

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

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12-21-21
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PRINTED: 12/21/2021
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 165602	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 12/07/2021
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NAME OF PROVIDER OR SUPPLIER SUNNY BROOK LIVING CARE CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 400 HIGHLAND STREET FAIRFIELD, IA 52556
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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
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F 000	<p>INITIAL COMMENTS</p> <p>Correction date: <u>1/7/22</u></p> <p>The following deficiencies relate to the Recertification Survey, Complaint # 96526, Facility Reported Incident #100967, and Mandatory #100337-M conducted November 29, 2021 to December 7, 2021.</p> <p>Complaint #96526-C was substantiated.</p> <p>Facility Reported Incident #99880-I was substantiated.</p> <p>See Code of Federal Regulations (42CFR) Part 483, Subpart B-C.</p>	F 000		CW
F 550 SS=D	<p>Resident Rights/Exercise of Rights</p> <p>CFR(s): 483.10(a)(1)(2)(b)(1)(2)</p> <p>§483.10(a) Resident Rights. The resident has a right to a dignified existence, self-determination, and communication with and access to persons and services inside and outside the facility, including those specified in this section.</p> <p>§483.10(a)(1) A facility must treat each resident with respect and dignity and care for each resident in a manner and in an environment that promotes maintenance or enhancement of his or her quality of life, recognizing each resident's individuality. The facility must protect and promote the rights of the resident.</p> <p>§483.10(a)(2) The facility must provide equal access to quality care regardless of diagnosis, severity of condition, or payment source. A facility must establish and maintain identical policies and</p>	F 550		1-4-22 CW

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Cynthia [Signature] CNHA TITLE: Administrator (X6) DATE: 12/21/2021

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 550	<p>Continued From page 1</p> <p>practices regarding transfer, discharge, and the provision of services under the State plan for all residents regardless of payment source.</p> <p>§483.10(b) Exercise of Rights. The resident has the right to exercise his or her rights as a resident of the facility and as a citizen or resident of the United States.</p> <p>§483.10(b)(1) The facility must ensure that the resident can exercise his or her rights without interference, coercion, discrimination, or reprisal from the facility.</p> <p>§483.10(b)(2) The resident has the right to be free of interference, coercion, discrimination, and reprisal from the facility in exercising his or her rights and to be supported by the facility in the exercise of his or her rights as required under this subpart. This REQUIREMENT is not met as evidenced by: Based on clinical record review, staff interview, and observation, the facility failed to treat the residents with dignity and respect when staff threw a resident's doll on the floor for 1 of 25 residents reviewed (Resident #45) for dignity. The facility reported a census of 64 residents.</p> <p>Findings include:</p> <p>The Minimum Data Set (MDS) assessment dated 7/14/21 listed diagnoses for Resident #45 including depression, psychotic disorder, and dementia. The resident's Brief Interview for Mental Status (BIMS) scored "6" indicating severe cognitive impairment.</p> <p>The Care Plan documented Resident #45 had a</p>	F 550		
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F 550	<p>Continued From page 2</p> <p>doll, which she cared for like a baby on 9/4/21. It stated the doll comforted the resident.</p> <p>An observation on 11/29/21 at 2:45 p.m., revealed Resident #45 seated in the recliner in her room holding a doll.</p> <p>An observation on 11/29/21 at 4:00 p.m., revealed Resident #45 walking down the hall holding a doll.</p> <p>An observation on 11/30/21 at 2:00 p.m., revealed Resident #45 seated in a chair in the dining room holding a doll.</p> <p>On 11/29/21 at 2:45 p.m., Resident #45 stated her baby is very good, enjoys looking at people, and hardly every cries.</p> <p>On 11/29/21 at 2:55 p.m., Resident #56 stated on 9/19/21 Staff A, Certified Nurse Aide (CNA), walked into Resident #45's room, took the doll, and threw it on the floor.</p> <p>On 11/29/21 at 4:30 p.m., Staff H, Registered Nurse (RN), reported on 9/19/21 Resident #45 informed her Staff A, CNA, had thrown her baby on the floor.</p> <p>On 11/30/21 at 10:50 a.m., Staff G, RN, stated she observed Staff A, CNA, and Resident #45 standing in Resident #45's doorway around 2:00 p.m. on 9/19/21. Staff G, RN, observed Resident #45 crying. Resident #45 reported Staff A, CNA, had thrown her baby.</p> <p>On 11/30/21 at 11:13 a.m., Staff I, Licensed Practical Nurse (LPN) stated on 9/19/21, Staff A, CNA, reported getting frustrated and throwing the doll across the floor. Resident #45 stated Staff A</p>	F 550		
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F 550	Continued From page 3 had thrown the baby. On 11/30/21 at 1:40 p.m., the Administrator stated the doll is real to Resident #45 and staff are expected to treat the doll like a real baby.	F 550		
F 580 SS=D	Notify of Changes (Injury/Decline/Room, etc.) CFR(s): 483.10(g)(14)(i)-(iv)(15) §483.10(g)(14) Notification of Changes. (i) A facility must immediately inform the resident; consult with the resident's physician; and notify, consistent with his or her authority, the resident representative(s) when there is- (A) An accident involving the resident which results in injury and has the potential for requiring physician intervention; (B) A significant change in the resident's physical, mental, or psychosocial status (that is, a deterioration in health, mental, or psychosocial status in either life-threatening conditions or clinical complications); (C) A need to alter treatment significantly (that is, a need to discontinue an existing form of treatment due to adverse consequences, or to commence a new form of treatment); or (D) A decision to transfer or discharge the resident from the facility as specified in §483.15(c)(1)(ii). (ii) When making notification under paragraph (g) (14)(i) of this section, the facility must ensure that all pertinent information specified in §483.15(c)(2) is available and provided upon request to the physician. (iii) The facility must also promptly notify the resident and the resident representative, if any, when there is- (A) A change in room or roommate assignment as specified in §483.10(e)(6); or	F 580		CU 14-22

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F 580	Continued From page 4 (B) A change in resident rights under Federal or State law or regulations as specified in paragraph (e)(10) of this section. (iv) The facility must record and periodically update the address (mailing and email) and phone number of the resident representative(s). §483.10(g)(15) Admission to a composite distinct part. A facility that is a composite distinct part (as defined in §483.5) must disclose in its admission agreement its physical configuration, including the various locations that comprise the composite distinct part, and must specify the policies that apply to room changes between its different locations under §483.15(c)(9). This REQUIREMENT is not met as evidenced by: Based on clinical record review, staff interview, and policy review, the facility failed to notify the resident's representative of a change in condition for 1 of 1 residents reviewed (Resident #1) for falls. The facility reported a census of 64 residents. Findings: 1. The Minimum Data Set (MDS) assessment, dated 11/11/21, documented Resident #1 had diagnoses of heart failure, Parkinson's disease, and nontraumatic chronic subdural hemorrhage. Resident #1 required supervision assistance of 1 staff for bed mobility, transfers, walking, and eating, limited assistance of 1 staff for dressing, and extensive assistance of 1 staff for toilet use, personal hygiene, and bathing. The MDS listed the resident's Brief Interview for Mental Status score as 11 out of 15, indicating moderately	F 580			

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F 580 Continued From page 5

impaired cognition and stated the resident had 1 fall without injury in the review period. The MDS stated the resident was not steady, but able to stabilize without staff assistance when moving from seated to standing, walking, turning around, and moving on and off the toilet.

An 11/16/21 Nursing Note stated a staff member heard a loud noise described as a "crash" and found the resident laid on his right side with his head toward the door. The resident stated he hit his back and the right side of his head on the hard surfaced floor. The note did not include documentation the facility notified the family of the fall.

A 5/29/19 Care Plan entry directed staff to communicate with the resident/family/caregivers regarding the resident's capabilities and needs.

The Notification of Change Policy dated 2/20/17, directed staff to notify the resident's representative of changes in condition.

During an interview on 12/1/21 at 1:50 p.m., the interim Director of Nursing (DON) stated she could not locate family notification of the resident's 11/16/21 fall.

During an interview on 12/2/21 at 1:30 p.m., the interim DON stated the facility should notify the family of falls.

F 580

F 607 Develop/Implement Abuse/Neglect Policies
SS=D CFR(s): 483.12(b)(1)-(3)

F 607

§483.12(b) The facility must develop and implement written policies and procedures that:

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F 607	<p>Continued From page 6</p> <p>§483.12(b)(1) Prohibit and prevent abuse, neglect, and exploitation of residents and misappropriation of resident property,</p> <p>§483.12(b)(2) Establish policies and procedures to investigate any such allegations, and</p> <p>§483.12(b)(3) Include training as required at paragraph §483.95, This REQUIREMENT is not met as evidenced by: Based on personnel file review, policy review, and staff interview, the facility failed to ensure completion of two hours of dependent adult abuse training within 6 months of hire for 1 of 7 personnel files reviewed for abuse training. The facility reported a census of 64.</p> <p>Findings include:</p> <p>Review of Staff A's, Certified Nurse Aide, personnel file showed Staff A hired on 2/5/21. The personnel file failed to contain completion of a two-hour dependent adult abuse training.</p> <p>The facility's Abuse, Prevention and Prohibition Policy dated 11/2018 documented facility staff shall be trained on the Abuse Prohibition Program during orientation, annually, and ongoing during educational sessions. Included with the facility's policy is a printout of Mandatory Child and Dependent Adult Abuse Reporter Training printed 2/16/21, which reported the requirement of two hours of dependent adult abuse training through the Department of Human Services (DHS).</p> <p>On 11/29/21 at 3:40 p.m., the Administrator stated the employee file contained no evidence of completion of a two-hour dependent adult abuse</p>	F 607		<p><i>CLP</i></p>
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F 607 Continued From page 7 training. F 607

On 11/29/21 at 3:50 p.m., the Office Manager reported requesting evidence of completion of dependent adult abuse training of staff upon hire. If evidence does not exist, she sets them up in the facility's online class system for a one-hour abuse training as well as through DHS for a 2-hour dependent adult abuse training. She noted Staff A did not have the dependent adult abuse training completed and updated supervisors to remove Staff A from the floor if not completed within six months of hire. Due to staffing, Staff A remained on the schedule, working up until 9/19/21.

On 11/30/21 at 1:40 p.m., the Administrator reported the expectation that all staff complete a two-hour course on dependent adult abuse training within six months of hire. Upon hire, they review the DHS information, abuse and reporting requirements and are set up to take the two-hour training online.

F 609 Reporting of Alleged Violations F 609
SS=D CFR(s): 483.12(c)(1)(4)

§483.12(c) In response to allegations of abuse, neglect, exploitation, or mistreatment, the facility must:

§483.12(c)(1) Ensure that all alleged violations involving abuse, neglect, exploitation or mistreatment, including injuries of unknown source and misappropriation of resident property, are reported immediately, but not later than 2 hours after the allegation is made, if the events that cause the allegation involve abuse or result in serious bodily injury, or not later than 24 hours if

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F 609	Continued From page 8 the events that cause the allegation do not involve abuse and do not result in serious bodily injury, to the administrator of the facility and to other officials (including to the State Survey Agency and adult protective services where state law provides for jurisdiction in long-term care facilities) in accordance with State law through established procedures. §483.12(c)(4) Report the results of all investigations to the administrator or his or her designated representative and to other officials in accordance with State law, including to the State Survey Agency, within 5 working days of the incident, and if the alleged violation is verified appropriate corrective action must be taken. This REQUIREMENT is not met as evidenced by: Based on clinical record review, facility investigation review, and staff interview, the facility failed to notify local law enforcement when reporting an abuse concern to the Department of Inspections and Appeals. The facility reported a census of 64 residents. Findings include: The Minimum Data Set (MDS) assessment dated 7/14/21 listed diagnoses for Resident #45 including depression, psychotic disorder, and dementia. The resident's Brief Interview for Mental Status (BIMS) scored "6" indicating severe cognitive impairment. The MDS assessment dated 7/28/21 for documented Resident #56 scored "15" on the BIMS, indicating intact cognition. The facility reported an allegation of abuse to the	F 609			

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F 609	<p>Continued From page 9</p> <p>Department of Inspections and Appeals (DIA) hotline on 9/19/21 with intake number 120793 for an incident occurring 9/19/21. A written report to DIA on 9/20/21 stated Resident #45 reported Staff A, Certified Nurse Aide (CNA), grabbed her arms and face. Staff noted a red bruise to Resident #45's right wrist. Resident #56 reported Staff A grabbed Resident #45 by the arms, shoved her into a chair, and threw her doll onto the floor.</p> <p>The facility's Abuse, Prevention, and Prohibition Policy dated 11/2019 stated allegations of abuse will be reported to the mandated state agency and law enforcement within two hours of the allegation if the events that caused the allegation involve abuse or result in serious bodily injury. If the events that caused the allegation do not involve abuse and do not result in serious bodily injury, these will be reported to the state agency not later than 24 hours.</p> <p>The facility failed to notify local law enforcement of the alleged abuse until 11/29/21.</p> <p>On 11/30/21 at 1:40 p.m., the Administrator stated she did not report the incident to law enforcement because with review on 9/20/21 she did not feel evidence of any physical contact existed.</p>	F 609		
F 625 SS=D	<p>Notice of Bed Hold Policy Before/Upon Trnsfr CFR(s): 483.15(d)(1)(2)</p> <p>§483.15(d) Notice of bed-hold policy and return-</p> <p>§483.15(d)(1) Notice before transfer. Before a nursing facility transfers a resident to a hospital or the resident goes on therapeutic leave, the nursing facility must provide written information to</p>	F 625		<p><i>CLP</i></p> <p><i>1-4-22</i></p>

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F 625	<p>Continued From page 10</p> <p>the resident or resident representative that specifies-</p> <p>(i) The duration of the state bed-hold policy, if any, during which the resident is permitted to return and resume residence in the nursing facility;</p> <p>(ii) The reserve bed payment policy in the state plan, under § 447.40 of this chapter, if any;</p> <p>(iii) The nursing facility's policies regarding bed-hold periods, which must be consistent with paragraph (e)(1) of this section, permitting a resident to return; and</p> <p>(iv) The information specified in paragraph (e)(1) of this section.</p> <p>§483.15(d)(2) Bed-hold notice upon transfer. At the time of transfer of a resident for hospitalization or therapeutic leave, a nursing facility must provide to the resident and the resident representative written notice which specifies the duration of the bed-hold policy described in paragraph (d)(1) of this section. This REQUIREMENT is not met as evidenced by:</p> <p>Based on clinical record review, Policy review, and staff interviews the facility failed to provide bed-hold notification for 1 of 2 residents reviewed (Resident #32) for bed hold. The facility reported a census of 64.</p> <p>Finding include:</p> <p>Review of Resident #32's clinical record revealed a lack of notice of bed-hold to Resident # 32 or the resident representative when transferring to the hospital.</p> <p>In and interview on 12/02/21 at 11:20 AM, the Director of Nurses stated she believed because</p>	F 625		
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F 625	Continued From page 11 the resident was Medicaid and the facility has an automatic 10 day bed hold that they did not have to provide the resident or the family with a notification of bed hold. DON stated that they did not provide notification to all residents on Medicaid. The Bed-Holds and Returns policy dated March 2017 states prior to transfers and therapeutic leaves, residents or resident representatives will be informed in writing of the bed-hold and return policy. The current bed-hold and return policy established by the state if applicable will apply to Medicaid residents in the facility. Prior to a transfer, written information will be given to the resident and the resident representatives that explain in detail: the rights and limitations of the resident regarding bed-holds, the reserve bed payment policy as indicated by the state Medicaid residents, the facility per diem rate required to hold a bed for non-Medicaid residents, hold a bed beyond the state bed-hold period for Medicaid residents, and the details of the transfer per the notice of transfer.	F 625			
F 657 SS=E	Care Plan Timing and Revision CFR(s): 483.21(b)(2)(i)-(iii) §483.21(b) Comprehensive Care Plans §483.21(b)(2) A comprehensive care plan must be- (i) Developed within 7 days after completion of the comprehensive assessment. (ii) Prepared by an interdisciplinary team, that includes but is not limited to-- (A) The attending physician. (B) A registered nurse with responsibility for the resident. (C) A nurse aide with responsibility for the	F 657		CC 12-30-21	

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 12/21/2021
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 165602	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 12/07/2021
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F 657	<p>Continued From page 12 resident.</p> <p>(D) A member of food and nutrition services staff.</p> <p>(E) To the extent practicable, the participation of the resident and the resident's representative(s). An explanation must be included in a resident's medical record if the participation of the resident and their resident representative is determined not practicable for the development of the resident's care plan.</p> <p>(F) Other appropriate staff or professionals in disciplines as determined by the resident's needs or as requested by the resident.</p> <p>(iii) Reviewed and revised by the interdisciplinary team after each assessment, including both the comprehensive and quarterly review assessments.</p> <p>This REQUIREMENT is not met as evidenced by: Based on observation, clinical record review, policy review, and staff interview, the facility failed to include 1 of 19 residents in care conferences (Resident #19), failed to update the Care Plan after a fall for 1 of 1 residents reviewed (Resident #1) for falls, and failed to update the Care Plan for 2 of 5 residents reviewed (Residents #27 and #59) for pressure ulcers. The facility reported a census of 64 residents.</p> <p>Findings include:</p> <p>1. The Minimum Data Set (MDS) assessment dated 9/1/21, listed diagnoses for Resident #19 of heart failure, diabetes, and depression. The MDS stated the resident required limited assistance of 1 staff for bed mobility, transfers, walking, dressing, toilet use, and personal hygiene, and extensive assistance of 1 staff for bathing. The MDS listed the resident's Brief Interview for Mental Status (BIMS) score of 15 out of 15,</p>	F 657		<p><i>Cee</i></p>
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F 657	<p>Continued From page 13 indicating intact cognition.</p> <p>During an interview on 11/30/21 at 10:10 a.m., Resident #19 stated the facility did not invite her to care conferences and she had not attended.</p> <p>A Care Conference entry dated 8/16/21, directed staff to provide opportunities for residents and resident families to participate in care and activities.</p> <p>During an interview on 12/1/21 at 11:55 a.m., the interim Director of Nursing (DON) stated she could not locate any documentation of Resident #19's care conference reports.</p> <p>2. The MDS assessment dated 11/11/21, listed diagnoses for Resident #1 of heart failure, Parkinson's disease, and nontraumatic chronic subdural hemorrhage. Resident #1 required supervision assistance of 1 staff for bed mobility, transfers, walking, and eating, limited assistance of 1 staff for dressing, and extensive assistance of 1 staff for toilet use, personal hygiene, and bathing. The MDS listed the resident's BIMS score as 11 out of 15, indicating moderately impaired cognition and stated the resident had 1 fall without injury in the review period. The MDS stated the resident was not steady, but able to stabilize without staff assistance when moving from seated to standing, walking, turning around, and moving on and off the toilet.</p> <p>Observations revealed the resident walking in the hall without his cane on 11/29/21 at 2:46 p.m., on 12/1/21 at 9:19 a.m., and on 12/2/21 at 6:38 a.m.</p> <p>A 3/18/20 Care Plan entry stated the resident was independent in his room and hall with a single</p>	F 657		
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FORM APPROVED
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NAME OF PROVIDER OR SUPPLIER SUNNY BROOK LIVING CARE CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 400 HIGHLAND STREET FAIRFIELD, IA 52556
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F 657	<p>Continued From page 14 point cane.</p> <p>A 6/16/21 Incident Report stated the resident was walking in the hallway and lost his balance and stated he was on his way to the courthouse.</p> <p>A 6/25/21 Care Plan intervention directed staff to provide standby assistance with ambulation when disoriented.</p> <p>A 10/27/21 Incident Report stated staff reported the resident fell attempting to pick something up off the floor.</p> <p>An 11/1/21 Care Plan entry stated the resident fell on 10/27/21 and directed staff to intervene if the resident tried to get something off the floor.</p> <p>An 11/16/21 Nursing Note stated a staff member heard a loud "crash" and found the resident laid on his right side with his head toward the door. The resident stated he hit his back and the right side of his head on the hard surfaced floor.</p> <p>An 11/27/21 8:28 a.m. Nursing Note stated staff saw the resident lying on the floor on his back and the resident stated he hit his head. The resident had a large lump with redness on the back of his head and was very drowsy with left sided weakness. The facility obtained an order to send the resident to the ER.</p> <p>An 11/27/21 11:45 a.m. Nursing Note stated the resident returned from the hospital and had a normal Computed Tomography scan but had a slightly swollen ankle.</p> <p>The Care Plan lacked interventions to prevent further falls after the resident's 11/16/21 and</p>	F 657		
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DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

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F 657	<p>Continued From page 15 11/27/21 falls.</p> <p>The facility policy "Fall Interventions", updated 1/25/17, stated most falls were the result of unmet needs and stated the goal was to determine what the need was and meet it. The policy included multiple interventions to prevent falls including: assess for pain, evaluate medications, promote sleep, eliminate slick clothing, order a Physical Therapy screen.</p> <p>During an interview on 12/1/21 at 2:26 p.m., the interim Director of Nurses stated after each fall the facility should create a new intervention. She stated the facility needed to put many things in place.</p> <p>3. The MDS assessment dated 9/1/21, listed diagnoses for Resident #27 included heart disease, diabetes, and muscle weakness. The MDS stated the resident required limited assistance of 1 staff for bed mobility, transfers, dressing, toilet use, and personal hygiene, and extensive assistance of 1 staff for bathing. The MDS listed the resident's BIMS score as 15 out of 15, indicating intact cognition.</p> <p>Observations at revealed the resident in his wheelchair without his feet elevated on 11/30/21 at 9:53 a.m., 10:12 a.m., 10:28 a.m., and 12:10 p.m., and on 12/1/21 at 8:10 a.m. and 1:40 p.m.</p> <p>During an observation on 12/01/21 at 2:17 p.m., Staff N, Registered Nurse (RN) cleansed an area on the right outer ankle and measured the area. Staff N reported the area measured 1 centimeter (cm) in length by 1.7 cm in width by 0.2 cm in depth. The wound had a red center and white edges.</p>	F 657		

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CENTERS FOR MEDICARE & MEDICAID SERVICES

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F 657	Continued From page 16 A 7/28/21 Provider Note stated the resident had a left outer ankle ulcer and refused to lie down or elevate his legs to reduce swelling. The note directed staff to encourage elevation of the lower extremities and remove shoes intermittently to decrease pressure. A Care Plan entry, dated 9/4/21, stated the resident had a deep tissue injury to the left ankle. The Care Plan lacked interventions of encouraging the resident to elevate his feet and to remove his shoes. During an interview on 12/2/21 at 1:25 p.m., the Administrator stated she expected staff to update the Care Plans. During an interview on 12/6/21 at 9:56 a.m., the Director of Nurses stated she expected Care Plans to include pressure ulcer interventions. 4. An order dated 5/20/21 Betadine Skin Cleanser Solution (Povidone-Iodine) Apply to Resident #59's great left toe topically every day and evening shift for scab The Care Plan dated 06/28/21 identified potential impairment to skin integrity r/t fragile skin and directed staff to maintain clean and intact skin, avoid scratching and keep hands and body parts from excessive moisture, keep fingernails short, educate me/family/caregivers of causative factors and measures to prevent skin injury, follow facility protocols for treatment of injury, and cushion in my wheel chair to help prevent any skin breakdown. The Care Plan lacked the wound to left great toe. Review of the Care Plans, Comprehensive	F 657			

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DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

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F 657	Continued From page 17 Person-Centers policy dated December 2016 identifies a comprehensive person-centered care plan that includes measurable objectives and timetables to meet the resident's physical, psychosocial and functional need is developed and implemented for each resident. In an interview on 12/01/21 at 12:01 p.m., Staff N, Registered Nurse, stated that wound care for Resident # 59 orders are noted on the chart and are within a spreadsheet she uses. Staff N stated that she does not know about care planning on the wounds because she does not look at them for cares. Staff N stated that the wound has been getting better over time and is a scab currently. Observed wound and treatment. No concerns with treatment or wound.	F 657			
F 658	Services Provided Meet Professional Standards SS=D CFR(s): 483.21(b)(3)(i) §483.21(b)(3) Comprehensive Care Plans The services provided or arranged by the facility, as outlined by the comprehensive care plan, must- (i) Meet professional standards of quality. This REQUIREMENT is not met as evidenced by: Based on clinical record review, policy review, and staff interview, the facility failed to follow physician's orders for 1 of 5 residents reviewed (Resident #1) for medication orders. The facility reported a census of 64 residents. Findings include: 1. The Minimum Data Set assessment dated 11/11/21, listed diagnoses for Resident #1 included heart failure, Parkinson's disease, and	F 658		14-22	

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

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NAME OF PROVIDER OR SUPPLIER SUNNY BROOK LIVING CARE CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 400 HIGHLAND STREET FAIRFIELD, IA 52556
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F 658	<p>Continued From page 18</p> <p>nontraumatic chronic subdural hemorrhage. The MDS stated the resident required supervision assistance of 1 staff for bed mobility, transfers, walking, and eating, limited assistance of 1 staff for dressing, and extensive assistance of 1 staff for toilet use, personal hygiene, and bathing. The MDS listed the resident's Brief Interview for Mental Status score as 11 out of 15, indicating moderately impaired cognition.</p> <p>The Order Summary Report listed a 7/21/21 order for warfarin (blood thinner) 6 milligrams (mg) by mouth every day.</p> <p>A 10/5/21 Lab/Pathology report listed the resident's International Normalized Ratio (INR) (test to determine therapeutic levels) had a 10/6/21 handwritten order on the bottom of the report which directed staff to continue the same warfarin dose and repeat the INR on 11/2/21.</p> <p>An 11/27/21 lab report listed the resident's INR.</p> <p>The facility lacked documentation staff completed an INR test prior to this date.</p> <p>A Care Plan entry 8/20/20 directed staff to report adverse reactions to anticoagulant therapy.</p> <p>The Medication and Treatment Orders policy, dated 2001, stated the facility would complete orders utilizing the principles of safe and effective order writing. The policy stated the facility would carry out laboratory monitoring for anticoagulants.</p> <p>During an interview on 12/1/21 at 1:50 p.m., the interim Director of Nursing (DON) stated she could not locate an INR the facility completed in November. She stated she located the order on</p>	F 658		
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DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

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FORM APPROVED
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--	--	--	--

NAME OF PROVIDER OR SUPPLIER SUNNY BROOK LIVING CARE CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 400 HIGHLAND STREET FAIRFIELD, IA 52556
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F 658	Continued From page 19 the former DON's desk. During an interview on 12/2/21 at 1:30 p.m., the interim DON stated staff should not leave orders on a desk without following up.	F 658		
F 677 SS=D	ADL Care Provided for Dependent Residents CFR(s): 483.24(a)(2) §483.24(a)(2) A resident who is unable to carry out activities of daily living receives the necessary services to maintain good nutrition, grooming, and personal and oral hygiene; This REQUIREMENT is not met as evidenced by: Based on observation, clinical record review, policy review, and staff interview, the facility failed to provide assistance with oral care for 2 of 3 residents sampled (Residents #30 and #45) for oral care. The facility reported a census of 64 residents. Findings include: 1. The Minimum Data Set (MDS assessment dated 9/15/21, listed diagnoses for Resident #30 which included non-Alzheimer's dementia, high blood pressure, and constipation. The MDS stated the resident totally depended on 1 staff for eating, dressing, and bathing, and totally depended on 2 staff for bed mobility, transfers, and toilet use. The MDS listed the resident's cognition as severely impaired. A Care Plan entry dated 9/23/15, stated the resident's Activities of Daily Living ability had deteriorated due to a decline in health and directed staff to assist with morning and evening cares.	F 677		CE 1-4-22

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

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FORM APPROVED
OMB NO. 0938-0391

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F 677 Continued From page 20

F 677

During an observation on 12/2/21 at 6:18 a.m., revealed Resident #30 in bed and Staff C, Certified Nurse Aide, entered the room and assisted the resident with dressing and transferred the Resident #30 to the wheelchair with Staff E, Certified Nurse Aide. Staff E brushed the resident's hair and Staff C pushed her in her wheelchair from her room to the dining room. The staff failed to provide oral cares. Observation of the bathroom after the cares revealed one white toothbrush in a basin on top of the paper towel dispenser with dry bristles.

During an observation on 12/2/21 at 9:15 a.m., Staff D, Certified Nurse Aide, pushed the resident in her wheelchair into the shower room. After her shower at 9:28 a.m., Staff D and Staff F, Certified Nurse Aide, transferred the resident to her recliner. The staff failed to provide oral cares.

Observations of the Dining Room and Hall until 10:25 a.m., with the exception of leaving the area for 5 minutes at 7:30 a.m., revealed the Staff failed to provide oral cares.

During an observation on 12/02/21 at 11:47 a.m., revealed the resident was in her room in the recliner and the tooth brush had dry bristles.

2. The MDS assessment dated 10/14/21, listed diagnoses for Resident #45 which included depression, psychotic disorder, and non-Alzheimer's dementia. The MDS stated the resident required limited assistance of 1 staff for eating, and extensive assistance of 1 staff for bed mobility, transfers, walking, dressing, toilet use, personal hygiene, and bathing. The MDS listed the resident's cognition as severely impaired.

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F 677 Continued From page 21

F 677

A Care Plan entry dated 8/12/21, stated the resident had a self-care deficit due to dementia and directed staff to encourage her to do as much for herself as she is able.

During an observation on 12/2/21 at 6:39 a.m., Staff C, Certified Nurse Aide, assisted the resident to walk to the bathroom and dress. Staff C then assisted the resident to walk out to the breakfast table. Staff C failed to provide oral cares. Observation of the resident's bathroom revealed on 1 green toothbrush with dry bristles.

During an observation on 12/2/21 at 9:08 a.m., Staff D, Certified Nurse Aide, walked with the resident back to her room and assisted her to the bathroom. Staff D failed to provide oral care and the toothbrush remained dry.

Observations of the Dining Room and Hall until 10:25 a.m., with the exception of leaving the area for 5 minutes at 7:30 a.m., revealed the Staff failed to provide oral cares.

During an observation on 12/2/21 at 12:15 p.m., the resident's toothbrush remained dry.

The Teeth Brushing policy dated February 2018, stated the purpose of the policy was to assist the resident with oral hygiene and directed staff to assist the resident with teeth brushing.

During an interview on 12/2/21 at 1:24 p.m., Staff D, Certified Nurse Aide, stated typically the person getting residents up in the morning assisted with oral cares. She stated this morning Staff C worked until 8:00 a.m. and then Staff D took over.

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DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

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NAME OF PROVIDER OR SUPPLIER SUNNY BROOK LIVING CARE CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE 400 HIGHLAND STREET FAIRFIELD, IA 52556		
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F 677	Continued From page 22	F 677		
F 689 SS=D	Free of Accident Hazards/Supervision/Devices CFR(s): 483.25(d)(1)(2)	F 689		
	<p>§483.25(d) Accidents. The facility must ensure that - §483.25(d)(1) The resident environment remains as free of accident hazards as is possible; and</p> <p>§483.25(d)(2) Each resident receives adequate supervision and assistance devices to prevent accidents. This REQUIREMENT is not met as evidenced by: Based on observation, clinical record review, policy review, and staff interview, the facility failed to implement interventions to prevent further falls for 1 of 2 residents reviewed (Resident #1) for falls. The facility reported a census of 64 residents.</p> <p>Findings include:</p> <p>1. The Minimum Data Set (MDS) assessment, dated 11/11/21, listed diagnoses for Resident #1 which included heart failure, Parkinson's disease, and nontraumatic chronic subdural hemorrhage. The MDS stated the resident required supervision assistance of 1 staff for bed mobility, transfers, walking, and eating, limited assistance of 1 staff for dressing, and extensive assistance of 1 staff for toilet use, personal hygiene, and bathing. The MDS listed the resident's BIMS score as 11 out of 15,</p>			<p><i>Cee</i> <i>1-4-22</i></p>

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 12/21/2021
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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 165602	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 12/07/2021
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NAME OF PROVIDER OR SUPPLIER SUNNY BROOK LIVING CARE CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 400 HIGHLAND STREET FAIRFIELD, IA 52556
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F 689 Continued From page 23

indicating moderately impaired cognition and stated the resident had 1 fall without injury in the review period. The MDS stated the resident was not steady, but able to stabilize without staff assistance when moving from seated to standing, walking, turning around, and moving on and off the toilet.

Observations revealed the resident walking in the hall without his cane on 11/29/21 at 2:46 p.m., on 12/1/21 at 9:19 a.m., and on 12/2/21 at 6:38 a.m.

A 3/18/20 Care Plan entry stated the resident was independent in his room and hall with a single point cane.

A 6/16/21 Incident Report stated the resident was walking in the hallway and lost his balance and stated he was on his way to the courthouse.

A 6/25/21 Care Plan intervention directed staff to provide standby assistance with ambulation when disoriented.

A 10/27/21 Incident Report stated staff reported the resident fell attempting to pick something up off the floor.

An 11/1/21 Care Plan entry stated the resident fell on 10/27/21 and directed staff to intervene if the resident tried to get something off the floor.

An 11/16/21 Nursing Note stated a staff member heard a loud noise described as a "crash" sound and found the resident laid on his right side with his head toward the door. The resident stated he hit his back and the right side of his head on the hard surfaced floor.

F 689

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F 689	<p>Continued From page 24</p> <p>An 11/27/21 at 8:28 a.m. Nursing Note stated staff saw the resident lying on the floor on his back and the resident stated he hit his head. The resident had a large lump with redness on the back of his head and was very drowsy with left sided weakness. The facility obtained an order to send the resident to the ER.</p> <p>An 11/27/21 at 11:45 a.m. Nursing Note stated the resident returned from the hospital and had a normal Computed Tomography scan but had a slightly swollen ankle.</p> <p>The Care Plan lacked interventions to prevent further falls after the resident's had falls on 11/16/21 and 11/27/21.</p> <p>The Fall Interventions policy updated 1/25/17, stated most falls were the result of unmet needs and stated the goal was to determine what the need was and meet it. The policy included multiple interventions to prevent falls including: assess for pain, evaluate medications, promote sleep, eliminate slick clothing, order a Physical Therapy screen.</p> <p>During an interview on 12/1/21 at 2:26 p.m., the interim Director of Nurses stated after each fall the facility should create a new intervention. She stated the facility needed to put many things in place.</p>	F 689		
F 690 SS=D	<p>Bowel/Bladder Incontinence, Catheter, UTI</p> <p>CFR(s): 483.25(e)(1)-(3)</p> <p>§483.25(e) Incontinence. §483.25(e)(1) The facility must ensure that resident who is continent of bladder and bowel on admission receives services and assistance to</p>	F 690		<p><i>CLC</i></p> <p><i>1-4-22</i></p>

DEPARTMENT OF HEALTH AND HUMAN SERVICES
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F 690	Continued From page 25 maintain continence unless his or her clinical condition is or becomes such that continence is not possible to maintain. §483.25(e)(2) For a resident with urinary incontinence, based on the resident's comprehensive assessment, the facility must ensure that- (i) A resident who enters the facility without an indwelling catheter is not catheterized unless the resident's clinical condition demonstrates that catheterization was necessary; (ii) A resident who enters the facility with an indwelling catheter or subsequently receives one is assessed for removal of the catheter as soon as possible unless the resident's clinical condition demonstrates that catheterization is necessary; and (iii) A resident who is incontinent of bladder receives appropriate treatment and services to prevent urinary tract infections and to restore continence to the extent possible. §483.25(e)(3) For a resident with fecal incontinence, based on the resident's comprehensive assessment, the facility must ensure that a resident who is incontinent of bowel receives appropriate treatment and services to restore as much normal bowel function as possible. This REQUIREMENT is not met as evidenced by: Based on observation, clinical record review, Policy review, resident, resident family and staff interviews the facility failed to ensure a resident who enters the facility with a catheter is assessed for removal of the catheter as soon as possible for 1 of 1 residents reviewed (Resident #61) for indwelling catheters. The facility reported a	F 690			

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F 690	Continued From page 26 census of 64. Findings include: An interview on 11/30/21 at 09:41 AM, Resident #61 and the Daughter stated she had catheter from her hospital stay and wanted to have it removed but it has not happened. The Daughter stated that she addressed this with staff and asked to have the catheter removed. Review of medical records did not identify an order for Foley catheter on admission or on a later date. The Care Plan dated 10/28/21 identified the resident had an Indwelling Foley Catheter and will show no sign or symptoms of a urinary infection through review date, will be/remain free from catheter-related trauma through review date, 16 French Foley catheter to be changed every 30 days and as needed, position catheter bag and tubing below the level of the bladder and away from entrance room door, monitor/record/report to physician for signs and symptoms of a urinary tract infection (pain, burning, blood tinged urine, cloudiness, no output, deepening of urine color, increased pulse, increased temp, urinary frequency, foul smelling urine, fever, chills, altered mental status, change in behavior, change in eating patterns. Review of the Catheter Care, Urinary policy dated September 2014 did not address to assess for removal of the catheter as soon as possible. Observation on 12/02/21 at 10:08 AM, revealed Staff I, Licensed Practical Nurse, performed catheter care.	F 690			

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F 690 Continued From page 27

During an interview on 12/02/21 at 11:05 AM, the Director of Nurse (DON) stated she was unable to find an order for the catheter in the record for Resident #61. DON stated that it is the expectation to have orders entered for the catheters if they are from outside the facility or placed during the resident's stay. DON stated that she did receive a phone call from the daughter on 12/02/21 asking to have the catheter removed.

In an interview on 12/02/21 at 02:22 PM with Resident # 61 and Resident #61's Husband. Both stated that they wanted the catheter removed. The Husband stated that the hospital had put the catheter in when they went to the Emergency Room and it has not been removed. The Husband stated that they have asked for it to be removed and was told by the neurologist that they should have it removed with their last office visit. Resident # 61 and husband agreed to allow their interviews to be used as stated.

F 732 Posted Nurse Staffing Information
SS=C CFR(s): 483.35(g)(1)-(4)

§483.35(g) Nurse Staffing Information.
§483.35(g)(1) Data requirements. The facility must post the following information on a daily basis:
(i) Facility name.
(ii) The current date.
(iii) The total number and the actual hours worked by the following categories of licensed and unlicensed nursing staff directly responsible for resident care per shift:
(A) Registered nurses.
(B) Licensed practical nurses or licensed vocational nurses (as defined under State law).

F 690

F 732

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1-4-22

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F 732	<p>Continued From page 28</p> <p>(C) Certified nurse aides. (iv) Resident census.</p> <p>§483.35(g)(2) Posting requirements. (i) The facility must post the nurse staffing data specified in paragraph (g)(1) of this section on a daily basis at the beginning of each shift. (ii) Data must be posted as follows: (A) Clear and readable format. (B) In a prominent place readily accessible to residents and visitors.</p> <p>§483.35(g)(3) Public access to posted nurse staffing data. The facility must, upon oral or written request, make nurse staffing data available to the public for review at a cost not to exceed the community standard.</p> <p>§483.35(g)(4) Facility data retention requirements. The facility must maintain the posted daily nurse staffing data for a minimum of 18 months, or as required by State law, whichever is greater. This REQUIREMENT is not met as evidenced by: Based on observation, policy review, and staff interview, facility failed to post nurse staffing hours and the census on a daily basis in a prominent location for 1 of 1 days. The facility reported a census of 64 residents.</p> <p>Findings include:</p> <p>During observations on 12/1/21 on the Bonnifield, Highland, and Walton units the nursing department staffing hours and census could not be located.</p> <p>The Posting Direct Care Daily Staffing Numbers</p>	F 732		
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F 732 Continued From page 29
policy dated July 2016, directed staff to post, on a daily basis of each shift, the number of nursing personnel responsible for providing direct care to residents.

F 732

During an observation an interview on 12/01/21 at 4:30 p.m., the interim Director of Nursing (DON) located the the staffing posting on the Highland unit on a shelf. The posting had a date of 11/21/21. The interim DON reported an expectation of staff to post it near the front door and the night shift staff had the responsibility of posting it every day.

F 755 Pharmacy Svcs/Procedures/Pharmacist/Records
SS=D CFR(s): 483.45(a)(b)(1)-(3)

F 755

§483.45 Pharmacy Services
The facility must provide routine and emergency drugs and biologicals to its residents, or obtain them under an agreement described in §483.70(g). The facility may permit unlicensed personnel to administer drugs if State law permits, but only under the general supervision of a licensed nurse.

§483.45(a) Procedures. A facility must provide pharmaceutical services (including procedures that assure the accurate acquiring, receiving, dispensing, and administering of all drugs and biologicals) to meet the needs of each resident.

§483.45(b) Service Consultation. The facility must employ or obtain the services of a licensed pharmacist who-

§483.45(b)(1) Provides consultation on all aspects of the provision of pharmacy services in the facility.

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F 755	<p>Continued From page 30</p> <p>§483.45(b)(2) Establishes a system of records of receipt and disposition of all controlled drugs in sufficient detail to enable an accurate reconciliation; and</p> <p>§483.45(b)(3) Determines that drug records are in order and that an account of all controlled drugs is maintained and periodically reconciled. This REQUIREMENT is not met as evidenced by: Based on observation, clinical record review, and staff interviews, the facility failed to safeguard and accurately count an anti-anxiety medication for 1 of 3 residents reviewed (Resident #35) with controlled substances. The facility reported a census of 64 residents.</p> <p>Findings include:</p> <p>The Minimum Data Set (MDS) assessment dated 6/30/21 documented Resident #35 had short and long-term memory problems. The MDS documented diagnoses of altered mental status and adult failure to thrive.</p> <p>Review of Physician Orders dated 6/1/21 revealed an order for lorazepam (medication for anxiety) 0.25 milliliters (mL) every four hours as needed for anxiety and restlessness for 3 days.</p> <p>Review of an Order Audit Report showed an order dated 8/1/21 for lorazepam 0.25 mL every six hours as needed for restlessness and anxiety.</p> <p>Review of the Progress Notes showed the facility obtained the lorazepam from the emergency kit on 6/1/21.</p>	F 755		<p style="text-align: right;"><i>CEO</i></p>

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F 755	<p>Continued From page 31</p> <p>Review of the Controlled Substance Shift Count & Usage Record revealed the lorazepam bottle contained 30 mL on 6/1/21 and 29 mL following the administration of four doses given from 6/1/21 to 6/3/21. The amount of Lorazepam remained at 29 mL until 8/9/21 when nurses corrected the amount to 23 mL. On 8/14/21, the amount changed from 23 mL to 14 mL without additional doses documented as given.</p> <p>An observation on 11/30/21 at 2:20 p.m. revealed refrigerated controlled substances on two of two areas reviewed to be double locked behind medication room and refrigerator doors. The doors had either a key or a code to unlock.</p> <p>On 11/30/21 at 12:08 p.m., Staff B, Registered Nurse (RN), former Director of Nursing (DON) reported staff notified her on 8/14/21 of a discrepancy in the amount of Lorazepam on hand; however, she had not been aware of the 8/9/21 discrepancy until investigating the 8/14/21 discrepancy.</p> <p>On 12/2/21 at 6:30 a.m., Staff J, Registered Nurse, stated she and another nurse changed the amount of Lorazepam on the Controlled Substance Shift Count & Usage Record sheet from 29 mL to 23 mL after noting the amount on the sheet did not match the amount in the bottle on 8/9/21 at 10:00 p.m. Staff J reported updating the DON of the discrepancy as she left the facility at the end of her shift on 8/10/21 around 6:00 a.m.</p> <p>On 12/2/21 at 7:45 a.m., Staff K, Certified Medication Aide (CMA), reported not looking at the Lorazepam bottle every time staff counted it at shift change.</p>	F 755	

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F 755 Continued From page 32

F 755

On 12/2/21 at 10:15 a.m., Staff L, Registered Nurse, stated when she and Staff J, Registered Nurse, noted the Lorazepam bottle to contain 23 mL and not 29 mL, she felt the 29 mL had been transcribed incorrectly off the previous count sheet. She stated she probably looked at the bottle at the beginning of her shift to count. She stated she thought she brought the discrepancy to Staff J's attention when Staff J reported for her shift. She did not notify anyone else of the discrepancy. Staff L reported looking closely at the Lorazepam bottle from 8/9/21 to 8/14/21. On 8/14/21 at the start of her shift at 2:00 p.m., she observed 9 mL less in the bottle than last recorded on the count sheet on 8/14/21 at 6:00 a.m.

On 12/2/21 at 10:45 a.m., Staff M, Certified Medication Aide, reporting not looking closely at the bottle of Lorazepam when she arrived on 8/14/21 at 6:00 a.m.

The facility Controlled Substances policy dated April 2019 stated:

a. Controlled medications are counted at the end of each shift. The nurse coming on duty and the nurse going off duty determine the count together.

b. Any discrepancies in the controlled substance count are documented and reported to the DON immediately

On 12/6/21 at 11:48 a.m., the Interim Director of Nurses (DON) reported the expectation for nurses and medication aides to look at each controlled substance when counting with each

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F 755	Continued From page 33 other at each shift change. Staff are expected to notify the DON of any discrepancies. Staff B, former DON, provided education regarding the expectations.	F 755		
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The response or providers plan of correction contained herein shall not be construed as an admission of the validity of the citation or alleged deficiency to which it is addressed.

Accept this as the facility's credible allegation of compliance.

F 550 Resident Rights/Exercise of Rights

SunnyBrook Living Care Center ensures that residents have the right to a dignified existence, self-determination, and communication with and access to persons and services inside and outside the facility. The facility ensures that the resident can exercise his or her rights without interference, coercion, discrimination, or reprisal from the facility.

On 09/19/21 staff member A was placed on immediate suspension for allegation of abuse. Staff A provided written testimony that she did throw resident baby doll on the floor. Facility Self-report filed to DIA on 9/19/21. Facility has not had any contact with Staff member A since her suspension on 9/19/21. On 12/31/21 facility has terminated Staff member A as a result of investigative findings.

All nursing department staff were re-educated on Identification, Prevention, Investigation and Reporting of Abuse on 12/23/21. All nursing department staff will be re-educated on Resident rights during in-service scheduled for January 2nd and January 4th, 2022.

All allegations of resident abuse are addressed immediately, reviewed daily at a.m. QAPI meeting. All reports of resident concerns are addressed daily at a.m. QAPI meeting. Identified concerns are addressed appropriately and reviewed again by the QAPI committee monthly.

Substantial date of compliance: January 4th, 2022.

F 607 Identification, Investigation and Reporting of Abuse/Policies

SunnyBrook Living Care Center has written policies and procedures that include training all new and existing staff in the following topics which include Identification, Investigation and Reporting of Abuse.

Upon initial employment, each employee shall be provided with a copy of and training on the facility's policy and procedures relating to abuse identification, prevention and reporting requirements. Staff are also re-trained one hour education annually and on-going as appropriate. Within six months of hire each employee shall be required to complete an initial 2-hour training course provided by the Iowa Department of Human Services relating to the identification and reporting of dependent adult abuse. Each employee will take a 1-hour recertification training within 3 years of the initial training and every 3 years thereafter.

Staff member identified as not having completion of 2-hour training course provided by the Department of Human Services has been on suspension since 9/19/21. This staff member is no longer employed with facility.

On 12/30/21 all employee personnel files were audited to review current status of 2-hour training certificate on identification and reporting of dependent adult abuse.

New hire personnel files will be audited monthly by the Business Office Manager and/or Administrator to assure employee names are added to the employee file audit tool for compliance. Identified education/training concerns will be addressed immediately. Results of audits will be reported to the monthly QAPI committee for intervention & follow-up. All new hires will be allowed the opportunity to complete the required 2-hour training module prior to being scheduled to work a shift on the floor or for position hired for.

Substantial date of compliance: 12/30/21

F 609 Reporting of Alleged Allegations

SunnyBrook Living Care Center ensures that all alleged violations involving abuse, neglect, exploitation or mistreatment, including injuries of unknown source and misappropriation of resident property, are reported immediately, but not later than 2 hours after the allegation is made, if the events that cause the allegation involve abuse or result in serious bodily injury, or not later than 24 hours if the events that cause the allegation do not involve abuse and do not result in serious bodily injury, to the facility administrator and to other officials including State Survey Agency and local law enforcement.

The facility Administrator or DON will report all allegations of abuse to appropriate agencies within appropriate timeframes. A list of entities to report and appropriate timeframes is added to the abuse reporting policy. The administrator or DON will report to the Iowa Department of Inspection & Appeals and Law Enforcement all allegations of abuse. If the allegation of abuse involves someone who is not an employee of the facility the Department of Human Services shall also be notified.

All allegations of abuse are reported to the QA/QAPI committee daily during a.m. meeting and reviewed again by the QAPI committee monthly and quarterly. Identified concerns will be addressed immediately for interventions and follow-up.

Substantial date of compliance: 12/30/21

F 580 Notify of Changes

SunnyBrook Living Care Center ensures that the facility notifies the resident physician and the resident family/representative immediately to inform of changes, as a result of an accident; significant change in the resident's physical, mental or psychosocial status; a need to alter treatment; or a decision to transfer/discharge from the facility.

All licensed nurses will be re-educated on physician and resident representative notification at in-service scheduled for January 2nd and January 4th.

The Director of Nursing/designee will conduct random audits 5 times per week times 4 weeks concerning resident changes to monitor physician and resident representative notifications. Identified

concerns will be addressed immediately for resolution. Resident status changes and outcomes will be reported to the daily a.m. QAPI committee for further investigation, interventions and follow-up.

Substantial date of compliance: January 4th, 2022.

F 625 Notice of Bed Hold Policy Before/Upon Transfer

SunnyBrook Living Care Center ensures that before a resident is transferred to a hospital or the resident goes on therapeutic leave, the facility provides written information to the resident and/or the resident representative that specifies the duration of the bed-hold policy, during which the resident is permitted to return and resume residence at facility.

All residents who are transferred to a hospital or on therapeutic leave will be provided a written bed-hold policy at time of transfer. This also will include all residents who are on Medicaid. Bed-hold notice forms are located at each nurse's station. The facility Social Worker or the Business Office Manager will follow up with resident and/or resident family/representative next business day to obtain needed verification/understanding of the bed-hold policy and their preferences.

All residents transferred to hospital are reviewed at daily a.m. QAPI meeting. A box has been added to the daily QA minutes sheet to verify that a bed-hold policy has been completed with each resident transfer.

Re-education will be provided to licensed nurses at in-service scheduled January 2nd & January 4th. Any concerns will be addressed immediately for interventions/follow-up.

Substantial date of compliance: January 4th, 2022.

F 657 Care Plan Timing and Revision

SunnyBrook Living Care Center ensures that a comprehensive care plan is developed within 7 days after completion of the comprehensive assessment by the interdisciplinary team.

To the extent possible resident # 19 and all facility resident's and/or the resident representative will be invited to their individual care plan meeting. Individual care plan meeting invites are coordinated by the facility social worker or MDS/Care Plan nurse. Facility will provide opportunities/accommodations for residents and resident representatives to participate in care plan activities. A list of residents including date, time and location of scheduled care plan meetings is provided to the interdisciplinary team from the social worker weekly. An attendance sheet is completed at the time of the care plan conference meeting.

Attendance sheets will be audited weekly X 3 months by the Social Services Director/designee to monitor for compliance. Care Review form/attendance sheet will be kept in the resident medical chart. Identified concerns will be addressed immediately for resolution. Interventions will be reviewed monthly by the QAPI committee members.

Substantial date of compliance: 12/30/21

On 12/30/21 the Interim DON/MDS nurse updated the care plans on residents #1 for fall interventions and resident's # 27 (12/21/21) & # 59 (12-30-21) for pressure ulcer interventions. Resident #27 is encouraged frequently to elevate feet.

All Licensed nurses will be re-educated on Care Plan Timing and Revisions/Interventions at in-service scheduled January 2nd and January 4th.

The Director of Nursing will conduct random audits of resident care plans 3 times weekly times 4 weeks to monitor for care plan interventions/updates. Identified concerns will be addressed immediately. Outcomes will be reported to the QAPI committee monthly for further discussion and follow-up.

Substantial date of compliance: 01/04/22

F 658 Services provided meet professional Standards

SunnyBrook Living Care Center ensures that the services provided or arranged by the facility, as outlined by the comprehensive care plan meets professional standards of quality.

All licensed nursing staff will be re-educated on January 2nd and January 4th, 2022 by the Interim DON in regard to the Medication and Treatment Orders Policy & Procedures.

The Director of Nursing/designee will conduct random audits 3 times weekly times 4 weeks to monitor for compliance. Identified concerns will be addressed immediately for resolution. Outcomes will be reported to the QAPI committee monthly for discussion and follow-up.

Substantial date of compliance: January 4th, 2022.

F 677 ADL Care Provided for Dependent Residents

SunnyBrook Living Care Center ensures that a resident who is unable to carry out activities of daily living receives the necessary services to maintain good nutrition, grooming, personal and oral hygiene.

All nursing department staff will be re-educated on oral care policy and procedure at in-service scheduled January 2nd and January 4th.

The Director of Nursing/designee will conduct 3 random oral care audits weekly times 4 weeks. Identified concerns will be addressed immediately for resolution and shared with the QAPI Committee monthly for further interventions and follow-up.

Identified CNA staff members have been re-educated individually and written disciplinary actions put in place.

Substantial date of compliance: January 4th, 2022

F 689 Free of Accident Hazards/Supervision/Devices

SunnyBrook Living Care Center ensures that the resident environment remains as free of accident hazards as is possible and each resident receives adequate supervision and assistance devices to prevent accidents.

All nursing department staff will be re-educated on Falls Interventions Policy @ in-service scheduled on January 2nd and January 4th. Fall Interventions as appropriate will be added to the resident care plans timely.

The Director of Nursing/designee will conduct random audits 3 times weekly times 4 weeks monitoring fall interventions and care plan updates compliance. Identified concerns will be addressed immediately.

Resident falls/incidents are reviewed daily in a.m. QAPI meeting for review and discussion. Further outcome reporting is provided by the Director of Nursing/designee monthly to the QAPI committee for follow-up.

Substantial date of compliance: January 4th, 2022.

F 690 Bowel/Bladder Incontinence, Catheter, UTI

SunnyBrook Living Care Center ensures that a resident who is continent of bladder and bowel on admission is receives services and assistance to maintain continence unless his or her clinical condition is or becomes such that continence is not possible to maintain.

The facility is responsible for the assessment of the resident at risk for urinary catheterization and/or the ongoing assessment for the resident who currently has a catheter. The Director of Nursing will re-educate all the licensed nursing staff at in-service scheduled January 2nd and January 4th urinary catheter policy and procedures and assessment for discontinuation of catheter when appropriate.

Resident # 61 urinary catheter removed on 12/4/21.

Substantial date of compliance: January 4th, 2022

F 732 Posted Nurse Staffing Information

SunnyBrook Living Care Center ensures to post the nurse staffing information daily. This information will include facility name, current date, total number of actual hours worked by all Licensed nurses, CNA's, & CMA's per shift and the resident census number.

The daily nursing department staffing posting is located at the main front entrance of the facility at the receptionist desk area.

The Director of Nursing will re-educate the night shift nurses to post the staffing and census information every day at in-service scheduled for January 2nd and January 4th, 2022. The DON or the Administrator will monitor daily for compliance and report to the daily a.m. QAPI meeting. Daily staff posting has been added to the Q.A. a.m. meeting minutes sheet.

Substantial date of compliance: January 4th, 2022

F 755 Pharmacy Services/ Procedures/Pharmacist/Records

SunnyBrook Living Care Center ensures to provide routine and emergency drugs and biologicals to its residents or obtain them under an agreement described in 483.70 (g).

All licensed nurses and CMA's will be re-educated on appropriate and accurate reconciliation of controlled substances and the Controlled Substances Policy during In-service scheduled for January 2nd and January 4th. Staff are expected to notify the DON/Administrator immediately of any discrepancies.

Audits will be performed by the Director of Nursing observing each Licensed Nurse and CMA to demonstrate compliancy and accuracy during controlled substances count. Identified concerns will be addressed immediately for resolution.

Outcomes will be reported to the monthly QAPI committee for follow-up.

Substantial date of compliance: January 7th, 2022.