STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	165232	A. BUILDING _____ B. WING _____	08/17/2020

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
FRIENDSHIP HOME ASSOCIATION	**714 DIVISION AUDUBON, IA 50025**

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)
F 0689 **Level of harm -** Minimal harm or potential for actual harm **Residents Affected -** Few	**Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interviews and record reviews, the facility failed to provide adequate supervision to prevent accidents for one of four residents reviewed (Resident #4). The facility did not toilet Resident #4 for 3 hours. The resident got up per self, was incontinent of urine and fell hitting their head. The facility reported a census of 37 residents. Findings include: The Minimum Data Set (MDS) completed with an Assessment Reference Date (ARD) of 6/22/20 showed Resident #4 with short and long-term memory problems. The documentation showed the resident's cognitive status as severely impaired and the resident never or rarely made decisions. The resident required extensive assistance of two staff with toileting, transfers, ambulation, and locomotion in the seven day lookback period. The resident had two or more falls with no injury since the prior assessment. The resident was on a toileting program and was incontinent of urine seven or fewer times in the seven day lookback period. Record review A progress note dated 6/1/20 at 1:46 AM showed the Chronic Confusion, and Dementing Illness (CCDI) Certified Medication Aide (CMA) called the nurse at 8:00 PM to report finding the resident on the floor. Staff found the resident lying on the floor with their head near the recliner chair and the feet towards the bathroom door. The resident wore wearing regular clothing with socks and shoes. The resident reported no pain but stated they hit their head on the floor. Assessment showed no redness or raised areas to the resident's head and no injuries observed elsewhere. The resident reported they tried to walk to the bathroom and fell . Before the fall, the resident slept in the recliner. At the time of the fall, the resident was incontinent of urine. After the fall, two staff assisted the resident to their feet with a gait belt and sat them in the wheelchair and took the resident to their room for bedtime cares and assisted to bed. A Fall Investigation form dated 5/31/20 at 8:00 PM revealed the resident attempted to go to the bathroom independently. Staff last observed the resident one minute before the fall. At that time, the resident slept in a recliner in the day room with three staff present. The last time staff assisted the resident to the toilet was 5:00 PM. At the time of the fall, the resident was incontinent and hit their head. An Event Report dated 5/31/20 at 8:00 PM showed the resident fell unwitnessed in the day room. The resident did not sustain injuries and moved all extremities without pain or limitations. The resident was alert with weak facial, bilateral upper, and lower extremities movements. The resident responded to pain and their name. The resident had a recent decline in activities of daily living (ADL) abilities and dementia that were possible contributing factors. The resident used [MEDICATION NAME], antihypertensives, antipsychotics, diuretics, and anti-depressants. Immediate measures taken after the fall included bedtime cares and neurological (neuro) checks. Care plan review The care plan problem dated 3/9/20 showed the resident's ability to walk and actively participate in their ADLs decreased related to a cognitive decline and a decline in the resident's general health. The resident required assistance with all ADLs. The care plan intervention dated 3/9/20 showed that the resident required limited assistance of one staff with bed mobility, transfers, hygiene, and eating. The resident required extensive assistance of one staff with dressing and wore TED hose (anti-embolism or anti-blood clot stockings). The resident required limited assistance of one staff with walking and toileting. The resident was dependent on staff for locomotion in the wheelchair and bathing. The resident sometimes responded to verbal cueing, and other times the resident may not. The care plan intervention dated 3/9/20 showed the resident had a restorative nursing program for eating and walking. The resident should walk in the hall twice daily as the resident allows when not too fatigued. The resident required two staff to assist with ambulation. The care plan problem dated 3/9/20 documented that the resident was occasionally incontinent of bowel and bladder related to a cognitive decline. The intervention dated 3/9/20 showed the resident required the assistance of two staff with toileting. The care plan problem dated 3/29/20 identified the resident at risk for falls related to a history of falls, advanced dementia, advanced age, high-risk medications, and unsteady gait with impaired balance. The resident fell on the following dates: 9/9/19, 1/18/20. 1/26/20, 4/21/20, 5/28/29, and 5/31/20. The care plan intervention dated 3/9/20 showed the resident could sit in the recliner in the day room when not in bed; this allowed the staff to respond promptly if the resident attempted to get up on their own. The care plan intervention dated 3/9/20 documented to take the resident to the bathroom, give a magazine, or walk in the hall when restless. Staff interviews On 8/17/20 at 1:16 PM, Staff A, Certified Nurses' Aide (CNA), reported the expectation is to take the residents to the bathroom every couple hours. On 8/17/20 at 1:26 PM, the Director of Nursing (DON) explained the expectation is to assist a resident to the toilet every two hours. If a resident was sleeping, sometimes staff wake them and sometimes they don't. On 8/17/20 at 4:45 PM, the Administrator reported the facility probably didn't have a policy related to when a resident was to be toileted. The Administrator said that it was standards of care to help a resident to the toilet every two hours.
F 0880 **Level of harm -** Minimal harm or potential for actual harm **Residents Affected -** Some	**Provide and implement an infection prevention and control program.** Based on observations and staff interviews, the facility failed to implement appropriate infection control practices. The facility reported a census of 37 residents. Findings include: Observations On 8/13/20 at 9:25 AM, observed one staff member behind the nurses' station with no mask. On 8/13/20 at 2:29 PM, Staff C, Certified Nurses' Aide (CNA), assisted a resident with their snack providing bites of food. Staff C walked away from the resident to the kitchen area to get the resident something to drink. Without hand hygiene, Staff C got a cup from the cupboard and cranberry juice out of the fridge. Staff C poured a cup of cranberry juice and then brought it to the resident to drink. The resident drank independently at first, then required Staff B assistance. On 8/17/20 at 10:11 AM, Staff B, Registered Nurse (RN), answered questions from the surveyor. While answering the questions, Staff B sat behind the nurses' station with a mask down below the chin. The surveyor stood on the other side of the nurses' station. The interview ended at 10:14 AM, and Staff B never moved the mask over their face. On 8/17/20 at 11:36 AM, observation showed 18 residents eating in the dining room. Of the 18 residents, 12 sat two to a table less than six feet in distance apart. Only one table contained a married couple sitting at the table. At two of the dining room tables, observation showed one resident at each table coughing. Both residents coughed without their mouth covered part of the time. On 8/17/20 at 1:05 PM, observation showed the Housekeeper with housekeeping cart in a resident area and face mask pulled down to their chin. On 8/17/20 at 1:16 PM, Staff A, Certified Nurses' Aide (CNA), completed an interview with the surveyor in front of the nurses' station with their face mask pulled down under Staff A's chin. On 8/17/20 at 1:24 PM, observed the same Housekeeper in Hallway One with their mask pulled down to their chin. On 8/17/20 at 1:26 PM, the Director of Nursing said the facility expected staff to wear their face masks appropriately. Interview On 8/17/20 at 1:26 PM, the Director of Nursing (DON) identified the dining room tables as approximately four feet in size. With the new regulations, she understood that residents could sit at tables six feet apart. She stated the residents did not need to sit six feet apart as long as there was a limited number of residents to the table. According to the Iowa Department of Public Health (IDPH) reopening guidelines for facilities in Phase 2 status, residents may eat in the

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

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F 0880 **Level of harm -** Minimal harm or potential for actual harm **Residents Affected -** Some	(continued... from page 1) same room with social distancing (limited number of people at tables and spaced by at least 6 feet).