INITIAL COMMENTS

F 000

The following deficiencies relates to the annual recertification and state licensure survey and complaint investigation 34546-C conducted 07/05/11 to 07/08/11. See Code of Federal Regulations (42 CFR) Part 483, Subpart B-C 483.15(h)(1)

F 252

SAFE/CLEAN/COMFORTABLE/HOMELIKE ENVIRONMENT

The facility must provide a safe, clean, comfortable and homelike environment, allowing the resident to use his or her personal belongings to the extent possible.

This REQUIREMENT is not met as evidenced by:

Based on observation and interview the facility failed to provide a clean and comfortable, homelike environment for the residents (Residents #3, #6, #7, and #16). The facility reported a census of 159 residents.

Findings include:

f. Observation on 7/05/11 at 2:30 p.m. in Residents #3 and #16’s room revealed six draws by the sink very difficult to open and the bottom drawer falling apart. The bathroom had a missing gripper strip on the floor which had accumulated debris of hair, and dirt in the remaining adhesive material. The door facing the inside of the room revealed a vinyl covering with two holes and exposed wood to the right bottom corner with a measurements of 4 inches wide by 9 inches in length, and 3 inches wide by 1 and one half inches in length. The bathroom door

Preparation and/or execution of this plan of correction does not constitute admission or agreement by this provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because it is required by the provisions of federal and/or state law.

This is my credible allegation of compliance with F252. This allegation does not constitute guilt but that the facility is in compliance with F252.

Without waiving the foregoing statement, in regards to resident #3 and #16, the drawers in the vanity have been repaired and allow for easy opening. In addition, the gripper strips have been replaced and both doors have been repaired.

In regards to resident #6 the sink, faucet and baseboards have all been replaced. Resident #7’s room has had the faucet and sink replaced. The veneer on the counter and baseboard in this room has also been replaced.
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION

Heritage Nursing & Rehab Center

(1) PROVIDER/SUPPLIER/LIA IDENTIFICATION NUMBER
163210

(2) MULTIPLE CONSTRUCTION
A BUILDING
B WING

(3) DATE SURVEY COMPLETED
07/08/2011

NAME OF PROVIDER OR SUPPLIER
Heritage Nursing & Rehab Center

STREET ADDRESS, CITY, STATE, ZIP CODE
203 Clive Drive SW
Cedar Rapids, IA 52404

SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)

F 252
Continued From page 1
revealed a two inch gray scrap all along the bottom of the door about six inches from the bottom edge of the door.

2. The initial tour of the facility on 7/5/11 revealed the following:
   a. At 2:05 p.m., the sink in Resident #6's room with grayish discoloration, base to the faucet with calcification deposits and erosion noted beneath the right faucet. The baseboards with brown residue noted along the seams above the floor to the resident's room.
   b. At 2:10 p.m., the sink in Resident #7's room with gray discoloration. The veneer to the edge of the counter had peeled approximately 12 inches away from the counter. The cream colored baseboards to the room had gray/brown residue along the entire length of the baseboards.

F 281
483.20(k)(3)(i) SERVICES PROVIDED MEET PROFESSIONAL STANDARDS

The services provided or arranged by the facility must meet professional standards of quality.

This REQUIREMENT is not met as evidenced by:
Based on observation, record review and staff interviews, the facility failed to provide medication according to the physician's order for 1 resident and administer medication according to acceptable standards for 2 residents of 21 residents reviewed. (Residents #6, #3, #26)

Findings include:

The facility's QA team will audit rooms frequently to ensure that the rooms remain clean and homelike. Areas of concern will be addressed immediately by the housekeeping or maintenance supervisor.

Date of correction: July 30, 2011

Preparation and/or execution of this plan of correction does not constitute admission or agreement by this provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of Correction is prepared and/or executed solely because it is required by the provisions of federal and/or state law.

This is my credible allegation of compliance to F-281. This allegation does not constitute guilt but that the facility is in compliance with F-281.
Physician's orders: Resident #6 is receiving all meds as ordered by physician effective 07/08/11. All residents are receiving meds as ordered and all nursing staff have been educated on transcribing orders and on double checking orders effective 07/18/11 and 07/21/11. Transcribing of orders will be audited routinely by nursing supervisors with problems corrected when identified. Physician's orders will also be reviewed with POS reconciliation.

Date of Correction: July 26, 2011

Facilities QA process will ensure audits/reviews will occur and corrective actions are taken under the direction of the Director of Nursing.

The Director of Nursing reports to the facility Administrator.

Medication administration: Resident #3 is receiving oral medications with proper technique effective 07/08/11. Nursing staff received education on 07/14/11 and 07/26/11 that it is not acceptable to touch oral medications with bare hands. Staff S received written counseling on 07/27/11. Resident #26 is receiving inhaler per proper administration effective 07/08/11. Staff R received written education on proper administration of an inhaler on 07/21/11.
F 281 Continued From page 3

three times daily for 7 doses.

Review of the nurse’s notes for 5/17/11 revealed new orders were received, however, the new orders did not address the increase in Valtrex dosage.

In an interview on 7/9/11 at 4:15 p.m., the Director of Nursing (DON) verified the order not changed on 5/17/11 to increase the dosage of Valtrex to 1600 mg three times daily for 7 days and reported the nurse responsible for the order was no longer employed at the facility.

In an interview on 7/9/11 at 7:00 a.m., the DON reported the night shift supervisor responsible to double note all orders on a daily basis.

Review of a letter submitted by the DON dated 7/7/11 revealed the nurse who wrote "duplicate" on the order dated 5/17/11 received an education in December regarding double noting as it was one of that nurse’s primary duties and again on 8/9/11.

The DON reported the facility did not have a policy to address transcription of physician orders and checking of MARS against new orders.

2. Observation on 7/9/11 at 8:13 a.m. revealed Staff S, registered nurse, as she administered oral medications to Resident #3 and handled 2 pills with bare hands as she placed each pill in the pill splitter, removed each split pill with her bare hands and returned to the medication cup with the other oral medications, then administered to the resident.

3. Observation on 7/9/11 at 7:25 a.m. revealed

Nursing staff received review/education of the facility policy on administration of an inhaler on 07/14/11.

Date of Correction: July 21, 2011

Medication administration will be monitored routinely through auditing by nursing supervisors/staff development coordinator with problems corrected when identified under the direction of the Director of Nursing.

The Director of Nursing reports to the facility Administrator.
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<thead>
<tr>
<th>ID</th>
<th>PREMIX TAG</th>
<th>SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL, REGULATORY OR LEG IDENTIFYING INFORMATION)</th>
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</table>
| F281 | Continued From page 4  
Staff R, a medication technician, as she administered a ProAir HF Inhaler (a bronchodilator medication for breathing conditions) to Resident #23, allowed the resident to take 2 inhalation in succession and did not wait at least 1 minute between the inhalations.

According to the 2011 Mosby's Nursing Drug Reference 24th Edition, the facility's drug book, page 98 provided the following directions for the administration of inhaled bronchodilator medications:
1. Shake the metered dose inhaler.
2. Exhale breath.
3. Place mouthpiece in mouth.
4. Inhale slowly while depressing cannister on inhaler.
5. Hold breath.
6. Remove mouthpiece.
7. Exhale slowly.
8. Administer subsequent inhalations at least 1 minute apart. | F281 | |
| F309 | 483.25 PROVIDE CARE/SERVICES FOR HIGHEST WELL BEING  
Each resident must receive and the facility must provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being, in accordance with the comprehensive assessment and plan of care.  
This REQUIREMENT is not met as evidenced by:  
Based on record review and staff interview, the | F309 | |

Preparation and/or execution of this plan of correction does not constitute admission or agreement by this provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of Correction is prepared and/or executed solely because it is required by the provisions of federal and/or state law.

This is my credible allegation of compliance to F-309. This allegation does not constitute guilt but that the facility is in compliance with F-309.
21060

NAME OF PROVIDER OR SUPPLIER

HERITAGE NURSING & REHAB CENTE

STREET ADDRESS, CITY, STATE, ZIP CODE

200 OLIVE DRIVE SW
CEDAR RAPIDS, IA 52404

F 303

Continued from page 5

facility failed to maintain the highest practicable physical well-being in accordance with the comprehensive assessment and plan of care for 2 of 14 residents reviewed (Residents #7 and #23). The facility reported a census of 159 residents.

Findings include:

1. The July 2011 Medication Administration Record (MAR) identified Resident #7 with the following diagnoses: aneurysm (an abnormal widening of a portion of an artery due to a weakening of the wall of the blood vessel) of the heart, chronic kidney disease and coronary atherosclerosis (a condition in which fatty material collects along the walls of arteries).

The Minimum Data Set (MDS) assessment tool dated 6/22/11 identified the resident had short-term and long-term memory problems, severely impaired with making decisions, and was totally dependent on staff to assist with moving in and out of bed and the unit, dressing, eating, toileting, bathing and had impairment to both arms.

The care plan with last review date of 7/6/11 identified the resident with the problem of potential for constipation and directed staff to:

a. intervene if no bowel movement (BM) for 2 to 3 days.

b. document when the resident has a BM

c. administer laxatives/as directed

d. notify the physician as needed

e. encourage fluids and in-between meals as needed

The Minimum Data Set (MDS) assessment tool dated 6/22/11 identified the resident had short-term and long-term memory problems, severely impaired with making decisions, and was totally dependent on staff to assist with moving in and out of bed and the unit, dressing, eating, toileting, bathing and had impairment to both arms.

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<th>SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LEG IDENTIFYING INFORMATION)</th>
<th>ID</th>
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<th>PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)</th>
<th>COMPLETION DATE</th>
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<tbody>
<tr>
<td>F 309</td>
<td>Continued From page 6</td>
<td>a. assess and monitor bowel sounds, abdomen for distention as needed and report to the physician as needed</td>
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<td>b. administer medications as ordered and monitor for side effects and complications with medication use and notify the physician as needed</td>
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<td>The physician ordered orders for milk of magnesia 30 cc (cubic centimeters) twice daily as needed.</td>
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<td>Review of the activities of daily living sheets revealed the resident did not have a BM for:</td>
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<td>a. 4 days on May 28, 29, 30 and 31</td>
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<td>b. 4 days on June 6, 8, 10 and 11</td>
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<td>Review of the MARS and nurse's notes revealed the resident did not receive any milk of magnesia from May 28-31 or June 8-11.</td>
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<td>2. The May 2011 MAR identified Resident #23 with the following diagnoses: diabetes, hemiplegia (paralysis of one side of the body), renal artery atherosclerosis (a condition in which fatty materis collects along the walls of arteries).</td>
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<td>The MDS dated 4/3/11 identified the resident as totally dependent on staff for moving in and out of bed and the unit, toileting, required the assistance of staff for dressing, eating and bathing. It did not identify the resident with a problem constipation.</td>
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<td>The care plan with last review date of 4/18/11 identified the resident with the problem of a history of constipation which the family preferred the use of prune juice to help and directed staff to offer the resident prune juice as needed.</td>
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### F 309

Continued From page 7

The physician's orders for from April through June 2011, aligned by the physician 5/15/11 had orders for milk of magnesia 30 milliliters daily as needed and bisacodyl 10 mg suppository one daily as needed for constipation.

Review of the activities of daily living sheet dated April 2011 did not have a BM for:
- 5 days on April 5, 6, 7, 8 and 9
- 5 days on April 23, 24, 25, 26, 27 and 28

Review of the MARs and nurse's notes revealed the resident did not receive any milk of magnesia or bisacodyl suppository from April 5-9 and April 23-28.

The nurse's note dated 3/28/11 at 7:00 p.m. revealed the family stated the resident will go without a BM for 7 days and requested prunes or corn as they work better than laxatives.

The resident assessment data collection form initial care plan dated 3/23/11 did not identify the resident with a problem of constipation.

Review of the nurse's notes revealed lack of complete assessment of the resident after the resident had an emesis on 5/5/11 at 2:15 p.m. on the following entries:
- 5/5/11 at 2:15 p.m. bowel sounds active (no documentation of when resident had BM last, palpation of abdomen, amount of emesis)
- 5/5/11 at 2:30 p.m. Phenergan (for nausea) 25 mg suppository was given
- 5/5/11 at 7:18 p.m. resident's urine orange in color, call placed to the doctor. (no documentation of effectiveness of Phenergan given earlier, of concentration or amount of urine
Continued from page 8

- 5/5/11 at 7:30 p.m. orders received to collect urine specimen for culture and sensitivity
- 5/5/11 at 8:00 p.m. no further emesis, had two large BMs this shift
- 5/6/11 at 2:00 p.m. no documentation of assessment of abdomen
- 5/6/11 at 5:00 p.m. first dose of antibiotic given
- 5/6/11 at 7:30 p.m. call placed to doctor related to low urine output, poor skin turgor, generalized weakness and abdominal pain (no documentation of amount of urine, assessment of abdomen)
- 5/6/11 at 8:15 orders received to send resident to the hospital
- 5/6/11 at 8:40 p.m. resident taken to hospital per ambulance

In an interview on 7/7/11 at 8:37 a.m., Staff F, licensed practical nurse (LPN), reported the resident had a history of constipation and the resident's family member reported it was usual for the resident to go 7 to 10 days without a BM. Staff F also reported it was the facility's policy to determine the location and cause of pain reported by the resident, administer pain medications ordered and evaluate the effectiveness of the medication and if ineffective to notify the doctor.

In an interview on 7/7/11 at 7:00 a.m., the Director of Nursing reported when a resident complained of abdominal pain, he/she expected nursing staff to assess bowel sounds, palpate the abdomen, check when the date of the last BM, quality of urine, give any pain medications ordered, if no medications ordered call the physician for orders. If the resident continued to...
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<tr>
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<td>F 309</td>
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</table>

**Summary Statement of Deficiencies**

**Provider's Plan of Correction**

- **ID**: F 309
- **Prefix**: 
- **Tag**: 
- **Date Survey Completed**: 07/08/2011

**Heritage Nursing & Rehab Center**

206 Clive Drive SW
Cedar Rapids, IA 52404

**Statement of Deficiencies and Plan of Correction**

**Provider/Supplier Identification Number**: 163310

**Multiple Construction**

A. Building

B. Wing

**Name of Provider or Supplier**

**Street Address, City, State, ZIP Code**

206 Clive Drive SW
Cedar Rapids, IA 52404

**Review of the facility "laxative protocol" dated 11/9/07 revealed the following:**

- a. Bowel monitoring to be done by the 2nd shift nurse every day.
- b. Review activity of daily living sheets for each resident BM.
- c. If a resident has not had a BM for 3 days, administer milk of magnesia per physician order on day 3. Place the resident's chart on the hot rack. Once a BM has occurred and is documented, the chart can be removed.
- d. If still no BM on the fourth day, give suppository per physician order. Rectal check can be completed at the time suppository is administered. Complete an abdominal assessment for bowel sounds, distention, and firmness. Don't forget to document the assessment in the chart. Again, the chart can be removed from hot rack once results are achieved.
- e. If a pattern is noticed with a resident being habitually constipated, you may initiate "Repep" (a food combination to aid in elimination) 15-30cc daily to twice daily. This is a nursing measure, but do not forget to inform the physician.
- f. Continue to record the result of your daily monitoring on the evening shift BM monitoring log.

**Review of the facility policy, "change of condition/chart protocol" dated March 2007 revealed the following:**

**Purpose**: To provide care to residents through nursing assessments, interventions, and appropriate follow up.
**F 309** Continued from page 10

Definition: condition change is an alteration from normal status. Could include, but not limited to: accidents, incidents with or without injury, noted reaction to medications, skin changes, vital sign changes, decreased urinary output, signs and symptoms of dehydration, physical decline in resident’s condition, cognitive changes in the resident and emotional changes in the resident.

Procedure:
- a. observe/assess resident to determine resident’s status
- b. notify the attending physician as appropriate
- c. notify resident's family/responsible party
- d. carry out new orders received
- e. monitor resident for response
- f. establish advance directive status as needed

Documentation:
- a. date and time of assessment and any interventions provided
- b. date and time of physician notification and if orders are received
- c. date and time of family/responsible party notification
- d. observation/assessment of the resident, to include response to interventions until the problem resolves
- e. signature and title

**F 318**

483.25(e)(2) INCREASE/PREVENT DECREASE IN RANGE OF MOTION

Based on the comprehensive assessment of a resident, the facility must ensure that a resident with a limited range of motion receives appropriate treatment and services to increase range of motion and/or to prevent further decrease in range of motion.
<table>
<thead>
<tr>
<th>ID</th>
<th>Provider's Plan of Correction</th>
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<tbody>
<tr>
<td>F318</td>
<td>Preparation and/or execution of this plan of correction does not constitute admission or agreement by this provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of Correction is prepared and/or executed solely because it is required by the provisions of federal and/or state law. This is my credible allegation of compliance to F-319. This allegation does not constitute guilt but that the facility is in compliance with F-318. Range of motion: Residents #14, #19 and #20 are receiving appropriate ROM exercises for their restorative programs as of 07/11/11. Staff Q received education from D.C.M. on 07/11/11 and received instructional education from ONR therapist on 07/20/11 for appropriate ROM techniques. Nursing supervisors/staff development coordinator to audit restorative programs routinely with problems corrected when identified. Facilities Date of Correction: July 20, 2011</td>
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<td>F318</td>
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Restorative aide complete passive range of motion to both upper extremities 5-10 repetitions.

Review of restorative aide notes dated 8/29/11 revealed Staff W, registered nurse (RN), as documented the restorative aide program to continue.

Observation with the resident in bed on 7/7/11 at 8:10 a.m., revealed Staff Q, oral medication technician (OMT) completing ROM for Resident #14.

Staff Q, OMT began passive ROM with the resident’s left upper extremity, then the right upper extremity, the left lower extremity and then to the right lower extremity.

Range of motion finished at 8:17 a.m., a total of 7 minutes for the completion of passive range of motion for the resident.

Observation revealed the lack of ROM technique to allow each muscle and joint to move through its full range of motion.

Observation of Staff Q’s ROM for Resident #14’s upper extremities revealed no adduction of the left or right arms, (movement toward the center of the body). Observation revealed no supination or pronation (movement of rotation upward/movement of rotation downward) of the left or right elbow. Observation revealed only two motions of the right and left wrists for flexion (bending) and extension (straightening) and two wrist rotations (circular motion) in only one direction for the left and right wrists. No ulnar (keeping hand and fingers straight and moving...
Continued From page 13

the hand towards the little finger) or radial deviation (keeping the hand and fingers straight and moving the hands toward the thumb) exercises took place with either the left or right hands. A thumb motion consisted of extending the thumbs of both the right and left hands twice away from the palm of the hand. No flexion, rotation, or opposition (holding of the thumb and index finger, touching the tips together, and then straightening the fingers) of the thumbs occurred. Continued observation revealed the flexion and extension of the fingers all together only twice on the left and right hands.

No removal of the bed cradle from the lower portion of the resident's bed occurred before Staff Q began ROM exercises to the resident's lower extremities.

Staff Q, completed ROM to the left lower extremity, abducting (moving the leg away from the center of the body) the leg only to the point where the leg could go no further as the aluminum frame of the bed cradle hindered the leg from being abducted to full range. Observation revealed no internal or external rotation (rolling the leg inward/rolling the leg outward) of the left or right leg. No rotation of the right ankle took place. The left ankle rotation consisted of 2 circular motions in one direction. No flexion or extension of the toes on the left or right foot took place. Footles remained on the resident as range of motion exercises took place. No dorsiflexion (bending of ankle towards leg) or plantar flexion (pushing of ankle downward) of the right or left ankles took place.

Review of the 6/15/11 plan of care for Resident
Continued from page 14

#14 revealed a problem of physical functioning and impaired mobility and directed staff to complete the restorative program per physical therapy/occupational therapy or per nursing recommendations.

2. Resident #19 had diagnoses listed on the 7/18/11 MDS which included Alzheimer’s disease. The MDS documented total dependence on 2 persons for bed mobility, transfers, toilet use, and bathing and total dependence of 1 staff for dressing, and personal hygiene.

The MDS documented functional limitations of the upper extremities.

Review of a physical therapy recommendation for restorative/functional maintenance program dated 9/27/10 documented the restorative program for the resident which consisted of:

- Supine: hip and knee extension
  Knee extension with hold at end range x 2 x 30 seconds each leg.

- Hip abduction - on back with knees apart. Have patient brings legs apart with rehab aide assist by holding legs apart and rehab aide assist by holding at end range x 2 x 30 seconds.

Review of occupational therapy recommendations for restorative/functional maintenance programs dated 9/28/10 consisted of active assistive range of motion 2-3 times a week for bilateral (left and right) upper extremities 10 repetitions each.

Review of restorative aide notes dated 6/29/11
Continued from page 15
revealed Staff W, RN, as documenting the restorative slide program to continue...

Observation on 7/7/11 at 9:30 a.m. revealed Staff Q, completing ROM exercises for the resident.

Upper extremity ROM showed the resident as not very cooperative.

Lower extremity ROM revealed the resident cooperative and Staff Q completing the program as outlined for hip abduction.

Continued observation of the passive range of motion exercises completed by Staff Q revealed no hold at the end of range x 2 for 30 seconds of the right or left leg as outlined for the hip and knee exercises by physical therapy.

Review of the plan of care dated 7/7/11 documented a problem with needing assistance with mobility and at risk for falls related to impaired cognition, poor balance, peripheral neuropathy, incontinence, weakness, history of falls, near vision impairment, Alzheimer's disease, dementia, overactive bladder with urge incontinence and directed staff to complete the restorative program as indicated.

3. Resident #20 had diagnosis listed on the 4/18/11 MDS which included Alzheimer's disease, heart failure, and anemia. The MDS documented total dependence on staff for bed mobility, transfers, dressing, eating, toilet use, and bathing. The MDS documented functional limitations in range of motion of the shoulder, elbow, wrist, and hand, and no ability to walk.
F 318  Continued From page 16

In comparison the previous MDS dated 1/31/11 documented extensive assistance with bed mobility, dressing, eating, and toileting use. The MDS documented no range of motion limitations of the shoulder, elbow, wrist, or hand.

Review of a physical therapy recommendation for restorative/functional maintenance program dated 8/8/10 documented the restorative program 3 times a week for the resident which consisted of:

2 x 10 reps:
- ankle pumps
- knee extension with 2 pound weights
- hip flexion with 2 pound ankle weights

Review of occupational therapy recommendations for restorative/functional maintenance programs dated 1/8/10 consisted of bilateral exercises 3 times a week with 1 pound weights for 10 repetitions.

Review of restorative aide notes dated 6/29/11 revealed Staff W as documenting the restorative aide program to continue.

Observation on 7/8/11 at 7:42 a.m. revealed Staff Q completing ROM exercises for Resident #20. Staff Q stated they only complete 5 repetitions as the resident has congestive heart failure and starts coughing. Review of the restorative aide notes reveals no mention of this and no change in the rehabilitation program for the resident as noted by Staff W.

With the resident sitting up in the wheelchair Staff Q completed passive range of motion exercises to the left and right upper extremities in 3
The exercises consisted of 5 repetitions of the left and right arms with a 1 pound weight for elbow flexion and 5 repetitions of the left and right arms for abduction. Passive range of motion for the left and right wrists consisted of a back and forth motion of 5 repetitions. The left and right thumb range of motion consisted of an outward movement from the fingers twice.

Review of the 4/25/11 plan of care revealed a problem of the resident needing assistance with activities of daily living related to confusion, weakness, altered mental status, pain to joints, Alzheimer's dementia, osteoarthritis of the hips and knees, recurring urinary tract infections, and decreased range of motion to the bilateral (left and right) shoulders. An approach directed staff to refer to physical therapy, occupational therapy as needed and to follow recommendations.

With the resident sitting up in the wheelchair Staff Q completed passive range of motion to the left and right lower extremities in 30 seconds with 2 pound weights. Dorsiflexion of the left and right ankles occurred twice and left and right knee/hip flexion consisted of 5 repetitions. Continued observation revealed 2 back and forth motions of the left and right ankles for ankle pump completion.

The facility form PROCEDURE: RANGE OF MOTION EXERCISES included point #5: Place patient in comfortable supine position (on his/her back) with his/her knees extended and his/her arms at his/her sides.
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<th>ID</th>
<th>TAG</th>
<th>SUMMARY STATEMENT OF DEFICIENCIES</th>
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<th>PROVIDER'S PLAN OF CORRECTION</th>
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<td>Review of facility information titled REHABILITATIVE ASPECTS OF NURSING revealed under Responsibility to the patient point #7:</td>
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<td>Know and understand the techniques used in physical rehabilitation in order to:</td>
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<td>a. Supply supportive measures which help prevent deformity</td>
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<td>b. Maintain muscle tone and range of joint motion</td>
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<td>c. Evaluate and develop physical activities within the patient's maximum capacity</td>
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<td>d. Carry out programs prescribed by the doctor which compliment programs initiated by physical therapist, occupational therapist and other members of the team.</td>
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<td>Interview on 7/3/11 at 8:10 a.m. with Staff P, licensed practical nurse, revealed Staff W, registered nurse, as responsible for rehabilitation oversight for the 3 residents on this side of the facility building.</td>
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**F 323**

483.25(h) FREE OF ACCIDENT HAZARDS/SUPERVISION/DEVICES

The facility must ensure that the resident environment remains as free of accident hazards as is possible; and each resident receives adequate supervision and assistance devices to prevent accidents.

This REQUIREMENT is not met as evidenced by:

Preparation and/or execution of this plan of correction does not constitute admission or agreement by this provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of Correction is prepared and/or executed solely because it is required by the provisions of federal and/or state law.
HERITAGE NURSING & REHAB CENTER

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION

NAME OF PROVIDER OR SUPPLIER:
HERITAGE NURSING & REHAB CENTER

STREET ADDRESS, CITY, STATE, ZIP CODE:
260 CLIVE DRIVE SW
CEDAR RAPIDS, IA 52404

DATE SURVEY COMPLETED:
07/05/2011

ID NUMBER:
165310

MULTIPLE CONSTRUCTION:
A. BUILDING:
B. WING:

DEFICIENCY IDENTIFICATION NUMBER:
F 323

SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LIC IDENTIFYING INFORMATION):
Continued From page 19
Based on observation and interview the facility failed to provide a hazard free environment for the residents. The facility reported a resident census of 169 residents.

Findings Include:
1. Observation on 07/06/11 in room 1C-22 revealed the inside of the door had irregular shaped sharp wood and plastic veneer edges from just below the doorknob to the bottom edge of the door.
2. Observation during environmental tour with the Administrator, Staff T, the maintenance supervisor, and Staff O, the housekeeping and laundry supervisor on 7/7/11 between 11:50 a.m. and 1:30 p.m. revealed:

The door to the physical/occupational therapy room near Station 2 closed but not locked, with a hydrocollator (machine that contains and heats water) on the counter that measured approximately 18 inches wide by 10 inches across and 24 inches high upon the counter and very warm to touch. A log with temperatures recorded daily revealed the temperature 169 degrees Fahrenheit on that date, and a range of 164 to 170.8 degrees Fahrenheit between 4/7/11 and 7/8/11.

During an interview on 7/7/11 at 12:05 p.m., Staff T indicated he had made multiple repairs of the therapy door lock over the last few weeks. Therapy staff present in the room at the time indicated they had trouble with the lock over the past few weeks and maintenance notified for repairs.

This is my credible allegation of compliance to F323. This allegation does not constitute guilt but that the facility is in compliance with F323.

Preparation and/or execution of this plan of correction does not constitute admission or agreement by this provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because it is required by the provisions of federal and/or state law.

Without waiving the foregoing statement, the door on room 1C-22 has been repaired to remove any sharp wood or veneer edges. The push-button locking door knob was repaired by a local locksmith and is operating correctly.

All department supervisors were reeducated that any physical plant safety concerns must be addressed immediately or take measures to remove any items presenting a safety concern.
### F 323

Continued From page 20

During an interview on 7/7/11 at 12:00 p.m., the administrator directed housekeeping staff to remove the hydrocollator from the therapy room and directed Staff T to contact a lock repair service to fix the door lock.

On 7/8/11 at approximately 11 a.m., Staff T provided a handwritten receipt from a locksmith that indicated the therapy door lock repaired on that date.

During an interview on 7/8/11 at 2:20 p.m., Staff V, a physical therapist, indicated the therapy department acquired the hydrocollator in April, 2011, and provided policy and written information that did not include safeguarding residents from burn hazards and harm.

**Date of correction: August 3, 2011**

### F 387

483.40(c)(1)(2) FREQUENCY & TIMELINESS OF PHYSICIAN VISIT

This resident must be seen by a physician at least once every 30 days for the first 90 days after admission, and at least once every 60 days thereafter.

A physician visit is considered timely if it occurs not later than 10 days after the date the visit was required.

This REQUIREMENT is not met as evidenced by:

- Based on record review and staff interview the facility failed to provide documentation of physician visits every 30 days for the first 90 days after admission for one resident (Resident #20), and every 60 days for two residents (Residents #24, and #2) of 24 residents reviewed in the open...
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<tr>
<th>ID PREFIX TAG</th>
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<th>DATE COMPLETION</th>
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<tr>
<td>F 387</td>
<td>Continued from page 21 sample. The facility census was 159 residents.</td>
<td>F 387</td>
<td>Physician's visits: Residents #20 and #24 no longer reside at the facility. Resident #2 is receiving q 60 day physician's visits effective 07/08/11. Nursing supervisors were educated on 07/07/11 and 07/14/11 on the frequency of physician's visits. Date of correction: July 14, 2011. Physician’s visits will be monitored by nursing supervisors routinely with problems corrected when identified. Facilities QA process to ensure auditing and corrective actions taken. Nursing Supervisors report to the Director of Nursing.</td>
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<td>Findings include:</td>
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<td>1. A History and Physical dated 12/14/2007 documented Resident #2 had diagnoses including hypertension, coronary artery disease, nonfunctioning kidney, and chronic indwelling Foley catheter. The Minimum Data Set (MDS) assessment tool with a reference dated 02/02/11 revealed the resident had a brief interview for mental status total score of 12 out of 15 which indicated moderate cognitive impairment. The MDS documented the resident required limited assistance of one staff member for transfers, ambulation in room and corridor, dressing, and extensive assist of one person for toilet use. The MDS revealed the resident had a urinary tract infection in the last thirty days, and a multidrug-resistant organism infection. Review of the resident's clinical record revealed physician visits for the following dates: 6/02/10, 12/08/10, and 06/01/11. During an interview on 7/06/11 at 4:10 p.m., the Director of Nursing reported that the facility practice is to do physician visits every 6 months for residents that are private pay. 2. Resident #20 had diagnoses listed on the facility face sheet which included of hypothyroidism, generalized anxiety, and general osteoarthritis.</td>
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**NAME OF PROVIDER OR SUPPLIER**  
HERITAGE NURSING & REHAB CENTE

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| F 387  | Continued From page 22  
The facility face sheet documented an admission date of 12/04/09.  
Review of the clinical record revealed physician visits until and over the required 60 days between visits.  
Physician visits occurred on the following dates:  
6/8/2010  
11/19/2010 (greater than 50 days)  
1/21/11  
Interview with Staff P on 7/7/11 at 4:00 p.m. revealed no ability to find records other than the ones listed.  
F 441  
483.65 INFECTION CONTROL, PREVENT SPREAD, LINENS  
The facility must establish and maintain an Infection Control Program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of disease and infection.  
(a) Infection Control Program  
The facility must establish an Infection Control Program under which it -  
(1) Investigates, controls, and prevents infections in the facility;  
(2) Determines what procedures, such as isolation, should be applied to an individual resident; and  
(3) Maintains a record of incidents and corrective actions related to infections.  
(b) Preventing Spread of Infection  
(1) When the Infection Control Program determines that a resident needs isolation to prevent the spread of infection, the facility must | F 387 | | |
|        | Preparation and/or execution of this plan of correction does not constitute admission or agreement by this provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of Correction is prepared and/or executed solely because it is required by the provisions of federal and/or state law.  
This is my credible allegation of compliance to F-441. This allegation does not constitute guilt but that the facility is in compliance with F-441. |
## HERITAGE NURSING & REHAB CENTER

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| F 441  | Continued from page 23 isolate the resident.  
(2) 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.  
(3) The facility must require staff to wash their hands after each direct resident contact for which hand washing is indicated by accepted professional practice.  
(c) Linens  
Personnel must handle, store, process and transport linens so as to prevent the spread of infection.  
This REQUIREMENT is not met as evidenced by:  
Based on observation, record review and staff interview the facility failed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of disease and infection for 1 of 14 residents reviewed (Resident #8). The facility reported a census of 159 residents.  
Findings include:  
1. According to Resident #8's Minimum Data Set (MDS) assessment tool dated 5/09/11 diagnoses include hypertension (high blood pressure), diabetes mellitus, dementia, and recent hospitalization for pneumonia.  
According to the MDS dated 6/09/11, Resident #8 had short and long term memory problems and moderately impaired cognitive skills for daily | F 441  | Sanitary/comfortable environment:  
Resident #8 is provided a sanitary and comfortable environment effective 07/06/11.  
Staff K and L received verbal education from the D.O.N. on 07/05/11 and 1:1 education with the staff development coordinator on 07/13/11 covering infection control and peri-care. Nursing staff received education on 07/18/11 and 07/26/11.  
Date of Correction: July 26, 2011  
Infection control will be monitored routinely by nursing supervisors and staff development coordinator with problems corrected when identified. Facilities QA process to ensure auditing and corrective actions taken.  
Nursing Supervisors report to the Director of Nursing |
F 441 Continued From page 24

decision making, Resident #8 required extensive assistance of 2 staff for bed mobility, transfers, walking in the room, and toilet use. The resident was totally dependent of 1 staff for dressing and personal hygiene and totally dependent on 2 staff for bathing.

The resident's Care Plan dated 6/23/11 directed the nursing staff that the resident wore a brief/pad for dignity and toilet the resident routinely around meals, at bedtime, and as needed. Encourage resident participation with toileting tasks as able and as needed, provide check and change, and assist the resident with perineal care after each incontinence episode and as needed.

During observation on 7/5/11 at 3:45 p.m., until 4:30 p.m., Staff K and Staff L, Certified Nurse Aides (CNA) toileted and prepared Resident #8 for a shower. Staff K and Staff L stood the resident up from the wheelchair and proceeded to pull down pants and incontinent brief and noted the resident was incontinent of a large loose bowel movement (BM). It was noted the BM had dripped on the bottom and outer aspect of the upper leg also. Staff K and Staff L sat the resident down on the toilet without cleansing off the BM and a small amount of BM fell to the floor in front of the toilet. Staff K and Staff L disposed of the soiled brief ungloved and regloved and noted the BM remained on the floor in front of the toilet. Staff K prepared washcloths at the sink in the bathroom by wetting the clothes and spraying with per-Fspray. Staff K proceeded to wash the resident with the use of only 2 cloths and then utilized toilet paper to finish cleaning Resident #8. Staff K and Staff L sat the resident down on the shower chair and noted the resident's bottom and upper legs.
F 441 Continued from page 25

remained soiled. The toilet seat remained totally covered with BM and BM remained on the floor in front of the toilet and BM smears were also on the right grab bar along the toilet. While Staff L
showered the resident staff K proceeded to clean up the toilet and surrounding areas. Staff K
observed to clean the BM off the floor in front of the toilet with toilet paper and then walked on the area without further cleaning. Staff K then cleaned the BM off the seat of the toilet with toilet paper and then sprayed the toilet seat with a cleaner and wiped off the seat in less than 10 seconds. Staff K observed to place the spray bottle on the floor in front of the toilet where the BM had been cleaned up with no further cleaning and then Staff K placed the bottle back into the cupboard when done cleaning without ungloving.
Staff K continued to walk through the area in front of the toilet where the BM had fallen while cleaning up the area with no further cleaning of the floor. When Staff K left the room with garbage bags containing soiled linens and garbage, observation revealed BM remained under the rim to the back of this toilet seat and to the front of the seat and the floor area in front of the toilet was not disinfected.

Staff L finished resident #8's shower and Staff K returned to the shower room to assist with transferring the resident. Resident #8 observed to sit on the shower chair and noted BM remained to the outer aspect of the right upper leg with the resident's T-shirt hanging down over the area. Observed Staff K and Staff L stand the resident up from the shower chair and the resident's bottom remained soiled with BM, Staff L grabbed a towel and wiped off the resident's bottom without wetting the towel or utilizing any...
<table>
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<th>(Kx) IDENTIFICATION NUMBER: 165310</th>
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<td>NAME OF PROVIDER OR SUPPLIER: HERITAGE NURSING &amp; REHAB CENTE</td>
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<td>STREET ADDRESS, CITY, STATE, ZIP CODE: 200 CIVIL DRIVE SW, CEDAR RAPIDS, IA, 52403</td>
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<td>DATE SURVEY COMPLETED: 07/06/2011</td>
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<td>F 441</td>
<td>Continued From page 26 perk-spray. Staff K and Staff L pulled up the resident's brief and noted dried BM remained to the outer upper right leg and then pulled up the resident's pants and sat the resident back down in the wheelchair. When Staff L completed wiping off the resident with the towel, observed the staff to drop the towel on the floor of the shower area. Staff K assisted the resident out of the shower room and observed Staff L unglove and proceed to pick up the soiled towel off the floor with bare hands and take the soiled towel to clean off the BM soiled seat of the shower chair with bare hands. Staff L proceeded to the cupboard to get the spray bottle of cleaner without washing hands and sprayed the seat of the shower chair thoroughly with the spray. Staff L then wet a clean towel and wiped off the shower chair in less than 1 minute, while completing this a gait belt hanging around the neck of Staff L hung into the soiled area and balled into the shower chair prior to cleaning and while cleaning the chair. Staff L then sprayed the shower area floor with the cleaner as a small amount of BM observed near the drain and then proceeded to turn on the shower in less than 30 seconds, rinsed the floor down, put a towel on the floor of the area and wiped the floor with his/her foot, then bent over with bare hands wiped the floor with the towel with the gait belt dragging in the area on the floor from Staff L's neck. At the end of clean up, observed Staff L exit the room and noted BM remained under the rim of the toilet, the floor in front of the toilet where the BM fall never sprayed or cleaned with disinfectant, and BM smear remained to the front edges of the toilet seat. Review of the spray bottle cleaner utilized by Staff L and Staff K revealed the product entitled</td>
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<td>Century Q 258, a disinfectant-cleaner, sanitizer, fungicide, mildewstat, virucide, deodorizer for hospitals, institutional or industrial use. The label instructions directed to thoroughly wet the surface with a cloth, mop, sponge, or sprayer and then treated surfaces must remain wet for 10 minutes (2 minutes for disinfection against all viruses except HBV). Wipe dry with a clean cloth, sponge, or allow to air dry. For heavily soiled areas, a preliminary cleaning required.</td>
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<td>Review of an undated Whirlpool, Tub, Shower and Shower Chair Cleaning Policy indicated the policy was for whirlpools, tubs, showers, and shower chairs and must be cleaned with disinfectant and rinsed between each resident to provide quality infection control. An important reminder instructed staff to remember to scrub the underneath side of all shower chairs and whirlpool lift chairs.</td>
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<td>During an Interview on 7/6/11 at 8:28 a.m., Staff O, Housekeeping/Laundry Supervisor, reported the Century Q 258 cleaner used by all housekeeping staff and unsure if used by the CNA's, but reports only in current position 2 weeks. Staff O indicated awareness of the 10 minute contact time for the cleaner and housekeeping staff are trained to follow that direction.</td>
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<td>During an Interview on 7/6/11 at 8:33 a.m., Staff N, CNA indicated using the Century Q 258 spray on shower chairs prior to use and after each use with a resident. Staff N reported she sprays down the chair and leaves the spray on for 10 minutes.</td>
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<td>During an Interview on 7/8/11 at 8:35 a.m., the</td>
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| F 441 | Continued From page 28  
Director of Nursing (DON), reported she had talked to Staff K and Staff L and the staff were re-educated for infection control/hand washing/wearing gloves and cleaning up shower rooms after showers. The DON did report the staff were nervous and felt they knew what to do properly.  
During an interview on 7/7/11 at 11:11 a.m., Staff M, CNA, explained that the shower chairs needed cleaned between each resident use and to spray the Century Q 258 to cover the chair seat completely till wet and leave on for at least 15 minutes then wipe off.  
During an interview on 7/8/11 at 12:15 p.m., the DON reported the re-education was completed with Staff K and Staff L as earlier reported, but no formal documentation with the staff training on 7/6/11 was completed. | F 441 | 483.70(h)  
SAFE/Functional/Sanitary/Comfortable Environment  
The facility must provide a safe, functional, sanitary, and comfortable environment for residents, staff and the public.  
This REQUIREMENT is not met as evidenced by:  
Based on observation and interviews, the facility failed to provide a safe, sanitary and comfortable environment for residents and the public. The facility census was 159 residents.  
Findings included: | F 465 |

Preparation and/or execution of this plan of correction does not constitute admission or agreement by this provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because it is required by the provisions of federal and/or state law.
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<th>(x2) PROVIDER/SUPPLIER IDENTIFICATION NUMBER</th>
<th>(x3) MULTIPLE CONSTRUCTION COMPLETED DATE</th>
<th>(x4) ID/PREFIX TAG</th>
<th>SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LIC IDENTIFYING INFORMATION)</th>
<th>ID/PREFIX TAG</th>
<th>PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)</th>
</tr>
</thead>
</table>
| F 465         | Continued From page 29                      |                                          | F 465             | This is my credible allegation of compliance to F465. This allegation does not constitute guilt but that the facility is in compliance with F465.  
Without waiving the foregoing statement, the lounge furniture on Station 2 has been repaired and stained. Wooden door frames, doors and walls throughout the building have been replaced or repaired to remove scratches and grooves from the wheelchair footrests. The border around the dining room tables have been repaired and are not longer fallen away from the main part of the table.  
Replacement and repair of facility furnishings are ongoing and will be reviewed with the QA team and directed to the facility Maintenance Supervisor. The QA team will monitor to ensure that the environment remains clean and in good repair.  
Date of correction: August 8, 2011 |
<table>
<thead>
<tr>
<th>ID</th>
<th>TAG</th>
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<tbody>
<tr>
<td>F 465</td>
<td>Continued From page 30</td>
</tr>
<tr>
<td></td>
<td>power-washed all of the round dining room tables on 7/3/11, and noticed on 7/8/11 that the borders of each table had separated and fallen away from the main part of the table, and in the process of ordering new table tops.</td>
</tr>
<tr>
<td></td>
<td>During an interview on 7/7/11 at 2:50 p.m., the Administrator provided a copy of an electronic transmission from the corporate vice president that described a proposed total remodel of the facility and included flooring, lighting and improvements to the rehab to home unit (skilled service resident). The communication lacked documentation of repairs to resident rooms throughout the building.</td>
</tr>
</tbody>
</table>