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| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 165145 | (X2) MULTIPLE CONSTRUCTION A. Building B. Wing | (X3) DATE SURVEY COMPLETED 05/04/2023 |
| NAME OF PROVIDER OR SUPPLIER Embassy Rehab and Care Center | | STREET ADDRESS, CITY, STATE, ZIP CODE 206 Port Neal Road Sergeant Bluff, IA 51054 | |

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

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| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information) |
| <p>F 0550</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p> | <p>Honor the resident's right to a dignified existence, self-determination, communication, and to exercise his or her rights.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 26527</p> <p>Based on record review, staff, and resident interviews, the facility failed to assure residents were treated with respect and dignity for 5 of 19 residents reviewed (Resident #22, #8, #12, #35, and #14). The facility reported a census of 38 residents.</p> <p>Findings include:</p> <p>1. According to the Minimum Data Set (MDS) assessment dated [DATE] Resident #22 scored 10 on the Brief Interview for Mental Status (BIMS) indicating moderate cognitive impairment. The resident required extensive assistance with dressing, personal hygiene, and bathing did not occur in the previous 7 day period. The resident's diagnoses included a stroke.</p> <p>The Care Plan included Resident #22 showed the behavior of abusive language initiated 2/14/20. Interventions included that the resident would show respect towards staff at all times, the staff would redirect the resident as needed, and the staff would show the resident respect at all times.</p> <p>A typed note documented on 7/23/22 at approximately 2 p.m. the Administrator received a call from a staff member reporting that other staff went to her about an incident that took place on 7/21/22 between Resident #22 and Staff D, a staffing agency Certified Nursing Assistant (CNA). The incident took place in the shower room, as the aide gave the resident a shower.</p> <p>On 4/17/23 at 1:40 p.m. Resident #22 stated last summer a male CNA took water in his hand, put it up to Resident #22's face, and tried to get it up his nose. He didn't remember the whole situation, what happened, or what started it. He did know something happened and he said something derogatory to the CNA which he thought made the CNA mad. And that's when he took the water up and put it in his face.</p> <p>On 4/25/23 at 12:12 p.m. Staff E, CNA, stated (on 7/23/22) they noticed Resident #22's face was like 1/2 shaved and they asked him what happened. He told them what happened when he had a shower (7/21/22). He was afraid to tell anyone because he said something derogatory to Staff D. Staff E and Staff F, CNA, reported it to the nurse.</p> <p>On 4/26/23 at 2:38 p.m. Staff F stated (on 7/23/22) that as they got Resident #22 up, he looked 1/2 shaven. When they asked him why he only had half of his face shaved, he replied that when he got his shower (7/21) Staff D got mad at him and put water in his face.</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.

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| LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE |
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| <p>F 0550</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p> | <p>The facility policy Resident Rights revised 4/1/19, documented that the resident had the right to a dignified existence, self-determination, and communication with and access to persons and services inside and outside the facility. The resident had a right to be treated with respect and dignity.</p> <p>44474</p> <p>2. The Minimum Data Set (MDS) assessment dated [DATE] for Resident #8 included diagnoses of heart failure, anxiety, and arthritis. The MDS showed the Brief Interview for Mental Status (BIMS) score of 13, indicating moderate cognitive impairment.</p> <p>On 4/18/23 at 3:27 p.m. Resident #8 reported that the staff came into her room without knocking or waiting before entering her room.</p> <p>3. The MDS assessment dated [DATE] for Resident #12 included diagnoses of hypertension (high blood pressure), depression, and anemia (low iron in the blood). The MDS showed the BIMS score of 14, indicating no cognitive impairment.</p> <p>On 4/17/23 at 1:18 p.m. Resident #12 explained that when she asks for a fresh water pitcher or a refill of her water the staff tell her they are too busy to get the water for her.</p> <p>4. The MDS assessment dated [DATE] for Resident #35 included diagnoses of anemia, hypertension, and depression. The MDS showed the BIMS score of 14 indicating no cognitive impairment.</p> <p>On 4/24/23 at 5:11 p.m. observed Resident #35 being wheeled out of the dining room with the urinary catheter bag hanging under the wheelchair with no privacy cover over the urinary catheter bag.</p> <p>On 4/24/23 at 5:17 p.m. watched Resident #35 being wheeled into the dining room to the table with a urinary catheter bag hanging under the wheelchair with no privacy cover over the urinary catheter bag.</p> <p>The Resident Rights policy revised 11/23/20 directed the following information:</p> <p>The resident has the right to voice grievances to the facility or other agency or entity that hears grievances without discrimination or reprisal. Such grievances include those with respect to care and treatment which has been furnished as well as that which has not been furnished; and the behavior of staff and of other residents; and other concerns regarding their LTC facility stay. The resident has the right to and the facility must make prompt efforts by the facility to resolve grievances the resident may have. The resident has a right to be treated with respect and dignity. Personal privacy includes accommodations, medical treatment, written and telephone communications, personal care, visits, and meetings of family and resident groups.</p> <p>On 5/4/23 at 12:27 p.m. the Director of Nursing (DON) explained that she expects staff to knock on the resident's door before entering the room, that catheter bags should be covered with a privacy cover, and if a resident requests water they should get it right away.</p> <p>44475</p> <p>(continued on next page)</p> | | |

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| <p>F 0550</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p> | <p>5. Resident #14's MDS dated [DATE] identified a BIMS score of 15, indicating intact cognition. The MDS revealed the resident needed extensive assistance of 1 person with transfers and toilet use. The MDS included diagnoses of heart failure (heart does not pump blood as effectively), orthostatic hypotension (blood pressure suddenly drops when you stand up from a seated or lying position), hip fracture, vascular dementia (problems with reasoning, planning, judgment, memory and other thought processes caused by brain damage from impaired blood flow to your brain), asthma (COPD, chronic obstructive pulmonary disease, cause airflow blockage and breathing-related problems) or chronic lung disease, respiratory failure, and renal insufficiency, renal failure, ESRD (end stage renal disease). The MDS listed Resident #14 as frequently incontinent of urine.</p> <p>On 4/17/23 at 3:46 PM, Resident #14 reported that she does not track how long it takes for her call light to be answered but that it takes a long time for staff to assist her to the restroom and she soils herself. She does not like to sit in her wet pants. Resident #14 explained that she sits in them a long time when staff do not answer her call light.</p> <p>The Care Plan revealed:</p> <ul style="list-style-type: none"> a. The resident requires assistance by one staff for toileting initiated 12/2/22. b. The resident requires assistance by one staff to move between surfaces initiated 12/2/22. c. The resident has a history of chronic UTI's (urinary tract infections) and is incontinent initiated 5/25/21. <p>The Call Light Accessibility and Timely Response Policy and Procedure dated October 2022 instructed to answer the call light as soon as possible.</p> <p>On 5/3/23 at 1:43 PM the Director of Nursing (DON) reported this was not acceptable practice and that rounding should be done more frequently for this resident.</p> | | |

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| <p>F 0584</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p> | <p>Honor the resident's right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 44474</p> <p>Based on record review and interviews, the facility failed to exercise reasonable care for the protection of the resident's property from loss or theft for 2 out of 3 residents reviewed (Resident #7 and #17). The facility reported a census of 38 residents.</p> <p>Findings include:</p> <p>1. Resident #7's Minimum Data Set (MDS) assessment dated [DATE] included diagnoses of multiple sclerosis (an illness that affects a person's movement), heart failure, and anemia (low iron in the blood). The MDS showed a Brief Interview for Mental Status (BIMS) score of 9, indicating moderate cognitive impairment.</p> <p>On 4/17/23 at 4:38 p.m. Resident #7's family revealed Resident #7 received some perfume as a Christmas gift and it went missing. Resident #7's family told the facility staff and did not know if the facility replaced the item.</p> <p>Review of Resident #7's medical record lacked information regarding her missing perfume.</p> <p>Review of the facility grievance logs lacked information that Resident #7 had missing perfume or the facility replacing the item.</p> <p>2. Resident #17's MDS assessment dated [DATE] included diagnoses of heart failure, hypertension (high blood pressure), and diabetes mellitus. The MDS showed a BIMS score of 14, indicating no cognitive impairment.</p> <p>Review of the grievance log dated 3/28/23 listed that Resident #17 had a current investigation due to a missing cell phone. The grievance log lacked a resolution, follow up, answer to be satisfied with the resolution, and additional follow up needed.</p> <p>On 4/25/23 at 8:48 a.m. the Administrator reported that Resident #17 went to the hospital, the clinic, and had a change in condition all within one week. The Administrator explained that Resident #17 reported her cell phone missing and the facility began to look for the phone. The facility could not locate the phone inside the facility or outside of the facility. The Administrator added that she had talked to Resident #17's daughter and her insurance covered almost all the cost of the cell phone. The facility was working with the family to cover what was not covered. The Administrator revealed Resident #17 not having her cell phone has had a large impact on her quality of life as that is how she communicated with her family.</p> <p>On 4/26/23 at 9:33 a.m. Resident #17 explained that she had a missing cell phone. She did not know the status of her phone being replaced at the time and to talk with her daughter as she might know more. Resident #17 further revealed she is lonely without her phone.</p> <p>(continued on next page)</p> | | |

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| <p>F 0584</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p> | <p>On 4/27/23 at 12:45 p.m. Resident #17's family revealed Resident #17 moved from one room to another and after the move she could not find her phone since. Resident #17's family revealed the insurance replaced the phone. The facility has been unable to tell them what happened to the phone. Resident #17's family revealed Resident #17 is getting frustrated not having a phone.</p> <p>Review of facility policy of Grievance or Concern revised March 2019 revealed the following information: To ensure the resident has the right to voice grievances to the facility or other agency or entity that hears grievances without discrimination or reprisal and without fear of discrimination or reprisal. Such grievances include those with respect to care and treatment which have been furnished as well as those which have not been furnished, the behavior of staff and of other residents; and other concerns regarding their stay at the facility. The procedure includes the following information:</p> <ol style="list-style-type: none"> 1. Grievances/Concerns will be submitted orally or in writing, using the Grievance/Concern Report form and signed by the person filing the report. 2. Completed Grievance/Concern form will be given to the facility Social Services Director or Administrator 3. All grievances/concerns will be logged and completed by the Social Services Director or assigned to the appropriate designated person for investigation. 4. A written report of investigation and recommended action(s) will be completed and returned to the Social Service Director/Administrator within 72 hours. 5. Administrator will review investigation findings and determine corrective actions to be taken. 6. A meeting with the resident/representative will occur to review the findings and actions(s) taken and/or those that will be taken. If they are not satisfied with the results, other actions will be developed as needed. 7. If the resident/representative is still not satisfied with the results of the investigation/actions, they may file a report with the Chief Operations Officer of the facility. A written response will be returned to the resident/representative within 10 (ten) days. The resident/representative also has the right to file a written grievance/concern with agencies/entities noted in policy above or others of their choice. <p>On 5/4/23 at 12:33 p.m. the Administrator explained that the facility has addressed the grievances since being brought to their attention.</p> | | |

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| <p>F 0600</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p> | <p>Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 26527</p> <p>Based on record review, staff and resident interview, the facility failed to assure residents were free from abuse for 1 of 2 resident's reviewed (Resident #22). The facility reported a census of 38 residents.</p> <p>Findings include:</p> <p>Resident #22's Minimum Data Set (MDS) assessment dated [DATE] identified a Brief Interview for Mental Status (BIMS) score of 10, indicating moderate cognitive impairment. The resident required extensive assistance with dressing, personal hygiene, and bathing did not occur in the previous 7 day period. The resident's diagnoses included a stroke.</p> <p>The Care Plan included Resident #22 showed the behavior of abusive language initiated 2/14/20. Interventions included the resident would show respect towards the staff at all times, the staff would redirect the resident as needed, and staff would show the resident respect at all times.</p> <p>A typed note documented on 7/23/22 at approximately 2 p.m. the Administrator received a call from a staff member reporting that other staff went to her about an incident that took place on 7/21/22 between Resident #22 and Staff D, a staffing agency Certified Nursing Assistant (CNA). The incident took place in the shower room, as the aide gave the resident a shower. The resident told the staff on duty when he got a shower on 7/21/22 a staff member got rough with him. The resident said he told the CNA the water was too hot and for the CNA to turn it down. The resident stated he turned it to ice cold. The resident stated he did make a racial comment, [NAME] of the jungle go back home. Then the CNA cupped his hand with cold water and put over the resident's mouth and nose, while pressing the resident's neck down until the water went up his nose. The resident tried to yell for help but could not. When the CNA let the resident go, the CNA stated he was not going to drown him.</p> <p>Staff E, CNA, wrote a statement on 7/23/22 that Resident #22 told her and Staff F, CNA, about his shower on 7/21/22. Resident #22 said Staff D was rough. Resident #22 told Staff D the water was too hot and Staff D turned it to ice cold. Resident #22 said Curious [NAME], go back to the jungle. Staff D then put cold water in his hands and began to push Resident #22's head down until he breathed in water. Resident #22 tried yelling for help and when Staff D let him go, Staff D told Resident #22 he was fine and that he was not going to drown him.</p> <p>Staff F documented on 7/23/22 at 1:30 p.m. that Resident #22 told her and Staff E about his last shower. Resident #22 said Staff D gave it to him and the water was hot so he complained to him to turn it down. He said Staff D turned the water ice cold. Resident #22 then made a bad comment calling Staff D [NAME] of the Jungle and that he should go home. Staff D cupped his hand with water, put it over Resident #22's mouth and nose, then pressed the back of his head down until water went up his nose. Resident #22 said he tried to yell for help but couldn't and when Staff D let him go he said he wasn't going to drown him.</p> <p>(continued on next page)</p> | | |

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| <p>F 0600</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p> | <p>On 7/25/22 Staff G, CNA, stated she had gone with Staff G to Resident #22's room to get him up for a shower. They proceeded to tell Resident #22 they would get him up for a shower. When the resident saw Staff G he got very inappropriate with her. Staff D asked the resident to please not to speak like that to her. The resident got angry that Staff D re-directed him so Resident #22 popped off telling him to go back to the jungle you Phillipine. Staff D asked Resident #22 to please stop making those racial comments, then proceeded to the shower room.</p> <p>Staff D wrote a statement indicating that on 7/21/22 he got scheduled as a shower aide for the 6th time in this daily position. He had showered 14 residents that day, both men and women. Resident #22 was scheduled that day. He transferred with the mechanical lift so he requested assistance from Staff G. They were getting Resident #22 ready to go for his shower and he started making sexual comments toward Staff G, and Staff D asked him to stop. Resident #22 got angry and told him to go back to the jungle you Phillipine. Staff D asked Resident #22 if that was a racist remark and if he could please stop. They went to the shower room and Staff D had the water running prior to starting in order to warm it up. He placed the resident in the shower stall and asked him to feel the water. He did and said it was fine. I started the limited assist shower, completed it, and told the resident thank you.</p> <p>On 4/17/23 at 10:25 a.m. the Social Services Director stated she found out about the incident (7/21/22) shortly after it occurred. She said the resident just prior to the incident had a BIMS score of 14 on July 20th. She said Resident #22 told her the staff member pushed his face into a handful of water with his other hand on the back of his neck. She didn't know when the resident first reported the incident. She said the previous Administrator conducted the investigation. She said Resident #22 had not made any false allegations against any staff member before or after this incident. Staff D was suspended during the investigation, and had not worked at the facility since.</p> <p>On 4/17/23 at 12:29 p.m. the previous Administrator stated she learned about the incident on the day of RAGBRAI (People who ride bikes from one side of the state to the other side). She had to get special permission to be able to get to the nursing home because of the area being cordoned off. She said she could only remember Resident #22 saying that the staff member had put water in his face trying to get it up his nose. She started an investigation and called the police. She didn't think Resident #22 would talk to the police at that time. She didn't remember exactly what happened, as it happened long ago. She said they decided to break Staff D's contract.</p> <p>On 4/17/23 at 1:40 p.m. Resident #22 stated he recalled a male CNA took water in his hand and put it up to his face trying to get it up his nose. He didn't remember the whole situation, what happened, or what started it. He did know something happened and he said something derogatory to the CNA which he thought made the CNA mad. The CNA scooped water up and put it in his face. He didn't feel it was abusive but it should never happen to anyone else. And if anybody else had that happen he would certainly tell somebody about it.</p> <p>On 4/18/20 at 2:41 p.m. Staff H, CNA, stated he only remembered Staff D as lazy and that he argued with the residents.</p> <p>On 4/18/23 at 2:52 p.m. Staff I, CNA, said she worked at the facility the previous summer and in July. She only remembered Staff D being rude to the residents and staff. He knew that Resident #22 didn't care for him and if he came in the room he told him to get out.</p> <p>(continued on next page)</p> | | |

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| <p>F 0600</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p> | <p>On 4/18/23 at 3:25 p.m. Staff K stated he was kind of a** to the staff and residents. Residents thought he was rude and didn't like him.</p> <p>On 4/19/23 at 8:05 a.m. Staff L, Licensed Practical Nurse (LPN), denied knowing anything about the incident first hand just hearsay. Some of the residents reported Staff D as rough after he left.</p> <p>On 4/23/23 at 10:48 a.m. Staff D stated he recalled an incident at the facility. He said the resident complained about him doing something to him in the shower. Staff D stated he did the showers and even put on his statement how many days that he had done showers. Staff D explained that he gave Resident #22 showers without any issues. He said prior to him going to the shower (7/21/22) he and his girlfriend, Staff G, went to get Resident #22 up with the sit to stand lift. During that time Resident #22 became inappropriate to Staff G. At that time, Staff D told Resident #22 that was inappropriate, and please do not talk to her that way. He said Resident #22 did get upset and said a racial comment to him but he couldn't remember what he said. Staff D took Resident #22 to the shower and he'd already had the water warming up. There were no issues with the water, no complaints. The shower went fine. Staff D reported being surprised when they called him to the office to talk about it. They did not have him finish out his contract.</p> <p>On 4/25/23 at 12:12 Staff E stated (on 7/23/22) they noticed Resident #22's face looked only 1/2 shaved and they asked him what happened. He told them what happened when he had a shower (7/21). He was afraid to tell anyone because he said something about a monkey and going back to the jungle. Staff E and Staff F reported it to the nurse.</p> <p>On 4/26/23 at 2:38 p.m. Staff F stated (on 7/23/22) that as they got Resident #22 up, he looked 1/2 shaven. When they asked him why he only had half of his face shaved, he replied that when he got his shower (7/21) Staff D got mad at him and put water in his face.</p> <p>The facility Abuse Prevention Policy and Procedure effective August 2018, revised March 2019 and December 2022 documented all residents had the right to be free from abuse, neglect, misappropriation of resident property, exploitation, corporal punishment, involuntary seclusion, and any physical or chemical restraint not required to treat the resident's medical symptoms.</p> | | |

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| <p>F 0622</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p> | <p>Not transfer or discharge a resident without an adequate reason; and must provide documentation and convey specific information when a resident is transferred or discharged.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 26527</p> <p>Based on record review and staff interview, the facility failed to allow a resident to allow a resident to return to the facility after hospitalization for 1 of 4 residents reviewed (Resident #39). The facility reported a census of 38 residents.</p> <p>Findings include:</p> <p>Resident #39's Minimum Data Set (MDS) assessment dated [DATE] identified that she had no short term memory problem and required modified independence with skills for daily decision making. The resident's diagnoses included paranoid schizophrenia and bipolar disorder.</p> <p>The Progress Notes dated 2/6/23 at 1:00 a.m. indicated that the staff heard Resident #39 yelling in her room while at the nurses station. The nurse and the Certified Nursing Assistant (CNA) entered the room and Resident #39 sat up in bed talking to herself. Resident #39 verbalized the medications (meds) were making her ill and the doctor and nurses were trying to kill her. She verbalized she would not take any more meds. Staff unsuccessfully attempted to redirect her. Resident #39 yelled at the staff to get out and leave her alone. The staff saw Resident #39 walking toward the nursing station shortly after with a purse, and bending down to lay across the floor. Resident #39 appeared alert with confusion, had dry, warm skin, denied pain, and shortness of breath (SOB). Vital Signs (VS): blood pressure 162/78 (an average range 120/80), pulse - 72 (average 60-100), respirations-16 (average 12-18), oxygen - 93% (average 90-100%) temperature - 98.1 (average 98.6). Resident #39 verbalized she was going home and had discharge papers at the nurse's station from the doctor. She also verbalized that her mom was a Registered Nurse (R.N.) and the only one who knew how to take care of her. Staff notified the on-call clinician 12:20 a.m. with a new order to send to the emergency room (ER) for evaluation due delusion and safety concerns.</p> <p>The Progress Notes dated 2/6/23 at 5:17 a.m. documented a call to the hospital to receive update on Resident #39 and spoke with an ER nurse who stated she would be admitted to the floor. In addition, the ER nurse stated they ran a lab test and diagnosed her with a urinary tract infection (UTI).</p> <p>A hospital Behavioral Medicine Progress Note dated 2/23/23 documented the resident was ready for discharge and the plan was for the next day but the staff at her facility were saying they could not take her back. They had not given her a 30 day notice, but due to previous behaviors they did not want her to come back. Unfortunately Resident #39 had nowhere else to go. Administration was working with the facility related to their reluctance to take her back. Resident #39 did not have a medical reason for her to remain in the hospital.</p> <p>Resident #39's clinical record lacked documentation about what needs the facility could not meet for Resident #39, and what attempts the facility had made to meet the needs. The record lacked the resident's physician documenting the basis for not allowing the resident to return to the facility.</p> <p>(continued on next page)</p> | | |

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| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 165145 | (X2) MULTIPLE CONSTRUCTION A. Building B. Wing | (X3) DATE SURVEY COMPLETED 05/04/2023 |
| NAME OF PROVIDER OR SUPPLIER Embassy Rehab and Care Center | | STREET ADDRESS, CITY, STATE, ZIP CODE 206 Port Neal Road Sergeant Bluff, IA 51054 | |
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| <p>F 0622</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p> | <p>On 4/25/23 at 11:05 a.m. the Long Term Care (LTC) Ombudsman said she received a call from the hospital about the facility refusing to take the resident back. The LTC Ombudsman contacted the facility and found they had not given the resident or her representative a 30 day discharge notice. The LTC Ombudsman informed the facility they would need to take the resident back, and then give the 30 discharge notice. The Administrator said they would not take her back, as they could not provide the care she needed.</p> <p>On 4/25/23 at 12:15 p.m. the Administrator stated the resident was having behavior issues and they couldn't provide the kind of care she needed at that time. They wanted to send her back when she wasn't stable, and they could not take her back that way. It had always been their intention to take her back when she was stable.</p> <p>On 4/26/23 at 2:13 p.m. a hospital representative stated the doctor determined Resident #39 to be stable and could return to the facility, but the facility refused to accept her back. They have had to change the way they do things to avoid having this happen again.</p> <p>The facility policy Discharge Plan and Summary revised March 2019 documented the resident's reason for discharge/transfer would be documented in the medical record: the basis for the discharge/transfer and appropriate information communicated to the receiving health care institution or provider. If the discharge/transfer was for resident needs unable to be met, documentation must include what needs, what attempts the facility has made to meet the needs, and the service available at the receiving facility to meet the needs. If the reason for transfer or discharge is a. or b. below the resident's physician MUST DOCUMENT IN THE MEDICAL RECORD, THE BASIS FOR THE TRANSFER. If the reason for transfer or discharge is c. or d. below, A PHYSICIAN MUST DOCUMENT IN THE MEDICAL RECORD THE BASIS FOR THE TRANSFER.</p> <p>a. Transfer/discharge necessary for the Resident's welfare and the Resident's needs cannot be met by facility.</p> <p>b. The transfer/discharge was appropriate because the Resident's health had improved sufficiently so the Resident no longer needs the services provided by the facility.</p> <p>c. The safety of individuals in the facility was endangered due to the clinical or behavioral status of the resident.</p> <p>d. The health of individuals in the facility would otherwise be endangered.</p> | | |

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| <p>F 0660</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p> | <p>Plan the resident's discharge to meet the resident's goals and needs.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 44474</p> <p>Based on clinical record review and interview, the facility lacked discharge planning for 1 of 3 residents reviewed in the closed record sample (Resident #38). The facility reported a census of 38 residents.</p> <p>Findings:</p> <p>Resident #38's Minimum Data Set (MDS) assessment dated [DATE] indicated the reason for the assessment due to his discharge from the facility without an anticipated return. The MDS identified a Brief Interview for Mental Status (BIMS) score did not get assessed. The MDS included diagnoses of diabetes mellitus, Bipolar disorder (mood disorder), and anxiety disorder.</p> <p>Resident #38's Census listed a discharge date of [DATE] with a status to stop billing.</p> <p>The Orders - Administration note dated 1/30/23 at 6:23 p.m. indicated that Resident #38 discharged from the facility at 3:55 p.m.</p> <p>Resident #38's Care Plan revised 2/13/23 lacked information regarding his plans for discharge.</p> <p>The 72 hour Care Plan Meeting and Discharge Plan lacked a list of attendees to the meeting and/or items needed to help the resident achieve his discharge goal.</p> <p>The Discharge Plan and Summary policy revised March 2019 instructed the following:</p> <ul style="list-style-type: none"> - When a resident's goal is to return to home/previous living, and the discharge is feasible, the facility will develop and implement an effective discharge planning process that focuses on: <ul style="list-style-type: none"> a. Resident's discharge goals. b. Preparing residents to be active partners in post-discharge care. c. Effective transition of the resident from skilled nursing care (SNF) to post SNF care. d. Reduction of factors leading to preventable readmissions. - Discharge planning will be initiated at time of admission. <ul style="list-style-type: none"> a. Complete the 72-hour Care Plan Meeting and Discharge Plan. - The facility will work with the resident and their representative(s) to develop a person-centered Care Plan for Discharge. The Care Plan should include: <ul style="list-style-type: none"> a. Resident's goals for facility stay and their desired outcomes will be care planned. b. Resident's preference and potential for future discharge. <p>(continued on next page)</p> |

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| <p>F 0660</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p> | <p>c. Document whether the resident's desire to return to the community was assessed and any referrals to local contact agencies and/or other appropriate entities for this purpose in discharge plan and care plan.</p> <p>d. Include discharge plans in the comprehensive care plan as appropriate.</p> <p>- Facility's discharge planning process will:</p> <p>a. Ensure that the discharge needs of each resident are identified and result in the development of a discharge plan for the resident.</p> <p>b. Include regular re-evaluation of the resident to identify changes that require modification of the discharge plan. The discharge plan must be updated as needed to reflect these changes.</p> <p>c. Consider caregiver/support person availability and the resident's or caregiver's capacity and capability to perform the required care as part of the Identification of discharge needs.</p> <p>d. Involve the Interdisciplinary team (IDT), resident, and resident representative(s) in development of the plan and inform resident and their representative(s) of the final plan.</p> <p>e. Address the resident's goals of care and TX preferences.</p> <p>f. Document that a resident has been asked about their interests in receiving info regarding returning to the community.</p> <p>- Facility will document and complete on a timely basis, based on the resident's needs, and include in the medical record, the evaluation of the resident's discharge needs and discharge plan. The results of the evaluation will be discussed with the resident or resident's representative. All relevant resident information will be incorporated into the discharge plan to facilitate its implementation and to avoid unnecessary delays in the resident's discharge or transfer.</p> <p>On 5/4/23 at 12:24 p.m. the Director of Nursing (DON) explained that in the electronic health record each department fills out the boxes for their department and signs them. They should be filled out completely.</p> | | |

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| <p>F 0661</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p> | <p>Ensure necessary information is communicated to the resident, and receiving health care provider at the time of a planned discharge.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 44474</p> <p>Based on clinical record review and interview, the facility lacked a discharge summary including a recapitulation of a resident's stay for 3 of 3 residents reviewed in the closed record sample (Resident #38, #45 and #46). The facility reported a census of 38 residents.</p> <p>Findings Include:</p> <p>1. Resident #38's Minimum Data Set (MDS) assessment dated [DATE] indicated the reason for the assessment due to his discharge from the facility without an anticipated return. The MDS identified a Brief Interview for Mental Status (BIMS) score did not get assessed. The MDS included diagnoses of diabetes mellitus, Bipolar disorder (mood disorder), and anxiety disorder.</p> <p>Resident #38's Census listed a discharge date of [DATE] with a status to stop billing.</p> <p>The Orders - Administration note dated 1/30/23 at 6:23 p.m. indicated that Resident #38 discharged from the facility at 3:55 p.m.</p> <p>Resident #38's clinical record lacked a completed discharge summary including a recapitulation of the resident's stay.</p> <p>Resident #38's clinical record included an incomplete Discharge or Transfer Summary that lacked signatures and information regarding his stay in the facility.</p> <p>Resident #38's Discharge instructions lacked signatures and instructions for the receiving facility.</p> <p>2. Resident #45's MDS assessment dated [DATE] indicated the reason for the assessment due to his discharge from the facility without an anticipated return. The MDS identified a BIMS score of 15, indicating no cognitive impairment. The MDS included diagnoses of hypertension, major depressive disorder, and anemia.</p> <p>Resident #45's Census listed a discharge date of [DATE] with a status to stop billing.</p> <p>The Discharge Note dated 3/9/23 at 12:20 p.m. identified that Resident #45 discharged from the facility at 12:07 p.m. to another facility.</p> <p>Resident #45's clinical record lacked a completed discharge summary including a recapitulation of his stay.</p> <p>Resident #45's clinical record included an incomplete Discharge or Transfer Summary that lacked signatures and information regarding his stay in the facility.</p> <p>Resident #45's Discharge Instructions lacked signatures and instructions for the receiving facility.</p> <p>(continued on next page)</p> |

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| <p>F 0661</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p> | <p>3. Resident #46's MDS assessment dated [DATE] listed the purpose of the assessment due to her discharge without an anticipated return to the facility. The MDS identified a BIMS score of 15, indicating intact cognition. The MDS included diagnoses of hypertension, major depressive disorder, and anemia.</p> <p>Resident #45's Census listed a discharge date of [DATE] with the status to stop billing.</p> <p>The Orders - Administration Note dated 11/4/22 at 11:29 a.m. indicated that Resident #46 discharged from the facility at 11:20 a.m. to another facility.</p> <p>Resident #46's clinical record lacked a completed discharge summary including a recapitulation of the resident's stay.</p> <p>The Discharge Plan and Summary policy revised March 2019 instructed the following:</p> <p>- IDT will complete the discharge summary on all residents who are discharged to include but not limited to:</p> <p>a. recapitulation of the resident's stay that includes, diagnoses, course of disorder/treatment or therapy, pertinent lab, radiology, and consult results.</p> <p>b. A final summary of the resident's status to include items in the comprehensive assessment at the time of discharge.</p> <p>c. Reconciliation of all pre-discharge medications with the resident's post discharge medications (both prescribed and over-the counter)</p> <p>d. A post-discharge plan of care that is developed with the participation of the resident and, with the resident's consent, the resident representative, which will assist the resident to adjust to his/her new living environment. The post-discharge plan of care must indicate where the individual plans to reside, any arrangements that have been made for the resident's follow-up care, any post-discharge medical and non-medical services</p> <p>e Follow-up plans for resident post-discharge</p> <p>f. Resident's consent acquired to share information</p> <p>g. Resident's name and signature and date</p> <p>h. Name of Practitioner</p> <p>i. Ongoing SpecialInstructions</p> <p>j. Advance Directive</p> <p>On 5/4/23 at 12:24 p.m. the Director of Nursing (DON) explained that in the electronic health record each department fills out the boxes for their department and signs them. They should be filled out completely.</p> | | |

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| <p>F 0676</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p> | <p>Ensure residents do not lose the ability to perform activities of daily living unless there is a medical reason.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 44474</p> <p>Based on clinical record review, facility policy review, resident, and staff interviews the facility failed to provide bathing assistance twice weekly and/or per resident preference for 4 of 4 residents reviewed for bathing (Residents #5, #7, #12 and #26). The facility reported a census of 38 residents.</p> <p>Findings include:</p> <p>1. Resident #5's Minimum Data Set (MDS) assessment dated [DATE] identified a Brief Interview for Mental Status (BIMS) score of 13, indicating no cognitive impairment. The MDS included diagnoses of anxiety, pain in the right hip, and hypothyroidism (underactive thyroid that regulates metabolism).</p> <p>Resident #5's MDS assessment dated [DATE] listed her functional status for bathing as totally dependent with one person physical assistance.</p> <p>Resident #5's Care Plan revised 4/14/23 lacked information regarding bathing assistance.</p> <p>The Documentation Survey Report reviewed from 11/1/22 until 1/31/23 included documentation to indicate Resident #5 received a bath on 11/29/22 and 1/20/23. The forms lacked additional documentation to indicate Resident #5 received or got offered a bath except on 11/18/22. The documentation listed the task as not applicable.</p> <p>The February 2023 Documentation Survey Report lacked documentation to indicate Resident #5 received a bath from 2/1/23 - 2/10/23 and 2/12/23 - 2/18/23.</p> <p>The March 2023 Documentation Survey Report lacked documentation to indicate Resident #5 received a bath from 3/2/23 - 3/7/23 and 3/12/23 - 3/17/23. The documentation for 3/8/23 listed the task as not applicable.</p> <p>The April 2023 Documentation Survey Report reviewed on 4/24/23 lacked documentation to indicate Resident #5 received a bath from 4/1/23 - 4/3/23 and from 4/15/23 - 4/24/23.</p> <p>2. Resident #7's MDS assessment dated [DATE] identified a BIMS score of 9, indicating moderately impaired cognition. The MDS include diagnoses of multiple sclerosis, heart failure, and anemia. The MDS indicated Resident #7's functional status for bathing required physical help in part of the bathing activity from one person physical assistance.</p> <p>Resident #7's Care Plan revised 4/18/23 identified that bathing and showering required assistance of two people.</p> <p>The Documentation Survey Report reviewed from 11/1/22 until 12/31/22 included documentation to indicate Resident #7 received a bath on 11/2/22 and 12/14/22. The forms lacked additional documentation to indicate Resident #7 received or got offered a bath except on 11/26/22. The documentation listed the task as not applicable.</p> <p>(continued on next page)</p> | | |

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| <p>F 0676</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p> | <p>The January 2023 Documentation Survey Report lacked documentation that Resident #7 received a bath from 1/1/23 - 1/13/23 and 1/15/23 -1/20/23.</p> <p>The February 2023 Documentation Survey Report lacked documentation that Resident #7 received a bath from 2/6/23 - 2/13/23 and 2/16/23 - 2/21/23.</p> <p>The March 2023 Documentation Survey Report lacked documentation that Resident #7 received a bath from 3/2/23 - 3/7/23 and 3/16/23 -3/21/23.</p> <p>The April 2023 Documentation Survey Report reviewed on 4/24/23 lacked documentation that Resident #7 received a bath from 4/1/23 - 4/5/23 and 4/18/23 - 4/24/23.</p> <p>3. Resident #12's MDS assessment dated [DATE] identified a BIMS score of 14, indicating intact cognition. The MDS included diagnoses of hypertension, depression and anemia. The MDS indicated Resident #12's functional status for bathing required physical help in part of the bathing activity from one person physical assistance.</p> <p>On 4/17/23 at 1:20 p.m. Resident #12 explained that when the facility is short staffed, residents did not get their baths done.</p> <p>Resident #12's Care Plan revised 4/10/23 lacked any information on bathing assistance.</p> <p>The Documentation Survey Report reviewed from 11/1/22 until 1/31/23 included documentation to indicate Resident #12 received a bath on 11/4/22 and 11/29/23. The forms lacked additional documentation to indicate Resident #12 received or got offered a bath except on 11/18/22 and 1/24/23. The documentation listed the task as not applicable.</p> <p>The February 2023 Documentation Survey Report lacked documentation that Resident #12 received a bath from 2/1/23 - 2/10/23 and 2/12/23 - 2/17/23.</p> <p>The March 2023 Documentation Survey Report lacked documentation that Resident #12 received a bath from 3/2/23 - 3/7/23 and 3/12/23 - 3/17/23. The documentation on 3/8/23 listed the task as not applicable.</p> <p>The April 2023 Documentation Survey Report reviewed on 4/24/23 lacked documentation that Resident #12 received a bath from 4/10/23 - 4/24/23. The documentation on 4/13/23 listed the task as not applicable.</p> <p>4. Resident #26's MDS assessment dated [DATE] identified a BIMS score of 15, indicating no cognitive impairment. The MDS included diagnoses of hypertension, atrial fibrillation (abnormal heart rate) and cardiac murmur (abnormal heart rhythm).</p> <p>The Documentation Survey Report reviewed from 11/1/22 until 2/28/23 included documentation to indicate Resident #26 received a bath on 11/7/22, 11/10/22, 11/21/22, and 1/12/23. The forms lacked additional documentation to indicate Resident #26 received or got offered a bath.</p> <p>The March 2023 Documentation Survey Report lacked documentation to indicate Resident #26 received a bath from 3/17/23 - 3/22/23.</p> <p>(continued on next page)</p> | | |

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| <p>F 0676</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p> | <p>The April 2023 Documentation Survey Report reviewed on 4/24/23 lacked documentation to indicate Resident #26 received a bath from 4/1/23 - 4/5/23 and 4/7/23 - 4/24/23. The forms lacked additional documentation to indicate Resident #26 received or got offered a bath except documentation on 4/3/23, 4/10/23, and 4/13/23 that listed the task as not applicable.</p> <p>The facility verified that they do not have a policy on bathing.</p> <p>On 5/4/23 at 12:42 p.m. the Director of Nursing (DON) reported that bathing is to be done two times a week or as the resident prefers.</p> | | |

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| <p>F 0684</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p> | <p>Provide appropriate treatment and care according to orders, resident's preferences and goals.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 26527</p> <p>Based on record review, staff, and resident interview, the facility failed to assess residents after alleged reports of physical abuse for 1 of 3 residents reviewed (Resident #22). The facility reported a census of 38 residents.</p> <p>Findings include:</p> <p>According to the Minimum Data Set (MDS) assessment dated [DATE] Resident #22 scored 10 on the Brief Interview for Mental Status (BIMS) indicating moderate cognitive impairment. The resident required extensive assistance with dressing, personal hygiene, and bathing did not occur in the previous 7 day period. The resident's diagnoses included a stroke.</p> <p>The Care Plan included Resident #22 showed the behavior of abusive language initiated 2/14/20. Interventions included that the resident would show respect towards staff at all times, the staff would redirect the resident as needed, and the staff would show the resident respect at all times.</p> <p>A typed note documented on 7/23/22 at approximately 2 p.m. the Administrator received a call from a staff member reporting that other staff went to her about an incident that took place on 7/21/22 between Resident #22 and Staff D, a staffing agency Certified Nursing Assistant (CNA). The incident took place in the shower room, as the aide gave the resident a shower. The resident told the staff on duty when he got a shower on 7/21/22 a staff member got rough with him. The resident said he told the CNA the water was too hot and for the CNA to turn it down. The resident stated he turned it to ice cold. The resident stated he did make a racial comment, [NAME] of the jungle go back home. Then the CNA cupped his hand with cold water and put over the resident's mouth and nose, while pressing the resident's neck down until the water went up his nose. The resident tried to yell for help but could not. When the CNA let the resident go, the CNA stated he was not going to drown him.</p> <p>The resident's clinical record lacked any documentation that the facility conducted an assessment or follow-up of the resident related to the report.</p> <p>On 5/2/23 at 11:48 a.m. an email from the Administrator documented there should have been a Risk Management Incident Report that would have prompted staff to contact the physician and follow appropriate measures. The Administrator could not find any documentation in his chart for any follow up and interventions. The Administrator remarked that an incident such as this should have been examined by the Interdisciplinary Team to ensure proper treatment and Care Planning. The Risk Management Incident would have driven this focus to this incident.</p> | | |

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| NAME OF PROVIDER OR SUPPLIER Embassy Rehab and Care Center | | STREET ADDRESS, CITY, STATE, ZIP CODE 206 Port Neal Road Sergeant Bluff, IA 51054 | |
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| <p>F 0689</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Some</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** 44474</p> <p>Based on clinical record review, staff interviews, facility record review and facility policy review, the facility failed to ensure residents at risk for elopement were unable to exit the facility unattended for 2 of 2 residents reviewed for elopement (Residents #39 and #18). The facility's failure resulted in an Immediate Jeopardy to the health, safety, and security of the residents.</p> <p>The State Agency informed the facility of the Immediate Jeopardy (IJ) that began as of January 17, 23 on April 18, 23 at 12:58 p.m. The Facility Staff removed the Immediate Jeopardy on April 19, 23 through the following actions:</p> <p>a. The facility engaged an additional keypad door alarm on the North Door. The door alarm sound is loud and heard throughout the facility. When the door alarm goes off, staff must enter a code at the door to turn it off. The keypad door alarm activated immediately at 1:30 p.m. on 4/18/23. The [NAME] President of Operations (VPO) and Administrator called a staff meeting to educate all present employees that effective immediately to not use the North door unless taking out trash. The Administrator notified all staff not present by a text message at 1:59pm.</p> <p>b. The Director of Nursing (DON) educated the resident who smoked to no longer use the North Door and if followed by another resident to immediately alert a staff member. The facility moved the designated smoking area to the front of the building at the time.</p> <p>c. The facility contacted the alarm company to verify the installation time of the new alarm system. The company verified the date for the alarm as 4/25/23.</p> <p>d. The facility will educate all staff to respond to all door alarms to ensure that it is not a resident leaving the facility by 4/19/23.</p> <p>f. The facility will educate all staff by 4/19/23 on the risk of elopement for residents, the facilities elopement policy and the importance of responding to door alarms.</p> <p>g. The facility will complete an updated elopement risk assessment on all residents by 4/19/23.</p> <p>h. The facility will educate the staff on the revised elopement book. The elopement book will flag residents at risk for eloping. The Maintenance Director or designee will conduct an audit twice a day to ensure that all door alarms work correctly and that the staff respond to the alarms until the installation of the new door lock system on the north double doors by 4/26/23. The facility will continue to do audits until the installation of the new locking system.</p> <p>The scope lowered from a K to an E at the time of the survey after ensuring the facility implemented education and their policy and procedures.</p> <p>(continued on next page)</p> | | |

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| <p>F 0689</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Some</p> | <p>Findings Include:</p> <p>Resident #39's Minimum Data Set (MDS) assessment dated [DATE] identified a Brief Interview for Mental Status (BIMS) score of 13, indicating intact cognition. The MDS included diagnoses of diabetes mellitus, Bipolar disorder (mood disorder), and anxiety disorder. Resident #38 completed all her activities of daily living independently.</p> <p>The Social Services Note dated 1/17/23 at 10:51 a.m. indicated that the Social Services Director (SSD) sat and discussed the incident of when Resident #39 decided to take a walk outside without permission. Resident #16 explained that she talked with a cousin friend the day before. They mentioned donuts, so she went out for donuts. But once outside she forgot about the donuts. Resident #16 added that she became confused about her location and her plan. Resident #16 added that she wanted to go outside to get fresh air, as she had not been outside for ages. The SSD reminded her that they had colder weather then when she usually goes out for her walks. The SSD also reminded Resident #39 that when went out for a walk, she usually walked in the front lot area. This allowed the staff to keep an eye on her and know that she is out there. Resident #16 reported that she thought she told another resident. The SSD stated that she could not tell another resident. Resident #16 replied no, she told the Administrator. The SSD planned to investigate her report. The SSD reminded Resident #16 to ask a staff member to go outside with her, if she wanted to get some fresh air. If the floor staff is busy, she could ask the Activity Director (AD) or the SSD, and they would help.</p> <p>The Orders - Administration Note dated 1/30/23 at 12:08 AM indicated that staff completed hourly checks on Resident #16 due to exit seeking behavior that day and the day before.</p> <p>The Behavior Note dated 1/30/23 at 7:18 AM identified that Resident #16 attempted to exit the facility early in the shift.</p> <p>The Behavior Note dated 2/5/23 at 10:00 PM indicated that Resident #16 attempted to go out the front door twice with other residents' visitors as they left. She verbalized that she wanted to go outside because of it being so nice out. The staff explained to Resident #16 that she could only go out with staff for her safety. The remaining of the shift, she remained on one to one (1:1) supervision until she went to her room and got in bed. The facility then completed 15 minutes checks on her.</p> <p>2. On 4/18/23 at 9:22 a.m. watched Resident #1 exit the building out of the north service entrance to smoke. Exited the building with Resident #1 and heard the door alarm sounded until the door closed. When asked if he needed to enter a code to go back into the building, Resident #1 reported the door did not have a code that worked. He added that someone could just open the door and when they close the door the alarm turns off. Resident #1 remarked that he did that every day. Witnessed Resident #1 reentered the door with the alarm sounding and turned off after entering the building and closing the door.</p> <p>On 4/18/23 at 9:47 a.m. the Maintenance Director reported that he checked the door alarms weekly. When asked about the north service entrance he revealed that the mag lock did not work due to shifting of the door frame. The facility applied a temporary alarm after Resident #39 left the building. The facility is working on getting alarms on the double doors before the exit but are currently waiting on alarm company.</p> <p>(continued on next page)</p> | | |

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| <p>F 0689</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Some</p> | <p>On 4/18/23 at 10:52 a.m. Staff C, Licensed Practical Nurse (LPN), reported that the facility has an elopement binder for all the residents at risk for elopement. Upon further examination Staff C, explained that the binder contained all the residents in the facility. Staff C explained that they determined the resident's elopement risk by looking in the computer under the elopement risk form.</p> <p>On 4/18/23 at 11:15 a.m., Staff C explained that he worked at the facility as a Certified Medication Aide (CMA) when Resident #38 left the building. Staff C reported that Resident #38 exited the facility on the north side of the building. He added that the facility did not have an alarm on the door. Staff C explained that after Resident #38 exited the facility, they installed a makeshift alarm on the north exit door. Staff C reported that the staff cannot hear the alarm unless staff members are at or close to the nurses' station. Staff C confirmed that he did not receive education or training after Resident #38 exited the building without staff knowing.</p> <p>The list of residents at risk for elopement dated 4/18/23 listed Resident #33.</p> <p>The Elopement Policy revised March 2019 instructed that the facility nursing personnel must report and investigate all reports of missing residents.</p> <p>On 4/19/23 at 11:23 a.m. the Administrator vocalized that the facility had a different Administrator at the time of the incident but she did review the report and understood that Resident #38 left the building through the north doors. When the police department called Resident #38 gave them a false name. After sometime the police department called back again, then the staff figured out that Resident #38 left the facility. The Administrator reported that she expected the staff to answer a door alarm if the door alarms worked.</p> <p>44475</p> <p>3. Resident #18's MDS dated [DATE] identified a BIMS score of 3, indicating severely impaired cognition. The MDS indicated that Resident #18 required extensive assistance from two persons with bed mobility, transfers, toilet use. Resident #18 independently used his manual wheelchair. The MDS including a diagnosis of encephalopathy (disease that affects brain function).</p> <p>The resident's Electronic Health Record (EHR) included a form labeled Identified Wander/Elopement Risk dated 11/19/22. The Emergency Medical Information list that Resident #18 had a diagnosis of dementia.</p> <p>The Elopement Risk Assessments summary question if the resident had an elopement risk, included documentation in each assessment that Resident #18 did not have a risk for elopement on the following dates:</p> <ol style="list-style-type: none"> 1. 12/21/22 2. 3/27/23 3. 4/19/23 <p>(continued on next page)</p> | | |

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| <p>F 0689</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Some</p> | <p>On 4/17/23 at 1:02 PM observed Resident #18 sit in his wheelchair in front of the nurses' station in between a space of the facility entrance and the North hall. During the observation the resident moved around the space using his feet to propel the wheelchair, looking around as though he needed assistance. During the observation, Resident replied when asked that he wondered where he should go, what he should do, and reported that he wanted to go home.</p> <p>On 4/18/23 at 10:25 AM, Staff M, Certified Nurse Aide (CNA), reported that Resident #18 knew where to find his room, they explained that he wandered the building. Resident #18 has reported to Staff M that he did not know where he's going, that he occasionally reports that he wants to go home, but he did not have exit seeking behaviors and usually congregated towards groups of people.</p> <p>26527</p> <p>4. On 4/18/23 at 9:10 a.m. the Marketing/Admissions Director stated if the front door opened without putting in the code the alarm sounded and got louder until somebody checked it and put in the code. The side doors that go out to the dumpsters (alarm) sounded when the door opened, and when the door closed it went off.</p> <p>On 4/18/23 at 9:25 a.m. the Business Office Manager (BOM) stated if the front door opened the alarm sounded and someone needed to go to the alarm and see if a resident went out. They could shut the alarm off by putting in the code. If someone put the code in, the alarm sounded if the door stayed open too long.</p> <p>On 4/18/23 at 9:30 a.m. Staff Q, CNA, said she would need to ask someone what she would do if a door alarm sounded. She went to the nurses' station and asked what they should do. She returned and said if an alarm sounded they went and checked the door. If they did not see a resident they reported it to the nurse so they could check the residents.</p> <p>The BOM reported the alarm sounded if the (alarm) door stayed open more than 19 seconds.</p> <p>On 4/18/23 at 9:35 a.m. Staff T, Dietary Aide, stated they take garbage out the side door and it beeps while open and stops when it shuts.</p> <p>On 4/18/23 at 10:38 a.m. Staff N, Licensed Practical Nurse (LPN), denied knowing if the facility had an elopement risk. She did not really know who was at risk. She said residents with mental impairment would be at risk. She added that she would check on who was at risk.</p> <p>At 10:42 a.m. Staff N explained that they did assessments on residents. She said they did have an elopement binder and she would get it.</p> <p>(continued on next page)</p> |

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| <p>F 0689</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Some</p> | <p>On 4/18/23 at 11:17 a.m. the Social Services Director stated the day of Resident #39's elopement she came in late. They asked her check Resident #39's BIMS and she scored a 15, indicating no cognitive impairment. Resident #39 said she went to meet her mom, as her mom and dad were going to pick her up in the pickup truck. She went out the side smoking door which didn't have an alarm at that time. She said they put the current alarm in place at that time. She could not even guess how long they didn't have an alarm on that door. They questioned if she followed another resident out. She said Resident #39 used to go out all the time and walk last fall. She said prior to her elopement, Resident #39 started packing up her things and pushed it out in the hall because she was leaving here. But she had never exit seek before.</p> <p>On 4/18/22 at 11:41 a.m. the Administrator at time of Resident #39's elopement stated she stopped working at the facility on 1/20/23. She thought Resident #39 got out and down past the fire department. She thought they went and got her, but not sure. She was tying up loose ends because she was leaving. Resident #39 did like to go out and walk. She knew the passcode to go out the front door. The Administrator thought that she went out there. She said someone called but they did not think anyone was missing. She thought Resident #39 packed her stuff up one time. She did not exit seek. The Administrator at the time said they had someone in the offices that could observe her when she went outside. On the weekend they had a nurse manager who could observe her outside. She said they had never had an elopement before. She thought Resident #39 had something mentally going on. She said that all the door alarms alarmed at that time. If they had a door without an alarm they would have someone watching that door.</p> <p>On 4/18/23 at 12:16 p.m. the BOM stated Resident #39 got out (eloped) before she got to work. She did know for sure what door she went out, but Resident #39 did know the code to the front door. She did not know if all the doors had the same code but she would find out.</p> <p>The BOM came to report all the doors had the same code to get out without alarming.</p> <p>On 4/19/23 at 3:20 p.m. Staff X, CNA, stated she just returned from maternity leave that day. She thought the facility maybe had 1 or 2 residents at risk for elopement. She said residents who were elopement risks would be on 15-minute checks. She said if a door alarm went off she would check where the alarm went off and check to see if anyone went out. If she didn't see anyone outside she would probably check to make sure no one was missing by looking in each resident's room.</p> <p>On 4/19/23 at 3:45 p.m. Staff W, CNA, said she didn't think the facility had anyone at risk for elopement at that time. If a door alarm went off she would go to the nurses' station to see which door it was, and go to the door to check if anyone went out. Then she would go and tell the nurse that no one left.</p> <p>On 4/20/23 1:15 p.m. Staff V, CNA, explained that the facility did tell them what they needed to know about door alarms and any new policies. She said they cannot go out the side door unless taking garbage out. Now the door had an alarm on it with the door code. She said if you hear a door alarm you have check whichever door it was and make sure that no residents went out. If you could not identify who went out, you must go check and make sure everybody's accounted for. She said reported Resident #33 as an elopement risk so they watched her more closely. She'd never actually seen Resident #33 try to go out. Staff V said that she received education about alarms and elopement yesterday.</p> <p>(continued on next page)</p> | | |

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| <p>F 0689</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Some</p> | <p>On 4/20/23 at 1:23 p.m. Staff U, CNA, explained that she knew what to do with the alarms and elopements, as they received education. She felt up to date on how to answer the alarms, how to deal with alarms, and the elopement risk. They had received new direction on using the side door, and that they could only use the door to take out the garbage. The door had a full alarm and a keypad.</p> <p>On 4/20/23 at 1:32 p.m. Staff B, CNA, able to tell the new policy with the side door and the alarm for that door, and who could go out that door. She knew of the elopement risk. In addition, Staff B knew how to answer the door alarms and ensure the safety of everyone.</p> | | |

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| <p>F 0725</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p> | <p>Provide enough nursing staff every day to meet the needs of every resident; and have a licensed nurse in charge on each shift.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 44475</p> <p>Based on clinical record, facility policy, resident interview, and staff interview, the facility failed to answer a resident's call light in a timely manner for 1 of 19 residents reviewed (Resident #4). The facility reported a census of 38 residents.</p> <p>Findings include:</p> <p>Resident #4's Minimum Data Set (MDS) assessment dated [DATE] identified a Brief Interview for Mental Status (BIMS) score of 15, indicating intact cognition. The MDS included diagnoses of multiple sclerosis and paraplegia. The MDS indicated that Resident #4 required extensive assistance of two persons with bed mobility and total assistance from two persons with transfers. The MDS identified Resident #4 with a risk of developing pressure ulcers/injuries.</p> <p>On 4/26/23 at 11:48 AM, Resident #4 reported that on 4/25/23 she laid in her bed on her back from 1:30 PM to 4:30 PM without having a position change. Resident #18 explained that she put her call light on at 3:30 PM. Someone answered the call light and told her that another staff person would need to be located to assist with the transfer. After 30 minutes, Resident #4 put back on her call light. Someone told her that they needed to locate another staff person to assist with her transfer. Resident #4 reported that at 4:30 PM, they transferred her from her bed to her wheelchair.</p> <p>The Call Light Accessibility and Timely Response Policy and Procedure policy dated October 2022 directed:</p> <ol style="list-style-type: none"> 1. The process for responding to call lights: Answer the call light as soon as possible. 2. If the resident needs assistance with a procedure, summon help by using the call light, and stay with the resident until help arrives. |

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| <p>F 0727</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p> | <p>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.</p> <p>44475</p> <p>Based on facility nursing schedule reviews and staff interviews, the facility failed to assure a registered nurse (RN) on duty for 8 hours a day, 7 days per week. The facility reported a census of 38 residents.</p> <p>Findings include:</p> <p>Review of the facility's nursing staff schedule dated 10/01/22 through 12/05/22 revealed the following days lacked a RN on duty for 8 hours</p> <p>10/3/22</p> <p>10/12/22</p> <p>10/13/22</p> <p>10/26/22</p> <p>11/4/22</p> <p>11/19/22</p> <p>11/20/22</p> <p>11/24/22</p> <p>11/26/22</p> <p>11/27/22</p> <p>12/4/22</p> <p>On 4/24/23 at 3:50 p.m. the Director of Nursing (DON) reported she was the only RN on the schedule when she started PRN (as needed) in October 2022.</p> <p>On 4/25/23 at 7:35 a.m. the DON verified the lack of RN coverage in October and November 2022. The DON stated she would expect to have 8 hours of RN coverage every day.</p> <p>On 4/25/23 at 7:55 a.m. the DON reported the facility does not have a policy on RN coverage.</p> |

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| <p>F 0755</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p> | <p>Provide pharmaceutical services to meet the needs of each resident and employ or obtain the services of a licensed pharmacist.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 41785</p> <p>Based on policy and chart review, and interviews the facility failed to accurately document the use of narcotic medications for 1 of 3 residents reviewed. The facility reported a census of 38 residents.</p> <p>Findings include:</p> <p>Resident #40's Minimum Data Set (MDS) assessment dated [DATE] identified a Brief Interview for Mental Status (BIMS) of 00, indicating severe cognitive impairment. The MDS listed that Resident #40 received Hospice services. The MDS included diagnoses of type II diabetes mellites, anxiety disorder, and urinary tract infections.</p> <p>The Order details dated 1/18/22 at 10:53 PM listed an order for hydrocodone-acetaminophen (pain medication narcotic) tablet 5-325 milligrams (MG). The order directed to give one tablet two times a day for breakthrough pain and one tablet every 4 hours as needed (PRN) for pain.</p> <p>The Controlled Medication Utilization Record for 7/21/22 through 7/31/22 had documentation to indicate that Resident #40 received three doses of hydrocodone-acetaminophen tablet 5-325 milligrams (MG) on 7/28/22.</p> <p>Resident #40's July 2022 Medication Administration Record (MAR) received her scheduled dose of hydrocodone-acetaminophen tablet 5-325 milligrams (MG) twice that day. The PRN dose lacked documentation that Resident #40 ever received a dose.</p> <p>A bound book used for documentation of the utilization of narcotics showed that on 11/23/22 Resident #40 had 29 hydrocodone pills left. On the bottom of the form it had documentation indicating the destruction of the medication on 1/23/23. The document lacked signatures.</p> <p>On 4/26/23 at 4:24 PM, the Director of Nursing (DON) said that she and the previous administrator destroyed the remaining 29 tablets of hydrocodone on 1/23/23. She acknowledged that they failed to sign the document and she understood that the policy instructed to have two nurse signatures for the destruction of controlled substances.</p> <p>On 4/27/23 at 1:00 PM the Administrator said they expected the staff to have two signatures when destroying controlled substances.</p> <p>The Narcotics-Counting and Destruction policy dated March 2019 directed to provide accurate regulation and maintenance of controlled substances. The narcotic record number should correspond with the number in the index. Staff were to chart the disposal of controlled substances from in the resident chart and the narcotic book with two nurse's signatures. Medication destruction on controlled substances needs completed by DON/license nurse designee and a second license nurse.</p> | | |

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| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information) | | |
| <p>F 0804</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p> | <p>Ensure food and drink is palatable, attractive, and at a safe and appetizing temperature.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 41785</p> <p>Based on observation, interview, and policy review the facility failed to serve food at the recommended temperatures to ensure palatability for 38 residents. The facility reported a census of 38 residents.</p> <p>Findings include:</p> <p>1. On 4/20/23 from 11:00 through the end of the lunch service, observed the fruit ambrosia salad left sitting out without a cooling method in place. At the end of service at 12:09 PM the temperature of the salad was 61 degrees Fahrenheit.</p> <p>The Healthcare Services Group Dining Service Department Policy and Procedure Manual last revised on September 2017, the section titled; Food Storage; Cold Food instructed that all perishable foods would maintain a temperature of 41 degrees or below.</p> <p>26527</p> <p>2. On 4/20/23 at 7:25 a.m. observed glasses of liquids (including milk) sitting on tables with no residents in the dining room. At 7:50 a.m. Resident #22 came to the breakfast table (liquids had been sitting out since 7:25 a.m.). At 8 a.m. another resident had milk sitting out in lidded cups came to the table, and another resident came to the dining room, both liquids sat out since 7:25 a.m. At 8:48 a.m. Resident #20 came to the dining room and sat at a table with liquids including milk sitting out. The staff pushed the milk up to the resident and asked the kitchen for her food. When asked, the Dietary supervisor temped the milk at 67.8 degrees, said it was too warm, and removed it from the table.</p> <p>44474</p> <p>3. Resident #8's Minimum Data Set (MDS) assessment dated [DATE] identified a BIMS score of 13 indicating moderate cognitive impairment. The MDS included diagnoses of heart failure, anxiety and arthritis.</p> <p>On 4/18/23 at 3:22 p.m., Resident #8 remarked that she eats in her room and the dining room. She explained that she receives many of her meals cold. Resident #8 added that it does not make a difference if she eats in the dining room or in her room for the temperature of the food.</p> <p>A test tray received on 4/26/23 at 9:12 a.m. consisting of scrambled eggs, oatmeal, and bacon. The temperature of the food assessed revealed the temperature of the eggs at 118 degrees Fahrenheit (F), oatmeal at 128.9 F, and bacon warm to the touch</p> <p>A second test tray received on 4/26/23 at 1:01 p.m. consisted of a meal of ham, cooked cabbage, and sweet potatoes. The temperature of the food assessed identified a temperature for ham at 133 F, cabbage at 119.7 F, and sweet potatoes at 137.4 F.</p> <p>44475</p> <p>(continued on next page)</p> | | |

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| <p>F 0804</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p> | <p>4. Resident #24's MDS assessment dated [DATE] identified a BIMS score of 15, indicating intact cognition. The MDS listed Resident #24 as independent with eating with set up assistance only. The MDS included diagnoses of unspecified vision loss, vitamin d deficiency, and alcohol use, unspecified with other alcohol-induced disorder.</p> <p>On 4/17/23 at 1:30 PM Resident #24 reported that she gets her food served cold sometimes.</p> <p>The Food: Quality and Palatability policy revised September 2017 revealed food will be palatable, attractive, and served at a safe and appetizing temperature.</p> | | |

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| <p>F 0805</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Some</p> | <p>Ensure each resident receives and the facility provides food prepared in a form designed to meet individual needs.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 41785</p> <p>Based on observations, clinical record review, resident and staff interviews and facility policy review the facility failed to assure that resident received the recommended therapeutic menu for residents at risk for choking for 5 of 5 residents reviewed (Residents #8, #6, #13, #22, and #27). This failure increased the risk of residents choking or aspirating (something entering the lungs), therefore causing an Immediate Jeopardy to the health, safety, and security of the resident.</p> <p>The State Agency informed the facility of the Immediate Jeopardy (IJ) that began as of April 24th at 3:45 P. M. The Facility Staff removed the Immediate Jeopardy on April 25, 2023 through the following actions:</p> <ol style="list-style-type: none"> 1. [NAME] President of Operations, Nurse Consultant, Director of Nursing, Administrator, and Dietary Manager met at 3:20 PM on 4/24/23 to discuss Therapeutic Diets to gain understanding of problem areas. 2. The facility educated the Dietary Manager on subject of diet types, mechanically altered, additives, and consistencies on 4/24/2023 at 4:40PM. 3. The facility instructed the Dietary Manager to oversee all special instruction diets that came out of the kitchen <p>from 4:40 PM on 4/24/23 to lunchtime on 4/25/23 to ensure the staff follow the resident's diets according to the physician's order. The facility instructed the Dietary Manager on specific instructions in the case that a resident refused the diet as ordered on 4/24/23.</p> <ol style="list-style-type: none"> 4. The facility planned a meeting for on 4/25/23 at 9:30 AM between dietary cooks, Speech Therapy, management crew and a representative from their consulting company to provide education. The staff received education on following diet orders, communication to Speech Therapy and their involvement, and steps to ensure staff followed the physician's orders. 5. The facility created audits to ensure regular compliance weekly for one month and once a month for one year to follow. The Dietary Manager will complete the audits beginning the week ending 4/28/23. <p>The scope lowered from a K to an E at the time of the survey after ensuring the facility implemented education and established procedures to ensure resident safety at meal time.</p> <p>Findings Include:</p> <p>(continued on next page)</p> | | |

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| <p>F 0805</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Some</p> | <p>1. Resident #13's Minimum Data Set (MDS) assessment dated [DATE] identified a Brief Interview for Mental Status (BIMS) score of 10, indicating moderately impaired cognition. The MDS indicated that Resident #13 only required set up assistance for eating. The MDS included diagnoses of heart failure, renal insufficiency, diabetes mellitus and seizure disorder. The MDS listed that Resident #13 had a mechanically altered diet (thickened liquids, ground, or pureed food).</p> <p>The Care Plan Focus revised 6/15/22 indicated that Resident #13 ate independently but had dietary restrictions due to his diagnosis of diabetes. The Interventions directed the following</p> <p>a. Revised 4/1/21: Speech Therapy (ST) evaluate and treat him as needed.</p> <p>b. Staff to give him, his diet as ordered and monitor him for the need to change his diet and/or texture.</p> <p>The Order Details dated 9/22/22 listed an order for dysphagia advanced diet texture with regular fluid consistency.</p> <p>On 4/24/23 at 12:50 PM, observed Resident #13 receive a hamburger patty on a bun. He took one bit of the sandwich and chewed for a long period of time. He then removed the top of the bun and with his fork pulled pieces of meat apart to eat in smaller bites.</p> <p>2. Resident #6's MDS assessment dated [DATE] identified a BIMS score of 11, indicating moderately impaired cognition. The MDS included a diagnosis of cerebral palsy. The MDS indicated that Resident #6 required supervision with set-up assistance with meals. The MDS listed that Resident #6 received a mechanical altered diet.</p> <p>The Speech Therapy Evaluation and Plan of Treatment dated 11/10/22 identified that the ST saw Resident #6 due to her having an increased dislike of her current diet of mechanical soft textures. Resident #16 warranted an analysis of her diet textures and liquid consistencies to ensure safe swallowing and her risk for aspiration. Resident #6 had a risk for aspiration, a further decline in function, and pneumonia. The documentation indicated that Resident #16 tolerated her mechanical soft diet with no signs or symptoms of aspiration. She required moderate verbal and visual cues to use safe swallow strategies. Resident #16 demonstrated the highest level of safe intake with the mechanical soft textures. The ST recommended that Resident #16 continued her diet texture. Resident #16 had inadequate mastication (rotary chew pattern) and poor attention to task decreased self-monitoring.</p> <p>The Order Details dated 4/6/22 listed an order for dysphagia advanced diet texture with regular fluid consistency.</p> <p>On 4/24/23 at 12:50 PM, observed the staff serve Resident #6 a hot dog cut into bite sized pieces. She ate the pieces without assistance with several staff members in the dining area.</p> <p>On 4/24/23 at 2:17 PM the Dietary Manager (DM) said that the residents get a list of food options. At the bottom of the list had options classified as always available which included a hot dog and a hamburger on a bun. She said that a resident on the dysphasia advanced diet would need to have the hamburger and/or hot dog ground before they received it.</p> <p>(continued on next page)</p> |

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| <p>F 0805</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Some</p> | <p>On 4/24/23 at 2:24 PM Staff R, Dietary Aide, said that none of the residents with a mechanical soft diet chose a hamburger or hot dog for lunch that day. She said that she did not grind any hamburger patties or hot dogs for lunch.</p> <p>On 4/27/23 at 11:52 AM the DM looked at the list of education for the kitchen staff and verified that only 1 of the 4 current dietary staff received education on texture modification. She said that the company provided the education on a rotation basis. The DM reported September 2022 as the last time the education module offered and 3 of the 4 current staff did not start until after that date.</p> <p>According to the Diet and Nutritional Care Manual dated 2019, the National Dysphagia Diet Levels were as follows:</p> <ul style="list-style-type: none"> a. Level 1: Dysphagia Pureed b. Level 2: Mechanically Altered c. Level 3: Dysphagia Advanced d. Regular Diet. <p>The allowed Dysphagia Advanced foods included moistened meats with sauce or gravy, must be tender, fruits without skins and moistened breads. The Dysphagia Advanced foods not allowed included dry tough meat, grapes, corn, potato skins, dry, tough, or crusty bread.</p> <p>On 4/24/23 at 5:08 PM the Registered Dietician (RD) for the facility said that the DM had the responsibility to educate new staff and make sure they understand the diets they serve. She agreed that the always available listed on the bottom of a resident's menu may be confusing if staff do not understand that they need to grind these meats for an Advanced Dysphasia diet.</p> <p>On 4/25/23 at 9:26 AM the ST reported that she gave a very specific description of diets to include meat textures, veggies, and fruits. She then sends these recommendations to the doctor for the orders. She agreed that an Advanced Dysphagia diet must have the meats ground.</p> <p>44474</p> <p>3. Resident #8's MDS assessment dated [DATE] identified a BIMS score of 13, indicating intact cognition. The MDS included diagnoses of heart failure, anxiety and arthritis.</p> <p>The General Note dated 2/17/23 at 12:50 p.m. indicated that Resident #8 had a choking episode out of the facility. The provider indicated they would send over orders for ground meat.</p> <p>The General Note dated 2/17/23 at 3:33 p.m. listed the facility received the ground meat order.</p> <p>The Health Status Note dated 4/20/23 at 1:21 p.m. identified that the facility received an order by fax from the primary care physician for Resident #8's diet to change to a regular consistency, carbohydrate-controlled diet.</p> <p>(continued on next page)</p> | | |

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| <p>F 0805</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Some</p> | <p>Resident #8's medical chart lacked documentation of a Speech Evaluation to assess for safety to advance her diet.</p> <p>26527</p> <p>4. On 4/19/23 at 1:12 p.m. Resident #22 sat in the dining room. He stated he finished his lunch. Meat remained on the plate, splayed out. Resident #22 stated they didn't have any mashed potatoes. Resident #22's menu showed garlic mashed potatoes circled. His tablemate, Resident #27 said they didn't have any mashed potatoes, they got stir fry instead. There were red skinned potatoes on Resident #27's plate. Resident #22 and Resident #27's menus both showed Regular-Dysphagia Advanced diet. The menus did not have the option for red skinned potatoes. A menu indicating Regular diet had garlic roasted red skinned potatoes on the menu.</p> <p>The Dietary Manager (DM) checked the menus and said Resident #22 and Resident #27 received the wrong food items. She thought that they were the only ones.</p> <p>On 4/20/23 at 10:02 a.m. Resident # 24 stated she was on a special diet because of difficulty swallowing. She said sometimes they ground the meat and sometimes they didn't. She said she couldn't eat the ground sometimes because it was so dry. Some broth or gravy on it would help. She said she had been eating the meat when they didn't grind it.</p> <p>At 10:08 a.m. Resident #6 said they did not grind her meat.</p> <p>On 4/20/23 at 12:35 p.m. staff delivered resident noon meals. Residents on dysphagia advanced diets, and requested a sandwich received the contents ground including the bread. Two residents pushed it away and asked where their sandwich was.</p> <p>At 1:20 p.m. the DM stated she would have to get a therapeutic menu they didn't have one in the kitchen and they should have.</p> <p>At 2 p.m. the Dietician stated residents should receive their diets as ordered. She stated she knew some of the residents were on mechanical soft due to the status of their teeth.</p> <p>At 2:45 p.m. the DM pulled up the therapeutic menu dysphagia advanced and it showed ground meat went on the bun. Looked at other menus and they called for ground meat on bread (not a ground meat sandwich).</p> <p>On 4/24/23 at 12:49 p.m. Resident #24 received the casserole, carrots and cauliflower, bread and cake. Resident #24's menu called for no peas. The casserole had both peas and corn in it. Resident #24 stated she received the carrots not entirely cooked and were too hard to eat. She could not eat peas because if the skin sloughed off it could get stuck in her throat. Resident #22 received the casserole, cauliflower and carrots, bread and pineapple. Resident #27 received the same, and said she received carrots not fully cooked enough and hard to eat.</p> <p>On 4/24/23 at 1:17 p.m. the DM confirmed Resident #24 should not have received the casserole with peas in it, and those on advanced dysphagia diets should not have received corn. The resident should have completely cooked carrots and soft for dysphagia advanced diets.</p> <p>(continued on next page)</p> | | |

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| <p>F 0805</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Some</p> | <p>44475</p> <p>5. The MDS dated [DATE] for Resident #27 revealed a BIMS of 15 which indicated intact cognition. The same MDS revealed the resident had diagnoses of metabolic encephalopathy (a brain condition that can cause confusion and memory loss), anemia (low amount of iron in blood, iron found in meat), and mental disorder. The MDS revealed the resident was independent with eating, had speech therapy service from 12/2/22 to 12/23/22, and had a mechanically altered diet - require change in texture of food or liquids (e.g., pureed food, thickened liquids).</p> <p>The SPL (Speech Language Pathologist) Evaluation and Plan of Treatment with a start of care date of 12/6/22 revealed:</p> <p>1. Reason for referral: Resident #27 referred to Speech Therapy (ST) by dietary due to their reports of difficulty with mastication (chewing) of meats/harder textures. The ST recommended Skilled ST to evaluate for analysis of diet texture and liquid consistencies to determine least restrictive diet and implement preventative strategies for decreased risk of aspiration. Without skilled ST Resident #27 has at risk for aspiration and malnutrition due to their inability to safely consume regular textures.</p> <p>2. Intake recommendations mechanical soft/ground textures.</p> <p>The Order dated 12/6/22 signed by a physician revealed per speech therapy, may we have an order for diet change to mechanical soft, ground meat, soft veggies, soft bite sized bread, and purred fruits with the physician response as yes.</p> <p>On 4/17/23 at 12:37 PM observed Resident #27 receive a formed meat patty. Resident #27 left the meat patty uneaten.</p> <p>In an interview on 4/17/23 at 12:37, the resident reported he should have ground meat and pointed out the ground meat only wording on his menu slip that came with his noon meal. The resident reported he receives the incorrect texture for foods often.</p> <p>On 4/19/23 at 1:33 PM, Resident #27 reported that he received soft roast beef for lunch that he could, but the meat did not get ground. In addition, he received potatoes with the skin on them.</p> | | |

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| <p>F 0812</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p> | <p>Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards.</p> <p>44475</p> <p>Based on observations, facility policy, and staff interview, the facility failed to store kitchen ware in a way to protect it from contaminants, seal and date opened food, and failed to provide a sanitary kitchen environment. The facility reported a census of 38 residents.</p> <p>Findings include:</p> <ol style="list-style-type: none"> 1. On 4/17/23 at 10:34 AM observed the following: <ol style="list-style-type: none"> a. Silverware divider open to air with adaptive silverware including regular forks and knives. b. Container of spoons open to air. c. Open bag of potato flakes not sealed. d. Open bag of corn starch not sealed. e. Microwave with dried brown substance splattered on inner door, bottom, and sides. f. Drawer in stainless steel unit that contained a two basin sink with brown and red dried substance. g. Undated orange, apple, and cranberry juice bags fed into a serving unit. h. Serving table with dishes serving side up. i. Storage and mixing bowls not inverted. j. Dried brown substance on serving table unit. k. Dried brown substance and brown dried debris in two drawers in stainless steel food preparation table. l. Open and undated hardboiled eggs in a clear plastic bag in the refrigerator. <p>The Food Storage: Cold Foods policy revised April 2018 instructed to store all foods wrapped or in covered containers, labeled and dated, and arranged in a manner to prevent cross contamination.</p> <p>The Environment policy revised September 2017 directed that the Dining Services Director would ensure that a routine cleaning schedule is in place for all cooking equipment, food storage areas, and surfaces.</p> <p>On 5/4/23 at 12:48 PM the Dietary Manager (DM) reported that she expected the kitchen to be clean, open foods sealed and dated, and kitchenware to be stored in a manner to prevent contamination.</p> <p>(continued on next page)</p> | | |

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| <p>F 0812</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p> | <p>41785</p> <p>2. The continuous observation of the lunch service on 4/20/23, witnessed Staff S, Dietary Aide, wear the same gloves throughout the meal service (at 12:20, 12:24, 12:25, 12:26, 12:40 and 12:45). Staff S touched many surfaces, utensils, bread bags, then touched the pizza, and handled buns with same pair of gloves.</p> <p>On 4/20/23 at 1:53 PM the Dietary Manager said that she expected staff to use tongs to handle food, not gloved hands, and that she expects them to change their gloves after staff had touched potentially contaminated surfaces.</p> <p>The Healthcare Services Group Dining Service Department Policy and Procedure Manual revised September 2017 instructed all staff to practice proper hand hygiene and glove use. The staff would adhere (follow) to proper utensils or clean gloved hands for food handling. The section titled; Food Storage; Cold Food directed that all perishable maintain a temperature of 41 degrees or below.</p> |

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| <p>F 0880</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p> | <p>Provide and implement an infection prevention and control program.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 41785</p> <p>Based on observations, interviews, record, and policy review the facility failed to establish and implement effective infection control practices. The staff failed to review the infection control policies annually and failed to establish a process for monitoring the threat of water borne pathogens. In addition, the staff failed to use proper personal protective equipment (PPE) while caring for a resident in transmission-based precautions (Resident #16), and the staff failed to use proper hand hygiene and PPE during care for 1 resident, (Resident #4). The facility reported a census of 38 residents.</p> <p>Findings include:</p> <p>1. On [DATE] at 3:49 PM the Maintenance Manager (MM) said that when first started at the facility, he had some education on the management of water borne pathogens but they last tested the water for legionella three years before. He said that the facility had some test strips on the shelf but they already expired. He acknowledged that they hadn't established a process for monitoring for water borne pathogens and they did not flush the lines in the building.</p> <p>On [DATE] at 1:00 PM the Administrator said that she consulted with someone at the corporate office that said there weren't any tests to monitor for legionellae. She said they would do some further research.</p> <p>The facility provided a copy of a handbook developed by the Centers for Disease Control (CDC) titled: Developing a Water Management Program to Decrease Legionella Growth and Spread in Building dated [DATE]. The handbook directed staff to actively identify and manage hazardous conditions that support growth and spread of Legionella. Staff need to identify and control hazardous conditions that increase the chance of Legionella growth and spread.</p> <p>A workbook tool provided by the facility titled: Legionella Water Management Plan included a step by step process for monitoring. The purpose of the tool was to promote proactive steps to establish healthy, infection-free environments for residents, staff and visitors. When residents contract Legionnaires' disease, it is often the result of exposure to inadequately managed building water systems, that is preventable. The document remained incomplete.</p> <p>2. A review a policy titled: Infection Prevention and Control Program Overview Policy reviewed in March of 2019.</p> <p>The Policy lacked additional documentation of reviews after [DATE].</p> <p>On [DATE] at 11:09 AM the Director of Nursing (DON) and Assistant Director of Nursing ADON confirmed that the last update of the infection control policy happened in 2019.</p> <p>(continued on next page)</p> | | |

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| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 165145 | (X2) MULTIPLE CONSTRUCTION A. Building B. Wing | (X3) DATE SURVEY COMPLETED 05/04/2023 |
| NAME OF PROVIDER OR SUPPLIER Embassy Rehab and Care Center | | STREET ADDRESS, CITY, STATE, ZIP CODE 206 Port Neal Road Sergeant Bluff, IA 51054 | |
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| <p>F 0880</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p> | <p>3. On [DATE] at 1:48 PM Staff P, Certified Nurse Aide (CNA), came in the front door and said she was just beginning her shift. She explained that due it being the beginning of her work week she took the COVID-19 test. She said that the facility tested on ce a week, or twice a week if someone tests positive. Staff P swabbed her nose without using gloves or completing hand hygiene after doing the test. She laid the test on the table without barrier, grabbed a pen off the table, and wrote her name on the sheet. She then grabbed some things in her purse, waited seven minutes, and documented that the test as negative. Two more staff members came in the door and started to get tests out of the box without the use of gloves. Staff P put the pen down on the notebook and invited the other staff members to use it if they needed. She then entered the facility without completing any hand hygiene.</p> <p>44475</p> <p>4. Resident #16's Minimum Data Set (MDS) dated [DATE] identified a Brief Interview of Mental Status (BIMS) score of 13, indicating intact cognition. The MDS included diagnoses of medically complex conditions of major depression, diabetes mellitus, and cellulitis. The MDS listed that Resident #16 had a pressure ulcer and infection in his foot (such as cellulitis skin infection or purulent drainage infection related drainage).</p> <p>The Microbiology Routine Culture laboratory report dated [DATE] indicated that Resident #40's wound had resistance to vancomycin.</p> <p>The Health Status note dated [DATE] at 10:56 PM revealed Resident #16 had a wound to his left leg that tested positive for VRE (bacteria resistant to some antibiotics). The note indicated the next shift received notification of the infection. The note included that the facility initiated and followed isolation precautions.</p> <p>The Order signed [DATE] by a physician revealed left buttock wound: cleanse with soap and water, dry, apply Aquacel Ag or calcium alginate and cover with border gauze. Change daily and PRN (as needed) for wound care and every day shift for wound care.</p> <p>On [DATE] at 2:00 PM observed Staff N, Licensed Practical Nurse (LPN), with the Director of Nursing (DON) present perform a dressing change procedure to Resident #16's pressure ulcer to her left buttock. After cleansing the wound with soap, Staff N changed her gloves without performing hand hygiene. In addition, Staff N failed to wear a face shield during the procedure.</p> <p>On [DATE] at 2:23 PM the DON agreed that the staff needs to complete hand hygiene with glove changes and educated Staff N during the interview. Staff N reported that she needed to hurry the procedure because Resident #16 made her feel rushed when she called out for her to complete the procedure quickly. Staff N reported that she usually performed hand hygiene with glove changes. During the interview both the DON and Staff N acknowledged that they knew Resident #16's wound had an infection. When asked how the staff know when to apply all the PPE or only part of the PPE required for contact precautions as listed on the sign on the resident's room door, the DON responded that she personally always puts on all the required PPE because she never knows for sure if the resident will need help going to the bathroom or if body fluids could splash. The DON reported that PPE for contact precautions did not require a face shield.</p> <p>(continued on next page)</p> | | |

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| <p>F 0880</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p> | <p>On [DATE] at 2:27 PM the DON reported that the facility had issues with communication of resident information from the wound clinic. The facility explained that due to the issues with communication, they did not know Resident #16 had VRE (bacteria resistant to the vancomycin antibiotic) for two days.</p> <p>The Centers for Disease Control and Prevention (CDC) article Implementation of Personal Protective Equipment (PPE) Use in Nursing Homes to Prevent Spread of Multidrug-resistant Organisms (MDROs) reviewed [DATE] directed that with contact precautions, the staff may need face protection if performing an activity with risk of splash or spray.</p> <p>The VRE policy revised [DATE] directed that</p> <ol style="list-style-type: none"> 1. Enterococci are bacteria that are normally present in the human intestines and in the female genital tract. 2. They can cause urinary tract, bloodstream, wound infections, or other infections. 3. Caregivers can pass VRE from person to person by their hands following contact with a resident or contaminated surfaces. <p>5. Resident #4's Minimum Data Set (MDS) assessment dated [DATE] identified a Brief Interview for Mental Status (BIMS) score of 15, indicating intact cognition. The MDS included diagnoses of multiple sclerosis and paraplegia. The MDS indicated that Resident #4 required extensive assistance of two persons with bed mobility and total assistance from two persons with transfers. The MDS identified Resident #4 with a risk of developing pressure ulcers/injuries.</p> <p>The Medication Review Report dated [DATE] signed by a physician revealed an order to change urostomy every week every evening shift every Wednesday.</p> <p>Observation on [DATE] at 2:01 PM of Staff C, Licensed Practical Nurse (LPN), perform a urostomy appliance change procedure with the ADON present. During the procedure, Staff C removed his gloves, and without performing hand hygiene, looked through supplies in the resident's drawers to find a new extension piece for the catheter tubing, scratched his face under his face mask, and failed to perform hand hygiene before putting on gloves. Staff C then applied the tubing extension to the catheter bag and tubing.</p> <p>On [DATE] at 2:26 PM, the ADON agreed that staff need to do hand hygiene in between glove changes and after touching their face.</p> <p>The Handwashing/Hygiene policy revised [DATE] instructed the following</p> <ol style="list-style-type: none"> 1. Handwashing, being the single most effective way of controlling the spread of infection, staff to perform routine and thorough hand hygiene to protect residents from the spread of infection. 2. The staff are to complete hand hygiene before donning (putting on) and after the removal of gloves and/or other PPE (such as a gown, facemask, etc.) 3. The use of gloves does not replace handwashing/hand hygiene. | | |

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| <p>F 0887</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p> | <p>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.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 41785</p> <p>Based on interviews, policy and chart review the facility failed to offer the COVID-19 booster immunizations to 3 of 5 residents reviewed (Residents #31, #14, and #16).</p> <p>Findings include:</p> <p>1. Resident #31's Minimum Data Set (MDS) assessment dated [DATE] listed an admitted [DATE]. The MDS identified a Brief Interview for Mental Status (BIMS) score of 5, indicating severely impaired cognition.</p> <p>Resident #31's Immunization Record listed that she received her first dose of COVID-19 vaccine on 11/10/21 and the second dose on 12/6/21. The Immunization Record lacked documentation of other COVID-19 vaccines.</p> <p>Resident #31's clinical record lacked documentation that the facility offered or gave her a COVID-19 booster vaccine.</p> <p>2. Resident #14's MDS assessment dated [DATE] listed an admitted [DATE]. The MDS identified a BIMS score of 15, indicating intact cognition.</p> <p>Resident #14's Immunization Record listed that she received her first dose of COVID-19 vaccine on 1/15/21 and the second dose on 2/26/21. The Immunization Record lacked documentation of other COVID-19 vaccines.</p> <p>Resident #14's clinical record lacked documentation that the facility offered or gave her a COVID-19 booster vaccine.</p> <p>3. Resident #16 Minimum Data Set (MDS) dated [DATE] identified a Brief Interview of Mental Status (BIMS) score of 13 which indicated intact cognition. The MDS listed Resident #16's admitted as 11/30/22.</p> <p>Resident #16's Immunization Record listed that she received her first dose of COVID-19 vaccine on 6/4/21, a second dose on 2/26/21, and a third dose on 1/6/22. The Immunization Record lacked documentation of other COVID-19 vaccines.</p> <p>Resident #16's clinical record lacked documentation that the facility offered or gave her an additional COVID-19 booster vaccine.</p> <p>(continued on next page)</p> | | |

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| <p>F 0887</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p> | <p>On 4/20/23 at 11:09 AM, The Director of Nursing (DON) and the Assistant Director of Nursing (ADON) said that they did not know why the residents did not receive an offer to have the COVID-19 booster but they thought it had something to do with the pharmacy's availability to come to the facility to provide the immunizations. They remarked that the residents could get their booster vaccines from their primary care doctor as the only other option when the residents went to their appointments. They acknowledged that the facility lacked an established system or process to ensure that the residents received the opportunity to have the COVID-19 boosters.</p> <p>The COVID-19 Vaccination Policy and Procedure dated October 2022 instructed the staff to offer the COVID-19 vaccination to residents when supplies were available, and as recommended by the Centers for Disease Prevention and Control.</p> | | |