Department of Health & Human Services
Centers for Medicare & Medicaid Services

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	165577	A. Building B. Wing	11/21/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Green Hills Health Care Center	2200 Hamilton Drive Ames, IA 50014

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 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Honor the resident's right to a dignified existence, self-determination, communication, and to exercise his or her rights. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 49698 Based on observation, clinical record review, resident and staff interviews, and policy review, the facility failed to maintain dignity in dining for 2 of 4 residents (Resident #10 and #23) reviewed. The facility reported a census of 44 residents. Findings include: 1. The Minimum Data Set (MDS) dated [DATE] identified Resident #10 having BIMS (Brief Interview for Mental Status) of 10, indicating moderate cognitive impairment and had the following diagnoses: Alzheimer ' s Disease, Non-Alzheimer ' s Dementia, and history of stroke. The MDS also identified Resident #10 needing partial to moderate assistance with eating and no impairment of upper extremities. Review of Resident #10's Care Plan initiated on 8/12/24 indicated Resident #10 has potential for malnutrition as evidenced by nutritional screening tool with an intervention for Resident #10 to eat in the assisted dining room with no adaptive devices. Review of Resident #10's Dietary/Nutrition Profile dated 10/29/24 indicated the resident's diet included puree texture with thin liquids. Resident #10's Oral Status indicated holding food in mouth/cheeks or residual food in mouth after meals. Interventions included encourage fluid intakes at meals, snacks and all nursing cares to continue with other nutritional interventions in place. 2. The MDS dated [DATE] identified Resident #23 having BIMS of 7, indicating severe cognitive impairment and had the following diagnoses: Senile Degeneration of Brain, Stage 3 Chronic Kidney Disease, and Diabetes Mellitus. The MDS also identified Resident #23 needing partial to moderate assistance with eating and no impairment of upper extremities. Review of Resident 23's Care Plan initiated on 9/4/24 indicated Resident #23 has potential for malnutrition as evidenced by nutritional screening tool with an intervention for Resident #23 to eat in the assisted dining room where I need assistance, one on one with encouragement and cues. Review of Resident #23's Dietary/Nutrition Profile dated 11/18/24 indicated Resident #23's diet included a regular diet with thin liquids and use of foam silverware and two handled cups. The Dietary/Nutrition Profile also indicated Resident #23 eats in the assisted dining room where she receives partial assistance as needed. (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 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Observation on 11/20/24 at 10:03 AM revealed a small room across the hall from the facility's opening dining room. This room was labeled on the door with Assisted Dining, inside a square table. Observation of the assisted dining room on 11/20/24 at 5:16PM, revealed a CNA sitting with three residents including Resident #10 and Resident #23. Resident #23 had not received her meal, Resident #10 eating independently as well as the third Resident eating independently with CNA ' s supervision. During observation on 11/21/24 at 12:18 PM, Resident #23 stated she liked the other dining room, it's bigger and a lot nicer. Resident #23 stated I don't like being put in this room, I feel like I'm being discarded. Interview on 11/20/24 at 5:04 PM, Resident #10 stated she does not like the room that she eats meals in, four people sit at that table and they do not talk much and would like to visit with more residents while eating her meals. Resident #10 stated she does not need assistance to eat. Interview on 11/20/24 at 2:46 PM, Staff D, CNA revealed there are four residents that eat in the assisted dining room. Only one of the residents needs staff to fully assist them with eating, the other three are only supervised and able to feed themselves. The CNA supervising the assisted dining has three residents at a time. In the past they had done assisted dining in an area of the open dining room. At that time there were eight or nine residents that assisted or supervised. Since the number has gone down they moved back to the small assisted dining room. Staff D, had the understanding they were fed separate from the other residents for dignity. Interview on 11/20/24 at 2:51 PM, Staff F, RN, stated the residents needing assistance were moved to the separate assisted dining room due to residents with higher cognition had complained about the residents needing assistance being in the open dining room. Interview on 11/21/24 at 11:18 AM, Staff G, CNA, stated only one of the four residents that eat in the assisted dining room needs full physical assistance, the other three need supervision and or prompting. The assisted feeding residents started in the assisted dining room, then were moved to the open dining room because there were more residents needing assistance. They have now been moved back to the current assisted dining room because there wasn't as many residents needing assistance. In an interview on 11/21/24 at 2:35 PM, the Director of Nursing stated when the resident is evaluated and determined to need monitoring or assistance and/or the resident ' s family requests assistance or monitoring, the resident is placed in the assisted dining room for meals. When there were more residents that needed assistance or monitoring, they were in the big dining room, and had moved these residents to the small assisted dining room for dignity. Review of facility provided Stewardship of Resident Rights Policy, revision date 1/20/20, stated the following: 1. Respect for Individuality: We acknowledge and respect the uniqueness of each resident, including their beliefs, values, and cultural background. We will provide person-centered care that honors their individual preferences and choices to the fullest extent possible. (continued on next page)

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F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	2. Non-Discrimination: We will not discriminate against any resident based on race, color, religion, gender, sexual orientation, national origin, age, disability, or any other protected status. All residents will receive equal access to services, care, and facilities without any form of discrimination.

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F 0655 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Create and put into place a plan for meeting the resident's most immediate needs within 48 hours of being admitted 40905 Based on resident record review, staff interview, and facility policy review the facility failed to develop and implement a base line care plan to include a resident's use of a high-risk medication for 1 resident (Resident #35) of 5 residents reviewed for base line care plans. The facility reported a census of 44 residents. Findings include: The Minimum Data Set (MDS) for Resident #35, dated 11/8/24, included diagnoses of transient cerebral ischemic attack (stroke) long term use of anticoagulants (blood thinner medication). The MDS documented the resident was receiving an anticoagulant. Resident #35's Order Summary Report documented a physician's order for Warfarin Sodium (blood thinner medication with high-risk for bleeding) 5 milligrams (mg) every Monday, Tuesday, Wednesday, Thursday, Saturday, and Sunday and 2.5 mg. on Friday. Resident #35's New Resident Initial Care Plan/Resident Summary dated 11/5/24, lacked inclusion of the anticoagulant and monitoring for side effects. Facility policy MDS Assessment and Care Plan Procedure, reviewed/revised 11/1/2020, documented the admitting registered nurse will develop and implement a baseline care plan for each resident within 48 hours and the care plan will include initial goals based on orders and physician orders. Interview on 11/21/24 at 10:04 AM, the Director of Nursing stated her expectation for anticoagulant medication and monitoring to be included in the baseline care plan.

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured. 40905 Based on resident record review, staff interview, and facility policy review the facility failed to develop and implement a comprehensive person-centered care plan to include a resident's pressure ulcer and treatment for 1 resident (Resident #22) of 12 residents reviewed for care plans. The facility reported a census of 44 residents. Findings include: The Minimum Data Set (MDS) for Resident #22, dated 10/8/24, included diagnoses of stroke and Parkinson's. The MDS documented the resident had a Stage 2 (partial-thickness skin loss with exposed dermis) and Stage 3 (full-thickness skin loss) pressure ulcer. Resident #22's Skin Evaluation dated 10/2/24 documented a new skin issue of an unstageable (obscured full-thickness skin and tissue lose) pressure ulceration to the right heel present and measuring approximately 1.5 centimeters(cm) X 0.5 cm., with site moist with eschar tissue (dead tissue) present. Resident #22's Care Plan lacked inclusion of the pressure ulcer and treatment until 11/19/24. Facility policy MDS Assessment and Care Plan Procedure reviewed/revised 11/1/20 documented the resident's care plan will address pressure ulcers. Interview on 11/21/24 at 10:04 AM, the Director of Nursing stated would expect a pressure ulcer and treatment to be included in the care plan timely.

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure services provided by the nursing facility meet professional standards of quality. 40905 Based on observation, resident record review, resident and staff interview, and facility policy review the facility failed to followed a physician's order for 1 resident (Resident #22) of 12 residents reviewed. The facility reported a census of 44 residents. Findings include: The Minimum Data Set (MDS) for Resident #22, dated 10/8/24, included diagnoses of stroke and Parkinson's. The MDS documented the resident had a Stage 2 (partial-thickness skin loss with exposed dermis) and Stage 3 (full-thickness skin loss) pressure ulcer. Resident #22's Skin Evaluation dated 10/2/24 documented a new skin issue of an unstageable (obscured full-thickness skin and tissue lose) pressure ulceration to the right heel present and measuring approximately 1.5 centimeters(cm) X 0.5 cm., with site moist with eschar tissue (dead tissue) present. Resident #22's Physician Order Summary dated, 11/20/24, documented an order to apply prevalon boots (padded boots to prevent pressure to areas) to both lower extremities at all times due to pressure injury, every day and night shift with starting order date of 9/30/24. Observations on the following dates: 11/19/24 at 11:19 AM, 11/20/24 at 8:23 AM, and 11/21/24 at 9:20 AM, resident up in wheelchair with prevalon boot on right foot and gripper sock only on left foot. Interview on 11/20/24 at 4:03 PM, Resident #22 stated the staff talked about a boot for both heels but have never had one for the left foot, only for the right foot, and staff thought maybe hospice was going to provide the other boot. Interview on 11/21/24 at 9:30 AM, Staff C, Certified Nurse Aide (CNA) and Staff D, CNA stated always just 1 boot on the resident's right foot and have never put a boot on the left foot. Facility policy, Physician Orders Procedure reviewed/revised 719/24, documented it is the policy of the facility that all physician orders are followed as written. Interview on 11/21/24 at 10:04 AM, the Director of Nursing stated expectation was to follow physician's order.

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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** 49698 Based on record review, facility provided documents, and policy review the facility failed to ensure residents received care to prevent hospitalization by administering incorrect medications to 1 of 1 (Resident #8) resident reviewed. The facility reported a census of 44. Findings include: Review Resident #8's Minimum Data Set (MDS) dated [DATE] revealed a Brief Interview for Mental Status (BIMS) score of 4, indicating severe cognitive impairment. The MDS indicated the following diagnosis: Hypertension, Hyperlipidemia, Non-Alzheimer ' s Dementia, and Depression. Review of Functional Abilities and Goals assessment dated [DATE], indicated Resident #8 was dependent on assistance with toileting, showering, dressing, and transferring. Review of Resident #8's Census report indicated hospitalization on [DATE] and returning to the facility on [DATE]. Review of Resident #8's Progress Notes revealed the following: On 9/1/24 at 3:09 PM: Notified at 1:00 PM by Medication Aide on duty that resident had possibly received the wrong medications. Upon assessment- this RN confirmed that the resident did receive another resident's medication instead of her own. Medications received included Losartan 50mg, Aspirin 325mg, Cetrizine 5mg, Mag Ox 400mg, Namenda 10mg, Metoprolol 25mg, Montelukast 10mg, Vitamin D3 5000 units, and Verapamil 240mg. Most pertinent was 50mg of Losartin, 25mg of short-acting metoprolol and 240mg Verapamil SR. Vital signs upon assessment: 119/81-52-97.0-19-97% RA. Phone call to on call provider and reviewed situation with him including what medications the resident was given vs. what should have been given. Will go ahead and place a one time order for Celexa 20mg by mouth and then resume medication as scheduled/ordered. Will monitor vital signs closely for an adverse effect. ARNP called and also updated on situation. Will monitor vital signs for the next 24 hours for any changes- Vital signs will be monitored every hour x 6 hours and then move to every 2 hours until 2:00 PM on 9/2/24. On 9/1/24 at 3:25 PM: Verbal order given by physician that if Resident #8 does become bradycardia with a defined parameters of heart rate below 50-then send to ED for further evaluation. On 9/2/24 at 1:04 AM: Resident admitted to hospital- diagnosis: accidental drug ingestion and bradycardia. (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of Hospital Admission documents dated 9/1/24 revealed at 1:00 PM on 9/1/24 Resident #8 was given the incorrect medications by staff at her care center. She received all of another resident's medication. The full list included: Losartan 50mg, Aspirin 325mg, Cetrizine 5mg, Mag Ox 400mg, Namenda 10mg, Metoprolol 25mg, Montelukast 10mg, Vitamin D3 5000 units, and Verapamil 240mg. Most pertinent was 50mg of Losartin, 25mg of short-acting metoprolol and 240mg Verapamil SR. Resident #8's vital signs were monitored closely throughout the day, on the evening of 9/1/24 Resident #8 developed bradycardia, heart rate had been between 41 and 48 beats per minute and her blood pressure had been 112-130/57-63. Review of Hospital Progress Note dated 9/2/24 at 10:38 AM indicated Resident #8's bradycardia due to meds. No symptoms, no pauses, no heart block. Resident #8 planned to discharge tomorrow (9/3/24) back to her Long Term Care facility. On 9/3/24 at 2:13PM, the Facility's Investigation indicated the following statement made by Staff H, CMA: I tried to give (another resident) his pills, but he refused. I put his pills in the med cart and would reapproach him later. I got Resident #8's pills ready, but she was still sleeping. So I put her meds back in the cart and went to break. Later, when I came back, Resident #8 was up and in her room. So, I went to give her the pills and took her blood pressure. I realized I grabbed the wrong pills when I opened the med cart and noticed Resident #8's pills were still in the med cart. I went to report to the charge nurse and told her what happened. Review of Oral Medication Administration Procedure Policy revised 4/20/18 indicated the following: 1. All medications are kept locked in the medication cart in labeled cards. 2. Utilize five rights of medications administration: right time, right resident, right medication, right route and right dosage.

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. 40905 Based on observation, policy review, and staff interview, staff failed to serve food under sanitary conditions, in order to reduce the risk of contamination and foodborne illness. The facility reported a census of 44 residents. Findings include: On 11/20/24 with meal service starting at 11:10 AM, Staff A, Food & Beverage Coordinator put on a glove, with the gloved hand opened a drawer, and with the same gloved hand touched tater tots, placed tater tots on a pan and into the oven. While preparing residents' plates, Staff A frequently leaned over the plates sitting on the shelf of the steam table with his apron touching the top surface side of the plates where food was placed. Staff A applied gloves, with gloved hands sliced a cucumber on a cutting board and with same gloved hands touched the cucumber slices. Staff A proceeded to wipe the cutting board with a dry cloth that was sitting on the counter, then placed green beans on the cutting board to cut into smaller pieces. Throughout the meal service, Staff A rested his bare hands on the cutting board and then placed food on the cutting board. Staff A got a drink from his personal cup, sitting beside the stove, and then continued to serve more plates, not washing his hands. The 2 scoops used to serve mashed potatoes were completely in the mashed potato container, including the handles, touching the mashed potatoes, Staff A removed the scoops with his bare hand and continued to serve the mashed potatoes with the scoops. The serving scoop, including the handle, fell into the broccoli, Staff A used tongs to remove the scoop by the handle of the scoop, then used the tongs to scoop cooked broccoli from a pan to the serving container. Staff B, Dietary Aide, after pouring drinks into 2 handled cups, moved the cups by holding the cups from the top, placing fingers around the top edge of the cups and then placed the cups on a tray to be served to a resident. Facility policy, Preventing Foodborne Illness-Employee Hygiene and Sanitary Practices revised 1/10/22, documented employees must wash their hands after drinking, before coming in contact with any food surfaces, after handling soiled utensils and during food preparation, as often as necessary to prevent cross contamination when changing tasks and gloves are considered single-use items and must be discarded after completing the task for which they are used. Interview on 11/20/24 at 2:26 PM, the Director of Dietary Services stated expectation for gloves to be a 1-time usage. The 2013 Food Code, published by the Food and Drug Administration and considered a standard of practice for the food service industry, includes the following requirements: 1) Single-use gloves are to be used for only one task, such as working with ready-to-eat food and for no other purpose, and discarded when damaged or soiled, or when interruptions occur in the operation, 2) prohibits food employees from bare hand contact with ready-to-eat food (unless washing fruits and vegetables) and requires food employees to wash their hands immediately before engaging in food preparation, including before donning gloves for working with food, in order to prevent cross contamination when changing tasks.

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F 0842

Level of Harm - Minimal harm or potential for actual harm

Residents Affected - Few

Safeguard resident-identifiable information and/or maintain medical records on each resident that are in accordance with accepted professional standards.

40905

Based on observation, resident record review, resident and staff interview, and facility policy review the facility failed to complete physician treatment orders that were documented as completed for 1 resident (Resident #22) of 12 residents reviewed. The facility reported a census of 44 residents.

Findings include:

The Minimum Data Set (MDS) for Resident #22, dated 10/8/24, included diagnoses of stroke and Parkinson's. The MDS documented the resident had a Stage 2 (partial-thickness skin loss with exposed dermis) and Stage 3 (full-thickness skin loss) pressure ulcer.

Resident #22's Skin Evaluation dated 10/2/24 documented a new skin issue of an unstageable (obscured full-thickness skin and tissue lose) pressure ulceration to the right heel present and measuring approximately 1.5 centimeters(cm) X 0.5 cm., with site moist with eschar tissue (dead tissue) present.

Resident #22's Physician Order Summary dated, 11/20/24, documented an order to apply prevalon boots (padded boots to prevent pressure to areas) to both lower extremities at all times due to pressure injury, every day and night shift with starting order date of 9/30/24.

Observations on the following dates: 11/19/24 at 11:19 AM, 11/20/24 at 8:23 AM, and 11/21/24 at 9:20 AM, resident up in wheelchair with prevalon boot on right foot and gripper sock only on left foot.

Review of Resident #22's Treatment Administration Record (TAR) for 10/1 to 31/24 and 11/1to 21/24, order for apply prevalon boots to both lower extremities, documented/signed as completed every day.

Interview on 11/20/24 at 4:03 PM, Resident #22 stated the staff talked about a boot for both heels but have never had one for the left foot, only for the right foot, and staff thought maybe hospice was going to provide the other boot.

Interview on 11/21/24 at 9:30 AM, Staff C, Certified Nurse Aide (CNA) and Staff D, CNA stated always just 1 boot on the resident's right foot and have never put a boot on the left foot.

Interview on 11/21/24 at 9:45 AM, Staff E, Registered Nurse stated she signed Resident#22's TAR today for order of apply prevalon boots bilateral as completed. Staff E acknowledged the order stated prevalon boots to bilateral lower extremities at all time, the resident only had a boot on 1 foot and should have boots on both feet per order.

Facility policy, Physician Orders Procedure reviewed/revised 719/24, documented it is the policy of the facility that all physician orders are followed as written.

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Interview on 11/21/24 at 10:04 AM, the Director of Nursing stated expectation to not sign as completed for an order not completed.