STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	165161	A. BUILDING _____ B. WING _____	**08/11/2020**

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
TOUCHSTONE HEALTHCARE COMMUNITY	**1800 INDIAN HILLS DRIVE SIOUX CITY, IA 51104**

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F 0554 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	**Allow residents to self-administer drugs if determined clinically appropriate.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, record review and staff interview the facility failed to assure the facility administered medication by a licensed healthcare professional for 1 of 26 residents reviewed (Resident #24) The facility reported a census of 69 residents. Findings include: A Minimum Data Set ((MDS) dated [DATE], assessed Resident #24 with a Brief Interview for Mental Status (BIMS) score of 5 which indicated severely impaired cognition. The resident required extensive assistance of 2 staff with bed mobility, transferring and toileting. A care plan last updated on 4/1/20 revealed the resident required special services due to [DIAGNOSES REDACTED]. The care plan included a focus area of communication due to difficulty understanding and being understood. The care plan directed staff to allow adequate time to respond, request clarification and to make eye contact when speaking to the resident. The physicians order set signed 6/18/20, revealed [DIAGNOSES REDACTED]. Observation showed on 4/14/20 at 8:00 AM, the resident seated in a wheel chair in her room with the bedside table in front of her. The resident held an empty plastic cup in her hand and observation showed a small medication cup in front of her with several pills inside. Staff V CNA (certified nurse aide) worked in the room making the residents bed. The resident held up her empty water glass toward Staff V and at that time Staff V asked if the resident if she needed more water. The surveyor asked Staff V if the resident usually took her medication without a licensed nurse present and she said she did not know and added she usually did not work on Resident #24's hall. Observation revealed on 4/14/20 at 8:03 a medication cart down the hallway from the resident's room and the chart for Resident #24 pulled up on the computer with no nurse in the hall. At 8:05 AM Staff S CMA (certified medication aide) came through the closed double doors onto the unit and went to the medication cart. The surveyor asked Staff S about Resident #24 taking her medications without supervision and Staff S stated she thought the resident took her medications and said that she usually stayed with the residents until they took the medications. According to the electronic chart, the medications administered by Staff S included: [MEDICATION NAME] 250 milligrams (mg.) for [MEDICAL CONDITION], Aspirin 81 mg. blood thinner, AzoCranberry with [MEDICATION NAME] Vitamin C daily, [MEDICATION NAME] 0.25 (vitamin) micrograms (mcg.), [MEDICATION NAME] (diuretic) 40 mg., [MEDICATION NAME] (for low [MEDICAL CONDITION]) 125 mcg., [MEDICATION NAME] (laxative)17 grams, Potassium ER (electrolyte) 20 MEQ, Senna (laxative) 8.6 mg., [MEDICATION NAME] (diuretic)25 mg., Vitamin B-12 1000 mg., Calcium 600 + vitamin one tab., [MEDICATION NAME] (diabetes) 500 mg., and [MEDICATION NAME] (anticonvulsant) 300 mg. On 7/16/20 at 7:45 AM, the Director of Nursing (DON) stated the facility assesses residents to determine if they can safely take their medication unsupervised. The DON acknowledged Resident #24 not at a cognitive level to administer her own medications. A policy last revised in May of 2020 titled: Self Administration of Medications, directed staff to assess residents for cognitive ability to self-administered medications. Along with the assessment, staff need to obtain a physician's orders [REDACTED].
F 0584 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Some	**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.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation and interviews the facility failed to provide a clean, comfortable, and homelike environment. Facility reported a census of sixty-nine (69) residents. Findings include: 1. On 7/15/20 at 5:35 AM Staff J Licensed Practical Nurse (LPN) stated staff informed maintenance several times during the last three months about water leaking from roof and water damage on the ceiling by central nursing station in main facility area. Staff J also identified the ceiling in the dining room as not very good. Observation of the ceiling area in the main area above the vending machines showed water damage to the area in several different spots covering approximately three by three foot area in one spot and three foot by four foot in another spot. Observation of the dining room ceiling showed bowed and discolored ceiling tiles that were bowed and discolored making the room very dingy. Observation of ceiling above screening area at main entrance has an area about 1 foot by 2 feet of peeling textured covering. 2. On 7/14/20 at 8:47 AM, observation of the floor outside room B16 showed it covered with water almost to the middle of the hallway. Three residents sat in the common room with the water dividing the hall and common room. On 7/14/20 at 8:49 AM, observation of room B16 showed it flooded with water from the window to the door of the room with no wet floor signs noted near the room or in the hallway and one wet floor sign seen by room B7. On 7/14/20 at 8:51 AM, the resident of one of the affected rooms reported not able to enter his room to use the bathroom due to water being on the floor. On 7/14/20 at 8:51 AM, Staff H, Registered Nurse (RN), said she knew there was water on the floor of room B16. The staff notified maintenance, and they were waiting for a shop vacuum. On 7/14/20 at 8:54 AM, Staff H took a wet floor sign from the middle of the hallway, folded it up, and placed it against the wall by room B6. On 7/14/20 at 8:58 AM, the floor remained wet with no wet floor sign and no maintenance staff. On 7/14/20 at 9:09 AM, Staff U, Certified Nurses' Aide (CNA), placed two wet floor signs on each side of the water in the hallway near room B16. Staff then took a towel and dried the floor of the hall. On 7/14/20 at 9:11 AM, the Maintenance man arrived at Bayberry Hall. On 7/14/20 at 9:16 AM, the Maintenance man exited Bayberry Hall. On 7/15/20 at 11:18 AM, observed the broken pipe on the floor beneath the sink in the women's bathroom. The ceiling around the vent showed peeling plaster, and the sprinkler head showed a thick layer of dust. 3. Observation of Resident #8's room on 7/14/20 at 10:40 AM, showed a large transparent bag of empty soda cans and bottles on the floor in the corner of his room. Observation on 7/14/20 at 11:00 AM in the room of Resident #4, revealed a large transparent garbage bag filled with soda cans and bottles on the floor in the corner of the room. The resident voiced she needed staff to take them to the redemption center for redemption. On 7/14/20 at 2:30 PM, Staff W acknowledged many of the residents like to drink soda and the empty cans accumulated over the past couple of months. Staff W stated staff took cans and bottles in for redemption for the residents but since the Covid-19 restrictions, many recycling businesses closed and they could not redeem the cans. 4. Observation on 7/21/20 at 8:15 AM showed Resident #26's room with the bed bed unmade and two trash cans next to the bed full of trash. Resident #26 admitted to the hospital on [DATE] and did not yet return from the hospital.
F 0607 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	**Develop and implement policies and procedures to prevent abuse, neglect, and theft.** Based on personnel file reviews, facility policy review and staff interview, the facility failed to provide dependent adult abuse (DAA) training within 6 months of hire for 1 of 3 current employees sampled. (Staff D) The facility identified a census of 69 residents. Findings include: 1. The personnel file for Staff D, Certified Nursing Assistant (CNA) documented a hire date of 9/25/19. The file did not contain documentation of dependent adult abuse training. On 7/22/20 at 2:45 PM Staff J (human resources) stated she did not know why the personnel file did not contain a copy of DAA training since Staff D

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F 0607 **Level of harm -** Minimal harm or potential for actual harm **Residents Affected -** Few	(continued... from page 1) completed it through the college. Staff D tried to communicate with the college to obtain a copy, but could not obtain it. Staff J identified employee should have proof of training within six months of hire. Staff J stated employees receive information on how to obtain the training on the Department of Human Services with Iowa State. Review of staff orientation checklist contained an orientation plan for vulnerable Adult and Mandated Reporting Review of the Hiring Policy dated 9/2015 lacked information regarding a requirement for DAA training.
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, interviews and record review, the facility failed to update and implement a comprehensive care plan to accurately reflect the needs for 2 of four resident reviewed (Resident #3 and Resident #12). The facility reported a census of sixty nine residents. Findings include: 1. A Minimum Data Set (MDS) completed with an Assessment Reference Date (ARD) of 5/5/20 for Resident # 3 showed a Brief Interview for Mental Status (BIMS) score of 6 indicating severe cognitive impairment. The Resident's [DIAGNOSES REDACTED]. A care plan with initiation date of 2/20/19 revealed the resident received a regular diet. The care plan directed staff to ensure all personal items and call light are within reach with an initiated date of 2/20/2019 for a fall intervention. The care plan also directed staff to hang reminder signs in room to remind the resident to wait for help with an initiated date of 3/11/19 for fall intervention. Physician orders [REDACTED]. On 7/8/20 at 1:35 pm the dietary manager stated the facility knew the resident received a new order for a mechanical soft diet. Progress notes revealed the resident had falls on 2/28/20 at 4:45 AM, 3/10/20 at 5:51 PM, 3/20/20 at 12:30 PM, 3/25/20 at 6:30 PM, 5/15/20 at 3:45 PM, 6/7/20 at 2:15 AM, and 7/11/20 at 4:06 PM On 7/13/20 at 10:08 AM observation showed the resident in his room sitting in a recliner with the recliner positioned across the room in the east corner. Observation showed the call light cord looped around the box mounted on the west wall with the roommate's bed positioned in front of the call light box thus making the resident unable to reach the call light. The room did not contain signage directing the resident to wait for assistance. The Person Center Plan of Care Policy with revision date of 11/ revealed the facility should review and revise the plan of care. On 7/16/20 at 9:45 AM the Director of Nursing (DON) stated staff tries to update care plans daily and review them during care plan conferences. The DON identified revising diet orders as part of nursing's responsibility. The DON stated all residents should have call lights in reach. 2. The MDS completed for Resident #12 with an ARD of 6/22/20 showed a BIMS score of 14, indicating intact cognition. The resident required total assistance of two staff with transfers. The resident had one fall with major injury since the prior assessment. The resident had an impairment to one side of the lower extremity. The resident had [DIAGNOSES REDACTED]. Progress notes dated 5/15/20 at 2:32 PM identified staff called the nurse called to the resident's room. The resident laid on their left side on the floor, and was incontinent of bowel movement (BM). The Certified Nurses' Aide (CNA) stated the mechanical lift strap broke. The resident fell from the lift during the transfer. The resident complained of their back and hips hurting. The resident did not want to be moved. The nurse was unable to reach the primary physician by phone, 911 called-the resident's contact listed on the chart notified by phone. The resident left per ambulance at approximately 3:00 PM. An incident report dated 5/15/20 at 3:36 PM said the resident laid on the floor on their left side at the foot of the lift when the nurse entered the room at 2:32 PM. The resident complained of pain nine on a ten-point scale, indicating severe pain to the left leg and hip. No bleeding, bruising, or bumps visualized to head arms, torso, or legs. The resident was able to move the arms and right leg without difficulty. The resident was orientated to person, place, time, and situation. The resident was taken to the hospital by ambulance. The witness to the fall was Staff D, Certified Nurses' Aide, CNA. The care plan problem with a revision date of 4/18/18 showed that the resident required assistance with transfers. The resident could make minor changes in position while in bed. The resident was currently non-ambulatory. The goal dated 4/11/19 specified the resident would be safe in all movements. The intervention with a revision date of 2/6/19 showed the resident required a mechanical lift and two staff to transfer. Interviews On 7/7/20 at 7:32 AM, the resident reported remembering the fall as the resident got up for physical therapy (PT). The resident waited with the staff for another person to come help get the resident into bed. The staff hooked the resident up to the mechanical lift slip, lifted the resident into the air, and the strap snapped resulting in a fall that fractured the resident's pelvic bone. The resident said staff should have wrapped the strap twice twice but they only wrapped it once. The resident reported hitting the left hip on the ground during the fall. The resident said now the resident makes sure to hold on to prevent it from happening again and he also ensures the lift is double strapped around the machine. The resident stated there was only one staff (Staff D), doing the transfer that day. The resident said that all slings are brand new now. On 7/7/20 at 2:30 PM, Staff D reported attempting to ask another aide to assist with the resident's transfer but they were busy. Staff D identified nothing wrong with the straps, but when she went to pull the resident back, the straps broke. Staff D explained moving the resident off the mechanical lift to get the resident off the mechanical lift's leg. Staff D reported transferring the resident per self with the mechanical lift and did not feel like having another staff could have prevented the fall. Staff D reported that all of the facility's mechanical lift slings were a little old looking. Staff D said that she fully believed that if she had doubled all the straps, it could've prevented the fall. Staff D stated this was not the first time to transfer the resident alone due to shortage of staff. Director of Nursing (DON) interview On 7/27/20 at 11:40 AM, the DON reported it is the expectation to discard slings at the first sign of wear. Staff are to follow the care plan and the facility disciplined the staff member for not following it.
F 0658 **Level of harm -** Minimal harm or potential for actual harm **Residents Affected -** Few	**Ensure services provided by the nursing facility meet professional standards of quality.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interviews and record reviews, the facility failed to receive and or implement physician orders [REDACTED].#6, #1, and #26). The facility reported a census of 69 residents. Findings include: Chart review 1. A Minimum Data Set (MDS) completed for Resident #6 with an Assessment Reference Date (ARD) of 4/27/20 showed a Brief Interview for Mental Status (BIMS) score of 11, indicating moderate cognitive impairment. The resident took anti-anxiety, anti-[MEDICAL CONDITION], and antidepressants for seven days in the lookback period. The resident [DIAGNOSES REDACTED]. A Patient Visit Note dated 6/19/20 showed the following orders a. Discontinue [MEDICATION NAME] (antipsychotic) as soon as possible (ASAP) to avoid polypharmacy. b. Decrease scheduled [MEDICATION NAME] (antipsychotic) to 100 mg twice daily (BID) due to excessive sedation. c. Start [MEDICATION NAME] (antidepressant) 15 milligrams (mg) by mouth (PO) at bedtime (HS) to target her depression and other unspecified anxiety. d. Continue the rest of the current [MEDICAL CONDITION] medications e. Status update in two weeks. f. The next follow-up in two months or sooner if needed. The Medication Administration Record [REDACTED]. [MEDICATION NAME] tablet 5 mg (aripiprazole) 2.5 mg by mouth one time a day related to anxiety disorder, unspecified with a start date of 10/19/19, and a discontinue date of 6/29/20. No missing documentation noted. b. Aripiprazole tablet 5 mg give 0.5 tablets by mouth one time a day related to unspecified dementia without behavioral disturbance with a start date of 6/30/20 and a discontinued date of 7/13/20. No missing documentation noted. c. [MEDICATION NAME] tablet ([MEDICATION NAME]) 100 mg by mouth one time a day related to [MEDICAL CONDITION], unspecified with a start date of 2/2/18, and a discontinued date of 7/13/20. No missing documentation noted. d. [MEDICATION NAME] tablet ([MEDICATION NAME]) 125 mg by mouth one time a day related to [MEDICAL CONDITION], unspecified with a start date of 2/2/18, and a discontinued date of 7/13/20. No missing documentation noted. f. The MAR indicated [REDACTED]. The progress notes lack documentation related to the resident's appointment or medication changes from the visit on 6/19/20. Interview On 7/13/20 at 4:30 PM, the Director of Nursing (DON) said the order went directly to Medical Records. They scanned the form directly into the resident's chart. The nurse who took care of the resident told the DON she never saw or knew about the psychiatrist's order. The order was never known about it as it went straight to Medical Records. 2. A MDS with an ARD of 3/2/20 for Resident #1 showed a BIMS score of 12 which indicated moderate cognitive impairment. MDS shows resident #1 to have a [DIAGNOSES REDACTED]. The resident fell on [DATE] at 5:22 AM, transferred to the emergency department on 3/31/20 at 6:04 AM, returned to the facility on [DATE], passed away on 4/10/20 at 3:00 AM physician's orders [REDACTED]. A PT Evaluation and Plan of Treatment dated 11/15/19 by Staff G showed bed mobility not tested . Review of PT Progress notes with services through 11/15/19 through 12/30/19 showed no bed mobility goals or assessments. A PT Discharge Summary dated 1/3/20 and signed by Staff G showed discharge status and recommendations with functional outcomes of bed

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F 0658 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	(continued... from page 2) mobility DNT (did not test). On 7/23/20 at 8:00 AM Staff EE physical therapist assistant stated PT did not see the resident after the discharge date of [DATE]. On 7/23/20 at 11:15 AM the DON stated staff should implement all physician orders. The facility failed ensure a PT order to assess and treat bed mobility was followed. 3. A MDS dated [DATE] assessed Resident #26 with a BIMS score of 14 out of 15, indicating intact cognitive ability. The electronic chart documented the resident had [DIAGNOSES REDACTED]. According to the MDS, the resident required limited help with one person assistance for bed mobility and extensive assistance with one person for toileting. The care plan last updated on 6/8/20, indicated Resident #26 admitted to the facility with a Groshong device to receive intravenous antibiotic for osteo[DIAGNOSES REDACTED] and received [MEDICAL TREATMENT] treatment three times a week for end stage [MEDICAL CONDITIONS]. Progress notes showed on 7/15/20 at 5:28 p.m. the resident received supplemental oxygen due to low oxygen saturation levels. Oxygen treatment continued on 7/16/20. On 7/17/20 the resident admitted to the hospital. Resident #26 returned from the hospital on [DATE] with supplemental oxygen. The electronic chart lacked a physician's orders [REDACTED]. On 7/23/20 at 9:34 AM, the surveyor asked Staff FF LPN (licensed practical nurse) how many liters of oxygen the resident used. Staff FF said she thought 2 liters but did not know for sure. When Staff FF attempted to look up the physicians order, she could not locate an order for [REDACTED]. On 7/27/20 at 12:55 PM, the DON said that she expected a physician order [REDACTED].
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 clinical record review, facility policies, interviews and observations, the facility failed to ensure that a resident who could not carry out activities of daily living received the necessary services to maintain grooming and personal hygiene for 7 out of 26 residents reviewed (Residents #8, #7, #19, #12, #17, #25 and #14). 1. Resident #8's Minimum Data Set (MDS) dated [DATE] revealed the resident with [DIAGNOSES REDACTED]. The facility did not complete the Brief Interview for Mental Status (BIMS) test and the MDS identified the resident as rarely/never understood. The resident required extensive assistance of two staff for bed mobility and was totally dependent with the assistance of 2 staff for transfers, toileting and bathing. A care plan dated 5/5/20 revealed the resident could not voice his likes and dislikes to staff regarding activities due to his high degree of physical and cognitive limitations. The care plan indicated the resident could not care for himself or communicate his needs. Observation on 7/9/20 at 8:20 AM showed Resident #21 and Resident #8 sat in their wheel chairs. Resident #8 could not communicate and his hands, arms and legs appeared severely contractured. When asked about assistance with activities of daily living (ADL) Resident #21 stated he could perform most of his own ADL's. Resident #21 said he missed getting his bath on Monday of that week because of shortage of staff and one aide working. When asked if staff offered his bath later or if he needed to wait for his next bath, the resident stated he had to wait for the next bath day. Resident #21 then stated his roommate, can't speak for himself. He said that the overnight shift rarely checks on his roommate and sometimes the roommate is covered in poop by morning. Resident #21 said staff puts Resident #8 to bed in the afternoon for a nap and he stays there until the next morning. This happens often. The 2-10 shift serves Resident #8 his meal in bed and they may change him once or twice but staff rarely checked him on the 10 pm shift and last night staff did not come in at all. On 7/22/20 a review of the clinical chart revealed that there were no bath or showers documented for the month of July. At 9:00 AM on 7/22/20 further bath documentation was requested from the Director of Nursing but none was provided. On 7/22/20 at 13:48 it was documented in the electronic chart that the resident had a bed bath. 2. Resident #7's MDS dated [DATE]th 2020 assessed the resident with a BIMS score of 10 (moderate cognitive deficit). The resident required extensive assistance of 2 staff with bed mobility, toileting and transfers. The MDS revealed the resident required physical help in part of bathing activity. The resident had [DIAGNOSES REDACTED]. A care plan last updated 5/4/20 revealed the resident required the assistance of one staff with bathing and the resident wished to participate in dressing, grooming and bathing. The resident's electronic medical record (EMR) and bath records revealed Resident #7 had only two showers for the entire month of May 2020. In the month of July 2020 bath records showed she was only offered bed baths. On 7/23/20 at 2:00 PM, Resident #7 stated she couldn't remember the last time that she received a shower and she would like to have one. When asked about getting bed baths she stated that she didn't know what that was. 3. The MDS completed for Resident #12 with an ARD of 6/22/20 showed a BIMS score of 14, indicating intact cognition. The resident required total assistance of two staff with transfers. The resident had one fall with major injury since the prior assessment. The resident had an impairment to one side of the lower extremity. The resident had [DIAGNOSES REDACTED]. Interviews On 7/9/20 at 11:37 AM, the resident said he did not receive baths. Staff tell the resident they are the only staff working and don't have time. The resident stated he should get a shower the next day. On 7/20/20 at 10:45 AM, the resident reported not having a shower or a bed bath for many weeks. The resident identified his chances of getting a shower as better before the [MEDICAL CONDITION]. Now the facility does not have enough staff to give baths and showers. The resident prefers a shower. On 7/21/20 at 8:45 AM, the resident reported not receiving a bath the day before. The resident stated he should receive a shower before a scheduled surgery this Friday. Record review The EMR showed the only bath documented as a bed bath on 6/13/20 from 6/7/20 through 7/7/20. Paper bath sheets completed show the resident had bed baths on the following dates 6/9/20 6/20/20 6/27/20 7/4/20 Paper bath sheets completed show the resident had showers on the following dates 6/16/20 6/23/20 6/30/20 7/7/20 4. The MDS completed for Resident #17 with an ARD of 7/15/20 showed a BIMS score of 12, indicating moderate cognitive impairment. The resident had one fall with major injury since prior assessment or admission. The resident required total assistance of two staff with transfers in the seven day lookback period. The resident required limited assistance of one staff with eating in the seven day lookback period. The resident had impairment to bilateral lower extremities. The resident had [DIAGNOSES REDACTED]. Interview On 7/13/20 at 1:10 PM, the resident reported not receiving baths but did have a bed bath that morning. The resident said that was the first time that they ever received one of those. The resident stated she would like to have a bath. The resident reported that they had false teeth and cleaned them with a toothette, but the teeth were not removed to be brushed as the staff never did that. Record Review The electronic health record showed the following dates documented that the resident had a bed bath 7/8/20, 7/9/20, 7/14/20, and 7/22/20. The care plan problem dated 6/22/17 showed that the resident required staff assistance with dressing, grooming, and bathing. The goal dated 11/3/18 explained that the resident did not want a decline in their activities of daily living. The intervention dated 2/6/19 documented the resident required staff assistance of one with dressing, grooming, and bathing. The resident was blind in the right eye with normal vision in the left eye. The resident has adapted to the vision, and it did not affect their self-care abilities. 5. The MDS completed for Resident #14 with an ARD of 6/29/20 showed a BIMS score of 6 indicating severe cognitive impairment. The resident required extensive assistance of one staff with personal hygiene - how the resident maintains personal hygiene, including combing hair, brushing teeth, shaving, applying makeup, washing/drying face and hands (excludes baths and showers) in the seven days of the lookback period. The resident required total dependence of one person for bathing in the seven days of the lookback period. The resident required extensive assistance of one staff with eating. The resident had [DIAGNOSES REDACTED]. Interviews On 7/6/20 at 6:27 PM, the Resident's Representative A reported that when the resident discharged to home on Hospice, the resident had clumps of something in his mouth. The resident's face and hands appeared dirty. On 7/6/20 at 6:45 PM, the Resident's Representative B said the resident discharged from the facility to home on Hospice. The resident arrived home with white gunk caked in his mouth. The family needed to use a sponge on a stick to pull the food out. The resident had not eaten in one week so the food in his mouth had been there that long. The resident's hands and face appeared dirty. The resident was soiled when the transportation staff arrived. After the resident was cleaned, he had a big split in his lip. On 7/7/20 at 9:56 AM, the [MEDICAL TREATMENT] nurse reported only seeing the resident once for his first treatment on 6/22/20. At that time, the nurse did not observe any concerns with the resident not clean. On 7/7/20 at 10:00 AM, the Hospice Nurse reported being at the resident's house when the resident arrived from the facility. The Hospice Nurse remembered the ambulance crew taking a while to come with the resident from the facility. The paramedics reported having to wait thirty minutes while the staff cleaned the resident due to stool incontinence. When the resident arrived home, his gown was covered entirely with food. The resident's daughter and the Hospice Nurse worked to clean out the resident's mouth and removed several chunks of unknown white objects from the resident's cheeks. The Hospice Nurse reported not knowing the last time the resident ate.

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F 0677 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Some	(continued... from page 3) The Hospice Nurse said she didn't see the resident before hospice admission as the resident was not their client. The Hospice Nurse stated she would not have let the resident go home like that to prevent the family from seeing them like that. The Hospice Nurse reported that the facility was aware of the resident's transfer time of 2:00 PM as it was prearranged. On 7/7/20 at 11:11 AM, the Paramedic reported providing transportation for the resident. The Paramedic said the resident was not shaved, and food was on the gown. The overall appearance of the resident was very dirty. The stubble noted on the resident's face appeared to be longer than one day of stubble. The resident's room was very dirty. The resident was soiled, and the bedding was very soiled. Once the resident arrived home, the Paramedic reported apologizing to the family due to the resident's appearance and the sheet. The sheet used to transfer the resident onto the cart, and it was very dirty. The resident was challenging to move due to his condition. They attempted to transfer the resident with the mechanical lift but could not as the resident became very stiff. The facility reported that the paramedics were to take belongings, but nothing was packed. The Paramedic said that they were unable to take the belongings as there was no space. The facility's staff became annoyed as Hospice told them the paramedics would take the belongings. There was no paperwork prepared for the resident to discharge. The Paramedic reported having to wait 40-45 minutes before they left with the resident. The Paramedic said they thought the facility would show some care regarding the resident's appearance. On 7/7/20 at 12:10 PM, the resident's daughter, reported having a picture of the stuff that was removed from the resident's mouth. The daughter said it appeared to be about 12 cloves of garlic removed. Afterward, the resident had sores on their tongue. The resident's mouth and lips were parched. On 7/13/20 at 12:39 PM, the Dietary Manager reported resident started on regular food and went to mechanical soft food. The Dietary Manager said the resident was on a renal diet and did not like pork because it upset their stomach. On 7/13/20 at 12:10 PM, the Speech Therapist (ST) reported the resident came into the facility on a regular diet for the first day the resident was able to tolerate regular food. The diet was downgraded to a mechanical soft diet on 6/24/20. The ST stated the reason for the change was they didn't want the resident to fall asleep with a big chunk of food in their mouth. After the resident's evaluation, the ST reported cleaning the resident's mouth before leaving. The ST did not observe any food in the resident's mouth at the beginning of the treatment. Record review The Follow-up Question Report dated from 5/13/20 through 6/29/20 showed not applicable for the resident's bathing self-performance on 6/1/20 and 6/11/20. The paper Bath Sheet showed the resident received a bed bath on 5/18/20, 5/25/20, and 6/1/20. The census report showed an admission date of [DATE]. On 6/6/20, the resident went on unpaid therapeutic leave. The resident readmitted to the facility on [DATE] and discharged home on[DATE]. Progress notes dated 6/23/20 at 11:30 AM documented the resident went to [MEDICAL TREATMENT] and appeared clean, dry, and appropriately dressed. Progress notes dated 6/23/20 at 2:32 PM showed the resident unable to complete the consent forms and would not have [MEDICAL TREATMENT] until the family could complete the paperwork. The resident's next [MEDICAL TREATMENT] appointment scheduled for 7:00 AM on 6/24/20. Progress notes dated 6/23/20 at 4:29 PM showed the facility informed the physician the resident pocketed food. Progress notes dated 6/24/20 at 6:40 AM documented the resident left for [MEDICAL TREATMENT]. Progress note dated 6/24/20 at 12:53 PM revealed the resident returned to the facility from [MEDICAL TREATMENT]. Progress notes dated 6/24/20 1:42 PM identified ST assessed the resident and downgraded the resident's diet to mechanical soft. A Nursing-Dietary Communication Form dated 6/24/20, noted on 6/25/20 by nursing showed the resident changed to a renal mechanical soft diet with regular liquids due to an evaluation completed by ST. Progress notes dated 6/26/20 10:43 AM revealed the nurse received a message from the Director of Nursing (DON) to call the Hospice Nurse as the resident's family wants the resident to go home with them on Hospice. The nurse talked to the resident's daughter and wife, who confirmed this. The Hospice Nurse stated she would get everything arranged, including having the doctor send a discharge order to the facility allowing him to go home. The Social Worker relayed this to the floor nurse and the nurse management team. The progress note dated 6/27/20 at 4:59 PM showed the resident refused to get ready for [MEDICAL TREATMENT]. The [MEDICAL TREATMENT] center contacted twice, but no answer. The primary care provider notified. Progress notes dated 6/29/20 at 10:21 AM revealed the facility received verbal orders from the physician for the resident to discharge from skilled level of care on 6/28/20 to home with hospice care on 6/29/20. Hospice would provide medications. Progress notes dated 6/29/20 at 2:30 PM revealed the Paramedics understood the discharge instructions. The resident discharged home with hospice care via non-emergency ambulance at 2:30 PM with a list of medications, the resident's face sheet and ambulance transfer form. The resident discharged to the resident's home, accompanied by paramedics with no medicines, equipment, supplies, or belongings sent with the resident as the paramedics stated they didn't have room. The resident's Personal Hygiene task record showed that the resident required one person total physical assistance from 6/23/20 through 6/29/20. On 6/24/20, the resident's charting revealed the resident required the total assistance of 2 with personal hygiene, including combing hair, brushing teeth, shaving, washing/drying face, and hands (excluding baths and showers). The last documented meal eaten was on 6/27/20 as 0-25 percent (%) for supper. The date of 6/27/20 lacked documentation of breakfast or lunch. The task record for Amount Eaten lacked documentation related to the amount of food eaten for 6/28/20 and 6/29/20. On 6/26/20, the resident's intake documented for breakfast and lunch was 51-75% and 26-50% for supper. 6. The MDS completed for Resident #19 showed an ARD of 6/23/20 showed a BIMS score of 7, indicating severe cognitive impairment. The resident required supervision with setup help only for personal hygiene - how the resident maintains personal hygiene, including combing hair, brushing teeth, shaving, applying makeup, washing/drying face and hands (excludes baths and showers) in the seven days of the lookback period. The resident required the physical help of one staff for bathing in the seven days of the lookback period. The resident had [DIAGNOSES REDACTED]. Interview On 7/14/20 at 9:18 AM, observed the resident covered in facial hair approximately one inch in length. On 7/14/20 at 11:44 AM, the resident reported the razor did not work, and if someone could find a new razor to help with shaving, it would be great. Chart review The care plan problem dated 10/15/19 instructed the resident required assistance with dressing, grooming, and bathing. The goal dated 5/28/19 stated that the resident wished to participate in dressing, grooming, and bathing. The intervention dated 02/06/19 indicated that the resident needed reminders to shave. The intervention revised on 7/13/20 showed that the resident required the assistance of once staff with bathing. The resident could dress and groom independently but needed cues/reminders at times. The Bathing task record showed one bath on 6/20/20 for the previous 30-day record from 7/14/20. Staff interview On 7/7/20 at 2:21 PM, Staff D, Certified Nurses' Aide (CNA), reported it was difficult to get the baths done, pass linens, and water. Bayberry Hall always only has one person to work, and there are many behaviors in that hall. Bayberry Hall is the heaviest hall to work. The evening shift does baths. Multiple aides complete baths as there is no specific bath aide. Staff D stated that she brushes the resident's teeth at night. Staff D reported that she is one of the few who help residents brush their teeth. Staff D said the facility doesn't have much staff with enough time to brush teeth and complete baths. The facility's biggest problem is having enough aides. On 7/7/20 at 3:55 PM, The Director of Nursing said that it was expected that all residents received a bath at least once per week. Policy review The Contingency Staff Plan dated 5/11/20 revealed if a reduction in essential services was necessary, the residents were to have a bath once per week. 7. A MDS dated [DATE] assessed Resident #25 with a BIMS score of 8 out of 15, indicating severe cognitive deficits. The MDS included [DIAGNOSES REDACTED]. The MDS identified the resident as independent with bed mobility, transfers, dressing and toileting with no set up needed. On 7/23/20 at 12:06, the Administrator at the [MEDICAL TREATMENT] unit where the resident received [MEDICAL TREATMENT] stated the resident came to the center on 7/13/20. The Administrator read nursing notes to the surveyor that documented a conversation with the driver that transported the resident to [MEDICAL TREATMENT] that day. The driver reportedly told the nurses that they didn't clean him up before the resident got into the van, and that he had feces all over him. The MDS and care plan for Resident #25 identified the resident as independent with toileting.
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 observation, clinical record review and interview, the facility failed to complete accurate and timely assessments and communication to the physicians in a timely manner to ensure that all residents received timely assessment and intervention for condition changes for 4 of 26 residents reviewed (Resident #25, #26, #3 and #15). The facility reported a census of 69 residents. Findings include: 1. A Minimum Data Set ((MDS) dated [DATE] for Resident #26 assessed the resident with a Brief Mental Status (BMI) score of 14 out of 15 indicating intact cognitive ability. [DIAGNOSES REDACTED]. According to the MDS the resident required limited with one person assistance for bed mobility and needed extensive assistance with the help of one person for toileting. The care plan last updated on 6/8/20 indicated that the resident admitted to the

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	165161	A. BUILDING _____ B. WING _____	**08/11/2020**

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TOUCHSTONE HEALTHCARE COMMUNITY	**1800 INDIAN HILLS DRIVE SIOUX CITY, IA 51104**

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 0684 **Level of harm -** Minimal harm or potential for actual harm **Residents Affected -** Some	(continued... from page 4) facility with a Groshong device (used to receive intravenous antibiotic) for osteo[DIAGNOSES REDACTED]. The care plan included directives for the resident to participate in [MEDICAL TREATMENT] treatments three times a week. Observation on 7/14/20 at 5:23 AM revealed Resident #26 sat on side of her bed with her head on the bed stand. Her right leg rested over her left knee and she was moaning. At 5:32 AM she laid back in bed. At 8:04 AM she sat up on the side of the bed. When asked how she felt, she said her chest hurt I didn't have a good night. She went on to say that over the last couple of days her cough got worse and she experienced body aches. Nursing notes on 7/14/20 at 17:24 identified the resident with an oxygen saturation of 94%, temperature of 97.8 and no new symptoms. The record lacked any further information regarding the resident's condition. Nursing record documentation dated 7/15/20 at 1:54 PM, identified the resident's temperature as 99.5 degrees Fahrenheit and the oxygen saturation as 80% on room air, with no new symptoms. Nursing documentation showed that at 5:28 PM on 7/15/20, the resident received supplemental oxygen to the resident and the oxygen saturation increased to 94%. The chart lacked any communication to the physician. Nursing record documentation dated 7/16/20 at 11:18 AM, revealed the resident with increased [MEDICAL CONDITION], complaints of shortness of breath, and her vitals were as follows: blood pressure, 168/87, heart rate 66, temperature 97.7, and oxygen level of 86% on 2 liters of supplemental oxygen. Nursing notes revealed the nurse called [MEDICAL TREATMENT] because the resident was scheduled to go to [MEDICAL TREATMENT] that day, and the doctor at Siouxland [MEDICAL TREATMENT] said they would assess her when she got to [MEDICAL TREATMENT]. The chart lacked documentation of the time of return, vital signs, or the condition of the resident on 7/16/20 after her return to the facility from [MEDICAL TREATMENT]. On 7/22/20 at 12:06 PM the Administrator at Siouxland [MEDICAL TREATMENT] she stated according to the nursing notes on 7/16/20, the resident came to them with a productive cough and the physicians' assistant ordered a chest X Ray and cough syrup for Resident #26. The resident's record revealed a nursing note dated 7/17/20 at 1:25 PM that identified the resident with an elevated temperature, generalized weakness, shortness of breath and a dry cough. She transferred to the emergency room (ER) later that day and admitted to the hospital with [REDACTED]. A MDS dated [DATE] assessed Resident #25 with a BIMS score of 8 out of 15, indicating severe cognitive deficits. The MDS included [DIAGNOSES REDACTED]. The MDS identified the resident as independent with bed mobility, transfers, dressing and toileting with no set up needed. The care plan, last updated on 2/13/20, revealed the resident spoke Arabic and English and had [MEDICAL CONDITION] which caused him to be unable to verbalize responses and thoughts. The care plan identified the resident with difficulty communicating and frustration. The care plan indicated that the resident had stage 5 kidney disease and attended [MEDICAL TREATMENT] on Monday, Wednesday Friday at Midwest [MEDICAL TREATMENT] in Sioux City. According to the electronic chart, on 7/10/20 Resident #25 had an elevated temperature of 99.9 degrees Fahrenheit, had a low oxygen saturation of 91% and had refused lunch and dinner. On 7/12/20 he tested positive for Covid-19. On 7/12/20 at 11:58 PM documentation revealed he had no symptoms, lungs clear. According to the resident's electronic record, Resident #25 was picked up by the transportation services on 7/13/20 at 5:00 PM to go to Siouxland [MEDICAL TREATMENT]. Due to his recent [DIAGNOSES REDACTED].#25's [MEDICAL TREATMENT] routine changed from attending Midwest [MEDICAL TREATMENT] to Siouxland in the evenings because that's when they treated the positive cases. The resident's record nursing notes dated 7/13/20 at 11:58 AM identified the resident with a temperature of 98.1 degrees, a heart rate (HR) of 84, and 89% oxygen saturation on room air. The nurse documented that the resident generally did not feel well with loss of appetite, increased weakness and lethargy. The record lacked any documentation of communication with a physician. At 4:44 PM, just before he left for [MEDICAL TREATMENT], his vitals included a temperature of 97.9, 83 HR, 16 respirations and oxygen saturation 92% on room air. The resident's record nursing notes revealed oxygen saturation levels for the resident from July 1st until the 10th contained no oxygen saturation levels under 92% oxygen. The month of June 2020 contained no documented oxygen levels under 91%. The resident's nursing notes revealed on 7/13/20 at 5 PM the resident left for [MEDICAL TREATMENT] treatment with no lethargy, no cough and lung sounds clear. On 7/14/20 at 1:48 AM documentation revealed the resident was due to return from [MEDICAL TREATMENT] at 9:30 p.m. to 10 p.m. When he did not return, the facility placed a call to Siouxland [MEDICAL TREATMENT] with no answer. They then phoned the ER and they informed the facility the resident admitted to the hospital with [REDACTED]. At 6:20 PM, the resident had a temperature of 100.3 degrees and received 6 liters of supplemental oxygen, resulting in a 94% oxygen saturation level. As of 7/27/20 the resident was still in the hospital recovering from [MEDICAL CONDITION]. On 7/21/20 at 7:32 AM, the Administrator at the [MEDICAL TREATMENT] unit stated she remembered the day Resident #25 came to [MEDICAL TREATMENT] with shortness of breath. They decided not to begin [MEDICAL TREATMENT] and sent him directly to the ER. The Administrator then indicated that she would have to return a phone call later. In a returned phone call on 7/23/20 at 12:06, the administrator at the [MEDICAL TREATMENT] unit reiterated that the resident came to them on 7/13/20 with a temperature of 99.9 degrees and oxygen saturation level 74% on room air. The nurses gave the resident supplemental oxygen at 5 liters per minute but could only get the saturation level up to 93% so they called the doctor and sent him to the hospital. The Administrator went on to read the nursing notes that documented a conversation with the driver that transported the resident to [MEDICAL TREATMENT] that day. The driver reportedly told the nurses that they didn't clean him up before the resident got into the van, and that he had feces all over him. The MDS and care plan for Resident #25 identified the resident as independent with toileting. On 7/21/20 at 10:15 AM, Staff K RN (registered nurse) stated she worked the evening the resident went to [MEDICAL TREATMENT] and subsequently to the hospital and that she didn't have any concerns about his condition at the time and his vitals were stable. On 7/22/20 at 7:30 AM the ER house supervisor registered nurse (RN) revealed they updated the facility on the resident's status on 7/13/20 at 11:01 PM. At 8:28 AM on 7/22/20 a nurse at the hospital reported they did not intubate the resident and identified his current condition as not doing too bad. On 7/21/20 at 3:04 PM, the Director of Nursing (DON) said that she expected the nurses to communicate with the primary care physician when there is anything outside the normal which would depend on the resident's baseline vitals and presentation. She went on to say that communication with the primary care physicians is often times very challenging and frustrating when they have difficulty getting through or put on hold for long periods of time. She said that having agency nursing staff is also a challenge with physician communication because they may be unfamiliar with the process. 3. Resident #3's clinical chart revealed the resident transferred to the hospital 7/16/20 at 10:50 PM. On 7/17/20 at 3:09 PM staff completed a daily Covid-19 assessment and documented him with a temperature of 96.5 degrees and oxygen level of 98% oxygen saturation per nasal cannula. Nurses notes revealed the resident was not actually at the facility at that time but remained hospitalized on that date. 4. The MDS completed for Resident #15 with an ARD date of 6/25/20 showed a BIMS score of 5, indicating severe cognitive impairment. The resident required limited assistance from one staff for personal hygiene and one person physical assist with bathing. The resident had [DIAGNOSES REDACTED]. The resident admitted to the facility on [DATE]. The History and Physical printed on 6/19/20 showed a ground-level fall with a [MEDICAL CONDITION]. The head, ears, eyes, nose, and throat (HEENT) section showed the resident had a sutured 4 centimeter (cm) laceration (cut) to the left posterior occiput (backside on the left side of the head). The admission orders [REDACTED]. On 6/20/20, the SNF Admit/ReAdmit Tool skin section showed the skin warm, dry, with normal turgor. The comments section stated the skin was warm, dry, pink, blanchable, and intact. There was no documentation regarding sutures. A Medication Review Report dated 6/22/20 lacked documentation related to the resident's sutures. The Medication Review Report dated 6/22/20 revealed a physician order [REDACTED]. The MAR for 6/20 showed a weekly skin assessment completed on 6/23/20 and 6/30/20. The Medication Administration Record [REDACTED]. The MAR indicated [REDACTED]. On 7/10/20 at 10:00 AM, the Fall Incident progress note showed a hematoma to the right forehead caused by an unwitnessed fall. No further injuries noted. The skin assessment showed the skin warm, dry, and intact. On 7/17/20 at 11:55 AM, the Health Status Note documented three sutures removed from the top right side of the resident's head. On 7/20/20 at 10:35 AM, the Director of Nursing (DON) said the resident did not have sutures at the time of admission and the sutures did not relate to the hematoma. On 7/20/20 at 11:15 AM, Staff I, Certified Nurses' Aide (CNA), reported the resident had stitches to the top of her head. Staff I stated she found them while brushing the resident's hair. Staff I pointed to the left backside of Staff I's head. On 7/20/20 at 3:50 PM Staff JJ, Licensed Practical Nurse (LPN), said she did not know the resident had stitches until Staff S, Certified Medication Aide (CMA), told her they needed removal. On 7/27/20 at 11:46 AM, the DON said she expected the staff to complete a full head to toe assessment on residents. She said that it could be challenging to find things on a resident's head due to the hair. The DON reported she followed-up with the nurse about the stitches. The DON said she reviewed the hospital paperwork that showed no treatments related to the stitches and stated this happened all the time from the hospital. They frequently need to follow-up with treatment orders as they are missing on hospital discharge orders.

F 0689 **Level of harm -** Immediate jeopardy **Residents Affected -** Few	**Ensure that a nursing home area is free from accident hazards and provides adequate**

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F 0689 **Level of harm -** Immediate jeopardy **Residents Affected -** Few	(continued... from page 5) **supervision to prevent accidents.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, interviews, and record reviews, the facility failed to ensure adequate supervision for three of five residents that required staff assistance resulting in major injuries (Residents #1, #12, and #17). Resident #1 fell from bed shortly following one staff positioning the resident in bed on her air mattress. The resident's roommate reported the fall to staff. Resident #1 suffered an unspecified displaced fracture of second cervical vertebra (C2). The resident was admitted to the hospital on [DATE] until 4/9/20, returning on hospice care, and passed away in the facility on 4/11/20. The death certificate identified the manner of death as accident and due consequences following surgery for [REDACTED]. Staff reported the resident never moved or tried to get out of bed and had a specific preference as to how she laid in bed. The resident did not have a bed mobility assessment completed even though the physician signed an order for [REDACTED]. The resident's care plan directed two staff to transfer the resident with all mechanical full-body lift transfers. The hospital records showed the fall resulted in a fracture of unspecified parts of the lumbosacral spine and pelvis (pelvis fracture) with a displaced intertrochanteric [MEDICAL CONDITION] femur (left [MEDICAL CONDITION]). The resident required treatment in the Intensive Care Unit (ICU) following admission to the hospital. Resident #17 reported calling for staff assistance on 3/31/20 and staff did not come and identified her call light not in reach. Resident #17 reached to move her glass, falling forward out of her wheelchair, landing on the resident's left side. The fall resulted in a [MEDICAL CONDITION] end of the left femur. In the early morning of 3/31/20. 1. The Minimum Data (MDS) with an Assessment Reference Date of (ARD) of 3/2/20 for Resident #1 shows a Brief Interview Status Score (BIMS) of 12 which indicates moderate cognitive impairment. The MDS revealed the resident required extensive assistance of one staff for bed mobility, transfers, and wheelchair locomotion. The resident did not ambulate. The resident was always incontinent of bowel and bladder. The resident had [DIAGNOSES REDACTED]. The resident did not have fall since the previous assessment. The resident measured 62 inches tall and weighed 106 pounds. The MDS identified the resident as using a pressure reduction device to the bed. A care plan with initiation date of 9/20/19 revealed a focus problem of transfers/bed mobility/ambulation. The focus identified the resident required the assistance of one staff with transfers, bed mobility and ambulation. The resident used a wheelchair and wheeled walker. The care plan identified the resident used an air mattress on her bed. The care plan also identified the resident at risk for falls due to decreased mobility, deconditioning and medication she received. The care plan did not identify the resident's preferred side to lie on with back against the wall. A fall risk assessment dated [DATE] did not identify if the resident was at risk for falls. It stated the resident did not have falls in the past quarter and continue the plan of care. A multidisciplinary care conference summary locked on 3/16/20 at 11:46 a.m. identified the resident continued at risk for falls due to need for assist and generalized weakness. Resident needs assist of 1 with bed mobility. An incident report (IR) dated 3/31/20 at 5:22 AM and prepared by Staff C unit manager RN (registered nurse) revealed resident's roommate summoned staff to the resident's room. The roommate heard the resident call out for help. After finding staff, they entered the resident's room and found the resident on the floor next to the bed, facing the bed on the right side with blood pooling from the right side of the forehead. A CNA provided incontinence care and repositioned the resident facing the wall 10 minutes prior. The resident was confused and thought she worked in a hospital and must have tripped. The resident stated she needed a doctor quickly. Staff observed a hematoma at the top of the scalp. The IR narrative revealed staff sent the resident to the hospital for evaluation of head injury. However when answering the IR question if the resident went to the hospital, Staff C answered no and stated no injuries observed post incident. The IR identified the resident's mental status as oriented to person. Predisposing physiological factors identified as: drowsy, gait imbalance and impaired memory. The IR identified no other factors to contribute to the fall. The IR did not contain an assessment for pain. There was no documentation of head/neck stabilization. EMS identified the resident's head on a pillow when they arrived on 3/31/20 at 5:32 a.m A form with no title dated 3/31/20 and completed 4/2/20 identified the issue as accident/incident. Attached to the form was a facility summary of the incident. It contained information that Staff E's statement indicated he was in the room approximately 10 minutes prior to the fall and provided incontinence care. he repositioned the resident on her side facing the wall and in the center of the bed. The form identified this as the resident's preferred position. The conclusion was that the resident may have rolled or changed position during sleep causing the fall from bed. The facility will assess the resident upon return and new interventions included a mattress with bolsters to identify the edge of the bed and safe positioning. Physical therapy (PT) and occupational therapy (OT) will evaluate the resident. An internal investigation form no date and completed by Staff C identified the resident as only oriented to person following the fall which was a change for the resident. Review of Post Fall Review dated 3/31/20 at 4:20 PM identified the incident as the first known fall but the resident had risk for falls due to need for assist, weakness and mental status varies. A Sioux City Fire Rescue Patient Care Record dated 3/31/20 for Resident #1 revealed Emergency Medical Services (EMS) reported to the facility on [DATE] at 5:32 A. EMS report shows the resident laid in the right recumbent position on the floor covered with a light blanket and head on a pillow. The report identified the resident as conscious and alert x2 to what roommate stated is her normal standard as staff did not know the residents normal standard. The report shows injury was due to a fall from 3 feet in a Nursing Home. ED (emergency department) physician notes dated 3/31/20 at 6:04 a.m. revealed the resident arrived to the ER (emergency room) after falling from bed. The resident complained of pain to her head and neck to low back and feet. The resident had the most complaint with her neck. The resident had a small bruise to the anterior right frontal area and also to the anterior lower upper arm. A CT (computerized tomography) of the spine showed a C2 body vertebral fracture with displacement measuring less than 2 mm (millimeters) and age indeterminate C5, C7, T1, T3 and T4 compressions fractures. A CT of the spine completed on 3/31/20 at 7:44 a.m. identified age indeterminate L2 and L3 compression fractures. The assessment was C2 vertebral body fracture with 2 mm displacement and mild closed head injury status [REDACTED].#1. When Staff C arrived to the room, the resident laid on the floor on her right side lengthways in line of the bed. Staff C stated she did not know how the resident transferred from bed. At the time of the incident, Staff C RN identified the only other person working besides herself as 1 CNA (certified nurse aide). Review of call light report from 3/31/20 12 a.m. to 11:59 p.m. did not identify a call light activated during the timeframe of the fall. On 7/8/20 at 11:35 AM Staff C RN revealed she did not think the fall was preventable related to the resident using an air mattress and the resident did not have previous falls. Staff C RN cannot explain how the resident fell out of bed. She stated the resident seemed more confused that day and talked of working in healthcare. She stated the resident did not have prior falls so staff did not expect a fall to occur. On 4/1/20 at 10:30 a.m. Staff C stated Staff E provided care to the resident at approximately 5:10 a.m. and repositioned the resident toward the wall with call light in reach. Following the fall the staff called 911 and the ambulance arrived at 5:35 a.m. On 7/7/20 at 12:00 PM with Staff E Certified Nurses Aid (CNA) stated he completed rounds and checked on the resident about 10 minutes before the resident's roommate alerted them to the fall. Staff E stated he changed the resident due to incontinence at that time. On 4/1/20 Staff E wrote a statement for the facility. Staff E referenced coming to work at 2 a.m. on 4/1/20 (the day after the incident). He stated at that tine the resident slept in the center of the bed and he checked and changed the resident at 2:30 a.m. and 5:15 a.m Each time, he positioned the resident on her right side in the center of the bed with the call light in reach. On 7/8/20 at 12:45 PM with Staff E CNA stated the resident must have just rolled out of bed. On 7/8/20 at 1:05 PM the surveyor interviewed Resident #4 (Resident #1's roommate). A MDS dated [DATE] identified Resident #4 with a BIMS score of 12 (moderate cognitive impairment). Resident #4 stated she remembered Resident #1's fall on 3/31/20. She stated Resident #1 woke her up yelling for help. Resident #4 got up and saw the resident on the floor in front of the bed. Resident #4 stated no one came to help so she went to get help and found the girl that works here to help the resident. In a written interview report form dated 4/1/20 at 2:30 p.m. the Director of Nursing (DON) interviewed Resident #4 (roommate). Resident #4 stated she didn't see the fall. She heard Resident #1 call for help and then observed the resident on the floor. On 7/7/20 at 11:30 AM Staff B Licensed Practical Nurse (LPN) stated she heard about the resident falling out of bed resulting in a fractured neck and stated she did not know how the resident could fall out of bed since the resident never moved on her own in bed. On 7/7/20 at 2:25 PM Staff D CNA stated the resident always stayed in the fetal position with back against the wall laying on her right side. She revealed this position as the resident's preferred position in bed. Staff D identified the resident as a one-person assist with transfers and used a pivot motion to transfer the resident from wheelchair to bed. Staff D identified the height of the resident's bed as always about hip level or slightly lower. On 7/7/20 4:30 PM Staff F RN stated the resident never left her room and always slept with her back against the wall on her right side. Staff F identified back against wall laying on

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	165161	A. BUILDING _____ B. WING _____	**08/11/2020**

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
TOUCHSTONE HEALTHCARE COMMUNITY	**1800 INDIAN HILLS DRIVE SIOUX CITY, IA 51104**

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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 0689 **Level of harm -** Immediate jeopardy **Residents Affected -** Few	(continued... from page 6) the right side as the resident's preferred position. The resident's bed was never in the low position and bed remained about hip height. She stated the resident never tried to move from that position. A documentation survey report for the month of March 2020 revealed staff documented the resident as totally dependent on staff for bed mobility on 3/30/20 at 6:28 PM. On 7/14/20 at 11:00 AM with Staff I CNA states she was very surprised to hear that the resident fell out of bed because the resident always remained in the same spot in bed which was her back next to the wall on her right side. Staff I stated the resident never moved in bed. Interview on 7/14/20 at 11:15 AM with Staff H RN states the resident didn't move on her own and was considered a totally dependent on staff except with eating as the resident could feed herself. Staff H stated the resident used an air mattress. She identified 1 nurse and 1 aide on the night shift as unsafe. Interview on 7/14/20 at 1:25 PM the Director of Nursing (DON) states the resident had delusions that she was a nurse and needed to get to work and tried to get out of bed and fell . The height of the bed was unknown at the time of facility investigation as the EMTs moved things around in the room. Review of documentation survey report shows, not applicable was documented for the entire month of March showing no behaviors. There were no behaviors such as delusions documented in the resident progress notes. Interview on 7/14/20 at 2:25 pm Staff E CNA states resident would exhibit confusion with people's names sometimes but never any delusions or behaviors. Staff states he was surprised the resident fell since the resident had stiff lower extremities. Staff E didn't understand how it could have happened. Staff E stated he never saw the resident try to get up on her own. He stated if the resident could stay in bed all day, she would be happy. Staff E stated the resident acted the same during his shift on 3/31/20. Interview on 7/15/20 at 9:10 AM Staff C RN states the Resident never tried to get up out of bed on her own before. Staff C states the resident did not have delusions and was orientated and alert. Staff C stated the resident lived and spoke of the the past and talked about her daughter that passed away a lot, and about the days she use to work in healthcare. On 7/13/20 at 2:15 pm Staff G Registered Physical Therapist (RPT) states the resident could move if she chose to. He identified the resident's positioning in the fetal position when in bed as more of a behavior than physical. Staff G stated the resident could physically move in bed if she choose to. A physician's orders [REDACTED]. A PT Evaluation and Plan of Treatment dated 11/15/19 and completed by Staff G identified bed mobility was not tested . PT Progress notes with services through 11/15/19 through 12/30/19 revealed no bed mobility goals or assessments. The most recent PT Discharge Summary prior to the fall dated 1/3/20 at 1:43 PM showed PT did not test the resident's bed mobility. The resident transferred with maximum assist and on level surfaces the resident was totally dependent without attempts to initiate. On 7/23/20 at 8:00 AM Staff EE physical therapist assistant (PTA) stated PT did not see or evaluate the resident after the PT discharge date of [DATE]. Air Mattress: The user manual from Medline for air mattress use on the bed identified close supervision as necessary when the product is used by, on, or near children or invalids. The user manual from Invacare for air mattress use on resident beds revealed proper patient assessment and monitoring required. Work with therapist, physician and other medical staff to perform assessment and patient monitoring. Center the patient on the bed from side-to-side and head-to-foot. Ensure the resident lays flat on his/her back in the middle of the mattress Interview with Staff BB Central Supply Clerk on 7/21/20 at 8:30 AM shows the facility used two types of air mattresses located in the facility. One type was purchased from Medline and a few older air mattresses from Invacare purchased through direct supply. Staff BB cannot determine which mattress was on the resident's bed at the time of the fall due to bed being removed from the room. No staff could identify what air mattress the resident used. Staffing when incident occurred: Review of staff schedules revealed Staff C RN and Staff E CNA as the only staff on duty from 2 am until 6 am on the early morning of 3/31/20 with a facility census of 72 residents. 30 of the resident's required 2 person assist. Review of punch source report showed Staff C RN worked 7:57 am to 12:01 pm and then 8:37 pm to 9:39 am through 3/31/20. Staff E CNA worked 8:38 am to 4:42 pm then 2:03 am to 6:22 am through 3/31/20. The surveyor asked the DON if she felt 1 nurse and 1 Aid was enough to work the whole building. The DON stated if the nurse felt like she didn't have things under control then she would have called. The DON stated she received a call from the facility in the morning and everything was taken care of at that point. The DON stated she has calls out to several agencies and other staff members to fill open positions. The DON states she expected nursing staff to complete rounds on all residents every two hours. Return to Facility: Review of progress notes dated Resident returned to facility with Hospice services on 4/9/20 at 10:31 AM via stretcher with admitting [DIAGNOSES REDACTED]. Review of the progress note dated 4/10/20 the resident passed away at 3:00 AM Death Certificate: A death certificate with file date of 5/28/20 identified the manner of death as: accident. The immediate cause of death was: complications following surgery for [REDACTED]. The time interval documented as 11 days. The description of the injury was: rolled/fell out of bed, striking head on floor. Policy: Accident/Falls policy with revision date of 2/2014 reviewed showing the facility must provide an environment that is free from any hazards for which the facility has control and by providing appropriate supervision and interventions to prevent avoidable accidents. Abatement: This situation resulted in immediate jeopardy for the facility. The facility abated the immediate jeopardy on 7/27/20 after assessing all residents for bed mobility and bed mobility when air mattresses in use, ensuring the information was on the resident' plan of care and educating all staff on all of the above. The surveyors ensured the new policies/procedures in place on 7/27/20. The facility was notified of the immediate jeopardy on 7/22/20. 2. A MDS completed for Resident #12 with an ARD of 6/22/20 showed a BIMS score of 14, indicating intact cognition. The resident required total assistance of two staff with transfers. The resident had one fall with major injury since the prior assessment. The resident had an impairment to one side of the lower extremity. The resident had [DIAGNOSES REDACTED]. A care plan problem with a revision date of 4/18/18 revealed the resident required assistance with transfers. The resident could make minor changes in position while in bed. The resident could not ambulate. The goal dated 4/11/19 specified the resident would be safe in all movements. The intervention with a revision date of 2/6/19 showed the resident required a mechanical lift and two staff to transfer. The SNF - Fall Full Risk Screen Tool dated 3/30/20 identified, based off of the information collected, the resident at risk for falls due to the resident requiring assistance from two staff with a mechanical lift and at risk for falls due to the need for extensive assistance with activities of daily living (ADLs). The SNF (skilled nursing facility) Quarterly Fall Risk Tool dated 6/1/20 documented that based on the information collected, the resident at risk for falls due to required total assistance for transfers. Progress notes dated 5/15/20 at 2:32 PM revealed staff called the nurse called to the resident room. Upon entry observation revealed the resident lying on the floor on their left side. The resident was incontinent of bowel movement (BM). The Certified Nurses' Aide (CNA) stated the mechanical lift strap broke and the resident fell from the lift during the transfer. The resident complained of back and hips hurting. The resident did not want to be moved. The nurse could not reach the primary physician by phone so called 911 and the resident's contact listed on the chart. The resident left per ambulance at approximately 3:00 PM. An incident report dated 5/15/20 at 3:36 PM revealed when the nurse entered the room at 2:32 p.m. she observed the resident laying on the floor on the left side at the foot of the lift. The resident appeared alert and orientated to person, place, and time. The resident's pupils were equal, round, reactive to surroundings, light, and accommodation (PERRLA). The resident's vital signs: temperature of 97.7, pulse 82, respirations 18, blood pressure 128/72, and 96% oxygen saturation on room air. The resident complained of pain nine on a ten-point scale with 10 being the worst imaginable pain, severe pain to the left leg and hip. Observation revealed no bleeding, bruising, or bumps to the head arms, torso, or legs. The resident could move the arms and right leg without difficulty. The resident transferred to the hospital by ambulance and the facility sent the resident's information with the emergency responders. In the section predisposing environmental and situational factors, it stated others. The other information identified the mechanical lift straps as defective. The witness to the fall was Staff D, Certified Nurses' Aide, (CNA). The IDT (interdisciplinary team) Post Fall review dated 5/15/20 identified the cause of the fall as due to equipment failure. Facility investigation: The facility investigation revealed on 5/15/20 at around 2:30 PM, the resident was transferred from the wheelchair to bed via the mechanical lift and sustained a fall. Staff immediately assessed the resident for injury, which revealed pain to the left hip. The resident transferred to the hospital and x-rays identified a fractured pelvis. The resident admitted to the hospital for treatment. Immediate interventions following the incident included: suspension of the CNA that assisted the resident. The facility removed the mechanical lift from the unit 5/15/20 until inspected. The facility evaluated all mechanical lift slings for safety. Appropriate staff received education on the safety and use of the mechanical lift. The conclusion of the investigation identified the mechanism of the incident as due to the failure of the sling as the support straps broke bilaterally. The investigation identified the mechanical lift sling appropriate for the resident and the mechanical lift system. The EZ Way sling was the appropriate sling for the EZ lift system. The sling was removed on 5/15/20. All total lift slings were evaluated for wear and tear, ensuring all sling integrity intact on 5/15/20 for all halls. The Laundry Environmental Manager audits the slings monthly and with each

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F 0689 **Level of harm -** Immediate jeopardy **Residents Affected -** Few	(continued... from page 7) washing. All slings inspected on 5/18/20. Slings are laundered based on the recommendations from the manufacturer. Lifts are inspected and maintained monthly. All lifts inspected on 5/18/20. The investigation stated the facility staff and the facility did not have culpability in the incident as the equipment failed. The investigation stated the staff member did not violating policy; (however, the care plan said for the resident to be a two-assist when using a lift). The staff member did not ask for assistance from a second individual. The facility suspended the staff member pending the investigation. The facility identified staffing as adequate to meet the resident's needs. The time of the incident was at 2:30 PM. and 7 nursing staff were still in the building as well as management. The facility updated policy to include the assist of two when using the lift. Staff received education to use two-assist according to the updated facility policy. Staff received education on the need to evaluate the sling for problems or wear before using them and the facility completed lift competencies for appropriate staff members. The investigation revealed the staff member followed the policy but did not follow the care plan at the time of the incident. The facility implemented a 30-day audit of the use of the lift to ensure all safety measures in place during care. Staff D CNA's Checklist with a hire date of 9/25/19 for Staff D showed education for the sit to stand lift, the total lift, and the care plan completed on 3/18/20. Staff D's file showed Electronic Total Lift Competency completed for Staff D on 5/20/20. An Employee Counseling Record dated 5/20/20 for Staff D indicated that on 5/15/20, the staff member used the mechanical lift with the resident and did not follow the care plan. The care plan directed staff to use two staff for transfers. The staff member experienced a malfunction of the equipment during the transfer, resulting in a resident's fall. At the time of the fall, adequate staff worked in the building, and the staff member reported only asking one person to help, and that person was busy. The Staff member verbalized they did not ask for assistance from anyone else. The staff member then utilized the lift per self. The reason indicated performance for not following the care plan on 5/15/20 with a final suspension. The completed form for When Using the Mechanical Lift Education dated 5/15/20 showed that 24 staff members received education. Hospital records: Hospital Records showed the resident admitted to the hospital on [DATE] and discharged on [DATE]. The resident's reasons for the hospital stay were elevated troponin level, Diabetes Mellitus, [MEDICAL CONDITION] with a catheter, [MEDICAL CONDITION] [MEDICAL CONDITION] Arthritis, [MEDICAL CONDITIONS], closed [MEDICAL CONDITION], and a closed comminuted intertrochanteric [MEDICAL CONDITION] femur. The resident arrived in the emergency room due to a fall from a mechanical lift at the nursing facility. The resident complained of severe pelvic pain. The resident required 6 liters (L) of oxygen due to [MEDICAL CONDITION] to keep oxygen saturation greater than 90%. The resident required [MEDICAL CONDITION] therapy to maintain oxygen levels. The resident continued to have severe pain after a dose of [MEDICATION NAME]. On 5/26/20, the resident became unstable with renal status due to profound [MEDICAL CONDITION] requiring medication and transfer to the intensive care unit (ICU). Hospital staff interviews: On 7/8/20 at 2:42 PM, the Hospital Registered Nurse #1 (RN), reported remembering the resident. The CT scan showed a displaced inferior anterior and left trochanter femur. The overnight Advanced Registered Nurse Practitioner (ARNP) saw the resident in the emergency room (ER) that night. On 7/9/20 at 11:46 PM, the ARNP said she did admit the resident but wasn't the resident's attending physician for the hospital stay. The ARNP reported the resident did have a pelvic fracture and a [MEDICAL CONDITION] with an underlying [DIAGNOSES REDACTED]. The cause of [MEDICAL CONDITION] could have happened due to the underlying condition. The resident started on a broad spectrum of antibiotics due to meeting the criteria [MEDICAL CONDITION]. The ARNP said the resident could have gotten hurt worse than the resident did. Interviews: On 7/7/20 at 7:32 AM, the resident reported remembering the fall occurring when staff got the resident up for physical therapy (PT). The resident waited with the staff for another person to come to assist with the transfer into bed. The staff hooked the sling and resident up to the mechanical lift, lifted the resident into the air, and the strap snapped, fracturing the resident's pelvic bone. The resident said staff should have wrapped the straps twice but wrapped once. The resident reported when he fell the left hip hit the floor. The resident said he makes sure to hold on to prevent from happening again and makes sure the lift is double strapped around the machine. The resident stated there was only one staff, Staff D, doing the transfer that day. The resident does not want anyone to have to deal with that. The resident said that all slings are brand new now. On 7/7/20 at 2:30 PM, Staff D reported she asked another aide to assist with the resident's transfer but they were busy. Staff D said nothing appeared wrong with the sling straps, but when she went to pull the resident back, the straps broke. Staff D explained moving the resident off the mechanical lift to get the resident off the mechanical lift's leg. Staff D reported transferring the resident per self with the mechanical lift and did not feel like having another staff could have prevented the fall. Staff D reported that all of the facility's mechanical lift slings were a little old looking. Staff D said she fully believed doubling all the straps could have prevented the fall or something worse. Staff D reported all the straps looked as if cut. Staff D said that the bottom straps broke and identified the top straps as still intact. The staff used the same sling to transfer the resident that morning without any issues. Staff D said the resident liked to tie the sling straps to the wheelchair's sides and wondered if they caught in the wheels. Staff D reported the facility got all new slings after the fall. Staff D stated this was not the first time to transfer the resident alone due to staff shortage, but it did not happen often. Staff D said the resident helped with transfers, and the resident very cognitively alert. On 7/13/20 at 11:39 AM, the resident said he never got his straps caught in the wheels. The resident said the strap material appeared thick. The resident reported only having a fracture in the pelvis. After the fall, the staff asked the resident if he wanted to transfer to the hospital. Observation: On 7/13/20 at 11:39 AM, observation showed Staff U, CNA, tie the straps of the sling into a knot behind the resident's wheelchair. A photo provided by the facility of the sling involved in the incident, showed the lower sling straps broken bilaterally. Staff interviews: During a follow-up interview on 7/7/20 at 2:21 PM, Staff D, Certified Nurses' Aide (CNA), reported that Bayberry Hall always only has one person to work, and there are residents with many behaviors that reside on that hall. Bayberry Hall is the heaviest hall to work. Staff D said the facility didn't always have many staff that would have time to assist with transfers. The facility's biggest problem is having enough nurse aides. Staff D stated falls could be prevented if the facility hired more staff. On 7/15/20 at 10:45 AM, the Laundry Environmental Manager reported that she audits the slings and showed the surveyor two slings. The Laundry Environmental Manager stated she did not know where one of the slings came from, and the other one had a tear in the fabric, indicating it unsafe to use. The Laundry Environmental Manager stated if she saw any fraying on the sling, she marks it and washes it to see if the fraying expands. If the fraying does not expand she puts the sling back into service and continues to watch it, and if the fraying does expand then she disposes of the sling. If the sling shows an indentation, she circles the indentation with a marker to monitor, after first testing it by pulling on the fabric to see if it tore. If it didn't tear during the test then the Laundry Environmental Manager puts the sling into service and just watches it. During a follow-up interview on 7/16/20 at 10:30 AM, the Laundry Environmental Manager said she never saw the resident's sling before taking the sling out of the garbage after the fall. The Laundry Environmental Manager thought it was weird when she pulled it out of the garbage because it looked different from all the other facility slings. The Laundry Environmental Manager stated it probably was not numbered and might have come from the hospital. She reported never remembering auditing the sling before and that the sling wasn't on her audit sheet. The Laundry Environmental Manager stated the strap very strangely broke. It wasn't frayed but almost looked like it was cut. The Laundry Environmental Manager reported that none of the standing lift slings come to the laundry, so they don't get audited. During a follow-up interview on 7/16/20 at 10:45 AM, the Laundry Environmental Manager reported that her District Manager trained her in her process of examining and auditing the slings. On 7/27/20 at 11:46 AM, the Director of Nursing (DON) reported sling should be t
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 record review, interviews and observations, the facility failed to assure the facility had sufficient qualified nursing staff available at all times to provide nursing and related services to meet the residents' needs for six residents (Resident #1, # 2, #5, #20, #12, and # 8) out of twenty residents reviewed. The facility reported a census of sixty-nine residents. Findings include: 1. The Minimum Data (MDS) with an Assessment Reference Date of (ARD) of 1/24/20 for Resident #2 showed a Brief Interview Status Score (BIMS) of 07 indicating severe cognitive impairment. MDS identified the resident with [DIAGNOSES REDACTED]. The resident admitted to the Emergency Department (ED) on 3/31/20 at 8:21 AM and passed away on 4/3/20 at 3:18 PM. Progress notes dated 3/31/20 at 7:30 AM revealed the resident laid in bed with head of bed elevated at forty-five degrees with an emesis of undigested food. As staff cleaned up the resident, she had another emesis with

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F 0725 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Some	(continued... from page 8) resulting oxygen levels of 64 percent. Staff placed oxygen on the resident and the oxygen levels rose to 84 percent. An emergency room (ER) report identified the resident admitted to theER on [DATE] at 8:21 AM. The ER report dated 3/31/20 at 11:59 AM revealed the facility reported the resident had a coughing spell and vomited and identified the resident with aspiration pneumonia and [MEDICAL CONDITION]. A History and Physical (H&P) report dated 3/31/20 at 11:59 AM revealed the ER contacted Staff B Licensed Practical Nurse (LPN) at the facility who reported staff found the resident with emesis on her and when cleaning the resident up, the resident vomited again. On 7/8/20 at 11:00 AM Staff C (RN) stated she last saw Resident #2 around 4:00 AM to 4:30 AM as she started the 5:00 AM medication pass. At that time, the resident appeared fine and acted like her normal self. The resident laid in bed on her back with the head of the bed slightly elevated. Staff C stated staff never gave the resident anything to eat or drink during the shift (8:37 PM to 9:39 AM). Staff C stated she did not see the resident until the resident went the ER. On 7/7/20 at 4:30 PM Staff F Registered Nurse (RN) stated the resident never had any problems with eating or swallowing and that she loved to eat. The resident always laid on her back in bed and slept in her recliner sometimes. Staff F stated she turned in her two-week notice as she was tired of working the whole building as the only nurse with only one certified nurse aide (CNA) during the overnight shift. Staff F stated the DON told her that one nurse and one CNA could work the whole building. On 7/8/20 at 11:50 a.m. Staff B Licensed Practical Nurse (LPN) states she went to the resident's room to obtain the roommate's blood sugar when she observed dried vomit on the resident's chest, neck, and mouth. Staff B took vital signs which were in normal limits. Staff B did not see any food in the resident's room at the time. The head of the resident's bed was elevated. Staff B stated about forty-five minutes later, staff called her to the resident's room and she appeared in respiratory distress with an oxygen level in the sixties. Staff B tried to suction residents' airway, applied oxygen, and called 911. Staff B voiced frustration with staff shortages and stated the residents did not always get baths due to not having the staff. Staff B observed residents wearing the same clothes the next day. Residents do not receive the care they should due to no help. On 7/8/20 Staff E CNA (certified nurse aide) stated he last saw the resident about 4:15 AM to 4:30 AM and the resident appeared fine at that time. He checked on her for a bowel movement since she used a catheter and she seemed her normal self. He did not see vomit or food in the room. He stated the resident usually had candy on the bedside table. He stated no food or drink was given to resident during the shift of 2:03 AM to 6:22 AM. Review of staff schedule for the overnight shift on 3/30/20 showed one nurse and one CNA on duty from 2 AM to 6 AM, review of staff punch source report shows Staff C RN worked 7:57 AM to 12:01 pm and 8:37 PM to 9:39 AM making a 17.25 hr. shift. Staff E CNA worked 8:38 AM to 4:42 PM and the 2:03 AM to 6:22 AM making a 12.25 hour shift. The DON (Director of Nursing) stated on 7/14/20 at 1:25 PM if the nurse felt like they didn't have things under control then they would call. The DON stated her expectations are that nursing staff complete rounds on all residents every two hours. 2. A MDS with an ARD of 3/2/20 for Resident #1 shows a BIMS of 12 which indicated moderate cognitive impairment. The MDS identified the resident with [DIAGNOSES REDACTED]. The resident was independent with eating, and used one person assist for transfers and bed mobility. The resident fell on [DATE] at 5:22 AM, transferred to the ED on 3/31/20 at 6:04 AM, returned to the facility on [DATE], passed away on 4/10/20 at 3:00 AM Progress notes dated 3/31/20 at 5:22 AM revealed Resident #1's roommate (Resident #4) summoned Staff C RN to the room to help Resident #1 after a fall from bed. The resident yelled for help but staff did not come to assist until Resident #4 found them for assistance. A review of the incident report dated 3/31/20 at 5:22 AM showed staff summoned to the resident's room by the resident's roommate. The ER report dated 3/31/20 at 6:04 AM showed Resident assessment findings to include: C2 (cervical spine) vertebral body fracture with 2 mm of displacement and mild close head injury status [REDACTED]. Staff stated that it is hard to get things done when there is no staff to do it. Staff stated the residents are not getting adequate care as in getting their clothes changed or baths due to short-staffing. It's hard to answer call lights in a timely manner. Staff B identified staffing as typically one nurse and one CNA to work the whole building during the overnight shift. Staff stated the scheduler puts names on the paper schedule to make it look good. On 7/7/20 at 12:00 PM Staff E CNA stated he made rounds on resident about ten minutes before the fall happened and he changed the resident's protective undergarment at that time. On 7/8/20 at 12:45 PM Staff E CNA stated the resident's roommate (Resident # 4) came out of the room to notify staff of the resident lying on the floor. On 7/7/20 at 4:22 PM Staff C RN stated Resident # 4 came to notify staff that the resident laid on the floor. The resident laid on her right side lengthways of the bed. She stated she did not know how the resident transferred and would need to check the care plan. Staff C identified herself and Staff E CNA working and they are to complete rounds every two hours on all residents. On 7/7/20 at 4:30 PM with Staff F RN stated she resigned due to working with insufficient staff. Staff F stated it is common to work short-staffed and resident's cares suffer because of it. Staff stated not all the residents get checked and changed, sometimes they don't get water passed, sometimes they don't receive pericare, and sometimes the residents don't get a bath because there is not enough staff. On 7/8/20 at 1:05 PM Resident #4's MDS with ARD of 2/25/20 identified her with a BIMS of 12 indicating moderate impaired cognition. Resident #4 stated she heard Resident #1 yelling for help due to a fall waking Resident #4 up. Resident #4 stated nobody came so Resident #4 left room and went down the hall to get help and found the girl that works there to help her. On 7/14/20 at 11:15 AM Staff H RN identified resident cares as lacking due to short-staffing and some go without baths. Staff H stated it is not safe for one nurse and one CNA to work the whole building. Progress notes dated 4/9/20 at 10:31 AM revealed Resident #1 returned to the facility via stretcher with admitting [DIAGNOSES REDACTED]. 3. A MDS with an ARD of 7/13/20 for Resident #5 shows a BIMS of 13 which indicated intact cognition. The MDS revealed [DIAGNOSES REDACTED]. The resident required limited assistance of one staff with transfers and extensive assistance one staff for hygiene. On 7/14/20 at 10:50 AM with Resident #5 identified an incident of having loose stools one night around 4:00 AM and went to the bathroom to clean up and another incident around 5:15 AM and went to the bathroom again to clean up. She had another incident at 6:30 AM and went to the bathroom to clean up. The resident removed soiled sheets from the bed and rested in a recliner due to feeling tired from not sleeping and loose bowels. The resident stated around 7:30 am to 8:00 am staff came to the room to help him clean up and change his bed. The resident stated he did not see any staff from 4:00 am until the 7:30-8 am when staff came in and checked on him. The resident stated that he did not use his call light because he knew it would take a while before staff would come and he didn't have time to wait. Review of progress notes dated 7/14/20 at 10:59 a.m. revealed staff notified the resident's physician of loose stools. Resident Council meeting minutes for the month of January 2020 revealed old concerns with call lights. Minutes for the month of February 2020 revealed concerns with overnight staff not answering call lights timely, overnight staff not changing residents or assisting residents to the restroom or completing rounds, and concerns with call light response time. Minutes for the month of April 2020 revealed concerns with staff not checking oxygen and refilling timely, and a concern with getting medication on time. Minutes for the month of May 2020 showed residents voiced concerns with not getting evening snacks. 4. According to the MDS dated [DATE], Resident #20 had a Brief Interview for Mental (BIMS) score of 8 out of 15 points, indicating moderate cognitive impairment. The MDS indicated the resident required limited assistance of two staff for bed mobility and extensive assistance with help of two for dressing, eating and toileting. The resident had [DIAGNOSES REDACTED]. According to the electronic chart, the resident admitted to the facility on [DATE]. She admitted to Hospice services on 10/1/19 and passed away on 4/11/20 from [MEDICAL CONDITION]. According to a nutritional assessment dated [DATE], the resident experienced a significant weight loss of 9% over 90 days. Her weight on 1/9/20 was 79.5 pounds and on 4/2/20 it was 72.1 pounds. The care plan for Resident #20 showed that she was at risk for weight loss and needed assistance from staff and much encouragement with meals. On 7/8/20 at 1:15 PM, the Director of Nursing (DON) stated that Hospice services changed dramatically since the onset of Covid-19. She said that Hospice nurses were not allowed in the facility the building except at end of life situations since March and that the facility nurses stayed in touch with Hospice regarding resident needs and changes. O 7/7/20 at 3:44 PM, manager of hospice services said they had Resident #20 in Hospice services for one year and three months. She identified the resident with difficulty swallowing and loss of appetite. The resident required assistance with eating but was not totally fed. In March 2020 when Hospice could no longer come into the facility, they began to rely on staff to give them information about the resident's condition and they received reports that the resident left 25% or more on the plate, with 3 meals a day. A comparison of amount eaten and fluid intake reviewed between the first 10 days in March 2020 (when Hospice assisted) and the first ten days in April 2020 (without Hospice). The hospice aides had been coming into the facility to assist with feeding the first couple of weeks in March, in April the facility staff was responsible for eating assistance. A review of the documentation reveled the following for the first 10 days of March: Total of 30 meals, 11 meals 0-25% eaten, 6 meals 26-50% eaten, 3 meals 51-75% eaten and 7 meals 76-100% eaten. Documentation showed that in the first 10 days of April, on 2 days only one meal was

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	165161	A. BUILDING _____ B. WING _____	08/11/2020

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
TOUCHSTONE HEALTHCARE COMMUNITY	1800 INDIAN HILLS DRIVE SIOUX CITY, IA 51104

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 0725 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Some	(continued... from page 9) documented and on 2 days, just 2 meals were documented. Of the remaining 24 meals; 20 were 0-25% eaten, 1 meal 26-50% eaten and 2 meals 76-100% eaten. On 7/14/20 6:35 AM Staff S CNA said she remembered Resident #20 and her eating patterns prior to her passing. Staff S said staff had to feed the resident and the resident did not reach out for food or drinks on her own especially in the last weeks before she passed away. Staff S said she remembered feeling very concerned about the resident and the fact that she was getting so thin. She identified the resident as total cares and if the Hospice nurses didn't come to feed the resident, she would have gone downhill sooner. Staff S said they just didn't have the extra person to help with the eating assistance needed. She did not express her concerns to the Director of Nursing or any other administration staff. On 7/14/20 at 7:00 AM, Staff I CNA stated she remembered Resident #20 and that, especially near the end of her life, the resident required feeding and needed a lot of encouragement. Staff I said that the resident would not eat without having someone there to encourage and help her and she noticed a marked difference after Hospice no longer came into the facility. On 7/15/20 at 4:30 PM, Staff B LPN stated she was very tired and just finished working 20 hours straight on the COVID-19 wing. Staff B expressed extreme frustration over the issue of working with limited staff and felt like they didn't get the needed support from those in leadership. When asked if the lack of staff caused a safety risk to the resident she said yes. She said that the staff are burnt out and asked to work more shifts. 5. The MDS completed for Resident #12 with an ARD of 6/22/20 showed a BIMS score of 14, indicating intact cognition. The resident required total assistance of two staff with transfers in the seven day lookback period. The resident had one fall with major injury since the prior assessment. The resident had an impairment to one side of the lower extremity. The resident had [DIAGNOSES REDACTED]. Interview On 7/20/20 at 10:45 AM, the resident reported not having a shower or a bed bath for many weeks. The resident said that getting showers was better before [MEDICAL CONDITION] but now the facility did not have enough staff. 6. The MDS completed for Resident #8 with an ARD of 5/4/20 showed the resident had short and long term memory impairment and cognitive skills for daily decision making severely impaired. The resident required total assistance of one staff with eating in the seven day lookback period. The resident had [DIAGNOSES REDACTED]. On 7/14/20 at 8:55 AM, resident continues to sit alone with food covered on the tray table. On 7/14/20 at 9:02 AM, food still covered on tray table with no staff present to assist resident with breakfast. Staff U CNA, stated she needed Staff I, CNA, to help resident eat. On 7/14/20 at 9:13 AM, food remained covered with no staff present to assist the resident with eating breakfast. Staff U exits the hallway to go to Cherry Blossom Hall. On 7/14/20 at 9:16 AM, Staff I enters the hallway. On 7/14/20 at 9:17 AM, Staff I enters resident's room to assist resident with breakfast. Interviews On 7/27/20 at 12:56 PM, the Administrator reported he knew of the concern with resident's getting hot food and not receiving help with eating. The Administrator said he was working on improving it as it has been one of the complaints from residents. Policy review The Communal Dining Education dated 3/14/20 said residents that can eat independently will be served first, and preferably in their rooms. Staff are to then serve residents that require assistance. Residents can be seated one to a table and need to maintain six feet of distance between them. Staff will need to assist multiple residents. Staff that are trained as a CNA but work in other departments should report to assist residents with eating. All other staff should be rounding in the halls to ensure residents' safety. The form labeled Meal Service Times dated 3/14/20 showed the following meal times 1. Breakfast a. 8:15 AM for residents that could eat independently b. 9:15 AM for residents that required staff assistance 2. Lunch a. 12:00 PM for residents that could eat independently b. 1:00 PM for residents that required staff assistance 3. Dinner a. 5:00 PM for residents that could eat independently b. 6:00 PM for residents that required staff assistance 7. The Contingency Staffing Plan dated 5/11/20 documented the maximum hours per day or in-between shifts was a maximum of sixteen hours per day. The optimal staffing model was the following Day shift (AMs) - 3 Nurses, 6 aides, 3 dietary, 3 Housekeeping, laundry, and plant operations. Evenings (PMs) - 3 Nurses, 6 aides, 3 dietary Overnights (NOCs) - 2 Nurses, 3 aides The reduced staffing model was the following Day shift (AMs) - 2 Nurses, 4 aides, 2 dietary, 2 Housekeeping, laundry, and plant operations. Evenings (PMs) - 2 Nurses, 4 aides, 2 dietary Overnights (NOCs) - 2 Nurses, 2 aides The emergency staffing model was the following Day shift (AMs) - 2 Nurses, 3 aides, 1 dietary, 1 Housekeeping, laundry, and plant operations. Evenings (PMs) - 2 Nurses, 3 aides, 1 dietary Overnights (NOCs) - 2 Nurses, 2 aides
F 0726 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	**Ensure that nurses and nurse aides have the appropriate competencies to care for every resident in a way that maximizes each resident's well being.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, chart review and staff interviews the facility failed to ensure adequate and professional nursing evaluating, planning and implementing of residents plan of care necessary to assure the needs of the residents are met for 2 of 26 residents reviewed (Residents #26 and #1). The facility reported a census of 69 residents. 1. According to the Minimum Data Set ((MDS) dated [DATE], Resident #26 had a Brief Interview for Mental Status (BIMS) score of 14 out of 15, indicating intact cognitive ability. The electronic chart documented that the resident had [DIAGNOSES REDACTED]. According to the MDS, the resident required limited help with one person assistance for bed mobility and extensive assistance with one person for toileting. The care plan last updated on 6/8/20, indicated that Resident #26 was admitted with a Groshong device to receive intravenous antibiotic for osteo[DIAGNOSES REDACTED] and received [MEDICAL TREATMENT] treatment three times a week for end stage [MEDICAL CONDITION]. On 7/23/20 at 9:34 AM, the surveyor asked Staff FF LPN (licensed practical nurse) how many liters of oxygen Resident #26 was on, Staff FF said she thought it was 2 liters but she was not sure. When she went to look up the doctor's order, she was unable to find an order for [REDACTED]. When asked about nurse to nurse shift change report, Staff FF said that she did not get report about the oxygen or that the resident had returned to the facility so she was surprised to see the resident there this morning when she got to the unit. When asked if it was unusual for information regarding important resident status omitted from report, she said not when it's agency. Review of the nursing schedule showed the overnight nurse responsible for passing on resident information to the next shift was not agency staff but a full time employee of the facility. In an interview on 7/27/20 at 12:57, The Director of Nursing (DON) stated she expected that the nurses would pass on any changes in the resident's condition and that having a resident return from the hospital would be an important detail to communicate at shift change. 2. The Minimum Data (MDS) with an Assessment Reference Date of (ARD) of 3/2/20 for Resident #1 shows a Brief Interview Status Score (BIMS) of 12 which indicates moderate cognitive impairment. MDS shows resident #1 to have a [DIAGNOSES REDACTED]. On 7/7/20 at 4:22 PM Staff C Registered Nurse (RN) stated Resident # 4 came to notify staff that the Resident was lying on the floor. The Resident was found lying on her right side lengthways of the bed. Staff stated unsure on how the Resident transferred that they would need to look at the care plan. Record review of Sioux City Fire Rescue Patient Care Record dated 3/31/20 for Resident shows Emergency Medical Services (EMS) reported to the facility on [DATE] at 5:32 A.M. EMS report revealed resident found lying in the right recumbent position on the floor, covered with a light blanket and given a pillow. Written in report the following: the resident is conscious and alert x 2. Roommate states this is her normal standard as Staff did not know the residents normal standard.
F 0804 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	**Ensure food and drink is palatable, attractive, and at a safe and appetizing temperature.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, record review and interviews, the facility failed to provide the resident with a hot palatable meal for one resident's reviewed (Resident #12). The facility reported a census of 69 residents. Findings include: Resident #12's Minimum Data Set (MDS) completed with an assessment reference date (ARD) of 6/22/20 showed a Brief Interview for Mental Status (BIMS) score of 14, indicating intact cognition. The resident required total assistance of two staff with transfers. The resident had one fall with major injury since the prior assessment. The resident had an impairment to one side of the lower extremity. The resident had [DIAGNOSES REDACTED]. On 7/14/20 at 8:47 AM, Staff H, Registered Nurse (RN), passed resident meal trays. On 7/14/20 at 9:06 AM, Staff H delivered a room tray to Resident #12. The tray contained milk and water covered with saran wrap with no additional heat to meal or cooling to the drinks noted. On 7/14/20 at 11:48 AM, the resident reported only eating Rice Krispies as the rest of the meal was cold and not good. On 7/27/20 at 12:56 PM, the Administrator reported being aware of the concern with residents getting hot food and getting help with eating. The Administrator said he was working on improving it as it has been one of the residents' complaints. The Communal Dining Education dated 3/14/20 said residents who can eat independently would be served first, and preferably in their rooms. The staff is to serve the residents that require assistance. Residents can be seated one to a table and need to maintain six

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F 0804 **Level of harm -** Minimal harm or potential for actual harm **Residents Affected -** Few	(continued... from page 10) feet of distance between them. Staff will need to assist multiple residents. The staff trained as a CNA but work in other departments should report to assist residents with eating. All other staff should be rounding in the halls to ensure residents' safety. The form labeled Meal Service Times dated 3/14/20 showed the following meal times 1. Breakfast a. 8:15 AM for residents that could eat independently b. 9:15 AM for residents that required staff assistance 2. Lunch a. 12:00 PM for residents that could eat independently b. 1:00 PM for residents that required staff assistance 3. Dinner a. 5:00 PM for residents that could eat independently b. 6:00 PM for residents that required staff assistance
F 0836 **Level of harm -** Minimal harm or potential for actual harm **Residents Affected -** Few	**Ensure the facility is licensed under applicable State and local law and operates and provides services in compliance with all applicable Federal, State, and local laws, regulations, and codes, and with accepted professional standards.** Based on chart review and interview the facility failed to operate and provide services in compliance with applicable state regulation that require physical examination before employment and every 4 years for three out of three charts reviewed. (Staff S, D, and K). 1. In a review of staff personnel files, the chart for Staff S CNA (certified nurse aide), hired 1/2/20 lacked documentation of a physical examination before hire. 2. Record review on 7/22/20 shows Staff D CNA with hire date of 9/25/19, personnel record lacked a completed physical. 3. The review of the employee file for Staff K, Admission Nurse Registered Nurse (RN), hired 3/1/16 lacked documentation of a completed physical at the time of hire or following. On 7/22/20 at 12:51 PM, Staff J, Human Resources, reported the facility did not do physicals. She was unsure if the facility should to be do them. POLICY: The agency policy titled: HDG Managed Community Human Resources Policy: Physical Examination/Pre-Employment Physicals/Fitness for Duty Evaluation policy dated September 2015 included the following guidelines: 3. HDG Managed Community should not engage in physical examinations for purposes of pre-employment requirements unless express approval is provided by HDG Human Resources and HDG Safety and Risk Management. 4. All required physical examination/pre-employment physicals/fitness for duty evaluations for purposes of pre-employment and employment requirements must be completed by a third-party qualified medical professional.
F 0880 **Level of harm -** Immediate jeopardy **Residents Affected -** Some	**Provide and implement an infection prevention and control program.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, interviews, and record review, the facility failed to implement and monitor an effective screening process to prevent the spread of the novel Coronavirus 2019 (COVID-19). The facility failed to appropriately screen staff for signs and symptoms of COVID-19. Staff reported only having their temperatures taken. Some staff reported not even having their temperature taken with no further symptoms screened to determine the need for an additional assessment or to identify staff with symptoms so they could be sent home to prevent an outbreak. Staff did not have screening forms completed. The facility was identified as a COVID-19 outbreak facility. The facility had nine COVID-19 positive staff members and 16 COVID-19 positive residents. Staff worked after positive COVID tests. On [DATE], one resident died from COVID-19 (Resident #22), and four additional residents required hospitalization (Residents #25, #3, #27, and #11). Screening forms did not contain all COVID symptoms listed by the CDC. This resulted in immediate jeopardy for the facility. The facility reported a census of 69 residents. Findings include: 1. Staff Interviews: On [DATE] at 2:30 PM Staff S, Certified Medication Aide (CMA), reported the facility refused to test staff that previously tested positive for COVID-19 due to a possible false positive. The facility couldn't afford to lose staff causing staffing shortages. Staff S said when screened, staff only had their temperature checked with no screening questions asked. Staff S identified herself as positive for COVID-19 and only recently returned to work. Staff S was not asked screening questions. Staff S said she still had a sore throat but thought it was because she smoked. She stated she did not have a sore throat before having COVID-19. During a follow-up interview on [DATE] at 10:16 AM Staff S, said during [DATE] and [DATE], she got her temperature taken but was not sure if she completed the questionnaire. Staff S noted that her throat's dryness did not show up until the end of her shift on the day she received [DIAGNOSES REDACTED]. Staff S then went home and took a nap, when she woke up she was barking like a dog. On [DATE] at 11:55 AM, Staff U, Certified Nurses' Aide (CNA), said she received COVID testing on [DATE], and the results came back positive on [DATE]. The staff was tested every Wednesday. Staff U said she didn't have any symptoms until [DATE] and now experienced chills, body aches, and a headache. Staff U reported she never had a fever and reported her temperature checked when screened. No screening questions were asked but Staff U was told let the facility know if she experienced any symptoms. On [DATE] at 3:15 PM Staff K, Admissions Nurse said Staff U's COVID report date as [DATE] and Staff K notified Staff U on [DATE]. Staff K said the results probably showed up on the website late in the day. Staff K said she needs to check the website throughout the day, at least five to six times a day. Staff K stated when she saw the morning of [DATE] Staff U was positive, she immediately pulled her off the floor and sent her home. She stated the website did not give a notification to alert to results being available for review and she needed to open each of the staff's results to check their COVID test status. There was no sort of notification email to notify of status. The website was recently updated to show green or red for COVID. Staff K said they need to open the website and choose employees or residents to see results. The facility is now only using the state lab as it is faster and easier. The state lab sends an email to notify of the result and if the lab was received. The email doesn't specify the results, just that there are results available to review. Sometimes the email is only a lab requisition. During a follow-up interview on [DATE] at 5:10 PM, Staff U said she was notified around noon and left the facility around 12:15 PM. That day Staff U worked in the COVID unit, and when staff worked the COVID unit, they could not go to any other floor without going home and taking a shower. She did not go to any other floor that day. Staff U recently talked to her manager and asked if she could go back to work on Sunday. She was she could if she was symptom-free without medications for three days. The COVID unit housed residents diagnosed with [REDACTED]. Record review: a. The screening record for Staff S lacked documentation of screening from [DATE] through [DATE]. Staff S's time clock showed that Staff S worked [DATE], [DATE], and [DATE]. The time clock record showed that Staff S worked every day from [DATE] through [DATE] except the following dates: [DATE], [DATE], [DATE], [DATE], and [DATE]. Staff S's After Visit Summary dated [DATE] showed a [DIAGNOSES REDACTED]. b. Staff DD's Screening of Infection or Communicable Disease lacked documentation of screening from [DATE] through [DATE]. Staff DD's Individual Timecard showed Staff DD worked the following dates from [DATE] through [DATE]: [DATE], [DATE], [DATE], [DATE], [DATE], [DATE], [DATE], [DATE], [DATE], [DATE], [DATE], [DATE], [DATE], [DATE], [DATE], [DATE], and [DATE] 2 p.m. to 10 p.m. Staff DD's Analytical Report showed that Staff DD tested positive for COVID-19. The date collected was on [DATE] and received on [DATE] with results released on [DATE] at 3:35 p.m. c. Staff U's COVID-19 Test Result Summary showed a positive result. The nasopharyngeal swab specimen collected on [DATE], the date received was [DATE], and the report date was [DATE]. Staff U's time card for [DATE] showed Staff DD worked from 6:11 AM on until 12:13 PM. d. Staff FF had a screening sheet completed [DATE] that did not identify all symptoms of COVID per CDC. On that date, Staff FF's temperature was 99 degrees. All other dates in June and [DATE] only contained temperatures. The screening sheet identified Staff FF worked 71-,[DATE]. The facility identified Staff FF as positive for COVID on [DATE]. e. Staff V did not have screening April or [DATE]/1-,[DATE], [DATE], ,[DATE] or [DATE]. The facility reported Staff V was COVID positive [DATE]. f. Staff GG had one screening sheet dated [DATE] that did not contain all CDC symptoms for COVID. After the [DATE] sheet, Staff GG only had temperature checks ,[DATE]-,[DATE], ,[DATE]-,[DATE] and [DATE], and ,[DATE]-[DATE]. On [DATE] Staff GG's temperature was 99.2 degrees, [DATE] temperature was 99 degrees. On [DATE] Staff GG's temperature is not legible, Staff GG tested positive for COVID [DATE]. All temperatures other than [DATE] contained Staff GG's initials that she checked her own temperature. g. Staff LL had a screening sheet dated [DATE] that did not have all CDC symptoms of COVID listed. Following that Staff LL only had temperature checks completed. Staff LL had a screening sheet dated [DATE] that did not have all CDC symptoms of COVID listed. Following that Staff LL only had temperature checks completed and did not have anything documented between ,[DATE]-,[DATE] Staff LL had a screening sheet dated [DATE] that did not have all CDC symptoms of COVID listed. Following that Staff LL only had temperature checks completed through [DATE]. An analytical report identified Staff LL positive for COVID with result released [DATE] at 3:35 p.m. Temperature checks identified Staff LL worked [DATE] and [DATE] after testing positive for COVID 19. h. Staff MM had a screening sheet dated [DATE] that did not contain all CDC symptoms of COVID. Staff MM only had temperature checks for the rest of [DATE] until a new screening sheet [DATE] completed. Following

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F 0880 **Level of harm -** Immediate jeopardy **Residents Affected -** Some	(continued... from page 11) that date Staff MM only had temperature checks for the remainder of [DATE] and the month of [DATE]. 11 out of 20 times, Staff MM checked her own temperature. A screening form for Staff MM with the date [DATE] was blank. The back of the form only contained temperature checks for [DATE] and [DATE]. 28 of 32 temperature checks were completed by Staff MM. A screening sheet dated [DATE] for Staff MM was blank. The back of the form contained temperatures for [DATE], [DATE], [DATE], [DATE], [DATE] and [DATE]. An analytical form revealed Staff MM tested positive for COVID with results released [DATE] at 11:43 p.m. Staff MM worked [DATE] and [DATE] after testing positive for COVID. Follow-up Staff Interviews On [DATE] at 8:36 AM, the Minimum Data Set (MDS) Coordinator said she provided all that she could find related to documentation for screening staff. On [DATE] at 10:30 AM, Staff HH, Activities Staff, said all screening sheets for staff went to the Infection Control Nurse on Friday. On [DATE] at 3:09 PM, the Director of Nursing (DON) said that as soon as she is aware of a positive COVID-19 test result, she pulls staff. The DON said she would never work a positive staff member. Facility screening forms did not contain all the symptoms listed by the CDC. COVID-19 positive resident review The facility provided information showing sixteen positive residents with COVID-19. Of the sixteen residents that tested positive for COVID-19, four residents required hospitalization related to complications of COVID-19. One resident admitted to hospice and passed away due to complications of COVID-19. All resident's resided down the Daisy Hall. Facility information revealed the following: Resident #25 admitted to the hospital on [DATE] with no discharge from the hospital during the survey. Resident #3 admitted to the hospital on [DATE] through [DATE] and an emergency room (ER) visit on [DATE]. Resident #27 admitted to the hospital on [DATE] through [DATE] with an ER visit on [DATE]. Resident #11 admitted to the hospital on [DATE] through [DATE]. Resident #22 was admitted to hospice on [DATE] for COVID-19 complications and expired on [DATE] at 7:30 AM. Lab staff interview On [DATE] at 7:58 a.m, Clerk 3 at the State Hygienic lab stated COVID results were released to the facility on [DATE] via web portal. Until the facility had access to the web portal, they would receive results by mail. An email dated [DATE] at 4:49 p.m. from the State Hygienic lab IT support analyst stated he received a request for a portal account and activated the facility that morning. On [DATE] at 10:32 a.m. the State Hygienic lab manager stated if the facility would have called to get COVID results prior to portal activation that the State hygienic lab would have provided the results per phone. On [DATE] at 4:06 p.m. the Administrator stated the Human Resources (HR) person tried to get results on [DATE] and was told she needed to sign a form and fax it in before she could receive information. The Administrator stated the HR person did not ask for results per phone. Following that the facility received some faxed results. Corporate Nurse interview On [DATE] at 10:33 AM, the Corporate Nurse reported the facility found issues with screening the week before and started an ad hoc quality assurance and performance improvement (QAPI) plan on [DATE]. The facility removed the single line item from the screening page on [DATE]. The facility then assigned a designated screener and sent a recording to every staff member of the facility to update the noted changes. The noted staff of the screening process with the hashtag (#) symbol, so the staff knew who the screener is for the day. The staff was educated on how to do the screener temperature checks. The staff screener received a walkie talkie to reach out to staff, that became available on [DATE]. When the facility first started screening, they had two areas of screening. One was in the back hallway, and one was at the front entrance. Now the back hallway is locked. The staff member did have a screening form completed, and it showed no symptoms. The testing was done as part of the mandated facility-wide testing. Once the results were received, the staff was removed from the unit. The staff member did not work after that. Testing started after it was developed in the residents. Testing was done for the residents first. Education reviewed The Action Plan - Staff Screening dated [DATE] indicated a nursing staff member on each shift would be assigned to be responsible for screening staff/or visitors (Surveyor), especially when the reception desk is unoccupied ([DATE]). The daily assignment sheet contains a # by the staff designated as screener. The facility will screen staff before and at the end of each shift. Staff will go to the screening area by the front door before and after their shift. All the screening questions will be asked, and temperatures will be taken a the beginning and at the end of the shift. If any answers are different from the start of the shift, call management on duty for further instruction. If all questions are satisfactory and no fever (Temperature is less than 100 degrees Fahrenheit (F)), sanitize hands, remove the mask, and place it in a brown paper bag accordingly. The HDG Health Dimensions Group completed date [DATE] showed the issue of F880 Infection Control related to COVID-19 screening. Screening of visitor (Surveyor) not fully completed per policy on the off shifts. Screening forms will be audited by the Infection Preventionist or designee daily for two weeks, then weekly for one month. Abatement The lack of proper screening and staff working after positive COVID testing with nonCOVID residents resulted in immediate jeopardy for the facility. The facility corrected the immediate jeopardy on [DATE] after they revised their screening forms and policies. The facility educated staff to complete a full screening for each staff each day. Surveyors verified the new processes in place [DATE]. The State Agency notified of the immediate jeopardy on [DATE]. 2. On [DATE] at 6:15 AM this surveyor rang the doorbell at the outside door of the facility. Staff F opened the door without asking any question as to the nature of visit and did not offer a screening. Staff F passed by and out into the parking lot. No one was at the front desk so this surveyor put her bags in the conference room and then went back out to the main lobby. Staff P was just coming in the door and the surveyor asked him if he would like to take my temperature, he did so and then took his own as he continued to fill out his own screening questions. No screening questions were asked of this surveyor. In an interview on [DATE] at 7:10 AM the Director of Nursing (DON) said that Staff E had been assigned to be at the front desk to screen the morning staff and should have been there when the morning shift arrived. She said her expectation is that staff would not screen themselves and that someone would be at the desk to do the screening. DON said they have been trying to make sure someone is at the desk at 5:00 AM and typically, we don't open the door for anyone. I don't want anyone to screen themselves. In an observation on [DATE] at 5:30 AM Staff F walked down the hall wearing a mask under her nose. The surveyor spoke with her and she stated she worked the overnight shift and planned to go home soon. She went into the room of A-11 where both residents sat in their wheelchairs. She stayed in the room with them for about 10 minutes and then left the hallway with her mask still under her nose. Abatement The lack of proper screening and staff working after positive COVID testing with nonCOVID residents resulted in immediate jeopardy for the facility. The facility corrected the immediate jeopardy on [DATE] after they revised their screening forms and policies. The facility educated staff to complete a full screening for each staff each day. Surveyors verified the new processes in place [DATE]. The State Agency notified of the immediate jeopardy on [DATE].