STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	165268	A. BUILDING _____ B. WING _____	**09/30/2020**

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
REHABILITATION CENTER OF DES MOINES	**701 RIVERVIEW DES MOINES, IA 50316**

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 0552 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	**Ensure that residents are fully informed and understand their health status, care and treatments.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review, family and staff interviews the facility failed to complete the necessary admission information needed for a resident to be admitted to the facility. The facility failed to inform the resident's responsible party and obtain proper consents for care and billing and the right for the resident and/or his responsible party to establish his healthcare directives as required when admitted to the facility for 1 of 4 residents reviewed (Resident #18). The facility reported a census of 72 residents. Findings include: A Minimum Data Set (MDS) for Resident #18, with a completion date of 2/24/20, listed [DIAGNOSES REDACTED]. The MDS scored the resident with a Brief Interview for Mental Status (BIMS) of 7, which indicated severe cognitive impairment. The MDS documented the resident required extensive assistance of 2 staff for bed mobility, transfers, eating, personal hygiene and toileting. Progress notes: 2/24/20 at 12:47 PM, Social Services- Admit Note- Resident unable to state year, month, or day of the week. He is pleasantly confused and able to make needs known. He is able to discuss his past history and family members. He states he wants to go home after therapy. He has an anxious behavior of softly hitting his right wrist against the wall. He was unable to state who his primary physician was. He has little belongings. He denies wearing dentures or hearing aids. He states he wears glasses, but unable to find that he brought a pair with him. Social services to work with resident on discharge planning and proceed to care plan. 2/21/20 at 6:30 PM, Nursing-Report received that resident arrived at 3:30 PM today. Resident was oriented to room and call button. Resident is confused and anxious but appears comfortable. Review of admission orders [REDACTED]. Review of the clinical record revealed it lacked documentation of Resident #18's responsible party informed of admission requirements including the need to designate his code status or informed of billing procedures. There was no record of a signed Do Not Resuscitate (DNR) order for the resident or the family to review and sign, nor an Iowa physician's orders [REDACTED]. There was no record of any Advance Directives or power of attorney papers in the record. There was a signed physician's orders [REDACTED]. During an interview with Staff II on 8/11/20 at 1:27 pm, she stated she did not recall anything about Resident #18's admission paperwork. Staff II's signature was noted to be on the admission documents for the business office and also contained the resident's signature. Staff II stated although she signed some admission forms with Resident # 18, she could not recall doing them. During an interview on 8/11/10 at 2:56 pm, Staff SS- Social Services stated cognitively impaired residents should not sign their admission paperwork. Staff SS stated if a resident is unable to sign their paperwork, staff are to talk with the nurse, the MDS coordinator or the DON on how to proceed. Staff SS stated she trained Staff II that if a resident is not cognitively able, they have to find the paperwork and verify if there is a power of attorney (POA) or durable power of attorney (DPOA). During an interview with the Director of Nurses (DON) on 8/17/20 at 11:55 am she revealed she searched the records and did not locate completed nursing admission records, no signed DNR form and no consents signed for care. The DON stated the facility should have given the full nursing admission paperwork to the resident's family but there was no record of any of this documentation. The DON further stated Resident #18 was not cognitively able to sign for himself and the facility should have contacted the responsible party to sign the admission nursing paperwork. During an interview with the Administrator on 9/15/20 at 1:22 pm she acknowledged she knew that none of the nursing admission paperwork was ever provided and that Resident #18 was not cognitively able and should not have been allowed to sign the business office paperwork.
F 0580 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Some	**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, facility policy review and family and staff interview, the facility failed to promptly report a resident's change of condition to the physician and/or family/resident representative 5 of 6 residents reviewed. (Resident #1, #2, #9, #16,#18 and #26) The facility identified a census of 72 residents. Findings include: 1. A Minimum Data Set (MDS) assessment form dated 7/11/20 documented the Resident #1 without a Brief Interview for Mental Status (BIMS) score which signified a cognitive deficit. A Progress Note form dated 7/31/20 at 10:35 a.m. documented Resident #1 received a new order for liquid protein for wound healing. Per documentation from the Director of Nursing (DON) dated 8/14/20 (no time identified) she confirmed the facility staff failed to have notified the family of the new Physician order. 2. An Incident Report form dated 2/10/20 at 10:04 a.m. documented the nurse as summoned to the room of Resident #2. As the nurse entered she observed the resident as he sat on the floor between the bed and the wheel chair. During the assessment the nurse observed the resident wore a non skid sock on the right foot and nothing on the left foot. The resident denied pain. Staff assisted him off the floor with a gait belt and 3 staff assistance to his wheel chair. Range of motion (ROM) assessed and within normal limits (WNL). The nurse described the resident as alert and oriented and able to make his needs known. The report documented the facility notified the physician, but failed to identify family/responsible party notification. Review of the facilities Progress Note forms on the date of the fall and post fall revealed no documentation of family/responsible party notification. During an interview 8/13/20 at 10:37 a.m. a family member confirmed at times the facility failed to inform her of the resident's condition changes and/or medication changes. 3. A MDS assessment dated [DATE] documented Resident #9 with a BIMS score of 7 out of 15 which signified a cognitive deficit. An Incident Report form dated 6/6/20 at 3:25 p.m. documented the nurse as called to the room of Resident #9 by a certified nursing assistant (CNA) and observed the resident as he knelt on the floor. The resident stated that he attempted to use the restroom. The nurse assessed the resident with a blood pressure (B/P) 101/60, pulse (P) 63, respirations (R) 16 and an oxygen saturation rate (O2) of 93% at room air (RA). Respirations even, non-labored, no signs and symptoms of acute distress, alert and orientated, denied pain, ROM WNL. Staff observed a skin tear on the left posterior arm and left dorsal hand and an abrasion to the left lateral back. The nurse cleansed the areas, applied dry dressings and contacted the physician and reported the incident and injuries but failed to contact the family/responsible party. During an interview 8/5/20 at 4:44 p.m., the DON (director of nursing) confirmed facility staff failed to notify the resident's family/responsible party. During an interview 8/5/20 at 3:52 p.m., the DON confirmed on 7/22/20 the resident received a new open area on his right heel but the facility staff failed to notify the resident's family/responsible party. 4. A MDS assessment form dated 7/2/20 documented Resident #16 with a BIMS score of 6 out of 15 which signified cognitive impairment. A Progress Note form dated 4/23/20 at 1:56 p.m. documented the resident as moved for medical purposes as well as the long term care residents requirement to have transitioned off of the skilled flour however the facility failed to notify family/responsible party of the resident's room move. 5. An Incident Report form dated 6/7/20 at 7:34 p.m. revealed Resident #26 sustained an unwitnessed fall which

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 0580 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Some	(continued... from page 1) re-opened an abrasion to the resident's left knee. The report documented the facility notified the physician but failed to notify the family/responsible party. Review of Progress Note forms on the date of the fall and post fall revealed no documentation of any family/responsible party notification. An Incident Report form dated 7/20/20 at 5:04 p.m. documented the resident sustained [REDACTED]. The report documented the Physician as notified but failed to identify family/responsible party notification. Review of Progress Notes forms on the date of the fall and post fall revealed no documentation of any family/responsible party notification. An Incident Report form dated 8/7/20 at 7:15 p.m. documented the resident sustained [REDACTED]. The report documented the facility staff failed to notify the Physician and the family/responsible party. Review of the facilities Progress Notes forms on the date of the fall and post fall revealed no documentation of any Physician and family/responsible party notification. The facility policy on Notification, Physician or Responsible Party form (not dated) directed the staff to have promptly notified the the resident, his/her attending physician and the family/responsible party of changes in the resident's condition and/or status which included the following: a. The resident had been involved in any accident or incident. b. An altered treatment. 6. A MDS for Resident #18, with a completion date of 2/24/20, listed [DIAGNOSES REDACTED]. The MDS scored the resident with a BIMS of 7, which indicated severe cognitive impairment. The MDS documented the resident required extensive assistance of 2 staff for bed mobility, transfers, eating, personal hygiene and toileting. Clinical record review on 8/11/20 revealed progress notes dated 2/25/20 that Resident #18 pulled out his indwelling bladder catheter twice. Once at 3:07 am and again at 7:07 am. The nurse reinserted the catheter after the first incident of the catheter pulled out. The facility left the catheter out after the second incident of the resident pulling the catheter out. The record did not contain documentation that the facility informed the family. During an interview on 9/15/20 at 1:22 pm the Administrator confirmed no family notification done when Resident #18 pulled out his urinary catheter twice on 2/25/20. During an interview on 8/17/20 at 11:55 am the Director of Nurses (DON) confirmed no family notification. A facility policy revised 8/2007 titled Resident Rights, Notification, Physician or responsible Party stated in part that: It is the policy of this facility to promptly notify the resident, his/her attending physician, and/or family/responsible party of changes in the resident's condition and/or status. Procedure: The nurse supervisor will notify the resident's family/responsible party when: A. The resident is involved in any accident or incident. B. There is a significant change in the resident's physical, mental, or psychosocial status. C. There is a need to alter the resident's treatment significantly.
F 0656 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	**Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, clinical record review and staff interview, the facility failed to follow interventions for the comprehensive plan of care for 2 of 5 residents reviewed. Staff failed to follow Residents #26 and Resident #30's care plan. Resident #30 sustained a fractured distal right tibia. The facility identified a census of 72 residents. Findings include: 1. A Minimum Data Set (MDS) assessment form dated 7/20/20 documented Resident #26 with [DIAGNOSES REDACTED]. The assessment documented the resident with a Brief Interview for Mental Status (BIMS) score of 2 out of 15 which signified severe cognitive deficit. The MDS identified the resident as non-ambulatory and required extensive assistance of two (2) staff members with transfers and toilet use. The resident had 2 falls without injury the past assessment period. A Care Plan with a Focus area initiated 8/22/19 documented the resident at risk for falls related to [MEDICAL CONDITIONS], pain, diabetes, a history of falls, potential medication side affects (antidepressants, diuretic and opioid [MEDICATION NAME]). The interventions included the following: a. Dycem to the wheel chair. (initiated 8/12/20) b. Floor mat at bedside. (initiated 7/27/20) c. Floor mat to both sides of the bed. (initiated 8/8/20) d. The bed kept locked and in the lowest position. (initiated 7/20/20) An observation 8/14/20 at 1:40 p.m. revealed the resident positioned in bed. The bed was not in the lowest position and without floor mats in place beside the resident's bed. At that time, Staff G, Licensed Practical Nurse (LPN) confirmed the surveyor observation and stated she directed staff to inform her when they placed the resident in bed due to him falling out of bed a lot. 2. A Minimum Data Set (MDS) assessment dated [DATE] identified Resident #30 with [DIAGNOSES REDACTED]. The assessment indicated the resident had a Brief Interview for Mental Status (BIMS) score of 15 out of 15 (cognitively intact), weighed 250 pounds (#), required extensive assistance of two (2) staff with transfers, non-ambulatory and with no falls in the past 3 months. A Care Plan with a focus area dated 10/30/18 identified the resident as at risk for falls related to left [MEDICAL CONDITION] with new prosthesis, obesity, potential side effects of medications received to manage multiple health conditions and the resident required assistance to complete activities of daily living (ADL's) due to decreased mobility following a left [MEDICAL CONDITION] with a new prosthesis, weakness and obesity. The approaches included the following: a. Transferred with the assistance of 2 staff members with an mechanical lift device. Date initiated 11/2718 An Incident Report form dated 8/7/20 at 6:31 p.m. documented the following: A CNA (certified nurse aide) got this Registered Nurse (RN) and oncoming LPN to assist the resident. Upon entrance to the room observation showed the resident leaned with her back against the bed with her right lower extremity (RLE) bent at the knee resting below the knee amputated left lower extremity (LLE). The resident complained of pain to her ankle of the LLE. The resident's vital signs (VS) registered within normal limits (WNL), fall witnessed and assistance given by 2 CNA's. Staff heard a loud pop when the resident stood with the assistance of 2 and transferred from the wheel chair to bed. The resident then stated she had intense pain and could not complete the transfer process. Staff assisted the resident to the floor. No injury noted to the head. Resident safely assisted by four (4) staff into a mechanical lift pad then transferred via the mechanical lift device to bed. The resident yelled out when staff palpated her ankle/lower leg however she minimally wiggled her toes. The resident stated I heard a loud pop and fell . Staff T, Certified Nursing Assistant (CNA) stated that she and Staff E, CNA completed a 2 person transfer from the bed to the wheel chair positioned at a 90 degree angle. As the resident stood on her right leg they heard a pop so the resident had been unable to stand on her right leg and they lowered her to the floor. Staff E stayed with the resident and Staff T went and notified the RN and LPN who came on shift. After the nurse assessed the resident they transferred her per a mechanical lift device onto her bed. Staff E stated that she and Staff T, CNA completed a 2 person transfer from the bed to the wheel chair positioned right next to the bed. When the resident stood up she yelled out in pain and quit bearing weight at all to her leg. They lowered her straight down to the floor at that time and obtained nurse assistance. They they used a mechanical lift device and transferred the resident to bed. During an interview 8/31/20 at 4:54 p.m. Staff T stated the resident fell on [DATE] around suppertime. Herself and Staff E had been in a hurry because they had a call in that evening and they needed to get the resident up in her wheel chair for supper so they could get out and pass supper trays. Both of the staff members realized they both had regular sized gait belts and the resident required an extra large gait belt which had been usually in the room however they could not find the device at that time. Since they were in a a hurry Staff T tried to use her regular sized gait belt on the resident as she placed it under both of the residents arm pit areas but decided that had not been safe either so they removed the device so they transferred the resident without a gait belt. Staff T stood on the resident's left side as Staff E stood on the residents right said and faced the resident. They stood her up at bed side and heard a loud crack as the resident leaned towards the right side due to her having been an [MEDICAL CONDITION] on the left leg then she fell towards Staff T so the staff lowered her to the floor. Staff T stayed with the resident as Staff E reported the incident to the nurse who assessed the resident. When Staff T spoke to the Director of Nursing (DON) the following day she told her the fall had been totally her fault as they had not utilized a gait belt device during the transfer process. Staff T stated she knew after the fall the resident told people they used a gait belt with the transfer but Staff T told the resident they failed to use a gait belt a the time of the fall and she knew that. The staff member again confirmed she was at fault. A radiology report dated 8/7/20 identified post fall /pain. The x-ray revealed a nondisplaced oblique fracture involving the right distal tibia.
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** Based on clinical record review and staff interview the facility failed to update and manage resident care plans 1 of 5

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F 0657 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	(continued... from page 2) residents reviewed. (Resident #12) The facility identified a census of 72 residents. Findings include: 1. A MDS for Resident #12, with a completion date of 6/3/20 listed [DIAGNOSES REDACTED]. The MDS documented the resident required extensive assistance of 2 staff for bed mobility, transfers, toileting and bathing and required extensive assist of 1 staff with dressing and personal hygiene. Review of residents care plan with revision date of 1/20/19 revealed the care plan stated to weigh resident weekly per facility policy and was initiated on 8/19/19. Record review of Resident #12's physician's orders [REDACTED]. During an interview on 9/4/20 at 3:44 p.m. with Staff R-Licensed Practical Nurse/ Unit Manager, stated she had noticed Resident #12's daily weights not getting done. She further stated daily weights are the nurses responsibility and it is on the Medication Administration Record [REDACTED]. During an interview on 9/15/20 at 1:22 p.m. with the Administrator, she stated she was not aware that Resident #12's care plan did not contain the update to reflect the need for daily weights. A facility policy titled Comprehensive Person-Centered Care Planning revised on 8/17 stated the policy of the facility is that the interdisciplinary team (IDT) shall develop a comprehensive person-centered care plan for each resident that includes measurable objectives and timeframes to meet a resident's medical nursing, mental and psychosocial needs that are identified in the comprehensive assessment. The policy further stated that the resident's comprehensive plan of care will be reviewed and revised by the IDT after each assessment.
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 record review, policy review, and staff interview the facility failed to meet professional standards of care for 4 of 4 residents (Resident #3, Resident #9, Resident #17, and Resident #25) reviewed by not having a Registered Nurse (RN) complete the initial admission assessments and for 1 of 2 residents (Resident #12) for not following physicians orders. The facility reported a census of 72 residents. Findings Include: 1. A Minimum Data Set (MDS) Entry tracking form for Resident #17, with a completion date of 6/24/20, documented admitted to the facility on [DATE]. Census in Electric Health Records (EHR) confirms date of admission to the facility 6/23/20. Initial Admission assessment with a completion date of 6/23/20, was signed by a Licensed Practical Nurse (LPN). 2. A MDS Entry Tracking form for Resident # 9, with a completion date of 6/12/20, documented admitted to the facility on [DATE]. Census in EHR confirms date of admission to the facility 6/5/20. Initial Admission assessment with a completion date of 6/5/20, was signed by an LPN. 3. A MDS Entry Tracking form for Resident #25, with a completion date of 7/25/20, documented admitted to the facility of 7/24/20. Census in EHR confirms date of admission to the facility 7/24/20. Initial Admission assessment with a completion date of 7/28/20, was signed by an LPN. In addition the initial assessment was not completed within 24 hours of the residents' admission to the facility. 4. A MDS Entry Tracking form for Resident # 3, with a completion date of 7/15/20, documented admitted to the facility 7/13/20. Census in EHR confirms date of admission to the facility 7/13/20. Initial Admission assessment with completion date of 7/13/20, was signed by an LPN. Policy and Procedure titled Resident Assessment, Nursing dated 5/2007 stated the facility would complete a Nursing assessment within 24 hours of admission. The purpose was to establish parameters and gather vital information that will be relevant in maintaining and/or reaching the resident's highest practicable physical, mental, or psychosocial well-being. Interview with the Director of Nursing (DON) at 11:33 AM, on 8/25/20, confirmed the above initial admission assessments completed by an LPN and did not have a co-signature of an RN (registered nurse). The DON stated she was not aware that an RN was required to complete initial assessments for residents. The DON stated she would get a system in place to have an RN complete all admission assessments. 5. The MDS for Resident #12, with a completion date of 6/3/20 listed [DIAGNOSES REDACTED]. The MDS scored the resident with a Brief Interview for Mental Status (BIMS) of 15, which indicated intact cognition. The MDS documented the resident required extensive assistance of 2 staff for bed mobility, transfers, toileting and bathing. Resident required extensive assist of 1 staff with dressing and personal hygiene. Review of Resident 12's care plan with revision date of 1/20/19 stated to weigh resident weekly per facility policy, initiated on 8/19/19. Clinical record review of Resident #12's physician's orders [REDACTED]. Review of Resident #12's weights in the clinical record revealed no weights recorded on the following days: -May 8,10,11, 12,13,14,16,17,18,19,20,30th -June 2,4,9,10,12,13,14,16,17,18,19,20,30th -July 2,7,8,9,10,11,12,13,14,15,17,18,19,20,21,22,24,25,26,27th -August None for August 1-17th, and also not done on the 19, 20,21,22,23,25,26,27,29,30,31 -September 1,2,3,9,11,13,14,15th An interview with the facility Dietician on 9/1/20 at 3:12 p.m. revealed he was frustrated the facility staff does not obtain daily weights as ordered. The Dietician stated the weights are not done consistently at the facility which made it was hard for him to assess residents accurately. An interview with the DON on 9/2/20 at 3:44 p.m., revealed facility nurses are to review the orders on the treatment administration record and have the nurse aides obtain the daily weights as ordered. DON verified staff did not weigh Resident #12 daily as ordered and that she could not find a facility policy on weighing residents. An interview on 9/4/20 at 3:44 p.m. with Staff R- LPN Unit Manager, she stated she noticed Resident #12's daily weights not getting done. Staff R stated the daily weights are the nurse's responsibility to ensure they are done. b. Review of Resident #12's October 2019 Medication Administration Record (MAR) revealed an order for [REDACTED].) tablet, 1 tablet by mouth every 4 hours for left lower leg pain. The MAR lacked documentation for 4 missed doses of [MEDICATION NAME] 20 mg. tabs not administered on 11/12/19 at 4:00 p.m., and on 11/13/20, no doses administered at 8:00 a.m., 12:00 p.m. and 4:00 p.m. Review of Resident # 12's 11/12/19 controlled medication utilization record revealed the last dose of [MEDICATION NAME] 20 mg tabs administered at 1:00 pm that day, leaving zero pills left over for additional doses. Further review of the controlled medication utilization record for 11/13/20 revealed the facility did not receive a refill of the medication until 9:30 p.m. The facility ran out of his pain medication and did not re-order it in a timely manner. Review of Resident 12's care plan with revision date of 1/20/19 listed a focus that identified the resident with acute and chronic pain related to venous ulcers to bilateral lower extremity with a goal to not have an interruption in normal activities due to pain. Interventions included: -anticipate need for pain relief and respond immediately to any complaint of pain -Evaluate the effectiveness of pain interventions, Review for compliance, alleviating of symptoms, dosing schedules and resident satisfaction with results, impact on functional ability and impact on cognition. -Follow pain scale and medicate as ordered. Review of Resident #12's progress notes for 11/12/19 and 11/13/19 revealed no reason why the facility did not reorder the [MEDICATION NAME] 20 mg. or why it was not available from the pharmacy and or if a physician had been contacted regarding running out of the medication. An interview with Staff K CMA (certified medication aide) on 8/26/20 at 11:08 a.m. revealed she worked as the medication aide on 11/13/20 when Resident#12's [MEDICATION NAME] 20 mg. tabs ran out. She stated this happens on numerous occasions and she would leave notes for the nurse to reorder the medication. An interview with DON on 9/1/20 at 8:10 a.m. revealed she did not know Resident #12 missed 4 doses of [MEDICATION NAME] in October 2019. The DON reviewed the MAR and the controlled medication records, for 11/12/19 and 11/13/19, and stated she expected nurses to attempt to replace the missing doses and to remove a dose from emergency kit. On review of incident reports in the electronic medical record the DON identified only 2 medication errors on record for the last year at the facility. The DON stated there was no medication error report completed for Resident #12 missing 4 doses of [MEDICATION NAME] in October 2019. The DON further stated the facility did not complete medication error reports for omitted doses of medication and that the nurse's on duty on 11/12/20 and 11/13/20 should have taken the [MEDICATION NAME] 20 mg tablets from the emergency medication kit and administered the medication to Resident #12. An interview with Resident #12 on 9/1/20 at 11:15 a.m., revealed staff ran out of his [MEDICATION NAME] 20 mg tablets more than once and went almost 2 days without his pain medication at times. An interview on 9/1/20 at 3:44 p.m. with Staff R- LPN Unit Manager revealed if the resident needs narcotic medications, she expected nurses to call the physician office or the pharmacy to request a stat dose. If a stat dose was not available then she would expect a nurse to remove the medication from the emergency drug kit located at the facility after getting an order from the physician.
F 0661 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Some	**Ensure necessary information is communicated to the resident, and receiving health care provider at the time of a planned discharge.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review, policy review, and staff interview the facility failed to communicate the necessary discharge information to the receiving facility and/or resident representative for 4 of 5 residents reviewed (Residents #15, #18, #20 & #21). The facility reported a census of 72 residents. Findings include: 1. A Minimum Data Set (MDS) for Resident #20 with

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F 0661 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Some	(continued... from page 3) a completion date of 1/4/20, listed [DIAGNOSES REDACTED]. The MDS scored the resident with a Brief Interview of Mental Status (BIMS) of 13, cognitively intact. The MDS documented the resident as requiring assist of one staff person for bed mobility, transfers, dressing, toileting, and personal hygiene. Progress Notes: 3/9/20 at 12:55 PM, Social Services, resident transferring to another facility tomorrow between 9:00-10:00 AM 3/10/20 at 10:10 AM, Nursing, resident left per receiving facility vehicle and staff. Medications (meds) and belongings sent with resident. 3/10/20 at 12:42 PM, Social Services, resident discharged today to another facility Clinical record lacked documentation of the residents' physician notification with an order to discharge, the recapitulation of stay, or the summary of the resident status. On 8/18/20 at 1:49 PM, Staff G, Licensed Practical Nurse (LPN) stated when a resident transfers to another facility, she prints out a transfer sheet and documents the residents' future appointments. The LPN stated the transfer sheet contains residents insurance, physician information, and demographics. The LPN stated the Unit Manager would gather all documentation required and place in an envelope for the nurse. The LPN stated she was not aware of any documentation the nurse on duty needed to complete when a resident is transferred or discharged . On 8/18/20 at 3:00 PM, Staff H, Registered Nurse (RN)/MDS Coordinator/Unit Manager stated the nurse on duty when the resident is transferred or discharged was responsible for completing the Discharge Summary and Post Discharge Plan of Care form. The RN stated if she was available, she would assist the nurse on duty with the completion, however, the nurse on duty was ultimately responsible. The RN stated she was not working the day Resident #20 discharged to another facility. 2. A MDS for Resident #21, with a completion date of 2/4/20, listed [DIAGNOSES REDACTED]. The MDS scored the resident with a BIMS of 13, cognitively intact. The MDS documented the resident required supervision for bed mobility, transfers, and toileting. The resident required the assistance of one staff person for dressing and personal hygiene. Progress notes: 2/20/20 at 10:21 AM, Social Services, spoke with the resident prior to discharge and resident did not have concerns with the move and felt ready to go with bags packed. 2/20/20 at 11:06 AM, Nursing, resident discharged from the facility at this time. Medications sent with resident, except controlled medications. Escorted by social services and nurse to the Midwest Van Transport to the receiving facility with all belongings sent with. Report called to the receiving facility by the nurse. Physician order dated 2/20/20: discharge from the facility and transfer to receiving facility on 2/20/20, continue intermediate level of care with same medications and treatments. Clinical record lacked documentation of the residents' recapitulation of stay or the summary of resident status. On 8/13/20 at 1:21 PM, Staff A, LPN confirmed she was working as the nurse on the day Resident #21 transferred to another facility. Staff A stated she was a fairly new employee at the time the resident transferred to another facility and thought the Unit Manager completed the required documentation. The LPN confirmed she did not complete a Discharge Summary and Post Discharge Plan of care form. On 8/13/20 at 1:38 PM, Staff I, LPN/MDS Coordinator/Unit Manager stated she did not complete the Discharge Summary/Post Discharge Plan of Care form for Resident #21 when she transferred to another facility. Staff I identified the nurse on duty as responsible to complete the required documentation. Document titled Discharge Summary and Post Discharge Plan of Care undated, contains: Recapitulation of Stay Final Summary of resident status [REDACTED]. resident from the facility Ensure linen and personal care items are removed and notify housekeeping Nursing to notify administration of discharge Document entire process in the nurses notes On 8/19/20 at 4:30 PM, the Director of Nursing (DON) stated she expected staff to complete the Discharge Summary and Post Discharge Plan of Care form when a resident transferred or discharged . In addition staff would print physician orders with a report called to the receiving facility, make an entry made in the residents' clinical record, and complete inventory form. 3. A MDS for Resident #15, with a completion date of 5/28/20, listed [DIAGNOSES REDACTED]. The MDS scored the resident with a BIMS of 14, indicating he was cognitively intact. The MDS documented the resident required extensive assistance of 2 staff for bed mobility, transfers, and limited assist of 2 staff with toileting. Assist of one staff with dressing and personal hygiene. Progress notes: 5/23/20 at 10:39 AM, Social Services- Staff II spoke with the resident to discuss discharge plans scheduled for next Thursday the 28th. Resident #15 stated he would wait and see if he discharged next week. Staff II made calls to his responsible party and she stated she would set up a transfer with Ambucare on 5/28/20 between 10-11 am if possible. 5/28/20 at 10:08 AM, Nursing, Ambucare here to pick resident up and take home. Walker and all belongings and meds sent with. Assisted resident to to the van per Ambucare's wheelchair. Review of the Physician's order dated 5/27/20 stated Resident #15 may discharge home on 5/28/20. The clinical record lacked documentation of the residents' recapitulation of stay for the care and services that the facility's interdisciplinary team had provided for him during his stay. On 9/2/20 at 12:15 PM, the DON stated she expected all nurses to complete a Discharge Summary and a Post Discharge Plan of Care form (Recapitulation of stay) in Point Click Care (electronic medical record) whenever a resident discharged home. The DON stated her expectation for the discharge process is print the resident's current physician's orders, an entry made in the resident's clinical record, and complete an inventory sheet. 4. A MDS for Resident #18, with a completion date of 2/24/20, listed [DIAGNOSES REDACTED]. The MDS scored the resident with a BIMS of 7, indicating severe cognitive impairment. The MDS documented the resident required extensive assistance of 2 staff for bed mobility, transfers, eating, personal hygiene and toileting. Progress notes: 2/25/20 at 4:43 PM, Nursing- Staff G attempted to replace catheter that resident pulled out, son at bedside, while inserting catheter felt resistance, resident complained of pain and returned blood in tubing. Family requested to send resident to emergency room . Dr. gave okay for resident to go by ambulance, Frazier called to transport. 2/25/20 at 10:11 PM, Nursing, Resident admitted to hospital with [DIAGNOSES REDACTED]. Clinical record review completed for Resident #18's transfer to the hospital on [DATE] that identified the following: There was no physician's order in the resident's chart nor any record of a discharge summary or recapitulation of stay when resident did not return. The clinical record lacked documentation of the residents' recapitulation of stay or the summary of resident status at the time of transfer. During an interview on 9/10/20 at 2:01 p.m. with Staff V- Registered Nurse revealed that they searched through the entire chart and could not find the physician's orders. On 9/2/20 at 12:15 PM, the DON stated Resident # 18 did not return to the facility following hospitalization . The DON stated she expected the unit managers/MDS nurses to complete a Discharge Summary and a Post Discharge Plan of Care form in Point Click Care once it is known that a resident would not return to the facility. The DON confirmed that the nurses did not complete a recapitulation of stay or a summary of resident status at the time of transfer and or when the facility knew the resident would not return to the facility. Document titled Discharge Summary and Post Discharge Plan of Care undated, contained instruction to complete: Recapitulation of Stay Final Summary of resident status [REDACTED]. Escort resident from the facility Ensure linen and personal care items are removed and notify housekeeping Nursing to notify administration of discharge Document entire process in the nurses notes
F 0677 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Some	**Provide care and assistance to perform activities of daily living for any resident who is unable.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, clinical record review and resident interview, the facility failed to ensure a resident who could not carry out activities of daily living received the necessary services to maintain good grooming, and personal hygiene for 7 of 13 residents. (Resident #12, #10, #11, #15, #1, #5, #25) The facility identified a census of 72 residents. Findings include: 1. A Minimum Data Set (MDS) for Resident #12, with a completion date of 6/3/20 listed [DIAGNOSES REDACTED]. The MDS scored the resident with a Brief Interview for Mental Status (BIMS) of 15, which indicated intact cognition. The MDS documented the resident required extensive assistance of 2 staff for bed mobility, transfers, toileting and bathing. Resident required extensive assist of 1 staff with dressing and personal hygiene. During an interview on 8/6/20 at 8:35 a.m., Resident #12 stated he did not receive enough baths and he preferred showers at least a couple times a week and more often if he could get them. Clinical record review of Resident 12's survey documentation report reviewed on 8/12/20 at 12:30 p.m. revealed for the last 30 days, he received 5 baths in July. In August 2020, he received 3 baths. The record lacked any further information of baths given. During an interview with Staff R-LPN (licensed practical nurse), Unit Manager on 9/1/20 at 3:44 p.m., she stated the facility used to have a bath aide a few months ago that bathed the residents regularly but the facility stopped the bath aide position. When Covid-19 hit the facility, staff was scarce and residents did not go to shower rooms due to isolation. An interview on 9/1/20 at 5:58 p.m. with Staff D- CNA (certified nurse aide), revealed on 7/4/20, Resident #12 had maggots fall out in a big clump onto the shower room floor from his right leg when staff removed his leg dressings. Staff D reported the maggots in the wound and Staff D gave him a bath and rinsed the

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F 0677 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Some	(continued... from page 4) maggots away in the shower. Staff D stated she called Staff R-LPN Unit Manager to the shower room and Staff D came down and verified the maggots. Staff R instructed Staff D to continue with the shower and she would complete a dressing change afterward. An interview with the DON (Director of Nursing) on 9/2/20 at 3:44 p.m., revealed the facility did not have bath aides on a regular basis and residents did not receive regular baths. The facility eliminated the bath aide position due to lack of staff. On 9/15/20 at 1:22 p.m., the Administrator stated she expected residents to receive twice weekly baths or as the resident requested. The Administrator stated she knew of Resident #12's leg maggots found 9/5/20. She did not know this was the second incident of leg maggots with the first occurring on 7/4/20. On 9/16/20 at 4:43 p.m. Staff UU -CNA revealed that she worked 9/5/20 and assisted with Resident # 12's shower and found maggots in his right leg wounds when she removed his dressing in the shower room. Staff UU stated that Staff BB- CNA/CMA(certified medication aide) entered the shower room and Staff BB reported the maggots to Staff TT-LPN. Resident #12 stated flies flew around the resident's legs all the time. Staff TT-LPN arrived into the shower room and looked at the leg wounds to ensure no more maggots remained in the wounds. Resident #12 then received his shower. Staff UU stated Resident #12 the resident does have a lot of flies hovering around his legs and dressings frequently and that the facility has a lot of flies buzzing in the facility. On 9/17/20 at 1:09 p.m. Staff TT-LPN stated he worked Saturday 9/5/20 and Resident #12 was due for his shower. Staff BB approached Staff TT and stated that Resident #12 was in the shower room and needed a nurse as he had maggots in his leg wound. Staff TT stated he arrived in the shower room, and most of the maggots had been washed away. Staff TT stated he took care of the secretions coming from the wounds with gauze and looked all over the wounds and did not observe any maggot tunneling in the wounds. Staff TT stated he assumed the maggots got into the wound while the resident did not have dressings on his legs while he waited to get his treatments completed. Staff TT stated that Resident # 12's legs are usually wrapped all of the time. An interview on 9/17/20 at 3:42 p.m. with Staff BB- CNA/CMA revealed she worked when staff found maggots in Resident #12's right leg wound on 9/5/20. Staff BB stated she went into the shower room that morning to give the resident a medication. At that time, Staff BB and Staff UU observed maggots on the shower room floor after removal of his leg dressing. Staff BB stated the maggots laid on the floor below the resident's chair and under the area below his right leg wounds. Staff BB stated she went and found the nurse. Staff KK-LPN came down to the shower room and cleaned the right leg wounds and checked Resident #12 over and didn't see any additional maggots in the wounds. Electronic record nursing progress notes dated 9/5/20 at 2:38 p.m. revealed when a nurse aide removed the resident's leg dressing she observed maggots on the bandage. The nurse aide got the nurse, who observed more maggots on the floor. Staff thoroughly cleansed the resident's right ;eg with much soap and water and pat dried. Staff notified the physician. Electronic record nursing progress notes dated 9/7/20 at 4:34 p.m. revealed when a nurse aide got the resident ready for his shower she observed numerous gnats on the dressing. The dressing was dripping wet with drainage and a foul odor. Staff removed the dressing and noticed several gnats on the wound from behind the knee to halfway down the calf. Staff washed and redressed the wound after applying [MEDICATION NAME] (antibacterial and antimicrobial cleanser). Electronic record nursing progress notes dated 912/20 at 12:19 p.m. revealed the nurse observed gnats on the resident's leg dressing. Staff took the resident to the shower room and when staff removed the dressings, numerous gnats flew out of the dressing. The dressing was soaked with drainage and dripping wet. Staff removed the dressing and washed the resident's leg in the shower. Review of the record failed to contain information regarding the maggot infestation of the leg wounds in July 2020. Interview with Resident #12 on 9/1/20 at 11:15 a.m. revealed that he confirmed he did have maggots on his right leg wound on 7/4/20 but he did not know how the flies got in there to lay eggs. Resident further stated he does get flies in his room a lot and in fact there are at least 2-3 of them in the room usually. Resident stated the flies are one of the reasons why he keeps the door in his room closed to stop the flies from coming into his room. Resident #12 stated now that he thought of it, the flies had more than likely gotten into his right leg wounds after he had his showers as sometimes it takes the nurses several hours to come to his room to do his wound treatment and wrap his legs up with the bandages. Resident #12 stated when his legs weep fluid due to his [MEDICAL CONDITION] drainage, the gnats swarm around his ankles as they like to drink the fluid. 2. A MDS for Resident #11, with a completion date of 6/29/20, listed [DIAGNOSES REDACTED].e Stroke), [MEDICAL CONDITION] Bladder and Heart Failure. The MDS scored the resident with a BIMS of 14, (intact cognition). The MDS documented the resident required extensive assistance of 2 staff for bed mobility, dressing, personal hygiene and toileting. Resident was dependent on 2 staff for transfers and bathing activity had not occurred within the last 7 days. Resident #11's care plan revised 7/16/20, identified he required assistance to complete ADLs, due to limited mobility following Stroke with weakness, altered mental status as evidenced by need for assistance to complete ADL's. The goal was to maintain current level of function in bed mobility, transfers, eating, toilet use and personal hygiene: ADL score through review date. Resident is an assist of one with bathing. The care plan stated he preferred to take 1 bath per week. Interventions for the residents included: -Toileting: Resident is an assist of 2 with easy stand for toileting/commode use. -Resident is able to don/doff (put on/take off) his brief following the same method as pants but may require some assist from staff. -Assist of 2 with toileting with easy stand for bedside commode use. -Resident is able to don/doff (put on/take off) his brief (incontinence undergarment) following the same method as pants but may require some assist from staff. On 8/26/2 at 11:49 a.m. Staff M-CNA stated she orientated a new staff member Staff N- CNA on 10/9/19. Staff M and Staff N got Resident # 11 ready to go into the shower and noted maggots in the resident's brief and on his buttocks when they turned the resident over to wash him. On 8/26/20 at 1:34 p.m. Staff N-CNA revealed on 10/9/19 she orientated as a new staff member with Staff M-CNA. Staff N stated Resident #11 had maggots in his feces, on his buttocks and in his brief when they turned him over for peri- care. Staff N identified the resident as caked with dried feces and a very strong foul bowel odor to him Staff N called Staff Y- CNA in to the room. Staff M and Staff N advised Staff Y that Resident #11 needed to be the next shower due to the amount of soiling he had as well as the maggots that were found in his brief. Staff N also stated resident had a catheter so he did not get checked and changed as often and with the way Resident # 11 looked that day, he had gone several days without being changed and he had an open area on his bottom too. Staff N stated that resident's skin was red and she retched upon smelling the foul odor and with the maggots after he had been cleaned up. Staff N stated it was awful to see maggots on a resident. On 8/27/20 at 8:09 a.m. Staff Y-CNA revealed she found maggots in Resident #11's brief with Staff M-CNA when they got the resident ready for his shower. Staff Y stated it was around 10 am and resident was in his bed and found to very soiled in his own feces with maggots in his brief and on his skin. Staff Y stated the resident had an open area on his buttock. Staff Y and Staff M noted the strong bowel odors and that the fecal material was dry and that staff had to really scrub the resident's skin to remove all of the bowel movement from his legs and buttocks. Staff Y stated that Resident #11 really hated to take baths and only took one shower per week but due to his refusals, he would sometimes go weeks without a shower. Staff Y stated as a bath aide, there were no shower sheets, or records to mark on to track the showers for Resident #11. An interview on 8/27/20 at 1:01 p. m. with Staff EE-LPN revealed she worked the day that the maggots were found in Resident #11's incontinence brief. Staff EE stated that Staff Y came to her and said she observed maggots in Resident #11's feces. Staff EE stated she did not see the maggots because Staff Y and Staff M cleaned Resident # 11 up by the time they came to get her. Staff E stated the resident received his shower and performed the treatment to his buttocks afterwards. Staff EE stated staff applied house barrier cream to Resident #11's buttocks for quite some time following discovery of maggots in his brief. Staff EE stated she could not remember if she completed a report on the maggots to anyone or who she reported it to. Staff EE stated she was pretty sure she reported the maggots to the DON. An interview on 9/2/20 at 12:15 p.m. with the DON revealed she stated she did not know Resident #12 had maggots in his brief. An interview on 9/15/20 at 1:22 p.m. with the Administrator revealed she did not know staff discovered maggots in Resident # 11's brief on 10/9/19. The facility failed to provide timely and appropriate peri-care and showers to prevent the formation of maggots within the resident's bowel movement that was in his incontinence brief. According to www.orkin.com : Eggs hatch within 24 hours, and house fly larvae emerge. House fly larvae, or maggots, appear similar to pale worms. Their sole purpose is to eat and store energy for their upcoming pupation. Larvae feed for approximately five days, after which they find dry, dark locations for pupal development. According to animals.mom.com: When it's warm outside, maggots can emerge from eggs laid only eight to 20 hours earlier. Resembling tiny white worms, maggots eat from the site where they emerged for up to five days. Due to 8-20 hours required for maggots to emerge, the facility failed to clean the resident's soiled brief for at least 8-20 hours. 3. A MDS for Resident #10, with a completion date of 6/9/20, listed [DIAGNOSES REDACTED]. The MDS scored the resident with a BIMS of 15, which indicated intact cognition. The MDS documented the resident required extensive assistance of 2 staff for bed mobility, personal hygiene and toileting. The resident is dependent on staff for transfers, and extensive assist of 1 staff with dressing and bathing. Resident #10's care plan revised 7/9/20, identified she required assistance to complete ADL's, due to limited mobility following right [MEDICAL CONDITION] completed on 10/4/19, weakness following [MEDICAL TREATMENT]

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F 0677 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Some	(continued... from page 5) sessions and obesity. The goal was to maintain current level of independence with ADL completion. The resident required the assistance of one staff with bathing. The care plan did not identify how often the resident should bathe. During an interview on 8/6/20 at 8:35 a.m., Resident #10 stated she did not receive enough baths and she preferred bed baths at least a couple times a week and more often if she could get one. Clinical record review of Resident 10's survey documentation report reviewed on 8/12/20 at 12:30 p.m. revealed since July 1st 2020, resident had been bathed once on August 1st. During an interview with Staff R-LPN, Unit Manager on 9/1/20 at 3:44 p.m., Staff R stated the facility used to have a bath aide a few months ago that bathed the residents regularly but the facility eliminated the bath aide position. When Covid-19 hit the facility, the facility had scarce staffing. Staff did not take residents to shower rooms due to residents isolated to their rooms. During an interview with the DON on 9/2/20 at 3:44 p.m., the DON stated they used to have bath aides that provided the residents showers on a regular basis but the facility is so short staffed, they have not completed baths done and they eliminated the bath aide position due to lack of staff . She confirmed she knew staff did not complete baths on a regular basis. On 9/15/20 at 1:22 p.m. the Administrator stated she expected resident to receive twice weekly baths or as the resident requests. 4. A MDS for Resident #15, with a completion date of 5/28/20, listed [DIAGNOSES REDACTED]. The MDS scored the resident with a BIMS of 14,(intact cognition). The MDS documented the resident required extensive assistance of 2 staff for bed mobility, transfers, and limited assist of 2 staff with toileting. He required the assistance of one staff with dressing and personal hygiene. Clinical record review of Resident #15's care plan revealed a focus of ADL (activities of daily living) self care performance deficit related to weakness, debility, decline in mobility following fall at home with residual back pain, [DIAGNOSES REDACTED]. The care plan did not address bathing needs. Clinical record review on 8/11/20 at 4:25 p.m. of Resident #15's survey documentation report revealed resident did not receive any baths during his stay at the facility from his admission on 5/6/20, until his discharge to home on 5/28/20. An interview with the DON on 8/11/20 at 4:25 p.m. revealed she did not know the resident did not receive baths 5/6/20 through 5/28/20. On 9/1/20 at 3:44 p.m., Staff R-LPN, Unit Manager stated the facility used to have bath aides but the facility eliminated the bath aide position when Covid-19 hit the facility. Residents were not taken to the shower rooms due to being isolated in their rooms. An interview with the DON on 9/2/20 at 3:44 p.m., revealed the facility did not have bath aides on a regular basis and residents did not receive regular baths. The facility eliminated the bath aide position due to lack of staff. An interview with the Administrator on 9/15/20 at 1:22 p.m. revealed she expected staff to bathe residents at least twice per week or at the resident request. Facility policy and procedure titled Routine Procedures, Bath and Shower revised on 5/2007, stated that it is the policy of the facility to promote cleanliness, stimulate circulation and assist in relaxation. Dependent residents are to be: a. Assisted to shower room b. Wash resident's body from top to bottom, and wash between and under toes c. Document all appropriate information in the medical record. 5. A MDS assessment form dated 6/11/20 documented Resident #1 with [DIAGNOSES REDACTED]. The assessment documented the resident with no Brief Interview for Mental Status (BIMS) score, the ability to make self understood and understand others and a modified independence with cognitive skills for decision making. The assessment documented the resident as dependent on two (2) staff members with bed mobility, transfers, dressing, toilet use and personal hygiene and as non-ambulatory. A Care Plan with a Focus area initiated 5/2/17 documented the Resident as at risk for an ADL's self care performance deficit related to (r/t) his disease process, pain in the right knee, a history of falls and [MEDICAL CONDITION]. (initiated 5/2/17) The approaches included the following: a. Encourage and assist the resident with shaving at shower times when the resident requests or as needed (PRN). (initiated 6/25/19) b. Required total staff assistance with personal hygiene care. (initiated 6/25/20) An observation 8/18/20 at 10:45 a.m. revealed the resident with approximately 1/2 inch long facial hair along his mustache, beard and bilateral cheek areas. When interviewed at the same time, the resident confirmed his preference would have been no facial hair. During an interview 8/19/20 at approximately 3 p.m. the surveyor informed the DON of the resident's desire for shaving. Observation on 8/24/20 at approximately 11 a.m. revealed the resident with approximately 1/2 inch long facial hair along his mustache, beard and bilateral cheek areas. During an interview 9/2/20 at 4:20 p.m. a family member confirmed the resident's preference as clean shaven. 6. A MDS assessment dated [DATE] documented Resident #5 as in a persistent vegetative state and dependent on 2 staff with personal hygiene. A Care Plan with a focus area initiated 7/13/20 documented the resident with an ADL self care deficit related to an intracranial bleed with brain herniation which resulted in a persistent vegetative state dependence upon staff to have completed all ADL's. The interventions included the following: a. Dependent on staff for personal hygiene. Observation on 8/13/20 at 2:15 p.m. revealed the resident positioned in bed with approximately 1/4 inch long black whiskers along her chin area. 7. During an interview 9/2/20 at 10:32 a.m., Staff DD, CNA confirmed staff failed to shower residents according to their schedules and/or requests. During an interview 9/2/20 at 10:47 a.m. Staff MM, CNA confirmed staff failed to shower the residents according to their schedules and/or requests and some residents have waited 2-3 weeks for showers and have begged for showers. During an interview 9/2/20 at 11:01 a.m. Staff NN, CNA confirmed residents went weeks without showers. During an interview 9/2/20 at 11:44 a.m., Staff OO, CNA confirmed resident showers not completed according to schedules and/or requests. 8. A MDS assessment form dated 8/12/20 documented Resident #25 with [DIAGNOSES REDACTED]. The assessment documented the resident with a BIMS score of 8 (moderate cognitive impairment), non-ambulatory, required extensive assistance of 2 staff with transfers and extensive assistance of one staff member with bed mobility. The assessment documented the resident as at risk for pressure ulcers, with surgical wounds, a pressure relieving device for the the bed, no pressure reducing device for the chair and not on a turning and repositioning program. A Care Plan with Focus areas initiated 7/25/20 included the following problems: a. The resident had a potential impairment to skin integrity related to (r/t) decreased mobility with a history of bowel and bladder incontinence, weakness, diabetes, new stroke with difficulty speaking upon admission, multiple areas of fungal rash to the buttocks and with thin frail skin. 1. Cushion to the wheel chair. (initiated 9/1/20) 2. Pressure reducing mattress to the bed. (initiated 7/25/20) 3. Use caution during transfers and bed mobility to prevent striking arms, legs and hands against any sharp or hard surface. (dated 7/25/20) b. Diabetes Mellitus currently managed with insulin therapy. 1. Check skin when assisted with ADL's. (initiated 7/25/20) c. Actual impairment to the skin integrity r/t a surgical incision to the left chest from a pacemaker implantation present upon readmission. (initiated 8/12/20) 1. Monitor and document location, size and treatment of [REDACTED]. (initiated 8/12/20) d. An ADL self care performance deficit r/t decreased mobility, weakness, a new stroke with residual weakness, a history of a left [MEDICAL CONDITION] several years ago as evidenced by a need for assistance to complete ADL's. (initiated 7/25/20) 1. Assistance of 2 staff and a mechanical lift device with all transfers and assistance of 1 staff with turn/repositioning when in bed. (initiated 7/25/20)
F 0684 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Some	**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 clinical record review, staff interview and facility policy review, the facility failed to complete timely resident assessments and interventions for 4 of 7 residents reviewed who required wound care and/or such assessments. (Resident #1, #9, #19, #24) The facility failed to assess residents completely upon admission to the facility, failed to assess residents' skin and implement needed interventions, failed to assess residents that experienced a change in condition. The facility identified a census of 72 residents. Findings include: On 8/24/20 at 3:48 p.m. the DON (Director of Nursing) confirmed the facility should complete Skin Pressure Ulcer Weekly forms. The Wound Care Nurse should complete the skin pressure ulcer weekly forms and the charge/floor nurse should complete the Weekly and PRN Skin Assessment forms. On an email dated 9/8/20 at 2:13 p.m. Staff V, Registered Nurse (RN)/Corporate Nurse/ Clinical Market Leader confirmed she expects measurements and descriptions of all skin areas/injuries as per the policy of the Rehabilitation Center of Des Moines (RCD) at least weekly. A policy on Care and treatment of [REDACTED]. A weekly skin assessment completed on all residents and documented in the nurse's notes. b. Documentation each wound measured in centimeters weekly. Measurements, size and depth, drainage, odor, color and a short statement on the progress (or lack of). 1. A Minimum Data Set (MDS) assessment form dated 6/11/20 documented Resident #1 with [DIAGNOSES REDACTED]. The assessment documented the resident with no Brief Interview for Mental Status (BIMS) score, the ability to make self understood and understand others and a modified independence with cognitive skills for decision making. The assessment documented the resident as dependent on two (2) staff members with bed mobility, transfers, dressing, toilet use and personal hygiene and as non-ambulatory. The assessment

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	165268	A. BUILDING _____ B. WING _____	09/30/2020

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
REHABILITATION CENTER OF DES MOINES	701 RIVERVIEW DES MOINES, IA 50316

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** - Some	(continued... from page 6) documented the resident as at risk for pressure ulcers and with no unhealed pressure ulcers/injuries. A Care Plan with a focus area initiated 5/2/17 documented the resident at risk for pressure ulcer development due to a history of a pressure ulcer to his buttock, decreased mobility, [DIAGNOSES REDACTED]. The Care Plan addressed a focus area of a pressure ulcer to his left heel and left buttock r/t (related to) decreased mobility, preference to have remained in bed the majority of the time, a history of refusals for repositioning, co-morbid conditions of hepatic failure with elevated ammonia levels, diabetes and a general ADL decline. (initiated 5/22/20) The interventions/tasks included the following: a. Assess/document potential causative factors and eliminate/resolve where possible. (initiated 5/2/17) b. Float heels. (initiated 6/25/19) c. Low air loss mattress provided by Hospice. (initiated 6/24/19) d. Administered treatments as ordered and monitor for effectiveness. (initiated (5/22/20) e. Assess/record/monitor wound healing. Measure length, width and depth where possible. Assess and document status of wound perimeter , wound bed and healing progress. Report improvements and declines the Physician. (initiated 5/22/20) f. Hospice Nurse to have assessed wound status/progress with each audio/virtual visit (initiated 7/29/20) Review of a Medication Administration Record [REDACTED]. (ordered 3/22/20 at 5 p.m. and dc' d 5/3/20 at 5:03 a.m.) b. [MEDICATION NAME] capsule 100 mg's 2 capsules po one time a day for [MEDICAL CONDITION]. (ordered 5/7/20 at 11 a.m. and discontinued (dc' d) 5/26/20 at 9:34 a.m. c. [MEDICATION NAME] capsule 100 mg's 2 capsules po every morning and at bedtime for [MEDICAL CONDITION]. (ordered 5/7/20 at 6:30 a.m. and dc'd 5/26/20 at 9:34 a.m.) d. [MEDICATION NAME] 15 mg tablet 1 tablet PO in the evening for pain. (start date 6/12/19 at 7 p.m. and discontinued 5/26/20 at 9:34 a.m.) e. [MEDICATION NAME] tablet 325 mg 2 tablets po every 4 hours as needed (PRN) for general discomfort. (start date 6/12/19 at 1:56 p.m. and dc'd 5/26/20 at 9:34 a.m. 1. Administered 5/14/20 at 5:26 p.m. - pain level 5 (on a scale of 1-10, 10 being the highest). 2. 5/21 at 7:46 p.m. - pain level rated at a 9 f. [MEDICATION NAME] HCI tablet 50 mg 1 tablet po every 6 hours PRN for pain mild-severe. (start date 6/14/19 at 1:30 p.m. and dc'd 5/26/20 at 9:34 a.m.) 1. 5/10 at 10:53 p.m. - pain level rated at a 10 2. 5/9 at 7:46 p.m. - pain level rated at a 9 Review of a MAR form dated 6/1/20 thru 6/31/20 included the following pain medication orders [REDACTED]. (ordered 6/5/20 at 7 p.m. and dc'd 8/14/20) b. [MEDICATION NAME] tablet 325 mg 2 tablets po every 4 hours as needed (PRN) for a temperature. (ordered 6/5/20 at 11:42 a.m.) 1. Not administered c. [MEDICATION NAME] HCI tablet 2 mg's 1 tablet po every 4 hours PRN for pain/restlessness/agitation/air hunger. (ordered 6/5/20 and dc'd 6/9/20) 1. Administered 6/5 at 4:35 p.m. - pain level an 8 2. 6/6 at 9 p.m. - pain level rated at a 10 3. 6/7 at 1:29 a.m. - pain level rated at a 6 and 11:04 p.m. - pain level rated at a 7 4. 6/8 at 1:12 p.m. - pain level rated at a 10 5. 6/9 at 4:41 a.m. - pain level rated at a 8 and 9:33 a.m. - pain level rated at a 10 d. [MEDICATION NAME] 20 mg/milliliter (ml) 0.25 ml po every 4 hours midnight, 4 a.m., 8 a.m., 12 p.m., 4 p.m. and 8 p.m. for pain. (ordered 6/12/20 and dc'd 7/10 at 11:50 a.m.) e. [MEDICATION NAME] 0.25 ml po every 2 hours PRN for shortness of breath (SOB) and pain. - (ordered 6/12 at 12:23 p.m. and dc'd 7/10 at 11:49 a.m.) Review of a MAR form dated 7/1/20 thru 7/31/20 included the following pain medication orders [REDACTED]. (ordered 6/5/20 at 7 p.m. and dc'd 8/14/20) b. [MEDICATION NAME] tablet 325 mg 2 tablets po every 4 hours as needed (PRN) for a temperature and pain. (ordered 6/5/20 at 11:42 a.m.) 1. Administered 7/1/20 at 8:31 p.m. - pain level rated at a 10. b. [MEDICATION NAME] 20 mg/milliliter (ml) 0.25 ml po every 4 hours midnight, 4 a.m., 8 a.m., 12 p.m., 4 p.m. and 8 p.m. for pain. (ordered 6/12/20 and dc'd 7/10 at 11:50 a.m.) c. [MEDICATION NAME] 0.25 ml po every 3 hours midnight, 3 a.m., 6 a.m., 9 a.m., 12 p.m., 3 p.m., 6 p.m. and 9 p.m. for pain - (ordered 7/10/20 and dc'd 7/14/20) d. [MEDICATION NAME] 0.25 ml po every 2 hours midnight, 2 a.m., 4 a.m., 6 a.m., 8 a.m., 10 a.m., 12 p.m., 2 p.m., 4 p.m., 6 p.m., 8 p.m. and 10 p.m. for pain - (ordered 7/14/20 and dc'd 7/17/20) e. [MEDICATION NAME] 0.50 ml po every 2 hours midnight, 2 a.m., 4 a.m., 6 a.m., 8 a.m., 10 a.m., 12 p.m., 2 p.m., 4 p.m., 6 p.m., 8 p.m. and 10 p.m. for pain - (ordered 7/17/20 and dc'd 8/25/20) f. [MEDICATION NAME] 0.25 ml po every 2 hours PRN for shortness of breath (SOB) and pain. - (ordered 6/12 at 12:23 p.m. and dc'd 7/10 at 11:49 a.m.) 1. Administered 7/1 at 7/2 at 5:24 p.m. - pain level at 8 2. 7/3 at 9:31 a.m. - pain level a 4 3. 7/4 at 3:50 a.m. - pain level a 6 4. 7/8 at 10 a.m. - pain level at a 10 5. 7/10 at 10 a.m. - pain level 9 g. [MEDICATION NAME] 0.25 ml po every 1 hour PRN for SOB and pain. - (ordered 7/10 at 11:49 a.m.) 1. Administered 7/11 at 7:07 a.m. - pain level 8 and 11:14 p.m. - pain level 7 2. 8/13 at 7:20 a.m. - pain level 8 3. 8/14 at 10:55 a.m. - pain level 10 4. 8/17 at 9 a.m. - pain level 8 5. 8.20 at 7:48 a.m. - pain level 7 Review of a MAR form dated 8/1/20 thru 8/31/20 included the following pain medication orders [REDACTED]. (ordered 6/5/20 at 7 p.m. and dc'd 8/14/20) b. [MEDICATION NAME] tablet 5 mg's po three times a day (TID) at 6 a.m., midnight and 3 p.m. for muscle spasms. (ordered 8/15/20 at 6:30 a.m. and dc'd 8/25/20 at 10:43 a.m.) b. [MEDICATION NAME] tablet 325 mg 2 tablets po every 4 hours PRN for a temperature and pain. (ordered 6/5/20 at 11:42 a.m.) 1. Not administered f. [MEDICATION NAME] 0.50 ml po every 2 hours midnight, 2 a.m., 4 a.m., 6 a.m., 8 a.m., 10 a.m., 12 p.m., 2 p.m., 4 p.m., 6 p.m., 8 p.m. and 10 p.m. for pain - (ordered 8/25/20 at 10:46 a.m.) g. [MEDICATION NAME] 0.75 ml po every 2 hours midnight, 2 a.m., 4 a.m., 6 a.m., 8 a.m., 10 a.m., 12 p.m., 2 p.m., 4 p.m., 6 p.m., 8 p.m. and 10 p.m. for pain - (ordered 7/17/20 and dc'd 8/25/20 at 10:46 a.m.) g. [MEDICATION NAME] 0.25 ml po every 2 hours PRN pain. - (ordered 7/10/20 at 11:49 a.m.) 1. Administered 8/4 at 8:30 a.m. - pain level a 5 and 12:30 p.m. with a pain level at a 9. 2. 8/10 at 12:57 p.m. - pain level rated at a 9 3. 8/12 at 6:56 p.m. - pain level rated at a 9 4. 8/24 at 6:48 a.m. - pain level rated at a 5 A Palliative Care Form signed by a Nurse Practitioner 8/17/20 indicated skin breakdown and/or pressure ulcers as expected with that resident. The facility/agency would plan and implement measures that would diminish weight loss as much as possible. During an observation 8/18/20 at 10:45 a.m. Staff QQ, CNA (certified nurse aide) and Staff RR, CNA provided anterior and posterior perineal care to the resident. The staff positioned the resident on his left side with the dressing intact on his left buttock however observation revealed a pea sized open area on the residents right upper to mid buttock close to the gluteal line. When the surveyor pointed out the area, Staff RR identified the area as a new open area. Record review of the facilities Progress Notes and/or any skin forms failed to reveal any assessment of the the new open area as stated above from the point of the original observation on 8/18/20 at 10:45 a.m. until on 8/19/20 at approximately 3 p.m. when the DON entered the resident's room upon request of the surveyor as the open area and surveyor pointed it out to her. At that time the DON measured the area at 0.5 cm x 0.5 cm and 0.1 cm deep with pink granulation tissue. During an interview 8/24/20 at 4:27 p.m. the DON called Staff R, LPN/Wound Care Nurse who confirmed she failed to assess the open area on the resident's right gluteal region on 8/19/20. Progress Notes from 8/18/20 to 8/24/20 only revealed the following entry as dated: a. The entry dated 8/21/20 at 1:15 p.m. revealed the following entry: On 8/17/20 during weekly skin assessments, a previously undocumented wound noted on the left buttock measured 1.3 cm x 0.8 cm and .01 cm deep. Wound nurse also on site. Area cleansed, patted dry and Duoderm applied. Resident education attempted regarding pressure relief with minimal evidence of learning noted. Would repeat education as needed. Provider, family, DON notified, all questions answered. Review of the facilities Skin Pressure Ulcer Weekly forms revealed the following assessments as dated: a. 5/8/20 at 5:18 p.m. - A stage 3 pressure ulcer on the left buttock measured 3.3 centimeters (cm) by (x) 1.9 cm and 0.1 cm deep with 40 % granulation tissue and 60% dark red [MEDICAL CONDITION]. The form described the exudate (drainage) type as serosanguinous with no amount, moderate odor, wound edges defined, normal surrounding tissue with pain related to the wound demonstrated by grimacing, guarding, irritability and tense. The present pain level at a 1-3 mild/slight pain with the worst pain level at a 4 - 6 moderate pain, the best pain level described as 1-3 and the acceptable level of pain described at 1-3. Staff discontinued current treatment and changed the order to have cleansed the are with a choice cleaner, alginate, cover with a foam border dressing and change 3 times a week (TID) and as needed (PRN). b. 5/13/20 at 7:02 a.m. - A stage 3 pressure ulcer on the left buttock measured 3.9 cm x 1.7 cm and 0.1 cm deep with 100 % granulation tissue. The form described the exudate as a moderate amount of serosanguinous, no odor, wound edges defined, normal surrounding tissue and with pain related to the wound demonstrated by grimacing, moaning/crying and guarded. No pain levels documented. 1. A new unstageable pressure ulcer on the resident's left heel as 100 % scabbed which measured 0.7 cm x 0.9 cm and 0.1 cm deep, no exudate or odor, wound bed with black/brown eschar, wound edges defined and normal surrounding skin. c. 7/29/20 at 7:22 a.m. - An unstageable pressure ulcer on the left buttock measured 0.3 cm x 0.3 cm and 0.1 cm deep with a pink wound bed, no exudate or odor, wound edges defined with normal surrounding skin with pain related to the wound demonstrated by moaning/crying with no pain levels documented. 1. An unstageable pressure ulcer on the resident's left heel as 100% scabbed which measured 1.0 cm x 1.0 cm and 0.1 cm deep, a small mount of serosanguinous drainage, no odor, wound edges defined and normal surrounding skin. d. 8/5/20 at 12:35 p.m. - An unstageable pressure ulcer on the resident's coccyx that measured 0.2 cm x 0.2 cm and 0.1 cm deep with a pink wound bed, no exudate or odor, wound edges defined with normal surrounding skin with pain related to the wound demonstrated by grimacing. The present pain level described at a 4 - 6 moderate pain with the worst pain level at a 4 - 6 moderate pain, the best pain level described as 0 and the acceptable level of pain described at 0. 1. An unstageable pressure ulcer on the resident's left heel as a 100% scabbed area which measured 0.8 cm x 0.8 cm and 0.1 cm deep, a scant amount of serosanguinous drainage, no odor, wound edges defined and normal surrounding skin. e. On 8/12/20 at 2:08 p.m. -

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F 0684 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Some	(continued... from page 7) An unstageable pressure ulcer on the resident's coccyx that measured 0.2 cm x 0.2 cm and 0.1 cm deep with a pink wound bed, no exudate or odor, wound edges defined with normal surrounding skin with pain related to the wound however no non-verbal described. The present pain level described at a 4 - 6 moderate pain with the worst pain level at a 4 - 6 moderate pain, the best pain level described as 0 and the acceptable level of pain described at 0. 1. On 12:48 p.m. - An unstageable pressure ulcer on the resident's left heel described as a 100% scabbed area which measured 0.8 cm x 0.8 cm and 0.1 cm deep, no drainage or odor, wound edges defined and normal surrounding skin. f. On 8/19/20 at 10:37 a.m. - An unstageable pressure on the resident's coccyx that measured 0.2 cm x 0.2 cm and 0.1 cm deep with a 100% pink wound bed, no exudate, odor or pain, wound edges defined and normal surrounding skin. 1. 8/19/20 at 10:33 a.m. - An unstageable pressure ulcer on the resident's left heel described as 100 % eschar which measured 0.8 cm x 0.5 cm and 0.1 cm deep, wound bed black/brown (eschar) with no exudate, odor or pain, wound edges well defined and normal surrounding skin. 1. 8/19/20 at 10:33 a.m. - An unstageable pressure ulcer on the resident's left heel as a 100% scabbed area that measured 0.8 cm x 0.5 cm and 0.1 cm deep, no exudate or odor, wound bed with slough, wound edges defined and with normal surrounding skin tissue. g. On 8/19/20 at 10:37 a.m. - A new area had been identified on the resident's left buttock with an onsite date documented at 8/18/20. The facility staff described the area as a sheared area that measured 1.3 cm x 0.8 cm and 0.1 cm deep with 75% pink granulation tissue and 25% [MEDICATION NAME] tissue, a scant amount serous exudate, blanchable with no odor or pain. h. On 8/19/20 at 3:38 p.m. - A new area on the resident's right buttock with an onset dated 8/19/20 and identified as a Stage 2 pressure ulcer that measured 0.5 cm x 0.5 cm and 0.1 cm deep with pink granulation tissue to the wound bed with pink smooth tissue surrounding the wound bed, no exudate, odor with pain related to the wound demonstrated by moaning/crying. The present pain level described at a 4 - 6 moderate pain with the worst pain level at a 7-10 severe pain, the best pain level described as 1-3 and the acceptable level of pain described at 1-3 Staff applied A & D ointment to the right buttock. Hospice nurse to have assessed and obtained orders from the Hospice wound care nurse. Review of the facilities Weekly and PRN Skin Evaluation assessments revealed the following documentation as dated: a. 5/10/20 (no time documented) - The resident had an open area on the his buttocks with a treatment in place. The heels of both feet described as soft, mush and painful to the touch. Dry skin on the feet and face noted and lotion applied. b. 5/17/20 (no time documented) - No new skin issues noted. c. 5/24/20 (no time documented) - No new skin issues noted. Treatments continued to the left foot and buttocks. d. 6/28/20 (no time documented) - No new skin issues noted at that time. Dressings clean dry and intact. e. 7/5/20 (no time documented) - Resident skin warm to touch, no open wounds, skin dry with a rash which [MEDICATION NAME] Powder had been applied and monitored. Would continue to monitor. f. 7/12/20 (no time documented) - Resident had a red spot on the right of the neck. [MEDICATION NAME] Powder applied at that time. g. 7/19/20 (no time documented) - Resident had a red spot on the right of his neck. [MEDICATION NAME] Powder applied at that time. h. 7/26/20 (no time documented) - [MEDICATION NAME] Powder applied to groin redness. i. 8/2/20 (no time documented) - No new skin issues noted at that time. Skin clean dry and intact. [MEDICATION NAME] Powder applied to groin for redness. j. 8/9/20 (no time documented) - A & D ointment to Left Ischial wound continued. [MEDICATION NAME] to groin for redness continued. No new skin concerns at that time. k. 8/10/20 (no time documented) - Skin tear to right fore arm bandage intact. Unknown cause. Area cleansed by that skilled nurse, new bandages applied. Resident unable to have explained what happened or when. l. 8/24/20 at 2:15 p.m. - Revealed the following skin issues with additional comments as follows: Noted today with bed bath/cares a blistered area to the right buttock near the cleft, intact dark purple in color and periwound dark purple. The right buttock measured 0.5 cm x 0.5 cm open are with a red wound bed and dark purple periwound. The left buttock continued to have an area from shearing, a pink wound bed and a dark purple peri wound. No odor noted and pain had been related to turning. No discomfort with palpation or measuring. The Hospice nurse there and planned to report the wounds to their wound care nurse for treatment. a. Coccyx blister that measured 3.0 cm x 0.5 cm and non-stageable. b. Coccyx deep purple areas that measured 4.0 cm x 3.0 cm and non-stageable. c. Right buttock 0.5 cm . 0.5 cm open area with no depth or stage documented. d. Left buttock 0.8 cm x 0.8 cm sheared area e. Left heel pressure area 0.3 cm x 0.5 cm with no depth or stage documented. During an interview 8/24/20 at 2:23 p.m. the Director of Nursing (DON) identified the left ischial area and the coccyx area as the same areas. During an interview 8/18/20 at 11:43 a.m. the DON confirmed no weekly pressure ulcer assessments from 5/13/20 until 7/29/20. During an interview 8/24/20 at 11:19 a.m. the Hospice Nurse indicated the resident admitted to Hospice on 6/5/20 at which time pressure ulcers identified on the resident's left heel and left ischial area however the nurse failed to measure the areas. After the date of admission and due to Covid 19 the facility staff refused visitors so the Hospice nursing staff were not allowed to enter the building for care and treatment of [REDACTED]. The Hospice nurse reviewed her Progress Notes on the computer and stated on 6/30/20 and 7/29/20 she requested pictures of the resident's wounds which would have allowed her to review the condition of the wounds with their wound care specialist. At the time the facility agreed however to date no pictures had been sent to Hospice. The Hospice Nurse also stated she asked for virtual visits with the resident but the facility declined her request. The Hospice Nurse stated today when she assessed the resident's ulcered areas initially the only dressing on his buttock had been on his left buttock at an approximate 4 cm by (x) 4 cm size with no dressings on the resident of his gluteal and/or open areas. The Hospice Nurse stated she had been unaware of the areas on the resident's gluteal region had been Kennedy ulcers but that she planned to reach out to the Hospice Wound Care Specialist. The Hospice Nurse offered that the Hospice Certified Nursing Assistant (CNA) also present with this visit observed all of the current skin issues on Friday 8/21/20. The Hospice Nurse stated on 8/11/20 she spoke with Staff G, LPN who stated the only wound present had been a left heel wound. During an interview 8/18/20 at 12:04 p.m. a Nurse Practitioner (NP) indicated she had not physically been in the Rehabilitation Center of Des Moines since March so she went off what staff tell her and documentation in the Point Click Care Computer System. The Nurse Practitioner confirmed there had been a lack of communication within the facility and she had tried multiple times to assist the facility with system changes as a means to enable better communication without success. The Nurse Practitioner also indicated paperwork and directives having been misplaced within the facility. The Nurse Practitioner confirmed she expected all skin issues to have been assessed and intervened on a weekly bases and per the facility policy and all new or changed skin issues reported to her. A Physician's Progress Notes form dated 8/27/20 at 2:41 p.m. included the following documentation from a Nurse Practitioner: Today while in the building I heard the patient moaning and yelling for 1-2 hours. He opened one eye when I went in his room and talked to him but I didn't really get any answers to questions. He appeared in pain. His sores on on his bottom have now progressed also. The main wound noted to have been a non blanchable purplish area surrounded the wound. I felt fearful it may continue to progress fast and present as a Kennedy Ulcer. He also had a blister on his right buttock and some shearing noted to his left buttock. 2. A MDS assessment dated [DATE] documented Resident #9 admitted to the facility on [DATE] with [DIAGNOSES REDACTED]. The assessment documented the resident had a BIMS score of 7 (cognitively impaired), non-ambulatory, required extensive assistance of 2 staff members with bed mobility and transfers, required extensive assistance of 1 staff member with dressing, toilet use and personal hygiene. The assessment documented the resident as at risk for pressure ulcers, with an unstageable pressure ulcer present on admission, one stage 3 pressure ulcer present on admission and with skin tears. The assessment documented the resident as on a pressure reducing device for the bed, no pressure relieving device on a chair/wheel chair and not on a turning and repositioning program. A Care Plan with focus areas initiated 6/5/20 included the following: a. The resident had actual impairment to his skin integrity related to open areas to the left heel and left great toe present upon admission with treatments in place to aid in wound healing. b. A performance deficit related to decreased mobility, debility, kidney failure, end stage kidney disease [MEDICAL CONDITIONS], osteo[DIAGNOSES REDACTED] with a need for long term IV antibiotic therapy as evidence by a need for assistance to complete activities of daily living (ADL's). c. Acute and chronic pain related to weakness, debility, open wounds to the left lower extremity, participation in therapy/exercises with a need for PRN pain medication to aid with management of symptoms. The Interventions to these problematic areas included the following as dated: a. Pressure reducing cushion to the wheel chair (initiated 6/5/20) b. Pressure reducing mattress to the bed (initiated (6/5/20) c. Encouragement to have ambulated with the assistance of 1 staff member and a front wheeled walker (FWW) to and from the bathroom in his room (initiated 7/1/20) d. Bed mobility required assistance of 1 staff member (initiated 6/5/20) e. Transferred with the assistance of 1 staff member with a FWW (initiated 6/5/20) A Initial Admission Record form dated 6/5/20 at 3:35 p.m. addressed no skin issues. During an interview 8/5/20 at 3:52 p.m., the DON confirmed the Initial Admission Record form documented no skin issues. admission orders [REDACTED]. A Referral Packet Index form from the hospital (prior to facility admission) documented the resident with the following wound/ulcer assessments on 5/26/20 at 1:46 p.m.: a. Left Great Toe #1 - Unstageable necrotic tissue (slough/eschar) 1.0 cm x 1.8 cm x 0.4 cm, granulation tissue bright, beefy red with 75 % to 100 % of the wound filled and/or tissue overgrowth. [MEDICATION NAME] 0 to less that 25% wound covered. Necrotic tissue

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F 0684 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Some	(continued... from page 8) type adherent, soft and black eschar. A small amount of bloody exudate. No undermining. Wound edges distinct, outline clearly visible and attached to the wound base. Periwound skin color pink or normal for his ethnic group with no swelling or [MEDICAL CONDITION]. b. Right heel - Unstageable necrotic tissue (slough/eschar) 0 cm x 0 cm x 0 cm, granulation tissue pink and/or dull, dusky red and/or fills less than 25% of the wound (dated 5/19/20 at 9:36 a.m.). [MEDICATION NAME] 100% of the wound covered (5/26/20 1:46 p.m.). Necrotic tissue non visible (dated 5/19/20 at 9:36 a.m.). Wound moist but no observable exudate (dated 5/24/20 8:30 a.m.). No odor (dated 24/20 at 8:30 a.m.) or undermining (dated 5/19/20 at 9:36 a.m.). Wound edges indistinct, diffuse and none clearly visible (dated 5/19/20 9:36 a.m.). Periwound skin color pink or normal for his ethnic group with no swelling or [MEDICAL CONDITION] (dated 5/19/20 at 9:36 a.m.). c. Left heel - Stage 3 0.7 cm x 0.7 cm x 0.2 cm, granulation tissue pink and/or dull, dusky red and/or fills greater than 25% of the wound (dated 5/26/20 at 1:46 p.m.). [MEDICATION NAME] 75% to less than 100% of the wound covered and/or [MEDICATION NAME] tissue extended greater than 0.5 % into the wound bed (5/26/20 1:46 p.m.). Necrotic tissue non visible (dated 5/26/20 at 1:46 p.m.). Serosanguineous thin, watery, plan red/pink color (dated 5/26/20 at 1:46 p.m.). No odor (dated 5/26/20 at 1:46 p.m.) Wound edges indistinct, diffuse and none clearly visible (dated 5/26/20 at 1:46 p.m.). Periwound skin color pink or normal for his ethnic group with no swelling or [MEDICAL CONDITION] (dated 5/26/20 at 1:46 p.m.). A Physician's Progress note dated 6/11/20 at 9:30 a.m. documented per nursing no acute skin issues. During an interview 8/5/20 at 3:52 p.m., the DON confirmed the facility staff failed to assess the resident's skin issues until 6/24/20 with the Wound Care Physician performed the following assessments. A Wound Treatment Plan dated 6/24/20 documented the following: a. Location: left hallux, distal Etiology: diabetic foot wound, Wagner scale, grade 1 Wound status: new Measurement: 1.5 cm x 2.3 cm x 0.1 cm Tissue: 100% unstageable eschar Wound bed: unable to assess; slightly boggy Exudate: scant, thin, serous Odor: none Pain: 0/10 Periwound: clean, dry, intact. (Larger) b. Location: left foot, 2nd digit, MT head Etiology: diabetic foot wound, Wagner scale, grade 1 Wound status: new measurement 0.5 cm x 0.8 cm x 0.1 cm Tissue: 100% eschar Wound bed: unable to assess Exudate: none Odor: none Pain: 0/10 Periwound: clean, dry, intact. c. Location: left foot 3rd digit, MT head Etiology: diabetic foot wound Wagner scale, grade 1 Wound status: new Measurement: 0.5 x 0.5 x 0.1 cm Tissue: 100% stable eschar Wound bed: unable to assess Exudate: none Odor: none Pain: 0/10 Periwound: clean, dry, intact. d. Location: left heel Etiology pressure ulcer, unstageable Wound status: new Measurement 5.0 cm x 4.0 cm x 0.1 cm Tissue: 10% deep tissue injury, 25% stable eschar, 25% partial thickness, 40% detached [MEDICATION NAME] Wound bed: unable to assess Exudate: scant, thin, serous Odor: none Pain: 0/10 Periwound: clean, dry intact. (Larger) e. Location right foot, 2nd digit, medial Etiology: diabetic foot wound, Wagner scale, grade 1 Wound status: new Measurement 0.3 cm x 0.4 cm x 0.1 cm Tissue 100% stable eschar Wound bed: unable to assess Exudate: none Odor: non Pain: 0/10 Periwound: clean, dry, intact. A Wound Treatment Plan dated 7/1/20 documented the following: a. Location: left hallux, distal Etiology: diabetic foot wound, Wagner scale, grade 1 Wound status: improved Measurement: 1.5 cm x 1.5 cm x 0.1 cm Tissue: 100% stable eschar Wound bed: unable to assess Exudate: none Odor: none Pain: 0/10 Periwound: clean, dry, intact. b. Location: left foot, 2nd digit, MT head Etiology: diabetic foot wound, Wagner scale, grade 1 Wound status: improved Measurement 0.4 cm x 0.3 cm x 0.1 cm Tissue: 100% stable eschar Wound bed: unable to assess Exudate: none Odor: none Pain: 0/10 Periwound: clean, dry, intact. c. Location: left foot 3rd digit, MT head Etiology: diabetic foot wound Wagner scale, grade 1 Wound status: not healed Measurement: 0.4 x 0.4 x 0.1 cm Tissue: 100% stable eschar Wound bed: unable to assess Exudate: none Odor: none Pain: 0/10 Periwound: clean, dry, intact. d. Location: left heel Etiology pressure ulcer, unstageable Wound status: improved Measurement 5.2 cm x 5.0 cm x 0.1 cm Tissue: 45% stable eschar, 55% pink [MEDICATION NAME] Wound bed: unable to assess Exudate: scant, thin, serous Odor: none Pain: 0/10 Periwound: clean, dry intact. e. Location right foot, 2nd digit, medial Etiology: diabetic foot wound, Wagner scale, grade 1 Wound status: improved Measurement 0.2 cm x 0.2 cm x 0.1 cm Tissue 100% stable eschar Wound bed: unable to assess Exudate: none Odor: none Pain: 0/10 Periwound: clean, dry, intact. A Physician's Progress note dated 7/8/20 at 9:45 a.m. documented per nursing no acute skin issues. A Wound Treatment Plan dated 7/8/20 documented the following: a. Location: left hallux, distal Etiology: diabetic foot wound, Wagner scale, grade 1 Wound status: not healed Measurement: 1.5 cm x 1.3 cm x 0.1 cm Tissue: 100% stable eschar Wound bed: unable to assess Exudate: none Odor: none Pain: 0/10 Periwound: clean, dry, intact. b. Location: left foot, 2nd digit, MT head Etiology: diabetic foot wound, Wagner scale, grade 1 Wound status: not healed Measurement 0.4 cm x 0.3 cm x 0.1 cm Tissue: 100% stable eschar Wound bed: unable to assess Exudate: none Odor: none Pain: 0/10 Periwound: clean, dry, intact. c. Location: left foot 3rd digit, MT head Etiology: diabetic foot wound Wagner scale, grade 1 Wound status: not healed Measurement: 0.4 x 0.4 x 0.1 cm Tissue: 100% stable eschar Wound bed: unable to assess Exudate: none Odor: none Pain: 0/10 Periwound: clean, dry, intact. d. Location: left heel Etiology pressure ulcer, unstageable Wound statu
F 0687 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	**Provide appropriate foot care.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, record review, and resident and staff interview, the facility failed to arrange and provide transportation to and from weekly podiatry appointments for foot care to assure treatment to prevent complications from conditions such as diabetes and [MEDICAL CONDITION] for 1 of 1 residents reviewed (Resident #10). The facility reported a census of 72 residents Findings included: A Minimum Data Set (MDS) for Resident # 10, with a completion date of 6/9/20, listed [DIAGNOSES REDACTED]. The MDS scored the resident with a Brief Interview for Mental Status (BIMS) of 15, which indicated intact cognition. The MDS documented the resident required extensive assistance of 2 staff for bed mobility, personal hygiene and toileting. The resident depended on staff for transfers, and extensive assist of 1 staff with dressing and bathing. The MDS identified the resident with a [MEDICAL CONDITION]. Record review of Resident #10's care plan with revision date of 7/9/20 listed a focus of a venous/stasis ulcer related to [MEDICAL CONDITIONS] to left ankle and left heel currently managed by podiatrists at the foot and ankle clinic. Goal was- Ulcer to left ankle will show no signs of infection throughout the review period and ulcer to left heel will resolve without complication of infection by the review date. Interventions listed were for staff to: -Document location of wound, amount of drainage, peri-wound area, pain, [MEDICAL CONDITION] and circumference measurement. -Dressing changes to be managed by Podiatrist. -Evaluate wound for: Size. Depth, Margins, peri-wound sinuses, undermining, exudates, [MEDICAL CONDITION], granulation, infection, necrosis, eschar and gangrene. - Document progress in wound healing on an on-going basis. Notify Physician as indicated. Further clinical record review for Resident # 10 revealed minimal documentation that she attended regularly scheduled weekly podiatry appointments for care of the left heel diabetic ulcer. The facility weekly skin assessment checks did not include documentation of the ulcer on left heel. An interview on 8/6/20 at 8:35 a.m. with Resident #10 revealed she lived at the facility for 3 years and went the foot and ankle clinic for years, even before she moved into facility. The resident reported a lack of transportation to the podiatry clinic and the clinic documented this in her medical record. During an interview on 8/12/20 at 1:25 p. m. with Resident #10's Podiatry clinic, the clinical supervisor stated resident had a history of [REDACTED]. Per clinic supervisor, the podiatrist saw the resident on 3/3/20 and then not again until 5/26/20. Podiatry clinic staff reported how important it was for facility to get Resident #10 to her appointments every time and if unable to get to the appointment, facility staff needed to reschedule the appointment as soon as possible. An interview on 8/12/20 at 4:45 p.m. with Staff R Licensed practical nurse (LPN), skin nurse, revealed that facility only treated Resident #10's skin for the upper half of body skin wise and resident goes to the podiatry clinic for all care for her wounds to left lower ankle and lateral leg/heel. They do not do the treatments at the facility. An interview on 8/17/20 at 11:55 a.m. the Director of Nursing (DON) confirmed Resident #10 missed Podiatry appointments on 7/7/20, 8/4/20 and 8/11/20. An interview on 8/18/20 at 11:44 a.m. with Staff X -Transportation supervisor, confirmed Resident #10 missed several podiatry appointments due to lack of communication between the nursing department and transportation. Staff X stated if residents go to hospitals and then come back, nursing does not always communicate with the transportation department for their follow up appointments. Staff X stated the residents suffer due to the lack of communication and not getting to their appointments. Per review of the facility's Podiatry Services/Podiatry Consultant policy revised 10/2007, stated in part-The facility does not maintain a podiatrist on staff and consults out for podiatry services to round at facility. If residents prefer, facility will arrange outside podiatry care. Policy further stated that providing consultation to physicians and providing other services relative to podiatry matters: To provide necessary information concerning residents to appropriate staff, care planning conferences, and/or committees.
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.** **Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents.**

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	165268	A. BUILDING _____ B. WING _____	09/30/2020

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
REHABILITATION CENTER OF DES MOINES	701 RIVERVIEW DES MOINES, IA 50316

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 9) **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review, staff interviews and facility policy review, the facility failed to ensure staff maintained a safe and secure environment for 1 of 7 residents reviewed. Resident #30's care plan directed staff to transfer the resident with 2 staff and Hoyer lift. On 8/7/20 2 staff transferred the resident without a Hoyer lift or gait belt. When the resident bore weight on her only remaining leg, staff heard a crack and lowered the resident to the ground. The resident immediately complained of pain and x-rays showed a nondisplaced oblique fracture involving the distal right tibia. The facility identified a census of 72 residents. Findings include: A Minimum Data Set (MDS) assessment dated [DATE] identified Resident #30 with [DIAGNOSES REDACTED]. The assessment indicated the resident had a Brief Interview for Mental Status (BIMS) score of 15 out of 15 (cognitively intact), weighed 250 pounds (#), required extensive assistance of two (2) staff with transfers, non-ambulatory and with no falls in the past 3 months. A Care Plan with a focus area dated 10/30/18 indicated the resident as at risk for falls related to left [MEDICAL CONDITION] with new prosthesis, obesity, potential side effects of medications received to manage multiple health conditions and the resident required assistance to complete activities of daily living (ADL's) due to decreased mobility following a left [MEDICAL CONDITION] with a new prosthesis, weakness and obesity. The approaches included the following: a. Transferred with the assistance of 2 staff members with an mechanical lift device. Date initiated 11/27/18 A Fall Risk Evaluation form dated 8/7/20 at 6:31 p.m. identified the resident at high risk for falls with [DIAGNOSES REDACTED]. Review of the facilities Progress Notes revealed staff documented the resident experienced no pain on the following dates and times: a. 8/7/20 at 1:47 p.m. b. 8/6/20 at 1:47 p.m. c. 8/5/20 at 1:47 p.m. d. 8/4/20 at 1:47 p.m. An Incident Report form dated 8/7/20 at 6:31 p.m. documented the following: A Certified Nursing Assistant (CNA) got this Registered Nurse (RN) and oncoming Licensed Practical Nurse (LPN) to assist the resident. Upon entrance to the room observation showed the resident leaned with her back against the bed with her right lower extremity (RLE) bent at the knee and resting below the knee amputated left lower extremity (LLE). The resident complained of pain to her ankle of the LLE. The resident's vital signs (VS) registered within normal limits (WNL), fall witnessed and assistance given by 2 CNA's. Staff heard a loud pop when the resident stood with the assistance of 2 staff and transferred from the wheel chair to bed. The resident then stated she had intense pain and could not complete the transfer process. Staff assisted the resident to the floor. No injury noted to the head. Resident safely assisted by four (4) staff into a mechanical lift pad then transferred via the mechanical lift device to bed. The resident yelled out when staff palpated her ankle/lower leg however she minimally wiggled her toes. The resident stated I heard a loud pop and fell . A typed statement from an unknown source documented the following information: On 8/7/20 report received that Resident #30 had an assisted fall. Two staff members transferred the resident from her bed to her wheel chair when they heard a pop and the resident sat straight down on the floor. Staff T, Certified Nursing Assistant (CNA) stated she and Staff E, CNA completed a 2 person transfer from the bed to the wheel chair positioned at a 90 degree angle. As the resident stood on her right leg they heard a pop so the resident had been unable to stand on her right leg and they lowered her to the floor. Staff E stayed with the resident and Staff T went and notified the RN and LPN who came on shift. After the nurse assessed the resident they transferred her per a mechanical lift device onto her bed. Staff E stated that she and Staff T, CNA completed a 2 person transfer from the bed to the wheel chair positioned right next to the bed. When the resident stood up she yelled out in pain and quit bearing weight at all to her leg. They lowered her straight down to the floor at that time and obtained nurse assistance. They used a mechanical lift device and transferred the resident to bed. Staff S, RN on duty and assessed the resident with complaints of RLE pain at about the ankle area after an assisted fall to the floor. Staff S noted she entered the room and observed the resident sitting on the floor with back leaning against the bed. The RLE appeared bent at the knee and resident below the amputated LLE. The resident c/o (complained of) pain to ankle of LLE. Resident VS (vital signs) WNL (within normal limits). Call placed to physician and updated the Nurse Practitioner (NP) the resident previously reported increased pain to the RLE and the 2 view x-ray completed on 8/2/20 with the following findings: Degraded by position and 2 views. Generalized soft tissue swelling. No gross fractures identified. Vascular calcifications. Short-term follow up 3 view radiographs may be helpful if symptoms persist. New order obtained for a 3 view right ankle x-ray at this time. Bio Tech X-ray notified and came that same night for an x-ray. On 8/31/20 at 4:35 p.m. Staff S identified herself as the charge nurse working on 8/7/20 when the resident fell . She stated Staff T came to her and told her the resident fell to the floor around 6 p.m. When Staff S walked into the room she observed the resident sitting on the floor complaining of right ankle pain. Staff S performed a full assessment of all extremities with no abnormalities or obvious fractures identified. The resident's vital signs (VS) registered as stable. Within the last couple of weeks the resident's transfer status changed from stand by assistance (SBA) to 2 staff assistance. The staff member could not recall if the staff used a walker with the transfer but she knew staff failed to utilize a gait belt device. On 8/31/20 at 4:54 p.m. Staff T stated the resident fell on [DATE] around suppertime. Staff T identified herself and Staff E as in a hurry because they had a staff called in that evening and they needed to get the resident up in her wheel chair for supper so they could get supper trays passed. Both of the staff members realized they both had regular sized gait belts and the resident required an extra large gait belt which was usually in the resident room however they could not find the device at that time. Since they were in a a hurry, Staff T tried to use her regular sized gait belt on the resident as she placed it under both of the residents arm pit areas but decided that was not safe either so they removed the gait belt and transferred the resident without a gait belt. Staff T stood on the resident's left side as Staff E stood on the residents right side and faced the resident. They stood her up at bed side and heard a loud crack as the resident leaned towards the right side due to her having been an [MEDICAL CONDITION] on the left leg. She then she fell towards Staff T so the staff lowered her to the floor. Staff T stayed with the resident as Staff E reported the incident to the nurse who assessed the resident. When Staff T spoke to the Director of Nursing (DON) the following day she identified the fall as totally her fault since they did not utilize a gait belt device during the transfer process. Staff T stated she knew after the fall the resident told people they used a gait belt with the transfer but Staff T told the resident they failed to use a gait belt a the time of the fall and the resident knew that. The staff member again confirmed she had been at fault. A Pain Management Review 8/7/20 at 6:31 p.m. indicated the resident received scheduled [MEDICATION NAME]. Despite receipt of the pain medication, the resident continued to have RLE pain. Treatments in place and ineffective so added [MEDICATION NAME] (non-steroidal anti-[MEDICAL CONDITION] drug) as needed (PRN). The form indicated the resident had pain rated at an 8, almost constant pain the past 5 days on her RLE described as burning, pressure and throbbing with her pain moderately managed the past 3 months. A 2 view Radiology Results Report form dated 8/2/20 at 4:53 p.m. documented a view as taken of the resident's right ankle due to extreme pain and difficulty with transfers. The findings/impression described generalized soft tissue swelling especially dorsally with no gross fractures identified, vascular calcifications and cortical thickening about the third metatarsal shaft consistent with a chronic process. A 3 view Radiology Results Report form dated 8/7/20 at 8:47 p.m. documented a view as taken of the resident's right ankle post fall and pain. The findings/impression described a non-displaced oblique fracture that involved the distal right tibia not visible on the prior study. No distal fibular fracture, normal joint alignment, joint spaces well maintained, no ankle joint effusion and prominent [MEDICAL CONDITION] observed in the soft tissues of the right leg and ankle. The facility reported the 8/7/20 completed X-ray result to the NP with new orders received by Staff KK, LPN for a no weight bearing (NWB) status to the RLE and follow up with Orthopedics. Orthopedics appointment scheduled for 8/12/20. On 9/2/20 at 11:38 a.m. the resident's NP stated, without review of the records she could not know if there had been another reason for the fall but stated she knew if the staff used the gait belt the fall could have been prevented. An Orthopedics Physician order [REDACTED]. The OT confirmed they always recommend the use of a gait belt device with any residents who require staff assistance with transfers. On 9/2/20 at 10:22 a.m., Staff PP, certified nursing assistant (CNA) confirmed anytime a resident requires assistance staff is required to use a gait belt with transfers. On 9/2/20 at 10:32 a.m., Staff DD, CNA confirmed anytime a resident requires assistance with transfers that gait belts are required. On 9/2/20 at 10:47 a.m. ,Staff MM, CNA confirmed she observed staff transfer residents without using a gait belt. The staff member indicated she knew of facility policy for using gait belts and she would use a gait belt with any resident who requires the assistance of 1 or 2 staff. On 9/2/20 at 11:01 a.m., Staff NN, CNA confirmed anytime a resident requires assistance with transfers that gait belts are required. On 9/2/20 at 11:44 a.m., Staff OO, CNA confirmed she observed staff as they transferred residents without using a gait belt. The staff member confirmed gait belts are required with any resident who requires the assistance of 1 or 2 staff assistance. A Policy/Procedure - Nursing Clinical form for gait belt/transfers described the policy as follows: a. Provided safety for the unsteady and/or confused resident. b. Aided in the transfer of the dependent resident. c. Prevented injuries to employees and residents. d. Allowed the resident and aid to have felt more secure during a transfer.

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NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
REHABILITATION CENTER OF DES MOINES	**701 RIVERVIEW DES MOINES, IA 50316**

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 10)
F 0693 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	**Ensure that feeding tubes are not used unless there is a medical reason and the resident agrees; and provide appropriate care for a resident with a feeding tube.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, record review, policy review, and staff interview the facility failed to check placement of a feeding tube prior to administration of medications through the feeding tube for 1 of 5 residents reviewed (Resident #22). The facility reported a census of 72 residents. Findings included: A Minimum Data Set (MDS) for Resident #22, with a completion date of 7/8/20, listed [DIAGNOSES REDACTED]. The MDS assessed the resident with short and long-term memory deficits and severely impaired for daily decision making. The MDS documented the resident required extensive assistance of 2 staff for bed mobility, dressing and personal hygiene. The resident depended on 2 staff for transfers, and toileting. The MDS documented the resident received 51% or more, of her daily calories from tube feedings and average fluid intake per day with the tube feeding as 501 milliliters or more. Resident 22's care plan revealed a nutritional problem related to stroke with left sided weakness, dysphagia, difficulty swallowing, need for altered texture diet and tube feeding to supplement due to history of adult failure to thrive prior to admission to the facility, initiated: 05/01/2020. The goal for Resident was to: o Maintain adequate nutritional status as evidenced by maintaining weight with no signs of malnutrition o Administer medications as ordered. Monitor/Document for side effects and effectiveness. o Diet as ordered by the physician. SMALL PORTION/CHO (carbohydrate), pureed texture, thin liquids (per speech therapy) o Honor resident rights to make personal dietary choices and provide dietary education as needed. o Monitor and report to MD as needed for any s/s of: decreased appetite, nausea or vomiting, unexpected weight loss, complaints stomach pain, etc. o Monitor/record/report to physician as needed sign or symptoms of malnutrition: emaciation (cachexia), muscle wasting, significant weight loss. o Provide supplements as ordered - liquid protein and fortified juice A review of Resident #22's signed physician's orders [REDACTED]. Check tube placement and patency prior to each feeding/flush/medication administration via air bolus auscultation (using syringe to instill a mass of air into tube while listening with stethoscope) or residual aspiration (pulling out contents from stomach with syringe) Observation of medication administration on 8/6/20 at 9:35 a.m., revealed Staff G-Licensed Practical Nurse (LPN) gathered Resident # 22's morning medications, crushed them and placed them into med cup. Nurse added water to the cup to dissolve pills. Staff G filled the graduate 1/3 of the way with water and then drew up 50 milliliters (ml) of water and hooked it into the feeding tube's port and flushed the tube. Staff G then instilled Resident # 22's medications through the syringe and then flushed the [DEVICE] with 50 mls. On 8/25/20 at 12:51 p.m. Staff G- LPN confirmed she did not check placement of the feeding tube prior to giving Resident # 22 her morning medications on 8/6/20. On 8/26/20 at 5:26 p.m., DON (Director of Nursing) stated Staff G came to her and said the surveyor observed her administer Resident #22's morning medications. Staff G informed the DON she did not check tube placement before administration of the medications. The DON stated she expected all nurses to check the placement of a feeding tube before they administer anything through the tube. A facility policy revised on 5/2007 titled Enteral Tube Policy directed staff to provide proper care and maintenance of an enteral (feeding tube) which included per daily checklist for gastrostomy tubes to verify tube placement before every feeding.
F 0725 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Some	**Provide enough nursing staff every day to meet the needs of every resident; and have a licensed nurse in charge on each shift.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, record review, and staff interview the facility failed to ensure call lights were answered in a timely manner for 4 of 6 residents reviewed (Residents #7, #8, #14, and #15). The facility reported a census of 72 residents. 1. A Minimum Data Set (MDS) with a completion date of 7/30/20, for Resident # 7, listed [DIAGNOSES REDACTED]. The Brief Interview for Mental Status (BIMS), documented a score of 10 (moderate cognitive impairment). The MDS coded the resident as requiring extensive assist of 1 to 2 staff for bed mobility, toileting, and personal hygiene. The resident depended on one staff for transfers. The MDS documented the resident as frequently incontinent of urine and bowel. Review of the residents' call light log, for the last 30 days (7/11/20-8/6/20), revealed the facility responded over 15 minutes 169 times with the longest response documented as 49 minutes. 2. A MDS with a completion date of 2/23/20, for Resident #8, listed entry date of 2/17/20 and discharge date [DATE]. The MDS listed [DIAGNOSES REDACTED]. The MDS identified no short term memory or decision making impairments. The MDS coded the resident as requiring supervision for bed mobility, transfers, and toileting. The resident was continent of bowel and bladder. Review of the resident's call light log for 2/17/20 and 2/18/20, revealed the resident activated her call light 16 times, with 27 minutes being the longest response time. 3. A MDS for Resident #14, with a completion date of 4/15/20, listed [DIAGNOSES REDACTED]. The MDS scored the resident with a BIMS of 15, indicating intact cognition. The MDS identified the resident as independent with all activities of daily living. The resident required set-up help with walking and personal hygiene. Resident was continent of bowel and bladder. Review of the resident's call light log for the month of February 1 through 29, 2020 revealed he activated the call light 60 times. On 8 occasions, staff took longer than 15 minutes to respond, with 23 minutes being the longest call light response. During an interview on 8/6/20 with Staff G LPN (licensed practical nurse), she stated staff try and answer the call lights as best they can but that they need more help on the floors. An interview on 8/11/20 at 2:15 pm with the Administrator revealed the call lights are [AGE] years old and the facility did a software upgrade in February 2020. The Administrator further stated nursing staff have call light pagers on their person and are learning how to use them. An interview on 9/1/20 at 1:21 p.m. with Staff A-LPN identified the call lights as crazy, especially on the second floor. She further stated they can't really send help to another floor when they don't have enough help on their own floor. A facility policy revised 5/2007 titled Call Light/Bell identified facility policy as: The facility provides the resident a means of communication with nursing staff. Procedures: 1. Answer the light/bell within a reasonable time (within 15 minutes to answer call light and meet resident needs). 4. A MDS for Resident #15, with a completion date of 5/28/20, listed [DIAGNOSES REDACTED]. The MDS scored the resident with a BIMS of 14, (cognitively intact) The MDS documented the resident required extensive assistance of 2 staff for bed mobility, transfers, and limited assist of 2 staff with toileting. The resident required the assistance of one staff with dressing and personal hygiene. The resident was occasionally incontinent of urine and frequently incontinent of bowel. Review of the residents' call light log from 5/8/20 to 5/22/20 revealed he activated his call light 105 times. On 19 occasions staff took longer than 15 minutes to respond, with 35 minutes being the longest call light response. 5. Resident Council Minutes: 12/17/19, residents on 2nd floor felt call lights on the overnight were answered slow 1/14/20, call lights were still an issue on 2nd and 3rd floor 2/18/20, 3rd floor call lights were still an issue 3/24/20, call lights go okay for a while and then back to the same 4/21/20, call lights with slow response times for 2nd and 3rd floor 5/5/20, call lights had improved, but not enough 6/9/20, call lights get better and then backslide 7/14/20, call lights on 2nd floor have slow response time 6. Observations: Observations on 8/11/20: room [ROOM NUMBER]-2 call light on at 2:34 PM and staff responded at 2:58 PM room [ROOM NUMBER]-1 call light on at 2:43 PM and staff responded at 2:59 PM room [ROOM NUMBER] call light on at 2:53 PM and staff responded at 3:24 PM room [ROOM NUMBER]-2 call light on at 3:10 PM and staff responded at 3:29 PM Observation on 8/13/20: room [ROOM NUMBER]-2 call light on at 12:48 PM and staff responded at 1:15 PM room [ROOM NUMBER]-2 call light on at 12:51 PM and staff responded at 1:07 PM room [ROOM NUMBER]-2 call light on at 1:39 PM and staff responded at 1:58 PM room [ROOM NUMBER]-2 call light on at 1:27 PM and staff responded at 2:06 PM 7. Policy and Procedure titled call lights, dated 5/2007, directed staff to answer call lights within a reasonable time, no more than 15 minutes and meet the resident's needs. 8. Staff Interviews: On 8/5/20 at 9:40 AM, Staff D Certified Nurse's Aide (CNA) stated residents' call lights took longer than 15 minutes for staff to respond. On 8/10/20 at 11:45 AM, Staff B Certified Medication Aide (CMA) stated call lights answered within 15 minutes depends on the day and how many staff are working. On 8/11/20 at 9:10 AM, Staff C CMA stated call lights are not answered within 15 minutes, staff answer them as soon as possible. On 8/11/20 at 2:49 PM, Staff E CNA stated call lights are not answered within 15 minutes, felt staff did not care. The CNA stated the residents were upset with call lights not being answered timely. On 8/18/20 at 1:49 PM, Staff G Licensed Practical Nurse (LPN) stated residents complained to her that there were not enough staff on the overnight shift and it took a long time for the call lights to be answered. On 8/19/20 at 4:30 PM, the Director of Nursing (DON) stated she expected staff to respond to call lights within 15 minutes and to meet resident needs.

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)
F 0725 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Some	(continued... from page 11)
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, policy review, and staff interviews the facility failed to have complete and accurate documentation in the clinical record for 2 of 2 residents reviewed (Resident #9 & #10). The facility reported a census of 72 residents. Findings include: 1. A `Minimum Data Set (MDS) with a completion date of 7/14/20, for Resident #9, listed [DIAGNOSES REDACTED]. The Brief Interview for Mental Status (BIMS), documented a score of 10 (moderate cognitive impairment). The resident required the extensive assistance of 2 staff for bed mobility and transfers. Care Plan: Care Plan focus for Intravenous (IV) antibiotic therapy with initiation date of 6/8/20, revealed Resident #9 required IV therapy due [MEDICAL CONDITION] with the need for prolonged administration of multiple antibiotics. The care plan directed staff to check the IV dressing daily and monitor IV site for signs and symptoms of infection. The care plan lacked documentation of type of IV line that staff administered the IV antibiotics through and location. Progress notes: 6/5/20 at 11:30 PM, medication administration note, unable to give IV antibiotic due to the resident pulled out the peripherally inserted central catheter (PICC line for IV use). 6/6/20 at 3:30 PM, the resident transferred to the hospital to replace the PICC line 6/6/20 at 3:32 PM, called to the resident's room by the Certified Nurse's Aide (CNA) due to the resident on the floor. The resident kneeled on the floor and identified self as on his way to the bathroom. 6/6/20 at 9:31 PM, the resident returned to the facility at approximately 9:00 PM 6/8/20 at 1:06 PM, the resident was scheduled for tunneled catheter placement on 6/12/10 at 2:00 PM Incident report dated 6/6/20 at 3:25 PM, revealed staff called the nurse to the resident room and observed the resident kneeling on the floor. emergency room (ER) documentation dated 6/6/20, revealed the resident entered ER at 3:36 PM and discharged at 8:54 PM. The clinical record lacked documentation on 6/5/20, to identify the resident pulled out his PICC line or of physician notification regarding the incident. On 6/12/20, the clinical record lacked documentation of when the resident left the facility for placement of a tunneled catheter. In addition, inaccurate documentation in the clinical record resulted in the inability to determine the time of the resident's fall. Facility policy titled charting and documentation dated 5/2007, identified the resident's clinical record to be a concise account of treatment, care, response to care, signs, symptoms, and progress of the resident's condition. Importance and use of the record: To the institution it reflects the quality of care given to the resident In legal defense, serves as valid information To the nurse, provides a multidisciplinary record for the physical and mental status of the resident Rules for charting: Continuous nurses notes are required on all residents as the necessary arises Every shift must document on change of condition for a minimum of 72 hours On 8/25/20 at 11:27 AM, the Director of Nursing (DON) stated she expected documentation in the progress notes when the resident left and returned to the facility on [DATE] for PICC line placement. On 8/25/20 at 12:15 PM, Staff L, CNA (certified nurse aide) confirmed she worked 6 AM - 2 PM on 6/6/20 when she found Resident #9 on the floor. The CNA stated she responded to the roommate's call light and found Resident #9 on the floor. The CNA stated the resident transferred back to bed after the fall and she did not know the resident transferred to the hospital. On 8/25/20 at 1:13 PM, Staff J, Registered Nurse (RN) confirmed she worked 6 AM - 6 PM on 6/6/20 when staff found Resident #9 on the floor and the resident transferred to the hospital. Staff J stated she did not transfer the resident to the hospital because of the fall. She transferred the resident due to the PICC line pulled out and need for replacement. Staff J stated she did not recall what time the fall occurred. On 8/26/20 at 9:36 PM, Staff F, RN stated Resident #9 pulled out his PICC line in a state of confusion. Staff F stated she went into Resident #9's room during rounds and found the PICC line pulled out. Staff F identified minimal bleeding and she applied a dressing. Staff F stated she completed an assessment of the resident and notified the physician on call, however, in the flurry of the night did not document in the resident's clinical record. On 8/26/20 at 10:20 AM, the DON (Director of Nursing) stated she could not provide the time of Resident #9's fall on 6/6/20. On 8/26/20 at 1:00 PM, the DON stated she expected the nurses to document accurately in the clinical record, even if they chart at a later time, they should change the time to reflect the time the incident occurred. The DON stated she expected the nurses to assess and document when the resident pulled out his PICC line. 2. A MDS for Resident # 10, with a completion date of 6/9/20, listed [DIAGNOSES REDACTED]. A BIMS score of 15 identified the resident with indicated intact cognition. The MDS documented the resident to require extensive assistance of 2 staff for bed mobility, personal hygiene and toileting. The resident is dependent on staff for transfers, and extensive assist of 1 staff with dressing and bathing. Review of Resident #10's care plan with revision date of 7/9/20 listed a focus area of a venous/stasis ulcer related to [MEDICAL CONDITIONS] to left ankle and left heel currently managed by podiatrists at the foot and ankle clinic. The goal was: the ulcer to left ankle will show no signs of infection throughout the review period and ulcer to left heel will resolve without complication of infection by the review date. Interventions directed staff to: -Document location of wound, amount of drainage, peri-wound area, pain, [MEDICAL CONDITION] and circumference measurement. -Dressing changes to be managed by Podiatrist. -Evaluate wound for: Size. Depth, Margins, peri-wound sinuses, undermining, exudates, [MEDICAL CONDITION], granulation, infection, necrosis, eschar and gangrene. - Document progress in wound healing on an on-going basis. Notify Physician as indicated. Further clinical record review for Resident # 10 revealed minimal documentation of the resident attending scheduled weekly podiatry appointments for care of the left heel diabetic ulcer. The facility weekly skin assessment checks did not include any documentation of the diabetic ulcer on left heel. An interview on 8/18/20 at 5:55 p.m. with Staff R-Licensed practical nurse (LPN), skin nurse, revealed the facility did not have complete records for Resident # 10's weekly skin records from podiatry appointments. Staff A stated she did not know the facility was responsible to obtain the clinic visit records, even though Resident #10's left foot wounds weren't managed/monitored by facility staff. Staff R stated she is now aware of the need to get the records so the facility can track the skin areas. On 8/26/20 at 5:26 p.m. the Director of Nursing (DON) revealed she did not know the nurses failed to call and obtain copies of Resident #10's podiatry records to assure continuity of care. The DON provided copies of the podiatry records obtained 8/12/20 per fax. The records received included Podiatry visit notes from 3/3/20, 5/26/20, 6/2/20, 6/9/206/23/20, 6/30/20, 7/14/20, 7/21/20, and 7/28/20 (all previously unavailable in the record prior to 8/12/20). Review of facility policy titled Wound management revised 12/2018 directed the facility to have a central consistent flow sheet to enable staff to evaluate status of wounds. A wound is identified as an arterial ulcer, diabetic neuropathic ulcer, pressure ulcer, [MEDICAL CONDITION] ulcer, surgical wound and lacerations.
F 0925 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Some	**Make sure there is a pest control program to prevent/deal with mice, insects, or other pests.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, policy review, and staff and resident interviews, the facility failed to provide adequate pest control procedures and processes to decrease the amount of houseflies and gnats present within the facility which created a risk to the safety of all residents that lived within the facility and contributed to the presence of maggots in the facility. The facility reported a census of 72 residents. Findings Included: 1. A Minimum Data Set (MDS) for Resident #11, with a completion date of 6/29/20, listed [DIAGNOSES REDACTED]. The MDS scored the resident with a Brief Interview for Mental Status (BIMS) score of 14 (no cognitive impairment). The MDS documented the resident required extensive assistance of 2 staff for bed mobility, dressing, personal hygiene and toileting. The resident depended on 2 staff for transfers and was frequently incontinent of bowels. Review of Resident #11's care plan with revision date of 7/16/20 revealed a focus area for Activities of Daily Living (ADL) for self-care performance related to disease process, limited mobility following stroke with weakness, altered mental status as evidenced by need for assistance to complete ADL's. The care plan's goal was to maintain current level of function in bed mobility, transfers, eating, dressing, grooming, toilet use and personal hygiene through review date. Interventions on care plan included -Assist of 2 with transfers, use Easy stand lift, follow therapy recommendations -Assist of 2 with bed mobility -Assist of 2 with toileting with easy stand for bedside commode use. - Resident is able to don/doff (put on/take off) his brief (incontinence undergarment) following the same method as pants but may require some assist from staff. On 8/26/2 at 11:49 a.m. Staff M-CNA (certified nurse aide) revealed Staff M-CNA

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	165268	A. BUILDING _____ B. WING _____	09/30/2020

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
REHABILITATION CENTER OF DES MOINES	701 RIVERVIEW DES MOINES, IA 50316

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 0925 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Some	(continued... from page 12) orientated a new staff member Staff N- CNA on 10/9/19. Staff M and Staff N prepared Resident # 11 for the the shower and observed maggots in the resident's brief and on his buttocks when they turned resident over to wash him. On 8/26/20 at 1:34 p.m. Staff N-CNA revealed she orientated as a new staff member on 10/9/19 with Staff M-CNA. Staff N identified Resident #11 with maggots in his feces, on his buttocks and in his brief when staff turned him over for peri- care. Staff N stated resident appeared caked with dried feces and had a very strong bowel odor to him. Staff N called Staff Y- CNA in to the room. Staff M and Staff N advised Staff Y that Resident #11 needed to be the next shower due to the amount of soiling he had as well as due to the maggots found in his brief. Staff N also identified the resident as using a catheter so staff did not check and change him as often and with the way Resident # 11 looked that day, he went several days without check/change. He had an open area on his bottom too. Staff N stated the resident's skin appeared red and Staff N retched with the smell and seeing the maggots after they cleaned him up. Staff N stated it was awful to see maggots on a resident. On 8/27/20 at 8:09 a.m. Staff Y- Certified Nursing Assistant (CNA) revealed she observed maggots in Resident #11's brief with Staff M-CNA when they prepared the resident for his shower. Staff Y identified the time as around 10 am and resident laid in his bed and staff found him very soiled in his own feces with maggots in his brief and on his skin. Staff Y stated the resident had an open area on his buttock. Staff Y and Staff M noted the strong bowel odors and observed the fecal material was dry and staff really scrubbed the resident's skin to remove all of the bowel movement from his legs and buttocks. Staff Y stated Resident #11 really hated to take baths and only took one shower per week but due to his refusals, he would sometimes go weeks without a shower. Staff Y stated as a bath aide, there were no shower sheets, or records to mark on to track the showers for Resident #11. On 8/27/20 at 1:01 p. m. Staff EE-LPN (licensed practical nurse) stated she worked the day staff found maggots in Resident #11's incontinence brief. Staff EE stated Staff Y came to her and said she observed maggots in Resident #11's feces. Staff EE stated she did not see the maggots because Staff Y and Staff M already cleaned Resident # 11 up by the time they came to get her. Staff EE stated the resident received his shower and Staff EE performed the treatment to his buttocks afterwards. Staff EE stated staff applied a house barrier cream on Resident #11's buttocks for quite some time prior to the finding of maggots in his brief. Staff EE stated she could not remember if she reported the maggots to anyone or who she reported it to. Staff EE stated she felt pretty sure she reported the maggots to the Director of Nurses (DON). Clinical record review of Resident # 11 Treatment Administration Record (TAR) listed an order for [REDACTED].#11's assessments in the Electronic Health Record (EHR) for October 2019 revealed no active pressure ulcers tracking forms for Resident # 11. Clinical record review of Resident #11's progress notes for 10/9/19 revealed no entries that day to identify staff discovery of maggots on the resident or that the facility notified the family or physician. Results of a web based search on 9/17/20 at 2:33 p.m. revealed the following: House fly populations can be harmful to human health: they carry multiple pathogens and have been linked to the spread of a number of diseases. House fly eggs look like small grains of rice. Eggs hatch within 24 hours, and house fly larvae emerge. House fly larvae, or maggots, appear similar to pale worms. Their sole purpose is to eat and store energy for their upcoming pupation. Larvae feed for approximately five days, after which they find dry, dark locations for pupal development. The gestation of a house fly egg is only 24 hours, and infestations spread at alarming rates. Larvae emerge from their eggs and begin feeding. Using their egg site as a source of food, the larvae, which are commonly referred to as maggots, eat for four days in order to store nutrients for metamorphosis. A female housefly is capable of laying up to 150 eggs in a batch. Over a period of a few days, she will produce five or six batches of eggs. Female house flies favor damp, dark surfaces such as compost, manure and other decomposing organic material for egg laying. Link :https://www.orkin.com/flies/house-fly/house-fly-larvae According to animals.mom.com: When it's warm outside, maggots can emerge from eggs laid only eight to 20 hours earlier. Resembling tiny white worms, maggots eat from the site where they emerged for up to five days. Due to 8-20 hours required for maggots to emerge, the facility failed to clean the resident's soiled brief for at least 8-20 hours. 2. A MDS for Resident #12, with a completion date of 6/3/20 listed a [DIAGNOSES REDACTED]. The MDS scored the resident with a BIMS of 15, which indicated intact cognition. The MDS documented the resident required extensive assistance of 2 staff for bed mobility, transfers, toileting and bathing . The resident required extensive assist of 1 staff with dressing and personal hygiene. On 8/27/20 at 11:04 a.m. with Staff P-LPN, revealed the unit manger reported Resident #12 had maggots in his right leg wound on 7/4/20. Staff P stated she changed the dressing on resident's right leg on 7/1/20 and then Staff R-LPN Unit manager changed the dressing on 7/4/20. Staff P revealed Staff R scraped maggots out of the wound. On 9/15/20 at 1:22 p.m. the Administrator revealed she knew of the maggots found in Resident #12's leg wound on 9/5/20. The Administrator did not know of a second incident involving Resident # 12 and maggots in the right leg wound on 7/4/20. On 9/16/20 at 4:43 p.m. Staff UU -CNA revealed she worked 9/5/20 and assisted Resident # 12 with a shower and at that time observed maggots in his right leg wounds following removal of the dressing. Staff UU stated that Staff BB- CNA/CMA(certified medication aide) entered the shower room and Staff BB left and informed Staff TT-LPN. Resident #12 stated that there were flies flying around his legs all of the time. Staff TT-LPN arrived into the shower room and looked into the leg wounds to ensure no maggots remained in the wounds. Staff UU stated Resident #12 did have a lot of flies hovering around his dressing frequently and that there are flies all over the building all of the time. On 9/17/20 at 1:09 p.m. Staff TT-LPN stated he worked Saturday 9/5/20 and Resident #12 was due for his shower. Staff BB approached Staff TT and stated Resident #12 was in the shower room and needed a nurse as Staff BB observed maggots in his leg wound. Staff TT stated he arrived in the shower room, and most of the maggots already washed away. Staff TT stated he took care of the secretions coming from the wounds with gauze and looked all over the wounds and did not observe tunneling of the maggots. Staff TT stated he assumed the maggots got into the wound while his legs were unwrapped waiting for staff to complete his treatment. Staff TT stated that Resident # 12's legs are usually wrapped all of the time. On 9/17/20 at 3:42 p.m. with Staff BB- CNA/CMA revealed she worked when staff observed maggots in Resident #12's right leg wound on 9/5/20. Staff BB stated she went into the shower room that morning to give a resident medications. At that time, she and Staff UU and observed maggots on the shower room floor after staff removed the leg wound dressing. Staff BB stated the maggots laid on the floor, right below his chair and under the area below his right leg wounds. Staff BB stated she notified the nurse. Staff KK-LPN came down to the shower room and cleaned the right leg wounds checked Resident #12 over and didn't see any more maggots in the wounds. On 9/1/20 at 11:15 a.m. Resident #12 confirmed he did have maggots on his right leg wound on 7/4/20 but he did not know how the flies got in there to lay eggs. The resident stated flies get in his room a lot and in fact there are at least 2-3 of them in the room at all times usually. The resident stated the flies are one of the reasons why he keeps the door to his room closed-- to stop the flies from coming into his room. Resident #12 stated now that he thought of it, the flies had more than likely gotten into his right leg wounds after he had a shower as sometimes it takes the nurses several hours to come to his room to do his wound treatment and wrap his legs up with the bandages. Resident #12 stated when his legs weep fluid due to his [MEDICAL CONDITION] drainage, the gnats swarm around his ankles as they like to drink the fluid. 3. A Minimum Data Set (MDS) for Resident #33, with a completion date of 7/15/20, listed [DIAGNOSES REDACTED]. The MDS identified the resident with short and long-term memory deficits and severely impaired decision making. The MDS documented the resident required extensive assistance of 2 staff for bed mobility, dressing and personal hygiene. The resident depended on 2 staff for transfers, and toileting. On 9/2/20 at 3:45 p.m. the resident stated the flies are bad at the facility. They are in his room and they are annoying. He stated he did not have a fly swatter but would like one. 4. Observation showed on 8/11/20 at 9:00 a.m. several gnats and at least 2 flies hovering around in the conference room. Observation showed on 9/2/20 at 3:36 p.m.,the buildings 4th floor, 5th window had a large torn screen that flies could enter the building potentially. 5. Review of the facility's Pest Control Visits policy revised on 5/2007 identified the facility would provide an environment free of pests by: a. The facility will have a pest control contract that provides frequent treatment of [REDACTED]. b. The pest control visits will occur at least monthly c. It will allow for additional visits when a problem is detected d. Monitoring of the environment will be done by the facility staff e. Pest control problems will be reported promptly to the administrator The facility provided records from their Pest Control Provider for all services received for pest control from September 2019 through August 2020. The facility's pest provider performed inspection of the facility and the spraying of insecticides to prevent pest's such as flies, bed bugs, spiders. The facility received pest services on the following dates: 9/3/19, 10/16/19, 11/5/19, 12/3/19, 1/28/20, 2/25/20, 3/6/20, 3/24/20, 5/26/20, and 6/19/20. The facility did not have any record of pest control services for April 2020.