STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	165798	A. Building B. Wing	07/03/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Hallmar Village	8900 C Avenue NE Cedar Rapids, IA 52402

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 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. 25854 Based on clinical record review, staff interview and facility policy review, the facility failed to follow physician's orders for 1 of 3 residents reviewed (Resident #3). The facility identified a census of 33 residents. Findings include: A Medication Administration Record (MAR) form dated 6.1.24 thru 6.30.24 for Resident #3 directed the facility staff to have administered the Resident's Carbidopa-Levodopa (Parkinson's medication) 25-100 milligram (mg) four (4) tablets by mouth (po) five (5) times a day at 2 a.m., 6 a.m., 10 a.m., 2 p.m. and 6 p.m. Review of a Medication Administration Audit Report form dated 7.2.24 at 4.07 p.m. revealed the Resident received the medications on the date and times specified below: a. 6.19.24 the 2 p.m. dose administered at 4:51 p.m. and the 6 p.m. dose at 5:31 p.m. which equated to a late administration at 2 p.m. followed by an administration of the 6 p.m. dose within 40 minutes. The facilities Medication Administration Policy modified 5.21 indicated the Purpose as an insurance of a safe, effective and timely drug therapy. The Procedure included administration of medication at the right time.

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 0690 Level of Harm - Actual harm Residents Affected - Few	Provide appropriate care for residents who are continent or incontinent of bowel/bladder, appropriate catheter care, and appropriate care to prevent urinary tract infections. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 25854 Based on observation, clinical record review, staff interview, resident interview, and family interview the facility staff failed to properly insert a catheter for 1 of 3 residents reviewed which resulted in hospitalization (Resident #3). The facility identified a census of 33 residents. Findings include: A Minimum Data Set (MDS) assessment form dated 3.27.24 indicated Resident #3 had diagnoses that included Parkinson's Disease, End Stage Renal Disease (ESRD), Benign Prostatic Hyperplasia with Lower Urinary Tract symptoms, Bladder Neck Obstruction, Urinary Tract Infection (UTI), and Diabetes Mellitus (DM). The assessment indicated the Resident had a Brief Interview for Mental Status (BIMS) score of 8 out of 15 (moderately impaired cognitive status), with the ability to understand others and make himself understood. The assessment indicated the Resident required maximum/substantial assistance to dependent on staff with activities of daily living (ADL's) and had a catheter. A Care Plan identified a Focus area of a catheter (revised 1.8.24). A Treatment Administration Record (TAR) form dated 5.1.24 thru 5.30.24 indicated the Resident's catheter as changed on 5.25.24 by Staff B, Registered Nurse (RN). During an interview 7.3.24 at 9:17 a.m. Staff D, Certified Nursing Assistant (CNA) indicated Staff B requested assistance with the resident's catheter change. Staff B removed the old catheter as Staff D observed thick, cloudy mucus discharge that followed the removal. Staff B used sterile technique with the re-insertion of the new catheter however the process had not appeared correct as the resident grimaced, shook, started sweating, and verbalized pain. Staff B met resistance during insertion so pulled catheter out a bit and pushed the catheter up more at which time there had been yellow urine return without blood in the catheter tubing. Staff B attempted to inflate the balloon but for some reason she met resistance and the fluid returned to the syringe. Staff B again re-adjusted the catheter a bit and pulled it back far enough that it protruded approximately 10 inches from the end of his penis. Staff D knew the catheter had not been placed properly at that point because too much of the catheter appeared exposed. Again, Staff B attempted to inflate the balloon but the fluid returned into the syringe. Staff B stated she had not known what had been going on. At that point Staff B requested Staff D to get Staff C, Licensed Practical Nurse (LPN). Staff C arrived and told Staff B the catheter had not been properly placed as Staff B continued to attempt to manipulate the catheter further into the penis with no urine return. Staff D reiterated the only urine return in the catheter tubing and/or bag had been with the original insertion. At that point Staff B re-inflated the balloon and put all 30 cc into the balloon and that had been the time the resident started continuously dripping, bright red blood from the end of his penis. The resident shook profusely because of the pain. Staff B asked the resident if he wanted something for pain which he agreed too. When Staff B left to retrieve the pain pill Staff D cleaned up the resident, placed a barrier under the resident, covered him up, turned the lights down and told him if he needed anything to use the call button. (continued on next page)

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F 0690 Level of Harm - Actual harm Residents Affected - Few	During an interview 7.2.24 at 4:45 p.m. Staff B, RN indicated on 5.25.24 she changed the resident's catheter with sterile technique. During the process she inserted the catheter to the bifurcation (where the catheter split into two (2) channels) of the catheter tubing, received a slug return followed by clear yellow urine so she inflated the balloon. Following the inflation of the balloon she pulled the catheter back gently to assure placement. The resident complained of pain and spasms so the staff member went and retrieved a pain medication. When she returned to the room she reassessed the resident's pain and catheter at which time she observed blood at the end of his penis. Staff B went and asked Staff C if the resident had ever bled for her during a catheter change. Both staff members returned to the resident's room again and noted the bleeding. Staff B had not been sure of the opinion of Staff C because she had been an LPN so she asked Staff A for another opinion. Staff A arrived in the resident's room with Staff B and at that time there had been a lot of bright red blood around the end of his penis with hematuria in the catheter tubing and bag. Staff A flushed the catheter line which flushed but with no return/back flow back into the catheter tubing. Staff A then removed the catheter. Staff A stayed with the resident as Staff B called the Physician, family, ambulance, and prepared for transport to the hospital. During an interview 7.2.24 at 4:07 p.m. Staff C indicated on 5.25.24 Staff B requested assistance after she changed the resident's catheter. Both nurses entered the resident's room and Staff B asked Staff C if the resident ever bled after she changed his catheter to which she answered no. Staff C indicated she had only been a nurse since July 2023 and the resident had been her 1st male catheter change but she had no problems with the insertion process. At that point they pulled back the resident's covers and noted bright red blood which came out of the tip of the resident's penis and around the catheter itself . Staff C noted the catheter protruded from the end of the resident's penis approximately 10 inches which made it obvious the catheter had not been properly placed. Staff C also noted blood in the catheter bag but could not tell if there had been urine present along with the blood. Staff C informed Staff B she felt the catheter had not been properly placed and she needed to deflate the balloon in the catheter which would have allowed her to guide the catheter into the resident's bladder however Staff B requested another opinion and that she planned to wait for a time to see if the bleeding subsided. Approximately 45 minutes later Staff B approached Staff C again and requested her assistance. Both nurses returned while Staff C deflated the catheter balloon, advanced the catheter close to the bifurcation of the catheter tubing until she observed urine return and re-inflated the balloon without difficulty however the resident continued to express severe pain as noted by his rapid breathing, pale skin, diaphoresis and stating oh, oh, oh through the process. Staff C exited the room and requested the assistance of Staff A. (continued on next page)

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F 0690 Level of Harm - Actual harm Residents Affected - Few	During an interview 7.3.24 at 10:54 a.m. Staff A confirmed on 5.25.24 she got wind of the catheter change situation so she asked Staff B what happened. Both nurses proceeded to the resident's room and when they pulled back the covers a blood clot approximately an inch wide and several inches long presented at the end of the resident's penis. Staff A assessed the catheter tubing and noted blood in tubing but no urine. Staff A also looked at the catheter bag and noted 10-20 milliliters (ml) of bright red blood present with no urine. Staff A then pushed 60 cubic centimeters (cc) of sterile water into the catheter tubing which went right into the tubing with no return however the process had been painful to the resident as noted by his facial expressions and his moaning. Staff A then removed the catheter and immediately after removal a continual flow of bright red blood drained from the resident's penis. At that point Staff A informed Staff B the resident required hospitalization . When the ambulance crew arrived they estimated the amount of blood loss at 100 ml of bright red blood. Staff A indicated she changed the resident's catheter in the past and it inserted without difficulty. A Transfer/Discharge Report form dated 5.25.24 confirmed the resident as transferred to the hospital related to excessive bleeding after a catheter change with complaints of pain. The resident experienced bleeding from the tip of his penis, around the catheter, and in the bag. The staff member deflated and advanced the catheter however the complaints of discomfort continued with no urine output. The catheter had been flushed with no return so staff removed the catheter. Upon removal the tip of the resident's penis became full of clots with a large fluid discharge that followed a stream of blood. The resident's blood pressure measured 117/109, pulse 116, blood sugar 203 and he experienced sweaty/clammy skin. The resident had been alert and oriented times (x) 4 (person, place, time and event). A Pre-hospital Care Report Summary Area Ambulance Service report form dated 5.25.24 with an in-route time of 4:46 p.m. included the following documentation: The patient alert as he laid in bed. The patient's airway patent, breathing rapid and labored with his skin pale, cool, and diaphoretic. Report received from the facility RN who stated that they changed out the patient's permanent catheter. Initial insertion of the catheter went fine. However, no output had been noticed after insertion. The catheter was flushed and the patient reported excruciating pain. No output was noted after flushing saline but the catheter flushed without problem. The catheter was pulled followed by 200 ml of bloody urine per the facility RN. A clot then formed at the end of the penis that stopped the blood flow. Vitals: Blood pressure: 175/91, pulse 129, respirations 36 and labored and pain a 9 on a scale of 0-10 with 10 having been the highest. A hospital Emergency Department Note dated 5.25.24 at 5:32 p.m. included the following: Presented with acute gross hematuria after a catheter had been exchanged at the nursing facility. Catheter no longer in place and currently had only minimal amount of bleeding at the meatus. However, given that he had gross hematuria the Physician had concerns that he may eventually form clots and became obstructed so discussed Lidocaine Uro-Jet (anesthetic) followed by three-way catheter placement which patient agreed upon. A Urology Consultation form dated 5.26.24 at 11:04 a.m. included the following: (continued on next page)

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F 0690 Level of Harm - Actual harm Residents Affected - Few	The patient had been well-known in urology with a chronic indwelling catheter and history of renal cell carcinoma. His catheter had been exchanged 5.25.24 however there had been difficulty. When the nurse called the Physician it sounded as though the catheter had been only advanced as far as the prostate and then inflated there which caused trauma. The patient began to have hematuria at that time as well. The patient had been admitted to the hospital and started on continuous and extensive bladder irrigation with additional hand irrigation 2 times for clot retention. During an interview 7.2.24 at 1:40 p.m. the resident and family indicated on 5.25.24 the family received a telephone call from Staff A, who reported there had been a bad catheter change by Staff B which ultimately resulted in hospitalization . One family member reported she arrived on 5.25.24 at approximately 5 p.m. at which time she found the resident in such pain he presented as diaphoretic (sweating) and shaking to the point when the ambulance crew arrived they asked her if someone had poured water on the resident. The family members also indicated Staff B had a similar incident with the resident when he resided at the previous location of the same nursing facility which also resulted in Physician intervention. On 5.27.24 the areas within the resident's urinary tract which continued to bleed had been cauterized. The family indicated the last traumatic change from Staff B had been on 6.15.23. 2. A Progress Note entry dated 6.10.23 at 2:58 p.m. included the following documentation from Staff B: Catheter replaced today per order. Tolerated the insertion but there had been mild bleeding coming from the Urethra. Good urine output and no clots noted in the urinary bag. Patient complained of penile pain. Physician Progress Notes dated 6.16.23 at 2 p.m. included the following documentation from a Urology Clinic: A [AGE] year old man came in today for an urgent visit as he had been catheter dependent from chronic bladder outlet obstruction. His catheter had been changed out last Saturday with worsening spasms and some hematuria which ultimately had been exchanged two (2) days ago. The Physician suspected a traumatic catheter placement with either the catheter itself caused the trauma during insertion or the balloon had been partially inflated in the bladder neck.

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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. 25854 Based on observation, staff interview, and facility policy review the facility failed to store, prepare, distribute, and serve food in accordance with the professional standards for food service safety. The facility identified a census of 33 residents. Findings include: During observation 6.28.24 at 10:30 a.m. with the Dietary Manager (DM) revealed the following items located in the stand up fridge in the prep area: 1. Two (2) long squeezable tubes full of whipped topping open and not dated. The DM confirmed the items should have been stored in a zip lock bag, labeled and dated. 2. Icing in squeeze bottle not labeled or dated. 3. Barbeque sauce in squeeze bottle not labeled or dated. The following items had been located in a walk-in cooler located in the prep area in the main kitchen: 1. Five (5) cheese cake bites in a Styrofoam container not labeled or dated. The DM indicated the items must have belonged to a staff member. 2. An open bag full of basil leaves not dated. The following items had been located in a walk-in freezer: 1. An open bag of hash browns not dated. 2. An opened bag of frozen green beans not dated. The following item had been located in a dry storage area: 1. One (1) open and not sealed bag of egg noodles not dated. During an interview at the same time the DM confirmed all of the above observations. Review of the facilities Labeling and Dating Policy updated 8.2019 included the following Procedure: Label and date ready to eat and/or potentially hazardous foods opened and/or prepared with the following information: a. Name of product. (continued on next page)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	b. Date food opened/prepared or when the food must have been used or discarded.