STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	165525	A. BUILDING _____ B. WING _____	08/17/2020

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
THE NEW HOMESTEAD	2306 STATE STREET GUTHRIE CENTER, IA 50115

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)
F 0561 **Level of harm -** Actual harm **Residents Affected -** Few	**Honor the resident's right to and the facility must promote and facilitate resident self-determination through support of resident choice.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review, staff and family interviews the facility failed to ensure resident rights were met due to a resident was not allowed to have family visit during the end of life for 1 of 2 (Resident #1) residents reviewed. The facility reported a census of 46 residents. Findings include: The quarterly Minimum (MDS) data set [DATE] for Resident #1 revealed the resident scored ,[DATE] for her Brief Interview of Mental Status, which indicated she was cognitively intact. The resident required extensive assist of 1 person for bed mobility, transfers, dressing and toileting and independent with eating with set up help only. The MDS revealed she weighed 133 pounds and did not have a significant weight loss or gain. The MDS identified the resident at risk for pressure related breakdown and identified the resident without pressure sores. The Face Sheet for the resident revealed [DIAGNOSES REDACTED]. The Care Plan focus screen for Covid-19 dated [DATE] included an intervention for staff to follow the guidelines from national, state and local authorities for visitation restrictions. The Progress Note dated [DATE] at 4:39 PM revealed a psychosocial assessment completed after the resident's daughter called concerned the resident had given up. The note revealed the resident stated she was very interested in talking with family. The Progress Note dated [DATE] at 3:04 PM revealed the daughter was concerned the resident was no longer interested in anything that she used to be. The facility notified Hospice and the physician and received new orders for an antidepressant. The Care Plan updated on [DATE] revealed the resident now received hospice care. The Hospice Comprehensive Assessment Note dated [DATE] revealed the daughter reported to the chaplain that she was upset she could not see her mom face to face. The Restricted Visitation for Covid-19 Policy updated [DATE] documented that entry only permitted to immediate family and friends whom need to visit for [MEDICATION NAME] care situations, such as end of life. The Progress Note dated [DATE] at 9:25 PM revealed the resident had started to mottle on her bilateral lower extremities and her hands and her respirations were now shallow. On [DATE] at 4:46 PM the resident's daughter stated her mother died at the facility without family allowed in to see her. She stated she had talked to the Administrator at one point voicing her concern that she was going to have to watch her mom die through her window and the Administrator told her they had to keep Covid-19 out of the facility at all costs and the facility would call her when the time was near. She stated she called hospice on the night of [DATE] because her mom was mottling and had shallow respirations. The nurse told her it was too soon and to call back the next morning. She stated she called the facility 5:00 AM the next morning and let it ring but no one picked up the call. On [DATE] at 9:13 a.m. the daughter reported calling the facility after the 5 a.m. call around 8:45 a.m. and Staff C told her the resident was transitioning. Staff C reported the resident was mottling with shallow breathing and her arms and feet were cold. The daughter asked to come see her mother and she was informed it was not time yet. At 9:30 AM the nurse called and informed her that her mom was dead. The daughter went to the nursing home and was told she could come inside and stay as long as she wanted to after the resident expired. The daughter denied that Hospice informed her she could not visit on [DATE]. The daughter stated Hospice just relayed what the facility said-that it was not time yet. Progress Notes dated [DATE] at 1:42 PM revealed the resident passed away at 9:30 AM and the facility informed the daughter at 9:40 AM. On [DATE] at 3:05 PM the Director of Nursing (DON) stated residents are allowed to have visitors at end of life. One visitor per day for one hour is allowed. She stated that she considered end of life as any significant change and she considered mottling a significant change and would allow for a family visit. She also stated the facility recently allowed some other hospice residents at the facility to have visitors for psychosocial health as well and they considered each resident case by case. On [DATE] at 2:10 PM the physician identified the resident with underlying health conditions which included [MEDICAL CONDITION] and condition likely caused her death but he felt the resident had given up in the end and not being able to visit her family could have hastened the process. On [DATE] at 8:55 AM the Administrator stated the resident's daughter had a difficult time with accepting her mother's nursing home placement. When the COVID visiting restrictions were put in place the facility made sure to place the resident on the ground floor with a patio window so the family could come and go as they pleased. The Administrator stated that once the resident went to hospice level of care she told the family they could visit with any significant change or with any signs that the resident was actively dying. She stated the resident had been like this for a while so that is why the facility wasn't allowing the family in when she first went to hospice. The daughter saw her in the hospital ([DATE]) when she fell recently and she stated the daughter had a window visit with her the day before she passed. The Administrator stated she was not aware of any staff or hospice nurse telling the daughter she couldn't visit the day before she passed away and considered mottling and shallow respirations as a significant change. The COVID-19 screening log for [DATE] lacked any signature for the resident's daughter ,[DATE]-[DATE]. During an interview with Staff C on [DATE] at 10:45 AM she stated she remembered the daughter calling around 7:45 AM on [DATE]. She stated she was in the middle of medication pass and did not recall the daughter specifically asking if she can come in but did ask for an update on her mom's condition. She stated the resident was resting peacefully and denied any pain. She stated the resident never seemed upset that the family wasn't visiting. The nurse stated the family was upset because the resident would never answer the phone and didn't always want to talk to them. She stated the resident was more reserved and wanted left alone to rest in her recliner. The nurse stated the resident was allowed to have visitors to have at end of life. If the family inquires, she is to let the DON Administrator know so they can make arrangements to screen them to allow them in. On [DATE] at 10:30 AM a call was made to the hospice agency providing cares. The Patient Care Manager stated she remembered the daughter calling after her mother passed away expressing concern about not being allowed in the night before to see her mom. During an interview on [DATE] at 11:15 AM Staff D stated she was the primary hospice nurse responsible for taking care of the resident. She stated the hospice nurses are allowed in once every fourteen days and if she feels the resident needs to be seen more often she has to get permission from the Administrator. She stated they are allowed in at end of life only when death of the resident is imminent. The Patient Care Manager was on the call as well and she stated the daughter told her that she was told that her mom was not imminent yet and the facility would not allow her in. During an interview on [DATE] at 11:25 AM Staff E stated that she was the on call nurse the night of ,[DATE]-[DATE]. She stated she received calls from the facility updating her that the resident was transitioning. The hospice nurse offered to make a visit and the facility stated it was not time. Staff E does not recall the daughter asking if she could come into the facility. On [DATE] at 8:47 a.m. Staff E stated she offered a visit but was told by the facility it was not necessary due to COVID. Staff E stated did not tell the daughter she couldn't visit. Staff E informed the daughter to try calling the facility in the morning around 7 a.m. During an interview on [DATE] at 11:30 AM the DON stated she never saw the resident in any distress over visitor restrictions and that the resident felt very content at the facility. The DON stated staff would have to encourage the resident to answer her phone from family because she would ignore the calls. During an interview on [DATE] at 11:40 AM with Staff F she stated that she found the

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE

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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F 0561 **Level of harm** - Actual harm **Residents Affected** - Few	(continued... from page 1) resident passed away the morning of [DATE]. She stated she had taken care of the resident earlier in the week and the resident never seemed to be in distress or upset about her family not visiting. On [DATE] at 12:12 p.m. via email, the Administrator stated facility policy does allow for end of life visits.
F 0580 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	**Immediately tell the resident, the resident's doctor, and a family member of situations (injury/decline/room, etc.) that affect the resident.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review, staff, family and physician interviews the facility failed to provide notification of a resident's changeof condition to the physician and family for 1 of 4 (Resident #1) residents reviewed. The facility reported a census of 46 residents. Findings include: The quarterly Minimum (MDS) data set [DATE] for Resident #1 assessed her with a Brief Interview of Mental Status (BIMS) score of 13 (cognitively intact). The resident required extensive assist of 1 person for bed mobility, transfers, dressing and toileting and independent with eating with set up help only. The MDS revealed she weighed 133 pounds and did not have any significant weight loss or gain. The MDS identified the resident at risk for pressure related breakdown but revealed she did not currently have pressure injury. The Face Sheet for the resident revealed [DIAGNOSES REDACTED]. A Weight Summary revealed the resident weighed 129 pounds on 3/20/20, 122.2 pounds on 4/17/20 and 116.2 pounds on 5/1/20. With the baseline weight of 133 pounds on the 2/20/20 MDS this indicated a significant weight loss. Review of the Progress Notes dated 2/17-5/1/20 revealed the facility failed to notify the physician and family of the significant weight loss. Review of the Progress Notes revealed the following: a. On 4/4/20 at 6:56 AM documentation identified the resident as non-ambulatory with transfer status change to full body lift with assist of 2 staff. b. On 4/22/20 at 10:18 PM documentation identified the resident no longer fed herself anymore. c. On 5/9/20 at 6:39 PM documentation identified the resident with a 1centimeter (cm.) open area on her coccyx. Review of the Progress Notes dated 4/4-5/11/20 revealed the facility failed to notify the family of condition changes; overall decline in functional ability with decline in transfers, ambulation and eating and new open area noted on 5/9/20. Review of the Care Plan activities of daily living (ADL) focus initiated 11/14/19 revealed the resident had a deterioration in ADL's and listed and intervention listsed as: report any further deterioration in status to the physician. During an interview with the daughter on 7/22/20 at 4:46 PM she stated she started to notice a decline in her mom in March. She stated she had to call and check on her mom because the facility never called them with updates. The daughter stated she started to notice a dramatic weight loss in April when visiting through the resident's room window but did not receive any notification by the facility of any weight loss or that her mother quit eating. The facility also started using a hoyer lift for transfers at some point but never told the family why. During an interview with the Director of Nursing on 7/28/20 at 3:05 PM she stated he expects her staff to notify the physician and family of any significant changes including open areas and weight loss. During an interview with the physician on 7/29/20 at 2:10 PM he stated that he was not notified of any weight loss or overall decline of the resident until he received a fax from the facility requesting hospice. A Hospice admission note identified the resident began receiving Hospice services 5/4/20.
F 0880 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Many	**Provide and implement an infection prevention and control program.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on clinical record review, observation, staff interview and facility policy review, the facility failed to utilize appropriate infection control practices during resident care for 1 of 3 residents reviewed (Resident# 2) and failed to complete adequate screening visitor logs for Covid-19 surveillance. The facility reported a census of 46 residents. Findings included: 1. A Minimum Data Set ((MDS) dated [DATE] revealed Resident #2 scored 15 out of 15 for her Brief Interview of Mental Status which indicated she is cognitively intact. The MDS revealed she required extensive assist of 1 staff for bed mobility, transfers, toileting, dressing, personal hygiene and walking in her room. The Face Sheet for the resident revealed [DIAGNOSES REDACTED]. The Care Plan with a revision date of 3/31/20 revealed the resident required hospice level of care, is incontinent of bladder with a personal history of urinary tract infection. The care plan directed staff to assist to toilet before meals, after meals, at bedtime and as needed. During an observation of Resident #2's cares on 7/27/20 at 1:50 PM, both staff knocked and introduced themselves upon entering the room. They washed their hands and then explained to the resident what they would be doing. Both staff donned gloves and then transferred the resident to her wheelchair with a gait belt. Staff applied wheelchair pedals to the chair and wheeled the resident into the bathroom with her feet on the pedals. Both staff transferred the resident to the toilet and the resident asked the staff to stay in the room because she wouldn't be long. The resident urinated in the toilet. Staff A stated the resident's brief was dry. Both staff still wore gloves. The resident stood and Staff B used toilet paper to wipe the resident front to back with her right hand. Staff B did not remove her gloves after wiping the resident. Both staff pulled the residents brief and pants up and then Staff B used her gloved right hand to unlock the wheelchair brakes and move the wheelchair pedal in place. Staff B removed her gloves and washed her hands while Staff A took the resident back into her room to her recliner. During an interview with the Director of Nursing on 7/28/20 at 3:05 PM she stated she expected her staff to remove their gloves and wash their hands or use hand sanitizer before touching any clean part of the resident or environment after providing toileting and wiping the resident. 2. During record review of the facility's Covid-19 surveillance/visitor logs, the facility failed to accurately and consistently record and document that all staff and visitors entering and exiting the facility were negative for Covid-19 symptoms. An audit of the facility's surveillance logs from 6/21/20 to 7/12/20 revealed no logs completed on 6/21/20, and included 11 pages with no date on the logs to indicate what date they completed the screenings. In addition, a total of 1,078 screenings were written on the logs and noted only 383 were completed fully with a staff member initialing that the screening had been verified and completed. The facility's rate of accurately completing the screening resulted in a 55% accuracy rate. The facility failed to consistently record and verify with another staff's signature, that the Covid-19 screening questions had been answered, and the temperatures recorded were accurate. During an interview with the DON on 7/23/20 at 3:15 p.m. DON reported that they are aware of all of the missing initials on the log sheets and that it is a work in progress. During an interview at 9:30 a.m. with the Administrator, she stated she is aware of numerous pages of the visitor surveillance logs not consistently having initials of another staff member had verified the information as correct on the log. The Administrator reported on-going education is provided to the staff regarding the need to have another staff member initial off on the assessments to assure that all visitors coming in and out of the building had been screened appropriately. Review of the facility's Restricted Visitation for Covid-19 policy revised on 3/17/20 stated all visitors, employees, contractors, consultants, etc. will be required to check in with staff upon entry for screening for respiratory symptoms/Covid-19. Review of the facility's Employee protocol for Covid Precautions and Covid cases dated 5/14/20 stated that all employees, including contract employee must complete screenings before the start of the shift and that temps MUST be taken at the end of the shift as well.