STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	165580	A. BUILDING _____ B. WING _____	**07/27/2020**

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
URBANDALE HEALTH CARE CENTER	**4614 NW 84TH STREET URBANDALE, IA 50322**

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 0692 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	**Provide enough food/fluids to maintain a resident's health.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on clinical record review, observation, and staff interview, the facility failed to assess a resident at high risk for dehydration and failed to initiate adequate interventions to prevent dehydration and overall health decline for one of four residents reviewed for hydration maintenance (Resident #1). The facility reported a census of 96 residents. Findings include: 1. The Minimum Data Set (MDS) assessment dated [DATE] for Resident #1 identified a Brief Interview for Mental Status (BIMS) score of 14 indicating cognitive intact. The MDS revealed the resident required set up assistance with eating. The MDS documented [DIAGNOSES REDACTED]. The MDS revealed the resident's weighed 193 pounds (lbs), and had no difficulty swallowing or loss of liquids or food during eating or drinking. The care plan focus area revised 6/16/20 identified Resident #1 required assistance with ADL's (activities of daily living) due to a [MEDICAL CONDITION]. The care plan documented the resident with a risk for nutritional deficits due to meals served in his room, and a possible decreased intake and poor appetite related to acute illness. The directives for staff included the following: a. Offer general/regular diet with thin liquids (added 11/25/19) b. Monitor weights as directed (added 12/2/19) c. Ensure optimal hydration and nutrition to maintain the highest practicable level (added 5/21/20) d. Monitor for decreased output and report significant changes to the physician (added 6/5/20) e. Accommodate food/fluid preferences (added 6/16/20) f. Provide additional high calorie/high protein snacks (added 6/16/20) g. Provide zinc/vitamin C supplements for immunity enhancement (added 6/16/20) h. Provide house supplement due to weight loss (added 7/9/20) The dietary quarterly review dated 6/4/20 revealed Resident #1's weight 193.4 pounds (lbs). The resident on a regular diet and oral intakes 75-100 % of estimated needs. The resident consumed 1500-2000 ml of fluids, and on no fluid restrictions. Resident appeared well nourished with body mass index 29.4. No adaptive equipment or assistance needed to eat past set up. No dietary changed needed at that time. The dietary notes revealed the following: a. On 7/9/20, weight 178.4 lbs, weight down 7.8 % in 30 days. Resident not eating well. Resident noted to stash food in drawers. Labs drawn and results pending. House supplement 60 milliliters (ml) three times a day (TID) recommended. Resident added to weekly nutrition monitoring list. b. On 7/16/20, weight 173.1 lbs, weight down 5.3 lbs in one week. Resident continues on house supplement 60 ml TID and not eating well. House supplement 90 ml TID and continued weekly monitoring recommended. The Medication Review Report dated 7/1-7/31/20 documented an active order that started 7/12/20 for a house supplement 60 ml TID for weight loss, and encourage 240 ml of water TID for dehydration. Staff documented water encouraged and house supplement provided 7/12-7/17/20 TID, and 7/18/20 on the morning and mid-afternoon shifts. The progress notes revealed the following: a. On 7/7/20 at 9:31 p.m., Resident #1 confused, skin pale, poor appetite. Fluids encouraged. The resident had no cough, dyspnea, [MEDICAL CONDITION], nausea, or emesis. The provider (ARNP) notified. New order received for labs (CBC, BMP, and UA with culture/sensitivity if indicated). b. On 7/8/20 at 2:38 p.m., blood drawn and sent to the lab. c. On 7/11/20 at 3:38 p.m., new order received for house supplement from the ARNP. At 3:39 p.m., the ARNP reviewed lab results. New orders received for 240 ml water TID and recheck BMP lab in one week. d. On 7/18/20 at 1:40 p.m., the resident had confusion but alert and oriented x 1, lethargy, and unable to answer questions. The resident had loose stools and an incontinence episode, but had no signs or symptoms of pain, nausea/vomiting, dyspnea or cough noted. Notified the physician and an order received for transfer to the Emergency Department (ED) for evaluation and treatment. At 7:20 p.m., notification received the resident admitted to the hospital for acute kidney injury and dehydration. A laboratory report dated 2/20/20 revealed the resident with a BUN 21 milligrams (mg) per deciliter(dl) (normal range is 6-25), creatinine 1.1 mg/dl (normal range is 0.50 - 1.20), a GFR (glomerular filtration rate) 77 ml/min (normal range is greater than 60), potassium 4.6 (normal 3.4 - 5.0), and glucose 105 (normal 70-99). The lab report was noted by the provider 2/24/20. A laboratory report dated 7/8/20 revealed the resident had a BUN (High) 95, creatinine 1.76, GFR 39 ml/min, potassium 5.7, and glucose 112. The lab report was noted on 7/10/20 by the provider and orders received for 240 ml water TID encouraged and recheck BMP in 1 week. The hospital history and physical dated 7/18/20, revealed the resident presented to the ED with altered mental status and [MEDICAL CONDITION]. At the time, the resident's vital signs revealed a blood pressure 62/45, temperature 97.3, pulse 83, respirations 11, pulse oximetry 96 %. The resident reported not able to eat or drink like he usually could because he had been too tired. The resident complained of abdominal pain, generalized headaches, shakes, and feeling weak and dizzy when he stood up. The hospital lab revealed bun 117, creatinine 3.24, potassium 5.2, glucose 182, lactic acid 2.3. The physician's impression and [DIAGNOSES REDACTED]. The record lacked documentation of intakes or outputs for Resident #1. The record lacked assessment for dehydration. During an interview 7/23/20 at 12:05 p.m., a hospital physician reported Resident #1 presented to the ED 7/18/20 and found severely dehydrated. The physician stated the resident's sodium and creatinine levels elevated which indicated altered kidney function, and the UA revealed the resident dehydrated. During an interview 7/23/20 at 10:05 a.m., Staff B, certified medication aide, reported whenever she saw a big change in how much a resident ate or drank, she let the kitchen staff know. Staff B reported a 7-day tracking form utilized for tracking a weight's weight gain or loss but only used for certain residents at admission or whenever they noted an issue. No record of intakes or outputs done on the residents. During an interview 7/23/20 at 10:30 a.m., Staff C, certified nursing assistant, reported she let the nurse know the amount a resident ate or drank, but didn't normally document intakes on the residents. During an interview 7/23/20 at 12:45 p.m., the Director of Nursing (DON) reported resident food intakes recorded on new admissions for a period of 7 days, whenever quarterly assessments completed, and whenever a resident had weight loss or they had noticed the resident had a change or not eating they monitored the resident's nutrition/hydration weekly. The DON reported the nurse manager assisted residents to fill out menu slips daily. Resident #1 had refused options on the menu as well as alternative food options. They started resident #1 on supplements the week of 7/8/20 when they noticed the resident had weight loss and not eating. During an interview 7/23/10 at 1:40 p.m., Staff D, Licensed Practical Nurse, reported they tracked resident intakes whenever a resident admitted to the facility and whenever had a concern with a resident's intakes or weights. Staff D reported the meal tickets stayed with the meal trays, sometimes they wrote on the meal tickets how much a resident ate. The trays and meal tickets were returned to the kitchen after the meals completed. During an interview 7/27/20 at 4:55 p.m., a hospital physician reported if a resident had symptoms of dehydration or decreased oral intake, she would expect staff assessed the resident at least twice a day for dehydration, monitored and documented all intakes and outputs, and encouraged fluids. If the facility had monitored the resident and took more aggressive measures for rehydration, the hospitalization would have been avoidable.
F 0880 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	**Provide and implement an infection prevention and control program.** Based on observations, staff interview, and policy review, the facility staff failed to followed infection control practices and wear gloves when a blood sugar check performed, in order to prevent or reduce the risk of spreading infection and disease, and failed to disinfect the glucometer properly for two of two residents observed. The facility reported a census of 96 residents. Findings include: During observation on 7/22/20 at 11:05 a.m., Staff A, Certified Medication

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 0880 **Level of harm -** Minimal harm or potential for actual harm **Residents Affected -** Few	(continued... from page 1) Assistant, performed a blood sugar check on Resident #5 without gloves on. At 11:06 a.m., Staff A disposed of the lancet into a sharps container, took the glucometer to the medication cart, opened an alcohol swab, and cleansed the glucometer machine for 15 seconds. Staff A did not wear gloves while she cleansed the glucometer machine. Staff A sanitized her hands with an alcohol based hand sanitizer, then took the glucometer machine to Resident #6's room. At 11:10 a.m. Staff A performed a blood sugar check on Resident #6 and did not wear gloves during the procedure. Staff A disposed of the used lancet in a sharps container by the medication cart, then cleansed the glucometer machine with an alcohol swab for 15 seconds. During an interview 7/22/20 at 4:00 p.m., the Director of Nursing (DON) reported she expected staff to wear gloves whenever a glucometer blood sugar performed. The DON reported she expected staff to cleanse the glucometer machine with a bleach disinfectant wipe, and then wrap the disinfectant wipe around the glucometer machine and let it set for at least 3 minutes. During an interview 7/23/20 at 10:05 a.m., Staff B, CMA, reported gloves worn whenever cares or a blood sugar performed. In a policy titled Glucometer: Routine Cleaning, dated 9/18/19, revealed gloves worn during a fingerstick for blood glucose monitoring, and the blood glucose machine cleansed and disinfected using an environmental protection agency approved germicide in-between each use in order to prevent the spread of infection and bloodborne pathogens.