STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	165181	A. BUILDING _____ B. WING _____	**08/11/2020**

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
ROCK RAPIDS HEALTH CENTRE	**703 SOUTH UNION ROCK RAPIDS, IA 51246**

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 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 and staff interview the facility failed to immediately notify the physician and resident representative of an incident resulting in a change of condition for 1 of 3 residents reviewed (Resident #1). The facility reported a census of 37 residents. Findings include: According to the Minimum Data Set (MDS) assessment dated [DATE], Resident #1 had a Brief Interview for Mental Status (BIMS) score of 2, indicating severe cognitive impairment. The resident required extensive assistance with activities of daily living (ADL's) including bed mobility and transfer. The resident's [DIAGNOSES REDACTED]. A Progress Note by Staff M, Licensed Practical Nurse (LPN) dated 6/5/20 at 2:19 p.m. documented when returning from the dining room after lunch, Staff D, Certified Nursing Assistant/Certified Medication Aide (CNA/CMA) pushed the resident in his wheel chair (w/c). When entering the resident's room, his foot hit the entry of the door. The resident called out in pain from his room. No redness, swelling or bruising noted. The resident reported it just really hurt, and application of ice ineffective. The resident requested to wear a Prevalon boot. The resident reported it felt better with the boot on and as needed (PRN) Tylenol 650 mg orally (PO) given, with staff to monitor. The clinical record lacked documentation the facility notified the resident's physician or family/resident representative of the incident and new onset pain. The Progress Notes dated 6/6/20 at 6:45 a.m. documented awaiting Hospice to return phone call regarding resident's left ankle, swollen & painful to touch. The prior nurse stated the resident's left side of foot hit while moving the resident via w/c through a doorway with no noticeable injury after the occurrence. In a Witness Statement dated 6/5/20 Staff D, Certified Nursing Assistant (CNA) stated she pushed the resident out of the dining room after lunch and the left side w/c foot pedal caught on the door and pulled the resident's leg back. The resident cried out in pain so she looked at his leg immediately and it already started to swell. Another CNA went with Staff D to lay the resident down, put ice on it, and notified the nurse to look at it. During an interview on 8/3/20 at 10:50 a.m. Staff D reenacted the event and stated she came around the corner (of a table in the dining room) and the front left foot pedal caught the door and went outward and twisted the resident's foot outward. She didn't think his foot hit the door. He hollered out in pain right away. She did not know if she turned too sharp or what happened. During an interview on 8/4/20 at 9:07 a.m. the Director of Nursing (DON) stated they did not have an incident report for the incident or physician and family notification until a later date, At 4 p.m. DON stated she expected the physician and the family would be notified as soon as possible after an incident occurred. During an interview on 8/5/20 at 11:57 a.m. Staff M stated if not documented, she did not notify anyone (of the incident). An Incident/Accident Management policy reviewed 11/19 included verifying notification of the physician and responsible party.
F 0604 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	**Ensure that each resident is free from the use of physical restraints, unless needed for medical treatment.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, record review, and staff interview, the facility failed to provide adequate assessment, evaluation, and documentation for the use of a seatbelt restraint for 1 resident reviewed (Resident #4). The facility reported a census of 37 residents. Findings include: According to the Minimum Data Set (MDS) assessment dated [DATE], Resident #4 scored 15 on the Brief Interview for Mental Status (BIMS) indicating no cognitive impairment. The resident required extensive assistance with activities of daily living including bed mobility, transfers, ambulation, dressing, and toilet use. The resident's [DIAGNOSES REDACTED]. A Physical Therapy Evaluation and Plan of Treatment with a start of care date 11/11/19 documented the resident had a manual wheelchair (w/c) with restraints for safety, An Occupational Progress Report with a start date of 11/11/19 identified a goal the resident would be able to buckle/unbuckle the w/c (belt) in 3/5 trials to promote increased independence during w/c management. On discharge 1/21/20 the resident could buckle/unbuckle in 3/5 trials. The Care Plan revised 12/3/19 identified the resident at very high risk for falls related to (r/t) [MEDICAL CONDITION] and involuntary movements revised 12/3/19. The interventions included: a. See restraint plan of care. The resident needed a safety seat belt on when in the w/c due to [MEDICAL CONDITION] and movements. All staff were to monitor and check the resident every 1-2 hours and as needed (PRN), in the w/c and bed due to [MEDICAL CONDITION] and safety needs. The restraint plan of care included: b. The resident needed and used a seat belt when in the w/c as a physical restraint r/t safety and protection from falls and injuries with [MEDICAL CONDITION] and movements. c. Discuss and record with the resident/family/caregivers, the risks and benefits of the restraint, when the restrains should/would be applied, routines while restrained and any concerns or issues regarding restraint use. d. Ensure valid consent on the chart prior to initiating restraint. e. Evaluate the restraint use when up in the w/c daily: Evaluate/record continuing risks/benefits of the restraint, alternatives to restraint, need for ongoing use, reason for restraint use (due to safety when in w/c seat belt with [MEDICAL CONDITION] and involuntary movement to protect from falls out of w/c and safety). f. The resident needed hourly toileting and PRN while restrained to promote continence. g. The resident needed the seat belt restraint applied when in the w/c and released every 30 minutes or repositioned every hour to bed. Document restraint use and release as per facility protocol. h. The resident needed opportunities for restraint-free time and physical activity daily. The resident would be restrained with the seat belt in the w/c only when up for meals and with w/c use. Check every 30 minutes and unbuckle and reposition out of the w/c into bed every hour. The clinical record lacked documentation regarding restraint use and release. During an observation on 8/4/20 at 8:20 a.m. the resident returned from the dining room with the w/c seatbelt buckled. The resident stated she could not unbuckle the seatbelt. She said some days she could. During an interview on 8/4/20 at 9:07 a.m. the Director of Nursing (DON) stated when they 1st evaluated the resident, she could unbuckle the seatbelt herself. She did not know if/when they reevaluated that. She said they had no restraint documentation (despite the care plan calling for it) for the seatbelt. She said they are now in the process of getting a physician's orders [REDACTED]. They had no documentation (since then) of the resident's ability to unbuckle the seatbelt herself. The facility Restraint Management policy 4/2013 documented the restraint would be re-evaluated for the use of the restraint at least quarterly or with a change of condition during the care management meeting.
F 0657 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	**Develop the complete care plan within 7 days of the comprehensive assessment; and prepared, reviewed, and revised by a team of health professionals.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	165181	A. BUILDING _____ B. WING _____	**08/11/2020**

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
ROCK RAPIDS HEALTH CENTRE	**703 SOUTH UNION ROCK RAPIDS, IA 51246**

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 0657 **Level of harm -** Minimal harm or potential for actual harm **Residents Affected -** Few	(continued... from page 1) Based on observation, record review, and staff interview the facility failed to update the care plan to reflect clear and correct directions for resident's care for 2 of 6 residents reviewed (Resident #1 and #5). The facility reported a census of 37 residents. Findings include: 1) According to the Minimum Data Set (MDS) assessment dated [DATE], Resident #1 had highly impaired hearing with no long and short term memory problem and some difficulty in new situations with decisions in regards to tasks of daily life. The resident depended on staff for activities of daily living (ADL's) including bed mobility, transfer, and toilet use. The resident's [DIAGNOSES REDACTED]. The current Care Plan identified the resident with self care deficit related to (r/t) altered balance revised 1/7/16. The interventions included a. The resident required up to limited assist with toileting. The resident would toilet self and ask for assist if needed. b. The resident was independent with wheelchair (w/c) pivot transfers in his room. c. The resident was independent with bed mobility. Provide assist as needed. d. The resident required total assistance with transfers. The Care Plan gave conflicting information on the resident's needs for ADL assistance and in contrast to the MDS assessment. During an observation on 7/30/20 at 12:30 p.m. Staff D, Certified Nursing Assistant/Certified Medication Aide (CNA/CMA) and Staff G, CNA transferred the resident to bed with the total mechanical lift. During an interview on 8/5/20 at 12:40 p.m. the Director of Nursing stated they had identified a problem with updating care plans. 2) According to the MDS assessment dated [DATE], Resident #5 scored 3 on the Brief Interview for Mental Status (BIMS) indicating severe cognitive impairment. The resident required extensive assistance with bed mobility, transfers, ambulation, dressing, and toilet use. The resident's [DIAGNOSES REDACTED]. The Kardex (interventions from the current care plan) dated 8/4/20 identified the resident independent with toilet use, independent with a walker in her room and throughout the facility, and independent with transfers. During an observation on 8/4/20 at 9:48 a.m. Staff L, CNA and Staff N assisted the resident with transfer and toilet use. Staff L stated they assisted the resident with cares. During an interview on 8/5/20 at 1 p.m. the DON stated the resident's care plan did not reflect her current needs.
F 0684 **Level of harm -** Minimal harm or potential for actual harm **Residents Affected -** Few	**Provide appropriate treatment and care according to orders, resident's preferences and goals.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review and staff interview, the facility failed to provide adequate assessment and timely intervention for an incident with a change in condition for 1 of 6 residents reviewed (Resident #1). The facility reported a census of 37 residents. Findings include: 1) According to the Minimum Data Set (MDS) assessment dated [DATE], Resident #1 scored 2 on the Brief Interview for Mental Status (BIMS) indicating severe cognitive impairment. The resident required extensive assistance with activities of daily living (ADL's) including bed mobility and transfer. The resident's [DIAGNOSES REDACTED]. The Care Plan revised 1/7/16 identified the resident with the potential for alteration in comfort. The interventions included instructing the resident to inform the nurse of any pain/discomfort and ask for pain treatment before pain became too severe, informing the nurse if pain relief not achieved, and observing for verbal and non verbal signs and symptoms of pain being experienced by the resident. The Progress Notes dated 6/5/20 at 2:19 p.m. documented when returning from the dining room after lunch, Staff D, Certified Nursing Assistant/Certified Medication Aide (CNA/CMA) pushed the resident in the wheelchair (w/c). When entering the resident's room, his foot hit the entry of the door. The resident called out in pain from his room. No redness, swelling or bruising noted. The resident reported it just really hurt, and application of ice ineffective. The resident requested to wear a Prevalon boot. The resident reported it felt better with the boot on and as needed (PRN) Tylenol 650 mg PO given, with staff to monitor. In a Witness Statement dated 6/5/20 Staff D stated she pushed the resident out of the dining room after lunch and the left side of the w/c foot pedal caught on the door and pulled the resident's leg back. The resident cried out in pain so she looked at his leg immediately and it already started to swell. Another CNA went with Staff D to lay the resident down, put ice on it, and notified the nurse to look at it. During an interview on 8/3/20 at 10:50 a.m. Staff D reenacted the event and stated she came around the corner (of a table in the dining room) and the front left foot pedal caught the door and went outward and twisted the resident's foot outward. She didn't think his foot hit the door. He hollered out in pain right away and the area appeared swollen. The clinical record lacked a complete assessment of the resident's left foot/ankle including palpation, range of motion, and an assessment of the severity of the resident's ankle pain. The June 2020 Medication Administration Record [REDACTED]. The resident received a PRN dose of Tylenol at 1:30 a.m. 6/6/20 for left ankle and left leg pain with no assessment of the severity of the pain. The MAR indicated [REDACTED]. The Progress Notes dated 6/6/20 at 6:45 a.m. documented awaiting Hospice to return a phone call regarding the resident's left ankle, swollen and painful to touch. The prior nurse stated the resident's left side of foot hit while moving the resident via the w/c through a doorway with no noticeable injury after the occurrence. A fax to the physician 6/6/20 asked for a clarification of the [MEDICATION NAME] ([MEDICATION NAME]/narcotic [MEDICATION NAME]) order (dose, amount, frequency) and if okay to change the Tylenol order to PRN every 6 hours. Hospice reported a voice order received. The physician responded [MEDICATION NAME] 5/325 1 tab every 6 hours PRN pain, and okay for an ace wrap to left ankle PRN swelling. The Pain Assessment in Advanced Dementia Scale (PAINAD) included instructions for observing the patient for five minutes before scoring his or her behaviors and score the behaviors according to the chart. Definitions of each item provided. The patient could be observed under different conditions (e.g., at rest, during a pleasant activity, during caregiving, after the administration of pain medication). The total score ranges from 0-10 points. A possible interpretation of the scores is: 1-3=mild pain; 4-6=moderate pain; 7-10=severe pain. The June MAR indicated [REDACTED]. He received [MEDICATION NAME] at 11:30 a.m., 5:28 p.m., and 11:35 p.m. with pain at 7 (severe pain) with each administration. The MAR indicated [REDACTED]. The MAR indicated [REDACTED]. The Progress Notes dated 6/7/20 at 7:09 documented the resident had frequent episodes of crying out, left ankle painful to touch, and resident saying Oh god please take me I just want to die, I don't want to do this anymore. The PAINAD rated at 7. The resident pulled away from gentle touch of the left lower extremity. The facility failed to notify the physician of the resident's severe pain and crying out. The Progress Notes dated 6/7/20 at 12:53 p.m. documented the resident had frequent episodes of crying out, left ankle painful to touch, saying Oh god, please take me, I just want to die, I don't want to do this anymore. The PAINAD rated at 7. The resident pulled away from gentle touch of the left lower extremity. Call received from hospice checking on the resident after beginning [MEDICATION NAME] ([MEDICATION NAME]). Hospice stated that it may be a better idea to schedule [MEDICATION NAME] 2 tabs 2 times a day (BID) and then 1-2 tabs every 4 hours PRN to stay ahead of the pain. Hospice stated voice order received. Call paced to verify voice order. The Progress Notes dated 6/7/20 at 1:08 p.m. documented voice order received to discontinue (D/C) current BID Tylenol 650 mg and change to [MEDICATION NAME] 5/325 2 tabs BID and 1-2 tabs every 4 hours PRN. OK to continue with PRN Tylenol as well. The MAR indicated [REDACTED]. The Progress Notes dated 6/7/20 documented the resident received [MEDICATION NAME] for continuing to call out, would try to alleviate pain with 1 tab (despite the fact they received orders for 1 to 2 tabs, 1 tab did not relieve the pain earlier, and hospice indicating the need to stay ahead of the pain). The Progress Notes at 9:22 p.m. documented the PRN was ineffective, pain at an 8 (more severe pain than previously indicated). The [DATE]/7/20 at 7 p.m. showed the resident received the scheduled dose of [MEDICATION NAME] with PAINAD of 8. The Progress Notes dated 6/8/20 at 3:28 a.m. documented the resident started [MEDICATION NAME] 2 tabs at bedtime (HS), and he rested comfortably. The Progress Notes dated 6/8/20 at 3:28 a.m. documented the resident continued with current pain management orders, starting [MEDICATION NAME]/Tylenol 5/325 mg 2 tabs orally at HS without signs and symptoms of adverse reaction. The left foot remained swollen even with the ACE wrap in place. The resident had light purple bruising to bilateral sides of the left foot. Applied pressure reducing boot per the resident's request. The Progress Notes dated 6/8/20 at 12:13 p.m. documented the resident had purple bruising to the left inner ankle and bottom of the heel. The resident yelled out when the left foot touched or moved. The Progress Notes dated 6/9/20 at 11:16 a.m. documented the resident seen in the a.m. by the physician's assistant (PA-C) via telehealth video visit to assess the left ankle injury. The resident hard of hearing and not able to answer questions. The resident laid in bed during the visit and yelled out when moving or touching the ankle. Per the PA-C, continue with pain management, and if the family wished an X-ray could be ordered. The Power of Attorney (POA)/family member called and updated. Hospice staff nurse at facility for 14 day Registered Nurse (RN) visit and would collaborate with the family and let the facility know how they wished to proceed. A late entry in the Progress Notes dated 6/9/20 at 11:00 a.m. documented the resident's POA called back and stated he would like to proceed with an x-ray regardless of the Hospice recommendations, and x-ray scheduled for 1 p.m. at the clinic. The Progress Notes dated 6/9/20 at 2:30 p.m. documented receipt of results from the resident's x-ray. He had a nondisplaced fracture to the left medial malleolar tip. Received a new order for

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	165181	A. BUILDING _____ B. WING _____	08/11/2020

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
ROCK RAPIDS HEALTH CENTRE	703 SOUTH UNION ROCK RAPIDS, IA 51246

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)
F 0684 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	(continued... from page 2) stirrup ankle brace and would continue with comfort cares and pain medication to control his pain. A Physician order [REDACTED]. New orders received for a universal stirrup ankle brace for 3 weeks. The Progress Notes dated 6/10/20 at 8:44 a.m. documented the resident had the brace on his left foot and propelled in his w/c, The resident took scheduled [MEDICATION NAME] and then slept with a pillow under his leg and it seemed to help until he moved around and he told the nurse he just hit a spot then he had tears in his eyes with pain. The resident received PRN pain med and TLC and he got calmer. A fax dated 6/11/20 asked the physician if the resident should wear the airform ankle brace continuously. The physician responded to wear continuously for 4 weeks. During an interview on 8/4/20 at 9:07 a.m. the Director of Nursing stated they did not have an incident report for the incident and no physician and family notification until a later date, During an interview on 8/5/20 at 11:57 a.m. Staff M, Licensed Practical Nurse (LPN) stated she probably did not do an incident report (for the 6/5/20 incident) because there was nothing objective except the resident's pain. Staff M stated if not documented, she did not notify anyone (of the incident). An Incident/Accident Management policy reviewed 11/19 documented incident/accident identification and reporting were the responsibility of all employees of the facility. The procedure included evaluating for injury and if injury suspected or present, providing first aide and/or outside medical intervention, verifying notification of the physician and responsible party, and any impact on the resident.
F 0689 **Level of harm** - Actual harm **Residents Affected** - Few	**Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review, and staff interview, the facility failed to provide adequate supervision, implement interventions per the care plan, and investigate incidents to identify risks to prevent accidents for 3 of 4 resident's reviewed (Resident #1, #4, and #5) and failed to prevent hazards in the environment by locking two fire doors which posed a hazard and impeded exit from the facility for all residents in the event of a fire or an emergency. The facility reported a census of 37 residents. Findings include: 1) According to the Minimum Data Set (MDS) assessment dated [DATE], Resident #1 scored 2 on the Brief Interview for Mental Status (BIMS) indicating severe cognitive impairment. The resident required extensive assistance with activities of daily living (ADL's) including bed mobility and transfer. The resident's [DIAGNOSES REDACTED]. The current Care Plan identified the resident with a self care deficit related to (r/t) altered balance, [MEDICAL CONDITION] disease, [MEDICAL CONDITION] history of neoplasm of the prostate revised 1/7/16. The interventions included providing supervision to set up help with locomotion in the wheel chair (w/c), the resident able to propel himself (revised 10/6/18). The Progress Notes dated 6/5/20 at 2:19 p.m. documented when returning from the dining room after lunch, Staff D, Certified Nursing Assistant/Certified Medication Aide (CNA/CMA) pushed the resident in the w/c. When entering the resident's room, his foot hit the entry of the door. The resident called out in pain from his room. No redness, swelling or bruising noted. The resident reported it just really hurt, with application of ice ineffective. The resident requested to wear a Prevalon boot. The resident reported it felt better with the boot on and as needed (PRN) Tylenol 650 mg PO given, staff to monitor. In a Witness Statement dated 6/5/20 Staff D stated she pushed the resident out of the dining room after lunch and the left side of the w/c foot pedal caught on the door and pulled the resident's leg back. The resident cried out in pain so she looked at his leg immediately and it already started to swell. Another CNA went with Staff D to lay the resident down, put ice on it, and notified the nurse to look at it. During an interview on 8/3/20 at 10:50 a.m. Staff D reenacted the event and stated she came around the corner (of a table in the dining room) and the front left foot pedal caught the door and went outward and twisted the resident's foot outward. She didn't think his foot hit the door. He hollered out in pain right away and the area appeared swollen. She did not know if she turned too sharp or what happened. The Progress Notes dated 6/6/20 at 6:45 a.m. documented awaiting Hospice to return a phone call regarding the resident's left ankle, swollen and painful to touch. The prior nurse stated the resident's left side of foot hit while moving the resident via w/c through a doorway with no noticeable injury after the occurrence. A fax to the physician 6/6/20 asked for a clarification of the [MEDICATION NAME] ([MEDICATION NAME]/narcotic [MEDICATION NAME]) order (dose, amount, frequency) and if okay to change the Tylenol order to PRN every 6 hours. Hospice reported a voice order received. The physician responded [MEDICATION NAME] 5/325 1 tab every 6 hours PRN pain, and okay for an ace wrap to the left ankle PRN swelling. The Pain Assessment in Advanced Dementia Scale (PAINAD) included instructions for observing the patient for five minutes before scoring his or her behaviors and score the behaviors according to the chart. Definitions of each item provided. The patient could be observed under different conditions (e.g., at rest, during a pleasant activity, during caregiving, after the administration of pain medication). The total score ranges from 0-10 points. A possible interpretation of the scores is: 1-3=mild pain; 4-6=moderate pain; 7-10=severe pain. The June MAR indicated [REDACTED]. He received [MEDICATION NAME] at 11:30 a.m., 5:28 p.m., and 11:35 p.m. with pain at 7 (severe pain) with each administration. The MAR indicated [REDACTED]. The MAR indicated [REDACTED]. The Progress Notes dated 6/7/20 at 7:09 a.m. documented the resident had frequent episodes of crying out, left ankle painful to touch saying Oh god please take me I just want to die, I don't want to do this anymore. The PAINAD rated at 7. The resident pulled away from gentle touch of the left lower extremity. The Progress Notes dated 6/7/20 at 12:53 p.m. documented the resident had frequent episodes of crying out, left ankle painful to touch, saying oh god, please take me, I just want to die, I don't want to do this anymore. The PAINAD rated at 7. The resident pulled away from gentle touch of the left lower extremity. Call received from hospice checking on the resident after beginning [MEDICATION NAME] ([MEDICATION NAME]). Hospice stated that it may be a better idea to schedule [MEDICATION NAME] 2 tabs 2 times a day (BID) and then 1-2 tabs every 4 hours PRN to stay ahead of the pain. hospice stated voice order received. Call paced to verify voice order. The Progress Notes dated 6/7/20 at 1:08 p.m. documented voice order received to discontinue (D/C) current BID Tylenol 650 mg and change to [MEDICATION NAME] 5/325 2 tabs BID and 1-2 tabs every 4 hours PRN. Okay to continue with PRN Tylenol as well. The MAR indicated [REDACTED]. The Progress Notes dated 6/7/20 documented the resident received [MEDICATION NAME] for continuing to call out, would try to alleviate pain with 1 tab. The Progress Notes at 9:22 p.m. documented the PRN was ineffective, pain at an 8 (more severe pain than previously indicated). The [DATE]/7/20 at 7 p.m. showed the resident received the scheduled dose of [MEDICATION NAME] with PAINAD of 8. The Progress Notes dated 6/8/20 at 3:28 a.m. documented the resident started [MEDICATION NAME] 2 tabs at bedtime (HS), and he rested comfortably. The Progress Notes dated 6/8/20 at 3:28 a.m. documented the resident continued with current pain management orders, starting [MEDICATION NAME]/Tylenol 5/325 mg 2 tabs orally at HS without signs and symptoms of adverse reaction. The left foot remained swollen even with the ACE wrap in place. The resident had light purple bruising to bilateral sides of the left foot. Applied pressure reducing boot per the resident's request. The Progress Notes dated 6/8/20 at 12:13 p.m. documented the resident had purple bruising to the left inner ankle and bottom of the heel. The resident yelled out when the left foot touched or moved. The Progress Notes dated 6/9/20 at 11:16 a.m. documented the resident seen in the a.m. by the physician's assistant (PA-C) via telehealth video visit to assess the left ankle injury. The resident hard of hearing and not able to answer questions. The resident laid in bed during the visit and yelled out when moving or touching the ankle. Per the PA-C, continue with pain management, and if the family wished an X-ray could be ordered. The Power of Attorney (POA)/family member called and updated. Hospice staff nurse at facility for 14 day Registered Nurse (RN) visit and would collaborate with the family and let the facility know how they wished to proceed. A late entry in the Progress Notes dated 6/9/20 at 11:00 a.m. documented the resident's POA called back and stated he would like to proceed with an x-ray regardless of the Hospice recommendations, and x-ray scheduled for 1 p.m. at the clinic. The Progress Notes dated 6/9/20 at 2:30 p.m. documented receipt of results from the resident's x-ray. He had a nondisplaced fracture to the left medial malleolar tip. Received a new order for stirrup ankle brace and would continue with comfort cares and pain medication to control his pain. A Physician order [REDACTED]. New orders received for a universal stirrup ankle brace for 3 weeks. The Progress Notes dated 6/10/20 at 8:44 a.m. documented the resident had the brace on his left foot and propelled in his w/c, The resident took scheduled [MEDICATION NAME] and then slept with a pillow under his leg and it seemed to help until he moved around and he told the nurse he just hit a spot then he had tears in his eyes with pain. The resident received PRN pain med and TLC and he got calmer. A fax dated 6/11/20 asked the physician if the resident should wear the airform ankle brace continuously. The physician responded to wear continuously for 4 weeks. During an interview on 8/3/20 at 12 p.m. Staff A, CNA stated the resident usually wheeled himself in and out of the dining room. She said if not busy they would push him out of the dining room and go lay him down. During an interview on 8/4/20 at 9:07 a.m. the Director of Nursing (DON) stated they did not have an incident report for the incident or physician and family notification until a later date, At 4 p.m. the DON stated Staff D probably pushed the resident out of the dining room so another resident could go in and eat, and probably in a hurry. The

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	165181	A. BUILDING _____ B. WING _____	08/11/2020

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
ROCK RAPIDS HEALTH CENTRE	703 SOUTH UNION ROCK RAPIDS, IA 51246

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 0689 **Level of harm -** Actual harm **Residents Affected -** Few	(continued... from page 3) DON confirmed the resident could wheel himself out of the dining room. She expected the physician and the family would be notified as soon as possible after an incident occurred. A facility Teachable Moment report dated 6/15/20 documented Staff D re-educated on w/c transport of residents including potential safety hazards of negotiating the w/c in room and hallway focusing on doorways, corners and decreasing velocity throughout. Patient specific training for left [MEDICAL CONDITION] to ensure left lower extremity and upper extremity properly positioned on pedals and arm rest. 2) According to the MDS assessment dated [DATE], Resident #4 scored 13 on the BIMS indicating no cognitive impairment. The resident required extensive assistance with bed mobility, transfers, ambulation, dressing, and toilet use. The resident's [DIAGNOSES REDACTED]. The interventions included see restraint plan of care, the resident needed safety seat belt on when in w/c due to [MEDICAL CONDITION] and movements. All staff to monitor and check the resident every 1-2 hours and as needed, in wheel chair and bed due to [MEDICAL CONDITION] and safety needs. The Care Plan revised 12/03/19 identified the resident needed and used a seat belt when in the wheelchair as physical restraints related to safety and protection from falls and injuries with [MEDICAL CONDITION] and movements revised 12/3/19. The resident needed the seat belt restraint applied when in the wheelchair and released every 30 minutes or repositioned every hour to bed. Document restraint use and release as per facility protocol. The resident needed assistance and supervision when not restrained due to [MEDICAL CONDITION] activity and involuntary movements and high fall risk. The Care Plan revised 12/3/19 identified the resident with progressive ADL self care performance and interventions included the resident needed the sit to stand lift or stand and pivot with 2 staff extensive assist for transfers. 1. The Progress Notes dated 4/12/20 at 5:11 p.m. documented the writer was urgently called to the dining room after the resident fell out of wheelchair. Upon arrival, the resident sat on the floor surrounded by copious amounts of blood with a large amount draining from 2 deep lacerations on the L forehead and L eyelid. Unable to measure due to the exudates. No change in mental status. The facility called the ambulance at 5 p.m. to transport the resident to the emergency department (ED). An emergency room Visit Note dated 4/12/20 at 6:26 p.m. documented the resident had a 1.5 cm long laceration to her left upper eyelid and a 2.3 cm long laceration to the left side of the forehead with the deepest portion of the laceration in the center of the wound, where fascia noted. In an undated Witness Report at 5 p.m. Staff B, CNA wrote he situated the resident at the dining room table then headed away. After about 40 seconds he heard a noise and found the resident on the floor with blood on the floor. The resident had not been seat belted in her chair. During an interview on 8/3/20 at 10:20 a.m. the Director of Nursing (DON) stated they did not let Staff B, agency staff, return after the incident (4/12/20). He admitted he did not buckle the resident in and knew she should be. At 12:45 p.m. the DON stated Staff B had worked at the facility on 4/5/20, 4/10/20, and 4/11/20. She said Staff B was very remorseful, but aware the seat belt needed to be in place. During an interview on 8/3/20 at 10:58 a.m. Staff D, Certified Medication Aide (CMA) stated the resident always wore the seatbelt when in the wheel chair. During an interview on 8/3/20 at 1:35 p.m. Staff H, Cook stated she saw Staff B wheel the resident to the dining room. She looked slouchy in the chair. She walked into the kitchen and when she looked through the window she saw the resident on the floor. She alerted staff to the fall. During an interview on 8/3/20 at 1:57 p.m. Staff F, CNA (worked 4/12/20) stated she thought Staff B got the resident up by himself. She didn't know if Staff B had worked with the resident before. She did not know how he would know how to care for the resident, or if he had access to the care plan. Staff B admitted he did not buckle the seat belt but said he didn't know she had a belt. She had not witnessed staff not applying the seat belt. She said an agency staff would normally be pared up with a facility staff, because facility staff were aware of the resident's needs. During an interview on 8/3/20 at 2:30 p.m. Staff I, CNA (worked 4/12/20) stated she did not assist Staff B get the resident up to the wheel chair. She said Staff B felt horrible about the fall. He said he did not buckle the seat belt, he forgot. She said usually agency staff would double up with regular staff . If agency staff had a question, they would need to ask a nurse. She said she and Staff F were busy and Staff B started getting residents up himself. She did not think the resident could unfasten the seatbelt herself. During an interview on 8/3/20 at 2:48 p.m. Staff E, (worked 4/12/20) Licensed Practical Nurse (LPN) stated she did not assist Staff B getting the resident up in the wheel chair. She did not see him push the resident into the dining room, she came after the fall. Staff B said he didn't even know she had a seatbelt to put on her. She said agency staff worked with a consistent staff member to learn the care of each resident. Staff B was sincerely upset about the incident. Staff E stated she had nothing but good things to say about Staff B. 2. A fax dated 11/23/19 notified the physician the resident fell off the toilet at 7 a.m. and hit her head on the floor causing a laceration to the left side of her head with a large pool of blood. The Care Plan identified the resident had progressive ADL Self Care Performance Deficit revised 12/3/19. The interventions included the resident required extensive assistance of 2 staff with transfers on and off the commode, and with adjusting clothing and cleansing and changing padding when using the commode. One staff to remain with the resident when on the commode due to movements and [MEDICAL CONDITION] revised 12/03/19. The Care Plan identified the resident at very high risk for falls and the interventions included assist of 2 when using the toilet r/t increased involuntary movements/tremors. An Incident Report dated 6/22/20 at 9:40 a.m. documented the resident used the toilet with staff by her side. Staff did not have wet wipes for cleaning the resident so she left the resident and went around the corner to look quickly. When she returned the resident was on the floor. The resident reported hitting her head, and laid on her left side with no clear injuries. During an interview on 8/3/20 at 10:20 a.m. the DON stated the CNA did not follow the care plan. During an interview on 8/3/20 at 10:58 a.m. Staff D, CMA (with the resident at the time of the fall) stated the resident needed 2 to transfer to the toilet, and 1 person to stay with her, with eyes on her at all times. If needed something another person could get it. During an interview on 8/3/20 at 11:54 a.m. Staff A, CNA stated never leave the resident alone on the toilet. During an interview on 8/3/20 at 1:57 p.m. Staff F, CNA stated no one with assist 1 or 2 should be left unattended on the toilet. During an interview on 8/3/20 at 2:30 p.m. Staff I, CNA stated when on the toilet could not leave the resident at all. The facility policy Transfer Techniques dated 1/13 identified the purpose to safely transfer a resident while minimizing the risk of injury to the resident and caregiver. The procedure included obtaining assistance as needed, and reviewing and revising the resident transferring plan as indicated. 3) According to the MDS assessment dated [DATE], Resident #5 scored 3 on the BIMS indicating severe cognitive impairment. The resident demonstrated independence in bed mobility, transfers, ambulation, dressing, and toilet use. The resident's [DIAGNOSES REDACTED]. The Progress Notes dated 3/24/20 at 5:07 a.m. documented a CNA stated she walked by the resident's room and observed the resident crawling out of the bathroom. The CNA alerted the nurse and staff entered the room to observe the resident moving herself from the floor and sitting in a chair. The resident's top and bottom lip were bloody with increased swelling towards the left side. The resident unable to give description (of the incident). Increased confusion noted during the night, with the resident awake and wandering from room to dining room all night, believing it was meal time and staff unable to redirect. Fax sent to the physician with update The Progress Notes dated 3/24/20 at 4:15 p.m. documented the resident up to the bathroom with assistance, noting a moderate amount of blood in her urine. The family notified and ambulance called. Resident evaluated in the ER. A Pre-hospital Care Report documented the ambulance dispatched for an elderly female who suffered a fall and urinating blood. Staff reported the resident had not been herself lately, gait impairment, increasingly confused, and suffered multiple falls that day. The resident had a laceration to her finger and multiple contusions to her face. Staff reported after the last fall (around 3:30 p.m.) the resident was unconscious when found. emergency room Visit Notes dated 3/23/20 at 5:09 p.m. documented the resident presented to the ER after 2 falls. The resident had a laceration to the right 3rd digit down to the tendon. The laceration was closed with 2 sutures. The Progress Notes lacked any documentation the resident had another fall, and lacked documentation of the resident's status between the 2 falls. An Incident report dated 3/24/20 at 3:45 p.m. documented the resident found on the floor near her bathroom, and was initially unresponsive, but aroused to stimuli. She had a laceration to her right middle finger and a small abrasion on the left side of her forehead. Resident assisted to ambulate to a chair near the nurse's station for constant monitoring, and seated at the nurse's station. They cleaned and steri stripped the wound pending further treatment. The report documented the resident had confusion all day and had not slept much the night before. The clinical record lacked documentation the facility provide increased supervision in regard to the early a.m. fall with increased confusion and lack of sleep. The Progress Notes dated 3/24/20 at 7:00 p.m. documented the resident returned to the facility with stitches to her right middle finger. The Progress Notes dated 3/25/20 at 1:26 a.m. documented the resident rested in bed since returning from hospital ED visit with 2 stitches present to the right middle finger laceration. The area looked clean and open to air. The resident continued with redness and increased swelling to the left side of the top and bottom lip, and redness to the left side of her chin. During an interview on 8/5/20 at 1 p.m. the DON stated`there were no new interventions put in place after either fall on 3/24/20. The Progress Notes dated 4/22/20 at 7:43 a.m. documented staff heard the resident calling out for help from her room. Staff entered and observed the resident face down on the floor

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	165181	A. BUILDING _____ B. WING _____	08/11/2020

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
ROCK RAPIDS HEALTH CENTRE	703 SOUTH UNION ROCK RAPIDS, IA 51246

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 0689 **Level of harm** - Actual harm **Residents Affected** - Few	(continued... from page 4) unable to tell staff details of the incident. The resident screamed out in pain and grabbed her left hip when assessing her left lower extremity. Call placed to on call provider and order received to send the resident to the ED for further evaluation of left hip pain and left sided low back pain. The resident left the facility at 7:43 a.m. on a stretcher via ambulance. The Progress Notes dated 4/22/20 at 10:34 a.m. documented receipt of a call from the ED and the resident fractured her left hip. The family wished to proceed with surgical intervention, and the resident would be transferred for surgery. The facility did not have an incident report or investigation of the fall to determine root cause and possible interventions to prevent falls. During an interview on 8/4/20 at 2:08 p.m. the DON stated they did not do an investigation after the 4/22/20 fall with fracture to determine the cause. An Incident/Accident Management policy reviewed 11/19 documented an investigation would be completed within 5 days of the occurrence. Upon entrance to the facility on [DATE] at 9:30 AM the surveyor entered through the front door. Signage was present at the entrance that directed, no visitors. A phone number was provided to call to enter the facility due to Covid-19 restrictions. The Administrator was observed to lock the dead bolt lock with a key from the inside after the surveyor entered. At that time the Administrator stated the door had been locked to prevent visitors from entering. The Administrator further confirmed the door would not open when locked and required the key to unlock. Surveyor attempted to open the door when locked and the door failed to open. The key is located either in a box to the left of the front door, or in the lock. The door is located at the front of the facility which is the main entrance/exit. The Administrator stated that a staff person is located in an office adjacent to the entrance during business hours only. The door is identified as a fire exit by signage and lighting. An Environmental tour of all exits was completed on 7/29/20 at 2:10 PM with the Director of Nursing (DON). An additional exit door, located between the kitchen and storage hall adjacent to the dining room was found to be locked and restricted exit from the facility. The exit was noted to be a double set of doors, facing the South East that was marked off with yellow tape. The door was identified as an emergency fire exit by signage with instructions for delayed egress. Emergency exit lighting present. The door was locked by an internal door handle lock. The surveyor was unable to open the door when locked even when keyed pad access code was entered. Door handle lock was turned to unlock which allowed the surveyor to open the door. The DON confirmed the door is locked at all times. Additionally, confirmed the front door was locked with a dead bolt lock at all times. In an interview on 7/29/20 at 3:30 PM the Administrator confirmed the doors have been locked to restrict visitor access since March 15, 2020. The Administrator stated there have been no fire or other emergency that required exit from the facility since that time. The Administrator provided a plan for having doors unlocked.
F 0690 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	**Provide appropriate care for residents who are continent or incontinent of bowel/bladder, appropriate catheter care, and appropriate care to prevent urinary tract infections.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, record review, and staff interview the facility failed to provide incontinent care in a manner to prevent infection for 2 of 3 residents reviewed (Resident #1 and #4). The facility reported a census of 37 residents. Findings include: 1) According to the Minimum Data Set (MDS) assessment dated [DATE], Resident #1 had highly impaired hearing with no long and short term memory problem and some difficulty in new situations with decisions in regards to tasks of daily life. The resident depended on staff for toilet use. The resident's [DIAGNOSES REDACTED]. The current Care Plan revised 5/5/19 identified the resident had occasional bladder and bowel incontinence. The interventions included the resident used a pull up disposable brief. Change with a.m. and bedtime (HS) cares and as needed (PRN). During an observation on 7/30/20 at 12:30 p.m. Staff D, Certified Nursing Assistant/Certified Medication Aide (CNA/CMA) and Staff G, CNA transferred the resident to bed with the total mechanical lift. Staff D performed perineal care of the groins, front, then the resident rolled to his right with bowel movement noted. Staff D wiped several times using a different cloth each wipe. The last wipe had bowel movement on it and Staff D placed a new incontinent pad without wiping clean and did not clean the scrotal area. The facility Perineal Care policy for a male revised 04/13 identified the purpose to promote cleanliness and prevent infection. The procedure included after cleaning the front to position to expose and clean the bottom of the scrotum and the anal area. 2) According to the MDS assessment dated [DATE], Resident #4 scored 15 on the Brief Interview for Mental Status (BIMS) indicating no cognitive impairment. The resident required extensive assistance with toilet use. The resident's [DIAGNOSES REDACTED]. The interventions included checking every 2-3 hours and as required for incontinence. Wash, rinse and dry the perineum. During an observation on 7/30/20 at 10:52 a.m. Staff L, CNA and Staff G, CNA provided incontinent care with Staff K, Licensed Practical Nurse (LPN) observing. Staff L performed front incontinent care and then the resident turned to her right. The resident had bowel incontinence. Staff L wiped multiple times turning the disposable wipe, then wiped the genital area using the same soiled wipe. During an interview on 8/4/20 at 4 p.m. the Director of Nursing (DON) stated she would expect staff to change gloves with hand hygiene, use a new wipe to clean the genital area after cleaning bowel incontinence from a resident, and clean thoroughly after incontinence. The facility Perineal Care policy for a female revised 04/13 identified the purpose to promote cleanliness and prevent infection. The procedure included washing the genital area avoiding the anal area. After cleaning in the front, cleansing the anal area starting at the posterior vaginal opening and wiping front to back, then removing gloves and washing hands.
F 0804 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Some	**Ensure food and drink is palatable, attractive, and at a safe and appetizing temperature.** Based on observations, record review and staff and resident interviews, the facility failed to prepare and provide palatable food to the residents. The facility reported a census of 37 residents. Findings Include: 1.The Minimum Data Set (MDS) assessment tool, dated 4/23/20, documented Resident #2 with a Brief Interview for Mental Status Score (BIMS) of 15, which documents intact cognition. In an interview on 7/29/20 at 2:20 PM Resident #2 stated most of the time the food is cold. Clarified all meals are cold, and she can't eat it. Stated she is the first in the dining room, but the last to eat. Able to eat independently. 2.The MDS assessment tool, dated 5/14/20, documented Resident #6 with a BIMS of 15, which documents intact cognition. In an interview on 7/30/20 at 10:30 AM Resident #6 stated the food is often cold, the other day the green beans were cold and couldn't eat them. Able to eat independently. Observation of the lunch meal on 7/29/20, from 11:17 AM to 1:07 PM, revealed Staff O, Cook, assigned to serve the meal. Food temperatures prior to initiation of meal service were as follows: Baked Fish 161 degrees and Cooked Carrots 174 degrees. Further observation revealed at 1:05 PM revealed Resident # 4 served baked fish. At 1:07 end temperatures revealed the following food temperatures: Baked Fish 115 degrees and Cooked Carrots 120 degrees. AT 1:08 PM Resident #4 stated her meal was OK. Evaluation of a test tray began at 1:10 PM. The baked fish was cold and inedible. The cooked carrots were also cool, lacked flavor, and unplatable. Staff O reported, baked fish was the alternative and 5 residents were served. In an interview on 7/29/20 at 1:20 PM Staff O, Cook stated she hasn't previously noted that the food wasn't staying hot. Stated all steam table controllers were on. Staff O stated the facility takes and documents beginning food temperatures but only takes ending food temperatures if food appears cold. Stated had made maintenance aware and will be evaluating. In an interview on 8/4/20 at 12:30 PM the Administrator reported maintenance had evaluated the steam table and it was working properly. The Administrator stated the table may not have been turned on properly, and reported the facility would now be monitoring end temperatures.
F 0842 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	**Safeguard resident-identifiable information and/or maintain medical records on each resident that are in accordance with accepted professional standards.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review and staff interview the facility failed to complete incident reports for 2 of 3 residents reviewed (Resident #1 and #5). The facility reported a census of 37 residents. Findings include: According to the Minimum Data Set (MDS) assessment dated [DATE], Resident #1 had no long and short term memory problem and some difficulty in new situations with decisions in regards to tasks of daily life. The resident depended on staff for toilet use. The resident's [DIAGNOSES REDACTED]. The Progress Notes dated 6/5/20 at 2:19 p.m. documented when returning from the dining room after lunch, Staff D Certified Nursing Assistant/Certified Medication Aide (CNA/CMA) pushed the resident in the wheelchair (w/c). When entering the resident's room, his foot hit the entry of the door. The resident called out in pain from his room. No redness, swelling or bruising noted. The resident reported it just really hurt and application of ice ineffective. The resident

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	165181	A. BUILDING _____ B. WING _____	**08/11/2020**

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
ROCK RAPIDS HEALTH CENTRE	**703 SOUTH UNION ROCK RAPIDS, IA 51246**

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 0842 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	(continued... from page 5) requested to wear a Prevalon boot. The resident reported it felt better with the boot on and as needed (PRN) Tylenol 650 mg PO given, with staff to monitor. A Witness Statement dated 6/5/20 Staff D stated she pushed the resident out of the dining room after lunch and the left side wheel chair (w/c) foot pedal caught on the door and pulled the resident's leg back. The resident cried out in pain so she looked at his leg immediately and it already started to swell. Another CNA went with Staff D to lay the resident down, put ice on it, and notified the nurse to look at it. During an interview on 8/3/20 at 10:50 a.m. Staff D reenacted the event and stated she came around the corner (of a table in the dining room) and the front left foot pedal caught the door and went outward and twisted the resident's foot outward. She didn't think his foot hit the door. He hollered out in pain right away. She did not know if she turned too sharp or what happened. A Physician order [REDACTED]. New orders received for a universal stirrup ankle brace for 3 weeks. During an interview on 8/4/20 at 9:07 a.m. the Director of Nursing (DON) stated they did not have an incident report for the incident. At 4 p.m. the DON stated she expected an incident report completed for each incident and confirmed they did not complete one for the incident. During an interview on 8/5/20 at 11:57 a.m. Staff M, Licensed Practical Nurse (LPN) stated she probably did not do an incident report (for the 6/5/20 incident) because there was nothing objective except the resident's pain. She said she did not know it qualified as an incident. She thought incidents included falls, skin issues and med errors. 2) According to the MDS assessment dated [DATE], Resident #5 scored 3 on the Brief Interview for Mental Status (BIMS) indicating severe cognitive impairment. The resident demonstrated independence in bed mobility, transfers, ambulation, dressing, and toilet use. The resident's [DIAGNOSES REDACTED]. Staff entered and observed the resident face down on the floor unable to tell staff details of the incident. The resident screamed out in pain and grabbed her left hip when assessing her left lower extremity. Call placed to on call provider and order received to send the resident to the Emergency Department (ED) for further evaluation of left hip pain and left sided low back pain. The resident left the facility at 7:43 a.m. on stretcher via ambulance. The Progress Notes dated 4/22/20 at 10:34 a.m. documented receipt of a call from the ED, the resident fractured her left hip. The family wished to proceed with surgical intervention and the resident would be transferred to for surgery. The facility had no incident report for the resident's fall with a fracture. During an interview on 8/4/20 Staff K, LPN stated she worked the day the resident fell and fractured her hip. She transferred the resident to the hospital. She did not complete an incident report. An Incident/Accident Management policy reviewed 11/19 documented incident/accident identification and reporting were the responsibility of all employees of the facility. The employee who witnesses or discovered the incident/accident would notify the supervisor to complete an incident/accident report. An Incident/Accident report would be completed no later than 24 hours after the occurrence. An investigation would be completed within 5 days of the occurrence. The procedure included evaluating for injury and if injury suspected or present, first aide and/or outside medical intervention provided. Verify notification of the physician and responsible party and any impact on the resident.
F 0849 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	**Arrange for the provision of hospice services or assist the resident in transferring to a facility that will arrange for the provision of hospice services.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review and staff interview, the facility failed to assure hospice provided the resident's plan of care and notes for 1 resident reviewed (Resident #1). The facility reported a census of 37 residents. Findings include: According to the Minimum Data Set (MDS) assessment dated [DATE], Resident #1 had highly impaired hearing with no long and short term memory problem and some difficulty in new situations with decisions in regards to tasks of daily life. The resident depended on staff for toilet use. The resident's [DIAGNOSES REDACTED]. The Progress Notes dated 6/3/20 at 12:31 p.m. documented the resident admitted to hospice on 6/2/20 for left side [MEDICAL CONDITION] and weight loss. The clinical record lacked any hospice notes or plan of care. During an interview on 8/4/20 at 9:15 a.m. Staff K, Licensed Practical Nurse (LPN) stated she did not think they had any of the hospice information at the facility, she would contact them. At 11 a.m. Staff K provided hospice information faxed to the facility on [DATE] at 10:43 a.m. During an interview on 8/5/20 at 12:40 p.m. the Director of Nursing stated they had nothing from hospice until 8/4/20.
F 0880 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Some	**Provide and implement an infection prevention and control program.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review, observation, and staff interview the facility failed to implement a comprehensive infection control program to mitigate the risk of the spread of infection during a COVID-19 outbreak by failing to immediately isolate a resident with Covid-19 (Resident #3) signs and symptoms and failed to clean and disinfect environmental surfaces in the dining room between residents during meal service. The facility reported a census of 37 residents. Findings include: 1. The Minimum Data Set (MDS) assessment dated [DATE], documented [DIAGNOSES REDACTED]. The MDS documented the resident scored 15 on the Brief Interview for Mental Status (BIMS). A score of 15 identified intact cognition. Resident #3 required limited assistance for bed transfer, and locomotion on the unit. Observation on 7/30/20 at 9:55 AM revealed door to Resident #3's room door open. No signage on door or exterior of room. No isolation cart present outside of room. Resident invited surveyor into room, however stated not having a good day as had been told she needed to go into isolation because had a temperature of 99.2 degrees. Resident not wearing a mask. Surveyor excused self and did not proceed into room. In an interview on 7/30/20 at 10:00 AM the Administrator and Director of Nursing (DON) confirmed Resident #3 would be moving, but hadn't yet. Further stated the resident had been informed to not come out of her room. Additionally confirmed there was no signage outside of room that would indicate that staff should not enter the room. The resident does have a private room. On 7/30 20 at 10:52 AM Resident #3 moved to a room in the designated Covid isolation hall. Isolation cart outside of door to room, and isolation precautions directed through a sign on the door. A nursing Progress Note dated 7/30/20 at 1:15 AM documented Resident #3 complained of a sore throat, had a productive cough with thick green mucous, and a temperature of 99.2 with temporal artery, oxygen saturation was 84% on room air and 90% with oxygen at 2 litres with a mask. PRN (as needed) Tylenol given at this time. In a Progress Note on that same date at 8:50 AM, Staff K, Licensed Practical Nurse (PRN) documented the resident was asked to remain in her room due to symptoms by the night nurse. The resident informed Staff K that she would not stay in room today and exited the room in her wheelchair. Staff K documented she made several attempts to stop the resident with education but all attempts were unsuccessful. It is further documented the DON approached the resident, education provided, resident refused to wear a mask, and finally agreed to return to room. In an interview on 8/4/20 at 12:45 PM the DON stated she would have expected the night nurse to immediately place the resident in isolation precautions when experienced signs and symptoms of Covid 19. The DON provided a screening tool utilized for screening staff and stated would use the same criteria for screening residents. The screening tool directed if experienced any two or the following symptoms: sore throat, headache, fever of 99 degrees, chills, muscle pain, diarrhea, repeated shaking with chills, or a new loss of taste or smell would need to contact supervisor. The DON confirmed Resident #3 experienced two or more symptoms, so would have expected to be placed in isolation precautions. In an interview on 8/4/20 at 1:00 PM, Staff K, LPN Infection Control Nurse stated she had received report from the night nurse who had informed Resident #3 complained of a sore throat, low grade temp. Staff K informed resident to not leave room and to keep the door shut. Stated she would have expected the night nurse to place Resident #3 in isolation right away. 2. During lunch observation on 7/29/20 at 12 Noon, Staff J, Dietary Aide wiped down table between residents in the dining room and allowed the table to dry. On 7/29/20 at 12:15 PM Staff J, Dietary Aide utilized a rag from a green bucket in the kitchen window to wipe down the table. The dietary aide identified the green bucket as filled with water and Dawn brand dish soap. A chemical strip identified no chemicals in the bucket of soapy water. In an interview on 8/3/20 at 3:30 PM the Facility Coordinator stated dining room and nursing staff are to use a mixture of Dawn, bleach and water to clean tables between resident with communal dining. She confirmed staff had not been instructed on a ratio of bleach, Dawn and water. The Facility Coordinator further stated this was unacceptable so effective immediately the facility will be using a pre-prepared bleach wipe to cleanse the tables between residents.