| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 165273 | A. BUILDING _____ B. WING _____ | 06/19/2020 |

| NAME OF PROVIDER OF SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP |
|---|---|
| FLEUR HEIGHTS CENTER FOR WELLNESS AND REHAB | 4911 SW 19TH STREET DES MOINES, IA 50315 |

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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| F 0584<br><br>**Level of harm** - Minimal harm or potential for actual harm<br><br>**Residents Affected** - Some | **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.**<br><br>Based on observation and staff interviews, the facility failed to maintain resident rooms and facility hallways in a clean, sanitary and homelike atmosphere. The facility identified a census of 57 residents. Findings include: 1. An observation 6/16/20 at 4:06 p.m. revealed the fitted bed sheet for Resident #4 with several scattered blood stains and a moderate amount of food debri/crumbs scattered around in mid to upper portion on the right side of the sheet. An observation 6/18/20 at approximately 2:50 p.m. with Staff B (Nurse Aide) revealed the fitted bed sheet for the resident with the same scattered blood stains present however the food debri/crumbs had been removed. During an interview 6/18/20 at 3:20 p.m. Staff B confirmed the observation of the pictures and the current bed sheets revealed the same blood stains however the food had been removed. The staff member also confirmed the resident slept in her bed. During the same interview the staff member confirmed the observation documented below. 2. An observation 6/16/20 at 4:27 p.m. revealed a metal exit door at the end of the 400 hallway with rust running along the base of the door and door jam with an approximate quarter sized open area present with 3 card board sticky bug/mouse pads running along the inside base and hallway that contained multiple types of small to larger sized bugs. |
| F 0677<br><br>**Level of harm** - Minimal harm or potential for actual harm<br><br>**Residents Affected** - Few | **Provide care and assistance to perform activities of daily living for any resident who is unable.**<br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**<br>Based on observation, clinical record review and staff and resident interview, the staff failed to provide assistance with activities of daily living for 5 of 6 sampled who were unable to carry out activities of daily living. Concerns identified for Resident #1, #3, #4, #5, #6. The facility reported a census of 57. Findings include: 1. A Minimum Data Set ((MDS) dated [DATE] indicated Resident #3 had [DIAGNOSES REDACTED]. The assessment indicated the resident had a Brief Interview for Mental Status (BIMS) score of 15 indicating no cognitive impairments, always incontinent of bowel and bladder and dependent on two (2) staff with toilet use. A Care Plan with a focus area initiated 4/17/19 documented the resident had an activities of daily living (ADL) self care deficit related to (r/t) impaired mobility and debility. The approaches included the following: a. Assistance of one (1) staff member with toilet use with a directive for staff to have provided assistance with perineal care during every incontinent episode and as needed (PRN). An observation 6/17/20 at 2:55 p.m., revealed Staff J (Nurse Aide) and Staff K (Nurse Aide) provided perineal care for Resident #3 after Staff J confirmed the resident incontinent of urine. Staff J cleansed the residents anterior perineal area and then both staff members positioned the resident on her right side and cleansed the resident's right buttock and placed a clean brief under the resident. The staff then positioned the resident on her left side, pulled the brief into position, assisted the resident onto her back and fastened the brief. The staff members failed to cleanse the resident's right buttock and hip. During an interview 6/17/20 at 3:15 p.m. Staff K confirmed the staff members failed to cleanse the resident's right buttock and hip. During an interview 6/17/20 at 2:00 p.m. Resident #3 confirmed the failure to control her bowel and bladder and staff failed to complete perineal care in a timely manner. The resident indicated staff entered her room and said they already assisted the resident with incontinent care that shift. The resident indicated staff were to check and change her every 2 hours but at times she went an entire shift without staff intervention. 2. A MDS assessment dated [DATE] indicated Resident #6 had [DIAGNOSES REDACTED]. The assessment indicated the resident had a BIMS score of 15 indicating no cognitive impairments, frequently incontinent and required extensive assistance of 2 staff with toilet use. A Care Plan with a focus area dated 4/11/19 indicated the resident had an ADL self-care deficit r/t tremors, impaired mobility, weakness and incontinence. The interventions included the following: a. Assistance of one (1) staff member with the use of a grab bar for toilet use. (revised 1/3/20) During an interview 6/17/20 at 11:25 a.m., Resident #6 reported last week staff failed to provide completed perineal care when she had been incontinent of her bowels for approximately 40 minutes which caused her to be very upset. 3. Review of an Incontinence Care/Peri Care policy (not dated) included the following guideline: a. Cleanse all soiled areas front to back having used a clean area of the clothe/wipe, especially between skin folds. 4. An observation 6/16/20 at 4:12 p.m. revealed the fingernails of Resident #1 as long with a build up of a brown substance under the nails. During an observation and an interview at the same time on 6/18/20 at approximately 2:10 p.m. Staff J (Nurse Aide) confirmed the resident's nails as long with a build up of a brown substance under random nails. 4. An observation 6/18/20 at 2:50 p.m., revealed Resident #4's fingernails long with a build up of a brown substance. Staff B confirmed the observation and described the brown substance appeared to have been feces. 5. An observation 6/18/20 at approximately 3:15 p.m. revealed Staff C (Nurse Aide) entered Resident #5's room, as this surveyor and Staff B (Nurse Aide) stood outside Resident #5's door due to droplet precautions. Staff B checked the resident's fingernails and confirmed them as long with a clear substance under the nails and a brown substance under other nails. Staff B confirmed the substance under Resident #5's nails visible from the hallway. |
| F 0689<br><br>**Level of harm** - Minimal harm or potential for actual harm<br><br>**Residents Affected** - Few | **Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents.**<br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**<br>Based on observation, clinical record review and staff interviews, the facility failed to ensure staff maintained a safe and secure environment for 1 of 6 residents reviewed. (Resident #1) The facility identified a census of 57 residents. Findings include: According to a Minimum Data Set ((MDS) dated [DATE] Resident #1 had [DIAGNOSES REDACTED]. Resident #1 had a Brief Interview for Mental Status (BIMS) score of 2 indicating severe cognitive impairments, fluctuating inattention and disorganized thinking, verbal behaviors 4 to 6 days towards others, non ambulatory (unable to or did not walk), dependent on staff with toilet use and required extensive assistance of 2 staff with bed mobility, transfers, dressing and personal hygiene. An undated side-rail usage report form assessed and completed by the facility's therapy services directed the facility staff that Resident #1 required bed rails. A Care Plan revealed Resident #1 sustained falls related to impaired mobility and revealed the following updates: a. On 5/3/19, transfer with a mechanical lift and assist of 1 staff. b. On 1/3/20, patient positioning device (partial side-rail) times 2 to promote bed mobility and re-positioning. c. On 5/3/20, bed in lowest position and locked while in it. A fall risk assessment dated [DATE] indicated Resident #1 scored 30 indicating a moderate risk for falls. An Un-Witnessed Incident Report form dated 5/2/20 at 6:50 p.m. documented when the |

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

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| F 0689<br><br>**Level of harm** - Minimal harm or potential for actual harm<br><br>**Residents Affected** - Few | (continued... from page 1)<br>nurse walked into the resident's room she found the resident lying on the floor on her stomach, head turned to the right with a large bump above her right eye, and feet positioned over the bottom of the beside table. The staff left the resident on the floor due to possible neck/head involvement and called 911. The immediate action (intervention) directed staff to place the bed in the lowest position and locked while positioned in bed. The injuries observed at the time of the incident included a hematoma on the top of the resident's scalp. During an interview 6/19/20 at 12:10 p.m., Staff I (Nurse Aide) indicated when the staff found the resident on the floor the head of the bed (HOB) had been elevated, the bed itself had been in the highest position from the floor and the side-rails up (meaning in an upward position, not down along the side of the bed). The tray table appeared to have been originally positioned across the bed but the resident may have reached for something across the tray table and pushed the tray table from the bed as she fell on to the floor face first (staff found the tray table along the side of the bed but pushed away from the bed). A Progress Notes entry dated 5/3/20 at 3:22 a.m. included the following documentation: Resident sent to a local hospital via the ambulance after an unwitnessed fall in her room that resulted at approximately 7:30 p.m. on 5/2/20. A call had been received from the emergency room (ER) nurse where she stated all neurological checks were negative. The resident did have a urinary tract infection and received intravenous [MEDICATION NAME] (an antibiotic) in the ER and had been on her way back with an order for [REDACTED].#1 had an acute urinary tract infection, a hematoma/swelling in the extracranial soft tissues in the right frontal region, and no evidence of an acute [MEDICAL CONDITION] or skull fracture. |
| F 0880<br><br>**Level of harm** - Minimal harm or potential for actual harm<br><br>**Residents Affected** - Some | **Provide and implement an infection prevention and control program.**<br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**<br>Based on observation, clinical record review, and interviews the facility failed to maintain an infection prevention and control program to provide a safe sanitary and comfortable environment to help prevent the development and transmission of communicable disease and infection for 3 of 6 sampled. (Resident #2, #3 and #5). The facility reported a census of 57. Findings include: 1. A Care Plan dated 5/4/20 documented Resident # 4 tested positive for COVID-19 and directed isolation per protocol. During an observation 6/16/20 at 3:55 p.m., revealed red and yellow waste containers positioned in the hallway and along the wall just outside of the Resident #4's room without any type of precaution sign present. Staff K (Nurse Aide) reported she thought the waste containers belonged across the hall (room [ROOM NUMBER]) for a resident that recently returned from the hospital. Record review revealed neither residents in room [ROOM NUMBER] had precautions. During an observation on 6/18/20 at 2:50 p.m revealed red and yellow waste containers positioned just inside Resident #4's room with a sign on the door indicating Resident #4 on droplet precautions. 2. An observation 6/17/20 at approximately 11:45 a.m., revealed two staff in room [ROOM NUMBER] and a resident present who had droplet precautions. The staff donned appropriate personal protective equipment (PPE) however when Staff F (Nurse Aide) exited the room she failed to remove and/or replace her mask and/or sanitize her protective face shield. During an observation 6/17/20 at 12:00 p.m., revealed Staff G (Nurse Aide) donned PPE and entered room [ROOM NUMBER] with a meal tray. room [ROOM NUMBER] had droplet precautions and delivered the resident's lunch. The staff removed her gloves and gown but failed to remove and/or replace her mask and sanitize her protective face shield. During an observation on 6/17/20 at 12:12 p.m., revealed Staff A (Nurse Aide) delivered a lunch room tray to Resident #2's room. Resident #2 had droplet precautions. Staff A failed to utilize a protective gown and gloves. Staff A confirmed she failed to utilize the appropriate PPE. 3. A Minimum Data Set ((MDS) dated [DATE] indicated Resident #3 had [DIAGNOSES REDACTED]. The assessment indicated the resident had a Brief Interview for Mental Status (BIMS) score of 15 out of 15 (cognitively intact). During an interview 6/17/20 at 2:00 p.m., Resident #3 confirmed she tested positive for COVID-19 and placed on isolation on droplet precautions. Resident #3 reported the staff failed to wear a gown when providing cares. 4. During an observation 6/17/20 at 3:55 p.m., revealed Staff C (Nurse Aide) and Staff K (Nurse Aide) entered Resident #2's room with a mechanical lift. Resident #2 had droplet precautions. At 4:19 p.m., Staff C and Staff K exited the room with the mechanical lift, placed it along the wall in the hallway. The staff failed to sanitized the mechanical lift. At 4:22 p.m., Staff C and Staff K pushed the same mechanical lift into into room [ROOM NUMBER]. The staff assisted a resident with a transfer, utilizing the mechanical lift. The staff failed to sanitize the mechanical lift prior to using it. Staff K confirmed the staff failed to sanitized the mechanical lift. During an observation on 6/17/20 at 4:20 p.m. revealed Staff C and Staff E (Nurse Aide) entered room [ROOM NUMBER] with a mechanical lift device and closed the door. At 4:33 p.m. Staff E exited the room with the mechanical lift. The mechanical lift had a sling laid across the top. Staff E positioned the device along the wall outside room [ROOM NUMBER]. At 4:37 p.m., Staff C confirmed the staff failed to sanitized the mechanical lift after use. 5. During an observation on 6/16/20 at 4:25 p.m., revealed a sign on Resident #5's door. The sign directed Resident #5 on droplet precautions. Staff D (Licensed Practical Nurse) pushed a medication half inside and half outside Resident #5's door. Staff D donned a gown, mask, goggles and gloves and administered Resident #5's medications, removed her gloves, washed her hands and returned to the medication cart with the same gown and mask and retrieved a blood glucose machine. Staff D re-entered Resident #5's room with the blood glucose machine. Staff D washed her hands, applied gloves and checked Resident #5's blood glucose level. Staff D removed her gloves, washed her hands and returned to the medication cart and placed the blood sugar machine on a clean paper towel. Staff D failed to removed her gown and mask. Staff C joined Staff D and they returned to Resident #5's bedside and completed personal cares. 6. During an observation on 6/17/20 at 12:25 p.m., revealed Staff H (Housekeeper) donned PPE and entered room [ROOM NUMBER]. room [ROOM NUMBER] had droplet precautions. The staff member mopped the floor. Staff H failed to doff his PPE. The staff member then proceeded into the room of Resident #5 and swept the resident's floor with a broom he removed from his cleaning cart. The staff member then left the broom in the room, returned to the cleaning cart and removed a scrapper from the locked portion of the cart, returned into the resident's room, scrapped an area on the resident's floor and continued sweeping. The staff member then returned the broom and scraper to the cleaning cart without disinfecting either item. The staff member then took a toilet bowl brush along with the holding container from the cleaning cart into the resident's bathroom and returned the item to the cleaning cart. During an interview at the same time the staff member confirmed he placed the same toilet brush back onto the cleaning cart without sanitizing the surface area. During this same observation an unknown Nurse Aide donned PPE and delivered the resident's lunch meal however when she exited the resident's room she failed to remove and replace her mask and/or sanitize her facial shield. During an interview 6/17/20 at 1:31 p.m. the Housekeeping Supervisor confirmed her staff should change their PPE between resident rooms and that they knew better. The Supervisor also confirmed staff should have sanitized their protective eye shield when they exit resident rooms in isolation by using the purple sani-wipes. 7. During an observation 6/18/20 at 12:15 p.m. revealed an unknown staff member delivered the lunch to Resident #2 (on droplet precautions) directly on the room tray and left the tray and food on the resident's bedside stand. An observation 6/18/20 at 12:55 p.m. revealed an unknown staff member delivered the lunch to Resident #5 (on droplet precautions) directly on the room tray and left the tray and food on the resident's bedside stand. During an interview 6/18/20 at 1 p.m. Staff L (Nurse Aide) confirmed the above stated observations but added that she had not delivered the meals. During an interview 6/18/20 at 2:12 p.m. Staff K (Nurse Aide) confirmed meals served to residents on isolation precautions should not have been served on a meal tray, rather the meal try should have been left in the hallway and only the food served to the resident and then thrown away in the resident's rooms. During an interview 6/18/20 at 12:45 p.m. Staff M (Nurse Aide) indicated when staff served meals to residents on isolation precautions 1 staff member stood in the hallway with the meal tray and another staff member donned the PPE and served the resident the food items only. During an interview 6/18/20 at 1:57 p.m. Staff J (Nurse Aide) indicated when staff served meals to residents on isolation precautions they were to leave the serving tray setting on a table outside the resident's rooms, don their PPE and deliver the food items only to the residents. During an interview 6/18/20 at 2:36 p.m. Staff B (Nurse Aide) indicated when staff served meals to residents on droplet/isolation precautions they were to remove the food from the serving tray and serve the food only to the residents. 8. During an interview 6/18/20 at 2:36 p.m. Staff B confirmed she witnessed staff not having worn appropriate PPE as they provided cares to residents in droplet precautions/isolation. 9. A General Isolation Technique form implemented 2/2020 and revised 6/2020 including the following information: PURPOSE: To have controlled the spread of infection for one resident to another according to general isolation practices in the facility. a. Arrangements for isolation would vary according to the physician orders [REDACTED]. b. A clean mask, when indicated, worn and discarded into the proper container after use. c. A clean disposable gown, when indicated worn when staff entered isolation areas and discarded into the proper container after use. d. Dressings and garbage discarded into the red biohazard bags and placed in a red biohazard barrel kept in the isolation area. e. Food delivered to the bedside table outside the room and nursing staff carried the food in with disposable dishes when indicated. f. Before staff entered the isolation area, all equipment needed to have performed cares and treatments should |

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| F 0880<br><br>**Level of harm** - Minimal harm or potential for actual harm<br><br>**Residents Affected** - Some | (continued... from page 2)<br>have been assembled and all disposable items discarded prior staff left the area. 10. Review of a 5 - Minute Meeting form dated 4/6/20 included the following directives to staff: a. All caregivers wear a mask and shield. Review of a 5 - Minute Meeting form dated 6/16/20 included the following directives to staff: a. Staff must have wiped down all equipment between residents. 10. Review of a 5 - Minute Meeting form dated 6/17/20 included the following directives to staff: a. All PPE must have been worn when staff entered resident isolation rooms and must have been cleansed when staff exit the rooms (shields and goggles) and a new mask placed. Hands should have been cleansed with hand sanitizer before placement of a new mask without having touched the mask rather the strings only. The Iowa Department of Public Health Personal Protective Equipment Guidance dated 4/1/20 recommended healthcare workers that provide patient care in long term care facilities should use a minimum level of personal protective equipment for all patient care activities. There healthcare workers should use a face mask and eye protection for all patient encounters. The CDC COVID-19, Preparedness Checklist for Nursing Homes and other Long Term Care Settings, dated 3/26/20, to complete frequent cleaning of high-touch surfaces and shared resident care equipment |