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

PRINTED: 09/04/2013
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	156034	A. BUILDING Macon 9/20/13 B. WING	08/15/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MANORCARE HEALTH SERVICES	201 WEST RIDGEWAY AVENUE WATERLOO, IA 50701

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 000	INITIAL COMMENTS Correction Date 9-19-13 The following deficiencies relate to the facility's annual health survey and investigation of Complaint #42885 and #44687. Both complaints were substantiated. (See Code of Federal Regulations (42 CFR) Part 483, Subpart B-C).	F 000	This serves as the Allegation of compliance for ManorCare Health Services Waterloo for the survey completed August 15, 2013. The statements made on this plan of correction are not an admission to and do not constitute an agreement with the alleged deficiencies. To remain in compliance with all Federal and State regulations, the center allegation	
F 156 SS=B	483.10(b)(6) - (10), 483.10(b)(1) NOTICE OF RIGHTS, RULES, SERVICES, CHARGES The facility must inform the resident both orally and in writing in a language that the resident understands of his or her rights and all rules and regulations governing resident conduct and responsibilities during the stay in the facility. The facility must also provide the resident with the notice (if any) of the State developed under §1919(e)(6) of the Act. Such notification must be made prior to or upon admission and during the resident's stay. Receipt of such information, and any amendments to it, must be acknowledged in writing. The facility must inform each resident who is entitled to Medicaid benefits, in writing, at the time of admission to the nursing facility or, when the resident becomes eligible for Medicaid of the items and services that are included in nursing facility services under the State plan and for which the resident may not be charged; those other items and services that the facility offers and for which the resident may be charged, and the amount of charges for those services; and inform each resident when changes are made to the items and services specified in paragraphs (5)	F 156	of compliance such that all alleged deficiencies cited have been or will be corrected by the date indicated. The facility will continue to provide or arrange service to meet professional standards of quality.	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE Administrator | (X6) DATE 9/18/13

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

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	165034	A. BUILDING _____ B. WING _____	06/15/2013

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MANORCARE HEALTH SERVICES	201 WEST RIDGEWAY AVENUE WATERLOO, IA 50701

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F 156	Continued From page 1 (i)(A) and (B) of this section. The facility must inform each resident before, or at the time of admission, and periodically during the resident's stay, of services available in the facility and of charges for those services, including any charges for services not covered under Medicare or by the facility's per diem rate. The facility must furnish a written description of legal rights which includes: A description of the manner of protecting personal funds, under paragraph (c) of this section; A description of the requirements and procedures for establishing eligibility for Medicaid, including the right to request an assessment under section 1924(c) which determines the extent of a couple's non-exempt resources at the time of institutionalization and attributes to the community spouse an equitable share of resources which cannot be considered available for payment toward the cost of the institutionalized spouse's medical care in his or her process of spending down to Medicaid eligibility levels. A posting of names, addresses, and telephone numbers of all pertinent State client advocacy groups such as the State survey and certification agency, the State licensure office, the State ombudsman program, the protection and advocacy network, and the Medicaid fraud control unit; and a statement that the resident may file a complaint with the State survey and certification agency concerning resident abuse, neglect, and misappropriation of resident property in the facility, and non-compliance with the advance directives requirements.	F 156	F 156 Resident #18 no longer resides at the facility. Residents residing in the facility, which meet the requirement for the need for Determination of Continued stay letter, had their records reviewed and appropriate documentation was present. Education to Social Service Department regarding resident's compliance with obtaining a Determination of Continued stay letters as needed upon discharge from skilled level of care. Audits of discharged residents requiring Determination of Continued Stay letters will be completed by Business Office Manager or designee weekly x 4 weeks with findings reviewed in Quality assurance meeting for recommendations or resolution.	9/19/13

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F 156	Continued From page 2 The facility must inform each resident of the name, specialty, and way of contacting the physician responsible for his or her care. The facility must prominently display in the facility written information, and provide to residents and applicants for admission oral and written information about how to apply for and use Medicare and Medicaid benefits, and how to receive refunds for previous payments covered by such benefits. This REQUIREMENT is not met as evidenced by: Based on facility record review and staff interview, the facility failed to provide one of three residents the opportunity to request a demand bill when services were no longer deemed covered by medicare (Resident #18). The facility census was 77 residents. Findings include: 1. Review of medicare billing information for Resident #18, revealed the resident received skilled services from 5/10/13 until 7/18/13. Review of facility records revealed no Determination on Continued Stay letter. During an interview on 8/14/13 at 1:46 p.m., the facility administrator stated that the facility has no record of the family or resident being offered a request for a demand bill.	F 156		
F 248 SS=D	483.15(f)(1) ACTIVITIES MEET INTERESTS/NEEDS OF EACH RES	F 248		

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F 248	Continued From page 3 The facility must provide for an ongoing program of activities designed to meet, in accordance with the comprehensive assessment, the interests and the physical, mental, and psychosocial well-being of each resident. This REQUIREMENT is not met as evidenced by: Based on clinical record review and staff interview the facility failed to complete quarterly activity notes for 3 of 10 current residents reviewed (Resident #8, #9, #10). The facility reported a census of 77 residents. Findings Include: 1. The Minimum Data Set (MDS) assessment reference dated 5/14/13, documented Resident #8 with diagnosis which included hypertension, diabetes mellitus, non-Alzheimer disease, anxiety, malaise and fatigue. The Brief Interview for Mental Status (BIMS) documented the resident scored a 3 out of 15 for cognitive patterns. The Resident Care Plan with a team conference dated 10/25/11, documented an activity calendar to be posted, family and friends visit and are supportive, patient prefers to wear a gown to meals due to tremors and dropping food, will encourage and invite to attend activities, enjoys bingo, magazines, television,newspaper, and will make in room materials when needed. Review of Residents clinical record revealed an activity progress note dated 8/14/13. Record review indicated prior activity note dated 2/15/13,	F 248	F 248 Resident #8, #9, #10 have had their activity participation and evaluation completed to ensure the facility offers activity programming on ongoing basis designed to meet their interests and their physical, mental, and psychosocial well-being. Residents residing within the facility have had their activity participation and evaluation completed in accordance with their comprehensive assessment and interventions placed as noted. Education provided to Activity Director/ designee regarding completion of evaluation completed in accordance with their comprehensive assessment. Audits of assigned quarterly activity assessments will be performed weekly x 4 weeks then monthly for 2 months.	9/19/13

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	165034	A. BUILDING _____ B. WING _____	08/16/2013

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F 248	Continued From page 4 with no activity note or assessment during this time frame. Interview on 8/14/13 at 10:50 p.m., the activity director confirmed and verified that no activity notes or assessment completed and the clinical record lacked any further activity assessments. 2. The Progress note dated 8/14/13, documented Resident #9 with diagnosis which included chronic airway obstruction, muscle weakness, hypertension, tremor and anxiety. The MDS assessment reference dated 7/5/13 documented Resident #9 with a BIMS score of 15 for cognition. The Residents Plan of Care dated 7/17/10, documented an activity calendar to be posted. family/friends are supportive and visits. will encourage and invite to activities of inters, patient enjoys reading, church, exercise, music, shopping, television and trips, will offer in room materials as needed. Review of residents clinical record revealed an activity progress note dated 4/3/13. Record review indicated no activity note or assessment prior to that date. Interview on 8/1413 at 10:50 a.m., the facility activity director confirmed and verified that the clinical record lacked any further activity assessments. 3. The Progress notes dated 8/14/13, documented Resident #10 with diagnosis for which included muscle weakness, congestive heart failure, difficulty walking, depression, and	F 248		

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F 248	Continued From page 5 venous insuffiency. The MDS assessment reference dated 8/2/13, documented Resident #10 with a BIMS score of 15 for cognitive patterns. The Leisure/Pursuits/Interests dated 5/2/13, documented resident interests included dogs and cats, movies, music, parties/socials, puzzles/word search games, religious involvement. Review of residents clinical record revealed an activity progress note dated 11/1/12 and 5/2/13. Record review indicated no activity note or assessment completed during these dates. Interview on 8/14/13 at 10:50 a.m., the facility activity director confirmed and verified that the clinical record lacked any further activity assessments.	F 248		
F 252 SS=E	483.15(h)(1) 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 staff interview, the facility failed to clean and maintain a resident's room furnishings and failed to clean and maintain floor mats used for resident's personal safety. The facility identified a census of 77 residents. Findings include:	F 252		

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F 252	Continued From page 6 1. An environmental tour on 8/14/13 at 8:55 a.m. with the Environmental Supervisor, Maintenance Director, Staff B, Registered Nurse, and the Administrator revealed the following: a. Room 152: 1 beige floor mat and 1 gray floor mat that contained several areas with white, black, yellow marks and streaks all each mat. b. Room 155: 1 burgundy floor mat and 1 gray floor mat that contained several areas with white, black, yellow marks and streaks all each mat. c. Room 205: 1 beige floor mat and 1 gray floor mat that contained several areas with white, black, yellow marks and streaks all each mat. d. Room 144: 2 burgundy floor mats that contained several areas with white, black, yellow marks and streaks all each mat. The Administrator agreed the mats were dirty and no one answered when asked for a date when they were last cleaned. 2. On 8/12/13 at 12:15 p.m., observation revealed a chair in resident room 156 with several large, dried stains on it. On 8/14/13 at 8:15 a.m., the stains remained on the chair. At 3:00 p.m., the facility administrator stated the chair had been removed from the room. 3. On 8/14/12 at 8:30 a.m., observation revealed the following items along a wall in the center hallway of the West wing: a. Three linen carts. b. Two medication carts. c. Numerous wheel chairs.	F 252	**F 252** Areas identified were cleaned and will continue to be cleaned with room cleaning schedules. Additional floor mats and additional identified chairs were evaluated and interventions placed. Education to facility staff to ensure the facility must provide a safe, clean, comfortable and homelike environment, allowing the resident to use his/her personal belongings to the extent possible. Environmental audits completed by Administrator/designee weekly x4 weeks with findings reviewed in Quality Assurance meeting for recommendations or resolution.	9/19/13

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F 252	Continued From page 7 d. An electric lift. e. A housekeeping cart. This equipment lined the majority of the wall from one end of the hallway to the other allowing space only for one way traffic.	F 252		
F 253 SS=E	483.15(h)(2) HOUSEKEEPING & MAINTENANCE SERVICES The facility must provide housekeeping and maintenance services necessary to maintain a sanitary, orderly, and comfortable interior. This REQUIREMENT is not met as evidenced by: Based on observation and staff interview the facility failed to provide a clean, sanitary and homelike environment throughout various areas of the facility. The facility identified a census of 77 residents. Findings include: 1. During environmental tour on 8/14/13 at 8:50 a.m. with the Administrator, Environmental Supervisor, Staff B, Registered Nurse and the Maintenance Director the following was observed: a. A narrow door in the front hall, on the right side leading to the Skilled Unit contained multiple black and gray markings along the bottom of the beige door. b. The right exit door in the front left side of the Rehabilitation Unit contained a large built up of dirt, dust and debris on the bottom of the silver door frame. The Environmental Supervisor	F 253	F 253 The identified areas have been evaluated and corrective practices initiated. Environmental rounds completed with Administrator, Environmental Director, Maintenance Director, and Guardian Angel Rounds for further areas if identified and evaluated with corrective practices in place. Education provided to facility staff on maintaining a clean, sanitary and homelike environment for residents residing in the facility. Environmental audits completed by Administrator/designee weekly x 4 weeks with findings reviewed in Quality Assurance meeting for recommendations or resolution.	9/19/13

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F 253	Continued From page 8 reported losing 2 housekeepers the previous week. c. The beige tiled floors going into residents' rooms (202, 203, 204, 205, 206, 207, 209, 211 and 215) contained built up wax, dark marks and built up gray debris into the door corners and the corners in the next wall area by the bathroom wall. d. The air exchange vent in the Therapy room covered with dust and debris. When asked when this was last cleaned, there was no answer. e. The silver protector panels on the bottoms of doors to the Critical Storage Room, Kitchen, Maintenance Room, Mechanical Room, and the Central Shower door (service hall) contained multiple different colored streaks. When asked when they were last cleaned, the Maintenance Director stated, "They look like they are due to be cleaned." f. The beige tiled floor under the Employee's Room door was almost black with markings and holes with multiple pieces of the tile missing. g. The exit door in the service hall contained a large built up of dirt, dust and debris on the bottom, silver door frame, giving it a black appearance. There were many pieces of the beige tile missing, filled in with black debris. h. The air vent in the front of the service hall (residents travel to go to the front of the building or to the activity room and dining room) was unevenly caulked, rough, with multiple coats of paint present. The Maintenance Director stated it could look better. . The service door to the kitchen in the service hallway was marked with black marks, uneven paint and discolored paint giving it an unclean appearance. The beige floor beneath it contained black markings on the beige floor. J. The back lounge area had wallpaper loosely	F 253		

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F 253	Continued From page 9 hanging near the exit door, toward the bottom of a short wall. k. The Central Shower Room door in the back hall contained black marks around the handle of the beige door. l. The small width wall by the back nursing station had the vinyl border pulled away from the wall. m. The bottom corner of the back Nurse's Station contained a small hole in the plaster. n. Room 160 had large streaks of green color showing through the beige door toward the bottom. o. Rooms 150, 156 and 161 have cracked beige tiles at the entrance way of the rooms. p. The bottom of the wall on the right side of the Center hallway (in the front area) has 10 feet of the beige vinyl border irregularly placed along side the floor exposing brown debris (paste) giving an unclean appearance. q. The far exit door off the central hall, at the end of the front hall (on the right side)contained a large built up of dirt, dust and debris on the bottom silver door frame, giving it a dark appearance. r. 2 washing machines in the Laundry room with silver frames were severely streaked in many colors along the front and on the sides. s. The Women's bathroom in the front of the building had a gray floor that is severely marked with different colors, mostly black and yellow. The entire floor ridge, going up toward the wall was very dark in appearance. The white toilet base contained a splash of a dried yellow substance on the bottom, side area that was observed since the initial tour of the facility (8/12/13) and remained in place when shown to the management team (8/14/13). The Administrator nodded with acknowledgement of the observations noted on tour. The	F 253		

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F 253	Continued From page 10 Administrator remsrked a contracted painter would be coming and there was a scheduled remodeling to be done in the front and Central and service hallways and those resident's rooms. 2. On 8/12/13 at 12:15 p.m., observation revealed a variety of debris on the hand rails of the center hallway. Numerous areas contained dried food, a crumpled straw paper cover, lint, hair and other debris. Observation revealed the dirt and debris also in various places and along the entire hand rail which ran around the span of the West wing of the building. 3. At 12:48 p.m., observation revealed large brown stains on two of the main dining room ceiling tiles. Observation at that time also revealed a wheeled cart in the dining room with a dried brown substance on it. 4. On 8/14/13 at 8:15 a.m., observation revealed the debris (dried food, paper straw cover, lint/hair) all remained in the same places on the hand rail of the West wing. At 8:45 a.m. Staff D (housekeeper) stated they were the only housekeeper in that part of the building for forty rooms and could not get it all cleaned. At 4:00 p.m., the facility Administrator stated two housekeepers were no longer with the facility and currently being replaced.	F 253		
F 281 SS=D	483.20(k)(3)(i) SERVICES PROVIDED MEET PROFESSIONAL STANDARDS The services provided or arranged by the facility must meet professional standards of quality.	F 281		

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F 281	Continued From page 11 This REQUIREMENT is not met as evidenced by: Based on observation and drug record book review, the facility failed to follow the administration of eye drops for one resident (Resident #19). The facility census was 77 residents. Findings include: 1. Observation on 8/14/13 at 9:46 a.m., revealed Staff G (director of care services) administering Timolol 0.5% eye drop into each eye every day in to Resident #19 eyes. Staff G failed to place a finger over the lacrimal sac of the eye or have the resident keep their eye closed for one minute. Review of the Nursing 2012 Drug Handbook, for Timolol 0.5% eye drops, instructed staff to: a. apply left finger pressure on lacrimal sac for one minute after instilling drug to minimize systemic absorption.	F 281	F 281 Resident #19 evaluated and interventions placed as necessary. Residents with Timolol 0.5% eye drops were evaluated and interventions placed as necessary. Education provided to licensed nursing staff regarding administration of eye medication to reduce systemic effects. Audits will be completed for ongoing compliance by ADNS/designee 3 x week x 4weeks with findings reviewed in Quality Assurance meeting for recommendations or resolution.	9/19/13
F 312 SS=D	483.25(a)(3) ADL CARE PROVIDED FOR DEPENDENT RESIDENTS A resident who is unable to carry out activities of daily living receives the necessary services to maintain good nutrition, grooming, and personal and oral hygiene. This REQUIREMENT is not met as evidenced by: Based on observation, clinical record review and staff interview the facility failed to provide	F 312		

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F 312	Continued From page 12 thorough grooming and incontinence cares for two of ten residents reviewed (Resident #2 and #8). The facility reported a census of 77 residents. Findings include: 1. The Minimum Data Set (MDS) assessment for Resident #2 dated 6/6/13, documented diagnoses which included muscle weakness and osteoporosis. The MDS documented the resident required extensive assistance of one with personal hygiene and dressing. The care plan dated 3/8/12, documented the resident would receive assistance necessary to meet ADL needs and included an intervention to assist with daily hygiene, grooming, dressing, oral care and eating as needed. On 8/13/12 at 8:05 a.m., Staff J, Certified Nurse Aide, CNA and Staff L CNA completed morning cares. The resident had a visible brown substance under and around the fingernails on both hands, which did not get cleaned during the observation. At 8:30 a.m., the resident sat in the main dining room and ate breakfast using both hands and no utensils. The brown substance remained under and around the fingernails. On 8/14/13 at 1:00 p.m., Staff F (Nurse Manager) assessed the residents nails at the surveyor's request. The brown substance remained under and around the resident's nails. At that time Staff F stated they would have someone clean the residents nails immediately. 2. A Minimum Data Set (MDS) assessment tool	F 312	F 312 Resident #2, and Resident #8 have been evaluated and interventions placed as necessary. Residents residing within the facility were reviewed with interventions placed as necessary. Education provided to certified nursing staff and licensed staff on nail care and incontinent care for male patients. Audits will be completed for ongoing compliance by ADNS/designee 3x a week x4 weeks with findings reviewed in Quality Assurance meeting for recommendations or resolution.	9/19/13

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F 312	Continued From page 13 dated 5/4/13 documented Resident #8 with diagnosis that included hypertension, diabetes mellitus, non-Alzheimer disease, anxiety, malaise and fatigue. The MDS documented the resident displayed severely impaired cognition, required extensive assistance for toilet use, personal hygiene and bed mobility and was occasionally incontinent of urine and bowel. The Plan of Care dated 11/14/12, documented urinary and bowel incontinence related to decreased mobility, functional limitations and directed staff to: a. apply skin moisturizer/barrier as needed. b. Observe for and report any changes in amount, color or odor of urine. c. Observe for and report any changes in skin integrity found during daily cars. d. Observe for and report and s/s of urinary tract infections. e. Use absorbent product such pads, liners, adult briefs to assist with moving urine away form ski/clothing and tor preserve dignity. f. Encourage and assist patient to toilet approximately every two hours and as needed and check for incontinence and provide incontinent care as needed. Observation on 8/13/13 at 10:22 a.m., Staff J (certified nursing assistant) and Staff L (certified nursing assistant) proceeded to do incontinent cares on the resident. Staff J proceeded to cleanse all areas of the resident perineal area where the soiled brief had touched the skin. Staff J failed to pull back the resident foreskin and clean the area underneath it. Interview on 8/13/13 at 10:46 a.m., Staff F (nurse	F 312		

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F 312	Continued From page 14 manager) confirmed and verified that the brief was soiled in the front and back with urine and that the staff failed to follow the peri care policy. Review of the facilities Incontinence Care dated 12/12, documented the procedures as follows: a. If uncircumcised, retract foreskin then proceed. b. Cleanse from the tip of the penis outward. Cleanse down to body including the scrotum and skin folds. Use alternate sites on washcloth with each downward stroke. c. Rinse using same procedure with clean washcloth. d. If uncircumcised, reposition foreskin to natural position.	F 312		
F 323 SS=E	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: Based on observation and staff interview the facility failed to ensure potentially harmful chemicals and items were stored in secured areas, failed to provide eating supervision/assistance for two of five residents reviewed on a mechanically altered diet and failed to ensure safety devices were in place as planned for one of thirteen residents reviewed (Resident	F 323		

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F 323	Continued From page 15 #13, #4 & #11). The facility reported a census of 77 residents. Findings include: 1. During the initial dietary tour on 8/12/13 at 8:50 a.m., observation revealed the following unlocked/unsecured items in the activity kitchenette area: a. A large bottle of hydrogen peroxide with a warning label keep out of reach of children. b. A bottle of Glycerin with a warning label keep out of reach of children and pets, avoid contact with eyes. c. An aerosol can of nail polish dryer with a warning label flammeble, keep out of reach of children. d. Four bottles of nail polish remover with a warning label keep out of reach of children. No staff were present. At 1:25 p.m., the Activity Director stated they had placed locks on the cupboards in the kitchenette area. 2. The Minimum Data Set (MDS) assessment dated 6/23/13 for Resident # 13, documented diagnoses which included osteoarthrosis and syncope with collapse. The MDS documented the resident required extensive assistance of two for bed mobility and supervision of one with eating. A transfer sheet dated dated 8/4/13, included an order for a pureed diet with honey thickened liquids. During observation on 8/13/13 at 11:35 a.m.,	F 323	F 323 Resident #13, #4, #11 have been evaluated and practices corrected and further interventions placed as necessary. Residents residing within the facility; and their environment evaluated for potentially harmful chemicals and items stored securely and that their safety devices are in place as planned; and diets reviewed with further interventions as necessary. Education to facility staff regarding the residents with mechanically altered diets will be supervised/assisted with oral intake when at risk for aspiration; potentially harmful chemicals and items stored in secured areas; safety devices will be in place as planned. Audits will be completed for ongoing compliance ADNS/designee 3 x week x 4 weeks with findings reviewed in Quality Assurance meeting for recommendations or resolution.	9/19/13

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dietary staff prepared a lunch trey for the resident with pureed foods and placed it on a cart with the room trays.

At 1:15 p.m., the resident sat alone in their room in a bed with the head of the bed elevated. The resident leaned to the left and held a spoon in their hand and ate the pureed food. The privacy curtain was pulled and no staff were present.

The facility administrator stated on 8/14/13 at 4:15 p.m., the resident would now be taken to the dining room for meals. At that time the facility provided the surveyor with a speech therapy eating and swallowing evaluation completed 8/13/13 which included a physician order for speech-language pathology that documented the resident required aspiration and dehydration precautions.

3. The Admitting Record printed on 8/14/13 identified Resident #4 with diagnoses that included pericardium disease and pneumonia.

The Minimum Data Set(MDS)dated 8/5/13 assessment tool identified the resident displsyed moderately impaired cognitive and required extensive staff assistance with transfers, mobility, dressing and bathing. The assessment tool noted the resident required limited staff assistance with eating, had complaints of difficulty or pain with swallowing and was on a mechanically altered diet.

The Medication Review Report dated 07/23/13 identified the resident's diet as regular food, mechanical son with nectar thickened liquids.

The resident's Care Plan dated 07/25/13 identified the resident with altered nutrition related

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to chewing and swallowing difficulties secondary to progressive disease processes as evidenced by coughing with foods/liquids with possible need for texture modified diet. The resident was hospitalized for acute mental changes thus requiring texture modified diet per Speech Therapy. The care plan directed staff to encourage and assist the resident as needed and provide the diet as ordered (mechanical soft foods with nectar thickened liquids).

The Speech-Language Pathology report dated 07/24/13 recommended mechanical soft foods with nectar thick liquids and aspiration precautions.

Observation on 8/12/13 at noon revealed the Speech Therapist sitting beside the resident in the resident's room, assessing and watching the resident eating the noon meal. The resident was eating a mechanical soft meal with nectar thickened liquids.

Observation on 8/13/13 at breakfast and the noon meal revealed the resident sitting in the main dining room with staff present, eating a mechanical soft meal with nectar thick liquids.

Observation on 08/14/13 at 8:15 a.m., revealed the resident in their room eating a mechanical soft meal with nectar thickened liquids from the bedside table tray stand. No staff persons were in the room with the resident. At 8:55 a.m., the resident's tray of food was gone, but the resident sat in the wheelchair at the tray table stand with a glass of thickened water to finish drinking. The resident reported what was eaten at the breakfast meal.

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F 323	Continued From page 18 Observation on 8/14/13 at 12:10 p.m., revealed Staff C, CNA setting up the resident's meal in the resident's room with the resident sitting in the wheelchair at a bedside table stand. Observation on 8/14/13 at 1:00 p.m., revealed Staff C wheeling the resident in the hallway back to the resident's room. When asked where the resident was coming from, Staff C reported bringing the resident back to their room from the main dining room where the noon meal was eaten. During an interview on 8/14/13 at 1:05 p.m., Staff E, Registered Nurse stated the resident is on an altered diet and is supposed to eat meals in the main dining room where the resident can be supervised. During an interview on 8/14/13 at 4:45 p.m., the Director of Nursing noted resident's with altered diets are supposed to eat in the main dining room, which is why staff transported him/her top the dining room. 4. The Physician Order Summary Report dated 8/1/13 through 8/31/13 identified Resident #11 with diagnoses that included lymphedema, congestive heart failure, insomnia, and osteoporosis. The Minimum Data Set (MDS) assessment tool dated 6/26/13 assessment tool identified the resident displayed moderately impaired cognitive status and required extensive staff assistance with transfers and bed mobility. The MDS noted the resident was unsteady with walking and turning around, but would stabilize without staff support. The MDS documented 2 falls without	F 323		

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F 323	Continued From page 19 any injuries since admission. The resident's Care Plan revised on 2/5/13 identified the resident at risk for falls due to a history of falls, potential medication side effects and a history of syncopal (fainting) episodes. The care plan directed staff to apply non-skid strips on the floor next to the resident's bed. The resident's Progress Report (Nurse's Notes) dated 8/12/13 at 8:41 p.m., documented the resident was found sitting on the floor wrapped in covers and reported trying to get to the bathroom. The entry documented staff will apply non-skid strips by the resident's bed. Observation on 8/14/13 at 8:00 a.m., and again at 3:00 p.m., revealed the resident sat in a chair in the room near the end of the bed. There are no safety strips or non-skid strips next to either side of the resident's bed. During an interview on 8/14/13 at 4:40 p.m., the Director of Nursing stated the non-skid strips should have been placed on the floor next to the resident's bed by now.	F 323		
F 364 SS=E	483.35(d)(1)-(2) NUTRITIVE VALUE/APPEAR, PALATABLE/PREFER TEMP Each resident receives and the facility provides food prepared by methods that conserve nutritive value, flavor, and appearance; and food that is palatable, attractive, and at the proper temperature. This REQUIREMENT is not met as evidenced by:	F 364		

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F 364	Continued From page 20 Based on observation and staff interview, the facility failed to maintain food temperatures at a safe and palatable temperature. The facility reported a census of 77 residents. Findings include: 1. On 8/13/13 at 8:28 a.m., observation revealed the facility Director of Nursing, DON passed trays on the West wing. At 8:45 a.m., the DON removed the last tray from the cart. The surveyor then requested a temperature. The oatmeal was 135 degrees Fehrenheit (F) and the eggs at 134 degrees (F). At that time, the surveyor tasted both of the items and noted the food tasted warm, but not hot. At that time, the Dietary Manager stated the temperature of the foods was too low and then replaced the tray. 2. Observation on 8/13/13 at 12:10 p.m., revealed the following temperatures on a test food tray, observed with Staff B, Registered Nurse, after the skilled unit received their noon trays: a. Zucchini: 133 F b. Sweet potatoes: 136 F c. Pork roast: 127 F d. Milk(fat free): 45 F Staff B, RN tasted the food items and reported they were warm, but not hot. Staff B did not taste the milk. The Food Service Director stated the food temperatures are to be at 135 F, but agreed when the surveyor stated the food temperatures are to be at least 140 F.	F 364	**F 364** The facility will continue to maintain food temperatures at a safe and palatable temperature. Food temperatures further evaluated per Dietary Manager/designee with interventions in place with food temperatures maintained at required temperature upon serving. Education to facility staff regarding all food or beverages capable of supporting rapid and progressive growth of microorganisms that can cause food infections or food intoxication shall be maintained at appropriate temperatures at all times. Audits will be completed for ongoing compliance Dietary Manager/designee 3x a week x4 weeks alternating meals with findings reviewed in Quality Assurance meeting for recommendations or resolution.	9/19/13
F 368 SS=E	483.35(f) FREQUENCY OF MEALS/SNACKS AT BEDTIME	F 368		

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F 368	Continued From page 21 Each resident receives and the facility provides at least three meals daily, at regular times comparable to normal mealtimes in the community. There must be no more than 14 hours between a substantial evening meal and breakfast the following day, except as provided below. The facility must offer snacks at bedtime daily. When a nourishing snack is provided at bedtime, up to 16 hours may elapse between a substantial evening meal and breakfast the following day if a resident group agrees to this meal span, and a nourishing snack is served. This REQUIREMENT is not met as evidenced by: Based on resident interview the facility failed to ensure all residents were offered a bedtime snack. Six of seven residents in the group interview and four of six residents individually interviewed reported not being offered a snack at any time in the evening between supper and bedtime. (Resident #4, #5, #6 & #7). The facility reported a census of 77 residents. Findings include: 1. During the group interview on 8/12/13 at 1:30 p.m., six of seven residents stated they did not routinely get offered snacks in the evening or at any time between the evening meal and bedtime. 2. During an interview on 8/12/13 at 3:00 p.m. Resident #7(identified on tour as	F 368	**F 368** The residents continue to be offered snacks at bedtime daily. Residents residing in the facility have bedtime snacks offered and available after supper and before bedtime. Education to licensed nursing staff, dietary staff, and certified nursing assistants regarding offering bedtime snacks to residents after supper and before bedtime. Audits will be completed for ongoing compliance by ADNS/designee 3x a week x4 weeks with findings reviewed in Quality Assurance meeting for recommendations or resolution.	9/19/13

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F 388	Continued From page 22 interviewable)stated of not being offered a bedtime snack since admission and noted of having a diagnosis of diabetes. During an interview on 8/13/13 at 8:30 a.m., Resident #7 reported receiving a bedtime snack last night for the first time. During an interview on 8/14/13 at 7:55 a.m., Resident #7 reported receiving a bedtime snack and stated the facility is working on providing that. 3. During an interview on 8/13/13 at 9:00 a.m., Resident #4 (cognitive score of 10 out of 15, indicating moderate impairment with making daily decisions), stated of receiving a bedtime snack about 2 or 3 times since being admitted. During an interview on 8/14/13 at 7:50 a.m., Resident #4 stated of not receiving a bedtime snack last night, but may have been sleeping. 4. During an interview on 8/13/13 at 12:00, Resident #5(with a score of 15 out of 15, indicating no cognitive problems)stated of never receiving a bedtime snack and replied of not thinking about having that offered here. During an interview on 8/14/13 at 9:05 a.m., Resident #5 stated of receiving a bedtime snack last night. 5. During an interview on 8/13/13 at 10:00 a.m., Resident #6 (with a score of 15 out of 15, indicating no cognitive problems)stated of never being offered a bedtime snack. During an interview 8/14/13 at 9:00 a.m., Resident #6 stated of receiving a bedtime snack	F 388		

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F 368	Continued From page 23 last night. During an interview on 8/13/13 at 3:55 p.m., Staff K, Certified Nursing Aide, noted the kitchen brings out the food/snack cart and the Nursing Aides are to pass the snacks to the residents around 7 to 8 p.m. Staff K remarked if a resident is sleeping, they won't wake them up for the snack. During an interview on 8/14/13 at 4:10 p.m., the Director of Nursing stated of having snacks and can always make sandwiches if desired and can go into the kitchen for more snack foods. During an interview on 8/14/13 at 4:11 p.m., the Administrator stated if the residents aren't being offered bedtime snacks, we will make sure that happens.	F 368		
F 371 SS=E	483.35(i) FOOD PROCURE, STORE/PREPARE/SERVE - SANITARY The facility must - (1) Procure food from sources approved or considered satisfactory by Federal, State or local authorities; and (2) Store, prepare, distribute and serve food under sanitary conditions This REQUIREMENT is not met as evidenced by: Based on observation and staff interview, the facility failed to properly refrigerate perishable foods, failed to maintain a clean and sanitary food preparation area and failed to properly cover,	F 371		

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CENTERS FOR MEDICARE & MEDICAID SERVICES

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	165034	A. BUILDING _____ B. WING _____	08/15/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MANORCARE HEALTH SERVICES	201 WEST RIDGEWAY AVENUE WATERLOO, IA 50701

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F 371	Continued From page 24 date and label foods for resident consumption. The facility reported a census of 77 residents. Findings include: Observation in the activity kitchenette area during the same tour revealed the following: a. An opened package of raw chicken in a freezer with the meat exposed and no date opened. b. An opened package of cake in the refrigerator with no date. c. An opened package of hashbrowns in the freezer with no date opened. d. A plastic bag with what appeared to be sliced onions with a date of 12/13/12. At that time, the Activity Director stated they did not believe it had been the right date. e. An opened container of cool whip with no date. The Activity Director stated all of the opened and undated food needed to be discarded and proceeded to do so. f. Numerous bags of puffcorn and popcorn inside the oven. One had been opened and not resealed, no date. g. Potato chips and cheese puffs in a cupboard, opened and not resealed, no date opened. On 8/13/13 at 10:15 a.m., observation in the kitchen revealed an uncovered plastic bin of dry cereal on a low shelf under a food preparation. At 10:45 a.m., observation revealed the cereal remained uncovered. During the same observation, the Dietary Manager used a washcloth from the 3 compartment sink that had a large amount of food debris floating in it to wipe a food preparation surface. When asked by the surveyor	F 371	**F 371** The identified areas have been corrected. Foods held in refrigerators or other storage areas were monitored with appropriate corrective interventions performed as necessary. Education to facility staff regarding Foods held in refrigerated or other storage areas shall be appropriately covered. Food that was prepared and not served shall be stored appropriately, clearly identifiable and dated. Audits will be completed for ongoing compliance by Dietary Manager/designee weekly x 4 weeks with findings reviewed in Quality Assurance meeting for recommendations or resolution.	9/19/13

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F 371	Continued From page 25 If this was the way the facility sanitized surfaces in the kitchen, the Dietary Manager stated no they had not done it correctly. The manager then filled a red bucket with a sanitizing solution (tested at 200 parts per million) and again wiped the food preparation surface. On 8/14/13 at 11:05 a.m., observation in the kitchen revealed the cereal on the low shelf remained uncovered.	F 371		
F 441 SS=E	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) Decides 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 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.	F 441	F 441 Resident #2 environment has been maintained in a sanitary manner. Biohazard material found in the hallway and on resident's floor have been corrected. Environmental rounds completed with ICSO and Guardian Angel Rounds for further areas if identified and evaluated with corrective practices in place. Education to facility staff regarding the facility must maintain resident's environment in a sanitary manner, and proper disposal of biohazard materials. Audits will be completed for ongoing compliance by Administrator/designee weekly x 4 weeks with findings reviewed in Quality Assurance meeting for recommendations or resolution.	9/19/13

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F 441	Continued From page 26 (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, staff interview and record review, the facility failed to maintain a resident's bathroom in a sanitary manner (Resident #2) and also failed to properly dispose of a biohazard material found in the hallway and on a resident's floor. The facility identified a census of 77 residents. Findings include: 1. On 8/12/13 at 12:15 p.m., observation revealed a used alcohol swab with what appeared to be blood on it sitting the center hall handrail of the West wing. 2. On 8/13/13 at 8:05 a.m., observation revealed a dried brown substance on the front of the sink in the bathroom in Resident #2's room. 3. On 8/14/13 at 8:17 a.m., observation revealed the dried brown substance remained on the sink in Resident #2's room. A used alcohol swab laid on the floor of the room with what appeared to be a small amount of blood on it. The surveyor then pointed these things out to the facility	F 441		

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F 441	Continued From page 27 Administrator who at that time stated the nurses checked a blood sugar and left the alcohol swab with the resident and it must have ended up on the floor. At 8:45 a.m., Staff D (housekeeper) stated they were the only housekeeper in that part of the building for forty rooms and could not get it all cleaned.	F 441		
F 465 SS=E	483.70(h) SAFE/FUNCTIONAL/SANITARY/COMFORTABL E ENVIRON 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 staff interview, the facility failed to ensure all resident areas were maintained in a clean and sanitary manner. The facility reported a census of 77 residents. Findings include: 1. During the initial dietary tour on 8/12/13 at 8:50 a.m., observation revealed the following in the kitchen: a. Dried food and peeling paint on a large stand mixer. b. Dried debris on the top and sides of the dishwasher. c. Dried food on the side of the stove.	F 465	F 465 The identified areas have been evaluated and corrective practices initiated. Environmental rounds completed with Administrator, Environmental Director, Maintenance Director, and Guardian Angel Rounds for further areas if identified and evaluated with corrective practices in place. Education to facility staff on maintaining a clean, sanitary and homelike environment for residents residing in the facility. Environmental audits completed by Administrator/deslgnee weekly x 4 weeks with findings reviewed in Quality Assurance meeting for recommendations or resolution.	9/19/13

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	165034	A. BUILDING _____ B. WING _____	08/16/2013

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F 465	Continued From page 28 d. Chipped paint on the legs of a metal table where a mixer sat. e. A dried brownish-black substance on a plate warmer. Observation in the activity kitchenette area during the same initial tour revealed an oven with a dried brown substance on the door. At that time the Activity Director stated they had cleaned it but must have missed the brown substance. 2. At 12:48 p.m., observation revealed large brown stains on two of the main dining room ceiling tiles. A serving cart sat in the dining room with a dried brown substance on it. 3. On 8/13/13 at 10:45 a.m., observation revealed the following: a. A plastic container laying on the floor under a metal shelf where cereal was stored. b. A wrapper and crumbs on a lower steam table shelf. c. A black substance on the floor in front of a sugar bin and between several floor tiles. d. A large amount of crumbs on the floor in front of the flour and sugar bins. e. An unidentified dried white substance on the floor in front of the steam table. f. A large amount of dried food on the floor under a cart of trays. The wheels of the cart contained a large amount of a black build-up. g. Dried food build-up and rust on the wheels of a steam oven. h. A large number of discarded plastic lids on the floor under a food service window. i. A spoon on the floor in front of the steam table. j. Dried food on the Robo Coupe and the stove	F 465		

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F 465	Continued From page 29 hood switch. On 8/14/13 at 11:05 a.m., observation in the kitchen revealed the following: a. The dried food remained on the mixer. b. The dried debris remained on the dishwasher. c. The black substance remained on the plate warmer. d. The plastic container remained on the floor under the cereal shelf. e. The wrapper and crumbs remained on the steam table. f. The black substance and crumbs remained on the floor in front of the flour and sugar bins. g. The white substance remained on the floor in front of the steam table. h. The dried food remained on the tray cart. i. A package of plastic lids laid on the floor under a shelf. j. The dried food remained on the Robo Coupe. k. The steam table pans remained on the floor. On 8/14/13 at 12:55 p.m., the Dietary Manager provided the surveyor with an incomplete cleaning schedule and stated the kitchen had not been cleaned on a routine basis. 2. An environmental tour on 8/14/13 at 8:55 a.m., with the Environmental Supervisor, Maintenance Director, Staff B, Registered Nurse, and the Administrator revealed the inside floor in the Activity Room toward the left wall contained some clumps of dirt, paper and dust all along the wall to where it met the floor. The dirt was especially plentiful in the corner by the sink area. This observation was noted upon entrance on 8/12/13 at 9:00 a.m. The Management team noted the observation. There were 2 large, dark yellow, circular water stains in the white ceiling of the main dining area.	F 465		

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DEPARTMENT OF INSPECTIONS AND APPEALS

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	IA0726	A. BUILDING: _____ B. WING _____	08/16/2013

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N 101	50.7(1) 481- 50.7 (10A,135C) Additional notification. 481-50.7 (10A,135C) Additional notification. The director or the director ' s designee shall be notified within 24 hours, or the next business day, by the most expeditious means available (I,II,III): 50.7(1) Of any accident causing major injury. a. " Major injury " shall be defined as any injury which: (1) Results in death; or (2) Requires admission to a higher level of care for treatment, other than for observation; or (3) Requires consultation with the attending physician, designee of the physician, or physician extender who determines, in writing on a form designated by the department, that an injury is a " major injury " based upon the circumstances of the accident, the previous functional ability of the resident, and the resident ' s prognosis. b. The following are not reportable accidents: (1) An ambulatory resident, as defined in rules 481-57.1(135C), 481-58.1(135C), and 481-63.1(135C), who falls when neither the facility nor its employees have culpability related to the fall, even if the resident sustains a major injury; or (2) Spontaneous fractures; or (3) Hairline fractures. This Statute is not met as evidenced by: Based on clinical record review, physician assistant (PA) and staff interview, the facility failed to notify the Department of Inspection and	N 101	This serves as the Allegation of compliance for ManorCare Health Services Waterloo for the survey completed August 15, 2013. The statements made on this plan of correction are not an admission to and do not constitute an agreement with the alleged deficiencies. To remain in compliance with all Federal and State regulations, the center allegation of compliance such that all alleged deficiencies cited have been or will be corrected by the date indicated. The facility will continue to provide or arrange service to meet professional standards of quality. **N 101** Resident #13 continues to reside at facility. Incidents and accidents reviewed with Eagle Room/QAA process to identify if meets definition of "Major Injury" and additional notification performed. Additional notification reviewed by Administrator and ADNS. Audits will be completed by Administrator/designee for ongoing compliance weekly x 4 weeks with findings reviewed in Quality Assurance meeting for recommendations or resolution.	9/19/13

DIVISION OF HEALTH FACILITIES - STATE OF IOWA

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE — TITLE: Administrator — (X6) DATE: 9/19/13

DEPARTMENT OF INSPECTIONS AND APPEALS

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N 1D1	Continued From page 1 Appeals of an accident causing major injury which required a higher level of care for one of two residents reviewed. (Resident #13). The facility census was 77 residents. Findings include: 1. The Minimum Data Set (MDS) assessment dated 6/23/13; documented Resident #13 had diagnoses that included hip fracture, osteoarthrosis and syncope with collapse. The MDS documented the resident required extensive assistance of two staff with bed mobility and transfer. An incident report dated 7/9/13 at 3:00 a.m., documented the resident was lowered to the floor on knees after an unsuccessful transfer from the bed to the wheel chair per staff, no injury sustained, range of motion within normal limits. The form documented the resident had an urgency to void and had been rushing to get into a wheel chair. An undated statement by the Certified Nurse Aide present during the 7/9/13 fall documented the aide answered the resident ' s call light and the resident stated they needed to use the bedpan. The resident was wet and the sheets were wet. The resident had sat on the edge of the bed. The resident was told not to get up. The aide applied a gait belt and went to get sheets and went into the resident ' s bathroom to get a brief. When coming back from the bathroom the resident was observed to stand up and shake the brief off and went down with bent left knee and the right knee was behind the resident on the floor. The aide was unable to get to the resident in time as the resident went down. The resident was instructed to stay put while the aide got the nurse. The resident was assisted to the chair and said 'ooh ooh', but did not have increased indication of pain than usual. The nurse gave the resident a pain pill after evaluating him/her.	N 1D1		

DEPARTMENT OF INSPECTIONS AND APPEALS

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N 101	Continued From page 2 On 8/14/13 at 1:21 p.m. the Director of Nursing (DON) was interviewed and stated the resident was attempting to transfer self when a staff person entered the room and attempted to get to the resident and then lowered the resident to the floor. The DON stated the resident's assessment appeared normal and the resident's physician had even seen the resident after the fall and had no assessment concerns. The DON stated the resident had gradually started having more pain so had been sent to a pain clinic at which time the fracture was discovered. The DON stated that even though the resident's injury resulted in surgery and the resident had experienced a condition change the physician felt the resident would eventually return to a normal level of function and that had been the reason for not reporting the fracture. A physician note dated 7/26/13, documented the resident was status post fall on July 9 which likely resulted in a newly discovered periprosthetic fracture found on July 19. The report documented the resident was in significant pain and would be admitted from their clinic appointment on 7/23/13 to the hospital for pain control. A major injury determination form dated 7/23/13, documented the resident had an oblique fracture at the distal end of a prosthesis, hip fracture with repair. A physician signed the form on 7/24/13, and indicated after reviewing the circumstances, injury and prognosis of the patient, the injury sustained had not been a major injury and to the best of their knowledge, barring any complications, the resident would return to their previous functional status.	N 101		