STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	165427	A. BUILDING _____ B. WING _____	09/14/2020

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
NEWTON HEALTH CARE CENTER	200 SOUTH EIGHTH AVENUE EAST NEWTON, IA 50208

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 0658 **Level of harm -** Minimal harm or potential for actual harm **Residents Affected -** Some	**Ensure services provided by the nursing facility meet professional standards of quality.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, record review, staff and resident interviews, the facility failed to meet professional standards of care by not notifying a Nurse Manager of the inability to access the facilities' Electronic Health Records (EHR) resulting in medications and treatments both being administered and not being administered without access to the residents' Medication Administration Records (MARs)/Treatment Administration Records (TARs) for 41 out of 47 residents. (The following residents were reviewed as a sample #1, #2, and #3). The facility reported a census of 47. Findings include: 1. A Minimum Data Set ((MDS) dated [DATE], documented Resident #1 reentered the facility on 3/26/2020 after an acute hospital visit. The Brief Interview for Mental Status (BIMS) showed resident had a score of 10 out of 15 indicating a mild cognitive deficit. The resident was independent for bed mobility, transfer and personal hygiene. [DIAGNOSES REDACTED]. A Care Plan directed staff to administer Resident # 1's medications per physician's orders [REDACTED]. This care plan directed staff to administer all of Resident # 1's medications per physician's orders [REDACTED]. A Medication Administration Record [REDACTED]. Atorvastin 40 mg ([MEDICAL CONDITION]) b. [MEDICATION NAME] 16 units (DM) c. Isosorb 0.5 mg (hypertension) d. Levetiraceta 250 mg ([MEDICAL CONDITION] disorder) e. [MEDICATION NAME] 50 mg (hypertension) f. [MEDICATION NAME] 160- 4.5 give 2 puffs ([MEDICAL CONDITION]). An untitled shift report dated 8/11/20, documented under the 6 p-6 a shift column for Resident #1: 18 units [MEDICATION NAME] and BS (blood sugar) 40. Progress Notes lacked documentation between 8/11/20 at 14:25 (2:46 p.m.) to 8/12/20 at 14:13 (2:13 p.m.). Respiratory status, low blood sugar and missing medication signatures were not addressed. In an interview on 9/1/20 at 3:40 p.m., Staff A, Licensed Practical Nurse (LPN) revealed he was an agency nurse from out of state. Staff A stated he worked the night shift of 8/11/20 after a storm had gone through on 8/10/20. Staff A stated he did not know the residents on the units he was covering and was directed to pass medications from Staff B, LPN without access to the EHR due to a power outage from a storm. Staff A stated he refused to administer medications. Staff A reported he did give narcotic medications to a couple of residents for pain and [MEDICATION NAME] to one resident with a BS (blood sugar) of 40. Staff A reported he gave these medications after he had talked with the other nurses. In an interview on 9/3/20 at 1:15 p.m., the resident stated he doesn't remember having a low blood sugar. Resident stated all of his care and needs were taken care of during and after the storm. 2. A MDS dated [DATE] documented Resident #2 reentered the facility on 3/31/20 after an acute hospital visit. The Brief Interview for Mental Status (BIMS) showed resident had a score of 1 out of 15 indicating severe cognitive deficit. The resident required extensive assist of 2 for bed mobility, transfer and personal hygiene. [DIAGNOSES REDACTED]. A Care Plan directed staff to administer Resident # 2's medications as ordered by physician for COVID-19 initiated on 7/22/20. This Care Plan directed staff to administer all of Resident # 1's medications as prescribed for [DIAGNOSES REDACTED]. A MAR indicated [REDACTED]. Senna Plus 2 tabs (constipation) b. [MEDICATION NAME] 500 mg (pain) c. [MEDICATION NAME] 300 mg (pain) d. Memantine 10 mg (Alzheimer's). A Treatment Administration Record (TAR) revealed a PRN (as needed) oxygen order at 2 to 3 liters /min per nasal cannula to keep oxygen saturations above 90% was not signed out as completed. An untitled shift report dated 8/11/20, documented under the 6 a-6 p that oxygen was bumped back up to 2 Liters after being at 90% on 1 liter. The 6 p-6 a columns showed *skilled charting*. The Progress Notes lacked documentation between 8/11/20 at 14:23 (2:43 p.m.) to 8/12/20 at 01:58 (1:58 a.m.). Respiratory status, oxygen administration and missing medication signatures were not addressed. An entry dated 8/11/20 at 11:42 documented that in the a.m. Resident #2 was at 97% (oxygen saturation percentage) on 2 Liters of O2 (oxygen) per nasal cannula (n/c). The nurse turned the O2 flow down to 1 Liter. Resident #2 would go between 89 -90%. The nurse placed the O2 flow back on 2 Liters, and the oxygen saturation went back up to 95%. In an interview with on 9/10/20 at 3:19 p.m., Staff C LPN/MDS Coordinator confirmed the 8/12/20 1:58 a.m. entry into Resident #2's Progress Note was entered in error. Staff C stated the entry should have said 8/12/20 at 1:58 p.m. and verified the nurse who entered the Progress Notes was not in the facility at 8/12/20 1:58 a.m. In an interview on 9/3/20 at 1:00 p.m., the Nursing Home Administrator (NHA) stated resident has periods of confusion but can be interviewable. NHA stated oxygen needs were PRN for this resident at the time of the derecho (storm) and power outage. In an interview on 9/3/20 at 1:18 p.m., Resident #2 stated she was not in the facility at the time of the storm. Resident stated oh yes when asked if she received the care she needed. In an interview on 9/16/20 at 10:18, Resident #2's daughter stated there was no issues with care of her mother with the power outage. In an interview on 9/1/20 at 3:40 p.m., Staff A, LPN stated that the oxygen was not working during the shift he worked (8/11/20 at 6 p.m. to 8/12/20 at 6 a.m.). He stated he had to use a green oxygen canister for oxygen administration which he was able to obtain from another unit. In an interview on 9/10/20 at 2:50 p.m., Staff B, LPN stated that Resident #2 was on PRN O2 (oxygen). Staff B said Staff A would not have known that Resident #2's oxygen was PRN. She stated that most people were on portable oxygen (green canisters) and there were a limited amount of red sockets (electricity plug ins powered by the generator). 3. A MDS dated [DATE] documented Resident #3 reentered the facility on 4/1/2020 after an acute hospital visit. The BIMS showed resident had a score of 13 out of 15 indicating intact cognition. The resident required extensive assist of 2 for bed mobility, transfer and personal hygiene. [DIAGNOSES REDACTED]. A Care Plan directed staff to apply Resident # 3's ointment to prevent skin breakdown due to immobility initiated on 11/12/19. This Care Plan directed staff to administer all of Resident # 3's medications as prescribed for COVID-19 monitoring/Care Plan initiated on 5/14/20. The Care Plan also directed staff that resident [MEDICAL TREATMENT] access is in his left arm with a goal that the resident will exhibit no signs of infection/complication to the [MEDICAL TREATMENT] initiated on 11/8/19. Furthermore it directs staff to give meds as ordered initiated on 11/24/19. A MAR indicated [REDACTED]. [MEDICATION NAME] 300 mg (pain) b. Senna (constipation) Staff D, Registered Nurse (RN), had signed for these HS (hour of sleep) medications. The following 5:00 a.m. medication was not signed for on 8/12/20: a. Levothyroxin. A TAR dated 8/1/20 to 8/30/20 revealed the following was not signed for on 8/11/20: a. [MEDICATION NAME] applied to area on buttocks for wound healing scheduled for 8 p.m. and an access site for [MEDICAL TREATMENT] on his left arm check scheduled for night shift. Progress Notes lacked documentation between 8/10/20 at 09:10 (9:10 a.m.) to 8/13/20 at 23:37 (11:37 p.m.). Missing medication, treatment and assessment signatures were not addressed. In an interview on 9/3/20 at 1:20 p.m., Resident #3 stated he was not in the facility at the time of the storm, he was at [MEDICAL TREATMENT]. Resident #3 stated his needs were met after the storm. In an interview on 9/14/20 at 3:05 p.m., Staff D, RN verified she worked that day and was able to use her personal phone's hot spot to access electronic health records. Staff D stated she left at 8 p.m. and had gave the medications she could prior to her leaving and signed for those medications. Staff D stated she did not give any HS meds. In an interview on 9/3/20 at 1:41 p.m., Staff E, LPN stated she did not pass any medications that night as she was unable to view the EHR and did not want to lose her license. Staff E stated she did give a narcotic to Resident #3 as he needs his pain medication in the morning and she was able to give it because she was able to chart it in the narcotic book. Resident #3's [MEDICATION NAME] 5 mg Controlled Drug Record sheet received on 8/4/20, showed Staff E's signature on 8/11/20 at 0640 (6:40 a.m.) and then not again until 8/12/20 at 1930 (7:30 p.m.). A Daily Assignment Sheet dated 8/11/20 showed Staff D worked 10 a.m. to 8 p.m. and Staff E worked 8 p.m. to 6 a.m The Daily Assignment Sheet was for the 100 and 200 halls. A Covid Unit Daily Assignments sheet dated

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 0658 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Some	(continued... from page 1) 8/11/20 showed Staff B, LPN worked 6 p.m. to 10 p.m. on the 300 hall and Staff A, LPN worked p.m. to 10 p .m. on the 300 hall and then Staff B worked 10 p.m. to 6 a.m. on the 300 and 400 halls. A Liberalized Medication Pass Policy & Procedure dated 11/28/17,stated the policy is to administer medications in a safe manner while honoring Resident's wishes in their daily activity and sleep schedules. The policy directed staff to Follow the 6 Rights: Follow 6 rights when passing medication: a. Right Drug b. Right Dose c. Right Route d. Right Resident e. Right Time (either per Resident or physician requirement) f. Right Documentation A Medication Administration-Disaster Preparedness Policy and Procedure dated March 8, 2019, directed staff in the event of interruption in electrical power and/or Internet access that prevents the facility from electronically accessing Residents' MARs and TARs, a staff member is to contact a sister facility or a member of Regional or Corporate Management to obtain printed copies of the MARs and TARs for the purpose of administering the Residents' medications and treatments. In an interview on 9/2/20 at 2:50 p.m., the NHA stated the derecho came on suddenly, the power went out and the generator kicked on. This happened at around noon. The generator powers hallway lights, parts of the nursing station and outlets in red. The NHA reports that her staff were using their personal phones to gain access to Point Click Care (electronic health record including MARs/TARs). The NHA was contacted on 8/12/20 regarding the Agency Nurse not being able to give medications. The NHA contacted Staff C, whom she identified as the ADON, regarding the concern and was told by Staff C that Staff C had left a hotspot for Staff A to use so he could give medications. NHA said that Staff A was trying to connect to the wrong phone and was able to connect to the correct phone so he was able to view MARs around 4 a.m. The NHA on the morning of 8/12/20 went to their sister facility and picked up printed MARs and another hot spot. In an interview on 9/1/20 at 3:40 p.m., Staff A said he showed up to work on 8/11/20 for a 6 p.m. to 6 a.m. Staff A reported there was no air conditioning, no electronic health records, no MARs, and no working phone. The generator only powered the lights in the hall and red outlets. Staff A said he was left without knowing anything about the residents' ages, allergies [REDACTED]. Staff A said he only knew he was to take vital signs (VS) on all residents on his units as he was working on the COVID positive units. He said there were no abnormal VS and added there was no place to document the VS that he had taken. Staff A called the manager on duty (MOD) several times and left messages but never got a call back. Staff A reported he did hourly rounds to ensure residents were breathing. Staff A said he resigned the next day. Staff A stated he was told by his agency the NHA said to thank him for his professionalism and the facility took full responsibility and made immediate changes. Staff A stated he was told by Staff B to look at the medication cards and if they would typically give the medication on the night shift then to go ahead and give it. Staff A disagreed and stating you cannot give medications off of the medication cards because orders can change, medications can change, and people can develop allergies [REDACTED]. He added that if there would have been a fall he would not have been able to notify family and wouldn't be able to chart or know which hospital to send someone to if a need for transfer would have arose. He repeated there was no documentation at all. Staff A also said there were hard charts on the other unit (100 and 200 halls) but they were not easy to access as he could not leave the COVID side to go to the non-COVID side. In an interview on 9/2/20 at 3:43, Staff F, Certified Nurse Aide (CNA), acknowledged she worked the night that there were issues with the hot spot (8/11/20). Staff C, LPN/MDS Coordinator had asked Staff F if she knew how to hook up to the hotspot and Staff F affirmed that she did. Staff F stated she tried several times to hook up to the hotspot but was unable. Staff F stated she then saw another phone, which she found out later was the on call phone, and was able to hook up to the 2nd phone. Staff C had told Staff F that she would leave a phone but Staff F didn't know which phone Staff C had left. Staff F said she was working with an agency nurse (Staff A). Staff F said another nurse Staff B was working as well on the COVID side but she left at 10 p.m. Staff A had voiced concerns about not being able to look at the MARs/TARs, code statuses and all that stuff. Staff F stated that Staff C was unable to hook up to the hotspot as well. Staff F thought both nurses did pass medications without being able to see the MARs unless they were using their own phones to connect. Staff F stated all of the day nurses were using the hot spots on their personal phones to connect to the MARs. Staff F commented the day nurses were using up all their data. Staff F was able to connect to the hotspot around 11 p.m. and told Staff A that he could use it. Staff A didn't use it so Staff F told him she was shutting it off and to let her know when he needed it and she would reconnect it Staff F plugged the phone in one of the red outlets in the hallway by a makeshift nurses' station next to his medication cart. Staff F stated she turned the hotspot on at 4 a.m. and let Staff A know. Staff A said okay and thank you. Staff F stated that she knew Staff A used the phone because he passed morning medications. Staff F stated that Staff E who was working the other side did not know that they had the on call phone on the COVID side In an interview on 9/2/20 at 4:41 p.m., the Director of Nursing (DON), stated she had worked overnight the night of 8/10/20 and had used the on call phone as a hotspot. DON stated she was okay with using the on call phone as she knew she could call Staff C if she needed her. DON stated she had no issues that night. The DON returned to work the morning of the 12th and relieved Staff A. Staff A was able to give the DON report and had told her the hotspot was spotty but Staff F was able to help him. The DON stated that Staff A did complain to Staff G, RN, the other day nurse about the night. The DON stated Staff A had access to all contact numbers as they were on the schedule. The DON stated the section they worked in was taped off but if he had a question or wanted a chart he could have just asked or paged overhead. The DON stated there was also a sticky note with her, Staff C, and the NHA's names and phone numbers. The DON stated that a dedicated hot spot was placed after hearing about Staff A's concerns. The DON said she worked the entire time (that there was not Internet) and did not have any issues with the on call phone or the hotspot. In an interview on 9/2/20 at 5:00 p.m., Staff C stated she worked the evening the derecho blew through (8/10/20). Staff C was not a floor nurse so she helped out. Staff C stated she had the on call phone and it worked immediately after the derecho. Staff C left her and the NHA's phone numbers taped down on the big conference table. Staff C said she was not aware of any issues. In an interview on 9/10/20 at 3:19 p.m., Staff C stated that Resident #1 received [MEDICATION NAME] per the report of a blood sugar of 40. Staff C stated the doctor should have been notified because Resident #1 did not have an order for [REDACTED]. Staff C directed them not to move the medication cart because the connection wasn't good if you moved the medication cart. Staff C stated she did not have a good answer for why the nurses didn't call. Staff C said even though they couldn't get a hold of the on call person they could have and should have called the Nurse Manager or Administrator. That would have been the expectation. In an interview on 9/3/20 at 1:48 p.m., Staff G stated she was off when the storm hit and returned to work the morning of 8/12/20. Staff A had reported to Staff G that it was difficult to get connected to the hot spot. Staff G stated she was able to pass medications and another nurse used her own personal phone to administer medications. The facility ended up bringing in another hotspot later that day. In an interview on 9/3/20 at 2:50 p.m., Staff B stated she did not feel she had the necessary tools to care for the residents after the power outage. On the night of 8/11/20 she worked 6 p.m. to 10 p.m. There was a hotspot but it had been spotty all day and Staff C had directed her to punch the HS cards out and to try the hot spot later. Staff B asked Staff C what she should do about charting to which Staff C responded they would worry about that later. Staff B said there were no printed MARs and the facility had no ability to print off the MARs. Staff B stated the NHA was told this by another nurse on 8/10/20. Staff B stated she tried to get the hotspot to work the evening of 8/11/20. Staff A was working that night as well. Staff C told us to go ahead and punch the medications out and told Staff A that Staff B knows the medications like the back of her hand. Staff B stated she does not know the medications like the back of her hand. Staff B stated that Staff A kept asking Staff C to print off the MARs and Staff C told him she couldn't. Staff C told me later that Staff A did not pass medications. That is untrue. Staff B watched Staff A pass medications. Staff B told Staff A to pass narcotics from the count in the narcotic book with the HS medications and showed him there was a nurse on the other side. Staff B stated there was no issues voiced from the residents other than they felt like bumps on a log without any TV. In an interview following a voicemail left at 9/3/20 at 1:41 p.m., Staff E called back and reported that the NHA knew on 8/10/20 that we didn't have a way of doing MARs/TARs because of power outage. The only thing we had paper of was the narcotic. Staff E stated she did not pass medications the evening/night of 8/11/20 as she did not want to lose her nursing license. Staff E stated a hotspot was provided for the COVID side but not for the non COVID side. Staff A had voiced concerns to Staff E about no MARs/TARs and no way to check code status. Staff H let Staff A know she had access to paper charts. Staff E called and text the on call phone with no answer back. Staff E stated she did not know who the on call person was. Staff E found out in the morning that the on call phone was left on the COVID side as a hot spot. Staff E text the NHA on 8/12/20 in the morning (end of her shift) and let her know there were no MARs/TARs available. Staff E reported she tried but could not get a hold of the on call person. Staff E stated she gave a narcotic to a [MEDICAL TREATMENT] resident (Resident #3) who needed his pain med in the morning as she could document it in the narcotic book. In an interview on 9/8/20 at 2:10 p.m., Staff H, RN, stated she worked 8/10/20 when the storm happened. Staff H reported she was able to pass medications until afternoon. The Internet was the last thing to go out. Staff H said she was able to get everything done. Staff H told the NHA that day

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F 0658 **Level of harm -** Minimal harm or potential for actual harm **Residents Affected -** Some	(continued... from page 2) while they were sitting at the Nursing Station that the Internet was out and the nurses would not be able to pass medications. Staff H stated that she sent a text to the clinical regional asking for MARs and TARs after taking report from Staff E 8/12/20 morning. The NHA then text and said she was picking up MARs/TARs from the sister facility and also grab hoyer slings as laundry was not working. Staff H added they did not run out of hoyer slings. Staff H used paper MARs/TARs as far as documentation/assessments. In an interview on 9/8/20 at 2:15 p.m., Staff I, LPN, stated she had to use her own cell phone to use the hotspot on her phone. Staff I continued she had access to MARs/TARs. Staff I stated the red outlets were limited and moved things around to make due. Staff I did not know of any poor outcomes for the residents. In an interview on 9/14/20 at 3:05 p.m., Staff D stated she was able to pull Wifi MAR up on her phone. Staff D worked 10 a.m. to 8 p.m. on 8/11/20 and was relieved by Staff E. The facility provided printed copies of MARs/TARs from the month of August (8/1/20-8/31/20) for all residents that resided at the facility on 8/11/20-8/12/20. Review of the MARs/TARs revealed that medications and treatments were both given and not given without access to the EHR. The MARs/TARs specifically shown they were lacking signatures and per interviews the nurses working the evening/night shift both gave and withheld medications in 41 out of 47 residents. The facility failed to meet professional standards by not notifying Administration of the inability to access the Electronic Health Records.