| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
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| | 165279 | A. BUILDING _____ B. WING _____ | 06/24/2021 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
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| MONTICELLO NURSING & REHAB CEN | 500 PINEHAVEN DRIVE MONTICELLO, IA 52310 |

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| F 000 | INITIAL COMMENTS<br><br>Correction Date: _____<br><br>The following deficiencies relate to the Recertification Survey and investigation of Complaints #95429, #95691, #96545, and #96998 conducted 6/21/21 through 6/24/21. Complaints #95691 and #96998 substantiated. (See Code of Federal Regulations (42CFR) Part 483, Subpart B-C). | F 000 | | |
| F 684 SS=D | Quality of Care<br>CFR(s): 483.25<br><br>§ 483.25 Quality of care<br>Quality of care is a fundamental principle that applies to all treatment and care provided to facility residents. Based on the comprehensive assessment of a resident, the facility must ensure that residents receive treatment and care in accordance with professional standards of practice, the comprehensive person-centered care plan, and the residents' choices.<br>This REQUIREMENT is not met as evidenced by:<br>Based on record review and staff interview, the facility failed to document an assessment of a resident after sustaining a fall which resulted in a hip fracture and before the resident transported to the hospital. (Resident #25). The facility reported a census of 57 residents.<br><br>Findings Include:<br><br>The Minimum Data Set (MDS) completed 3/11/21 for Resident #25 reflected the resident with the diagnoses of: Alzheimer's Disease, kidney | F 684 | | |

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE 06/30/2021

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
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| | 165279 | A. BUILDING _____ B. WING _____ | 06/24/2021 |

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|---|---|---|---|---|
| F 684 | Continued From page 1 | F 684 | | |

disease and diabetes, and rarely able to make themselves understood or understand others and required extensive staff assistance with transfers in and out of bed and with walking.

The MDS completed 6/15/21 reflected the resident sustained a fracture of her right hip and now required extensive staff assistance with most activities of daily living.

The Care Plan identified the resident with the problem of at risk for falls on 7/28/17 and directed staff to provide one staff to assist her with transfers with a gait belt and walker.

A review of the Incident Report dated 4/24/21 reflected the resident fell at 7:40 AM as she tried to walk around a table, complained of pain to her right leg with movement, vital signs stable, physician and family notified. The report failed to have documentation of the time the resident taken to the hospital and the mode of transportation.

A review of the Nurse's Notes documented the resident fell on 4/24/21 at 7:40 AM, at that time her vital signs had been stable, complained of pain when she moved her leg, and notified the power of attorney. At 8:40 AM, vital signs taken had been stable, the resident yelled when she moved her leg, and the physician gave orders to send the resident to the hospital to get assessed. The documentation failed to show an assessment of the resident prior to leaving and how she had been transported to the hospital where she stayed for 3 days after having a surgical repair of the fracture.

In an interview on 6/23/21 at 11:17 AM, Staff A,

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
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| F 684 | Continued From page 2<br>Registered Nurse (RN) reported before a resident is transferred to the hospital, the nurse should document in the Nurses's Notes the assessment of the resident, notification of the doctor and family, a set of vital signs and how the resident transported - by ambulance or per family.<br><br>In an interview on 6/23/21 at 1:27 PM, Staff C, Licensed Practical Nurse (LPN) reported before a resident transferred to the hospital, the nurse should document in the Nurse's Notes a full head to toe assessment of the resident, vital signs, the notification of the doctor and the family and how the resident transported either by ambulance or by family.<br><br>In an interview on 6/24/21 at 8:41 AM, the Director of Nursing (DON) reported she expected the nurse to complete an assessment, document how the resident transferred out, by car or ambulance and this should be documented in the Nurse's Notes. The DON also verified the nurse did not chart an assessment prior to the resident's transfer to the hospital, due to the facility lost the Internet connection that day and could not access the electronic record. The DON also reported she expected the nurse to document an entry in the paper chart when the electronic record unavailable, but the nurse forgot to do so before she left the facility that day. | F 684 | | |
| F 695 SS=D | Respiratory/Tracheostomy Care and Suctioning CFR(s): 483.25(i)<br><br>§ 483.25(i) Respiratory care, including tracheostomy care and tracheal suctioning.<br>The facility must ensure that a resident who needs respiratory care, including tracheostomy care and tracheal suctioning, is provided such | F 695 | | |

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|---|---|---|---|
| | 165279 | A. BUILDING _____ B. WING _____ | 06/24/2021 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
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|---|---|---|---|---|
| F 695 | Continued From page 3 | F 695 | | |

care, consistent with professional standards of practice, the comprehensive person-centered care plan, the residents' goals and preferences, and 483.65 of this subpart.
This REQUIREMENT is not met as evidenced by:
Based on observation, record review and staff interview, the facility failed to label the oxygen tubing to indicate the date when last changed for three of four residents reviewed in the standard sample. (Residents #8, #29 and #46). The facility reported a census of 57 residents.

Findings Include:

1. The Minimum Data Set (MDS) completed 4/8/21 for Resident #8 reflected the resident with the diagnoses of: pneumonia, dysrhythmia and malnutrition, identified a Brief Interview for Mental Status (BIMS) score of 15 which indicated cognition intact and independent with most activities of daily living.

The Care Plan identified the resident with the problem of altered respiratory status related to COPD (chronic obstructive pulmonary disease) with the goal target date of 9/15/21 and directed staff to:
a. For residents who should be ambulatory, provide extension tubing or portable oxygen apparatus.
b. Give medications as ordered.
c. Monitor for signs of respiratory distress and report to the physician as needed.
d. Monitor/document/report abnormal breathing patterns to the physician.
e. Oxygen as ordered.

The Care Plan failed to direct staff on how often

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 165279 | A. BUILDING _____ B. WING _____ | 06/24/2021 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
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|---|---|---|---|---|
| F 695 | Continued From page 4 | F 695 | | |

the oxygen tubing should be changed.

The Physician Order Sheet signed by the physician on 3/19/21 and the June 2021 Medication Administration Record (MAR) contained active orders for oxygen two liters per nasal cannula every shift related to COPD.

Observations of the resident revealed the following on:
a. On 6/23/21 at 1:07 PM showed the resident's oxygen tubing without a date.
b. On 6/24 21 at 6/24/21 7:45 AM showed the resident's oxygen tubing without a date.

2. The MDS completed 4/8/21 for Resident #29 reflected the resident with the diagnoses of: heart failure, diabetes mellitus and acute respiratory failure with hypercapnia (too much carbon dioxide in the bloodstream), identified a BIMS score of 15 which indicated cognition intact and independent with most activities of daily living.

The Care Plan identified the resident with the problem of altered respiratory status related to COPD (chronic obstructive pulmonary disease) with the goal target date of 8/6/21 and directed staff to:
a. For residents who should be ambulatory, provide extension tubing or portable oxygen apparatus.
b. Give medications as ordered.
c. Monitor for signs of respiratory distress and report to the physician as needed.
d. Monitor/document/report abnormal breathing patterns to the physician.
e. Oxygen as ordered.

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|---|---|---|---|---|
| F 695 | Continued From page 5 | F 695 | | |

The Care Plan did not direct staff on how often the oxygen tubing should be changed.

The Physician Order dated by the physician 4/27/21 contained active orders for continuous oxygen at two liters per nasal cannula every shift related to acute respiratory failure with hypercapnia.

Observations of Resident #29 revealed her oxygen tubing failed to show a date to indicate when the tubing changed last:
a. On 6/21/21 at 11:03 AM, as she sat in the recliner in her room and talked on her cellular phone.
b. On 6/21/21 at 11:35 AM assessment unchanged.
c. On 6/21/21 at 12:29 PM, as she sat in a main dining room chair.
d. On 6/21/21 at 12:38 PM, as she walked independently from the main dining room to the hallway.
e. On 6/21/21 at 12:58 PM, as she sat in the recliner in her room.
f. On 6/21/21 at 2:00 PM, as she walked independently in the hallway with a wheeled walker and portable oxygen tank stored securely in vinyl sleeve on walker.
g. On 6/22/21 at 6:40 AM, as the resident sat in the recliner in her room.
h. On 6/22/21 at 7:28 AM, as the resident walked independently in her room from bathroom to sit in her recliner with steady gait.
i. On 6/22/21 at 9:25 AM, assessment unchanged.
j. On 6/22/21 at 12:05 PM, as she walked independently from her room to the main dining room, with her portable oxygen tank.
k. On 6/22/21 at 2:10 PM, as she sat in the

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
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|---|---|---|---|---|
| F 695 | Continued From page 6 | F 695 | | |

recliner in her room.
l. On 6/23/21 at 7:49 AM, as she sat in the recliner in her room.

3. The MDS completed 5/27/21 for Resident #46 reflected the resident with the diagnoses of: chronic obstructive pulmonary disease, chronic respiratory failure with hypoxia (low oxygen level) and pulmonary hypertension, identified a BIMS score of 15 which indicated cognition intact and required extensive staff assistance with moving and transferring in and out of bed, dressing, toileting and bathing.

The Care Plan identified the resident with the problem of altered respiratory status related to COPD (chronic obstructive pulmonary disease) with the goal target date of 8/27/21 and directed staff to:
a. For residents who should be ambulatory, provide extension tubing or portable oxygen apparatus.
b. Give medications as ordered.
c. Monitor for signs of respiratory distress and report to the physician as needed.
d. Monitor/document/report abnormal breathing patterns to the physician.
e. Oxygen as ordered.

The Care Plan did not direct staff on how often the oxygen tubing should be changed.

The Physician Order dated by the physician 4/27/21 contained active orders for continuous oxygen at two liters per nasal cannula every shift related to acute respiratory failure with hypoxia.

Observations of Resident #46 revealed his

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 165279 | A. BUILDING _____ B. WING _____ | 06/24/2021 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
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|---|---|---|---|---|
| F 695 | Continued From page 7 | F 695 | | |

oxygen tubing failed to show a date to indicate when the tubing changed last:
a. On 6/21/21 at 10:32 AM as he sat in a wheelchair with continuous oxygen maintained at three liters per minute per nasal tubing via concentrator.
b. On 6/21/21 at 11:17 AM assessment unchanged.
c. On 6/21/21 at 12:20 PM as he sat in a wheelchair in the main dining room.
d. On 6/21/21 at 12:59 PM as he sat in a wheelchair in his room.
e. On 6/21/21 at 1:40 PM assessment unchanged.
f. On 6/21/21 at 2:15 PM assessment unchanged.
g. On 6/22/21 at 6:42 AM as he slept in bed.
h. On 6/22/21 at 7:15 AM as he sat on a commode chair in his room.
i. On 6/22/21 at 8:35 AM as he slept in bed.
j. On 6/22/21 at 9:24 AM as he sat in a wheelchair in his room.
k. On 6/22/21 10:19 AM as he laid in bed.
l. On 6/22/21 at 2:20 PM as he sat in a wheelchair in his room.
m. On 6/23/21 at 8:33 AM as he laid in bed.

In an interview on 6/23/21 at 11:17 AM, Staff A, Registered Nurse (RN) reported when a resident has continuous oxygen, the third shift nurses typically changed the tubing once a week and document it on the Treatment Administration Record (TAR) and they would write the date on the tubing.

In an interview on 6/23/21 at 1:15 PM, Staff B, RN reported when a resident has continuous oxygen, the third shift nurses typically changed the tubing once a week and document it on the TAR and they would write the date on the tubing and that it

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| | 165279 | A. BUILDING _____ B. WING _____ | 06/24/2021 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
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| F 695 | Continued From page 8<br>should be addressed on the Care Plan.<br><br>In an interview on 6/23/21 at 1:27 PM, Staff C, Licensed Practical Nurse (LPN) reported when a resident has continuous oxygen, the third shift nurses typically change the tubing once a week, document it on the TAR and write the date on the tubing and also be addressed on the resident's Care Plan.<br><br>In an interview on 6/24/21 at 5:33 AM, Staff F, RN reported when a resident has continuous oxygen, the third shift nurses typically change the tubing once a week on Friday and document it on the TAR, write the date on the tubing and be addressed on the resident's Care Plan.<br><br>In an interview on 6/24/21 at 8:41 AM, the Director of Nursing (DON) reported she expected the night shift nurses to change oxygen tubing once a week on Friday, document it on the TAR and be addressed on the Care Plan. | F 695 | | |