

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 165479	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 08/05/2021
NAME OF PROVIDER OR SUPPLIER CALVIN COMMUNITY			STREET ADDRESS, CITY, STATE, ZIP CODE 4210 HICKMAN ROAD DES MOINES, IA 50310		
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F 625	<p>Continued From page 1</p> <p>specifies the duration of the bed-hold policy described in paragraph (d)(1) of this section. This REQUIREMENT is not met as evidenced by:</p> <p>Based on clinical record review, staff interviews, and policy review, the facility failed to provide a bedhold notice for 2 of 2 residents reviewed (Resident #44 and #6). The facility reported a census of 48 residents.</p> <p>Findings include:</p> <p>1. According to the Minimum Data Set (MDS) assessment tool dated 5/23/21, Resident #44 discharged from the facility to the hospital on 5/23/21.</p> <p>Review of the Census List revealed Resident #44 discharged from the facility to the hospital on 5/23/21.</p> <p>The clinical record lacked documentation of any explanation of the bed hold notification to the resident or the resident's representative when the resident discharged to the hospital 5/23/21.</p> <p>During an interview 8/4/21 at 3:30 PM, Staff C, Registered Nurse reported she looked for a bedhold notice given to Resident #44.</p> <p>On 8/5/21 at 1:25 PM, the MDS Coordinator reported she could not locate a bedhold notice issued to Resident #44 on 5/2021.</p> <p>2. The MDS dated 7/16/21, documented Resident #6 discharged from the facility to the hospital on 6/30/21 .</p>	F 625			

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F 625	Continued From page 2 Review of Resident Progress Notes revealed the facility sent Resident #6 to the hospital on 6/30/21 at 4:30 PM and returned to the facility on 7/09/21 at 5:25 PM. The clinical record lacked documentation that showed staff gave the resident or the resident's representative any explanation or notification of bed hold when the resident discharged to the hospital 6/30/21. During an interview 8/5/21 at 1:58 PM, Staff C, Registered Nurse reported she could not locate a bedhold notice for Resident #6. She stated the facility's standard of practice required staff to provide a notification of bed hold to all residents upon discharge. An undated Admission Agreement packet revealed under section 483.12 Admission, Transfer, and Discharge Rights, regarding notice of bed hold policy. The nursing facility must provide written notice at the time of transfer to the resident or resident's representative which specified the duration of the bed hold policy whenever a resident transferred to the hospital or left for the facility for therapeutic leave.	F 625			
F 658 SS=D	Services Provided Meet Professional Standards CFR(s): 483.21(b)(3)(i) §483.21(b)(3) Comprehensive Care Plans The services provided or arranged by the facility, as outlined by the comprehensive care plan, must- (i) Meet professional standards of quality. This REQUIREMENT is not met as evidenced by:	F 658			

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F 658	<p>Continued From page 3</p> <p>Based on interview, record review, and facility policy review, the facility failed to ensure staff followed physician orders in an attempt to prevent infection nad subsequent hospitalization of (Resident #6). The facility reported a census of 48 residents at the time of the survey.</p> <p>Findings include:</p> <p>According to the Minimum Data Set (MDS) assessment tool dated 04/30/21, Resident #6 had diagnoses that included heart failure, end-stage renal disease (ESRD), diabetes mellitus, and chronic obstructive pulmonary disease (COPD). The MDS documented the resident scored 15 of 15 points possible on the Brief Interview for Mental Status (BIMS) test, which indicated Resident # 6 displayed intact cognitive abilities. The MDS revealed the resident required dialysis treatments, had the ability to communicate verbally, and required limited assist of one staff for bed mobility, surface-to-surface transfers, ambulation (walking), dressing, toilet use and personal hygiene. The MDS also documented Resident #6 required set up assist only for eating and experienced occassional bowel and bladder incontinence.</p> <p>The care plan last revised on 07/14/21 documented Resident #6 required staff assist to meet all Activities of Daily Living (ADL) needs. The care plan directed staff to complete a weekly head-to-toe skin observation with the resident's routine shower, and assist her with routine bathing. The care plan lacked any information, care requirements, or staff directives related to the resident's dialysis catheter site.</p>	F 658			

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F 658	<p>Continued From page 4</p> <p>The Physician Order Report signed 06/08/21 with a start date of 03/12/21 directed staff to not allow the central venous line dressing to become wet due to the risk of infection. The Physician Order Report also directed staff to give baths rather than showers to the resident's lower body and sponge baths to the upper body to achieve this.</p> <p>The Resident Progress Notes printed on 08/05/21 revealed the following:</p> <p>a. On 03/24/21, staff showered the resident that shift.</p> <p>b. On 06/05/21, the resident's fistula dressing came off; staff cleansed the area with normal saline and applied a sterile dressing.</p> <p>c. On 04/10/21 staff noted the resident took an evening shower with no skin issues noted.</p> <p>The Point of Care ADL report printed on 08/04/21 revealed staff showered the resident on 2 of the 7 bathing opportunities between 04/03/21 and 07/27/21.</p> <p>During an interview on 08/02/21 at 10:50 AM, Resident #6 stated her dialysis port became infected when it got wet when staff gave her showers. She reported she ended up in hospital for 10 days with an infection and had to have her dialysis port surgically changed. After that, she said she arranged for a bath every other Saturday with Staff E and then gave herself a sponge bath at other times.</p> <p>During an interview on 08/04/21 at 12:13 PM, Staff E stated she had assisted Resident #6 with baths since she began working on the 3rd floor. Staff E reported when Resident #6 first admitted to the 3rd floor she was assigned to do showers</p>	F 658			

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F 658	Continued From page 5 on the evening shift, but then Resident #6 decided to change to morning baths. Staff E logged into her computer to show where she charted baths or showers. On 08/05/21 at 01:35 PM, the Assistant Director of Nursing (DON) verified the facility expected staff to follow physician orders. On 08/05/21 at 1:58 PM, Staff C agreed the facility expected staff to follow physician orders .	F 658			
F 698 SS=D	Dialysis CFR(s): 483.25(l) §483.25(l) Dialysis. The facility must ensure that residents who require dialysis receive such services, consistent with professional standards of practice, the comprehensive person-centered care plan, and the residents' goals and preferences. This REQUIREMENT is not met as evidenced by: Based on clinical record review and resident and staff interviews, the facility failed to ensure assessments before and after hemodialysis treatments for one of one resident reviewed that required dialysis (Resident #6). The facility reported a census of 48 residents. Findings include According to the Minimum Data Set (MDS) assessment tool dated 04/30/21, Resident #6 had diagnoses that included heart failure, end-stage renal disease (ESRD), diabetes mellitus, and chronic obstructive pulmonary disease (COPD). The MDS documented the resident scored 15 of 15 points possible on the Brief Interview for	F 698			

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F 698	<p>Continued From page 6</p> <p>Mental Status (BIMS) test, which indicated Resident # 6 displayed intact cognitive abilities. The MDS revealed the resident required dialysis treatments, had the ability to communicate verbally, and required limited assist of one staff for bed mobility, surface-to-surface transfers, ambulation (walking), dressing, toilet use and personal hygiene. The MDS also documented Resident #6 required set up assist only for eating and experienced occasional bowel and bladder incontinence.</p> <p>Resident # 6's care plan, updated on 07/14/21, identified the resident required dialysis services and directed staff to complete a head-to-toe physical assessment prior to leaving for dialysis and upon return from dialysis. The care plan also directed staff to monitor and record fluid intake, obtain routine weights, observe for changes in cognition, observe for hyper/hypotension, tachycardia, and syncopal (fainting) episodes, observe for peripheral/sacral edema, dyspnea, and distended neck veins.</p> <p>Physician Order Report signed by physician on 06/08/21, directed staff to hold the resident's furosemide dose on pre-dialysis days, but did not direct staff to assess dialysis site/catheter observations and failed to direct staff to assess pre-dialysis and post dialysis vital signs.</p> <p>The Resident Progress Notes report from May and June of 2021 demonstrated that Resident #6 received pre-dialysis assessments on 11 of 17 dialysis days and received post-dialysis assessments on 12 of 17 dialysis days.</p> <p>The Physician Order Report dated 08/01/21 directed staff starting on 06/29/21 to assess a</p>	F 698			

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F 698	<p>Continued From page 7</p> <p>pain scale, the dialysis site, and the resident's vital signs before and after dialysis on dialysis days.</p> <p>On the Medication Administration History report printed 08/04/21, pre and post dialysis day pain scale and dialysis site/catheter observations were completed on dialysis days from the moment Resident #6 returned from the Hospital on 07/09/21. Pre and Post dialysis vital signs were started on 07/12/21 per physician orders and were completed on dialysis days.</p> <p>Interviews:</p> <p>a. On 08/03/21 at 10:30 AM, Resident # 6 reported staff members did not consistently complete assessments (inspecting the dialysis access site, checking vital signs, and/or gathering any pertinent data related to the resident's general condition before and after dialysis treatments.</p> <p>b. On 08/05/01:35 PM the Assistant DON confirmed the facility's expectation that staff provide pre and post assessments on dialysis days by the nurse. He also confirmed that even if the physician did not write a specific order to conduct pre and post dialysis assessments, the nurse would still be expected to provide those assessments.</p> <p>c. On 08/05/21 at 1:58 PM, Staff C agreed nurses are supposed to provide pre and post assessments on dialysis days and they should do so whether or not the physician wrote an order that directed those assessments.</p> <p>The Facility Assessment Tool, reviewed 06/30/21</p>	F 698			

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F 698	Continued From page 8 under section 1.4 Decisions Regarding Care for Residents with Conditions Not Listed Above (List above does not include dialysis). Admissions to Calvin Community are reviewed using an interdisciplinary approach involving social work, nursing, and any other entity that may be required to meet the needs of the potential resident. If Calvin Community determines that the staff is able to meet the needs of the potential resident; appropriate supplies, training, etc. are secured prior to the admission date. This includes special equipment needs, dressing supplies, dietary accommodations or feeding supplies, medications or therapies. Staff may make a face to face visit to personally assess and advise regarding admission. Under Category 2: Special Treatments and Conditions," the facility allows for 0-2 dialysis residents.	F 698			
F 725 SS=E	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).	F 725			

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F 725	<p>Continued From page 9</p> <p>§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:</p> <p>(i) Except when waived under paragraph (e) of this section, licensed nurses; and</p> <p>(ii) Other nursing personnel, including but not limited to nurse aides.</p> <p>§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.</p> <p>This REQUIREMENT is not met as evidenced by:</p> <p>Based on record review and resident, family, and staff interviews, facility staff failed to respond in a timely manner (15 minutes) when residents activated their call lights for seven of seven residents reviewed. The facility reported a census of 48 residents.</p> <p>Findings include:</p> <p>During a confidential group interview on 08/02/21 01:30 PM 4 of 5 residents present stated the facility had long call light response times. The residents reported it took staff up to 30 to 45 minutes to provide assistance after they had turned on their call light. Two residents reported it took longer on weekends or during care and meal times. Both reported they had "accidents" while waiting for assistance.</p> <p>On 8/2/2021 at 11:14 AM a family member reported her loved one had often waited up to 30 minutes for staff to answer their call light, especially on weekends with less staff scheduled.</p>	F 725			

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F 725	Continued From page 10 Review of call light reports dated 7/15/21 to 7/31/21 revealed call light response times greater than 15 minutes for the following: 1. Resident #9: 6 times with response time ranging from 16 to 76 minutes 2. Resident #15: 4 times with response time ranging from 19 to 34 minutes 3. Resident #26: 14 times with response time ranging from 15 to 70 minutes 4. Resident #33: 17 times with response time ranging from 16 to 36 minutes 5. Resident #37: 1 time with response of 25 minutes 6. Resident #42: 1 time with response of 29 minutes Review of the Resident Council Notes dated 5/24/21 revealed residents had reported concerns with call light response times of 40-50 minutes. The Resident Council Notes documented the residents' concerns were directed to the Health Center Director of Nursing (DON). On 8/5/21 at 1:19 PM, the DON stated she expected staff to respond to resident call lights within 15 minutes. The DON stated they had no call light policy. On 8/5/21 at 1:40 PM, the Assistant Director of Nursing stated he checked call light reports whenever he had resident or family concerns to confirm issues, then followed up with staff. The ADON stated he expected staff answer call lights within 15 minutes.	F 725		
F 868 SS=B	QAA Committee	F 868		

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F 868	<p>Continued From page 11 CFR(s): 483.75(g)(1)(i)-(iii)(2)(i)</p> <p>§483.75(g) Quality assessment and assurance. §483.75(g)(1) A facility must maintain a quality assessment and assurance committee consisting at a minimum of:</p> <ul style="list-style-type: none"> (i) The director of nursing services; (ii) The Medical Director or his/her designee; (iii) At least three other members of the facility's staff, at least one of who must be the administrator, owner, a board member or other individual in a leadership role; <p>§483.75(g)(2) The quality assessment and assurance committee must:</p> <ul style="list-style-type: none"> (i) Meet at least quarterly and as needed to identifying issues with respect to which quality assessment and assurance activities are necessary. <p>This REQUIREMENT is not met as evidenced by: Based on record review and staff interview, the facility failed to ensure the required staff attended facility Quarterly Assurance Performance Improvement (QAPI) committee meetings for 2 of 5 reviewed meetings. The facility reported a census of 48 residents.</p> <p>Findings include:</p> <p>In an interview on 08/05/21 at 12:50 PM, the Director of Quality Assurance Performance Improvement (QAPI) reported she started in April 2021. She stated there had been a time when the facility had not held any QAPI meetings. They held their last meeting on 07/22/21.</p> <p>In an interview on 08/05/21 at 02:38 PM, the</p>	F 868		

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F 868	<p>Continued From page 12</p> <p>Director of QAPI provided the sign-in sheets she could locate and speculated there may have been meetings where the administrator did not attend, but she knew the facility missed a quarterly meeting before she started working there in April.</p> <p>Facility records show the QAPI meeting attendance form dated July 2020 recorded the following members in attendance QAPI nurse, pharmacist, dietician, social worker, medical director, and DON.</p> <p>Facility records show the QAPI meeting attendance form dated August 2020 recorded the following members in attendance medical director, dietician, QAPI nurse, DON, and ADON.</p> <p>The facility could provide no records to indicate a January 2021 quarterly QAPI meeting occurred as required.</p>	F 868			

POC for Survey conducted on 8-02-21 thru 8-05-21

F000

This Plan of correction constitutes our credible allegation of compliance date completed: 08-28-21

F 625

The facilities process for completing a Bed Hold Notice was reviewed. The Charge nurse will complete a bed hold determination receiving written or verbal verification from the resident or resident representative. Education was provided during staff huddles and will be reviewed during an in-service on 9-7-21. Bed Hold Notice review will be completed weekly for one month. Continued monitoring will be part of the facility QAPI process.

F 658

Resident #6 care plan was updated to reflect physician's order regarding bathing. Education was provided to staff during huddles and will be reviewed during an in-service on 9-7-21. A review of the point of care report will be completed weekly for a month and reviewed monthly ongoing. Continued monitoring will be part of the facility QAPI process.

F 698

Resident #6 MAR was updated to include vital checks and dialysis assessment prior to and post dialysis treatment. Education regarding pre and post dialysis assessment was provided to staff on 8/16/2021. Education will be provided during an in-service on 9-7-21. A review of the documentation from the assessments will be completed weekly for a month and reviewed monthly ongoing. Continued monitoring will be part of the facility QAPI process.

F 725

Education provided to staff regarding the importance of responding to call lights promptly. Call light report will be reviewed daily for one month by DON or designee. Random call light audits will be completed three times per week for two weeks, then weekly for three months. Education was provided during staff huddles and will be reviewed during an in-service on 9-7-21. Continued monitoring will be part of the facility QAPI process.

F 868

A schedule was established for the QAA meeting. The QAA meetings are to be held the 4th Thursday of the following months January, April, July, October. The facilities QAPI nurse will be responsible for verifying the required members of the QAA meeting were in attendance. Continued monitoring will be part of the facility QAPI process.

