STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	165281	A. BUILDING _____ B. WING _____	C 10/07/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ON WITH LIFE AT GLENWOOD	714 SOUTH LACEY SUITE 100 GLENWOOD, IA 51534

(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 000	INITIAL COMMENTS Correction Date 10-8-21 A Focused COVID-19 infection survey was conducted in conjunction with an investigation of facility reported incidents 98580-I, 98581-I, 100161-I, and 100165-I on September 16 - October 7, 2021. The facility was NOT in compliance with CMS and Centers Disease Control and Prevention (CDC) recommended practices to prepare for COVID-19. Total residents: 31 Facility reported incidents 98580-I, 98581-I and 100161-I were substantiated Facility reported incident 100165-I was not substantiated	F 000		
F 550 SS=D	Resident Rights/Exercise of Rights CFR(s): 483.10(a)(1)(2)(b)(1)(2) §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. §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. §483.10(a)(2) The facility must provide equal	F 550		

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

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	165281	A. BUILDING _____ B. WING _____	C 10/07/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ON WITH LIFE AT GLENWOOD	714 SOUTH LACEY SUITE 100 GLENWOOD, IA 51534

(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 550	Continued From page 1	F 550		

access to quality care regardless of diagnosis, severity of condition, or payment source. A facility must establish and maintain identical policies and practices regarding transfer, discharge, and the provision of services under the State plan for all residents regardless of payment source.

§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.

§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.

§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 record review, staff interview, facility investigation review, and facility policy review, the facility failed to ensure 1 of 3 residents (Resident #1) was treated in a dignified manner during personal cares. The facility reported a census of 31 residents.

Findings include:

The Minimum Data Set (MDS) assessment dated 6/20/21 for Resident #1 identified a Brief Interview of Mental Status (BIMS) score of 11 which indicated moderate cognitive impairment. The MDS revealed the resident was totally

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	165281	A. BUILDING _____ B. WING _____	C 10/07/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ON WITH LIFE AT GLENWOOD	714 SOUTH LACEY SUITE 100 GLENWOOD, IA 51534

(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 550	Continued From page 2 dependent on two staff for bed mobility, transfers and extensive assistance on two staff for dressing. The MDS documented diagnoses that included non-traumatic brain dysfunction, pseudobulbar affect, and bipolar disorder. The care plan focus area dated 8/27/2020 documented Resident #1 had quadriparesis, impaired physical mobility, and was unable to complete cares on his own related to a traumatic brain injury. and The care plan provided Resident #1 was able to help reposition with rolling to the right, but not able to roll without assistance of two staff to the left side. The progress note dated 6/30/21 at 11:18 AM documented Staff C Licensed Practical Nurse (LPN) assessed Resident #1 due to being "flicked" in the head by a staff member, which caused him to bite his right hand. The assessment revealed no red marks or bruising, and his right hand had no new marks or other bruising. The facility's investigative file provided the following staff statements: a. On 6/30/21, Staff A, Certified Nursing Assistant (CNA) typed statement provided: after breakfast she and Staff B CNA assisted Resident #1 in his room. Staff A informed Staff B of him hitting staff. Staff B indicated she had worked with him before. Staff A asked Resident #1 to be nice. He was assisted to roll to the side that Staff B was on and he hit her. Staff B looked at him and said boy I wish it was like the older days where we could swing back. Resident #1 then said fuck you and Staff B flicked him on the head. Staff A told her she could not do that.	F 550		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	165281	A. BUILDING _____ B. WING _____	C 10/07/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ON WITH LIFE AT GLENWOOD	714 SOUTH LACEY SUITE 100 GLENWOOD, IA 51534

(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 550	Continued From page 3 b. On 6/30/21, Staff C's typed statement provided: around 8:45 AM, Staff A approached her with a concern. She informed Staff C that while in Resident #1's room, she witnessed Staff B flick the resident on the head. This caused him to have a behavior and bit his hand. Staff A stated she overheard Staff B tell the resident, I wish I could fucking hit you back. Staff C reported the incident to the Assistant Director of Nursing (ADON) and explained to the Administrator what happened. c. On 6/30/21, Staff B's written statement provided: during her interactions with Resident #1 he had hit her in the stomach. She said to him, if I could hit you back..but indicated she said this in a joking manner and was not mean about it. She wrote she would not hit any of the residents and she never said fuck to him. d. On 6/30/21, the Administrator's typed statement provided: she was approached by Staff O the previous Administrator, the ADON, and Staff C at approximately 9:04 AM in her office. Staff C stated Staff A reported to her that Staff B spoke to and treated Resident #1 inappropriately and in a threatening manner. Staff C immediately reported the situation to the ADON and previous Administrator. An investigation was immediately started. The Social Worker and Staff C approached Resident #1 following the incident to ensure he was calm and comfortable, followed by a physical assessment. Due to his cognitive deficits and significant communication barriers, the staff members were unable to retrieve verbal information from him regarding this incident. On 9/28/21 at 1:18 PM, Staff A was asked to	F 550		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	165281	A. BUILDING _____ B. WING _____	C 10/07/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ON WITH LIFE AT GLENWOOD	714 SOUTH LACEY SUITE 100 GLENWOOD, IA 51534

(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 550	Continued From page 4	F 550		

describe what happened 6/30/21 in Resident #1's room. Staff A reported she had warned Staff B about his behaviors which included the use of vulgar words and hitting staff members. Staff B told her she knew of these behaviors because she had worked on his hall before. Staff A stated they were in his room getting him ready for pool and Staff B she was on the side he swings at, so Resident #1 swung at Staff B and hit her in the chest area. Staff A stated Staff B said to Resident #1 do I need to have my boyfriend come in and show you respect? She also stated she wished it was like the old days where they could hit back; Resident #1 responded and said fuck you. When asked how Staff B said if it was like the older days, Staff A stated she said it with an attitude; she took it seriously and not as a joke.

On 9/28/21 at 1:56 PM, Staff C was asked to describe what happened on 6/30/21. She stated Staff A came to her and reported that Staff B was aggressive with Resident #1 and it was not ok how she talked to him. Staff A told her Staff B told the resident if it was the old days she would him hit back. Staff C said she talked with Staff B and had asked her what happened. At first, Staff B denied the allegation then confirmed she did say she wished it was like the old days. Staff C then assessed the resident and found no new skin issues, red marks, or bruising, and then she reported the allegation to the ADON.

On 9/29/21 at 10:39 AM, the Administrator stated the ADON told her Staff A reported to her that Staff B was rude to Resident #1. The Administrator indicated when Staff B wrote her statement she admitted to saying that if it was the older days, but shared that it was a joke. The Administrator reported she spoke to Staff B and

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	165281	A. BUILDING _____ B. WING _____	C 10/07/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ON WITH LIFE AT GLENWOOD	714 SOUTH LACEY SUITE 100 GLENWOOD, IA 51534

(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 550	Continued From page 5 explained she cannot talk to the residents like that. In an attempted interview with Resident #1 while he sat in the dining room on his hall, watching television On 9/29/21 at 11:47 AM, the resident was asked if anyone had ever been mean to him. The resident stated "Yeah" and when asked to name the person, he said, "Your mom," and began to use vulgar language. The resident did not provide any pertinent information. On 9/30/21 at 11:47 AM, Staff B reported she assisted Staff A with Resident #1 and went to his right side of the resident, the side he hits from. Resident #1 hit her and she stated to the resident boy if I could hit you back. Staff B stated she was joking and added Staff A did not say anything to her after she made that comment to Resident #1. Review of the facility's Behavioral Interview Policy, with a revised date of 1/2020, provided staff members are expected to take into account the cognitive challenges that are often associated with brain injuries. This impairment may not only cause emotional and behavioral challenges, but it may also make it difficult for the person served to effectively manage these challenges. It is essential that no matter what emotional or behavioral challenges staff members face, they are to remember that they are in charge with delivering professional, caring, and compassionate services unconditionally. Facility residents have the right to feel safe and know that staff members are there to help and support them through both the positive and the difficult times of their rehabilitation process.	F 550		
F 609 SS=D	Reporting of Alleged Violations	F 609		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	165281	A. BUILDING _____ B. WING _____	C 10/07/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ON WITH LIFE AT GLENWOOD	714 SOUTH LACEY SUITE 100 GLENWOOD, IA 51534

(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 609	Continued From page 6 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 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 record review, facility investigation review, staff interviews, and facility policy review the facility staff failed to report an injury of unknown origin to their supervisor for 1 of 3 residents (Resident #1) reviewed for injuries of unknown injuries. The facility reported a census of 31 residents.	F 609		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	165281	A. BUILDING _____ B. WING _____	C 10/07/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ON WITH LIFE AT GLENWOOD	714 SOUTH LACEY SUITE 100 GLENWOOD, IA 51534

(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 609	Continued From page 7 Findings include: The Minimum Data Set (MDS) assessment dated 6/20/21 for Resident #1 identified a Brief Interview of Mental Status (BIMS) score of 11 which indicated moderate cognitive impairment. The MDS revealed the resident was totally dependent on two staff for bed mobility, transfers and extensive assistance on two staff for dressing. The MDS documented diagnoses that included non-traumatic brain dysfunction, pseudobulbar affect, and bipolar disorder. The care plan focus area dated 8/27/2020 documented the resident had impaired physical mobility and was unable to complete cares on his own related to a traumatic brain injury and quadriparesis. The care plan provided Resident #1 could help reposition himself by rolling to the right, but could not roll without assistance of two staff to the left side. The progress note dated 9/29/21 at 3:31 PM, documented Resident #1 had a dark purple, swelling bruise under his left eye with a dark red area noted in the outer canthus area which seemed to be progressing posteriorly down his face. Observation on 10/6/21 at 10:54 AM, showed Resident #1 sat in his wheelchair in the blue hall dining room. Observation revealed various shades of blue and yellow to his left periorbital area. His sclera appeared red as well. The facility's investigative file provided the following staff statements:	F 609		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	165281	A. BUILDING _____ B. WING _____	C 10/07/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ON WITH LIFE AT GLENWOOD	714 SOUTH LACEY SUITE 100 GLENWOOD, IA 51534

(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 609	Continued From page 8 a. On 9/29/21 at 4:12 PM, Staff P Nursing Department Coordinator typed the following statement: Between 9:00 AM and 10:00 AM she walked into the dining room on Resident #1's hall and started talking with him when she noticed that his eye was a little black. She figured the nursing staff already knew about it so she did not say anything. When she was back in dining room during lunch time, Staff M Certified Nursing Assistant (CNA) said to Resident #1 your eye is black, what happened. Staff P looked at his eye and it looked worse than when she saw it earlier in the morning. She asked Staff M, you did not know he had a black eye? Staff M stated he did not notice it this morning when he gave him his bath. Staff P then went to the main nurse's station and reported his black eye. b. On 9/30/21 at 2:45 PM, Staff M typed the following statement: he arrived to work at 6:00 AM and he was the only CNA on the floor until 7:30 AM. He started with Resident #1's bath between 6:15 AM and 6:30 AM. He got the resident ready for his bath, completed the transfer with the hoyer and took him to the tub room. He did not think there were any issues in the tub room during the bath and the resident seemed to be in his usual mood. He does not like baths, so he was agitated, but nothing out of the ordinary for him. After he got him dressed for the day, he took him to the dining room for breakfast. There was no bruising that he noticed at that time. After breakfast the resident stayed in the dining/activity room during the duration of the morning. Between 12:15 PM and 12:45 PM, he noticed the bruising to his left eye. Staff P went and told the nurses while Staff M stayed with the resident. Staff M provided he did not feel that there was anything or anyone that could have caused the bruising.	F 609		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	165281	A. BUILDING _____ B. WING _____	C 10/07/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ON WITH LIFE AT GLENWOOD	714 SOUTH LACEY SUITE 100 GLENWOOD, IA 51534

(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 609	Continued From page 9	F 609		

He said he did not remember the hoyer hooks hitting him or anything happening during his bath or dressing. The only thing he could think of would be maybe he glasses got pushed into his eye when they were rolling him but was not positive if the glasses were on during that time or not.

On 10/6/21 at 10:17 AM, Staff P stated she went into the blue hall dining room after breakfast, between 9:00 AM and 10:00 AM and saw Resident #1 in the dining room with another resident. When she asked how Resident #1 was doing, she noticed black bruising under his left eye and asked what had happened. He talked inappropriately about nothing related to his eye. She did not report it because she figured staff already knew. Staff P admitted it was her mistake and she should have said something to the nursing staff when she first saw the black bruising to his eye. Resident #1 did not say anything about his eye when she had spoken with him. At lunch time, Staff M was in the blue hall dining room and asked Resident #1 what happened to his eye. Staff P indicated she asked Staff M, you didn't know about it? He said no. She went to look at his eye again and it was black, blue, and swollen. She stated that was when she went and got a nurse to report it.

On 10/6/21 at 11:20 AM, Staff E CNA when asked what she would do if she noticed a new bruise to a resident's chin, she stated she would report it to a nurse immediately.

On 10/6/21 at 11:32 AM, Staff J CNA when asked if she noticed a new bruise to a resident's chin what she would do, she stated she would report it to the charge nurse.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	165281	A. BUILDING _____ B. WING _____	C 10/07/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ON WITH LIFE AT GLENWOOD	714 SOUTH LACEY SUITE 100 GLENWOOD, IA 51534

(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 609	Continued From page 10 On 10/6/21 at 2:13 PM, Staff M reported he gave Resident #1 his bath between 6:15 AM and 6:30 AM and did not notice anything out of the ordinary. At lunch between 12:15 PM and 12:45 PM, he saw the purplish blue mark, so he Resident #1's glasses off and saw the black eye. Staff M reported Staff P told a nurse at that time about the eye. On 10/7/21 at 11:29 AM, the Administrator was asked if Staff P should have reported when she initially saw Resident #1's black eye between 9:00 AM and 10:00 AM. and the Administrator stated she should have. The Administrator provided Staff P informed her she thought staff already knew about it but educated her that she should have still reported it. Review of the facility's Mistreatment of Persons Served (residents) - Prevention and Reporting Procedures with a revision date of 8/2019 directed in all cases of suspected mistreatment the observer/reporter shall immediately report to any supervisor or manager on duty at the time.	F 609		
F 803 SS=D	Menus Meet Resident Nds/Prep in Adv/Followed CFR(s): 483.60(c)(1)-(7) §483.60(c) Menus and nutritional adequacy. Menus must- §483.60(c)(1) Meet the nutritional needs of residents in accordance with established national guidelines.; §483.60(c)(2) Be prepared in advance; §483.60(c)(3) Be followed;	F 803		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	165281	A. BUILDING _____ B. WING _____	C 10/07/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ON WITH LIFE AT GLENWOOD	714 SOUTH LACEY SUITE 100 GLENWOOD, IA 51534

(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 803	Continued From page 11 §483.60(c)(4) Reflect, based on a facility's reasonable efforts, the religious, cultural and ethnic needs of the resident population, as well as input received from residents and resident groups; §483.60(c)(5) Be updated periodically; §483.60(c)(6) Be reviewed by the facility's dietitian or other clinically qualified nutrition professional for nutritional adequacy; and §483.60(c)(7) Nothing in this paragraph should be construed to limit the resident's right to make personal dietary choices. This REQUIREMENT is not met as evidenced by: Based on record review, staff interview, facility investigation view, facility video footage review, and facility policy review, the facility failed to follow recommendations for the use of adaptive equipment when assisting 1 of 3 residents (Resident #2) with their lunch meal. The facility reported a census of 31 residents. Findings include: The Minimum Data Set (MDS) assessment dated 3/8/21 for Resident #2 identified a Brief Interview of Mental Status (BIMS) test score of 8 the resident demonstrated moderate cognitive impairment. The MDS revealed the resident required extensive assistance of one staff for eating. The MDS documented diagnoses that included non-traumatic brain dysfunction, pseudobulbar affect, and bipolar disorder. The care plan focus area dated 8/20/2020	F 803		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	165281	A. BUILDING _____ B. WING _____	C 10/07/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ON WITH LIFE AT GLENWOOD	714 SOUTH LACEY SUITE 100 GLENWOOD, IA 51534

(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 803	Continued From page 12 identified the resident as at risk for developing a respiratory infection related to the risk of developing aspiration pneumonia secondary to her brain injury as evidenced by a history of pneumonia. The diet card updated on 5/26/21 directed the resident is to receive nectar thick liquids given at 30 milliliters (mL) at a time via nosey cup, with no straws. Thin liquids are allowed with 10 mL Provale cup only. The progress note dated 5/21/2021 at 5:37 PM documented Resident #2 choked at lunch time when Staff H, Certified Nursing Assistant (CNA), gave her unthickened liquids. An assessment revealed the resident appeared at baseline with clear lung sounds. Staff will continue to monitor throughout the shift. Observation 9/29/21 at 10:30 AM, revealed Resident #2's dietary card in a folder on the refrigerator in the main dining room. At 12:35 PM, the dietary card laid on the table with her food tray and a piece of paper that contained her diet which included both the food and liquid consistencies. Observation of the video camera recording in the large dining on 5/21/21 revealed the following: a. 12:13 PM: Resident #2 sat at the dining room table, in her wheelchair with Staff H. On the table was the resident's plate with food, silverware, white cloth ,and a black cloth. Staff H gave Resident #2 four bites of her food. b. 12:15:19: a staff member gave Staff H a small can of soda, then walked away c. 12:15:37: Resident #2 started to cough	F 803		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	165281	A. BUILDING _____ B. WING _____	C 10/07/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ON WITH LIFE AT GLENWOOD	714 SOUTH LACEY SUITE 100 GLENWOOD, IA 51534

(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 803	Continued From page 13 d. 12:15:40: Staff H gave her a drink of her pop from the can, with no straw. The resident continued to cough e. 12:15: 50 Staff H gave her another drink of the soda from the same can; resident continued to cough f. 12:15:37: Staff F intervened The diet order sheet documented Resident #2 had the following diet order: nectar thick liquids given 30mL at a time through a nosey cup; no straw. Thin liquids allowed with 10mL provale cup only. The facility's investigative file provided the following staff statements: a. On 5/21/21, Staff D Certified Nursing Assistant (CNA) typed the following statement: Staff H CNA had poured Mountain Dew down Resident #2's throat. She started choking and turned red as a tomato. Staff H kept pouring the pop down her throat as she was choking. Staff F Therapy Activity Specialist ran over and told her it was not ok and she could not do that. b. On 5/21/21, Staff G Therapy Activity Specialist typed the following statement: she was in the large dining room modifying a cooking group lunch and running the blender and noted a rather loud cough. She turned around to see what was going on. Resident #2 was red in the face and coughing very forcefully. Staff F went over to assist Resident #2 and Staff H, as the other CNAs were not. Staff G heard Staff F coach Staff H on the correct cup and consistency Resident #2 used during meals. c. On 5/21/21, Staff F typed the following statement: he was in the large dining room when	F 803		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	165281	A. BUILDING _____ B. WING _____	C 10/07/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ON WITH LIFE AT GLENWOOD	714 SOUTH LACEY SUITE 100 GLENWOOD, IA 51534

(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 803	Continued From page 14	F 803		

he heard Resident #2 coughing quite a bit. He saw Staff H assisting Resident #2 with drinking a Mountain Dew; Staff H was holding the Mountain Dew can for Resident #2 and observed some of the liquid spilling down the front side of the can, onto Resident #2's chin. He immediately went over and interrupted. He noted Resident #2 looked flushed in the face with teary eyes. He explained why he interrupted and pointed out the coughing and teary eyes and warned to watch for aspiration while feeding her. He asked Staff H if she was aware that Resident #2 required an adaptive provale cup. She indicated she was not aware of that and he asked if anyone had taken the time to show her the dietary cards with useful information when helping the residents eat or drink. Staff H stated she was not made aware of these cards and thanked him for showing her. Staff F stated he took a few minutes and went over the card with her, then grabbed a cup and showered her how to use it correctly. He then put the pop in the cup for Resident #2, left the dietary card, and recommended she use one whenever helping someone eat or drink. Resident #2 indicated she was ok.

d. On 5/21/21, Staff H typed the following statement: she had assisted Resident #2 with her meal. She had lunch made in a cooking class for the group. She had given Resident #2 a bite of her broccoli and started to cough. Staff H reported there was a small can of soda on the table that another CNA brought to her. Staff H stated she had not gotten up to get her a cup because she was coughing and did not want to leave her alone because she "was at risk for choking and was already coughing." She was not told she needed a special cup by any of the other CNAs in the room. Staff F kindly approached with

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	165281	A. BUILDING _____ B. WING _____	C 10/07/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ON WITH LIFE AT GLENWOOD	714 SOUTH LACEY SUITE 100 GLENWOOD, IA 51534

(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 803	Continued From page 15	F 803		

the resident's diet cards and showed her the cups Resident #2 used. Staff H then used the cup given to her and read her dietary card so she was aware for the next time.

On 9/28/21 at 2:50 PM, Staff E CNA stated the diet cards are used during meals because they list what the residents diet orders, include the adaptive equipment needed, and identify which liquid consistency they require. She stated the diet cards are in a folder on the fridge. Regarding the incident on 5/2/21 in the main dining room, she provided Staff H used to be a facility staff member and she quit then came back as an agency staff. She stated Staff H knew where the dietary cards were but did not use them when she fed Resident #2 that day. Staff E stated she told Staff H that the pop for the resident needed to be thickened but gave her drinks without thickening it and the resident choked. When asked how she knew Resident #2 had been choking she stated she was coughing a lot and eyes had started to water.

On 9/28/21 at 3:01 PM, Staff D CNA when asked how staff learn about resident diet orders and adaptive equipment, she replied they go over those things in orientation and the information is on their tables that show what their diets are, what liquid consistency they drink, and what adaptive equipment is to be used. On the day of the incident Staff H had fed Resident #2 her homemade lunch. Staff D said Resident #2 did not have her cup or diet card on the table. When asked if diet cards are supposed to be out on the tables; she stated sometimes they are, sometimes they are not. Staff D stated Staff H gave the resident a drink of Mountain Dew straight from the can with a straw and Resident

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	165281	A. BUILDING _____ B. WING _____	C 10/07/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ON WITH LIFE AT GLENWOOD	714 SOUTH LACEY SUITE 100 GLENWOOD, IA 51534

(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 803	Continued From page 16 #2 was choking really bad, her face was turning purple, and she had tears in her eyes. Staff D stated some guy ran over and said that is not acceptable. Staff members informed leadership that the diet cards need to be on the table. When asked what liquid consistency and adaptive equipment Resident #2 was ordered to have, Staff D answered a provale cup or nectar thickened liquids. On 9/29/21 at 9:57 AM, the Assistant Director of Nursing (ADON) acknowledged the dietary cards were to be on the table and to be used. She stated the dietary cards show residents' diet orders, liquid consistency needed and adaptive equipment to be used. On 9/29/21 at 10:33 AM, the Administrator stated the dietary cards are laminated, in each dining in a folder on the fridge, and that folder is labeled so they know where they are. She provided they have completed quite of bit reminder education on diet cards by telling staff they are here for your reference and if unsure how to feed someone, ask. The Administrator indicated after this incident they revamped how they do agency staff orientation versus new staff orientation. On 9/29/21 at 11:06 AM, Staff G stated as she blended the food in the dining room on 5/21/21, she noticed Resident #2 coughing more than normal. She described the cough as loud and forceful and the resident's face was red, so Staff F went and coached her Staff H regarding the consistency as it changed frequently. Once she was coached and given the appropriate equipment, Resident #2 stopped coughing. On 9/29/21 at 3:43 PM Staff F provided on	F 803		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	165281	A. BUILDING _____ B. WING _____	C 10/07/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ON WITH LIFE AT GLENWOOD	714 SOUTH LACEY SUITE 100 GLENWOOD, IA 51534

(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 803	Continued From page 17 5/21/21 he was in the dining room modifying the lunch meal, He heard Resident #2 coughing quite a bit, turned around and saw Staff H had gave her a drink without the appropriate adaptive equipment. He went over and interrupted the interaction and asked if she knew what cup she used and if she had been trained, she said she was not aware of the cup used for her. He stated the other staff kept doing what they were doing; feeding, assisting, supervising the other residents. He asked her to stop, got the dietary card that no one had showed or nor was it on the table. He stated he retrieved the appropriate adaptive equipment for Staff H to assist Resident #2 with her drinks. He provided it seemed like she lacked the appropriate training. On 9/30/21 at 9:28 AM Staff H stated she worked at the facility previously as a facility employee then worked as agency. When asked what kind of orientation/training she received when she came back as an agency staff member, she stated the overnight girls walked through the halls and said this is who this is and what their assistance levels are. She remembered stuff from when she worked there before. When asked if she remembered the use of the dietary cards, she acknowledged she spaced the use of the meals and knew she should have asked questions about the adaptive equipment but did not do so. Staff H provided therapy had a cooking class that day, where they make meals with the residents. She remembered they did not have cups laid out per norm. She stated Resident #2 was actively eating, as she sat next to her. When she gave her a bite of her broccoli, Resident #2 began to cough and she saw tears in her eyes. Another staff member had placed a can of pop on the table before she started coughing and once she	F 803		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	165281	A. BUILDING _____ B. WING _____	C 10/07/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ON WITH LIFE AT GLENWOOD	714 SOUTH LACEY SUITE 100 GLENWOOD, IA 51534

(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 803	Continued From page 18 started to cough she opened it and gave her drinks to help clear her throat. Staff H indicated she did not walk away because she was actively choking. Then Staff F came over to give her the dietary card and the proper cup that needed to be used when giving the resident her liquids. When she was asked if the anyone try to give guidance in the beginning when they gave her the can of pop, she stated no, they dropped it off and left. The facility procedure titled Feeding a Person Served with an effective date of 2/7/2017 instructed staff to feed the residents according to speech orders. Staff are to check food and liquids for the correct level of consistency per speech orders prior to assisting a resident to eat.	F 803		
F 880 SS=E	Infection Prevention & Control CFR(s): 483.80(a)(1)(2)(4)(e)(f) §483.80 Infection Control The facility must establish and maintain an infection prevention and control program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of communicable diseases and infections. §483.80(a) Infection prevention and control program. The facility must establish an infection prevention and control program (IPCP) that must include, at a minimum, the following elements: §483.80(a)(1) A system for preventing, identifying, reporting, investigating, and controlling infections and communicable diseases for all residents, staff, volunteers, visitors, and other individuals providing services under a contractual	F 880		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	165281	A. BUILDING _____ B. WING _____	C 10/07/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ON WITH LIFE AT GLENWOOD	714 SOUTH LACEY SUITE 100 GLENWOOD, IA 51534

(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 880	Continued From page 19 arrangement based upon the facility assessment conducted according to §483.70(e) and following accepted national standards; §483.80(a)(2) Written standards, policies, and procedures for the program, which must include, but are not limited to: (i) A system of surveillance designed to identify possible communicable diseases or infections before they can spread to other persons in the facility; (ii) When and to whom possible incidents of communicable disease or infections should be reported; (iii) Standard and transmission-based precautions to be followed to prevent spread of infections; (iv)When and how isolation should be used for a resident; including but not limited to: (A) The type and duration of the isolation, depending upon the infectious agent or organism involved, and (B) A requirement that the isolation should be the least restrictive possible for the resident under the circumstances. (v) The circumstances under which the facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease; and (vi)The hand hygiene procedures to be followed by staff involved in direct resident contact. §483.80(a)(4) A system for recording incidents identified under the facility's IPCP and the corrective actions taken by the facility. §483.80(e) Linens. Personnel must handle, store, process, and	F 880		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	165281	A. BUILDING _____ B. WING _____	C 10/07/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ON WITH LIFE AT GLENWOOD	714 SOUTH LACEY SUITE 100 GLENWOOD, IA 51534

(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 880	Continued From page 20 transport linens so as to prevent the spread of infection. §483.80(f) Annual review. The facility will conduct an annual review of its IPCP and update their program, as necessary. This REQUIREMENT is not met as evidenced by: Based on observations, staff interviews, and facility policy review, the facility failed to follow accepted infection control practices during a COVID-19 outbreak. Staff failed to: sanitize a hoyer left after using it, two staff members failed to wear gloves while assisting two residents with activities of daily living (ADLS - one of the two staff members had long, artificial nails), and two staff members failed to wear the appropriate Personal Protective Equipment (PPE) while in the room of two residents with COVID-19. The facility reported a census of 31 residents. Findings include: On 9/16/21 at 9:25 AM during the entrance conference, the Administrator stated they had eight residents and six staff members that tested positive for COVID-19. The Administrator indicated all residents were being kept in their rooms. Observation on 9/16/21 at 10:12 AM revealed Staff J Physical Therapist Assistant (PTA) had assisted Resident #5 to a sitting position in his bed. Staff J wore the following PPE: N-95 mask, face shield, gown, and gloves. Staff J failed to don gloves while she touched the seizure pads on the bed rails and assisted Resident #5 to a sitting position on the side of his bed. Staff J placed her bare hands on Resident #5 as she assisted him	F 880		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	165281	A. BUILDING _____ B. WING _____	C 10/07/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ON WITH LIFE AT GLENWOOD	714 SOUTH LACEY SUITE 100 GLENWOOD, IA 51534

(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 880	Continued From page 21	F 880		

and as she handled the sit-to-stand lift. At 10:19 AM Staff J assisted Resident #5 to remain in the sitting position, touched her radio when she asked for assistance, and continued to touch the sit-to-stand lift without gloving. At 10:23 AM other staff members donned gloves and a gown to assist Staff J and Resident #5. Staff J then donned a pair of gloves to continue with the transfer.

On 9/16/21 at 10:45 AM Staff K Certified Nursing Assistant (CNA) and Staff L CNA assisted Resident #6 to the bath tub gurney. Staff L wore gloves as she assisted Resident #6, but Staff K did not as she assisted Resident #6 by touching him and the lift with her bare hands and artificial nails that extended past her fingertips. At 10:47 AM Staff K removed the hoyer lift from the bath house, placed it in the hallway by the computer and gowns that hung on the wall, then proceeded about her duties. Staff K failed to disinfect/sanitize the hoyer left after it was used. At 10:57 AM the hoyer lift still had not been disinfected/sanitized.

Observation on 9/16/21 at 11:58 AM on the COVID-19 hall revealed signs on rooms 126, 127, 130, 131, 132, and 133 that directed: Full PPE required including N-95 mask properly secured with both elastic bands, face shield, gloves, disposable gown, and shoe covers. After exiting the room, promptly remove all PPE except the N-95 and face shield and deposit into the infectious trash bin.

Observation on 9/16/21 at 12:02 PM, showed Staff N CNA, wearing an N-95 and face shield, donned gloves and a gown and then went into room 131 with the resident's lunch. Staff N failed

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	165281	A. BUILDING _____ B. WING _____	C 10/07/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ON WITH LIFE AT GLENWOOD	714 SOUTH LACEY SUITE 100 GLENWOOD, IA 51534

(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 880	Continued From page 22 to don booties before she entered the room. At 12:03 PM, Staff M CNA walked into room 133 wearing an N-95, face shield, gown, and gloves, but failed to don booties before entering the room. At 12:17 PM, Staff M exited room 133, doffed his gown and gloves, sanitized his hands, exited the hallway and left the building. Staff M did not have booties to remove and he did not disinfect/sanitize his shoes. At 12:35 PM Staff N exited room 131 doffed her gown and gloves, and sanitized her hands. Staff N did not have booties to remove and did not disinfect/sanitize her shoes. Staff N stood at the computer and charted before she donned a gown and gloves to enter room 131 again without donning booties. On 9/16/21 at 10:30 AM the Assistant Director of Nursing (ADON) provided a listed of three residents with active signs and symptoms of COVID-19. On 9/16/21 at 11:45 AM when asked what PPE should be worn on the two non COVID-19 halls when caring for the residents, the ADON stated N-95 masks, face shields, cloth gowns, and gloves. The ADON was asked if gloves should be worn when assisting residents to the bath or during transfers, and she replied she personally would wear them. The ADON verified transfer lifts should be sanitized after each use with their residents. The ADON was asked about the facility's artificial nail policy and she indicated she did not know what the policy included. On 9/16/21 at 12:45 PM the Administer was informed of staff not wearing the appropriate PPE while on the COVID-19 hall. She stated she will educate them and confirmed they should wear booties.	F 880		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	165281	A. BUILDING _____ B. WING _____	C 10/07/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ON WITH LIFE AT GLENWOOD	714 SOUTH LACEY SUITE 100 GLENWOOD, IA 51534

(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 880	Continued From page 23 On 9/17/21 at 1:58 PM the Administrator reported she spoke to the staff about the shoe covers. Staff told her the shoe covers do not fit over their shoes, so they were wiping down their shoes with sani-wipes between rooms. She was informed staff were not observed to be wiping down their shoes prior to leaving the COVID positive rooms. Review of email updates from the Administrator to all facility staff revealed the following: - 9/6/21 at 3:49 PM: more positive test results which included 4 residents and are on the COVID-19 hall. Staff are required to wear full PPE prior to entering the room. All residents that have tested negative require full PPE prior to entering the room. - 9/7/21 at 8:39 AM: As of today, N95's and face shields are to be worn at all times in the facility. In all resident rooms, full PPE is required. - 9/17/21 at 1:47 PM: on non COVID-19 halls gloves must be worn at all times and lifts must be sanitized before and after each use. On the COVID-19 unit shoe covers are provided and a variety of sizes were ordered to ensure all staff can utilize these. Review of the facility's Artificial Nails Policy 2012 stated fingernails should be kept clean, healthy, and short (1/4 inch or less beyond the tip of the finger). Long nails, both artificial and natural, harbor more microorganisms than short nails. Long fingernails may pose a hazed to resident safety when moving or positioning the resident. Artificial nails or nail enhancements should not be	F 880		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	165281	A. BUILDING _____ B. WING _____	C 10/07/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ON WITH LIFE AT GLENWOOD	714 SOUTH LACEY SUITE 100 GLENWOOD, IA 51534

(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 880	Continued From page 24 worn by any person whose responsibilities include direct hands-on resident contact. Review of the facility's Sanitizing Equipment policy indicated all reusable equipment shall be disinfected with facility approved disinfectant wipes or solution following use of each resident. One the resident is no longer using the equipment, staff will don gloves, and follow the disinfectant manufacturer's instructions for sanitizing. If staff are not immediately available to sanitize the equipment it will be placed in the soiled utility room to prevent anyone from using it until it can be sanitized. After the equipment has been sanitized per manufacturer's instructions it may be put back in service if charged and stored in the appropriate area.	F 880		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	165507	A. BUILDING _____ B. WING _____	10/21/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
VALLEY VIEW VILLAGE	2571 GUTHRIE AVENUE DES MOINES, IA 50317

(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 000	INITIAL COMMENTS Correction Date_____ The following deficiencies result from the facility's annual health survey and investigation of facility-reported incidents 98833-I and 100284-I. Both facility reported incidents were substantiated. See the Code of Federal Regulations (42CFR) Part 483, Subpart B-C.	F 000		
F 558 SS=D	Reasonable Accommodations Needs/Preferences CFR(s): 483.10(e)(3) §483.10(e)(3) The right to reside and receive services in the facility with reasonable accommodation of resident needs and preferences except when to do so would endanger the health or safety of the resident or other residents. This REQUIREMENT is not met as evidenced by: Based on observations, record review and staff interview the facility failed to provide a call light within reach to assist with their needs for 1 of 17 residents. (Resident #64) The facility reported a census of 67. 1. The Minimum Data Set (MDS) assessment with a reference date of 9/30/21 for Resident #64 identified a Brief Interview for Mental Status (BIMS) score of 3 out of 15 indicated severe cognitive impairment. According to the MDS, the resident required the assistance of one staff for transfers, personal hygiene, and bed mobility. Diagnosis included muscle weakness and	F 558		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Lexmarie Pagey | TITLE: Executive Director | (X6) DATE: 11/10/21

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.

Plan of Correction
On With Life at Glenwood
Survey: September 16, 2021 – October 7, 2021
Correction Date: 10/8/2021

The preparation of the following plan of correction for this deficiency does not constitute and should not be interpreted as an admission nor an agreement by the facility of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction prepared for these deficiencies were executed solely because provisions of State and Federal law require it.

1) Immediate Fix
2) Potential Residents Affected
3) System Changes
4) Monitoring/QAPI
5) DOC

F550 Resident Rights

1) Immediate Fix:
    a. Contracted agency CNA was immediately escorted out of the building and suspended indefinitely on 6/30/2021.
    b. The agency company the CNA was employed by was immediately contacted and informed of the incident.
2) All persons served may have the potential to be affected by this deficient practice.
3) System Changes:
    a. DON/designee completed an all-staff in-service on Dependent Adult Abuse/Mandatory Reporter and Behavior Management on 10/5/2021.
    b. DON/designee created binders for all dignity plan binders and placed at nurses' station on each hallway implemented on 10/25/21.
    c. DON/designee confirmed all contracted agency staff have Dependent Adult Abuse Certificate per signed contract for each agency on 10/19/2021.
    d. DON/designee educated staff on Resident Rights, Mandatory Reporting, Diet Recommendations, and Infection control and prevention on 10/8/21, 10/11/2021, 10/12/2021, 10/19/2021, 11/1/2021, 11/3/2021, and 11/4/21.
    e. DON/designee to complete an all-staff in-service on Dependent Adult Abuse/Mandatory Reporter and Behavior Management, infection prevention and control, and dietary requirements on 11/11/21.
4) DON/designee will monitor through facility audit tool 1x/week x90 days. Monitored Findings will be brought to Monthly QAPI Meeting for review.
5) Date of Compliance: 10/5/2021

F609 Reporting of Alleged Violations

1) The staff member was immediately educated on reporting requirements on 9/29/21.
2) All persons served may have the potential to be affected by this deficient practice.
3) System Changes:
    a. DON/designee completed an all-staff in-service on Dependent Adult Abuse/Mandatory Reporter and Behavior Management on 10/5/2021.
    b. DON/designee educated staff on Resident Rights, Mandatory Reporting, Diet Recommendations, and Infection control and prevention in daily huddles on 10/8/21, 10/11/2021, 10/12/2021, 10/19/2021, 11/1/2021, 11/3/2021, and 11/4/21.
    c. Staff member completed Dependent Adult Abuse training course on 10/14/21.
    d. DON/designee to complete an all-staff in-service on Dependent Adult Abuse/Mandatory Reporter and Behavior Management, infection prevention and control, and dietary requirements on 11/11/21.
4) DON/designee will monitor through facility audit tool 1x/week x90 days. Monitored Findings will be brought to Monthly QAPI Meeting for review.
5) Date of Compliance:10/5/21.

F803 Menus Meet Resident Nds/Prep in Adv/Followed

1) Contracted agency CNA was immediately educated on person served diet recommendations and location of all diet cards on 5/21/21.
2) All persons served may have the potential to be affected by this deficient practice.
3) System Changes:
    a. DON/designee completed education with staff on diet orders, adaptive equipment use, and appropriate supervision during mealtimes on 7/19/2021 and 8/23/2021
    b. DON/designee completed audit of new hire competencies and orientation checklists completed 8/26/21.
    c. DON/designee created binders for all dignity plan binders and placed at nurses' station on each hallway implemented on 10/25/21.
    d. DON/designee educated staff on Resident Rights, Mandatory Reporting, Diet Recommendations, and Infection control and prevention on 10/8/21, 10/11/2021, 10/12/2021, 10/19/2021, 11/1/2021, 11/3/2021, and 11/4/21.
    e. DON/designee to complete an all-staff in-service on Dependent Adult Abuse/Mandatory Reporter and Behavior Management, infection prevention and control, and dietary requirements on 11/11/21.
4) DON/designee will monitor through facility audit tool 2x/week x90 days. Monitored Findings will be brought to Monthly QAPI Meeting for review.
5) Date of Compliance: 10/8/21

F880 Infection Prevention & Control

1) Educated staff 1:1 on hand hygiene/gloving, shoe covers/disinfecting shoes, and sanitation of equipment before/after entering a room on 10/16/21.
2) All persons served may have the potential to be affected by this deficient practice.
3) System changes:
    a. DON/designee provided 1on 1 education with multiple staff on appropriate PPE use, hand hygiene, and sanitation of lifts between each use on 9/17/2021.
    b. DON/designee ordered a variety of sizes of shoe covers on 9/20/2021.
    c. DON/designee educated staff on Resident Rights, Mandatory Reporting, Diet Recommendations, and Infection control and prevention on 10/8/21, 10/11/2021, 10/12/2021, 10/19/2021, 11/1/2021, 11/3/2021, and 11/4/21.
    d. DON/designee to complete an all-staff in-service on Dependent Adult Abuse/Mandatory Reporter and Behavior Management, infection prevention and control, and dietary requirements on 11/11/21.
4) DON/Designee will monitor through facility audit tool 2x/week x 90 days. Monitored Findings will be brought to Monthly QAPI Meeting for review.
5) Date of Compliance: 10/8/2021.