| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | **165537** | A. BUILDING _____ B. WING _____ | **03/05/2020** |

| NAME OF PROVIDER OF SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP |
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| **HIAWATHA CARE CENTER** | **405 NORTH 15TH AVENUE HIAWATHA, IA 52233** |

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 0623<br><br>**Level of harm** - Potential for minimal harm<br><br>**Residents Affected** - Some | **Provide timely notification to the resident, and if applicable to the resident representative and ombudsman, before transfer or discharge, including appeal rights.**<br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**<br>Based on record review the facility failed to notify the Ombudsman for 4 of 5 residents reviewed who transferred to the hospital, admitted and returned to the facility (Resident #15, #5, # 32 and # 36). The facility reported a census of 99 residents. Findings include: 1. Record review showed resident # 15 with a hospitalization on [DATE], returning to the facility on [DATE]. Resident # 15 also hospitalized on [DATE], returning to the facility on [DATE]. Review of the Ombudsman Notification lists for November 2019 and December 2019 failed to show Resident #15 recorded as transferred out of the facility for either month.<br><br>2. Review of the Progress Notes for Resident # 5 dated 11/22/19, reflected the resident transferred to the emergency room . Review of the Progress Note dated 11/27/19, read Resident # 5 returned from the hospital [MEDICAL CONDITION]. Review of the Progress Note for Resident # 5 dated 12/11/19, identified the resident sent to the hospital. Review of the Progress Noted dated 12/17/19, read the resident readmitted to the facility [MEDICAL CONDITION] and Urinary Tract Infection [MEDICAL CONDITION] Review of the Admission/ Discharge To/From sheets submitted to the Ombudsman for November and December<br>2019, lacked identifying Resident #5's discharges to the hospital and returning to the facility.<br><br>3. Record review of Resident #36's Nurse's Notes dated [DATE] showed the physician came in to assess the resident and did a direct admit to the hospital, calls made and the ambulance transported the resident to the hospital. The facility's Admission/ Discharge To/From sheet submitted to the Ombudsman dated 12/1/19 through 12/31/19 failed to identify Resident #36 transferred and admitted to the hospital for the date of 12/15/20. 4. Record review of Resident #32's Nurse's Notes dated 11/1/19 showed the physician looked over the blood work of the resident and will direct admit the resident to the hospital. The facility's Admission/ Discharge To/From sheet submitted to the Ombudsman dated 11/1/19 through 11/30/19 failed to identify Resident #32 transferred and admitted to the hospital for the date of 11/15/20. During an interview on 3/3/20 at 4:20 p.m., the Minimum Data Set Coordinator reported Resident #15 chose to have a bed hold put into place, so not considered a discharge and not included on the report submitted to the Ombudsman. |
| F 0657<br><br>**Level of harm** - Potential for minimal harm<br><br>**Residents Affected** - Some | **Develop the complete care plan within 7 days of the comprehensive assessment; and prepared, reviewed, and revised by a team of health professionals.**<br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**<br>Based on observation, record review and staff interviews the facility failed to follow a Care Plan for 1 of 20 residents reviewed (Resident #32 ) by failing to use the adaptive equipment specified. The facility identified a census of 99 residents. Findings include: 1. Resident #32's Minimum Data Set (MDS) assessment dated [DATE] showed the resident with severe memory loss, required extensive staff assistance with meals, ate a mechanically altered diet (blended/puree foods), and displayed some coughing or choking during meals. The MDS identified the resident with [DIAGNOSES REDACTED]. The assessment showed the resident with no recent falls, had limited range of motion to all extremities and used a wheelchair. The Care Plan dated 3/22/17 showed the resident had a potential for a fall related to right [MEDICAL CONDITION] and positioning issue. Interventions for this concern include to have a Dycem (a non-slip pad) in the wheelchair and monitor the resident for slouching and assist to reposition when needed. Observation on 3/2/20 at 6:00 p.m., revealed Resident #32 sitting in the wheelchair, leaning far to the left, even though the soft Posey bolster sat on the left arm rest. The attached Posey pad looked well worn, leaned downward, not straight across, and not level on the wheelchair arm rest. No attempts were made by staff to sit the resident upright, throughout the whole meal. Observation on 3/3/20 at 11:00 a.m., the resident laid in bed noting the resident's wheelchair did not have a Dycem on or under the seat. Observation on 3/2/20 at 2:30 p.m. revealed the resident lying in bed with the wheelchair at the foot of the bed and failed to contain a Dycem on the seat. Observation and interview on 3/4/20 at 11:10 a.m. with Staff A, Certified Nursing Aide (CNA), Staff C, Registered Nurse (RN), and Staff B, Assistant Director of Nursing (ADON), all observed the Resident #32's wheelchair did not contain a Dycem on the seat nor under the seat of the wheelchair. Staff A reported the wheelchair is to have one and did not know if the Dycem discontinued. The ADON reported if the Care Plan states a Dycem is to be in Resident #32's wheelchair, then it should be present. Observation of the Care Plan easer board in the resident's room failed to mention a Dycem for the wheelchair. The ADON remarked if the Dycem is in the Care Plan to be in the resident's wheelchair, then it should be carried forward. During an interview on 3/4/20 at 4:30 p.m., the Director of Nursing (DON), reported the Care Plan for Resident #32 directed the Dycem be placed in the resident's wheelchair and needs to be in place and would follow up on that concern. |
| F 0684<br><br>**Level of harm** - Minimal harm or potential for actual harm<br><br>**Residents Affected** - Few | **Provide appropriate treatment and care according to orders, resident's preferences and goals.**<br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**<br>Based on observation, record review, family and staff interviews, the facility failed to appropriately position 2 of 20 residents reviewed (Resident #32 and #42) in their wheelchairs at mealtimes. The facility identified a census of 99 residents. Findings include: 1. Resident #32's Minimum Data Set (MDS) assessment dated [DATE] showed the resident with severe memory loss, required extensive staff assistance with meals, ate a mechanically altered diet (blended/puree foods), and displayed some coughing or choking during meals. The MDS identified the resident with [DIAGNOSES REDACTED]. The assessment identified the resident with no recent falls, had limited range of motion to all extremities and used a wheelchair. The Care Plan dated 3/13/19 identified the resident with altered nutrition related to many issues, including history of a stroke, dysphagia (difficult with swallowing), occasional coughing, nausea and vomiting. One of the interventions for this concern included to have the resident sit at a supervised table and assist with tray set up and provide cueing. The Care Plan dated 3/1/18 identified the resident with a fall potential related to the right side [MEDICAL CONDITION] and occasional positioning issues with an intervention including to monitor the resident for slouching and assist to reposition when needed. During observations of Resident #32 at meal times, the following noted with no staff interventions to assist the resident to reposition and sit more upright: a. On 3/2/20 at 1:10 p.m., the resident sat in the wheelchair eating the noon meal, leaned to the left, approximately at a 30 degree angle, not sitting upright. b. On 3/2/20 |

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 0684<br><br>**Level of harm** - Minimal harm or potential for actual harm<br><br>**Residents Affected** - Few | (continued... from page 1)<br>at 6:30 p.m., revealed the resident in the wheelchair leaning very far to the right at nearly a 45 degree angle position while feeding self. c. On 3/3/20 at 8:00 a.m., the resident leaning to the left side (30 degree angle) and leaned further to the left as the meal went on. d. On 3/3/20 at 1:00 p.m., the resident leaning to the left side in the wheelchair, approximately at a 30 degree angle. e. On 3/4/20 at 8:00 a.m., the resident leaning to the left, approximately at a 30 degree angle. During an interview on 3/3/20 at 8:30 a.m., the resident's relative; who assisted the resident with the meal, reported the resident does not use the molded arm rest assist as it does not fit the resident. The family member gently shook the molded arm rest which moved about. The resident's relative reported not liking how the resident leans so far to the left and felt the wheelchair doesn't fit the resident correctly. The resident's family member also reported bringing this subject up to the staff a few times, but nothing changed. The resident's family member also remarked the nylon (Hoyer) mesh sling the resident sits on, maybe slippery adding to the left lean in the wheelchair. Observation and interview on 3/4/20 at 11:10 a.m. with Staff A, Certified Nursing Aide (CNA), Staff C, Registered Nurse (RN), and Staff B, Assistant Director of Nursing (ADON) all noted the resident leans to the left almost all the time. One of the staff reported tried a wedge or something lateral in the wheelchair but the resident didn't like it. The ADON acknowledged not knowing the last time the resident had a Therapy evaluation for positioning in the wheelchair but concluded that may be in order now. They all acknowledged the padded Posey on the left arm rest of the wheelchair goes downward and looked overused. During an interview on 3/4/20 at 4:41 p.m., the Director of Nursing (DON) reported the resident does lean to the left and probably more so when the resident is tired. She said she would look into the resident's positioning in the wheelchair, and the padded Posey arm rest that looks broken down in the wheelchair. The DON acknowledged the resident could be evaluated by the Therapy Department for this concern, as it probably has been awhile. She also commented the resident's family did not speak to her directly, nor had any staff person report the family's concern with positioning or with the wheelchair, but would look into it. During an interview on 3/5/20 at 10:03 a.m., the Director of Therapy Services showed the Request for Therapy Screen dated 3/5/19. The Director of Therapy Services reported the resident's family brought concerns of not happy with the wheelchair as the resident continued to lean and did not look comfortable. The Therapy Screen noted would contact the Supply Company of the wheelchair to address issues. The Director of Therapy called the Supply Company for their notes, but they had not kept any notes regarding adjusting the wheelchair for the resident's position. 2. Resident #42's MDS dated [DATE] identified the resident with severe memory loss, inattention, disorganized thinking and required total staff assistance for all cares of daily life. The MDS documented the resident did not ambulate, had limited range of motion to both lower extremities, used a wheelchair, and required limited staff assistance with eating. The assessment also showed the resident with [DIAGNOSES REDACTED]. The Care Plan dated 4/26/19 identified Resident #42 for potential nutritional risk related to and including: jerky movement to hands/head with food/fluid spillage at meals, will resist staff assistance, and has thrown plates. Interventions for this concern included to be set up for the meals, receive shatter proof bowls with the cereal at breakfast and salads/deserts. Observations made during meal times revealed the following in regards to Resident #42: a. On 3/2/20 at 6:30 p.m., the resident sitting at the dining room table in a wheelchair for the evening meal leaning back as the wheelchair not in an upright position. The resident fed self with some cueing from the staff person next to the resident. The resident did a full arm reach to spoon the food to his/her mouth for the entire meal. At one time the resident leaned forward as possible trying to reach the desert bowl. After 2 attempts, the staff person (assisting another resident at the table) noticed and pushed the bowl within reach of the resident so could reach it to eat. b. On 3/3/20 at 12:40 p.m., the resident sitting in a wheelchair at the dining room table with the wheelchair not in an upright position and the resident leaning slightly back. The resident sat dozing, wearing a cloth protector which had 3 large pieces of meat or food debris on the cloth at various chest areas. A staff person woke the resident up and asked if they were finished eating. The resident woke up and took a full arm reach for a glass of fluid. The resident continued to use a full reach of the arm and arched the silverware of food toward the mouth. Another staff person sat at the table to assist another resident and would cue Resident #42 at times. c. On 3/4/20 at the noon meal, the resident sitting back in the wheelchair eating, using the full length of the arm to reach food to eat. After a few minutes the DON went to the resident and asked if could place the wheelchair in an upright position for the resident, and the resident said yes. During an interview on 3/4/20 at 4:45 p.m. at 7:09 p.m. the DON reported the resident should have the wheelchair in an upright position for eating, so the resident is not reaching so far to bring the food to his/her mouth. |
| F 0803<br><br>**Level of harm** - Minimal harm or potential for actual harm<br><br>**Residents Affected** - Some | **Ensure menus must meet the nutritional needs of residents, be prepared in advance, be followed, be updated, be reviewed by dietician, and meet the needs of the resident.**<br><br>Based on facility menu review, observation, document review, and staff interviews, the facility staff failed to ensure all residents on puree textured diets, received the proper portion size based on the planned menu for 8 of 8 residents on a pureed diet in the West dining room. The facility identified a census of 99 residents. Findings include: The facility's Week 3 Menu, signed by the Consultant Dietitian, identified 1 serving of creamy chicken carbonara on 3/3/20 for pureed diet. Review of the facility therapeutic and mechanically altered diet list revealed 9 residents on a pureed diet. One resident listed okay to have regular texture food as resident request/desires. During an observation on 3/3/20 at 10:32 a.m., Staff Q, Cook pureed 10 servings of the chicken carbonara casserole using the volume technique per the Mechanically Altered Diets Policy. Staff Q measured the volume of the casserole as 8 cups, requiring a # 8 and #12 scoop to make a serving for residents on a pureed diet. During an observation on 3/3/20 at 11:59 a.m. during serving of the noon meal, Staff L, Cook served the pureed chicken carbonara casserole using only a #8 scoop. Staff L failed to serve 8 pureed diets the #12 scoop also. Staff L used a #8 and a #12 scoop for the pureed bread instead of the casserole and at the end of meal service she ran out of the pureed bread. One resident did not receive a portion of pureed bread. A post it note hanging from the steam table stated to use a #8 and a #12 scoop for the casserole. During an interview on 3/3/20 at 12:40 p.m., the Assistant Certified Dietary Manager (ACDM) states Staff L, Cook used the scoops needed for the casserole on the bread and served less than required for the pureed casserole. The ACDM explained the pureed process when using different size scoops can be difficult. |
| 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 observations, record review and staff interviews, the facility failed to maintain Infection Control practices during 1 out of 3 wound care observations (Resident # 92), 2 out of 6 observations of residents with catheters (Residents #5 and #8), and during 3 out of 3 dining room observations of meal service. The facility reported a census of 99 residents. Findings included: 1. The Admission Record for Resident # 5 dated 12/2/19, listed [DIAGNOSES REDACTED]. The Minimum Data Set (MDS) assessment for Resident # 5 dated 12/[DATE]9, identified the resident with short and long term memory problems and severe difficulty with daily decision making skills. The MDS reflected Resident # 5 as dependent on staff for toileting and required extensive assist of 1 staff for dressing and personal hygiene. The MDS documented the resident with a urinary catheter. The Care Plan for Resident # 5 dated 6/27/18, directed staff to repot signs and symptoms of urinary tract infection [MEDICAL CONDITION]. During an observation on 3/2/20 at 10:31 a.m., Resident #5's catheter bag hung on the side of the bed in dignity bag on the floor. During an observation on 3/4/20 at 10:26 a.m., Resident #5 in bed with the catheter bag in a dignity bag on the side of the bed, the bed in a lower position resulting in the dignity bag on the floor. During an observation on 3/4/20 at 1:11 p.m., Staff P, Certified Nurses Aid (CNA) set the graduated cylinder that held 375 cubic centimeters (cc) of urine on the floor in the bathroom with no barrier under the cylinder. The Progress Note for Resident #5 dated 11/27/2019 at 2:56 p.m., read admitted following hospitalization [MEDICAL CONDITION]. The Progress Note dated 12/17/2019 at 11:45 a.m., read admitted back from the hospital a the [DIAGNOSES REDACTED]. During an interview on 3/5/20 at 8:45 a.m., Staff G, Assistant Director of Nursing (ADON)/Infection Control Monitor reported a graduated cylinder with urine in it should not be set on the floor with out a barrier. Staff G also stated the expectation is the catheter bag and dignity bags are up off of the floor.<br><br>2. Resident #92's Minimum Data Set (MDS) assessment dated [DATE] showed the resident with severe impairment with cognitive skills, required extensive staff assistance of two with transfers, toileting and personal hygiene. The assessment identified the resident with [DIAGNOSES REDACTED]. During an observation of toileting with Resident #92 on 3/4/20, Staff K, Certified Nursing Assistant (CNA) used gloved hands to wipe the residents buttocks with a disposable washcloth after the |

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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>resident had smearing of bowel movement in her adult incontinent brief to buttocks. Staff K, CNA then applied barrier cream wiping the area multiple times with the same gloved hand. Staff K, CNA failed to change gloves or wash hands in between wiping the buttocks and applying a barrier cream. During an interview on 3/4/20 at 3:38 p.m., Staff O, CNA states she would change her gloves and sanitize hands between cleaning bowel movement and applying cream to a resident's buttocks. During an interview on 3/4/20 at 3:41 p.m., Staff N, Registered Nurse (RN) stated expected CNA's to change gloves after cleaning up a soiled resident and then applying a barrier cream. During an interview on 3/5/20 at 11:18 a.m. the Director of Nursing (DON) stated aware of the glove issue and expected CNA's to change gloves prior to putting on a topical cream. The facility provided a policy dated 3/5/20 which directs staff to administer topical creams in an appropriate manner. The policy directed staff to apply gloves, cleanse and dry affected area. Remove gloves, perform hand hygiene, apply clean gloves and apply topical cream as directed.<br><br>3. During random observations of Resident #8, the following noted in regards to the resident's catheter drainage bag: a. On 3/2/20 at 2:14 p.m., Resident #8 resting in bed with her catheter drainage bag directly on the floor under the bed. b. On 3/2/20 at 3:30 p.m., Resident #8 resting in bed and the catheter drainage bag directly on the floor, under the bed. c. On 3/2/20 at 4:45 p.m., Resident #8 resting in bed and the catheter drainage bag directly on the floor, under the bed. d. On 3/3/20 at 11:11 a.m., Resident #8 resting in her recliner and the catheter drainage bag in a trash can beside the chair. During an interview on March 4, 2020 at 11:50 a.m., the Director of Nursing (DON) expected a resident's catheter drainage bag to be in a dignity bag and expected the drainage bag to not be directly on the floor. The DON also stated placing the catheter drainage bag in a trash can considered not a good practice. 4. During observations of 3 meal services the following noted: a. On 3/2/20 at 12:03 p.m., during the noon meal, Staff D, Certified Nurse Aide (CNA) took a tray from the serving line and served a resident at the table. When taking beverages off the tray, fingers touched the drinking rim of the glass. Staff D observed touching the drinking rim of the glass for 2 residents. b. On 3/2/20 during the noon meal, Staff E, CNA observed taking a tray from the serving line to a resident table. When taking the beverages off of the tray, her fingers touched the drinking rim of the glass for 1 resident. c. On 3/2/20 during the noon meal, Staff F, CNA observed taking a tray from the serving line to a resident table. When taking beverages off the tray, her fingers touched the drinking rim of the glass. Staff E observed touching the drinking rim of the glass while serving 2 residents. d. On 3/3/20 at 8:20 a.m., the Dietary Manager (DM) observed taking a tray from the serving line to a resident table. When taking the beverages off the tray, her fingers touched the drinking rim of the glass. The DM observed touching the drinking rim of the glass for 2 residents. e. On 3/3/20 during the breakfast meal, Staff G, the Assistant Director of Nursing (ADON) observed taking a tray from the serving line to a resident table. When taking the beverages off the tray her fingers touched the drinking rim of the glass. Staff G observed touching the drinking rim of the glass for 2 residents. f. On 3/3/20 during the breakfast meal, Staff H, Dietary Aide observed taking a tray from the serving line to a resident table. When taking the beverages off the tray, her fingers touched the drinking rim of the glass. Staff H observed touching the drinking rim of the glass for 1 resident. g. On 3/3/20 at 12:00 p.m., Staff I, Dietary Aide observed taking a tray from the serving line to a resident table. When taking the beverages off the tray, her finger touched the drinking rim of the glass. Staff I observed touching the drinking rim of the glass for 3 residents. h. On 3/320 during the noon meal, Staff H, Dietary Aide observed taking a tray from the serving line to a resident table. When taking beverages off the tray, her fingers touched the drinking rim of the glass. Staff H observed touching the drinking rim for 2 residents. i. On 3/3/20 during the noon meal, Staff J, CNA observed taking a tray from the serving line to a resident table. When taking the beverages off the tray, her fingers touched the drinking rim of the glass. Staff J observed touching the drinking rim of the glass for 1 resident. During an interview on 3/4/20 at 1:44 p.m., the Dietary Manager stated she expected staff to not touch the drinking rim of the glass when serving beverages to the residents. |