-counter - Special treatments and procedures (which includes therapies and restorative nursing) <p>The facility document failed to address the accuracy of the MDS.</p> <p>The Long-Term Care Facility Resident Assessment Instrument (RAI) 3.0 User's Manual, dated October 2023 directed:</p> <p>Section K: Nutritional Status</p> <ul style="list-style-type: none"> - Base weight on the most recent measure in the last 30 days - If the last recorded weight was taken more than 30 days prior to the ARD (the date of the assessment), or a previous weight is not available, weigh the resident again. - If a resident cannot be weighed, use the standard no-information code (-) and document rationale on the resident's medical record. <p>Section N: Medications</p> <ul style="list-style-type: none"> - Check if the resident is taking any medication by pharmacological classification, not how it is used, during the last 7 days or since admission/entry or reentry if less than 7 days. <p>-N0415E1. Anticoagulant, check if an anticoagulant medication was taken by the resident at any time during the 7-day look back period.</p> <p>Section O: Special Treatments, Procedures and Programs.</p> <p>(continued on next page)</p>		

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<p>F 0641</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>- O0500F, Walking. Code activities provided to improve or maintain the resident's self-performance in walking, with or without assistive devices. These activities are individualized to the resident's needs, planned, monitored, evaluated, and documented in the resident's medical record.</p> <p>-</p>		

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<p>F 0676</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Ensure residents do not lose the ability to perform activities of daily living unless there is a medical reason.</p> <p>50471</p> <p>Based on clinical record review, and staff interview, the facility failed to complete the residents restorative program 3-5 times a week for 1 of 2 residents reviewed for restorative program (Resident #15). The facility reported a census of 48 residents.</p> <p>Findings include:</p> <p>The Care Plan for Resident #15, revised 3/22/24 identified the resident's restorative program. The Care Plan informed the staff to review restorative records for the current restorative plan of care.</p> <p>The Restorative plan of care revealed the residents restorative program to be completed 3-5 times a week. Review of records revealed in March of 2024 the resident completed the program 5 times. In April of 2024 the resident completed the program 7 times. In May 2024 the resident completed the program 3 times. In June 2024 the resident completed the program 3 times.</p> <p>In an interview on 6/13/24 at 10:02 AM, the Director of Nursing (DON) stated she expects the restorative aides to complete the exercises with the resident per the Care Plan and to document in Point of Care (PCC) when completed.</p>

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<p>F 0690</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide appropriate care for residents who are continent or incontinent of bowel/bladder, appropriate catheter care, and appropriate care to prevent urinary tract infections.</p> <p>50471</p> <p>Based on clinical record review, observation, staff interview, and policy review the facility failed to follow infection prevention standards during incontinence cares for 1 of 4 residents review for incontinence cares (Resident #16). The facility reported a census of 48 residents.</p> <p>Findings include:</p> <p>The Minimum Data Set (MDS) assessment of Resident #16 dated 5/23/24 reflected the resident to have short term and long term memory problems. The MDS revealed the resident totally dependent on toileting and personal hygiene. The MDS reflected the resident always incontinent with urine and bowel.</p> <p>The Care Plan for Resident #16, last reviewed 5/24/24, identified the resident to be incontinent of bladder and bowel. The Care Plan directed staff to provide incontinence care after each incontinent episode.</p> <p>On 6/12/24 at 8:24 AM, Staff A, Certified Nurse Aide (CNA) was providing incontinence care to Resident #16. Resident #16 was laying in bed. Staff A performed hand hygiene and donned gloves. She provided privacy and stated task. Staff A removed the blankets, and opened the incontinent brief which was wet with urine. Staff A then took a clean wet soapy washcloth and performed peri care, front to back on the resident, folding the washcloth to a clean area with each wipe. Staff A then took a clean, dry washcloth and repeated the steps to dry the resident, failing to use a washcloth to rinse the soap off of the resident. Staff B, CNA, then assisted Staff A to turn the resident to her right side. Staff A then proceeded to use the same soiled washcloth to wash the resident's buttocks, front to back on the resident, folding the washcloth to clean area with each wipe. Staff A then took soiled dry washcloth and repeated the steps to dry the resident, failing to use a washcloth to rinse the soap off of the resident. Staff B removed soiled incontinent brief and placed clean incontinent brief. Staff B, then assisted Staff A to turn the resident to her back. Staff A placed soiled linen on floor with no barrier. Staff A, then assisted Staff B to turn the resident to her left side, to position incontinent brief. Staff A and Staff B, closed incontinent brief with fasteners. Staff A, undonned gloves, completed hand hygiene.</p> <p>On 6/13/24 at 12:50 PM the Director of Nursing (DON) stated the staff did not use enough washcloths, did not perform handwashing, did not change gloves, and should not have placed washcloths on the floor.</p> <p>The facility policy Incontinence care, revision date 3/28/24 documented:</p> <p>Residents that are incontinent of bladder and bowel will maintain clean perineal skin for incontinent residents, to examine the skin, and to prevent skin irritation.</p>		

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<p>F 0693</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Ensure that feeding tubes are not used unless there is a medical reason and the resident agrees; and provide appropriate care for a resident with a feeding tube.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 46873</p> <p>Based on clinical record review, observation, staff interviews and facility policy, the facility failed to administer tube feeding per physician orders for 1 of 1 resident reviewed for tube feeding (Res #51). The facility reported a census of 48 residents.</p> <p>Findings include:</p> <p>The Minimum Data Set (MDS) assessment of Resident #51 dated 6/4/24 documented a primary diagnosis of muscular dystrophy. The MDS documented the presence of a feeding tube. The MDS recorded the resident received 51% or more of total calories through tube feeding and 501 cc/day (cubic centimeters per day) or more fluid intake per tube feeding.</p> <p>The Care Plan of Resident #51 documented a focus area of nutrition dated 6/6/24, which revealed the resident to be NPO (nothing by mouth) and to have a need for alternate feeding method. It directed staff to provide tube feeding as ordered.</p> <p>The Medication Administration Record (MAR) of Resident #51, for June of 2024 revealed an order for Osmolite 1.2 Cal, give 552 mls (milliliters) via G-Tube (a gastronomy tube, a tube inserted through the abdomen that brings nutrition directly to the stomach) three times a day.</p> <p>On 6/12/24 at 8:36 am, Staff F, LPN stated she would be doing the resident's morning ordered tube feeding. Staff G, Registered Nurse, a nurse consultant for the facility stated she would be observing. Staff F, LPN stated she had been off work for three weeks and had not met or cared for Resident #51, who had admitted to the facility on [DATE]. Staff F first prepared Resident #51's morning medications. She checked his vital signs, and gathered the medications and three boxes of Osmolite 1.2 calories, each containing 237 mls of feeding.</p> <p>On 6/12/24 at 8:49 am, both staff members, after performing hand hygiene and donning personal protective equipment, repositioned Resident #51 to be at the top of the bed. After the resident was at the top of the bed and having raised the head of the bed to a safe position, Staff F removed her gloves, went to the restroom to wash her hands and don clean gloves.</p> <p>On 6/12/24 at 8:55 am, Staff F opened a new 60 ml syringe, and attached the resident's feeding tube to his Mic-Key feeding tube button. She auscultated the feeding tube with air to verify proper placement. She then flushed the feeding tube with 60 mls of water. After administering the resident's medication, and flushing with an additional 60 mls of water, she prepared for the tube feeding. She poured two boxes of Osmolite 1.2 feeding, totaling 474 mls, into a graduate cylinder that had been set up for the tube feeding. After opening the third box of Osmolite, she held the cylinder at eye level and measured the feeding, stating she had a total of 522 mls of feeding. She administered the feeding per gravity at a safe rate and after completing the feeding, gave an additional 60 mls of water per physician order. Staff F was asked to verify how much water and how much feeding she administered to Resident #51. She stated she administered 60 mls of water before medication administration, 60 mls of water after medication administration, 522 mls of feeding, and an additional 60 mls of water after the feeding. She then completed hand hygiene and cleaned her area and supplies.</p> <p>(continued on next page)</p>		

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<p>F 0693</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>On 6/12/24 at 9:20 am, Staff G, RN, Nurse Consultant verified Staff F administered 522 mls of feeding and verified the resident's order read to administer 552 mls of feeding.</p> <p>The facility document Enteral Feeding Via Nasogastric or Gastronomy tube, revision date 11/5/22 directed This facility shall provide and implement a plan of care for delivery of nutrients via percutaneous enteral gastric (PEG) tube when nutrients cannot be obtained through the alimentary route. Under Assessment, the facility document read Physician's orders for feeding shall include type, amount, frequency and strength of nutritional formula and amount of water used for flushing. Under Preparation, the facility document read:</p> <ul style="list-style-type: none"> - Ensure enteral feeding is the correct formula, amount and check frequency ordered - Confirm that the correct order is being given to the correct resident. 		

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<p>F 0725</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Provide enough nursing staff every day to meet the needs of every resident; and have a licensed nurse in charge on each shift.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 46873</p> <p>Based on clinical record review, observations, resident interviews and staff interviews, the facility failed to answer the residents' call light in less than 15 minutes for 3 resident call lights seen during observation. Additionally, two residents (Resident #1 and Resident #50) reported extended call light response time during resident interviews. The facility reported a census of 48 residents.</p> <p>Findings include:</p> <ol style="list-style-type: none"> The Social Services Assessment of Resident #50 dated 6/6/24 documented the resident to have a Brief Interview of Mental Status (BIMS) score of 15, indicating cognition intact. <p>On 6/10/24 at 11:19 am, Resident #50 stated that she experiences long wait times for her call light to be answered, often greater than 15 minutes.</p> <ol style="list-style-type: none"> The Minimum Data Set (MDS) assessment of Resident #1, dated 3/14/24 revealed a BIMS score of 14, indicating cognition intact. <p>On 6/10/24 at 11:25 am, Resident #1 stated she felt the facility to be short staffed and stated call lights are answered after at least 15 minutes and longer.</p> <ol style="list-style-type: none"> During observation beginning 6/12/24 at 11:55 am, it was noted that the staff tablet sitting at the nurses station area near room [ROOM NUMBER] could audibly be heard of call lights ringing. When the tablet was observed, it showed the call light for room [ROOM NUMBER], Bed B, had been turned on at 11:23:20 am. <p>During the continued observation, room [ROOM NUMBER], Bed A, was turned on at was turned on at 11:54:54 am and room [ROOM NUMBER], Bed A, was turned on at 12:04:53 pm.</p> <p>On 6/12/24 at 12:11 pm Staff D, Certified Nurse Aide (CNA) stated the staff is notified of call lights being on by hearing them ring from the tablet at the desk. She walked to the nearest tablet, at the station by the 320 rooms and noticed the tablet was turned off. She stated she was unaware of why it was turned off. She powered the tablet back on and stated she had to wait to log back into the system. On 6/12/24 at 12:12 pm, the tablet was logged back into. When Staff D was asked if she was aware that room [ROOM NUMBER], Bed B had been ringing for over 40 minutes, she stated she did not know that but had been in the room a few minutes earlier.</p> <p>On 6/12/24 at 12:14 pm, Staff E, CNA cleared the call light for room [ROOM NUMBER], Bed B. (Approximately 51 minutes)</p> <p>Observation continued for the tablet for the hall near the 320 rooms. The Director of Nursing came to check the monitor at 12:23 pm and then left the area. She returned at 12:26 pm to check the monitor again. No other staff was observed checking the monitor.</p> <p>(continued on next page)</p>		

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<p>F 0725</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>room [ROOM NUMBER], Bed A, which had been triggered at 11:54:54 was answered at 12:26 pm, a total of 31 minutes. room [ROOM NUMBER], Bed A, which had been triggered at 12:04:53 pm was answered at 12:27 pm, a total of 22 minutes.</p> <p>Observation was continued with the first tablet, near room [ROOM NUMBER] on 6/12/24 from 1:10 pm to 1:29 pm. The call lights could be heard ringing but despite numerous staff being in the area, no staff was observed checking the tablet to see what call lights were ringing.</p> <p>On 6/13/24 at 9:20 am, the Administrator stated via email the facility does not have a policy regarding call lights. She stated the facility is to follow the regulatory expectation.</p>		

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<p>F 0880</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide and implement an infection prevention and control program.</p> <p>40905</p> <p>Based on observation, policy review, and staff interview the facility failed to implement appropriate infection prevention and control practices during medication administration by staff not completing hand hygiene between residents and touching pills with a bare hand. The facility reported a census of 48 residents.</p> <p>Findings include:</p> <p>During a continuous observation on 6/11/24 from 8:25 AM - 8:48 AM, during the medication pass for 3 different residents, Staff C, Licensed Practical Nurse prepared and administered medication consecutively to 3 different residents without completing hand hygiene before or after administering the medications. Staff C poured 2 pills into the lid of a medication bottle and used her bare fingers to place 1 pill back into the bottle and proceeded to pull another pill out of a medication bottle with her bare finger.</p> <p>Facility policy, Medication Administration revised 4/1/23 documented to wash hands with soap and water prior to beginning medication pass and alcohol waterless sanitizer is acceptable between residents.</p> <p>Interview on 6/13/24 at 9:52 AM, the Director of Nursing stated her expectation is for staff to complete hand hygiene before and after administering medications, between residents and to not touch medications with bare hands, use gloves or pour the pill back into bottle without touching the pills.</p>		