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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	165268	A. BUILDING _____ B. WING _____	C 03/16/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
REHABILITATION CENTER OF DES MOINES	701 RIVERVIEW DES MOINES, IA 50316

(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: 5-15-21 An investigation of Complaints #94710-C, #95062, #95134, #95539, #95687, #95808, #96138, #96249 and Facility reported incident #96094 completed 2/9-3/16/21 resulted in the following deficiencies. Complaint #94710-C was substantiated. Complaint #95062-C was substantiated. Complaint #95134-C was not substantiated. Complaint #95539-C was substantiated. Complaint #95687-C was substantiated. Complaint #95808-C was substantiated. Complaint #96138-C was substantiated. Complaint #96249-C was substantiated. Facility Reported Incident #96094-I was substantiated. See the Code of Federal Regulations (42CFR) Part 483, Subpart B-C.	F 000		
F 584 SS=E	Safe/Clean/Comfortable/Homelike Environment CFR(s): 483.10(i)(1)-(7) §483.10(i) Safe Environment. The resident has a right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely. The facility must provide- §483.10(i)(1) A safe, clean, comfortable, and homelike environment, allowing the resident to use his or her personal belongings to the extent possible. (i) This includes ensuring that the resident can	F 584		

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

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

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F 584	Continued From page 1 receive care and services safely and that the physical layout of the facility maximizes resident independence and does not pose a safety risk. (ii) The facility shall exercise reasonable care for the protection of the resident's property from loss or theft. §483.10(i)(2) Housekeeping and maintenance services necessary to maintain a sanitary, orderly, and comfortable interior; §483.10(i)(3) Clean bed and bath linens that are in good condition; §483.10(i)(4) Private closet space in each resident room, as specified in §483.90 (e)(2)(iv); §483.10(i)(5) Adequate and comfortable lighting levels in all areas; §483.10(i)(6) Comfortable and safe temperature levels. Facilities initially certified after October 1, 1990 must maintain a temperature range of 71 to 81°F; and §483.10(i)(7) For the maintenance of comfortable sound levels. This REQUIREMENT is not met as evidenced by: Based on observation, record review and interviews the facility failed to maintain comfortable building temperatures between 71 degrees and 81 degrees in the resident's area of the facility and in 3 Resident rooms observed on each floor (Resident #16, #17, #18). The facility failed to provide additional blankets or move Residents to a warmer area of the building for 3 of the 4 resident's reviewed (Resident #16, #17, and #18). The facility reported a census of 70	F 584	Resident #16 has been discharged. Resident #1 has been discharged. Resident #17 has been discharged. Resident #18 states no issues since heat was fixed on 2/14/21 and he has been comfortable and warm. All residents will be protected from temperatures below 71 and above 81 (unless they prefer above 81 in summer months). In the occurrence of loss of heat or of extreme heat, maintenance department or designee will check room and hallway temperatures hourly and temperatures below 71 or above 81 lasting more than one hour will trigger a response call to outside contractors to repair heat or cooling system, or may escalate to a call to outside vendor for sourced in heat. Maintenance department or designee will audit room and hallway temperature weekly for 4 weeks and report findings at QAPI.	

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residents.

Findings include;

1. The Document tilted Weights and Vitals Summary provided by the facility 2/9/21 at 5:30 p.m. included resident's temperatures for the 2/7/21 through 2/9/21 morning. The document contained temperatures for 58 Residents and documented 26 Residents with temperatures lower than 97 degrees. The 26 resident's temperatures ranged from 95.7 to 96.9. Hypothermia is considered 95 degrees or below.

Observation showed on 2/9/21 between 4:14 p.m. p.m. and 4:35 p.m. while accompanied by Staff R Maintenance, temperatures of east end of building hallways, Dining rooms (west end building) and Nurses Station (middle of hallway) on 2nd, 3rd, and 4th floors. Staff R verified facility temperatures as follows:
2nd Floor Dining Room 65.1 degrees.
2nd Floor Nurses Station 61.9 degrees.
2nd Floor east end hallway 57.5 degrees.
3rd Floor east end hallway 58.1 degrees.
3rd Floor Nurses Station 60.6 degrees.
3rd Floor Dining Room 65.7 degrees.
4th Floor Dining Room 66.6 degrees.
4th Floor Nurses Station 62.8 degrees.
4th Floor east end hallway 62.7 degrees.

On 2/9/21 at 4:00 PM Staff R Maintenance stated the east side of the building surge pump went down and he called the service company this morning when he arrived at work.

On 2/10/21 at 12:41 PM Staff R Maintenance acknowledged the facility has an issue on the 4th Floor. Friday 2/5/21 the radiators on the wall felt

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cold so he checked the pump down in the boiler room and it felt cold. That is when they had the 1st pump replaced. He also noticed the heat not up to par on Monday so he had the service company return.

On 2/10/21 at 9:15 AM Staff D Administrator revealed the facility replaced the pump during regular maintenance on 2/5/21 and the facility temperatures felt fine afterward. The facility had heat on Monday (2/8/21) but not up to par so called the service provider back to the facility.

2. The Resident Response List provided 2/9/21 at 5:15 PM listed the Brief Interview for Mental Status (BIMS) Scores for residents and revealed:

a. Resident #16 had a BIMS score of 15 (intact cognition)

The Weights and Vitals Summary provided 2/9/21 at 5:50 p.m. included Resident #16's body temperature 2/8/21 at 4:22 p.m. 96.9 degrees and 2/9/21 at 10:35 a.m. 96.7 degrees.

Observation showed on 2/9/21 at 3:49 p.m. Resident #16's room the temperature read 61.9 degrees.

On 2/9/21 at 5:28 p.m. Resident #16 stated last night (2/8/21) she covered up with just her face out and the facility did not provide or ask if she needed additional blankets.

On 2/9/21 before leaving for the night, the surveyor voiced concerns to management about not offering blankets to residents or moving residents to warmer areas of the building.

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Observation and interview on 2/10/21 at 8:58 a.m. revealed Resident #16's room temperature read 66.2 degrees. Resident #1 stated staff offered more blankets last night and she stayed warmer. She acknowledged the problem with the heat started the day before yesterday (2/8/21 Monday).

b. Resident #17 had a BIMS score of 13 (intact cognition)

Observation revealed on 2/9/21 at 5:32 p.m. of Resident #17's room temperature read 65.5 degrees.

On 2/9/21 at 5:32 p.m. Resident #17 acknowledged he felt cold last night and he still felt cold. The facility failed to offer him additional blankets.

c. Resident #18 had a BIMS score of 15 (intact cognition).

Observation on 2/9/21 at 5:32 p.m. Resident #18's room temperature read 65.5 degrees.

On 2/9/21 at 5:34 p.m. Resident #18 stated the facility did not offer him more blankets. He stated he normally has a sheet and comforter.

On 2/10/21 at 9:21 a.m. Resident #18 acknowledged he did stay warm enough last night. The facility offered more blankets and brought them in around 6:30 p.m. last evening.

On 2/10/21 at 6:00 p.m. Staff G Certified Medication Aide stated residents told her they felt cold.

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F 584	Continued From page 5 On 2/11/21 at 9:25 a.m. the Director of Nursing (DON) acknowledged if residents felt cold she would expect staff to offer more blankets and/or move them to a warmer part of the building.	F 584	Resident #12 has been discharged. All residents discharged from facility will have a safe discharge as evidenced by verbal confirmation of acceptance from receiving facility, and visual confirmation by staff of Rehab Center of Des Moines, that discharging resident either ambulates or is assisted into accepting facility. Social Services or designee will audit all discharged from facility, with exception of hospital transfers, for the next 30 days for safe discharges and report findings for review at next QAPI meeting.	
F 624 SS=D	Preparation for Safe/Orderly Transfer/Dschrg CFR(s): 483.15(c)(7) §483.15(c)(7) Orientation for transfer or discharge. A facility must provide and document sufficient preparation and orientation to residents to ensure safe and orderly transfer or discharge from the facility. This orientation must be provided in a form and manner that the resident can understand. This REQUIREMENT is not met as evidenced by: Based on clinical record review, staff interview, and facility policy review, the facility failed to ensure a safe and orderly discharge for 1 out of 4 residents reviewed for transfer/discharge planning. (Resident #12). The resident discharged to a homeless shelter, that did not accept the resident to the shelter, resulting in the resident spending the night outdoors in subzero weather. The facility reported a census of 70 residents. Findings include: A Minimum Data Set (MDS) with an assessment dated 12/04/20 assessed Resident #12 with Brief Interview for Mental Status (BIMS) score was 14 out of 15 (no cognitive impairment). The MDS identified the resident as independent with ambulation, transfer, and personal hygiene. Active diagnosis listed on the MDS included: Schizophrenia and past fall resulting in fracture.	F 624		

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The discharge MDS revealed a discharge from the facility on 2/10/21.

A Discharge Summary and Post-Discharge Plan of care dated 2/10/21 revealed Resident #12 discharged to shelter per resident's choice.

On 3/2/21 at 9:31 a.m. Staff A, Social Worker, stated Resident #12 wanted to leave and did not care if she ended up living on the street. Staff A took Resident #12 to the shelter around lunch time. Staff A revealed prior plans for discharge made for an apartment but resident refused. Staff A acknowledged the resident did not go into the shelter with this resident to ensure the shelter accepted the resident for placement.

On 3/2/21 at 11:30 a.m. Staff B, Activities Assistant, stated she rode with Staff A to take the resident to the shelter. Staff B asked Staff A if they should go into the shelter with the resident and Staff A replied no they did not have to go in because the facility already discharged the resident. Staff B stated she observed the resident walk through the front door of the shelter and then Staff A drove off.

On 3/2/21 at 12:49 p.m. Staff C, Activities Assistant stated she rode along with Staff A to take Resident #12 to the shelter. Staff C stated Staff A identified the resident as no longer the facility's responsibility and the resident refused physical help to enter the shelter building.

On 3/3/21 at 2:20 p.m. Staff D, former Administrator stated she did not participate in Resident #12's discharge. When the surveyor asked Staff D if the resident safely and appropriately discharged from the facility, Staff D

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stated she terminated Staff A's employment due to the unsafe inappropriate discharge. Staff D stated staff should not leave a resident on the side of the road and it was cold out. Staff D stated that Staff A should have checked Resident #12 into the shelter due to the negative weather temperature. Staff D stated Staff A may have called about a bed at the shelter for the resident, but Staff A did not go inside and ensure the resident actually got a bed for the night. Staff D stated the facility usually follow-ups with a phone call within 3 days to a week. Resident #12's record did not contain any information that indicated the facility made a follow up call.

On 3/3/21 at 12:37 p.m. the Client Advocate/Team Leader for the shelter stated the shelter does not reserve beds. The shelter assigns clients a chair when they come in, and then second shift assigned the beds if available around 7:30 p.m. The Client Advocate stated she did not have any record of Resident #12 checking in to the shelter until 2/20/21.

On 3/3/21 at 3:42 p.m. Staff E stated she saw Resident #12 around 5:45 a.m. (the morning following discharge) at a convenience store sitting outside. Staff E asked resident what she was doing and the resident informed Staff E of trying to get to a mental health center. Staff E offered to call the nursing facility and Resident #12 refused. Staff E stated she gave her coffee and a couple of bucks for bus money.

On 3/4/21 the State Climatologist identified the temperature on 2/11/21 5:54 a.m. as negative 14 degrees.

On 3/4/21 at 12:09 p.m. Staff Q acting Director of

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Nursing (DON), stated she thought staff should have walked Resident #12 into the shelter to ensure safe placement.

During review on 3/4/21 of Policy/Procedure Admission, Transfer and Discharge Rights (subject Discharge Planning process) revised 11/2016 revealed the facility discharge planning process shall provide and document sufficient preparation and orientation to residents, in a form and manner that the resident can understand, to ensure safe and orderly transfer of discharge from the facility.

F 658 SS=D Services Provided Meet Professional Standards CFR(s): 483.21(b)(3)(i) — F 658

§483.21(b)(3) Comprehensive Care Plans
The services provided or arranged by the facility, as outlined by the comprehensive care plan, must-
(i) Meet professional standards of quality.
This REQUIREMENT is not met as evidenced by:
Based on clinical record review, staff and resident interview, the facility failed to follow professional standards to ensure adequate blood sugars of the resident were maintained. The facility failed to clarify whether a new admitted resident who received high doses of insulin should receive blood glucose testing. Within two days of admit, the resident suffered a hypoglycemic reaction and subsequently transferred to the hospital (Resident #13). The facility reported a census of 70 residents.

1. A Minimum Data Set (MDS) assessment dated 12/17/20 for Resident #13 identified a Brief Interview for Mental Status (BIMS) score of 15. A

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score of 15 indicated no cognitive impairment. The MDS identified the resident required extensive physical assistance for bed mobility and toileting. Active diagnoses listed on the MDS included: fracture of left lower leg and diabetes mellitus.

On 3/8/21 at 12:45 p.m. Staff M, Registered Nurse (RN) stated she completed rounds on 12/17/20 in the morning and found the resident on the floor. Staff M stated she checked the resident's blood sugar and it measured "low". Staff placed the resident back in bed and provided medication to raise blood sugar. Staff monitored blood sugars every 15 minutes.

On 3/8/21 at 11:01 a.m. Staff N, Interim Director of Nursing stated she verified Resident #13's admission orders which included high doses of insulin. Staff N stated she checked with Staff O, previous Director of Nursing to ensure the insulin dose was correct. Staff N stated she assisted in transferring resident to the hospital.

During review on 3/8/21 of the resident's Diabetic Administration Record dated 12/1/20-12/31/20 revealed resident had received insulin three times a day.

a. 85 units insulin a.m.
b. 60 units insulin mid-day
c. 60 units insulin p.m.

The Diabetic Administration Record revealed no blood sugar checks completed until after staff found the resident on the floor on 12/17/20.

On 3/11/21 at 12:00 p.m. Staff N, Interim Director of Nursing reported no blood sugar checks completed prior to fall. Staff N stated the physician did not order them.

F 658

Resident #13 is discharged from facility. All diabetic insulin dependent residents and newly admitted insulin dependent diabetic residents are at risk for hypoglycemic episodes. DNS or designee will audit all residents with orders for insulin currently in facility for blood glucose testing schedules and parameters set by physician for notification. All new admissions to facility in the next 30 days will be reviewed by DNS or designee for blood sugar parameters and scheduled blood glucose testing. Results of audits will be collected and presented at next QAPI meeting. All nursing staff will be educated on blood glucose testing for all residents that are insulin dependent per facility policy. Education will be completed by 4/15/21.

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On 3/11/21 at 1:46 p.m. Staff P, Nurse Consultant stated with the amount of insulin Resident #13 received, the facility should have talked to the physician related to monitoring blood sugar levels.

F 677 SS=D ADL Care Provided for Dependent Residents CFR(s): 483.24(a)(2) — F 677

§483.24(a)(2) A resident who is unable to carry out activities of daily living receives the necessary services to maintain good nutrition, grooming, and personal and oral hygiene;
This REQUIREMENT is not met as evidenced by:
Based on clinical record review, resident and staff interviews, the facility failed to complete baths for 3 of 3 residents reviewed for baths (Residents #8, #14, #15). The facility reported a census of 70 residents.

Findings include:

1. A Minimum Data Set (MDS) with an assessment date 12/9/20, revealed Resident #8 with diagnoses that included: quadriplegia (paralysis of all four limbs). The assessment revealed a Brief Interview for Mental Status (BIMS) score of 15 out of 15 (no cognitive impairment), The MDS indicated bathing did not occur during the assessment observation period. The MDS documented the resident required extensive assistance for personal hygiene and bathing.

During review on 3/3/21 of facility form identified as Task:Bathing revealed on 3/3/21 Resident #8 did not receive a shower, checked Not Applicable.

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F 677	Continued From page 11 Facility form revealed resident refused showers on 2/10/21, 2/24/21, and 2/27/21. Documentation revealed received a shower on 2/20/21. On 3/10/21 at 9:37 a.m. Resident #8 reported has not showered in a long time. Stated the shower chair utilized by the facility did not work for him and the facility did nothing about getting a different shower chair. Resident #8 stated did not receive a shower in months. The resident denied the facility offered a bed bath. On 3/9/21 at 1:34 p.m. Staff Q, Interim Director of Nursing reported staff needed more documentation if they check "not applicable" on the bath sheet. Staff Q revealed staff should provide a bed bath to Resident #8 or document rationale why the resident did not receive a bath. Staff Q stated she knew Resident #8 did not like the shower chair. 2. The MDS with an assessment date 11/20/20, revealed Resident #14's BIMS score as 15 out of 15. The MDS identified the resident as dependent on staff for bathing. Active diagnosis listed on the MDS included: heart failure and need for assistance with personal care. During review of the Care Plan on 3/3/21 revised 8/19/19 indicated resident needed assistance from staff for bathing. During review on 3/3/21 of facility form Task: Bathing revealed the resident showered one time on 3/3/21 between the dates of 2/15/21 - 3/8/21. Documentation on 3/1/21 identified the resident refused a shower. On 3/10/21 at 9:20 a.m. Resident #14 confirmed	F 677	Resident #8 states that he is agreeable to current schedule for showers of twice weekly. States that he will refuse when he does not feel like showering. New shower chair ordered on 4/5/21 to assist with his comfort. Resident #14 states that he is agreeable to his current schedule of showers twice a week and has no concerns with the current equipment or staff providing showers. States that he will refuse occasionally when he does not want a shower. Resident #15 states he is agreeable with current shower schedule and equipment and staff providing showers. States that he sometimes refuses if he does not feel like showering. MDS coordinator has updated all residents bathing schedules in PCC so that they reflect resident preference for day of the week and the time of day for showers. This system change facilitates better documentation opportunity for staff and reflects resident preference. DNS or designee will audit 10 residents bathing documentation weekly for 4 weeks for completion and will educate staff when showers are refused or not completed and report findings to QAPI meeting.	

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no bath received on 3/8/21. The resident reported when upstairs for 14 days, he did not receive a bath. The resident stated the facility just does not have enough staff and reported the issue as ongoing for 2 years.

3. The MDS with an assessment date 1/29/21 revealed Resident #15 BIMS score of 15 out of 15. The MDS identified the resident as dependent on staff for bathing. Active diagnosis listed on the MDS included: heart failure and depression.

During review of the Care Plan on 3/3/21 initiated 3/6/19 indicated the resident required staff assistance with bathing.

During review on 3/3/21 of facility form Task: Bathing revealed bathing "not applicable" on the following dates:
2/18/21
2/25/21
3/4/21
3/8/21

And revealed the resident refused showers on the following dates:
2/8/21
2/11/21
2/15/21
2/22/21
3/1/21

On 3/10/21 at 9:31 a.m. Resident #15 reported not receiving baths at times. The resident reported numerous occasions of not receiving baths in the last year.

On 3/9/21 at 11:19 a.m., Staff K, Certified Nursing Assistant (CNA) reported day shift did not

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provide showers 3/8/21, except for one resident. Staff K stated the facility used to have a shower aide. The facility bath schedule provided revealed both Resident #14 and #15 scheduled for baths on 3/8/21.

On 3/9/21 at 11:42 a.m. Staff L, CNA reported no showers completed on 6-2 shift second floor and stated this happened before. Staff L reported she was hired as a bath aide but has been working the floor.

On 3/10/21 at 10:01 a.m. the Interim ADON stated she expects staff to offer and provide showers.

F 684 SS=D Quality of Care
CFR(s): 483.25

§ 483.25 Quality of care
Quality of care is a fundamental principle that applies to all treatment and care provided to facility residents. Based on the comprehensive assessment of a resident, the facility must ensure that residents receive treatment and care in accordance with professional standards of practice, the comprehensive person-centered care plan, and the residents' choices.
This REQUIREMENT is not met as evidenced by:
Based on facility record review, resident and staff interview, the facility failed to ensure laboratory (lab) tests completed as ordered and catheters changed as directed by the physician. The facility failed to provide another urine sample after a lab result identified the specimen as contaminated. The facility failed to provide documentation related to not changing a catheter as ordered for 1 one 3 residents reviewed. (Resident #8) The

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F 684	Continued From page 14	F 684	Resident #8 has no current infection or treatment for UTI. Resident #8 catheter is to be changed every 21 days per Dr Order, last catheter change was completed on 3/17/21. Resident states he will refuse occasionally and it was explained to resident that nursing staff will notify Dr if he does refuse catheter change as ordered. Resident #8 voiced understanding. All residents with catheter in place and orders from Dr for catheter change and or UTI symptoms and orders for UA and or culture and sensitivity are at risk for similar outcomes. DNS or designee will audit all scheduled catheter changes weekly for 4 weeks, and will audit all orders for UA with or without culture and sensitivity for completion weekly for 4 weeks and report findings of both audits at next QAPI meeting. All nursing staff will be educated on completion of scheduled catheter changes, refusals and appropriate documentation, and Dr Notification. Nursing staff will also be educated on completion of ordered UA and or culture and sensitivity per Dr Order and if not completed within ordered time frame to contact Dr for further di-	

facility reported a census of 70.

1. A Minimum Data Set (MDS) with assessment date 12/29/20 revealed Resident #8's Brief Interview for Mental Status (BIMS) score of 15 out of 15 (no cognitive impairment). The MDS identified the resident required extensive assistance for personal hygiene, toileting, and dependent on staff for transfers. The MDS documented the resident utilized an indwelling catheter. Active diagnoses listed on the MDS included: quadriplegia (paralysis of all four limbs) and neurogenic bladder (urinary bladder problems due to disease or injury).

The Care Plan initiated 12/17/19 directed staff monitored for signs symptoms related to urinary tract infection and report to physician.

On 2/23/21 at 2:30 p.m. Resident #8 stated did not hear anything related to lab results after seven days of waiting. The resident stated he then asked the facility for a print out of the lab results. The resident reported the facility did not change his catheter timely and are sometimes 1-2 weeks late. He identified catheter changes should occur every 4 weeks.

A urine culture report revealed a urine specimen collected 11/12/20. The final report of the urinalysis verified on 11/14/20 revealed submission of another specimen suggested due to contamination.

A urine culture report from urine collected on 11/21/20 revealed a final report verified on 11/26/20 indicated the resident continued with urinary tract infection. The urinalysis report reflected 10,000 - 50,000 cfu (colony forming

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units) of pseudomonas aeruginosa (a type of bacteria) and 50,000-100,000 cfu of enterococcus species (a type of bacteria). The final report indicated susceptibility to antibiotics.

Policy/Procedure Nursing Clinical (subject Lab Test Results) revealed the facility will promptly notify the physician of the lab results.

On 3/10/21 at 10:21 a.m. Staff P, Nurse Consultant, verified the facility did not obtain a culture and sensitivity from 11/12/20 urinalysis collected. Staff P verified no urinalysis submitted until 11/21/20. Staff P reported this should not have happened, no follow through. Staff P reported she expected staff to follow physician orders and if staff did not follow orders they should notify the physician.

Review of the resident record for catheter changes revealed from 7/8/20 to 8/19/20 no documentation to indicate the facility changed the catheter.

An Order Summary Report identified a physician order dated 3/3/20 to change the catheter every 21 days. Staff should call for a urology appointment to have this completed.

On 3/01/21 at 3:00 p.m. Staff Q, Interim Director of Nursing, voiced she expected staff to document rationale if they did not complete a catheter change.

F 684

direction. All nursing education will be completed by 4/15/21.

F 689 SS=E Free of Accident Hazards/Supervision/Devices CFR(s): 483.25(d)(1)(2)

§483.25(d) Accidents.
The facility must ensure that -

F 689

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F 689	Continued From page 16 §483.25(d)(1) The resident environment remains as free of accident hazards as is possible; and §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 record review, facility policy review and staff interviews, the facility failed to ensure a safe environment related to the fire watch while utilizing the temporary heating system. The facility failed to accurately complete the documentation and records related to the fire watch. Facility self reported the incident related to falsified documentation during the fire watch on 2/14/21. The facility reported a census of 70 residents. Findings include: On 2/24/21 at 1:30 p.m. Staff B, Activities Assistant, stated around 9:35 a.m. she kept getting phone calls from Staff D (Administrator) saying a state inspector was in the facility. Staff B stated Staff D directed her to obtain the fire watch binder, not clock in and tell the State Inspector she worked in the building on fire watch since 6:00 a.m. Staff B admitted she falsified the fire watch document on 2/14/21 from 6:00 a.m. - 9:45 a.m. Staff B reported she felt the Administrator would fire her if she did not falsify the document. On 3/2/21 at 2:44 p.m. Staff G, Certified Medication Aide (CMA) stated Staff B came to work on 2/14/21 around 9:30 a.m. Staff G revealed the facility did not have anyone assigned to conduct fire watch until Staff B arrived.	F 689	All staff educated on 3/1/21by Charles Funk a member of our compliance department on falsifying documents. Staff D that requested Staff B falsify documents is no longer employed at facility. Company policy is a no tolerance for falsification of documentation and termination of staff D was appropriate. Any instance that requires a fire watch in the future will be completed per Fire Marshall and state recommendations. If an instance of this would occur, Administrator or designee would audit scheduling of staff and documentation every 24 hours for completion and accuracy.	

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On 3/3/21 at 2:49 p.m. Staff D, Former Administrator, stated she scheduled the staff for fire watch. Staff D, stated she knew Staff B routinely did not come to work until 10:00 a.m. Staff D stated she asked Staff I, Activity Director, to talk to Staff B. Staff D stated she called Staff B and she reported she could arrive at 6:00 a.m. Staff D denied asking Staff B to fill in documentation.

On 3/2/21 at 1:30 p.m. Staff I, Activities Director, stated she did not participate in the fire watch schedule or talk to Staff B. Staff I stated Staff B is scheduled to arrive at 10:00 a.m. routinely.

On 3/2/21 at 3:00 p.m. Staff J, Compliance Officer, stated during the facility investigation of this incident, they determined Staff B arrived at 10:00 a.m.

Facility document dated 2/14/21 identified Staff B signed the Fire Watch document from 6:00 a.m. - 9:45 a.m. that falsely indicated she conducted firewatch during those hours.

A document received from the facility Human Resources department on 3/3/21 indicated Staff B reported to work at 10:00 a.m. until 4:08 p.m. on 2/14/21.

Staff B's personnel file revealed a Counseling/Disciplinary Notice. A written warning dated 2/23/21 revealed Staff B falsified a fire watch document for the temporary heating system on 2/14/21.

Staff D's personnel file revealed a Counseling/Disciplinary Notice that identified Staff D's employment terminated 2/16/21 related to

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F 689	Continued From page 18 falsified business records and misrepresentation of that fact to a state surveyor. Falsification of any business record is prohibited in the Employee Handbook dated 8/18/18 and also is prohibited by the Code of Conduct dated April 2020.	F 689		
F 725 SS=D	Sufficient Nursing Staff CFR(s): 483.35(a)(1)(2) §483.35(a) Sufficient Staff. The facility must have sufficient nursing staff with the appropriate competencies and skills sets to provide nursing and related services to assure resident safety and attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident, as determined by resident assessments and individual plans of care and considering the number, acuity and diagnoses of the facility's resident population in accordance with the facility assessment required at §483.70(e). §483.35(a)(1) The facility must provide services by sufficient numbers of each of the following types of personnel on a 24-hour basis to provide nursing care to all residents in accordance with resident care plans: (i) Except when waived under paragraph (e) of this section, licensed nurses; and (ii) Other nursing personnel, including but not limited to nurse aides. §483.35(a)(2) Except when waived under paragraph (e) of this section, the facility must designate a licensed nurse to serve as a charge nurse on each tour of duty. This REQUIREMENT is not met as evidenced	F 725		

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F 725	Continued From page 19	F 725	Resident #8 states that the last week 3/28-4/3/21 call light responses times have improved and are being answered more timely. Resident #10 states that occasionally she feels she waits a bit but it has been much improved in the last 2 weeks. Nursing and C.N.A staff education to be completed on call light response time and facility policy by 4/15/21. DNS or designee to audit call light response time weekly for 4 weeks and report findings at QAPI meeting.	

by:
Based on facility record review, resident interview, and staff interview, the facility failed to ensure they responded to residents call lights in a timely manner to meet resident needs for 2 of 5 residents. (Resident #8, #10). The facility reported a census of 70 residents.

1. A Minimum Data Set (MDS) with an assessment date 12/29/20 revealed Resident #8's Brief Interview for Mental Status (BIMS) score of 15 out of 15. A score of 15 indicated no cognitive impairment. The MDS identified the resident required extensive assistance for personal hygiene and dependent on staff for transfer. Active diagnosis listed on the MDS included: quadriplegia (paralysis of all four limbs).

A Care Plan initiated 12/11/19 directed staff to ensure the call light within resident reach so the resident could access it for assistance as needed.

On 2/23/21 at 2:30 p.m. Resident #8 identified waiting 30-40 minutes last Friday or Saturday night for staff to answer the call light. The resident identified call lights as "terrible five - seven days a week". The resident had friend call the facility to get him help.

An untitled facility provided form showing call light response times revealed the resident activated the call light on 2/19/21 at 8:49 p.m. The form revealed staff did not answer the call light for 48 minutes.

An untitled facility provided form showing call light response times revealed the resident activated the call light on 2/20/21 at 12:31 p.m. The form

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revealed staff did not answer the call light for 40 minutes.

2. A Minimum Data Set (MDS) with an assessment dated 11/23/20 for Resident #10 identified a BIMS score of 15. A score of 15 indicated no cognitive impairment. The MDS identified the resident required extensive assistance for personal hygiene, dressing, and transfer. Active diagnoses listed on the MDS included: stroke, heart failure and repeated falls.

The Care Plan initiated 11/07/18 directed staff to ensure call light within reach for resident to access it for assistance as needed

An untitled facility provided form showing call light response times revealed the resident activated the call light on 2/18/21 7:35 p.m. Staff did not answer Resident #10's call light for 52 minutes.

On 3/11/21 at 11:05 a.m. Staff P, Interim Director of Nursing (DON) stated she expected staff to answer call lights within 15 minutes. Staff P stated she heard staff did not always answer call lights timely.

Facility policy titled Call light/bell revised 5/07 revealed staff should answer call lights within a reasonable time (15 minutes).