STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	165262	A. BUILDING _____ B. WING _____	07/23/2020

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
TRU REHAB OF GRINNELL	415 W SIXTH AVENUE GRINNELL, IA 50112

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 0550 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	**Honor the resident's right to a dignified existence, self-determination, communication, and to exercise his or her rights.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, clinical record review, staff and resident interviews and review of the Resident's Rights & Responsibilities, the facility failed to maintain the dignity of 1 of 8 residents reviewed. (Resident #4). The facility identified a census 27 residents. Findings included: 1. A Minimum Data Set (MDS) assessment form dated 5/26/20 indicated Resident #4 with [DIAGNOSES REDACTED]. The assessment indicated the resident had a Brief Interview for Mental Status (BIMS) score of 5 out of 15 (a cognitive deficit), made self understood and usually understood others and with continuous inattention and disorganized thinking. The assessment documented the resident as independent with transfers, ambulation in his room and corridor, locomotion on and off unit and with limited assistance with toilet use and personal hygiene. The resident's Care Plan included the following focus areas as dated: Impaired cognitive function or impaired though processes related to (r/t) a history of [MEDICAL CONDITION] (initiated 3/5/18), an impaired communication problem r/t impaired cognitive function (initiated 3/5/18), limited physical mobility r/t chronic back pain (initiated 3/5/18), a potential for falls r/t his unawareness of safety needs (initiated 3/5/18), a potential for demonstrative verbally abusive behaviors (initiated 3/5/18), could be resistive to cares (initiated (3/5/18) The approaches included the following: a. Maintenance of a consistent routine. b. Simple structured activities that avoided demanding tasks. c. Encouragement of the resident for continuance of his statement of thoughts even if he had difficulty. d. Independent ambulation but used a cane. e. Anticipation of the resident's needs. f. Analyze key times, places, circumstances, triggers, and what de-escalates the residents behavior and document. g. If the resident became agitated, intervene before the agitation escalated and guide him away from the source of distress and engage him calmly in conversation. I he responded in an aggressive manner staff should have walked away calmly and reproach later. h. Staff allowed the resident to make his own decisions about his treatment which provided him a sense of control. i. Staff provided the resident with opportunities for choices during care provisions. Review of physician progress notes [REDACTED]. -Struggled with confinement to room due to [MEDICAL CONDITION] situation for safety Plan: Continue current treatment plan, redirect and reinforce appropriate boundaries with others. A Progress Notes entry dated 6/7/20 at 6 a.m. from Staff C, Registered Nurse (RN) revealed the following documentation: Resident became increasingly more restless during the overnight hours. He refused to stay in his room. He seemed to have preferred the common area to have watched the television rather than is own . When asked why he did not want to use his own television he failed to have responded He at times seemed distracted and this nurse questioned his reality testing. Attempts had been made to redirect him to his room as the common area had been cleaned by sanitizing the surface areas. He had been given an explanation that having sat on the furniture during that process could have harmed his skin. He approached the night staff and stood close while he expressed menacing and guttural, almost growling type sounds. The resident failed to have slept that night. We wandered from his room to the common areas and seemed preoccupied with the resident television. He was at time intrusive in his body language while he stood as close as possible to individual staff members. His affect [MEDICATION NAME] and his responses slow and delayed often lacking clear content. During an interview 7/2/20 (time unknown), the Administrator indicated Resident #1 stated Staff D, an Agency Staff Certified Nursing Assistant (CNA) had spoken unkindly to the resident and at around 2 a.m. she posted the information on her Facebook account and the Director of Nursing (DON) had been notified. On Sunday morning the Administrator conducted a full investigation at which time more of the story came out. He became informed the resident intimidated staff and made sexual comments. Staff cleansed the lobby area and the resident wanted to be in the lobby area additionally he wet himself. Thru that process Staff C, RN threatened an administration of a shot to the resident per Staff D. Through the continuation of the investigation one the the staff members told the Administrator, Staff C placed barrels on wheels across the North hallway (where the resident resided) however he could not recall which staff member informed him of this process. When the Administrator talked to Staff C she confirmed she placed the barrels across the hallway as a means to detour him not to have restrained the resident. The Administrator confirmed this process as definitely inappropriate. The Administrator also indicated Staff C and Staff D also told the resident to have acted like a man and that they were not afraid of him. The Administrator felt there had been no physical altercation however the staff members got into the resident's face. During an interview 7/8/20 at 2:16 p.m., Staff D, CNA indicated on 6/7/20 during the 10 - 6 a.m. shift she heard Staff C, as she yelled at the resident to have returned back to his room and then she placed a barrier across the hallway that consisted on a dirty linen barrel, a trash barrel and an ice bin (all on wheels). Staff C said she had been tired of the resident's s#$% (explicit) and he needed to stay in his own room. As the resident returned into the hallway from his room Staff C stated he needed to go back into his room and he needed to grow up and act like a man that she had been tired of the s#$% (explicit). When the resident said what?, Staff C repeated herself. The resident turned around and headed towards his room. After awhile the resident became irritated and said you can not tell me what to do. Staff C then stated, I am in charge here and this nonsense needed to have been stopped as she unplugged the television set and placed lounge chairs in front of the television because she thought that had been the reason for the resident continually exiting his room. Staff D indicated this process continued until 2-2:30 a.m. when Staff C stated just let him go. Staff D confirmed the resident as able to have moved the the barrier in the hallway however he never tried to have removed the chairs around the television set however he reached over the chairs in an attempt to have turned on the television set and he tried to reach behind the television set as he attempted to find out the cause of the problem. Staff B, CNA provided the following written statement to the facility dated 6-8-20: I got to work at 10:00 p.m Staff A, CNA in report stated she sanitized the lobby. The resident sat in the lobby and she told him to go to bed. As I walked down the hallway I seen his pull-up was shredded in the hall so I got him a clean pull up and a new pad for his bed. He sat on his bed a few moments and then later he walked to the lobby. Staff C told him to go to bed and he went to his room and back to the lobby as Staff D repeatedly told him to go back to his room. He came back to the lobby and tried to turn the TV on but Staff C unplugged it. Staff C got him to go to his room. Staff C attempted to try to have kept him away from the TV as she placed chairs to block him from the TV. The staff member stated I'm not sure who it was that placed the barrels between doors so he couldn't go to the lobby. As I worked I had a routine of cleaning, checking the supplies, sterilized red hazard cans and etc. I heard(NAME)non-stop telling the resident to go to his room. I did tell her he wasn't going to go to bed. He had done this a few days earlier. Resident #1's light came on and I went and answered it. Resident # 1 said, I don't like that girl. Resident #1 said she yelled at him and said I'm not scared of you. Resident #1 told me she recorded(NAME)was gone to let the Director of Nursing listen to it because he has the right to go to the lobby. She asked me not to say anything but I pulled Staff C aside and told her what Resident #1 told me. I put all the chairs back and Staff E, Laundry Aide put the barrels in the soiled utility room. The TV was unplugged and the resident tried to turn it on. Staff C said it would be an every night thing if

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

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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F 0550 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	(continued... from page 1) he hung out in the lobby. During an interview 7/8/20 at 6:41 p.m., Staff B confirmed she worked 6/7/20 on the 10 p.m.-6 a.m. shift. When she arrived at the facility she received report that Staff A, CNA had just cleansed/sanitized the lounge area. Staff B also heard Staff A as she redirected the resident back to his room while Staff D had been with her. As Staff B sat on the couch in the lounge area as she looked in her purse and the resident approached her and she yelled just because the resident startled her not because he scared her. During an interview 7/14/20 at approximately 1 p.m. Staff E, Laundry confirmed she observed chairs around the television set in the lounge area when she arrived to work the morning of 6/8/20 and that she asked the night shift if they had a TV party that night. The staff member denied an observation of a barricade across the North hall at that time. An observation 7/7/20 at approximately 1:00 p.m. revealed the resident as he sat on his recliner in his room. When asked if he felt safe at the facility the resident shook his head yes. Random observations 7/10/20 revealed the resident ambulated independently throughout the facility and spent a great deal of time positioned in a recliner in the lounge area as he watched TV. Random observations 7/14/20 revealed the resident ambulated independently throughout the facility with the use of a cane and spent a great deal of time positioned in a recliner in the lounge area as he watched TV. Review of a Daily Staffing Assignments form dated 6/6/20 indicated Staff A, Certified Nursing Assistant (CNA) worked 2 p.m. until 10 p.m., Staff B, CNA, Staff D, CNA and Staff C, Registered Nurse (RN) worked the 10 p.m. until 6 a.m. shift. A Time Card form from 6/4/20 thru 6/8/20 indicated Staff A worked on 6/6/20 from 1:58 p.m. until 10:15 p.m. A Time Card form from 6/4/20 thru 6/8/20 indicated Staff B worked on 6/6/20 from 10:03 p.m. until 6:06 a.m. A Time Card form from 6/4/20 thru 6/8/20 indicated Staff C worked on 6/6/20 from 10:09 p.m. until 7:43 a.m. A Safety Data Sheet form issued 6/26/15 for Professional Lysol Brand Disinfectant Spray the possibility of a hazardous reactions under normal conditions of storage and use, the hazardous reactions would not have occurred. The potential acute health effects included the following: a. Inhalation, skin contact and ingestion: no known significant effects or critical hazards. b. According to a label on Lysol wipes, they have a contact time of 5 minutes. The Residents' Bill of Rights revised 11/16 included the following information: a. Resident's Rights: The resident had a right to a dignified existence, self-determination and communication with and access to persons an services inside and outside of the facility. (1) A facility must have treated each resident with respect and dignity and care for each resident in a manner and in an environment that promoted maintenance or enhancement of his or her quality of life and recognized each resident's individuality. The facility must have protected and promoted the rights of the resident. (2) A facility must have provided equal access to quality care regardless of diagnosis, severity of condition or payment source. b. Exercise of Rights: The resident had the right to have exercised his or her rights as a resident of the facility and as a citizen or resident of the United States. c. Respect and Dignity: The resident had a right to be treated with respect and dignity including: (1) The right to have been free from any physical or chemical restraints imposed for purposes of discipline or convenience. d. Self-Determination: The resident had the right to and the facility must have promoted and facilitated resident self-determination through support of the resident choice. (1) The resident had the right to choose activities, schedules (including sleeping and waking times), health care providers of the health care services consistent with his or her interests, assessments, plan of care and other applicable provisions of this part. (2)The resident had the right to make choices about aspects of his or her lift in the facility that are significant to the resident. A Restraint Management form revised 2014 included the following documentation: Physical restraints defined as any manual method, physical or mechanical device material or equipment attached or adjacent to the resident's body that the individual cannot remove easily, which restricts freedom of moment for normal access to one's body.
F 0684 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	**Provide appropriate treatment and care according to orders, resident's preferences and goals.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on clinical record review and staff interview, the facility failed to obtain weekly weights for 1 of 1 resident reviewed (Resident #3), failed to consistently provide skilled nursing assessments daily for 1 of 1 resident reviewed (Resident #3) from 9/13/2019 thru 10/17/2019 and failed to provide assessments for 1 of 1 resident with a medical condition (Resident #4). The facility reported a census of 27 at the time for the investigations. Findings include: 1. An Minimum Data Set ((MDS) dated [DATE] for Resident #3 included [DIAGNOSES REDACTED]. A Brief Interview for Mental Status (BIMS) is coded 15 which is indicative of intact cognition. Resident #3's weight is coded 298 pounds. A Care Plan with an initiated date of 10/22/18 revealed Resident #3 at risk for fluid volume overload related to her [DIAGNOSES REDACTED]. Revision date of 1/27/20. A Physician order [REDACTED]. Review of the weights revealed gaps of the following weekly weights; dates missing weights are 9/20/19, 9/27/19, 10/20/19, 10/27/19, 11/11/19, 11/18/19, 11/25/19, 12/11/19, 12/18/19 and 12/25/19. The Resident admitted skilled from 9/13/2019 thru 10/17/2019. Review of the Daily Skilled Nursing Assessments revealed the following missing documentation of Skilled Assessments: 9/16/19 thru 9/21/2019, 9/25/2019 thru 9/27/2019, 10/3/2019, 10/8/2019 and 10/12/2019. During an interview on 7/13/20 at 10:07 a.m, the Director of Nursing (DON) stated when residents are admitted especially with a [DIAGNOSES REDACTED]. We did miss several weekly weights after Resident #3's Skilled Date of admission on 9/12/2019. There was a one time order for daily weights but it was discontinued the day after it was ordered. The DON also stated her expectations are for Nursing Staff to obtain daily nursing assessments when a resident is admitted skilled care. The DON acknowledged the lack of assessments for 9/16/19 thru 9/21/2019, 9/25/19 thru 9/27/2019, 10/3/2019, 10/8/2019 and 10/12/2019. During an interview on 7/13/20 at 2:14 p.m., the Administrator stated his expectations are for all staff to follow Physician order [REDACTED]. I also would expect nurses to chart daily on the skilled residents obtaining the daily assessments. I would expect this to be done timely and documented in the chart. No facility policy was provided when asked if the facility had one. 2. A Minimum Data Set (MDS) assessment form dated 5/26/20 indicated Resident #4 with [DIAGNOSES REDACTED]. The assessment indicated the resident had a Brief Interview for Mental Status (BIMS) score of 5 out of 15 (a cognitive deficit), made self understood and usually understood others and with continuous inattention and disorganized thinking. The assessment documented the resident as independent with transfers, ambulation in his room and corridor, locomotion on and off unit and with limited assistance with toilet use and personal hygiene. The resident's Care Plan included the following focus areas as dated: impaired cognitive function or impaired though processes related to (r/t) a history of [MEDICAL CONDITION] (initiated 3/5/18), an impaired communication problem r/t impaired cognitive function (initiated 3/5/18), the resident had an altered cardiovascular status r/t heart failure (initiated 3/5/18). The approaches included the following: a. Monitor, document and report to the physician any signs and symptoms including chest pain or pressure, heartburn, nausea and vomiting, excessive sweating, shortness of breath, dependent [MEDICAL CONDITION] and the color and warmth of his extremities (initiated 4/11/18) b. Monitor, record and report to the Physician as needed changes in lung sounds on auscultation, increased weight or [MEDICAL CONDITION]. (initiated 4/11/18) Progress Notes entry dated 6/21/20 at 1:07 p.m. documented the Physician had been notified as the resident had gone into [MEDICAL CONDITION] and his oxygen saturation levels were 82%. The resident had been out of it and had not answered any questions. Vitals signs stable but the resident looked dazed. The resident sent to the hospital. A Progress Notes entry dated 6/21/20 at 9:14 p.m. documented the resident returned to the facility with no assessment completed. Review of the facilities Progress Note entries from 6/22/20 to present failed to address any thorough assessment of the residents [MEDICAL CONDITION] status and/or vital signs. Review of the facilities Vitals Summary forms revealed the following: a. On 6/22/20 at 11:11 a.m. - Blood pressure (b/p) 122/76 and 6/29/20 at 6:13 a.m. 113/70. b. The form failed to address any pulse (p), respirations (r) and oxygen saturation (O2) assessment from 6/6/20 to present. During an interview 7/2/20 at a time unknown, A Physician confirmed he would have expected the Nursing Staff to have documented according to the nursing standard of practice and it seemed reasonable to him that staff would assess residents following a recent hospitalization or a change of condition.