STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	165531	A. Building B. Wing	07/25/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Garden View Care Center	1200 West Nishna Road Shenandoah, IA 51601

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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 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	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** 49628 Based on clinical record review, staff interviews, and policy review the facility failed to revise and update the Comprehensive Care Plan for 4 of 17 residents (Resident #13, #2, #6, and #27) reviewed. The facility reported a census of 40 residents. Findings include: 1. Record review of the Minimum Data Set (MDS) 5 Day Medicare assessment for Resident #13, dated 5/7/24 documented a Brief Interview of Mental Status (BIMS) score of 13 indicating the resident cognitively intact. The document revealed the resident required dependence for toileting, bathing, lower body dressing, shoes, and partial moderate assistance for upper body dressing. The resident was dependent for rolling, lying to and from seated positions and transfers. Resident #13 had occasional bowel and bladder incontinence. Diagnoses included: orthostatic hypotension, renal insufficiency, hip fracture (fracture unspecified part of neck of left femur, subsequent for closed fracture with routine healing, seizure disorder/Epilepsy (conversion disorder with seizures or convulsions), left artificial hip joint; pain medication as needed, pain reported occasionally Resident #13's Baseline Care Plan dated 5/2/24 indicated in Section E the resident required total dependence for transfers. Section D of the document revealed safety concerns of history of falls, history of fall related injuries. Resident #13's Care Plan printed on 7/23/24 revealed the resident was a moderate risk for falls with initiation on 7/21/22 and revised 9/20/22. The interventions for staff to utilize included anticipating and meeting the resident's needs (9/20/22), resident required a safe environment (6/5/23), and evaluation for use of a walker (9/20/22). A focus area of renal insufficiency (revised 3/27/24) indicated an intervention for staff to use included assisting with activities of daily living (ADLs) and ambulation as needed. Watch for shortness of breath (SOB) and match the level of assistance to residents current energy level (initiated 7/19/23). The ADL focus revision was on 3/27/24 with the intervention of 2 staff participation to use the toilet, 2 staff to participate with transfers, and 2 staff to reposition and turn in bed. On 7/23/24 at 9:20 AM Staff B, Nurse Consultant, and the Director of Nursing (DON) stated the Care Plans should coincide with physician orders and reflect the resident's needs. (continued on next page)

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

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 7/23/24 at 2:56 PM Staff I, Physical Therapist Assistant (PTA), and Staff J, Occupational Therapist Registered (OTR), stated Resident #13 sustained a fall 2 years prior when preparing to go on a home safety assessment and sustained a left hip fracture. Staff I and Staff J stated the resident was not recommended for surgery and had been non weight bearing (NWB) until March 2024. The staff stated the resident had a hip replacement in 3/24 and while receiving therapy in the hospital the resident stood up and sustained a multisite left femur fracture. The resident returned to the facility with NWB to the left lower extremity (LLE). Staff stated the resident could not utilize a NWB dependent mechanical lift due to hip precautions/pain and the resident was unable to stand. Staff stated the resident needed to stand pivot independently or use a NWB dependent mechanical lift to attend dialysis. Staff I and J stated after missing 5 days of dialysis the resident returned to the acute hospital and remained there for 6 weeks. The staff stated upon return from the hospital (5/1/24) the resident had a LLE immobilizer and was NWB. Resident #13 could use the NWB dependent mechanical lift as hip precautions had been discontinued. The staff stated if a resident had a change in status/transfer/self care, the therapy department utilized a Therapy Communication Form to notify the facility. The document would go to the nurses station and would be placed up in the resident's room. Staff I and Staff J reiterated at the time 5/19/24 the resident required a NWB dependent mechanical lift. On 7/24/24 at 12:50 PM the Administrator stated the facility was a no lift facility and would not have required 2 staff for transfers. The Administrator did acknowledge the Care Plan may have indicated 2 staff when Resident #13 returned from the hospital briefly in March and was unable to use a non weight bearing (NWB) dependent mechanical lift due to precautions. The Administrator concurred the Care Plan was not up to date. 2. Review of the Minimum Data Set (MDS) assessment for Resident #2 dated 5/8/24 revealed a Brief Interview for Mental Status (BIMS) score of 15/15 indicating intact cognition. The MDS further revealed diagnosis of chronic kidney disease, stage 5, and morbid obesity. Review of Resident #2's Care Plan dated 7/23/24 revealed Resident #2 had a focus area of fluid restriction of 1500cc/24/hrs. due to: lymphedema and renal insufficiency initiated on 3/8/23. Interventions included: May have 400cc with lunch, document amt consumed. May have 200cc with the AM med pass. May have 120cc during afternoon/eve prn med pass. May have 400cc with dinner, document amt consumed. May have 200cc during night med pass. May have 400cc at bedtime, document amt consumed. Obtain weights as ordered. Date Initiated: 06/05/2014. Physician orders for Resident #2 dated 9/6/23 revealed fluid restrictions, 2000cc every 24 hours, Dietary provides 980 cc and nursing 1020cc every shift for monitoring of fluid intake related to chronic kidney disease, stage 5. Document amount of fluid consumed between meals. 3. Record review of the MDS assessment for Resident #6, dated 6/15/24 documented a BIMS score of 15/15 indicating normal cognition. Section M, Skin conditions, identified clinical assessment, at risk for pressure ulcers, no pressure ulcers, 2 venous and arterial ulcers present. Pressure reducing device for bed, nonsurgical dressing, ointments/medications. Resident #6 had diagnosis of end stage renal disease, chronic venous hypertension with ulcer of left lower extremity (LLE), and venous insufficiency (chronic) peripheral. (continued on next page)

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	The Care Plan revealed a focus area of actual impairment to skin integrity to the posterior right lower extremity (RLE), left foot, toes, wound care at [NAME] County Memorial Hospital initiated 7/14/23 and revised 717/23. Interventions identified for staff included 9/13/21 start dressing 2nd toe of the left foot, change every day. Follow physician orders for treatment of injury, monitor/document location, size and treatment of skin injury. Report abnormalities, failure to heal, signs/symptoms of infection, maceration etc. to physician, and obtain blood work and labs as ordered by physician with initiation on 8/2/21 and revision on 6/29/23. Resident #6's treatment order revealed 1) cleanse wounds with house wound cleanser; 2) apply Aquacel AG to wounds; 3) cover with ABD pads; 4) wrap c kerlix; 4) change one time a day for wounds related to Chronic Venous Hypertension (Idiopathic) with Ulcer of Left Lower Extremity. Change daily due to increase in drainage. Do not use Xeroform. Dated 2/10/24. 4. Record review of the MDS assessment for Resident #27, dated 6/15/24 documented a BIMS score of 15/15 indicating normal cognition. The resident had a diagnosis of renal insufficiency, renal failure, or end stage renal disease. The resident received dialysis. Resident #27's Care Plan focus area revealed renal insufficiency, end stage renal disease, hydronephrosis, UTI and is dependent on hemodialysis with date initiated of 05/03/2024 and revision on 06/12/2024. Interventions for staff included: monitor/document/report to physician as needed edema; weight gain of over 2 pounds a day; neck vein distension; difficulty breathing (Dyspnea); increased heart rate (Tachycardia); elevated blood pressure (Hypertension); skin temperature; peripheral pulses; level of consciousness ; monitor breath sounds for crackles; with date initiated on 05/03/2024 and revision on 06/12/2024. A focus area potential problem related to the right foot abscess with incision, end stage renal disease, low protein levels. Intervention for staff included weight at the same time of day and record; the resident is weighed at (TIME) using (specify scale) with date initiated 4/30/24 and revised 6/12/24. Provide, serve diet as ordered: Consistent Carbohydrate /Renal diet and 2000cc/24hrs. Monitor intake and record every meal with date initiated 04/30/2024. Resident #27's Physician Orders dated 6/1/24 revealed Fluid Restrictions, _2000____cc/24 hrs. Dietary provides _____cc, Nsg provides _____cc every shift for Monitoring of fluid intake. Document amount of fluid consumed between meals. The Electronic Health Record (EHR) revealed fluid intakes between meals were recorded on the Treatment Administration Record (TAR). The Task Tab of the EHR did not provide location for recording of fluids consumed at meals. Weight records for Resident #27 revealed the previous 6 months weights were taken on 6/24, 5/30, 4/29. The facility policy Care Plan Development dated 8/15 revealed the Comprehensive Care Plan is derived from the MDS assessment, and includes the resident needs/strengths, and be reviewed and revised as needed. The document indicated the Care Plan is an integral to the provision of care to the resident and will be available to team members responsible for providing care and services. Documentation must be consistent with the resident's Plan of Care and revisions completed as needed.

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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 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate treatment and care according to orders, resident's preferences and goals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 41785 Based on observations,staff interviews, provider interview, clinical record review and policy review the facility failed to ensure that residents had accurate and timely assessment and interventions for 2 of 13 residents reviewed. Resident #40 and Resident #6 had chronic skin ulcers, staff failed to complete weekly skin assessments and failed to provide skin treatments as ordered. The facility reported a census of 40 residents. Findings include: 1. According to the Minimum Data Set (MDS) assessment dated [DATE], Resident #40 was unable to complete a Brief Interview for Mental Status (BIMS). He had moderately impaired cognitive skills for daily decision making and disorganized thinking. The resident required set up assistance with eating and upper body dressing, partial assistance with lower body dressing and toileting hygiene. His diagnosis included heart failure, hypertension, peripheral vascular disease, aphasia and cerebrovascular accident (CVA). The Care Plan updated on 2/22/24, showed that Resident #40 had hemiplegia/hemiparesis related to CVA. He had difficulty communicating and would speak word salad and use hand gestures. He was receiving pain medication therapy, had altered cardiovascular status and was on diuretic therapy, furosemide. Staff were to administer medications as ordered and to monitor for side effects. Resident #40 had altered skin integrity related to venous stasis ulcers to bilateral lower legs. Staff were to monitor with weekly skin checks. In an observation on 7/22/24 at 12:00 PM, Resident #40 was sitting in his wheel chair, wearing shorts. The skin on his bilateral lower limbs was very tight, swollen and blotchy red with open areas. He was wearing gripper socks and no support hose. The resident had difficulty speaking and answered questions with just one word or a head nod. When asked if he should have his legs wrapped or support hose on, he said yes. A review of the electronic chart showed the following treatment orders: a. Order dated 3/22/24 at 8:57 AM, to cleanse with soap and water, apply moisturizing lotion to intact skin, cover ulcers with Xerofoam than apply UNNA boot, (compression dressing for leg and foot wounds) roller gauze then secure with Coban Wrap (breathable self-adherent wrap) on Tuesdays and Fridays. b. Order dated 4/4/24 at 1:43 PM, to cleanse the wound on the right foot 2nd toe, apply Puracol Plus (collagen wound dressing) to wound base and secure with Band-Aid every other day on Tuesday and Friday for venous stasis ulcer. The Treatment Administration Record (TAR) showed that the above treatments were not completed for June on the 7th, 18th, 21st, 25th. The nursing notes lacked explanation as to why the treatments were not completed. Weekly Skin Assessment showed the following: (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	a. 5/26/24 at 11:10 AM excoriated area in abdomen and groin. No mention of legs or toes. b. 6/29/24 at 2:16 AM abdomen and groin listed with no measurements. No mention of toes or legs. c. 7/14/24 at 1:11 AM right lower leg and left lower leg with no measurements sees wound care. d. 7/19/24 at 6:49 PM groin and bilateral lower extremity listed as site. No measurements, no definition or mention of the toes. An order dated 6/7/24 at 6:00 PM showed that staff were to complete head to toe skin checks weekly and to report any new skin areas. The chart lacked weekly skin assessments on 6/7/24 and 6/21/24. A Progress Note from Wound Care Services, dated 7/12/24 at 1:00 PM, showed that the bilateral lower extremities had scattered open lesions to bilateral ankles. There were larger areas of dermatitis to the right medial proximal lower leg measuring 2 centimeters (cm) x 6 cm x 0.2 cm. Left posterior leg measured 3 cm x 3 cm x 0.2 cm. The wound to the right foot third tow, after debridement of callous, measured 0.2 cm x 0.5 cm x 0.2 cm. Please monitor right 3rd toe closely for cellulitis. Nursing notes from 7/12/24 through 7/25/24 lacked reference to the condition of the toes on his right foot. On 7/23/24 at 2:22 PM, Staff A Registered Nurse (RN) provided treatment to the legs and to the toes on the right foot. The resident has an open spot on the back of his right knee and the back of his left calf. Resident #40 said that he had some pain in those areas. Staff A mentioned that the resident's legs were more swollen than the last time she had applied the treatments, one week prior. Staff A said that the open spot on his left leg was a new area. The Medication Administration Record (MAR) for Resident #40, showed an order dated 2/20/24 at 2:23 PM, for furosemide 20 milligrams (mg) (diuretic helps body get rid of extra water by increasing urine output) daily. The clinical record showed that the resident refused the medication 15 times in the month of June and 9 times in July. On 7/24/24 at 7:51 AM, Staff C, Certified Medication Aide (CMA) said that Resident #40 would often refuse the furosemide. She said that he would lay all of his pills out on the table, would single out the furosemide and say no. She said that she had tried to educate him many times about the edema. She said that she told the nurses whenever he refused. She didn't know if the doctor had been contacted. On 7/24/24 at 9:15 AM, the doctor said that he was aware that Resident #40 would occasionally refuse the furosemide. In relationship to the fluid retention, the doctor was mostly concerned about the condition of the skin on his legs. He said the last time that he saw the resident, he didn't think that he looked at the legs because the resident was focused on other concerns. He said that he would like to have updates on the skin condition if/when it got worse. According to a facility policy titled: Skin & Wound Care Management dated 6/2015, staff were expected to perform weekly skin reports. (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	A facility policy dated 6/2015 and titled: Clinical Change in Condition, staff were to perform daily observation and communication to identify changes in a resident that required further investigation. 49628 2. Record review of the Minimum Data Set (MDS) assessment for Resident #6, dated 6/15/24 documented a Brief Interview of Mental Status (BIMS) score of 15/15 indicating normal cognition. Section M Skin conditions identified clinical assessment, at risk for pressure ulcers, no pressure ulcers. 2 venous and arterial ulcers present. Pressure reducing device for bed, nonsurgical dressing, ointments/medications. Resident #6's Treatment Administration Record (TAR) for 7/2024 revealed 3 dates (7/2, 7/12, 7/22) wound care was not signed off as completed. The treatment order read 1) cleanse wounds with house wound cleanser; 2) apply Aquacel AG to wounds; 3) cover with ABD pads; 4) wrap c kerlix; 4) change one time a day for wounds related to Chronic Venous Hypertension (Idiopathic) with Ulcer of Left Lower Extremity. Change daily due to increase in drainage. Do not use Xerofoam. Dated 2/10/24. The Care Plan revealed a focus area of actual impairment to skin integrity to the posterior right lower extremity (RLE), left foot, toes, wound care at a local Hospital initiated 7/14/23 and revised 717/23. Interventions identified for staff included 9/13/21 start dressing 2nd toe of the left foot, change every day. Follow physician orders for treatment of injury, monitor/document location, size and treatment of skin injury. Report abnormalities, failure to heal, signs/symptoms of infection, maceration etc. to MD, and obtain blood work and labs as ordered by physician with initiation on 8/2/21 and revision on 6/29/23. Weekly Skin Assessments reviewed for the past month noted 3 assessments. Assessment 7/18/24 revealed open areas on the right left leg (RLL) front (vascular), left lower leg (LLL) (vascular), right hand back (skin). There were no measurements. Assessment 7/4/24 revealed open areas with no site information and no measurements. Assessment on 6/20/24 revealed open areas, the type of venous insufficiency, no measurements, location on the bilateral lower extremities (BLE). On 7/24/24 at 1:20 PM the Director of Nursing (DON), Registered Nurse, stated the Weekly Skin Assessments should be thoroughly completed each week. The DON indicated the dates were originally set up to coordinate with the resident's bath days. The DON stated if a resident sees wound care the nurses will sometimes not do measurements and defer to the measurements from the wound clinic. The DON stated Resident #6 does go to the [NAME] Wound Clinic. The DON indicated it was her expectation that the nurses complete measurements and the assessments weekly, and not depend on wound clinic documents. The DON stated if orders are written to have a treatment done daily, it would be expected the treatment would be done daily. The staff stated if the treatment could not be completed due to the availability of the resident, the TAR would be left blank and would alert red to the oncoming shift. The shift that wasn't able to complete the treatment would notify the oncoming shift of the treatment that needed to be completed and that shift would complete the treatment. The DON stated the Care Plans should reflect the current needs of the resident. The Care Plans were currently being completed by a staff off site. The facility just hired a staff to be the Unit Manager and this staff would be responsible for the MDS, Care Plans, and higher need Skin Assessments.

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F 0689 Level of Harm - Actual harm Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 49628 Based on observations, clinical record review, hospital document review, resident and staff interviews, and facility policy review, the facility failed to protect residents from possible accidents and injuries for 2 of 3 residents (Resident #13, and #39). The facility reported a census of 40 residents. Findings include: 1. Record review of the Minimum Data Set (MDS) 5 Day Medicare assessment for Resident #13, dated 5/7/24 documented a Brief Interview of Mental Status (BIMS) score of 13 indicating the resident cognitively intact. The document revealed the resident required dependence for toileting, bathing, lower body dressing, shoes, and partial moderate assistance for upper body dressing. The resident was dependent for rolling, lying to and from seated positions and transfers. Resident #13 had occasional bowel and bladder incontinence. Diagnoses included: orthostatic hypotension, renal insufficiency, hip fracture (fracture unspecified part of neck of left femur, subsequent for closed fracture with routine healing, seizure disorder/epilepsy (conversion disorder with seizures or convulsions), left artificial hip joint; pain medication as needed, pain reported occasionally. Resident #13's Baseline Care Plan dated 5/2/24 indicated in Section E the resident required total dependence for transfers. Section D of the document revealed safety concerns of history of falls, history of fall related injuries. Resident #13's Care Plan printed on 7/23/24 revealed the resident was a moderate risk for falls with initiation on 7/21/22 and revised 9/20/22. The interventions for staff to utilize included: anticipating and meeting the resident's needs (9/20/22), resident required a safe environment (6/5/23), and evaluation for use of a walker (9/20/22). A focus area of renal insufficiency (revised 3/27/24) indicated an intervention for staff to assist with activities of daily living (ADLs) and ambulation as needed. Watch for shortness of breath (SOB) and match the level of assistance to residents current energy level (initiated 7/19/23). The ADL focus revision was on 3/27/24 with the intervention of 2 staff participation to use the toilet, 2 staff to participate with transfers, and 2 staff to reposition and turn in bed. The electronic health record (EHR) revealed on 7/21/24 at 4:30 PM Resident #13 had increased pain, swelling and bruising to the left lower extremity (LLE). The document revealed a staff had attempted to transfer the resident to the wheelchair for toileting and the resident had fallen on 7/19/24. The resident was taken to the emergency department where the resident was diagnosed with a left ankle fracture and was non weight bearing (NWB). Resident #13's hospital medical record dated 7/21 and 7/22/24 revealed diagnosis of 1. acute comminuted impacted fracture of the distal tibia extending to the tibia plafond. 2. Acute comminuted fracture of the distal fibula above the level tibiofibular syndesmosis. 3. acute longitudinal mid calcaneal fracture extending to the mid subtalar joint. 4. Surround ankle swelling with ankle effusion. Swelling in the dorsum of the foot. (continued on next page)

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F 0689 Level of Harm - Actual harm Residents Affected - Few	On 7/23/24 at 2:14 PM Staff G, Certified Nursing Assistant (CNA) stated Resident #13's call light was on and she went into the room. The staff asked Resident #13 what she needed and the resident stated she was going to the bathroom. The staff stated she asked the resident if she needed the bedpan and the resident indicated no she was using the bathroom. Staff G stated Resident #13 was normally lying down in bed upon entry into the room, but at this time the resident was seated on the edge of the bed. The staff stated the resident stated she had been cleared by therapy for stand pivot transfers. Staff G stated she placed the wheelchair in front of the resident as the resident directed, the resident locked the brakes, and placed her arms on the armrests. The staff stated she went to help her, the resident stood for a couple of seconds and her leg gave out. Staff G stated she called Staff E for assistance. Staff E, Licensed Practical Nurse (LPN), and Staff H, LPN, came into the room. Staff G stated Resident #13 did not hit her head, was on her knees with her upper body on the wheelchair. Staff G stated Staff H and herself put a gait belt on the resident and attempted to get the resident up. Staff G acknowledged she had not put a gait belt on prior to this as she didn't know where one was. Staff G stated as Resident #13 was unable to get up from this position, the resident was lowered to the floor. The sling was obtained and placed under the resident. Resident #13 stated she thought she had twisted her ankle. Staff G stated she moved Resident's LLE and Staff H moved the right lower extremity (RLE) into position for use of the NWB dependent mechanical lift. Staff G stated she told Staff E that Resident 13's ankle looked like Jell-o. The staff stated she restated the RLE did not look right to Staff E once the resident was in bed. Staff G stated when Resident #13 was back in bed, it was noticed the resident did not have gripper socks on her feet (feet were bare) and they were donned at that time. Staff G stated Staff E directed her to get vitals. Staff G stated she took her blood pressure 4 times as it was low and she wanted to make sure it was right. Staff G stated the resident required a NWB dependent mechanical lift. The staff stated the resident had recently had the LLE brace removed and was more independent in self care. Staff G stated the resident was able to put on her brief, pants, and rolled in bed. The staff stated there were not big changes in Resident 13's abilities on dialysis and non-dialysis days as the resident was compliant with attending dialysis. Staff G stated she would know about a resident's assistance needs by reading the communication book, however unsure if this still exists, the CNA's report, and nurses would notify staff. The CNA did not recall anything specific to this resident during the report that night. (continued on next page)

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F 0689 Level of Harm - Actual harm Residents Affected - Few	On 7/23/24 at 2:56 PM Staff I, Physical Therapist Assistant (PTA), and Staff J, Occupational Therapist Registered (OTR), stated Resident 13 sustained a fall 2 years prior when preparing to go on a home safety assessment and sustained a left hip fracture. Staff I and Staff J stated the resident was not recommended for surgery and had been NWB until March 2024. The staff stated the resident had a hip replacement in 3/24 and while receiving therapy in the hospital the resident stood up and sustained a multisite left femur fracture. Resident #13 had surgery with screws and wires to put the bone back together. The resident returned to the facility with NWB to LLE. Staff stated the resident could not utilize a NWB dependent mechanical lift due to hip precautions and the resident was unable to stand. Staff stated the resident needed to stand pivot independently or use a NWB dependent mechanical lift to attend dialysis. Staff I and J stated after missing 5 days of dialysis the resident returned to the acute hospital and remained there for 6 weeks. The staff stated upon return from the hospital (5/1/24) the resident had a LLE immobilizer and was NWB. Resident #13 could use the NWB dependent mechanical lift as hip precautions had been discontinued. Staff I stated the immobilizer was to be in place at all times except for bathing. Staff I and Staff J stated trials had been to complete sit to stand at the parallel bars with the resident unsuccessful. The staff stated on 7/11/24 Resident #13 returned from the orthopedic physician with LLE immobilizer discontinued, range of motion (ROM) as tolerated, weight bearing as tolerated (WBAT) to the LLE, and follow up if needed. Staff I and Staff J stated therapies worked together on sit to stand at the parallel bars and were not successful. Staff J stated that Resident #13 on 7/16/24 stated she was worn out and couldn't complete the sit to stand as she had tried herself in her room. Staff I and Staff J stated education had been provided to the resident regarding safety and progression of therapy, and due to the extensive time of NWB the resident had significant weakness in the lower extremities. The staff stated the resident was cognizant and knew she had been unable to complete trials in therapy; however the resident had decreased safety, cognition and insight into abilities. Staff I and Staff J stated Resident #13 was still in therapy, and would work on strengthening. The staff stated if a resident had a change in status/transfer/self care, the therapy department utilized a Therapy Communication Form to notify the facility. The document would go to the nurses station and would be placed up in the resident's room. Staff I and Staff J reiterated at the time of the fall the resident required a NWB dependent mechanical lift. On 07/23/24 at 3:35 PM Resident #13 stated she wanted to get up and go to the bathroom on 7/19/24. The resident stated there was 1 CNA present and no gait belt, as she did not have a brief on just her top. Resident #13 stated she started to pivot and her right foot slid under the bed, and her arms and chest were on the wheelchair. Resident #13 stated the staff got a sling to get her off of the floor. The resident stated she didn't think any more about it as there was no pain, she thought she had sprained her ankle. Resident #13 stated she stayed in bed on Saturday, per normal, and when she tried to move around to get up on Sunday (7/21/24) she had increased pain. The resident requested nursing to wrap her ankle, as she thought she had sprained it. Resident #13 stated she went to the hospital and had 3 fractures. The resident stated she had been transferring with a NWB dependent mechanical lift prior to fall and now transferring that way again. The resident stated it was her own decision to transfer to the wheelchair and had set it up to do what she had done in therapy. (continued on next page)

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Garden View Care Center	1200 West Nishna Road Shenandoah, IA 51601

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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 0689 Level of Harm - Actual harm Residents Affected - Few	On 7/24/24 at 11:40 AM Staff E, Licensed Practical Nurse (LPN), provided the following information regarding the sequence of events on 7/19/24. Staff E stated she was getting a report from Staff H, LPN, when she received a call from Staff G, CNA, stating a nurse was needed to come to the resident's room. Staff E and Staff H went to the Resident #13's room and observed the resident on her knees with the top part of her body on a wheelchair in front and legs under the bed but not touching the bed. Staff G, E, and Staff H moved the wheelchair, placed the sling under the bed, and slid the resident out away from the bed to connect to the NWB dependent mechanical lift. The staff stated she could visualize the leg/ankle. Staff H moved the resident leg/ankle with the resident having no c/o pain. Resident #13 was transferred into bed. The staff stated Staff G stated the resident told her that she was released from therapy and refused to use the NWB dependent mechanical lift as she could transfer. Staff E stated the resident is very aware of things and could have stated that. Staff E stated she faxed the physician notifying of the fall. Staff E stated she would call the physician if the resident had hit head, or had an obvious injury, change in vitals. The staff stated she did not notify the Director of Nursing (DON), as there had been several DON's in the past few months and one DON has specified not to contact at night. The staff couldn't remember which DON it was. The staff stated the resident had no c/o pain on Friday night or Saturday night. Staff E stated an assessment was completed and placed in the Risk Management Document. Blood pressure was taken 3 different times as was low. Staff E stated she forgot to put the fall on the 24 hour sheet and in the Progress Notes. The staff stated as the fall was witnessed it did not trigger the Fall Assessment. On 7/24/24 at 12:50 PM the Administrator stated the DON and/or the Administrator should have been contacted on the night of the fall. The Administrator stated assessments were to be completed at the time of the fall and before moving the resident to ensure there was not an injury. The Administrator stated Staff E did not complete a Fall Assessment as the staff when completing the Risk Assessment did not select the correct category and therefore Fall Assessment did not trigger for completion. The Administrator indicated that Resident #13 has a history of lower blood pressures thus it may have required multiple assessments. The Administrator indicated the facility was a no lift facility and would not have required 2 staff for transfers. The Administrator did acknowledge the Care Plan may have indicated 2 staff when Resident #13 returned from the hospital briefly and was unable to use a NWB dependent mechanical lift due to precautions. The Administrator concurred the Care Plan was not up to date. On 7/24/24 at 1:40 PM the DON indicated the process for CNA finding a resident on the floor was to look for bodily fluids, call the nurse and teammates to get assistance. The nurse would complete a head to toe assessment, including vitals, prior to moving the resident with questions asked including what happened, pain, hitting of limb/head. Based on the assessment document pain and would seek physician orders for x-ray. If the resident complained of head pain/increased confusion or if the fall was unwitnessed neuro checks would be initiated. If there was no obvious injury the use of NWB dependent mechanical lift would be used to get the resident off of the floor. The DON stated a physician should be called, not faxed, to notify of a fall. Depending upon whether the resident was their own responsible part an emergency contact or Power of Attorney would be contacted, as well as the Facility Administrator and/or the DON. The DON stated a Fall Assessment should be fully completed. The DON indicated the Fall Assessment would be triggered from the Risk Assessment by selecting fall as the category. The DON stated an immediate intervention should also be put into place at the time of the fall. The DON expected a Progress Note would be entered into the EHR with the head to toe assessment, what happened, contacts made. (continued on next page)

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F 0689 Level of Harm - Actual harm Residents Affected - Few	On 7/24/24 at 2:05 PM Staff J, OTR, stated the Therapy Communication Form was utilized to communicate all changes in therapy to the facility. The document required the signature of the therapist and a representative from the facility acknowledging the change. Staff I, PTA, stated the facility was a no lift facility and 2 person transfers were not typically done. Staff I stated when a Therapy Communication Form was completed it was taken to the nurse in charge of that resident for education and signature, the CNA working with that resident was trained in the change, a copy was placed in the folder for scanning to EHR and Care Plan updating, and was posted in the resident's room. Staff I stated she would post in the resident's room during a treatment session to ensure completed and would document the posting. On 7/24/24 at 2:15 PM the Administrator stated the facility was moving to a no lift facility to ensure the safety of the residents and staff. The Administrator stated if there were special circumstances requiring a 2 person transfer there would be specific training for that resident. The Administrator acknowledged a person transitioning from a NWB dependent mechanical lift to stand pivot of one assist would be hard. The Administrator stated transitioning from a NWB dependent mechanical lift to weight bearing mechanical lift to stand pivot transfer would be a more natural progression. On 7/24/24 at 2:20 PM Staff K stated she would ask the nurse or DON about a resident's abilities, and ask to see a Care Plan. The staff stated if a resident had a change in function would ask the nurse or DON, but couldn't tell how she would know if someone had a change in function prior to her shift. On 7/25/24 at 11:26 AM the DON stated she felt every resident that requires assistance to transfer should be issued a gait belt or every CNA should be issued a gait belt for use with individuals needing assistance to prevent having to look for gait belts at times of transfers. The DON expected staff assisting residents with transfers utilize gait belts. Review of the facility's Fall Risk Reduction and Management Policy revised 12/15 revealed components of the falls risk reduction program contains, but not limited to identification of risks for falls, implementation of individualized interventions, interdisciplinary review of each fall, post fall care and management, and analysis of fall data for quality improvement opportunities. Procedures identified in the document include identified interventions with the fall risk, individualized goals and interventions in the care plan, and completion of the admission/re-admission documents and review of the initial Care Plan. Higher fall risk was defined as an individual with 2 or more falls in the previous 6 months, history of falls and determination by the Interdisciplinary Team. The documentation revealed the care plan would need to be revised with new interventions and as indicated, and changes would be communicated to the caregiving team. Review of the facility's Clinical Change in Condition Management Policy revised 6/15 revealed the resident would be assessed if there was a change in condition, review of the medical record, review of the condition with a Registered Nurse (RN), notification to the physician, complete documentation requirements, review the Care Plan interventions and modify, and update the staff of changes. 41785 2. According to the MDS assessment dated [DATE], Resident #39 had a BIMS score of 9 (moderate cognitive deficit). He required partial assistance with eating, dressing, toileting and transfers. (continued on next page)

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F 0689 Level of Harm - Actual harm Residents Affected - Few	The Care Plan updated on 1/29/24, showed that Resident #39 had chronic pain related to lung cancer and urothelial carcinoma of the bladder. He had an Activities of Daily Living (ADL) self-care performance deficit and he was a fall risk related to dementia. Staff were to provide frequent checks due to falls and to review information on past falls and attempt to determine cause of falls and remove any potential causes if possible. Observations revealed the following: On 7/22/24 at 11:50 AM, Resident #39 was in his recliner, sitting on edge of seat. The wheel chair was behind the recliner, and the call light was on the floor near the bed. On 7/22/24 at 2:32 PM, the resident was in his room, in the wheel chair, bent over and reaching for his shoes on the floor. On 7/22/24 at 3:02 PM, the resident was in his room, in the wheel chair. His glasses were on the floor and he is reaching for them. A review of the clinical record revealed that Resident #39 had the following falls since June 1,2024: a. 6/5/24 at 12:51 PM, he was found on floor in room said he was trying to reach the bed. b. 6/14/24 at 1:30 AM, he was lying on right side on floor. trying to get my shoes c. 6/15/24 10:20 PM, he was found on the floor, unable to say what happened, no injuries d. 6/16/24 at 6:00 AM, he was found lying on the floor next to the recliner. foot rest still extended. no clothes on trying to get rid of the smell. e. 6/18/24 at 5:35 AM he was standing, holding up brief and went backwards. f. 6/21/24 at 3:00 PM he was in his room alone, tried to transfer self on bed and was found sitting in front of the bed on his knees. g. 6/23/24 at 3:12 PM, he was found on the floor in room, on his hands and knees in front of his wheel chair. h. 6/23/24 at 9:37 PM he was found on the floor in the dining room. He stated that he slid to the floor. i. 6/24/24 at 10:57 AM, found on the floor in his room with the wheel chair behind him. The breaks were not locked. j. 7/4/24 at 3:15 PM found on the floor in his room. k. 7/8/24 at 7:26 PM, he was found on the floor in his room. The dinner tray was on the bedside table. And the wheel chair beside him. (continued on next page)

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F 0689 Level of Harm - Actual harm Residents Affected - Few	l. 7/12/24 at 8:30 PM found on the floor in his room. One shoe under his legs and one shoe under his head. Appears that he took his shoes off and got out of the wheel chair. m. 7/16/24 at 3:45 AM, found in his room on his knees in front of the bed. He was unable to say what happened. n. 7/18/24 at 3:00 PM found on the floor in his room, feet bent under him. I was trying to get on the floor. o. 7/12/24 at 9:00 PM found on flood on his knees in room facing recliner helped him into recliner. On 7/25/24 at 7:20 AM, the Director of Nursing (DON) said that she was aware of the problem of all of the falls that Resident #39 had and this week she was going to propose weekly root cause analysis meetings to determine what could be done differently. She acknowledged that interventions had not been implemented and care planned.

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F 0698 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide safe, appropriate dialysis care/services for a resident who requires such services. 49628 Based on clinical record review, resident and staff interviews, and policy review the facility failed to provide ongoing assessment and oversight for residents before and after dialysis for 2 of 2 residents (Resident #2, and #27) reviewed. The facility reported a census of 40 residents. Findings include: 1. Review of the Minimum Data Set (MDS) assessment for Resident #2 dated 5/8/24 revealed a Brief Interview for Mental Status (BIMS) score of 15/15 indicating intact cognition. The MDS further revealed diagnosis of chronic kidney disease, stage 5, and morbid obesity. Review of Resident #2's Care Plan dated 7/23/24 revealed Resident #2 had a focus area related to hemodialysis and renal failure. Interventions identified for staff included dates of dialysis, assessments per protocol, labs per protocol, and notification to the physician. Review of the Electronic Health Record (EHR) for the month of July 2024 noted 6/9 dialysis documents in the record. Documents 7/19 and 7/17 contained both pre and post dialysis assessments. Documents dated 7/12, 7/10, 7/8 and 7/5/24 contained pre-dialysis assessments and no post dialysis assessments. On 7/24/24 at 12:48 PM Staff A completed Resident #2's post dialysis assessment. The resident ended dialysis treatment early and went to the hospital due to pain in the back. It was reported the resident refused to be weighed upon return to the facility due to pain. Staff A completed hand hygiene, donned gown, and gloves. The staff completed vitals with blood pressure 138/62, temperature 96.2 degrees Fahrenheit, oxygen 99% on 2 Liters via nasal cannula, and heart rate 93. Assessment of resident's pain and location was completed. Staff A listened to the resident's fistula, lungs and stomach. The assessment revealed no concerns. Staff A completed hand hygiene at the end of the assessment. On 7/23/24 at 3:25 PM Resident #2 stated staff do not consistently do assessments before and after dialysis. 2. Record review of the MDS assessment for Resident #27, dated 6/15/24 documented a BIMS score of 15/15 indicating normal cognition. The resident had a diagnosis of renal insufficiency, renal failure, or end stage renal disease. The resident received dialysis. (continued on next page)

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F 0698 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Resident #27's Care Plan focus area revealed renal insufficiency, end stage renal disease, hydronephrosis, UTI and is dependent on hemodialysis with date initiated of 05/03/2024 and revision on 6/12/2024. Interventions for staff included monitor/document/report to physician as needed edema; weight gain of over 2 pounds a day; neck vein distension; difficulty breathing (Dyspnea); increased heart rate (Tachycardia); elevated blood pressure (Hypertension); skin temperature; peripheral pulses; level of consciousness ; monitor breath sounds for crackles; with date initiated on 5/03/2024 and revision on 6/12/2024. A focus area potential problem related to the right foot abscess with incision, end stage renal disease, low protein levels. Intervention for staff included weight at the same time of day and record; the resident is weighed at (TIME) using (specify scale) with date initiated 4/30/24 and revised 6/12/24. Provide, serve diet as ordered: Consistent Carbohydrate /Renal diet and 2000 cc/24 hrs. Monitor intake and record every meal with date initiated 04/30/2024. Review of the EHR for the month of July 2024 noted 3 dialysis documents were completed. Document review revealed incomplete documentation for the assessments completed. On 7/23/24 at 9:20 AM the Director of Nursing (DON) and Staff B, Nurse Consultant, stated assessments should be completed before and after dialysis. Assessments should include vitals, pain and assessment of fistula for bruit and thrill. The staff stated the Care Plan should support the requirements of pre and post dialysis assessments. On 7/23/24 at 2:40 PM Resident #27 stated the facility does not complete assessments upon returning from dialysis. The resident stated the facility may do assessments before dialysis and assessment were completed during dialysis. On 7/24/24 at 10:44 AM the Administrator and DON concurred that assessments for pre and post dialysis are not being completed as required. The staff confirmed Resident #27 attended dialysis 3 times a week. The facility has changed processes to try to improve the consistency. The facility has noted 2 nurses were completing assessments more consistently. Review of facility policy, Dialysis Communication revised 8/2015, revealed the nurse is responsible for completion of vital signs, last blood sugar, dietary concerns, medications pre dialysis, any changes for dialysis and special instructions if necessary. The document would be sent with the resident to dialysis. Upon return from dialysis the resident is assessed for vital signs and status of the shunt/catheter.

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F 0725 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Provide enough nursing staff every day to meet the needs of every resident; and have a licensed nurse in charge on each shift. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 41785 Based on observation, resident interviews, staff interviews, facility document review and clinical record review the facility failed to provide adequate staffing to ensure that the needs of the residents were met, and that the call lights were answered in a timely manner. The facility reported a census of 40 residents. Findings include: 1. According to the Minimum Data Set (MDS) assessment dated [DATE] Resident #35 had a Brief Interview for Mental Status (BIMS) score of 15 (intact cognitive ability). He was totally dependent on staff for eating, hygiene, dressing and transfers. Diagnoses to include injury of C5 level of cervical spinal cord, degeneration of the autonomic nervous system, and neurogenic bowel. The Care Plan last revised on 1/31/24, showed that Resident #35 had a diagnosis of C5 level spinal injury and quadriplegia. He had no control of muscles, and required the use of a mechanical lift for transfers, with 2 assistance. On 7/22/24 at 3:01 PM, Resident #35 said that sometimes the call lights could take up to an hour to get answered I understand, sometimes they are short staffed he said it's mostly at night and they have talked about it more than once at the Resident Council meetings. On 7/25/24 at 7:52 AM Resident Council President said that at every meeting they talk about the concerns with long call light response time. He said that it takes staff 20-30 minutes to answer the call light, worst times are on the weekends and night time. The Resident Council Meetings showed that in May 2024, the call lights were an on-going issues. The June 2024 minutes showed that residents were concerned about the lack of adequate staffing on evenings, resulting in long wait for call lights to be answered. 2. On 7/22/24 at 12:35 PM Resident #14 stated he did not see staff as often since moving to a room that was away from the main hallway. The resident stated he timed the staff on a call light and it took an hour for them to answer. 3. The MDS assessment dated [DATE] for Resident #2 documented a BIMS score of 15 out of 15 indicating intact cognition. On 7/22/24 at 1:01 PM Resident #2 stated call lights were not always answered in a timely manner. The resident stated she timed a call light once and it took one hour and eight minutes. (continued on next page)

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F 0725 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	On 7/25/24 at 7:20 AM, the Director of Nursing (DON) said she was very concerned about the ongoing staffing issues because she was getting pressured to cut staff in order to stay within a budget. She explained that the needs of the residents were very high and the expectations to have fewer staff was unrealistic and unsafe. She said that many of the residents required 2 staff assistance with transfers, extensive wound care, and there were 5 dialysis residents that required regular assessments. She said she had been forced to cut staff where many times in the evenings and overnight, leaving just the nurse and one Certified Nurse Aide (CNA) and the nurses are not able to get the wound treatments completed, and can't get through all the faxes to the doctors and do the charting. On 7/25/24 at 7:55 AM, the Activities Director said that call lights are an on-going conversation. The residents are very aware that there are times of short staffing and will say it's usually at night time when they need to be transferred to the toilet and have to wait a long time to get help. On 7/24/24 at 11:56 AM, Staff E, Licensed Practical Nurse (LPN), said there have been many nights that she and one aide have been the only staff on duty. On dialysis days, they would have the morning nurse come in to help around 2:00 AM but otherwise, with just the two people on, the residents that required 2 assist would just have to wait until the two of them could get there to help. She was aware that before the new DON was hired, there were a string of days with no RN coverage. On 7/24/24 at 1:57 PM, Staff C, Certified Medication Aide (CMA) said that there were times when the nurse on duty was not able to get to all of the treatments and it gets put off to the next shift or it just didn't get done. On 7/24/24 at 2:07 PM, Staff F, CMA said that the nurses do the best they can to try to get to the residents' treatments but it's a lot and they try to work as a team. She said that they are often short staffed and it's usually in the CNA area, when that happens, the CMA's have to jump in and help. The call light wait time gets longer and the residents do notice. On 7/24/24 at 3:35 PM, Staff D, LPN said that when a resident was a 2 assist, and it just her and one aide, they need her to help with transfers but she can't get to the things she needs to do. During the evenings meals, getting residents too and from dinner is a difficult time and the call lights can take longer than 30 minutes and the residents are the ones that suffer. According to the Facility Assessment the ratio of registered and licensed practical nurses to aides shall be sufficient to assure professional guidance and supervision in assuring care of the residents. The facility retains sufficient staffing to maintain a 24-hour licensed nurse (8 hours are a registered nurse, 7-days a week). The facility staffs with 1 nurse and 2 CMA's on day shift. Evening shift 1-1.5 CMA and nurse. CNA/CMA day shift: 4 CNA's, 2 CMA's, Evening shift: 3-4 CNA's, 1-1.5 CMA's, Night Shift: 2 CNA's.

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F 0727 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	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. 41785 Based on staff interviews, facility record review and policy review, the facility failed to provide Registered Nurse (RN) coverage for 8 consecutive hours each day. The facility reported a census of 40 residents. Findings include: A review of the nursing schedule for June and July 2024 revealed that on following days, the facility failed to provide 8 hours of RN coverage: June 10, 19, 22, 28, 11, 20, 27. July 1, 6 and 7th. On 7/23/24 at 11:37 AM, the Administrator acknowledged the gap in RN coverage. She said that it was in the timeframe when they were in transition with the Director of Nursing (DON) so they had to cover the shifts with Licensed Practical Nurses (LPN's.) On 7/24/24 at 11:56 AM, Staff E, LPN said that before the new DON started in July, there were strings of days with no RN coverage. The LPN's have stepped up to fill in the gap the best they could. On 7/24/24 at 3:35 PM, Staff D, LPN, said that the expectations on the nurses was overwhelming and many times they only have 2 staff people on the floor. When residents are a 2 assist, they need her there and she can't get to the things she needs to do. According to the Facility Assessment the ratio of registered and licensed practical nurses to aides shall be sufficient to assure professional guidance and supervision in assuring care of the residents. The facility retains sufficient staffing to maintain a 24-hour licensed nurse (8 hours are a registered nurse, 7-days a week). The facility staffs with 1 nurse and 2 CMA's on day shift. Evening shift 1-1.5 CMA and nurse. CNA/CMA day shift: 4 CNA's, 2 CMA's, Evening shift: 3-4 CNA's, 1-1.5 CMA's, Night Shift: 2 CNA's

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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 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. 49628 Based on observation, staff interview, and policy review the facility failed to prepare, serve and distribute food by failing to provide hand hygiene and glove use according to professional standards. The facility reported a census of 40 residents. Findings include: During a continuous observation on 7/23/24 at 11:00 AM Staff L, Cook, and Staff M, Dietary Aide, completed noon meal preparations. Staff L took temperatures as food items were removed from the steam oven (fried rice, plain rice, fried rice without vegetables, plain chicken) and broccoli from the stovetop. The staff did not clean the thermometer between food items and placed the uncovered thermometer(s) on the countertop throughout the meal process amongst papers, pen, and trash. Staff M moved in and out of the kitchen completing dining room tasks and kitchen tasks without hand hygiene. Staff L carried dirty dishes to the washroom, rinsed, placed dishes in the sink, and returned to the kitchen without hand hygiene. During the meal service there were 2 discarded plates with Staff M taking plates to the dish room to discard, came back to the main kitchen, and continued serving plates to residents without hand hygiene. Staff L stopped serving the meal, obtained a can of soup from the dry goods pantry, returned to the kitchen, and prepared the soup without hand hygiene. Staff L donned gloves without hand hygiene to prepare a peanut butter and jelly sandwich. The staff removed a single glove, placed it on the counter, untied the bread, put a new glove on, prepared the sandwich, removed the gloves and placed them on the counter next to the bread, peanut butter, and jelly. There was no hand hygiene during this task. Staff N delivered the room trays with hand hygiene completed 2/11 opportunities between the rooms. On 7/23/24 at 4:30 PM the Administrator stated the staff should have increased hygiene tasks in the kitchen by wearing gloves and washing hands. The Administrator stated she had noted the need for improved hygiene on occasions when she had been in the kitchen. The Dietary Manager had provided hand hygiene training to the staff. The facility policy Hand Hygiene reviewed in 3/22 revealed hand hygiene is the best way to prevent the spread of germs. The facility requires staff to perform hand hygiene per Center for Disease Control recommendations. The facility did not have a policy for hygiene specific to the kitchen.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	165531	A. Building B. Wing	07/25/2024

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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 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** 41785 Based on observations, clinical record review, staff interviews and policy review the facility failed to implement appropriate hand hygiene and infection control practices to mitigate the spread of pathogens for 2 of 4 resident reviewed. Wound care treatments without hand hygiene for Resident #40 and #6. The facility reported a census of 40 residents. Findings include: 1. According to the Minimum Data Set (MDS) assessment dated [DATE], Resident #40 was unable to complete a Brief Interview for Mental Status (BIMS). He had moderately impaired cognitive skills for daily decision making and disorganized thinking. The resident required set up assistance with eating and upper body dressing, partial assistance with lower body dressing and toileting hygiene. The diagnoses included heart failure, hypertension, peripheral vascular disease, aphasia and Cerebrovascular Accident (CVA). The Care Plan updated on 2/22/24, showed that Resident #40 had Hemiplegia/Hemiparesis related to CVA. He had difficulty communicating and would speak word salad and use hand gestures. He was receiving pain medication therapy, had altered cardiovascular status and was on diuretic therapy, furosemide. Staff were to administer medications as ordered and to monitor for side effects. Resident #40 had altered skin integrity related to venous stasis ulcers to bilateral lower legs. Staff were to monitor with weekly skin checks. In an observation on 7/22/24 at 12:00 PM, Resident #40 was sitting in his wheel chair, wearing shorts. The skin on his bilateral lower limbs was very tight, swollen and blotchy red with open areas. He was wearing gripper socks and no support hose. The resident had difficulty speaking and answered questions with just one word or a head nod. When asked if he should have his legs wrapped or support hose on, he said yes. On 7/23/24 at 2:22 PM, Staff A Registered Nurse (RN) asked Resident #40 if she could administer the wound treatment to his legs and to the toes on his right foot, and he agreed. The resident had open spots on the back of his right knee and the back of left calf. He said that it was painful. Staff A provided betadine treatment to the toes, removed her gloves and failed to perform hand hygiene. She wrapped the legs with an UNNA boot treatment, (compression dressing for leg and foot wounds), removed her gloves but failed to perform hand hygiene. She then said that she needed to get some tape, took off her gloves, then removed her gown, did not perform hand hygiene and left the room. A facility policy titled Infection Prevention reviewed on 3/2022 Hand hygiene is the number one way to prevent facility acquired infections by reducing the spread of harmful germs that can cause serious illness or death to residents. Healthcare providers must perform hand hygiene; before moving from work on a soiled body site to a clean bod site on the same patient, immediately after glove removal. 49628 (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	2. Record review of the MDS assessment for Resident #6, dated 6/15/24 documented a BIMS score of 15/15 indicating normal cognition. Section M Skin conditions identified clinical assessment, at risk for pressure ulcers, no pressure ulcers, and 2 venous and arterial ulcers present. Pressure reducing device for bed, nonsurgical dressing, ointments/medications. Resident #6's Care Plan revealed a focus area of actual impairment to skin integrity to the posterior right lower extremity (RLE), left foot, toes, wound care at [NAME] County Memorial Hospital initiated 7/14/23 and revised 717/23. Interventions identified for staff included 9/13/21 start dressing 2nd toe of the left foot, change every day. Follow physician orders for treatment of injury, monitor/document location, size and treatment of skin injury. Report abnormalities, failure to heal, s/sx of infection, maceration etc. to MD, and obtain blood work and labs as ordered by physician with initiation on 8/2/21 and revision on 6/29/23. Resident #6's treatment order revealed 1) cleanse wounds with house wound cleanser; 2) apply Aquacel AG to wounds; 3) cover with ABD pads; 4) wrap c kerlix; 4) change qd. one time a day for wounds related to Chronic Venous Hypertension (Idiopathic) with Ulcer of Left Lower Extremity. Change daily due to increase in drainage. Do not use Xeroform. Dated 2/10/24. Continuous observation on 7/23/24 at 10:12 AM, Staff A, Registered Nurse (RN) provided wound care to Resident #6 with the Director of Nursing (DON) present. The staff obtained supplies from the treatment cart at the nurses station and took them to the resident's room. Staff A donned a gown, placed a pad on the floor, paper barriers on the pad, and the supplies on the barrier. Staff A donned gloves without hand hygiene, removed Resident #6's socks, placed them in the red linen bag, gloves removed, and new gloves donned without hand hygiene. The staff removed the resident's band aid from the toe, gloves removed and new gloves donned without hand hygiene. Staff A cleansed bilateral lower extremities (BLE's) with 4 x 4 pads without changing gloves between the LE's. The staff removed gloves, donned new gloves without hand hygiene. Staff A took measurements of the wounds on each leg, left toe and right toe without cleaning the tape measure between each wound. Gloves were changed without hand hygiene. Staff A placed ointment onto a 4 x 4, used corners of same 4 x 4 for donning on left lower extremity (LLE). The staff used corners of a 4 x 4 for applying to areas on the RLE. Staff A changed gloves without hand hygiene. New ointment onto glove onto hand, and spread onto leg; glove removed from the right hand prior to applying ointment to RLE. Staff removed gloves, took scissors from her pocket, and put gloves on without hand hygiene. Staff A cleaned the scissors. Staff A cut pieces of Calcium Alginate to cover open areas. The staff completed all of LLE with right upper extremity (RUE) and then applied the Calcium Alginate to the RLE with the left upper extremity (LUE) and then began touching the areas with the RUE without hand hygiene. Staff A removed gloves and opened abdominal pads, donned gloves, taped pads together, and wrapped around Resident #6's LE's. Between LE's the staff placed items in the trash and continued with wrapping the resident's legs. The staff wrapped Kerlex around each leg, 2 Ace wraps, and socks. Staff A threw the packaging, gloves and gown away and proceeded to wash her hands before leaving the resident's room. On 7/23/24 at 10:51 AM the DON reviewed the process and indicated Staff A didn't change gloves enough, the tape measure should have been cleaned between wounds measured, and there should have been separation between cleaning, and wound management of each LE. The DON further stated hand hygiene was not present during the wound care.

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F 0883 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop and implement policies and procedures for flu and pneumonia vaccinations. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 41785 Based on staff interview, clinical record review and policy review the facility failed to offer influenza immunization to 1 of 5 residents reviewed. Resident #16 signed the consent for the immunization, but the chart lacked evidence that she received the shot. The facility reported a census of 40 residents. Findings include: According to the Minimum Data Set (MDS) assessment dated [DATE], Resident #16 had a Brief Interview for Mental Status (BIMS) score of 15 (intact cognitive ability). She was totally dependent for toileting, lower body dressing and transfers. Her diagnoses included anemia, heart failure, renal insufficiency, pneumonia and septicemia, and chronic respiratory failure. The Care Plan revised on 1/12/24 showed that Resident #16 had a tracheostomy and required suction as necessary. She had a cardiac pacemaker and an automatic cardiac defibrillator. According to the Immunizations tab in the electronic charting, Resident #16 did not receive the influenza vaccine in 2023. An Informed Consent for Influenza Vaccine showed that the resident had given the facility permission to administer an influenza vaccination. It was signed on 11/6/23 at 11:02 AM. On 7/25/24 at 10:54 AM, the Infection Preventionist (IP) said he looked for documentation that the resident had the influenza vaccine and did not find anything. He said that the immunization process began upon admission, with the social worker doing the paperwork, including consents for vaccinations. The social worker would then give the information to nursing, and nursing would follow up with a doctors order and providing the shot. The communication broke down somewhere along that line. Facility policy titled: Immunizations, dated 8/2023, stated that all residents of the facility regardless of age and medical condition will receive the influenza vaccine annually, conditioned upon the availability of the vaccines unless there is a documented contraindication, decline or refusal of vaccine and depending on availability of vaccine. The influenza vaccine will be administered during the optimal time for immunization, which is usually considered to be October 1st through March 31st.