

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 165798	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 12/10/2024
NAME OF PROVIDER OR SUPPLIER Hallmar Village		STREET ADDRESS, CITY, STATE, ZIP CODE 8900 C Avenue NE Marion, IA 52302	

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
<p>F 0689</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 19126</p> <p>Based on clinical record review, staff and resident interviews, observations, and policy review, the facility failed to have an effective process in place to identify residents who left their units for 1 of 3 residents reviewed (Resident #4). The facility reported a census of 41 residents.</p> <p>Findings include:</p> <p>Review of the Minimum Data Set (MDS) dated [DATE] Resident #4 had diagnoses which included poly substance abuse, vascular dementia, and acute kidney failure. The MDS indicated the resident had total independence with ambulation, transfers, and dressing, without the use of devices. The resident had a Brief Interview for Mental Status score of 14 which indicated the resident had intact cognitive ability.</p> <p>Review of the Care Plan updated on 9/26/24 revealed the resident will communicate with nursing staff when he has a need to go outside and get fresh air and will vocalize this to the staff prior to leaving the unit. The Care Plan informed staff the resident will communicate interest with the staff when he needs to step outside and staff will place a sign on the unit exit door to remind the resident to see the nurse prior to leaving.</p> <p>Review of Resident #4's Progress Notes revealed the resident left the unit on two occasions without staff knowledge after the implementation of the 9/26/24 Care Plan intervention:</p> <p>a. On 10/18/24 at 3:47 the resident left the unit without staff and without staff knowledge. The resident failed to sign himself out prior to leaving the unit.</p> <p>b. On 10/19/24 between 2-2:30 pm, the resident left the unit without staff and without staff knowledge. The resident failed to sign himself out prior to leaving the unit.</p> <p>Review of the Wandering and Elopement Policy modified on 12/2022 reveals each unit/ household will maintain a sign-in/sign-out log for residents leaving the unit or building.</p> <p>Review of the second floor sign in/sign out sheet dated 10/15-11/2/2024 failed to include Resident #4's name which would indicated he left and returned to the unit.</p> <p>(continued on next page)</p>

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
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<p>F 0689</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>During an interview with Staff A-RN/Director of Nurses on 12/10/24 at 12:30 pm, Staff A stated Resident #4 failed to sign himself out of the unit when he left on 10/18 and 10/19/24. Staff A stated she would have expected the resident to sign out when leaving so staff were aware of his location.</p>		

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<p>F 0925</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Make sure there is a pest control program to prevent/deal with mice, insects, or other pests.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 20331</p> <p>Based on clinical record review, facility policy review and staff interviews, the facility failed to maintain an effective pest control policy to ensure the facility is free of pests. The facility reported a census of 41 residents.</p> <p>Findings include:</p> <p>1. Resident #5's MDS (Minimum Data Set) dated 9/4/2024 revealed the resident had severely impaired cognitive abilities, required assistance of staff to transfer from one surface to another, and used a wheel chair for locomotion. The resident had diagnoses including dementia and a history of prostate cancer.</p> <p>Resident #5's Progress Notes included:</p> <p>On October 17, 2024, Staff A, DON (Director of Nursing) documented staff observed a bed bug in the resident's room. Staff collected the specimen and sent it to Plunkett's Pest Control.</p> <p>October 19, 2024 skin assessment revealed the resident had scratches on his face and a red groin.</p> <p>October 21, 2024 skin assessment revealed the resident had right forehead and bilateral ear scratches.</p> <p>On 12/9/2024, Staff C, maintenance submitted a copy of a proposal Plunkett's sent to the facility on [DATE] to be signed by the facility giving them permission to treat Resident #5's room.</p> <p>On October 21 Plunkett's administered the initial bedbug treatment for room [ROOM NUMBER]. They administered the second treatment on October 28, and third treatment on November 4.</p> <p>2. Resident #2's MDS dated [DATE] revealed the resident had severe cognitive impairment and diagnoses including Alzheimer's with late onset and COPD (Chronic Obstructive Pulmonary Disease). The resident required assistance to transfer from one surface to another and used a wheel chair that she could self propel for locomotion.</p> <p>Resident #2's Progress Notes and body audits included:</p> <p>10/27/2024 - Multiple blisters, bumps scattered on resident's back. The resident reports the rash is itchy.</p> <p>10/28/2024 - The resident's ARNP (Nurse Practitioner), Staff D visited the resident and ordered Hydrocortisone cream. The facility notified the resident's daughter of the rash and pest control's appointment to treat the room the following week.</p> <p>11/1/2024 - rash on bilateral arms and hands. New orders received for medication to help relieve the itching.</p> <p>(continued on next page)</p>		

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<p>F 0925</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>11/5/2024 - New physician orders received for staff to administer a cream to the affected areas two times a day for the itchy bites until resolved.</p> <p>Staff C submitted a copy of Plunkett's Bedbug proposal sent to the facility on [DATE].</p> <p>On November 5, 2024 Plunkett's administered the initial bedbug treatment for room [ROOM NUMBER]. They administered the second treatment on November 12 and third treatment on November 18.</p> <p>Plunkett's service reports revealed facility rooms 267, 260, 261, 262, 263, 264, 265, 267, 268, 270 and 273 were also treated as a precaution.</p> <p>On 12/10/2024 at 1:40 P.M., Staff A, DON reported after the facility discovered bedbugs, they implemented PPE (personal protective equipment) for staff, notified families, cleaned resident rooms, laundered resident linens and clothing, and had Plunkett's treat the rooms. Staff A indicated after bedbugs were identified, she would have expected pest control treatment in a more timely manner. When staff found bugs on Resident #5, Staff A took a photo of the bug and reported the findings to Staff C. Staff C reached out to Plunkett's and they initiated treatment.</p> <p>On 12/10/2024 at 11:00 A.M., Plunkett's staff revealed they sent the first proposal on October 17. When the facility signed and returned it, they provided treatment on October 21 to room [ROOM NUMBER]. They sent another proposal to treat room [ROOM NUMBER] on October 28 and the facility signed it on November 4. Plunkett's provided the treatment on November 5.</p> <p>On 12/9/2024 at 12:38 P.M., Staff D, ARNP reported Resident #2 in room [ROOM NUMBER] had bedbug bites when she visited her on October 21. Staff D asked about the resident's room and staff revealed her room had not yet been treated. Staff D reported it seemed the facility failed to have the room treated in a timely manner. Staff D saw the resident again on November 5 and she still complained of itching, and she had new bites on her left arm and face. Staff indicated her room had been treated.</p> <p>The 2020 facility Identification and Management of Bedbugs policy included:</p> <p>Environmental Controls:</p> <ol style="list-style-type: none"> 1. Perform inspection of resident furniture upon admission to the facility. 2. In resident with an unresolved rash that is not responding to treatment, don appropriate PPE (gloves and gowns) and inspect mattress and bed frame for the presence of bedbugs. Bedbug bites are usually noted on the arms, neck, torso or legs. 3. Provide resident with bath/shower and clean gown. Then place resident in a different room, leaving belongings until treated. 4. Wash all linens and clothing in resident rooms. 5. Review all residents with rashes and perform environmental audits for evidence of bugs. 6. Correctly identify bed bugs. <p>(continued on next page)</p>		

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