STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	165554	A. Building B. Wing	03/28/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Country View Manor Inc	100 Cedar Lane Sibley, IA 51249

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 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 44475 Based on clinical record, facility policy, and staff interview, the facility failed to develop care plans for side effects of high risk medications for 2 of 5 residents reviewed (Residents #9 and #27); develop an individualized care plan for a resident with diagnoses of dementia and Alzheimer's disease for 1 of 2 residents reviewed (Resident #31); include a resident's pressure ulcer on the care plan for 1 of 2 residents reviewed (Resident #29). The facility reported a census of 38 residents. Findings include: 1. The Minimum Data Set (MDS) dated [DATE] for Resident #9 revealed a Brief Interview of Mental Status (BIMS) score of 3 which indicated severely impaired cognition. The resident had a diagnoses of non-Alzheimer's dementia, anxiety, and depression. The Order Summary Report signed by a physician on 1/31/24 revealed, in pertinent part: 1. Buspirone 7.5 mg bid (twice daily) starting 10/3/23. 2. Seroquel 50 mg (milligrams) daily starting 1/3/24. The Care Plan revealed, in pertinent part, interventions with initiated dates of 3/25/24: 1. Please monitor for side effects of buspirone. 2. Please monitor for side effects of Seroquel. In an interview on 3/28/24 at 12:35 PM, Staff A, Registered Nurse (RN), MDS Nurse, Social Services (SS), reported that medication side effects are listed on the Medication Administration Record (MAR). The Director of Nursing (DON) reported that they try to have medication side effects on both MAR and care plan. When asked if Certified Nurse Assistants (CNA) have access to the MAR, the DON reported they do not. The DON shook her head yes in agreement that CNAs need to know the side effects of high risk medications to monitor a resident for in order to report to licensed nurses. The Care Plans Policy dated 7/18/23 directed, in pertinent part, the facility will develop a comprehensive person-centered care plan for each resident that includes services to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being. (continued on next page)

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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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	2. The MDS dated [DATE] for Resident #27 revealed a BIMS score of 15 which indicated intact cognition. The resident had diagnoses of cancer, heart failure, and diabetes mellitus. The Order Summary Report signed by a physician on 2/19/24 revealed, in pertinent part: 1. Furosemide 20 milligrams (mg) daily as needed for congestive heart failure with an order date of 8/8/22. 2. Insulin aspart, sliding scale dosing with an order date of 2/16/24. The Hospice Physician Order signed by a physician on 3/20/24 revealed, in pertinent part, MS (morphine sulfate) IR (immediate release) every 4 hours PRN (as needed) for pain. The Care Plan revealed, in pertinent part: 1. Intervention, I am currently taking Furosemide per physician orders, initiated 3/25/24. 2. No care plan information for insulin aspart or narcotic pain medication. 3. No focus area for pain or interventions related to the side effects of the pain medication she had orders for. The Care Plans Policy dated 7/18/23 directed, in pertinent part, the facility will develop a comprehensive person-centered care plan for each resident that includes services to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being. 3. The MDS dated [DATE] for Resident #31 revealed a BIMS score of 3 which indicated severely impaired cognition. The resident had diagnoses of dementia, Alzheimer's Disease, anxiety, and depression. The resident took antipsychotic (medications used to treat dementia and Alzheimer's Disease), antianxiety, and antidepressant medications. The resident's care plan did not contain a focus area specific to her diagnoses individualized how to proactively identify her symptoms of distress, basic needs such as pain, hunger, toileting. Nor did the care plan provide interventions for the resident or her representative's suggestions what to implement should she become distressed. The Care Plans Policy dated 7/18/23 directed, in pertinent part, the facility will develop a comprehensive person-centered care plan for each resident that includes services to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being. In an interview on 3/28/24 at 12:35 PM, when asked about the resident's lack of a dementia and Alzheimer's disease focus on her care plan, Staff A reported that she has to have behavior symptoms on the care plan because of the medications the resident has ordered. (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	4. The MDS dated [DATE] for Resident #29 revealed a BIMS score of 14 which indicated intact cognition. The resident had diagnoses of cellulitis (an infection that begins from a break in skin), atrial fibrillation (abnormal heart beat), heart failure (heart does not pump enough blood for your body's needs), peripheral vascular disease (reduced circulation of blood to a body part due to a narrowed or blocked blood vessel), urinary tract infection (UTI) in the last 30 days, anxiety, depression, lymphedema (swelling caused by a buildup of lymph fluid in the body), and long term use of anti coagulants (medications that thin blood). The resident was administered antidepressant, anticoagulant, and diuretic (medications that treat lymphedema and heart failure) medications in the last 7 days. The resident was documented as both not having a pressure ulcer and having a stage 2 pressure ulcer at admission. The resident was admitted to the facility 2/27/24. The Admit/Readmit Screener Form dated 2/27/24 lacked a comprehensive skin assessment. The Skin Condition Report dated 2/28/24 revealed the resident had a red, open area to her left buttock measuring 1 centimeter (cm) in length and 0.9 cm in width. No depth was given. The Patient Wound/Skin Assessment Form Dated 2/29/24 revealed the resident had a stage 2 pressure ulcer to her left buttock. The Care Plan with an initiated date of 1/19/24 did not have the resident's pressure ulcer included. In an interview on 3/28/24 at 12:35 PM, when asked about the lack of the resident's pressure ulcer on her care plan, Staff A reported the resident's clinical record was one of the Electronic Health Records (EHR) at the facility that malfunctioned over a week ago. All of the information requested for the resident during the survey had been on the EHR. Staff A called the EHR company to resolve the issue, has not had a return call yet. When asked for the company's phone number to obtain the requested information to complete investigations, the phone number was not provided.

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide and implement an infection prevention and control program. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 26527 Based on observation, record review and staff interview, the facility failed to assure appropriate infection control practices for 1 resident on transmission based precautions (Resident #38), failed to provide appropriate hand hygiene during assistance with feeding, and failed to have the medical director review and approve the infection control policies yearly. The facility reported a census of 38 residents Findings include: According to the Minimum Data Set (MDS) assessment dated [DATE] Resident #38 scored 13 on the Brief Interview for Mental Status (BIMS) indicating no cognitive impairment. The resident required substantial/maximal assistance for toileting hygiene. The resident had diagnoses including urinary tract infection, diabetes, stroke, ulcerative colitis, and weakness. The Care Plan revised 3/22/24 identified the resident had the potential for impaired skin integrity. The resident had ulcerative colitis and C-diff (colon infection). The interventions included the resident would be receiving oral Vancomycin as ordered by her Physician for C-diff with orders to remain in her room for 10 days with contact precautions with cares. The Care Plan identified the resident had weakness following a fall at home and a urinary tract infection. The interventions included the resident was independent with toileting, she wore incontinent products, and had problems with ulcerative colitis which caused incontinence with out warning. The resident would ask for assistance as needed, revised 3/12/24. The Progress Notes dated 3/20/24 at 10:42 a.m. documented a call placed to the clinic and spoke with the physician's nurse. He will be starting the resident on Vancomycin per the physician's recommendations. The resident and the resident's family member were aware. The physician recommended contact isolation x 10 days and the resident and her family member were aware of the isolation needs. On 3/26/24 at 8:52 a.m. observed a small dresser and a receptacle for trash and a receptacle for linens outside of the resident's room in the hall. There was a note on the door about Contact Precautions. On 3/26/24 at 9:28 a.m. the resident stated she was quarantined. On 3/28/24 at 10:33 a.m. a garbage and linen receptacle remained outside the resident's door. The sign on the door documented to take gown and gloves off before leaving the room. The Director of Nursing (DON) came to the room and said they should probably be in the room. On 3/28/24 at 12:04 p.m. the infection Preventionist (IP) stated trash and linen receptacles should be in the residents room for discarding of personal protective equipment (PPE) and linens. They should not be discarded outside the resident's room. On 3/28/24 at 12:12 p.m. the DON concurred with the IP. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	A sign on the resident's door had a stop sign at the top on each side. Verbiage included contact precautions: providers and staff must put on gloves before entering the room and discard before exiting the room, and putting on a gown before entering the room and discard before exiting the room. The facility policy Contact Precautions dated 2/23/21 directed wearing clean gloves when entering the resident's room and wearing a gown if anticipated substantial contact with the resident, the resident's items, environmental surfaces, or the resident was incontinent, and removing the gown and gloves before leaving the room. 44475 2. In an observation on 3/25/24 at 12:17 PM, Staff B, Certified Nurse Assistant (CNA) assisted Resident #5 with his lunch and without performing hand hygiene, assisted Resident #31 with eating her lunch. In an interview on 3/28/24 at 12:31 PM, the Director of Nursing (DON) reported that she does not want staff to assist 2 residents at the same time with eating a meal, but if they were to, hand hygiene would need to be performed in between assisting residents. The Hand Hygiene Guidance last revised 1/30/20 accessed at https://www.cdc.gov/handhygiene/providers/guideline.html on 3/28/24 directed, in pertinent part, healthcare personnel should use an alcohol-based hand rub or wash with soap and water for the following clinical indications: immediately before touching a patient, after touching a patient or the patient ' s immediate environment, and after contact with blood, body fluids, or contaminated surfaces. 3. In an interview on 3/28/24 at 10:50 AM, when asked if the facility performed an annual review of the facility's infection prevention and control policies and procedures, Staff C, Registered Nurse (RN) and Infection Preventionist (IP) reported that she did not know as she was new to this role. Staff C then went to have assistance from the Director of Nursing (DON) who was the previous IP. The DON reported that the facility did not do an annual review of their infection prevention and control policies and procedures, that this information was reviewed frequently because it was used all of the time. In an interview on 3/28/24 at 12:31 PM, when asked for the facility's policy for annual review of infection prevention and control policy, the DON reported the facility does not have a policy.

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F 0887 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Educate residents and staff on COVID-19 vaccination, offer the COVID-19 vaccine to eligible residents and staff after education, and properly document each resident and staff member's vaccination status. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 44475 Based on clinical record, United States Department of Health and Human Services (HHS), facility policy, and staff interview, the facility failed to screen and offer, if eligible, a resident for COVID - 19 vaccination for 1 of 5 residents reviewed (Resident #5). The facility reported a census of 38 residents. Findings include: The Minimum Data Set (MDS) dated [DATE] revealed Resident #5 was admitted to the facility on [DATE]. The Untitled Form signed by Resident #5's representative on 10/24/22 revealed, in pertinent part: 1. The resident was already vaccinated with a COVID-19 vaccine. 2. If I decide I want to receive a COVID-19 vaccine, I need to inform the Administrator or the Director of Nursing (DON) so that arrangements can be made. The Iowa Department of Public Health Certificate of Immunization revealed the resident had COVID-19 vaccination on 3/8/21 and 4/8/21. The COVID-19 Vaccines last reviewed 3/13/24 accessed at https://www.hhs.gov/coronavirus/covid-19-vaccines/index.html on 3/28/24 revealed, in pertinent part: 1. COVID-19 vaccines are safe, effective, and free. COVID-19 vaccines are available for free to everyone 6 months and older living in the United States, regardless of immigration or insurance status. Getting vaccinated is the best way to help protect people from COVID-19. Get vaccinated if you haven't. If you are fully vaccinated, get a booster when you are eligible. 2. COVID-19 vaccination included a booster dose starting on 9/25/21 when the HHS Secretary issued a directive to allow a booster dose of the Pfizer COVID-19 vaccine to certain populations. The COVID Vaccine Policy dated 5/3/23 directed, in pertinent part: 1. The facility will inquire about vaccination preference on admission and a consent form will be completed with acceptance or refusal of the vaccination. 2. The facility will offer COVID immunizations to each resident per consulting pharmacists recommendations. 3. Pharmacist will document vaccination in PCC (Point Click Care, electronic health record). (continued on next page)

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F 0887 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The Clinical Record lacked documentation that the resident was screened, or offered if eligible, to receive COVID-19 vaccination.