STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	165556	A. BUILDING _____ B. WING _____	04/11/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SUNNYCREST MANOR	2375 ROOSEVELT STREET DUBUQUE, IA 52001

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F 000	INITIAL COMMENTS Correction date: _____ The following deficiencies resulted from the facility's annual recertification survey conducted on April 08, 2024 to April 11, 2024. See the Code of Federal Regulations (42CFR) Part 483, Subpart B-C.	F 000		
F 637 SS=D	Comprehensive Assessment After Signifcant Chg CFR(s): 483.20(b)(2)(ii) §483.20(b)(2)(ii) Within 14 days after the facility determines, or should have determined, that there has been a significant change in the resident's physical or mental condition. (For purpose of this section, a "significant change" means a major decline or improvement in the resident's status that will not normally resolve itself without further intervention by staff or by implementing standard disease-related clinical interventions, that has an impact on more than one area of the resident's health status, and requires interdisciplinary review or revision of the care plan, or both.) This REQUIREMENT is not met as evidenced by: Based on clinical record review, Center for Medicare and Medicaid (CMS) Long-Term Care (LTC) Facility Resident Assessment Instrument (RAI) 3.0 User's Manual review, and staff interview the facility failed to complete a Significant Change in Status Minimum Data Set (MDS) Assessment within the required time frame for 1 of 2 residents sampled on hospice care (Resident #2). The facility reported a census of 62 residents.	F 637		

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	165556	A. BUILDING _____ B. WING _____	04/11/2024

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F 637	Continued From page 1	F 637		

Findings include:

Resident #2's Hospice Plan of Care documented a hospice admission date of 7/21/23 for a primary diagnosis of malignant neoplasm of colon.

Resident #2's MDS Assessment dated 8/02/23 showed a Brief Interview for Mental Status score of 12/15 indicating a moderate cognitive impairment. The MDS lacked documentation in section O, Special Treatments, Procedures and Programs, of Resident #2 receiving hospice services.

The MDS 3.0 Summary Page showed the 8/02/23 MDS with a completion date of 8/15/23. The facility failed to complete the significant change in status assessment (SCSA) MDS for admission to hospice by 8/03/24.

On 4/08/24 at 1:40 PM Staff D, Registered Nurse verbalized Resident #2 currently receives hospice care from a local provider.

On 4/10/24 at 9:16 AM the MDS Coordinator reported when a resident goes on hospice care they set the assessment reference date (ARD) within 14 days of the change. She inquired if there had been changes in the MDS as she was not aware of the requirement to complete the MDS within 14 days of identifying the significant change. She reported the facility does not have a policy but follows the RAI manual for completing the MDS.

During an interview on 4/10/24 at 9:55 AM Staff G, Co-Director of Nursing reported the Surveyor would have to check with the MDS Coordinator on her process, but she did expect the RAI to be

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	165556	A. BUILDING _____ B. WING _____	04/11/2024

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F 637	Continued From page 2 followed regarding the appropriate time frames for completion. The LTC RAI 3.0 User's Manual Version 1.18.1 October 2023 page 1-4 documents the RAI process has multiple regulatory requirements. Federal regulations at 42 CFR (Code of Federal Regulations) 483.20 (b)(1)(xviii), (g), and (h) require that the assessment accurately reflects the resident's status. The LTC RAI 3.0 User's Manual Version 1.18.11 October 2023 Page 2-17 directs the MDS completion date is no later than the 14th calendar day after determination that significant change in resident's status occurred (determination date + 14 calendar days). Page 2-25 directs An SCSA is required to be performed when a terminally ill resident enrolls in a hospice program (Medicare-certified or State-licensed hospice provider) or changes hospice providers and remains a resident at the nursing home.	F 637		
F 641 SS=D	Accuracy of Assessments CFR(s): 483.20(g) §483.20(g) Accuracy of Assessments. The assessment must accurately reflect the resident's status. This REQUIREMENT is not met as evidenced by: Based on clinical record review, Center for Medicare and Medicaid (CMS) Long-Term Care (LTC) Facility Resident Assessment Instrument (RAI) 3.0 User's Manual review, and staff interview the facility failed to accurately code the Minimum Data Set (MDS) assessment for 3 of 3 residents sampled (Resident #2, #23, and #32). The facility identified a census of 62 residents.	F 641		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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F 641	Continued From page 3	F 641		

Findings include:

1. Resident #2's Hospice Plan of Care documented a hospice admission date of 7/21/23 for a primary diagnosis of malignant neoplasm of colon.

Resident #2's MDS Assessment dated 8/02/23 showed a Brief Interview for Mental Status (BIMS) score of 12/15 indicating a moderate cognitive impairment. The MDS lacked documentation in section O, Special Treatments, Procedures and Programs, of Resident #2 receiving hospice services.

On 4/08/24 at 1:40 PM Staff D, Registered Nurse verbalized Resident #2 currently receives hospice care from a local provider.

On 4/10/24 at 9:16 AM the MDS Coordinator reported she must have accidentally miscoded the MDS in the wrong area. She reported the facility does not have a policy but she follows the RAI manual for completing the MDS.

During an interview on 4/11/24 at 9:55 AM Staff G, Co-Director of Nursing reported the Surveyor would have to check with the MDS Coordinator on her process, but she did expect the RAI to be followed regarding accuracy in coding of the MDS.

The LTC RAI 3.0 User's Manual Version 1.18.1 October 2023 page 1-4 documents the RAI process has multiple regulatory requirements. Federal regulations at 42 CFR (Code of Federal Regulations) 483.20 (b)(1)(xviii), (g), and (h) require that the assessment accurately reflects

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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F 641	Continued From page 4	F 641		

the resident's status. Page O-7 directs to code hospice care on the MDS for any resident identified as being in a hospice program for terminally ill persons where an array of services is provided for the palliation and management of terminal illness and related conditions.

2. Resident #32's medical record contained a Physician Order dated 12/19/23 to change the 16 French 10 cubic centimeters (cc's) balloon suprapubic catheter every 4 weeks and a 3/19/24 urology Physician Order to continue monthly suprapubic catheter changes at the nursing facility.

A review of Resident #32 MDS Assessments dated 10/25/23 and 1/10/24 documented Resident #32 with the presence of an ostomy. Both MDS's lacked documentation of the presence of a suprapubic catheter.

On 4/10/24 at 9:16 AM the MDS Coordinator reported she must have just miscoded Resident #32 MDS and would have to correct it. She indicated the Resident should have had the suprapubic catheter checked in section H of the assessment.

Observation on 4/10/24 at 10:30 AM revealed Resident #32 with a clean split dressing to the suprapubic catheter insertion site free of signs of infection.

The LTC RAI User's Manual, Chapter 3, Page H-2 under Coding Tips and Special Populations directs suprapubic catheters should be coded as an indwelling catheter only and not as an ostomy.
3. Review of Resident #23 MDS dated 2/28/24 indicated resident received 7 days of

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	165556	A. BUILDING _____ B. WING _____	04/11/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SUNNYCREST MANOR	2375 ROOSEVELT STREET DUBUQUE, IA 52001

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F 641	Continued From page 5 subcutaneous injections of insulin. Review of the MDS for Resident #23 dated 3/13/24 revealed 7 days of insulin injections. Review of the physician order sheet with active orders as of 2/28/24 did not have any orders for insulin listed. On 04/10/24 09:23 AM the RN/MDS Coordinator stated Resident #23 does not receive insulin and she was doing a lot of MDS at the time and probably just miscoded it. They follow the RAI manual for direction on how to complete the MDS.	F 641		
F 800 SS=E	Provided Diet Meets Needs of Each Resident CFR(s): 483.60 §483.60 Food and nutrition services. The facility must provide each resident with a nourishing, palatable, well-balanced diet that meets his or her daily nutritional and special dietary needs, taking into consideration the preferences of each resident. This REQUIREMENT is not met as evidenced by: Based on observations, policy review, and staff interviews the facility failed to maintain appropriate food holding temperatures to prevent food-borne illness and utilize the menu-approved serving sizes to meet resident nutritional needs. The facility reported a census of 62 residents. Findings include: During an observation of the puree preparation on 4/09/24 from 9:24 AM to 10:12 AM a milk carton was observed sitting directly on the	F 800		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	165556	A. BUILDING _____ B. WING _____	04/11/2024

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F 800	Continued From page 6	F 800		

counter. The temperature of the milk at 10:09 AM was 49.6° Fahrenheit (F). Staff A, Cook failed to dispose of the milk and placed it back in the refrigerator at 10:11 AM.

During an observation of the noon meal on 4/09/24 from 11:33 AM to 1:06 PM revealed the following:

A. The sliced onions, pickles, and tomatoes in containers were placed directly on a serving cart not on ice and used throughout meal service

B. Staff C, Food Service Worker was observed serving residents with the following scoop sizes:

a. Pureed BBQ riblets- scoop #12 (2 2/3 ounces (oz))
b. Diced BBQ riblets- scoop #12
c. Diced carrots- scoop #12
d. Mashed potatoes- scoop #12

According to DiningRD.com Diet Spreadsheet Day 10-Tuesday menu the following serving sizes were to be used:

a. Pureed BBQ riblets- scoop #6 (5 1/3 oz)
b. Diced BBQ riblets- scoop #6
c. Diced carrots- 4 oz
d. Mashed potatoes- scoop #8 (4 oz)

Post meal temperatures taken at 12:55 PM revealed the following foods did not maintain the appropriate internal holding temperature of 135° F for hot foods and 41° F or less for cold foods:

a. Ground BBQ riblets: 129.2° F
b. Pureed riblets: 114.4° F
c. Diced carrots: 121.4° F
d. Mashed potatoes: 99.1° F
e. Sliced onions: 48.5° F
f. Pickles: 51.8° F

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	165556	A. BUILDING _____ B. WING _____	04/11/2024

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F 800	Continued From page 7 g. Tomatoes: 47.3° F During an interview on 4/09/24 at 2:15 PM the Dietary Director expressed he was not aware that there was a discrepancy between the scoop size on the menu and the ones used for service at the noon meal. During an interview on 4/10/24 at 10:33 AM the Dietary Director reported he expected staff to ensure cold foods are held at 41° F degrees or below and hot foods at 140° F or above during meal service. Staff are directed to follow the dietician approved menu for serving sizes and to follow all facility policies. The undated policy titled Food Temperature educated staff that bacteria grow most rapidly in the range of temperatures between 40° F and 140° F, doubling in number in as little as 20 minutes. This range of temperatures is referred to as "The Danger Zone". It instructed staff to have a cooler packed with ice or frozen gel packs when transporting cold food. It further directed staff to handle, cook, and store foods at safe temperatures. It failed to direct staff on appropriate holding temperatures for hot foods. The undated policy titled Menus instructed staff to follow the approved Registered Dietician Menu. A 4/09/24 observation of the second floor Eagle Ridge unit revealed at 11:50 AM Staff E, CNA removed a gallon of white and chocolate milk from the nurses station refrigerator and placed them on the second shelf of a utility cart without being on ice. She then rolled the cart down the hallway and parked the cart outside of the village dining room. At 12:00 PM the cart remained outside of the village dining room door. At 12:15 PM Staff E passed the lunch meal trays to five	F 800		

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SUNNYCREST MANOR	2375 ROOSEVELT STREET DUBUQUE, IA 52001

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F 800	Continued From page 8 residents sitting in the village dining room, then proceeded to take the tray cart down the hallway by the nurses station. At 12:18 PM Staff F, Registered Nurse (RN) entered the village dining room and poured milk for the room trays and delivered the room trays out to Resident's #21 and #162. At 12:24 PM Staff E poured a glass of chocolate milk and served out to Resident #42. A test glass of chocolate milk at this time showed a temperature of 43.9 degrees.	F 800		
F 812 SS=F	Food Procurement,Store/Prepare/Serve-Sanitary CFR(s): 483.60(i)(1)(2) §483.60(i) Food safety requirements. The facility must - §483.60(i)(1) - Procure food from sources approved or considered satisfactory by federal, state or local authorities. (i) This may include food items obtained directly from local producers, subject to applicable State and local laws or regulations. (ii) This provision does not prohibit or prevent facilities from using produce grown in facility gardens, subject to compliance with applicable safe growing and food-handling practices. (iii) This provision does not preclude residents from consuming foods not procured by the facility. §483.60(i)(2) - Store, prepare, distribute and serve food in accordance with professional standards for food service safety. This REQUIREMENT is not met as evidenced by: Based on observation, policy review, and staff interview the facility failed to date opened foods, wear hair nets, use gloves appropriately for assembling and serving meals, and wash hands	F 812		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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F 812	Continued From page 9	F 812		

between glove use in order to serve meals under sanitary conditions. The facility reported a census of 62 residents.

Findings include:

During an observation of the kitchen on 4/09/24 at 9:12 AM the following items were found opened and undated: elbow macaroni, rigatoni noodles, and spiral noodles in an unlabeled plastic bag. At 9:22 AM Staff B, Cook failed to wear a hair net while cutting dessert bars. She was observed again at 11:51 AM without a hair net on while serving the noon meal.

An observation of the puree process on 4/09/24 from 9:24 AM to 10:12 AM revealed the following:

a. Staff A, Cook wore gloves and placed cooked riblet meat in a blender by hand. He then wiped his gloves on his apron and grabbed a recipe binder off a shelf. He used his hands to flip through the binder pages and then used a rubber spatula to scrape the ground meat into a measuring container. He again touched the paper in the binder. He then opened a bag of frozen riblets and failed to change his gloves before using his hands to place the riblets on a pan.

b. Staff A placed a serving scoop face down onto a wet cleaning towel. He then failed to use a clean scoop and transferred pureed carrots into a container with the soiled scoop.

An observation of the noon meal on 4/09/24 from 11:33 AM to 1:06 PM revealed the following:

a. Staff B wore gloves and touched a plate, tongs, the steam table, the bun bag, and then failed to change her gloves before using her hands to plate and open the bun. This occurred

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	165556	A. BUILDING _____ B. WING _____	04/11/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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F 812	Continued From page 10	F 812		

25 times affecting 25 residents.

b. Staff B used tongs to remove a pan lid and then failed to use clean tongs to plate tater tots. She then used the tongs to replace the lid. This occurred 6 times affecting 6 residents.

c. Staff B used tongs to remove a pan lid and then failed to use clean tongs to plate riblets and chicken. She then used the tongs to replace the lid. This occurred 3 times affecting 3 residents.

d. Staff B placed tongs for the chicken and riblets into the food pans with the handles directly touching the food. The food was then served to residents.

e. Staff C, Food Service Worker failed to secure a scoop that then fell into the corn with the handle directly touching the food. She then served the corn to residents.

f. Staff B failed to secure tongs that then fell into the tater tot pan with the handle directly touching the food. She then served the tater tots to residents.

g. Staff B and Staff C changed gloves between serving on the second floor and third floor, and again between the third floor and the main dining room. No hand hygiene occurred.

The document provided by the facility titled Food Temps Timeline reported on 12/14/23 the facility was aware the steam table wells were heating to different temperatures and the temperatures were dropping different amounts when checked at the completion of meal service.

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F 812	Continued From page 11	F 812		

During an interview on 4/10/24 at 10:33 AM the Dietary Director reported he expected staff to wear a hair restraint during preparation and serving of food. Staff are also to wash hands between glove changes. He acknowledged there was nothing on the portable carts for staff to do so during meal service. He explained staff are to use utensils to handle food if present, not hands. If assembling a sandwich, staff are expected to have one person dedicated to assembly. They must not touch food items and other surfaces with the same gloves. Staff are instructed not to use tongs to move lids and then food. Once a utensil is used for food it is only used for food. He further explained the handling surface of utensils should not touch the food. He expected staff to follow all facility policies.

The undated policy titled Proper Hand Washing and Glove Use directed staff to conduct hand washing procedures and glove usage in accordance with State and Federal sanitation guidelines. It instructed staff to wash hands before donning gloves and after removing gloves. It further instructed staff to change gloves any time they become contaminated by touching the face, hair, uniform, or other non-food contact surface. It directed staff not to place gloves on dirty hands and specified the procedure as wash, glove, remove, rewash, and re-glove.

The undated policy titled Hair Restraint explained all food handlers who have direct contact with food must wear hair restraints, such as hairnets, beard nets, and caps, that fully cover all exposed body hair.