STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	165411	A. BUILDING _____ B. WING _____	**06/25/2020**

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
SOUTHFIELD WELLNESS COMMUNITY	**2416 SOUTH DES MOINES STREET WEBSTER CITY, IA 50595**

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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 0580 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	**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 interviews and record reviews, the facility failed to notify the family representative of a change in resident condition for one of four residents reviewed (Resident #1). The facility reported a census of 70 residents. Findings include: Resident #1's Minimum Data Set (MDS) completed with an Assessment Reference Date 5/15/20 showed a Brief Interview for Mental Status score of 9, indicating moderate cognitive impairment. The resident required limited staff assistance of one staff for locomotion on and off the unit in the seven day lookback period. The resident required extensive assistance of two staff with transfers in the seven day lookback period. The resident has [DIAGNOSES REDACTED]. A progress note dated 6/13/20 at 1:06 AM identified the resident with an area approximately 4 centimeters (cm) in length and 1 cm wide to the lower abdomen. The area appeared bright red with red drainage that ran along a healed abdominal incision. The area appeared scratched open. Three clear hard stitches appeared inside the red area and stuck up approximately 0.5 cm straight out. Staff cleaned the area and covered it with an abdominal (ABD) dressing to keep the resident from scratching the area and keep any stool leakage out from the nearby [MEDICAL CONDITION]. A progress note dated 6/22/20 at 10:45 AM revealed the nurse notified the resident's representative regarding the resident's appointment and that the resident required an escort for the entire duration of the visit. The representative asked what was coming from the resident's incision? The nurse informed the representative part of a staple that didn't dissolve appeared from the incision. The representative questioned why no one notified her of this development. The representative then asked if the resident could see someone locally. The nurse explained that the provider received notification regarding the condition. The provider requested that the resident see the surgeon that performed the abdominal surgery. The facility informed the representative of the appointment time and date with the approximate time of 11:45 AM departure time. The representative stated they would ride with the resident. On 6/22/20 at 1:40 PM, the resident's representative revealed the facility called that morning. The representative reported the nurse did not know anything about the area. The nurse said the resident had a staple coming out of the incision. The representative did not wish for the resident to go back to Des Moines as the resident would require quarantine following the appointment. The representative stated that the resident requires staff assistance with eating. The facility was not equipped with enough staff to help the resident eat in their room. The representative reported not knowing of the new skin condition until that day. The representative said there was no notification from staff of the area before 6/22/20. The representative reported taking notes of the calls received from the facility and not having any notes related to this skin condition. The progress notes lacked notification to the family until 6/22/20. During an interview on 6/22/20 at 12:50 PM, the Director of Nursing (DON) reported that she had not checked the resident's progress notes. The DON indicated she had heard Staff J, Licensed Practical Nurse (LPN), call the resident's representative as her office is next to the nurses' station. The DON stated she didn't know if Staff J forgot to chart, but she would call to find out more about the situation. During an interview on 6/22/20 at 12:58 PM, Staff F, MDS/Care Plan Nurse, said that she did not talk to the resident's representative, she had just made the appointment. After scheduling the appointment, she called the representative. Staff F reported not knowing if anyone else contacted the resident's representative. During an interview on 6/22/20 at 1:14 PM, Staff J reported that she notified the resident's representative with all the new orders. Staff J said she explained why the resident needed all the laboratory (lab) tests. Staff J stated that she had notified Staff F to make the appointment. Staff J stated that she usually charted the representative notification. However, work has been crazy lately, but she said that she knew that was no excuse. A progress note dated 6/13/2020 at 10:30 AM with a creation date of 6/22/2020 at 4:25 PM labeled Communication - with Family/Related Party indicated the note was a Late Entry. The noted showed the nurse contacted the resident's representative and notified of the resident's new skin area with no new orders at this time. A review of the Nurses Schedule from 6/8/20 through 6/21/20 showed Staff J did not work 6/13/20. An interview on 6/23/20 at 9:36 AM, the Administrator, stated there was no time clock sheet available for date 6/13/20 for Staff J as Staff J did not work that day. The Professional Nursing schedule starting 6/7/20 through 6/13/20 indicated the shifts that Staff J worked were 6/7/20, 6/10/20, and 6/11/20. Staff J did not clock into the facility on [DATE].
F 0584 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	**Honor the resident's right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely.** Based on observations and interviews, the facility failed to provide an open safe path to one fire door in case of an emergency which created a hazard. Facility census was 70 residents. Findings include: 1. On 6/22/20 at 1:01 PM observation revealed a wheelchair scale next to the wall of the Edgewood Hallway approximately 8 feet from the fire door in the down position. The scale noted took up approximately more than half of the hallway, preventing a clear exit to the fire door. On 6/22/20 at 1:04 PM, Staff P, CNA (certified nurse aide), and Staff Q, CNA, report the scale location as that way since they worked there. On 6/22/20 at 2:50 PM, the DON (Director of Nursing) reported the scale used to be in the shower, but it became too dangerous for the residents as it took up too much space. Staff should place the scale in the up position when not in use. The DON was unsure if this was appropriate with the fire marshall. On 6/23/20 at 9:33 AM, observation showed the scale in the down position in the hallway near the fire door, taking up approximately more than half of the hall.
F 0689 **Level of harm** - Immediate jeopardy **Residents Affected** - Few	**Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interviews and record reviews, the facility failed to provide appropriate supervision for a cognitively impaired resident for one of four residents reviewed (Resident #1). On 4/22/20, the resident went on the facility provided van to an appointment in an unfamiliar clinic and town. Despite being informed by the clinic staff that the resident would need to wait awhile to see the Physician, the facility van driver left a business card with the hospital clinic staff and left the area. The facility van driver left the resident unsupervised to park the facility van and have lunch. While having lunch, the driver received a call from the clinic staff reporting the resident got upset and left the waiting area, taking an elevator to unknown regions of the hospital. Upon arriving at the floor, the resident's location was unknown, necessitating a search involving hospital security and other personnel. The length of time the resident was missing is unknown. However, the driver estimated the time to be 15 to 20 minutes. The van driver left the resident at an unfamiliar hospital clinic on

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 0689 **Level of harm -** Immediate jeopardy **Residents Affected -** Few	(continued... from page 1) the third floor unsupervised, which placed him at severe risk of injury or harm. There were hazards present, including stairwells and exits leading to areas trafficked with vehicles coming and going from the hospital. Either option would result in serious impairment or death. Due to the resident left alone in an unfamiliar area, the resident became upset, refused to be seen, and left the appointment. The resident then missed his appointment for evaluation and removal of 21 staples following a recent major abdominal surgery. Due to the lack of adequate supervision, the facility's actions caused the resident's health and safety to be in Immediate Jeopardy. The facility reported a census of 70 residents. Findings include: 1. Resident #1's Minimum Data Set (MDS) completed with an Assessment Reference Date (ARD) 5/15/20 showed a Brief Interview for Mental Status (BIMS) score of 9, indicating moderate cognitive impairment. The resident required limited staff assistance of one staff for locomotion on and off the unit in the seven day lookback period. The resident required extensive assistance of two staff with transfers in the seven day lookback period. The resident had [DIAGNOSES REDACTED]. A MDS with observation end date of 4/7/20 also identified the resident with a BIMS of 9. A Clinic/Office Note - Physician dated 6/24/20 indicated the resident had mild cognitive impairment so stated. The Mini Mental State Examination (MMSE) completed at the visit indicated a score of 6/30, indicating severe cognitive impairment. Resident interviews: On 6/22/20 a 1:05 PM the resident reported that his appointment in Des Moines was mediocre. The resident answered yes to seeing the doctor at the appointment. The resident responded yes to having the staples removed at the appointment by the doctor. During a follow-up interview on 6/23/20 at 9:36 AM, the resident did not know the day of the week or the name of the President. When asked if the resident knew the day of the week, the resident responded with their name. Resident's Durable Power of Attorney (DPOA)/representative interview: On 6/18/20 at 11:49 AM, the resident's DPOA/representative reported the facility did not ask her about going with the resident to the appointment or about using an escort. The resident previously went to the Veterans Affairs (VA) Hospital prior to nursing home placement, but the clinic 4/22/20 visit on was the first time to go to this clinic. The resident's representative stated the facility should not leave the resident unattended in the waiting room as the resident has a history of a [MEDICAL CONDITION] (TBI). Care plan review: A care plan problem dated 4/4/18 indicated the resident had a hearing deficit with difficulty communicating because of TBI. The TBI affected the resident's ability and willingness to participate in activities. The intervention revealed the resident would like staff to assist when the resident decides to attend the organized events. A care plan intervention dated 4/22/20 revealed when the resident goes out for a Physician appointment, that a staff should stay with the resident. The resident tends to become frustrated and refuse the appointment due to the resident's TBI. The intervention was updated on 6/23/20 to reflect the sister requested family or an escort to stay with the resident at outside medical appointments on 4/22/20. A care plan problem dated 12/9/16 indicated the resident requires assistance with activities of daily living (ADL's) related to right-sided weakness. An intervention dated 2/4/19 indicated the resident could assist one staff with a gait belt to stand at the sink for toileting tasks and perineal hygiene assistance during the day shift only. An intervention dated 4/4/18 indicated the resident required the moderate assist of 2 staff for transfers with a pivot disc/turner pro. Elopement and Fall Risk Assessments: The Elopement Risk Assessment V0714.1 dated 3/31/20 at 1:55 PM showed the resident disorientated in two spheres and unable to move independently in the wheelchair. The resident did not have a history of wandering. The resident had a [DIAGNOSES REDACTED]. The resident scored a ten which identified the resident at risk to wander. The Fall Risk Assessment V1013.1 dated 3/31/20 at 1:55 PM showed the resident with a score of 9, indicating moderate risk for falls. The Elopement Risk Assessment V0714.1 dated 5/15/20 at 10:44 AM showed the resident forgetful with a short attention span and could move independently in the wheelchair. The resident had no history of wandering. The resident did have a [DIAGNOSES REDACTED]. The resident scored a ten identifying the resident at risk to wander. The Fall Risk Assessment V1013.1 dated 5/15/20 at 10:42 AM showed that the resident with a score of 9, indicating moderate risk for falls. The daily skilled nursing assessment dated [DATE] at 6:46 PM completed by the DON stated that the resident had short term memory impairment. The assessment continued to show the resident orientation was only to only person and place with impaired decision-making ability. The daily skilled nursing assessment dated [DATE] at 7:28 PM completed by the DON stated the resident had short term memory impairment. The assessment continued to show the resident's orientation was to only person and place with impaired decision-making ability. Progress Notes: A progress note dated 4/22/20 at 5:36 PM revealed Staff I, Transportation, alerted the Director of Nursing (DON) that the resident wheeled away from the doctor's office due to the resident stating it took too long to be seen. The resident was found within the same building in a patient room. No injuries observed, family and doctor notified of this behavior. The progress note labeled 24 Hr Follow Up To Incident Report dated 4/23/20 with a creation date of 5/21/20 stated Late Entry revealed the driver alerted the DON that the resident wheeled himself away from the doctors' office due to resident saying it took too long to be seen. The resident was found within the same building in a patient room with no injuries observed. The family and doctor received notification of this behavior. An assessment of the resident was not applicable. New interventions following the incident identified as: driver not to leave the resident during appointments. No further notifications regarding the incident completed. No new injuries discovered due to the incident. The progress note labeled 1 Week Follow Up To Incident dated 4/29/20 at 4:35 AM with a creation date of 5/21/20 stated Late Entry revealed the driver alerted the DON that the resident wheeled himself away from the doctors' office due to the resident saying it took too long to be seen. The resident was found within the same building in a patient's room with no injuries observed. The family and doctor received notification of this behavior. An assessment of the resident was not applicable. New interventions following the incident identified as: was for the driver not to leave the resident during appointments. No further notifications regarding the incident completed. No new injuries discovered due to the incident. The progress note dated 4/22/20 at 4:36 PM labeled Communication - with Physician showed the clinic called to tell the staff that since the resident refused to come to the appointment that the nurse could have an order to remove the staples. The progress note dated 4/22/20 at 5:40 PM labeled Communication - with Family or Related Party indicated completion of the entry was late. The facility notified the resident's Power of Attorney (POA) regarding the resident leaving the doctor's appointment and not seeing the Surgeon. After the conversation, the POA voiced understanding that the resident became impulsive and left his appointment without being seen. The POA reported being thankful for the follow-up phone call. The progress note dated 4/22/20 at 6:19 PM labeled Communication - with Staff with a creation date of 6/22/20 at 9:23 AM by the DON identified going forward the facility did not plan to send the resident to any appointments alone. If the POA could not accompany the resident to doctor's appointments, the facility would make arrangements for the resident to have a staff member with him at all times while out to doctor's appointments. A progress note dated 4/22/20 at 5:42 PM identified the intervention following the incident as informing the van driver not to leave the resident unattended during appointments. Staff interviews: On 6/17/20 at 2:24 PM, Staff F, MDS/Care Plan Registered Nurse, reported the resident went to Des Moines to have staples removed following surgery. The van driver left the resident to park the van and planned to return. When the driver returned, the resident was gone. The resident left his appointment because he didn't want to be there. The resident then wheeled himself into an empty room. Once found, the resident was too late for the appointment, so they returned to the facility. The Administrator said that the incident did not need to be reported as the van driver left the resident with a nurse. When the driver returned to the clinic, the resident left the nurse. On 6/17/20 at 3:45 PM, Staff I said he provided the transportation for the resident to the appointment in Des Moines. When they arrived at the clinic, the staff stated there were a couple of people in front of the resident. Staff I reported telling the clinic staff that he needed to move the facility vehicle, and the clinic staff said it was no problem. Staff I said he parked the resident in between two chairs in the lobby before going down to move the facility van. Staff I stated he received a call from the clinic staff who reported the resident got upset because the resident was third instead of first. The clinic staff said that the resident began to push the wheelchair away from them and then got into the elevator. Staff I stated he went back up to the floor to speak to the clinic staff and Physician. The clinic staff reported the resident went towards the elevators. Staff I said after notifying security, he got back onto the elevator. Staff I stated he went to each floor and check with other staff. Staff I reported going into a conference room after seeing the resident in the doorway. The resident was calm, sorry, and knew he screwed up. The resident did not want Staff I to be mad with him. Once found, the resident repeatedly apologized for leaving the waiting area. Staff I took the resident back to the clinic, and the resident apologized to the clinic staff. The clinic staff said it was too late for the resident's appointment, so he could not be seen. During a follow-up interview on 6/17/20 at 4:02 PM, Staff I, said he stopped at the reception desk before going downstairs to move the van. The lady said there were a couple of appointments ahead of him that they would have him into the appointment and back out before he returned. After learning the resident left the clinic and got onto the elevator, Staff I said he rode up and down the elevators to look for the resident as the resident just went down on the elevator opposite of him. After the elevator, Staff I reported going up and down the stairs checking each floor

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F 0689 **Level of harm -** Immediate jeopardy **Residents Affected -** Few	(continued... from page 2) to make sure the resident wasn't there. Staff I stated the situation happened very fast but no longer than 15 to 20 minutes. Staff I (Van Driver) Undated Statement: An undated statement provided by the facility from Staff I indicated that on 4/22/20 Staff I drove the resident to an appointment in Des Moines. Once they arrived at the office, they went up to the third floor and met with the receptionist, who said they were in the right place. The receptionist told Staff I there were several people in front of the resident so that it would be a small wait. Staff I pushed the resident to the waiting area and told the resident that the doctor would see the resident shortly. Staff I told the receptionist that the van was parked out front and it needed to be moved. The receptionist said that it was fine. Staff I gave the receptionist a business card with Staff I's cellular (cell) phone number on it. Staff I left and went to get food from across the street of the hospital before parking the van in the parking lot. While Staff I ate, the receptionist called to report the resident refused care and became frustrated. Staff I moved the van back to the previous location in front of the hospital before returning to the clinic. Once Staff I got to the third floor, Staff I could not locate the resident. The receptionist reported the resident was mad and left the area towards the elevator, going down the opposite elevator Staff I came up on. Staff I went back to the entrance and spoke to the nurse taking temperatures who reported the resident did not come by her. Staff I then returned to the third floor in the opposite previously used elevator. Staff I went back to the receptionist, who stated the resident did not return to their floor. Staff I asked the receptionist to contact security to assist with finding the resident. Staff I returned to the elevator and went to the second floor before checking all the hallways and checking rooms that the resident could access. Then Staff I went to the first floor, where there were many corridors that the resident may have went down. This portion of the search was time-consuming but had a negative outcome on his location. Staff I moved to the stairwell and went back to the ground floor. While there, the same nurse reported not seeing the resident. Staff I gave the nurse his cell phone number in case the resident did come to that area. There, Staff I, went up the stairwell, checking each floor for the resident's movement. Upon returning to the third floor Staff I found the resident peeking from a door outside of the waiting room. The resident saw Staff I and reported that the resident messed up. The resident apologized for being a bother, and the resident wanted to tell the staff the resident was sorry. Staff I returned with the resident to the clinic area to allow the resident to apologize to the staff. Once the resident apologized, they left the hospital and returned to the facility. On 6/18/20 at 9:09 AM, the Administrator reported the standards were one driver and one resident per transport. The driver was not supposed to stay with the resident; they are to leave the resident with the medical professional. The facility only has two vans and two drivers. On 6/22/20 at 2:50 PM, the DON said the resident always went alone to appointments unless the resident's DPOA went with the resident. The team manager talked to the DPOA and notified the DON if the DPOA could not transport the resident. The transportation supervisor was notified and told no one is to leave Resident #1 alone, so this situation did not happen again. There was no education written. The DON did not know if any documentation was done about this as the DON was working in the Assisted Living at the time. On 6/23/20 at 10:34 AM, Staff L, Certified Nurses' Aide (CNA), said the resident was very cognitive. The resident could set up their television (TV), but anything could set the resident off. Then there are some days the resident is unable to say what is wrong. Some days, the resident would know the day but cannot tell who the President. The resident has a calendar. The resident does not know the staff by name but can recognize their voice and looks. On 6/23/20 at 11:29 AM, Staff K, CNA, reported the resident knows when the resident is in pain and able to report it to the staff. The resident can tell the staff if there is a problem with the [MEDICAL CONDITION] bag. The resident has a nightly routine, and if something is forgotten, the resident inform the staff. Staff K was not sure if the resident would know what to do if the resident were outside of the facility. In the evening, Staff K has to remind the resident two to three times that it is time for supper. If the resident was able to see a calendar, and it was updated, the resident would be able to say the date. The resident can identify the staff but not by their name. The resident has gone onto the patio but just stayed there. On 6/23/20 at 1:16 PM, Staff M, RN, stated the resident was pretty cognitive, but the resident apologized repeatedly. The resident apologizes whenever the [MEDICAL CONDITION] bag is changed as the resident feels its the resident's fault. Staff M said that staying in a familiar environment helped to keep the resident stable. Staff M reported surprise that more residents did not go to appointments with an escort. At a previous job, everyone went with an escort unless they were completely independent. Staff M said that when the resident apologizes, Staff M is unsure if the resident knows the reason for the apology. Staff M reported just seeing a paper from the DON that staff received education on 4/22/20 and something about the transportation staff. Staff M said the DON said this was for education on 4/22/20. Staff M reported that it was the first time to be educated about that situation. On 6/23/20 at 2:03 PM Staff N, Licensed Practical Nurse (LPN), reported that she did not know anything about education regarding the transportation policy. Staff N said the first time hearing about the information was from the surveyor. Staff N reported not working with the resident at all. On 6/23/20 at 2:23 PM, Staff O reported not regularly working with the resident. Staff O said that she remembered hearing about the situation with the resident at the clinic but did not personally remember getting educated about it before 6/23/20. On 6/23/20 at 4:08 PM, Staff A, RN, said that when hired, she received a brief explanation as to what the transportation's job duty was, but was not much on specifics. Staff A said she was familiar with completing BIMS on residents as the facility specifically educated on this for admissions or as needed. Staff A stated not being aware of any specific assessment related to transportation. Staff A said there was no education given because the nurses don't go to appointments, that is the transportation's job. Hospital clinic staff interview: During an interview on 6/23/20 at 2:51 PM, Hospital Clinic Staff #1, Receptionist, reported remembering the resident sitting in a wheelchair. However, the driver was not able to stay. The clinic had a long day that day, so they were slow. The resident kept asking about going back to see the doctor. When the resident couldn't go back to see the provider, the resident became frustrated and then suddenly used his legs to move the wheelchair and left the clinic area. The clinic manager attempted to stop the resident. The staff tried to get into touch with the driver but had problems reaching the driver. After reaching the driver, the driver came back to the floor. In the meantime, the resident disappeared out of the office. The staff started to look for the resident and called security, then the driver. The driver eventually brought the resident back, and the resident kept apologizing, but the resident did not want to stay. Hospital Clinic Staff #1 thought it was 5-10 minutes, ten minutes max that the resident's location was unknown. Hospital Clinic Staff #1 did not remember the driver asking if the resident could stay but did believe there was a receptionist there. Hospital Clinic Staff #1 stated if they knew the resident was mobile enough to wheel out of the clinic, the staff wouldn't have let the resident staff unaccompanied, but the staff did not know. Hospital Clinic Staff #1 said sometimes staff, family, or others come and sit with residents. This situation was the first time this issue ever happened since she worked at the facility since September or October of last year. On 6/23/20 at 4:20 PM, Hospital Clinic Staff #2, Certified Medical Assistant (CMA), reported the resident had an appointment scheduled with the emergent general surgeon. The clinic always sees patients once a week for one to one-half hour increments. The resident was to see the Surgeon at 2:00 PM. The driver brought the resident early to the appointment and dropped the resident off in the waiting room. The driver said he would be downstairs. The resident was placed into the waiting room. The clinic staff was unaware that the resident needed watching. Hospital Clinic Staff #2 reported that the staff wasn't instructed that the resident was nonverbal. The receptionist reported that the resident was yelling and angry. The resident kept saying the resident was done. Hospital Clinic Staff #2 stated that the resident would be seen next due to the resident being upset. Hospital Clinic Staff #2 went out to calm the resident and he continued to be angry. Hospital Clinic Staff #2 said their manager came out, as she was nearby, to stop the resident. They could not calm the resident down and left the clinic area. The resident got onto the elevator then went wandering around the hospital for about twenty minutes. The clinic staff called security and attempted to call the driver. The clinic staff was concerned as the resident needed to reschedule the appointment and the resident required an escort. The clinic staff asks for a companion for nursing home residents. However, they get some that are cognitive, and they don't usually screen for the need for an escort. Physician interview: On 6/24/20 at 7:57 AM, the resident's Primary Medical Doctor, Physician, reported not being aware of the situation but had taken a leave for the past six months. The Advanced Registered Nurse Practitioner (ARNP) assisted with covering the Physician's patients. The Physician reported that based on the resident's medical diagnoses, the resident has a cognitive impairment without documentation of dementia, [MEDICAL CONDITION], and mood disorder. The resident had all of these medical issues and would be safer if with someone with him. It would have been better if the driver could have moved the van after the appointment, but he was not there and was unsure of the situation. The Physician said he did not expect the drivers to know the resident's cognition. Residents with this [DIAGNOSES REDACTED]. This resident should not have been left alone. Residents with these conditions, if not in their natural settings as with residents with dementia, can become upset waiting. This situation is similar to leaving a child in the waiting area while the adult sat in a car. The loop lacked completion between the driver, the clinic, and the facility.

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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** - Immediate jeopardy **Residents Affected** - Few	(continued... from page 3) ARNP Interview: On 6/24/20 at 8:41 AM, the ARNP stated the resident's cognition varies. The ARNP reported overseeing the residents in the nursing back in January 2020. Since taking over, the ARNP saw the resident twice at the end of April in person and once in June through telehealth. The ARNP reported having a vague memory of seeing fax regarding the resident's incident in April. The ARNP did not recall notification that the resident never saw the Surgeon when the incident occurred. Since the resident never saw the Surgeon, the ARNP was concerned due to the intensity of the resident's surgery. The resident had staples from the sternum through the abdomen. Due to the current concern with the resident's incision, the ARNP was hoping the issues were with the sutures and not the surgery. The ARNP reported seeing the resident on April 13th without problems with the resident's surgical site. The ARNP said she monitored the resident's laboratory values (labs) and noted an increased sedimentation rate. The ARNP instructed the facility to notify the Surgeon. The ARNP said she only met the resident once in person and then once on telehealth. The ARNP reported being very concerned when the resident had staples that the resident would mess with the staples. The ARNP said thankfully, the resident did not mess with the staples and luckily did not get pneumonia. Psychiatry Note: A Psychiatry Note dated 6/25/19 indicated the resident was awake, alert, and orientated times three. The resident was wheelchair bound with left sided paralysis. The resident had minimal spontaneous speech. The resident had marginal insight and impaired judgement. His fund of knowledge was below average. The resident lived in a nursing home and was reliant upon others for twenty-four hours, seven days week care with chronic medical ailments. In the area protective factors the note revealed the resident received clinical care for mental and physical disorders and had access to a variety of clinical interventions and support for help seeking. The resident had restricted access to highly lethal means of suicide. Education: The Administrator provided an undated form identifying completion of education on 4/22/20 to nursing and transportation staff regarding the resident's transportation. The form said the family elected to have an escort to medical appointments. The DON and Administrator discussed with the Maintenance/Transportation Supervisor that nursing staff would communicate instructions regarding an escort for each resident at the time of transport. The staff received the facility's policy on transportation for review. The form continued to indicate that on 4/22/20 the facility provided education to the nursing staff re-iterating the facility's transportation policy by the Administration staff. The nursing staff received re-education on the policy and residents should have a family member, a facility escort, or a volunteer present as required based on the resident's assessment, for the duration of the medical appointment. The resident and or family may also choose to have an escort at any time. The staff received the facility's policy on transportation for review. Policy review: The Resident Transportation and Escort Policy - Medical revised 8/12 indicated the facility informed residents and/or families on admission that the facility did not routinely provide an escort to accompany the resident to medical appointments. If a resident required an escort to the medical appointment, the expectation is that the resident or the family arrange for someone to accompany the resident. If the resident and or family are unable to locate an escort, the facility will help find a volunteer that can provide the service. If the facility could not locate a volunteer, the facility would arrange for a paid escort. Abatement: The facility abated the immediate jeopardy on 4/22/20 after education of staff on the directive that no resident is to go to appointments without an escort other than [MEDICAL TREATMENT] residents. This abatement resulted in past noncompliance for the facility. The State Agency notified the facility of immediate jeopardy on June 22, 2020.
F 0880 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Some	**Provide and implement an infection prevention and control program.** Based on observations, interviews, and record reviews, the facility failed to provide appropriate infection control techniques. The facility reported a census of 70 residents. Findings include: During an interview on 6/17/20 at 11:40 AM, Staff A, Registered Nurse (RN), reported staff receives a new face mask every day and every time they enter an isolation room. Staff A reported staff to clean the face shields with Sani wipes whenever entering or exiting an isolation room. Staff A stated staff are to wash their face shields at the beginning and end of every shift. The face shields are store in room C-11 with the door closed. Observation revealed on 6/17/20 at 1:12 PM, a dietary staff walking through the hall, adjusting their face mask, and continued walking without hand hygiene. Observation revealed on 6/17/20 at 1:29 PM, Staff B, Certified Nurses' Aide (CNA), with the face shield in the up position on the face. Staff B used a bare hands and pushed the face shield down onto her face. Without completing hand hygiene, Staff B assisted a resident to the sink to wash their hands. Then Staff B sanitized her hands. On 6/17/20 at 1:59 PM, observation revealed Staff C, CNA, and Staff D, CNA, look through the box of face shields. After searching and determining their face shields were not in the box, the staff removed two different face shields. Staff D applied the face shield to her face without cleansing prior to application. During an interview on 6/17/20 at 1:59 PM, Staff C, and Staff D reported the facility ran out of face shields and staff has been sharing the face shields. Staff D said they sanitize them front and back at the beginning and the end of their shift. During an observation on 6/17/20 at 2:01 PM, observe two staff leaving for the day. The staff entered the room with shields on their faces, removed the shields, and placed them into the box with the other shields. During an observation on 6/17/20 at 2:06 PM, Staff H CNA entered the room and removed the face shield from her face and tossed it into the box without disinfecting the shield. During an observation on 6/17/20 at 2:07 PM, Staff E, CNA, entered the room and placed her face shield into the box without disinfecting. During an observation on 6/17/20 at 2:14 PM, two additional staff entered the room, removed face shields from their faces, and placed them into the box with disinfecting the shield after removal from the face. The policy labeled Appropriately Managing and Using PPE (Personal Protective Equipment) During Shortages - COVID-19 Pandemic Supply Management with a revision date of 4/5/20 indicated to extend the use of eye and face protection, eye protection should be sanitized by submerging in an approved disinfecting solution. The policy noted that once a face shield is sanitized and dried, eyewear could be reassigned to employees working subsequent shifts; it does not need to be permanently assigned to each employee -- that would significantly increase the number of PPE needed. Suggested products for sanitation are approved disinfectants from Heartland Paper Company for Disinfecting Reusable Eyewear: 1. Quat Stat 5 - Submerge in the solution for at least 5 minutes, hang dry. 2. Triforce - Submerge in the solution for at least 5 minutes, hang dry. 3. PH7Q Dual - Submerge in the solution for at least 10 minutes, hang dry. 4. pH7Q - Submerge in the solution for at least 10 minutes, hang dry. During an interview on 6/17/20 at 3:05 PM, the Administrator stated the facility never had a chemical to submerge the face shields. They were told to use germicidal wipes or Sani wipes to clean the face shields. The Administrator did not believe the facility had the chemicals listed in the policy available.