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	165625	A. BUILDING _____ B. WING _____	05/04/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
TERRACE GLEN VILLAGE	3400 ALBURNETT ROAD MARION, IA 52302

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F 000	INITIAL COMMENTS	F 000		

OK/TAG Correction Date: 06/03/2022

✓

The following deficiencies resulted from the facility's Recertification Survey and investigation of Complaints #91265-C, #92968-C , #97163-C, #98254-C, #100959-C and a Facility Self-Reported Incident #102083-I conducted on April 25, 2022 to May 4, 2022.

Complaint #91265-C, #92968-C, #97163-C, #98254-C, #100959-C were substantiated. Facility Self-Reported Incident #102083- I was substantiated.

See Code of Federal Regulations (42CFR) Part 483, Subpart B-C.

F 623 SS=B Notice Requirements Before Transfer/Discharge CFR(s): 483.15(c)(3)-(6)(8) — F 623

§483.15(c)(3) Notice before transfer.
Before a facility transfers or discharges a resident, the facility must-
(i) Notify the resident and the resident's representative(s) of the transfer or discharge and the reasons for the move in writing and in a language and manner they understand. The facility must send a copy of the notice to a representative of the Office of the State Long-Term Care Ombudsman.
(ii) Record the reasons for the transfer or discharge in the resident's medical record in accordance with paragraph (c)(2) of this section; and
(iii) Include in the notice the items described in paragraph (c)(5) of this section.

§483.15(c)(4) Timing of the notice.

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
[signature]	Executive Director 05/17/22	05/18/2022

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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(i) Except as specified in paragraphs (c)(4)(ii) and (c)(8) of this section, the notice of transfer or discharge required under this section must be made by the facility at least 30 days before the resident is transferred or discharged.
(ii) Notice must be made as soon as practicable before transfer or discharge when-
(A) The safety of individuals in the facility would be endangered under paragraph (c)(1)(i)(C) of this section;
(B) The health of individuals in the facility would be endangered, under paragraph (c)(1)(i)(D) of this section;
(C) The resident's health improves sufficiently to allow a more immediate transfer or discharge, under paragraph (c)(1)(i)(B) of this section;
(D) An immediate transfer or discharge is required by the resident's urgent medical needs, under paragraph (c)(1)(i)(A) of this section; or
(E) A resident has not resided in the facility for 30 days.

§483.15(c)(5) Contents of the notice. The written notice specified in paragraph (c)(3) of this section must include the following:
(i) The reason for transfer or discharge;
(ii) The effective date of transfer or discharge;
(iii) The location to which the resident is transferred or discharged;
(iv) A statement of the resident's appeal rights, including the name, address (mailing and email), and telephone number of the entity which receives such requests; and information on how to obtain an appeal form and assistance in completing the form and submitting the appeal hearing request;
(v) The name, address (mailing and email) and telephone number of the Office of the State

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Long-Term Care Ombudsman;
(vi) For nursing facility residents with intellectual and developmental disabilities or related disabilities, the mailing and email address and telephone number of the agency responsible for the protection and advocacy of individuals with developmental disabilities established under Part C of the Developmental Disabilities Assistance and Bill of Rights Act of 2000 (Pub. L. 106-402, codified at 42 U.S.C. 15001 et seq.); and
(vii) For nursing facility residents with a mental disorder or related disabilities, the mailing and email address and telephone number of the agency responsible for the protection and advocacy of individuals with a mental disorder established under the Protection and Advocacy for Mentally Ill Individuals Act.

§483.15(c)(6) Changes to the notice.
If the information in the notice changes prior to effecting the transfer or discharge, the facility must update the recipients of the notice as soon as practicable once the updated information becomes available.

§483.15(c)(8) Notice in advance of facility closure
In the case of facility closure, the individual who is the administrator of the facility must provide written notification prior to the impending closure to the State Survey Agency, the Office of the State Long-Term Care Ombudsman, residents of the facility, and the resident representatives, as well as the plan for the transfer and adequate relocation of the residents, as required at § 483.70(l).
This REQUIREMENT is not met as evidenced by:
Based on clinical record review, staff interviews and policy review the facility failed to notify the

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F 623	Continued From page 3	F 623		

State Long Term Care (LTC) Ombudsman for 1 of 2 residents reviewed for transfers out of the facility (Resident #4). The facility reported a census of 30 residents.

Findings Include:

Review of the Census List for Resident #4 revealed the following resident's status:
a. On Hospital Leave on 1/14/22 and returned on 1/18/22.
b. On Hospital Leave on 3/17/22 and returned on 3/19/22.
c. On Hospital Leave on 4/12/22 and returned on 4/15/22.

Review of Minimum Data Set (MDS) assessments dated 12/7/21, 3/19/22, and 4/15/22 revealed Resident #4 re-admitted to the facility on those dates from the hospital.

The facility failed to provide documentation that staff notified the LTC Ombudsman when Resident #4 transferred from the facility to the hospital on 1/14/22 and 3/17/22. The facility had not submitted for April 2022 hospitalizations at this time.

The Notice of Transfer Form to LTC Ombudsman for the facility lacked documentation of Resident #4 being sent to the hospital on 1/14/22 and 3/17/22. The facility had not submitted the Notice of Transfer Form to the LTC Ombudsman for April 2022 at this time.

In an interview on 5/2/22 at 10:15 AM, the Director of Nursing (DON) stated there was not a policy for notification of the LTC Ombudsman for hospitalizations and discharges from the facility.

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F 623	Continued From page 4 A blank Notice of Transfer Form to Long Term Care Ombudsman was submitted which indicated a reason code for hospitalization. In an interview on 4/28/22 at 10:53 AM, DON reported the facility failed to report hospitalizations to the Ombudsman, had only been reporting discharges. In an interview on 5/2/22 at 9:55 AM, Staff B, Registered Nurse (RN) reported she was responsible for notifying the LTC Ombudsman of hospitalizations and discharges from the facility each month. Staff B stated she had been in her current position since August 2021 and was still learning the new role. Staff B stated the Notice of Transfer Form to Long Term Care Ombudsman was submitted at the beginning of each month for the prior month. Staff B identified that she had not been submitting hospitalizations on the form as she thought if they were out of the facility on a bed hold, she did not need to submit the names. She now knows of the expectation and will be submitting them.	F 623		
F 644 SS=D	Coordination of PASARR and Assessments CFR(s): 483.20(e)(1)(2) §483.20(e) Coordination. A facility must coordinate assessments with the pre-admission screening and resident review (PASARR) program under Medicaid in subpart C of this part to the maximum extent practicable to avoid duplicative testing and effort. Coordination includes: §483.20(e)(1)Incorporating the recommendations from the PASARR level II determination and the PASARR evaluation report into a resident's	F 644		

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assessment, care planning, and transitions of care.

§483.20(e)(2) Referring all level II residents and all residents with newly evident or possible serious mental disorder, intellectual disability, or a related condition for level II resident review upon a significant change in status assessment.
This REQUIREMENT is not met as evidenced by:
Based on observation, clinical record review and staff interview, the facility failed to complete a follow-up Preadmission Screening and Resident Review (PASRR) for one of one residents reviewed in the current sample who had a change in mental health diagnoses and psychotropic medication (Resident #11). The facility reported a census of 30 residents.

Findings Include:

The Significant Change Minimum Data Set (MDS) Assessment dated 2/9/22 recorded Resident #11 had diagnoses that included non-Alzheimer's dementia, depression and psychotic disorder. The MDS indicated the resident with no serious mental illness and had not met criteria for a Level 2 PASRR. The assessment documented Resident #11 re-entered the facility on 9/23/20. The MDS further documented Resident #11 had a Brief Interview for Mental Status (BIMS) of 5 indicating severely impaired decision making skills. The MDS indicated Resident #11 received antipsychotic and antidepressant medications for 7 of 7 days during the look-back period.

The Care Plan with a revision date 3/15/21 revealed Resident #11 with diagnoses of Lewy

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body dementia, delusional disorder, psychosis and major depressive disorder and had hallucination and delusions that caused her to become agitated and fearful. The Care Plan directives for staff included monitoring mood/behaviors/cognition and side effects of antidepressant, anti-convulsant and antipsychotic medications.

The Medication Administration Record (MAR) dated 4/2022 revealed Resident #11 took the following medications:
a. Depakote (anticonvulsant) for major depressive disorder.
b. Lexapro (antidepressant) for major depressive disorder.
c. Seroquel (antipsychotic) for delusional disorder and unspecified dementia with behavioral disturbance.
d. Seroquel (antipsychotic) as needed for hallucinations.

The medical record revealed a negative Level 1 PASRR dated 8/5/19 completed by Ascend Management Innovation under contract with the Iowa Department of Human Services to perform Level 1 screens and Level 2 evaluations. The Level 1 PASRR screening documented Resident #11 did not have a diagnoses of major depression, psychotic/delusional disorder or dementia and did not exhibit hallucinations or delusions at the time of the screening.

Observation 4/25/22 at 1:11 PM, revealed Resident #11 in the hallway of the health care center with a visitor present inquiring about people in the hallway that are coming through the door. At the time of the observation, there were not people in the hallway nor people coming

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F 644	Continued From page 7 through the door. During an interview 04/27/22 at 11:10 AM the Director of Nursing (DON) acknowledged a Level 2 evaluation had not been submitted as it should have been since Resident #11 diagnosed with a new mental health diagnosis since the Level 1 PASRR had been completed. On 5/3/22 at 3:37 PM the DON reported they do not have a policy in place for PASRR completion.	F 644		
F 656 SS=D	Develop/Implement Comprehensive Care Plan CFR(s): 483.21(b)(1) §483.21(b) Comprehensive Care Plans §483.21(b)(1) The facility must develop and implement a comprehensive person-centered care plan for each resident, consistent with the resident rights set forth at §483.10(c)(2) and §483.10(c)(3), that includes measurable objectives and timeframes to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment. The comprehensive care plan must describe the following - (i) The services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §483.24, §483.25 or §483.40; and (ii) Any services that would otherwise be required under §483.24, §483.25 or §483.40 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(c)(6). (iii) Any specialized services or specialized rehabilitative services the nursing facility will provide as a result of PASARR recommendations. If a facility disagrees with the	F 656		

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findings of the PASARR, it must indicate its rationale in the resident's medical record.
(iv)In consultation with the resident and the resident's representative(s)-
(A) The resident's goals for admission and desired outcomes.
(B) The resident's preference and potential for future discharge. Facilities must document whether the resident's desire to return to the community was assessed and any referrals to local contact agencies and/or other appropriate entities, for this purpose.
(C) Discharge plans in the comprehensive care plan, as appropriate, in accordance with the requirements set forth in paragraph (c) of this section.
This REQUIREMENT is not met as evidenced by:
Based on clinical record review, staff interviews and facility policy review the facility failed to include a fall risk concern on the Comprehensive Care Plan for a resident with a recent fall with fracture for 1 of 3 residents reviewed for falls (Resident #22). The facility reported a census of 30 residents.

Findings Include:

The Admission Minimum Data Assessment (MDS) dated 8/4/20 identified diagnoses of Alzheimer's disease, dementia, anxiety disorder, hypertrophic osteoarthropathy and gastro-esophageal reflux disease (GERD) for the resident. A Brief Interview for Mental Status (BIMS) score of 10 indicated moderate cognitive impairment. Resident #22 required limited assistance of one staff for bed mobility, transfers and personal hygiene, extensive assistance of one for toileting and supervision for eating. The

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MDS indicated the resident unsteady from seated to standing position, walking, turning around and facing the opposite direction while walking, moving on and off the toilet and with surface to surface transfers. Resident #22 utilized a walker and wheelchair for mobility. The MDS revealed a fall in the month prior to admission, a fall in the previous 2-4 months prior to admission, a fall in the previous 2-6 months prior to admission and a fracture related to a fall in the previous 6 months prior to admission. The MDS also revealed 2 or more falls without injury since admission.

Per the MDS instructions in section V under the Care Area Assessment (CAA) Summary instructed for each triggered Care Area, staff are to indicate whether a new Care Plan, Care Plan revision, or continuation of current Care Plan is necessary to address the problem(s) identified in the assessment of the care area. Per the MDS dated 8/4/20, falls triggered as a problem and per the CAA Trigger Summary it was to be addressed on the Care Plan. The CAA worksheet revealed the following: I will be free of falls and need assistance with transfers and ambulation, however not added to the Comprehensive Care Plan.

The Baseline Care Plan on admission to the facility dated 7/27/20 indicated the resident at risk for falls, and the resident had a fall in the last 30 days with a fracture of the pubis in the last 6 months. A goal was set not to fall through the next review date.

The Initial Comprehensive Care Plan dated 9/21/20, revealed Focus Areas for alteration in nutrition, acute pain, disease management, impaired physical mobility, impaired social

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interaction, medication management, personalized care, risk for self-harm, risk for impaired urinary elimination, risk for insomnia, risk for self-care deficit, safety, assistance with meeting emotional, spiritual, intellectual, physical and social needs, activity of daily living assistance, and dementia. The Care Plan lacked a focus area addressing resident being a fall risk and no interventions in place for staff to monitor, evaluate or assist resident in preventing further falls.

The Fall Risk Assessment dated 8/21/20, revealed Resident #22 to be disoriented times 3, 1-2 falls in the previous 3 months, required regular assistance with elimination, balance problems with standing and walking, required the use of assistive devices and carried a diagnosis of dementia.

The Incident Report dated 8/2/20, indicated Resident #22 found on the floor in the hallway at 6:40 PM, sitting on buttocks with legs straight out in front of her and hands at her side. Resident had been ambulating alone and unattended. The report indicated resident confused and looking for an Uber to go home and this was baseline mental status for the resident. Resident had shoes on and not using an assistive device for ambulation. Root cause felt to be Resident #22 left in room alone and attempted to transfer. Intervention placed to not leave resident alone in room.

Progress Note dated 8/2/20 at 9:33 PM, indicated Resident #22 was found sitting on her buttocks on the floor outside her room with legs stretched out in front of her. The wheelchair and walker were next to her. Resident unable to recall what happened. Resident #22 denied pain, moved all

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extremities well, pupils were equal and reactive to light, grips equal and no change in mental status noted. Two staff assisted resident into wheelchair and resident was able to propel the wheelchair without difficulty or complaints of pain.

Progress Note dated 8/3/20 at 5:24 AM, indicated the granddaughter updated regarding the fall and the medical provider faxed regarding the fall.

Progress Note dated 8/3/20 at 12:53 PM, indicated the granddaughter concerned with the fall. Care plan reviewed with her. Resident #22 to be assisted by one staff and granddaughter had no further questions or concerns.

In an interview on 4/28/22 at 2:00 PM, the Director of Nursing (DON) stated it is his expectation that there be a fall risk concern on the Comprehensive Care Plan for a resident that came to the facility after a fall with fracture.

In an interview on 5/2/22 at 10:10 AM, Staff C, MDS Coordinator reported she had been in the position for 7 months. She stated it was an expectation a fall risk concern be put in place for a resident admitted to the facility after a fall with fracture. Staff C stated a fall problem, goal and interventions would be put in place to help prevent the resident from further falls or injuries. Staff C indicated Interventions on the Care Plan were instrumental in educating the staff on how to care for the resident.

The facility provided a policy titled Care Plans, Comprehensive Person-Centered dated December 2016. The policy stated the Interdisciplinary Team (IDT) and resident were to incorporate identified problem areas and risk

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F 656	Continued From page 12 factors associated with the identified problems into the Comprehensive Care Plan. The Comprehensive Care Plan was to reflect treatment goals, timetables and objectives in measurable outcomes. Identifying problem areas and their causes, and developing interventions that were targeted and meaningful to the resident was the endpoint of an interdisciplinary process.	F 656		
F 658 SS=D	Services Provided Meet Professional Standards 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 record review, observation, family and staff interviews, the facility failed to treat constipation in accordance with facility policy and professional standards (Resident #1) and failed to follow physician's orders for wound treatment (Resident #5) for 2 of 12 residents reviewed. The facility reported a census of 30 residents. Findings Include: 1. The Minimum Data Set (MDS) assessment dated 4/6/22 revealed Resident #1 with diagnoses that included non-Alzheimer's dementia, anxiety and depression. The MDS documented a Brief Interview for Mental Status (BIMS) score of 1 indicating severely impaired cognition. The MDS further documented Resident #1 required total dependence of 2 staff for transfers and extensive assistance of 2 staff for toilet use and was always continent regarding	F 658		

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bowel movements (BM).

The Care Plan initiated with a Focus Area initiated 1/10/22 revealed Resident #1 had an activities of daily living (ADL) self-care performance deficit related to impaired mobility, dementia and compression fractures of the vertebra. The Care Plan directed staff to check and change Resident #1 before and after meals, at bedtime and as needed.

The Progress Notes for 4/2022 contained the following entries:
a. On 4/3/22 at 9:42 AM, staff documented an Orders-Administration Note that showed they administered Milk of Magnesia Suspension (MOM) 1200 Milligrams (mg)/15 Milliliters (ml) by mouth as needed for constipation.
b. On 4/3/22 at 5:14 PM, staff documented an Orders-Administration Note that verified the administered MOM 1200 MG/15 ML as needed for constipation was ineffective.

Additional review of the Progress Notes revealed a lack of documentation to indicate staff administered Resident #1 MOM as needed.

The BM Record for 4/2022 revealed Resident #1 had a BM on the following dates:
a. On 4/3/22.
b. On 4/4/22.
c. On 4/9/22.
d. On 4/22/22.
e. On 4/23/22.
f. On 4/27/22.

Review of the Medication Administration Record (MAR) dated 4/2022 revealed the physician ordered Resident #1 the following with directives

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to staff related to constipation management:
a. MOM 1200 mg/15 ml Give 30 ml's by mouth every 24 hours as needed for constipation with a start date of 1/26/21.

The undated Bowel Movement Monitoring/Protocol directed the Night Nurse to review BM records daily by running the Look Back Report and communicate in morning report any resident without BM's for 2 days or more and implement the following protocol:
a. Day 0-Day 2= no interventions
b. Day 3 = Day shift administer as needed MOM/Miralax dose and document acceptance or refusals/results
c. Day 4 = Day shift administer as needed Bisacodyl suppository dose and document acceptance or refusal/results
d. Day 5 and every day thereafter = Check bowel sounds, abdominal status - any distention or pain and call Primary Care Physician for further directives.
e. Document completion and further interventions and results.

During an interview 4/26/22 at 3:28 PM, a family member revealed Resident #1's BMs were as big as a "horse".

During an interview 5/02/22 at 9:05 AM, the Director of Nursing (DON) revealed the bowel protocol not followed for Resident #1 as expected. The DON further revealed the only intervention that had been implemented as part of the bowel program for 4/2022 was when Resident #1 received MOM on 4/3/22.

2. The MDS Assessment dated 1/31/22

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F 658	Continued From page 15 documented Resident #5 with diagnoses of peripheral vascular disease, heart failure and malnutrition. The MDS further revealed Resident #5 had a BIMS of 10 indicating moderate cognitive impairment. During a wound treatment observation on 4/27/22 at 10:55 AM, noted Resident #5's right lateral distal foot wound with a scab. Staff D, Registered Nurse (RN), stated the current treatment for the distal wound is to keep it open to air since it is scabbed over and did not complete the treatment as ordered. Review of Resident #5's current Treatment Administration Record (TAR) for 4/2022 indicated the following Treatment Order with a Start Date of 2/16/22: a. Right lateral proximal foot and right lateral distal foot wounds: Cleanse with normal saline and pat dry. b. Paint with Betadine and allow to dry. c. Cover with silicone bordered foam dressing (Mepilex). d. Change Monday, Wednesday, Friday and as needed for soiling every day shift Monday, Wednesday and Friday for wound care. During an interview 4/27/22 at 3:35 PM, the DON revealed it is an expectation Physician's Orders are followed as written.	F 658		
F 689 SS=G	Free of Accident Hazards/Supervision/Devices CFR(s): 483.25(d)(1)(2) §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	F 689		

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F 689	Continued From page 16 §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 clinical record review, facility investigation review and staff interviews, the facility failed to protect residents from accidents that caused injury when wheelchair foot pedals were not in place during transport for 2 of 2 residents reviewed (Resident #1 and Resident #6). The facility reported a census of 30 residents. Findings Include: 1. The Minimum Data Set (MDS) Assessment dated 11/24/21 revealed Resident #1 had diagnoses of non-Alzheimer's dementia, seizure disorder and presence of right artificial knee joint. The MDS further documented a Brief Interview for Mental Status (BIMS) score of 0 indicating severely impaired cognition and Resident #1 required supervision for locomotion on and off the unit and required extensive assistance of 2 staff for transfers. The Significant Change in Status MDS dated 1/17/22 documented Resident #1 required extensive assistance for locomotion on and off the unit and required total dependence on staff for transfers. The MDS further revealed a diagnoses of fracture. The Care Plan dated 1/10/22 revealed Resident #1 had an activities of daily living (ADL) deficit related to immobility and used a wheelchair for mobility, self-propelled or pushed by staff.	F 689	Past noncompliance: no plan of correction required.	

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Review of a Facility Investigation Statement, noted Staff E, Dietary Aide, revealed on 1/8/22 at 5:20 PM he had pushed Resident #1 in her wheelchair without foot pedals in place down the hallway when she put her right foot down and the wheelchair stopped. Staff E reported he pulled the wheelchair back to assess the situation and to take a closer look at the leg because Resident #1 said "ouch". Staff E revealed he did not notice anything wrong with the leg and Resident #1 was able to lift her leg up. Staff E then proceeded to the dining room going backwards with Resident #1 in the wheelchair and reported everything seemed fine for the rest of the transfer to the dining room table.

In the Facility Investigation Report Statement dated 1/9/22, Staff F, Certified Nursing Assistant (CNA) revealed Staff E, brought Resident #1 to the dining room table pulling the wheelchair backwards without pedals. When Staff E turned Resident #1 to sit facing the table and wheeled her closer, Resident #1's foot bumped the table legs and she said she was hurting. Staff F then asked Resident #1 where she was hurting and the resident touched from her right knee and up and was shaking from her pain and could not eat. Staff F then notified the nurse.

In the undated Facility Investigation Report Statement, Staff G, Registered Nurse (RN) revealed on 1/8/22 around 5:30 PM, Staff H, Restorative Aide asked if Resident #1 could have some more pain medication as it appeared her right foot was hit on the table in the dining room as staff were repositioning her. Staff G administered as needed pain medication without difficulty and assessed Resident #1's foot and did

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not see any signs of injury. On 1/9/22 around 7:30 AM, Staff H requested Staff G come to assess Resident #1 as she felt she was in pain. During the assessment of Resident #1, Staff G noted she was tearful, felt warm and had a light colored bruise on her right lower extremity and she appeared to have increased discomfort with any touch. Vital signs were obtained, morning medications were administered as ordered and Resident #1 was assisted to the bed side commode. Staff G notified the On-Call Physician to get an order for a urinalysis with culture and sensitivity via a catheter due to fever, change in output, increased discomfort and change in behaviors. The physician requested Resident #1 be sent to the Emergency Room for evaluation and treatment for possible dehydration. Staff G notified Resident #1's Power of Attorney and requested she pick up Resident #1 and transport. The Executive Director (ED) arrived at the facility and was updated regarding the incident. Staff G watched the cameras with the ED and both agreed with the injury being so high on the right lower extremity they did not feel Resident #1 hitting her toes had anything to do with the bruise.

Review of Progress Notes dated 1/9/22 at 7:04 AM, revealed Resident #1 appeared to have increased pain to her right lower extremity. Resident #1 reported pain with any touch to her body and a bruise with edema to the right lower extremity. Progress Notes further documented Resident #1 had increased discomfort with range of motion and transfers with use of the right lower extremity and administration of scheduled medication for pain control appeared to be effective.

Review of Progress Notes dated 1/9/22 at 10:30

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AM revealed Resident #1's daughter arrived at the facility to take Resident #1 to the Emergency Department for evaluation and treatment of fever, decreased intake and output, behavior changes and a tearful episode that morning. The assessment findings related to the right lower extremity were shared with Resident #1's daughter and her daughter observed changes involving increased pain with range of motion and transfers. Resident #1's daughter revealed she would have the resident get an x-ray while at the Emergency Department.

Review of x-ray dated 1/9/22 at 12:42 PM of the right tibia and fibula revealed an oblique fracture at the proximal shaft of the tibia and a non-displaced fracture through the proximal shaft of the fibula.

Review of Medication Administration Record (MAR) for Resident #1 revealed the following order with a start date 1/10/22 and a discontinue date of 1/12/22:
a. Hydrocodone-Acetaminophen (narcotic) Tablet 5-325 milligrams (MG) give 1 tablet by mouth every 6 hours for pain- severe for 1 week.

Review of facility investigation report revealed on 1/10/22 at approximately 12:00 PM, the Director of Nursing reviewed camera footage which confirmed Staff E's statement of pushing Resident #1 in her wheelchair without foot pedals when she put her right foot down and stopped the wheelchair.

Clinical record review revealed Resident #1 received an order 1/9/2022 for a right lower immobilizer to be on at all times except with cares. Clinical record review further revealed a

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Significant Change in Status MDS was completed 1/17/22 as a result of the fractures.

2. The MDS dated 2/3/22 revealed Resident #6 had diagnoses of Alzheimer's disease, malnutrition and depression. The MDS further documented a BIMS of 2 indicating severely impaired cognition and Resident #6 required extensive assistance for transfers and locomotion on and off the unit.

The Care Plan revised 12/20/20 revealed Resident #6 with a need for assistance with ADLs due to impaired mobility and used her wheelchair for mobility propelled by herself or pushed by staff. The Care Plan directed staff to transfer with assistance of one staff with gait belt as stand-pivot-transfer or use of her walker. The Care Plan further revealed Resident #6 had a risk for falling and fall related injuries due to impaired mobility with a goal revised 11/22/21 that the resident will have no sustained injuries from a fall.

Progress Notes dated 3/38/22 at 9:23 PM, revealed at 7:45 PM, Staff I, Agency CNA, reported to Staff G, RN that Resident #6 was on the floor. Upon entering the room, Staff G noted resident lying face down on the carpet at the foot of the bed. Staff I reported she had been pushing the resident in her wheelchair from the dining room without foot pedals to provide evening cares when Resident #6 put her feet on the floor and fell out of the wheelchair and onto the floor. Resident #6 noted to have abrasions and erythema to the right side of forehead covering 3.2 centimeters (cm) x 4 cm and two skin tears to left hand measuring 2.5 cm x 0.4 cm and 1 cm x 0.5 cm. No other apparent injuries were noted.

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On call nurse and physician notified with no new orders obtained.

An undated facility form titled TGV Wheelchair Safety Training documented the following in regards to Proper and appropriate use of foot pedals:
a. When staff is propelling a resident in the wheelchair, foot rests must always be on and have resident feet properly positioned on the footrest.
b. If you have not been properly trained and/or do not fully understand the proper wheelchair education and precautions, DO NOT attempt to assist the resident in the wheelchair.

During an interview 4/28/22 at 2:32 PM, the Director of Nursing acknowledged Staff E, Dietary Aide failed to utilize wheelchair pedals as expected when transporting Resident #1 in her wheelchair resulting in injury and Staff I, Agency CNA also failed to utilize wheelchair pedals as expected when transporting Resident #6 in her wheelchair resulting in a fall with injury.

Review of the facilities Self-Report Documents revealed corrective action and education was provided to Staff E, Dietary Aide regarding the use of foot pedals when pushing wheelchairs. All staff education was provided related to pushing residents in wheelchairs and the foot pedals being required. Two Nurse Managers conducted inventory of all wheelchairs to assure all were equipped with foot pedals and a bag to hold the foot pedals when not in use.

The following corrective actions documented as follows prior survey entrance:
a. On 1/10/22- Foot pedal audit and staff

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F 689	Continued From page 22 education completed. b. On 1/11/22- Corrective action/education Staff E, Dietary Aide. c. On 3/29/22- Agency supervisor notified regarding Staff I, Agency CNA transporting without foot pedals. d. On 4/1/22- Education completed with Staff I, Agency CNA	F 689		
F 758 SS=D	Free from Unnec Psychotropic Meds/PRN Use CFR(s): 483.45(c)(3)(e)(1)-(5) §483.45(e) Psychotropic Drugs. §483.45(c)(3) A psychotropic drug is any drug that affects brain activities associated with mental processes and behavior. These drugs include, but are not limited to, drugs in the following categories: (i) Anti-psychotic; (ii) Anti-depressant; (iii) Anti-anxiety; and (iv) Hypnotic Based on a comprehensive assessment of a resident, the facility must ensure that--- §483.45(e)(1) Residents who have not used psychotropic drugs are not given these drugs unless the medication is necessary to treat a specific condition as diagnosed and documented in the clinical record; §483.45(e)(2) Residents who use psychotropic drugs receive gradual dose reductions, and behavioral interventions, unless clinically contraindicated, in an effort to discontinue these drugs; §483.45(e)(3) Residents do not receive	F 758		

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psychotropic drugs pursuant to a PRN order unless that medication is necessary to treat a diagnosed specific condition that is documented in the clinical record; and

§483.45(e)(4) PRN orders for psychotropic drugs are limited to 14 days. Except as provided in §483.45(e)(5), if the attending physician or prescribing practitioner believes that it is appropriate for the PRN order to be extended beyond 14 days, he or she should document their rationale in the resident's medical record and indicate the duration for the PRN order.

§483.45(e)(5) PRN orders for anti-psychotic drugs are limited to 14 days and cannot be renewed unless the attending physician or prescribing practitioner evaluates the resident for the appropriateness of that medication.
This REQUIREMENT is not met as evidenced by:
Based on clinical record review, policy review, staff and provider interviews. the facility failed to ensure as needed (PRN) psychotropic medication orders are limited to fourteen days, and residents have an in person evaluation prior to the prescription renewal for 1 of 5 residents (Resident #11) The facility reported a census of 30 residents.

Findings Include:

The Minimum Data Set (MDS) Assessment dated 2/9/22, listed diagnoses for Resident #11 that included: non Alzheimer's dementia, depression and psychotic disorder other then schizophrenia. The MDS indicated the resident required total assistance with bathing; extensive assistance of two staff for bed mobility, transfer, dressing, toilet

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use, and personal hygiene; and the supervision of one for eating. The MDS listed the resident's Brief Interview for Mental Status) score as 5 out of 15, indicating severely impaired cognition.

A 4/15/22 Monthly Medication Review (MMR) completed by the Consulting Pharmacy recommended an order for quetiapine (a psychotropic medication) 12.5 milligrams (mg) every 4 hours PRN for hallucinations be updated with a 14 day expiration date (4/28/22), and at the end of the 14 days the resident be evaluated in person by the physician and another 14 day PRN can be written.

On 4/18/22 the provider directed staff to administer quetiapine fumarate tablet 12.5 mg's by mouth every 4 hours as needed for hallucinations, delusions, and sun downing (a change that occurs after the sun has set for the day) that can cause behavioral concerns related to delusional disorders for 90 Days.

A review of the clinical record identified the resident last had an in person evaluation the provider on 4/9/22.

During an interview on 5/02/22 at 9:29 AM, the Consulting Pharmacist stated the recommendation on 4/15/22 was to change the expiration date for the PRN quetiapine fumarate tablet 12.5 mg by mouth every 4 hours to be changed to 4/28/22 so the requirement for a 14 day limit to the prescription met. The Consulting Pharmacist explained a new PRN order should not be written until the resident evaluated in person by the prescribing physician.

During an interview on 5/2/22 at 2:40 PM, the

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F 758	Continued From page 25 Director of Nursing (DON) stated he reviews MMR's when they are received, and if changes are recommended he would make a notations regarding what has been attempted in the past and the outcome. The DON explained the MMR's are then sent to the resident's physician for agreement, declination or other orders. The DON stated the MMR completed on 4/15/22 for Resident #11 was sent to the provider, but the facility did not follow up on the need for the provider to adhere to the 14 day limit on psychotropic PRN orders; or request an in person evaluation. During an interview on 5/2/22 at 3:07 PM, the resident's provider stated she was not informed by the facility that a PRN order for quetiapine needed to be limited to 14 days at a time, and she was not informed of the need for a face to face evaluation prior to a renewed PRN order. The facility policy, dated October 2019, titled Consultant Pharmacist Reports directed the facility to limit as needed psychotropic drugs to 14 days, and cannot be continued without a provider evaluation.	F 758		
F 812 SS=E	Food Procurement,Store/Prepare/Serve-Sanitary CFR(s): 483.60(i)(1)(2) §483.60(i) Food safety requirements. The facility must - §483.60(i)(1) - Procure food from sources approved or considered satisfactory by federal, state or local authorities. (i) This may include food items obtained directly from local producers, subject to applicable State and local laws or regulations.	F 812		

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(ii) This provision does not prohibit or prevent facilities from using produce grown in facility gardens, subject to compliance with applicable safe growing and food-handling practices.
(iii) This provision does not preclude residents from consuming foods not procured by the facility.

§483.60(i)(2) - Store, prepare, distribute and serve food in accordance with professional standards for food service safety.
This REQUIREMENT is not met as evidenced by:
Based on observation, policy review and staff interview, the facility failed to ensure they were not serving expired food items and failed to label and date food items when opened to reduce the risk of contamination and food-borne illness. The facility also failed to ensure food preparation equipment were clean and failed to maintain sanitary conditions in the kitchen. The facility reported a census of 30 residents.

Findings Include:

On 4/25/22 at 11:30 AM, during the initial tour of the facility kitchen with the Culinary Director, the following spice or seasoning containers noted opened with no dates when opened:
a. Cumin.
b. Lemon Pepper.
c. Everything But Salt.
d. Garlic Powder.
e. Coriander.
f. Greek Seasoning.
g. Classic Herb Seasoning.
h. Season Well Herbs and Spices dated as opened 6/29/20 (Culinary Director stated the facility discards spices after 6 months)
i. Mojito Lime.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	165625	A. BUILDING _____ B. WING _____	05/04/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
TERRACE GLEN VILLAGE	3400 ALBURNETT ROAD MARION, IA 52302

(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
F 812	Continued From page 27 j. Cinnamon. k. Thyme. l. Curry Powder dated as opened 9/16/21 (Culinary Director stated the facility discards spices after 6 months) m. Cajun Spice. n. Poultry Seasoning. o. Southwest Chipotle. p. Poultry Seasoning. q. Lemon Pepper. r. Sesame Seed. s. Mr. Dash. t. Bay Leafs. Also found during the initial tour, other undated food products opened or undated already prepared foods with no expiration dates: a. Shredded Cheddar Cheese. b. Mixed fruit in a bowl. c. Spinach salad in a container. d. Egg salad in a container that had a use by date of 4/23/22. e. Carrot raisin salad in a container. f. Chili in a container. g. Sauerkraut in a container. h. Marinara sauce in a container with an expiration date of 4/18/22 i. BBQ sauce in a container. j. Ranch dressing in a container. k. Mashed potatoes in a large bowl. l. Cheddar Cheese slices. m. Loaf of bread not labeled when opened and with an expiration date of 4/17/22. n. 4 loaves of bread with expiration date of 4/18/22. o. Elbow macaroni bag. p. Spaghetti bag. q. Biscuit Gravy Mix. r. Granola cereal bag.	F 812		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	165625	A. BUILDING _____ B. WING _____	05/04/2022

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TERRACE GLEN VILLAGE	3400 ALBURNETT ROAD MARION, IA 52302

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F 812	Continued From page 28 s. Nilla Wafers box. t. Yellow cake mix. On 4/25/22 at 11:30 AM, during the initial tour of the facility kitchen with the Culinary Director, the following issues were noted with cleanliness of the area: a. The floors noted to have debris and food particles on them. b. The 6 burners on the gas stove noted to have debris on them. c. The griddle located on the stove top dirty with food debris and very black in color. d. The outside of the oven and the handle noted to have debris on them. e. The inside of the oven noted to have some debris in it. f. The vegetable freezer noted to have debris in the bottom of it. On 4/26/22 at 9:15 AM, on a revisit of the facility kitchen, the following issues were noted: a. The floors noted to have debris and food particles on them. b. The chemical jug for the dishwasher noted to have a lot of grime/dirt debris on top of it. c. The griddle on the stove top very dirty and black in color. d. Handle on the black milk refrigerator dirty with debris noted. e. The vegetable freezer handle and outside door dirty with debris noted. f. The inside bottom of the vegetable freezer with debris noted. On 4/28/22 at 1:35 PM, on a revisit with the Culinary Director present the following was noted: a. Griddle on stove top noted to be very dirty. Staff reported they scrambled eggs on it at	F 812		

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	165625	A. BUILDING _____ B. WING _____	05/04/2022

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F 812	Continued From page 29	F 812		

breakfast and fried hamburgers on it at lunch. Noted scrambled egg and hamburger remnants on and around the griddle.
b. Debris noted on burners on the stove top.
c. Outside of oven doors dirty as well as the outside of the oven not currently working were dirty and noted debris on them.
d. The milk refrigerator handle dirty with debris noted.
e. The inside of the milk refrigerator with debris on the bottom of it.
f. Chocolate milk splattered on the inside of the door.
g. The vegetable freezer handle dirty with debris noted.
h. The vegetable freezer noted to have debris in the bottom of the freezer.

The Culinary Director provided daily and weekly cleaning schedule for the month of April. They revealed the cleaning completed as directed.

On 4/27/22 at 2:00 PM, the Culinary Director stated he expected all items be labeled and dated when opened and prior to putting the items away. He also stated he expected the staff go through the coolers and dry food supplies daily to check for outdated food items.

On 4/28/22 at 1:35 PM, the Culinary Director stated he expected the entire kitchen area be kept clean. He expected the staff be responsible to ensure all areas of the kitchen be kept clean and stated the cleaning schedules will need to be expanded.

The facility provided a policy, titled Food Receiving and Storage dated 10/18, revealed staff were to maintain clean food storage areas at

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	165625	A. BUILDING _____ B. WING _____	05/04/2022

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F 812	Continued From page 30	F 812		

all times, dry foods were to be labeled and dated ("use by" date), all food stored in the refrigerator or freezer were to be covered, labeled and dated ("use by" date) and open containers dated and sealed or covered during storage.

The facility provided policy, titled Refrigerators and Freezers dated 10/18, revealed all food to be appropriately dated to ensure proper rotation by expiration dates. "Use by" dates were to be completed with expiration dates on all prepared food in refrigerators. Expiration dates on unopened food was to be observed and "use by" dates indicated once food was opened. Supervisors were responsible for ensuring food items in pantry, refrigerator, and freezers were not expired or past perish dates. Refrigerators and freezers were to be kept clean, free of debris, and mopped with sanitizing solution on a scheduled basis and more often as necessary.

The enclosed Plan of Correction should constitute our credible allegation of compliance and we trust you will find it adequate and acceptable.

This Plan of Correction is submitted as required under State and Federal law. The submission of this Plan of Correction does not constitute an admission on the part of the Facility as to the accuracy of the surveyors' findings nor the conclusions drawn therefrom. The Facility's submission of this Plan of Correction does not constitute an admission on the part of the Facility that the findings cited are accurate, that the findings constitute a deficiency, or that the scope and severity regarding any of the deficiencies cited are correctly applied.

F623

1. In continuing compliance with **F 623** Notice Requirements Before Transfer/Discharge; 483.15(c)(3)-(6)(8)

   No residents had negative outcomes or adverse effects.

2. To correct the deficiency and ensure the problem does not reoccur, The Admission Coordinator and/or designee will be educated by the Administrator on how to report and use the Ombudsman Log. The log will have specific instructions at the top on how to report transfers and discharges on a monthly basis and where to send it at the end of each month. This education will be completed by 6/03/2022.

3. As part of Terrace Glen Village's ongoing commitment to quality assurance the Administrator will randomly audit to ensure all transfers and dischargers are being logged and sent to the Long-term Care Ombudsman each month. Audit results will be reported and reviewed at the monthly quality assurance performance improvement meetings and recommendations.

F644

1. In continuing compliance with **F 644** Coordination of PASARR and Assessments; 483.20(e)(1)(2)

   No residents had negative outcomes or adverse effects. The resident #11 PASSAR in question was resubmitted prior to survey exit.

2. To correct the deficiency and ensure the problem does not reoccur, The Director of Nursing or nurse designee will rerun or update all current resident PASARR with a mental health diagnosis and psychotropic medications. This will be completed by 6/03/2022. The Director of Nursing or designee will incorporate any new mental health diagnosis or psychotropic medications in to the weekly RISK meeting to insure new PASARR evaluations were completed.

3. As part of Terrace Glen Village's ongoing commitment to quality assurance the Director of Nursing or designee will randomly audit resident's with a mental health dx and psychotropic medications to make certain that PASARR evaluations are completed as required. Audit results will be reported at the quality assurance performance meeting and recommendations reviewed.

F656

1. In continuing compliance with **F 656** Develop/Implement Comprehensive Care Plans; 483.21(b)(1)

   No residents had negative outcomes or adverse effects. Resident 22's current Care Plan is updated with Falls Risk and interventions.

2. To correct the deficiency and ensure the problem does not reoccur, The Director of Nursing or nurse designee will review the care plans of residents who are at risk for falls to determine that appropriate fall interventions are in place by 06/03/2022.

3. As part of Terrace Glen Village's ongoing commitment to quality assurance the Director of Nursing or nurse designee will randomly audit and compare resident's baseline care plan to the comprehensive care plan to ensure accuracy. Audit results will be reported and reviewed at the monthly quality assurance performance improvement meetings.

F658

1. In continuing compliance with **F 658** Services Provided Meet Professional Standards; 483.21(b)(3)(i)

   No residents had negative outcomes or adverse effects.

2. To correct the deficiency and ensure the problem does not reoccur, The Director of Nursing will reeducate nursing staff on the facility's bowel monitoring protocol. This education will be completed by 6/03/2022. The Director of Nursing or ICQA nurse will monitor for compliance for 90 days utilizing PCC dashboard BM alerts which will flag when the resident does not have a bowel movement in 72 hours. The Director of Nursing or ICQA nurse will ensure appropriate interventions and documentation are in place.

3. As part of Terrace Glen Village's ongoing commitment to quality assurance random audits of the bowel monitoring protocol will be conducted and reported in quality assurance and performance improvement meetings to ensure compliance.

F658

1. In continuing compliance with **F 658** Services Provided Meet Professional Standards; 483.21(b)(3)(i)

   No residents had negative outcomes or adverse effects.

2. To correct the deficiency and ensure the problem does not reoccur, The Director of Nursing will reeducate nursing staff on the requirement of following physician orders and individual wound orders. This education will be completed by 6/03/2022.

3. As part of Terrace Glen Village's ongoing commitment to quality assurance the ICQA nurse or designee will conduct weekly wound audits to ensure physician treatment orders are being followed and if a resident has multiple wounds each wound has a separate treatment order. Audit results will be reported and reviewed at the monthly quality assurance performance improvement meetings.

F758

1. In continuing compliance with **F 758** Free from Unnecessary Psychotropic Meds/PRN Use; 483.45(c)(3)(e)(1)-(5)

   No residents had negative outcomes or adverse effects. The Director of Nursing corrected the problem by discontinuing resident #11 PRN Seroquel due to no provider face to face. Notification was sent to the physician of need for face to face before starting another PRN cycle for 14 days.

2. To correct the deficiency and ensure the problem does not reoccur, The Director of Nursing will reeducate nursing staff on the need for physician exams for PRN psychotropic and appropriate stop dates. This education will be completed by 6/03/2022. To ensure appropriate stop dates for all PRN psychotropic medications random audits will be completed by the DON and/or designee by 06/03/2022.

3. As part of Terrace Glen Village's ongoing commitment to quality assurance the Director of Nursing or nurse designee will monitor for compliance during monthly pharmacy reviews. Audit results will be reported and reviewed at the monthly quality assurance performance improvement meetings.

F812

1. In continuing compliance with **F 812** Food Procurement, Store/Prepare/Serve-Sanitary; 483.60(i)(1)(2)

   No residents had negative outcomes or adverse effects.

2. To correct the deficiency and to ensure the problem does not reoccur, The Culinary Director will reeducate all culinary staff regarding cleaning procedures using the cleaning checklist as a tool. Culinary staff will also be reeducated on the facility policy for proper food storage, labeling and dating of food according to the state and federal regulations. This education will be completed by 6/03/2022.

3. As part of Terrace Glen Village's ongoing commitment to quality assurance the Culinary Director will randomly audit to ensure cleaning tasks and food dating are being completed per regulatory requirements. Audit results will be reported and reviewed at the monthly quality assurance performance improvement meetings.

NOTICE OF TRANSFER FORM TO LONG TERM CARE OMBUDSMAN [42 C.F.R. 483.15(c)(3)(i)]

Fax to 515-725-3313 or email to katie.mulford@iowa.gov

Name of Facility : TGV) Terrace Glen Village

City: Marion, Iowa 52302

Reason Code: 1--Hospitalization, 2 Discharge home 3--Transfer to another facility, 4-- Therapeutic leave, 5 -- Other

Resident Name	Transfer/DC Date	Reason for transfer	Expected to Return (Y/N)	Voluntary	Involuntary

Bowel Movement Monitoring/Protocol

Purpose: To monitor residents for constipation and prevent fecal impactions and obstructions.

Procedure:

*Night nurse is to review BM records daily by running the Look Back Report (Clinical- Point of Care) and communicate in morning report residents without BM's for 2 days or more.

Calculate bowel movements status on a day-to-day basis.

Day 0) = the date resident had a medium or larger bowel movement. The count restarts with each BM.

Day 1) = the date 1 day after last BM

Day 2) = the date 2 days after last BM

Day 3) = the date 3 days after last BM

Day 4) = the date 4 days after last BM

Day 5) = the date 5 days after last BM

Protocol:

Day 0-Day 2) = No interventions

Day 3) Day shift Administer PRN Milk of magnesia/ Miralax dose & document acceptance or refusal/results

Day 4) Day shift Administer PRN Bisacodyl suppository dose & document acceptance or refusal/results

Day 5 and every day thereafter) Check bowel sounds, abdominal status-any distention or pain and CALL primary care physician for further directives. Document completion and further interventions and results.