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	165562	A. BUILDING _____ B. WING _____	03/13/2014

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MONROE CARE CENTER	120 NORTH THIRTEENTH STREET ALBIA, IA 52531

(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 The following deficiencies are the result of the recertification and state licensure survey conducted 03/10/14 to 03/13/14. See Code of Federal Regulations (42 CFR) Part 483, Subpart B-C. Correction Date:_____	F 000	Preparation of the following plan of correction does not constitute and should not be interpreted as an admission nor an agreement by the facility of the truth of facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction was executed solely because it is required by provisions of state and federal law.	
F 226 SS=D	483.13(c) DEVELOP/IMPLMENT ABUSE/NEGLECT, ETC POLICIES The facility must develop and implement written policies and procedures that prohibit mistreatment, neglect, and abuse of residents and misappropriation of resident property. This REQUIREMENT is not met as evidenced by: Based on record review and staff interviews, the facility failed to report suspected dependent adult abuse for an injury of unknown origin (Resident # 5) to the Department of Inspections and Appeals. The sample consisted of 14 residents and the facility reported a census of 56 residents. Findings included: 1. A quarterly MDS (Minimum Data Set) assessment with a reference date of 11/27/13 reflected Resident #8 had a BIMS (brief interview for mental status) score of 8. A score of 8 determined the resident to have moderate cognitive impairment. The MDS reflected the resident to exhibit behaviors of inattention and disorganized thinking. The MDS reflected the resident required extensive staff assistance for	F 226	HEALTH FACILITIES APR 18 2014 This resident has a diagnosis of osteoporosis. Upon diagnosis of ankle fracture facility did indeed conduct an investigation as part of the QA process. It was determined that a specific event did not occur resulting in the fracture but that due to the osteoporosis, the injury could have occurred when the resident was propelling herself. Any future occurrences involving this resident or other similarly situated residents will be reviewed by the facility interdisciplinary team, the attending physician and determination or whether injuries require reporting to DIA as suspected dependent abuse.	

OK 4-18-14 mw

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

Shelley Boone — Administrator — 4-17-14

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

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F 226	Continued From page 1 bed mobility, transfers, ambulating, toilet use and personal hygiene. The MDS indicated the resident required staff assistance to stabilize self for balance during moving from seated to standing position, on and off the toilet, turning around, and walking. The MDS indicated the resident's diagnoses included hypertension, peripheral vascular disease, other fracture, dementia, history of falls, unspecified osteoporosis, anxiety and depression. The MDS indicated the resident had several fall prior to the assessment period which included 2 with injury (skin tears, abrasions, lacerations, superficial bruises, hematomas, sprains and /or any fall related injury that caused the resident to complain of pain) and one indicated with major injury (bone fractures, joint dislocation, closed head injury with altered consciousness, and /or subdural hematoma). The annual MDS dated 02/05/14 reflected the resident had one fall during the assessment period causing a major injury The resident's care plan with a target date of 05/08/14 reflected the resident had a history of trying to get up unassisted and falling. An incident report dated 02/17/14 at 6:45 p.m. indicated while getting the resident ready for bed; a CNA removed the resident's right sock and noted the resident's entire right foot had dark purple bruising along both edges of the right foot and across the base of the toes. The staff documented the entire top of the foot and ankle had light purple bruising. The staff documented the injury to be of unknown origin and the resident unsure of source of injury. The staff documented the resident stated the area sore but had no complaints of discomfort when ambulated to the bathroom. On 02/18/14 at 1:50 p.m. the staff	F 226	injuries of unknown origin will be reviewed on an individual basis by the facility interdisciplinary team. They will be referred to the attending physician for review and a self report made to the State when needed. In addition to reviewing falls on a weekly basis by the interdisciplinary team, injuries of unknown origin will be included in this review. If warranted further investigation will be initiated for root/cause and followed up as required. Completion date 04-08-14	

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F 226	Continued From page 2	F 226		

documented the right foot/ ankle slightly swollen with complaints of tenseness. At 9:20 p.m. the staff documented the right foot/ankle with 1+ edema (swelling) and purple in color but with full range of motion and voiced complaints with movement. On 02/19/14 at 4:10 p.m. the staff documented the right foot/ankle swollen, no change in bruising, resident denied complaints of pain. On 02/24/14 at 7:00 a.m. the staff documented resident had obtained an x-ray of the right ankle/foot which revealed a fracture. The staff documented the resident to wear a walking boot at all times, circulation good, toes pink warm and dry, capillary refill brisk and no complaints of pain voiced.

A radiology report date 02/20/14 at 12:59 p.m. noted an impression of a subtle fracture involving the distal end of the right metatarsal (toe) and an acute non displaced fracture involving the lateral malleolus (ankle) at the joint level. A consultation/specialist note dated 03/03/14 at 11:41 a.m. noted the review of the x-rays showed a minimally displaced fracture involving the distal fibula.

The facility policy and procedure for resident incident/accident reports noted the goal and intent of the facility is to keep the residents of the facility safe and free of accidents and incidents. The document stated incident/accident reports are completed by the nursing or other facility staff with the intent to keep the report confidential and within the facility as part as the quality assurance program. Item #10 of the policy reflects an investigation of why and how the incident occurred must be completed along with suggestions of possible interventions

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F 226	Continued From page 3 On 03/11/14 at 3:30 p.m. the facility Director of Nursing (DON) stated the only investigation completed regarding the ankle/foot injury had been to look at the nurse ' s notes and talked to the resident who could not recall how the injury occurred. The DON stated prior to the injury the resident had been ambulating with assistance of staff, transferred with the assistance of staff and self- propelling the wheelchair using his/her feet but did not know if the resident could have injured the ankle/foot while self- propelling the chair. On 03/12/14 at 11:45 a.m. the Administrator stated the decision had been made to not report the injury of unknown origin (ankle fracture) because upon review, the staff felt the injury had probably been related to the resident's diagnoses of osteoporosis. The Administrator noted the facility did not ask the physician to review or complete the major injury form for the same reason.	F 226		
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 observations and staff interviews, the facility failed to ensure resident equipment used to perform mechanical lift transfers, and a straight chair observed in the Blue Hallway bathroom, were kept clean and in good condition for the safety and comfort of the residents requiring their use. This occurred for 2 of 4 mechanical lifts	F 253		

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F 253	Continued From page 4 observed. The facility reported a resident census of 56 at the time of the survey. Findings include: 1. During the Environmental Tour observations of the Blue Hall bath/shower room on 03/13/14 at 9:15 a.m. revealed a straight backed cushioned chair that had deep gouges in the surface finish of the the arm area and the leg areas of the chair. When asked what the chair had been used for the facility administrator noted that the staff use it to place bath supplies during a resident's bath. The facility administrator instructed the maintenance supervisor to remove the chair from the bath room and to make sure it gets discarded, the maintenance supervisor immediately removed the chair. 2. An observation made on at 9:45 a.m. revealed an E-Z stand up lift with the platform soiled stored in the Pink Hall bath/ shower room. The facility maintenance supervisor stated he had attempted to contact the vendor to purchase replacement parts for the lift but had been unsuccessful in making contact with them but would continue to try until he could find the replacement parts needed. 3. An observation made at 10:00 a.m. of the Green Hall shower/bathroom revealed a whirlpool chair lift platform that had been placed in the corner of the room. The lift platform had a substance covering the entire surface in a spotted pattern. The metal areas of the device contained areas of pitting and a rust colored substance on the wheels base. A shower aide in the room at the time noted that the device is not presently used because the aides prefer to just transfer the	F 253	The chair found in the shower room was removed immediately and discarded. The whirlpool chair lift was also removed from the facility. It was not even in use when noted by the surveyors. Staff indicated they did not use this piece of equipment at all. As indicated by the report, facility maintenance was aware of the need to replace the foot platform on the lift. Platform was ordered and replaced by maintenance. Maintenance will add the lifts to a checklist to at least monthly inspect the lifts for any needed upkeep and/or replacements needs. This will be reviewed/monitored at QA meetings. Completion date 04-18-14	

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F 253	Continued From page 5 resident from the wheelchairs right onto the tub chair using the gaitbelt.	F 253		
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 resident record review, observations, and staff interviews, the facility failed to provide the necessary assistance to residents unable to complete activities of daily living independently in order to maintain optimal personal hygiene, cleanliness, and oral hygiene. This occurred for 1 of 8 residents reviewed (Resident #3). The facility reported a resident census of 56 at the time of the survey. Findings include: 1. A quarterly MDS (Minimum Data Set) assessment dated 2/26/14 identified Resident #3 with the following diagnoses of anemia, hypertension, peripheral vascular disease, diabetes, hyponatremia, hyperlipidemia, cerebrovascular accident - (stroke), anxiety disorder, depression, Schizophrenia, chronic obstructive pulmonary disease, esophageal reflux, and mild intellectual disabilities. The resident scored 10/15 on the Brief Interview for Mental Status indicative of both impaired memory and cognitive function related to daily decision	F 312	Staff C & D were re-educated of the procedure for am cares. They were instructed that oral care is a very important part of daily care for not only this particular resident but for all residents. They acknowledged their understanding of this. A nursing staff meeting was conducted on 04-04-14 and this is one of the issues that was addressed and discussed during that meeting. The majority of nursing staff was present. Those not present received written documentation of the topics addressed. Facility will also work with contract dental services and schedule an oral care in-service for staff. Completion date 04-018-14	

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making skills. The MDS coded the resident required extensive staff assistance for dressing, toilet use, personal hygiene, and bathing needs.

The resident care plan identified a problem of the resident required help with activities of daily living due to getting easily confused, had mild intellectual disabilities, and had schizophrenia. The care plan identified the resident with an upper denture and required staff to assist with daily oral cares.

Observation made on 3/11/14 at 6:40 a.m. revealed the resident asleep in bed with oxygen on per nasal cannula. Staff C, CNA (Certified Nursing Assistant), washed her hands as Staff D, CNA, aroused the resident. Staff C and Staff D assisted the resident sit on the edge of the bed while Staff D donned the resident's slippers and Staff D placed a gaitbelt around the resident's waist. The CNAs assisted the resident to stand at the bedside as Staff C checked the resident's incontinent brief. Staff C reported the resident dry and removed the incontinent brief prior to assisting the resident onto the toilet. Staff D washed her hands, donned gloves, and rinsed off the upper denture stored in the denture cup and assisted the resident to insert the upper plate into the mouth. Staff D did not offer or assist the resident to complete oral care.

An interview conducted on 3/12/14 at 11:20 a.m. with Staff E, CNA, revealed as part of her a.m. routine with Resident #3, she provided assistance to brush teeth and insert the upper denture plate prior to coming out for breakfast.

An interview conducted on 3/12/14 at 11:22 a.m. with Staff F, CNA, revealed she routinely with

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F 312	Continued From page 7 a.m. cares assisted Resident #3 with dressing, brushing teeth and upper denture, assisted to insert the upper denture, and assisted the resident comb hair prior to coming to the dining room for breakfast. According to the facility policy for A.M. Care (Early Morning Care) revised on 11/08 it noted under PROCEDURE: 4. Allow the resident to brush teeth, or brush teeth or dentures for the resident if he/she is not able.	F 312		
F 315 SS=D	483.25(d) NO CATHETER, PREVENT UTI, RESTORE BLADDER Based on the resident's comprehensive assessment, the facility must ensure that a resident who enters the facility without an indwelling catheter is not catheterized unless the resident's clinical condition demonstrates that catheterization was necessary; and a resident who is incontinent of bladder receives appropriate treatment and services to prevent urinary tract infections and to restore as much normal bladder function as possible. This REQUIREMENT is not met as evidenced by: Based on observation, record review, and staff interview, the facility failed to perform incontinence/perineal cares in a sanitary manner for 2 of 8 resident who required incontinency care (Residents #3 and #5). The sample included 14 residents. The facility reported a census of 56 residents. Findings included:	F 315	Regarding the residents identified during the survey, the D.O.N witnessed the incontinent care provided. She immediately spoke with the C.N.A.s involved in performing the cares. She addressed with them the improper technique used and went over the correct procedure with each of them. Incontinent care policy/procedure was addressed and the nursing meeting on 04-04-14. In addition the Director of Nursing and/or her designee(s) will be providing re- education, monitoring and incontinent care audits of C.N.A.s. This will be documented for each individual C.N.A. and kept as part of the QA process. Random audits will be done throughout the year as well. This will be discussed at quarterly QA meetings with the committee. Completion date 04-18-14	

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1. A quarterly MDS (Minimum Data Set) with a reference date of 11/27/13 indicated Resident #5 with a BIMS (brief interview for mental status) score of 8 which indicated the resident to have moderate cognitive impairment. The MDS indicated the resident to exhibit behaviors of inattention and disorganized thinking. The MDS indicated the resident required extensive staff assistance for bed mobility, transfers, ambulating, toilet use and personal hygiene. The MDS indicated the resident showed impairment in the upper extremities. The MDS indicated the resident's diagnoses included hypertension, peripheral vascular disease, other fracture, dementia, history of falls, unspecified osteoporosis, anxiety and depression.

The resident's care plan with a target date of 05/08/14 indicated the resident required extensive staff assistance with dressing and grooming, often incontinent of urine, required staff assistance for pericare after incontinent episodes and required a flex brief. A handwritten note dated 03/03/14 indicated that the staff may check and change the resident while using the mechanical lift for transfers.

Observation on 03/10/14 at 2:55 p.m. revealed Staff C and Staff H, certified nursing assistants (CNA) entered the resident's room to get the resident up for an activity. The resident had been observed lying in the bed with eyes closed. The staff washed their hands and donned gloves. Staff H, picked up a package of disposable wipes and proceeded to pull a few wipes out of the package, grabbed hold of the resident's bed with one gloved hand and pulled the bed away from the wall, stepped behind the bed with the package and loose wipes in her hands. Staff C

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pulled the resident's pants down, unfastened the resident's urine soaked flex brief and tucked the brief between the resident's legs. Staff H handed one disposable wipe to Staff C who proceeded to cleanse the resident, folding the wipe after cleaning the right groin, then left groin, folding wipe and cleaning the periarea from the front to the back. Without changing gloves, Staff C pushed on the resident's shoulder and hip to position the resident to the left side. Staff H handed Staff C another wipe. Staff C cleansed the resident's right hip and inner buttock, folded the wipe and cleaned inner left buttock, pulled the soiled brief out from under the resident. Staff C removed gloves , picked up a new flex brief and placed under the resident, rolled the resident onto the flex brief, fastened the strap of the brief around the resident's waist and secured the brief. Staff C and Staff H pulled the resident's pants up and rolled the resident back and forth to position on a lift sling. Staff H without removing her gloves and washing hands exited the room to obtained a mechanical lift, then removed her gloves and washed her hands. After transferring the resident from the bed to a wheelchair with the lift, the staff combed the resident's hair, offered and provided a drink of water and propelled the resident to the dining room for the afternoon activity. The staff did not wash hands prior to exiting the room.

At 3:30 p.m. Staff C, CNA indicated she realized she had not provided the pericare the way she should have and asked if she could have another chance to do it right. The facility director of nursing observing the care acknowledged the cares given had not been what is expected from the staff.

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Observations on 03/11/14 at 10:15 a.m. revealed Staff C, Staff L and Staff K, all CNAs entered the resident's room to transfer the resident back to bed from the wheelchair to use the bedpan, utilizing the mechanical lift. After transferring the resident into the bed Staff C exited the room with the mechanical lift. Staff C did not wash hands prior to leaving the room. The resident told the staff he/she needed to use the toilet. The Staff informed the resident they would get him/her the bed pan. Staff L washed her hands and donned gloves and pulled down the resident's clothing, unfastened the flex brief, stating the resident had been incontinent. Staff L removed the wet brief and placed it into the garbage. Staff K with gloved hands, obtained a fracture bedpan wrapped in a plastic bag from the cabinet and removed the plastic bag. The staff rolled the resident from side to side and placed the bedpan under the resident. The staff covered the resident with a blanket Staff L without removing gloves exited the room to obtain a clean brief. When returned to the room, Staff L removed the gloves and washed her hands and donned clean gloves. The staff rolled the resident to the right side as Staff L removed the bedpan from the resident, Placed the clean brief under the resident, then placed the bedpan back into the bag and placed it on the floor. Staff K donned new gloves, obtained a package of disposable wipes, removed a couple of wipes from the package and handed the package to Staff L, (who had the same gloves on). Staff K proceeded cleaning the the resident's right hip and inner buttock, new wipe and cleansed rectal area wiping from the coccyx area down toward the perineum (wrong direction), obtained new wipe and repeated going down toward the perineum. Staff L instructed Staff K to wipe up on the hip. Staff L assisted the resident to

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turn on his/her back. Staff K obtained a clean wipe and started to clean the perineum until stopped and asked to change her gloves. Staff K removed her gloves, washed her hands, donned new gloves and proceeded to clean the perineum using the appropriate technique. After completing the perineum Staff K removed her gloves and washed her hands. Staff L fastened the brief which had been placed under the resident after the bedpan had been removed and prior to the pericare. Staff L then removed her gloves. The staff replaced the resident's slacks, positioned the resident in the bed for comfort and covered the resident, placed the call light string so resident could reach it, washed hands and exited the room.

At 10:30 a.m. upon exiting the room the facility Director of Nursing indicated she had noted the same concerns observed during the cares and would be providing some education to the staff involved.

2. A quarterly MDS (Minimum Data Set Assessment Tool) dated 2/26/14 identified Resident #3 with the following diagnoses of anemia, hypertension, peripheral vascular disease, diabetes, hyponatremia, hyperlipidemia, cerebrovascular accident - stroke, anxiety disorder, depression, Schizophrenia, chronic obstructive pulmonary disease, esophageal reflux, and mild intellectual disabilities. The resident scored 10/15 on the Brief Interview for Mental Status indicative of both impaired memory and cognitive function related to daily decision making skills. The MDS coded the resident required extensive staff assistance for dressing,

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F 315	Continued From page 12	F 315		

toilet use, personal hygiene, and bathing needs. The MDS coded the resident as occasionally incontinent of both bowel and bladder function.

The resident care plan identified as a problem the resident required help with activities of daily living due to getting easily confused, mild intellectual disabilities, and schizophrenia. The care plan indicated the resident frequently incontinent and directed staff to assist to the bathroom as needed and provided incontinence care after incontinent episodes.

An observation made on 3/11/14 at 6:40 a.m revealed Staff C, CNA, and Staff D, CNA, assisted the resident ambulate with walker from bed into the bathroom. Staff C verified the resident's incontinent brief dry and assisted the resident to sit down on the toilet. As Resident #3 sat on the toilet, Staff C requested a washcloth and towel to wash off the resident's back due to profuse perspiration. Staff C and Staff D applied a clean incontinent brief. The resident did not void while seated on the toilet. Staff C and Staff D pulled up the resident's outer pants and completed a.m. cares prior to exiting the room.

An interview conducted on 3/12/14 at 11:22 a.m. with Staff F, CNA, revealed as part of the early morning cares for Resident #3 she provided perineal care whether the resident had been incontinent or not as she explained that often the resident perspired during the night so she made sure she thoroughly washed the resident including perineal care.

An interview conducted on 3/12/14 at 11:24 a.m. with Staff G, CNA, revealed she routinely provided perineal care to Resident #3 as part of

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F 315	Continued From page 13 her early morning cares and stated she did so whether the resident had been incontinent or not. The facility procedure for A.M. Care (Early Morning Care) revised on 11/08 under PROCEDURE: 3. Offer the bedpan and toilet paper or take the resident to the bathroom. Change brief or pad if necessary. Provide incontinent care or peri care as necessary. Even though the resident was not incontinent, providing pericare with cares would freshen the resident who had heavy perspiration during the night.	F 315		
F 323 SS=D	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, clinical record review, and staff interview the facility staff failed to provide adequate supervision to prevent a fall that resulted in an injury for 1 of 7 resident reviewed who had documented fall history (Resident #7). The standard sample included 12 residents and two closed records. The facility reported a census of 56 residents. Findings included:	F 323	The resident identified indeed had a history of falls. Interventions were in place and care planned accordingly. This included the intervention of a low bed and a mat on the floor. Staff made aware of interventions through the care plan and communication books. After resident was assessed, Staff F called her D.O.N to report what had happened. The following Monday, the Admin and DON addressed the issue by investigating what had happened, talking to the resident's daughter and to the Staff F. Disciplinary action was also taken against Staff F. Staff was re-educated about the plan of care and interventions in place for this resident.	

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F 323	Continued From page 14 1. A quarterly MDS (Minimum Data Set) with a reference date of 01/01/14 indicated Resident #7 with a BIMS (brief interview for mental status) score of 3 which indicated the resident had severe cognitive impairment. The MDS indicated the resident exhibited behaviors of inattention and disorganized thinking. The MDS indicated the resident required total staff assistance for bed mobility, transfers,and toilet use and extensive staff assistance dressing, eating and personal hygiene. The MDS indicated the resident had range of motion impairment in the lower extremities. The MDS indicated the resident had two falls prior to the assessment period and indicated no injury with either fall. The MDS indicated the resident's diagnoses included hypertension, peripheral vascular disease, Alzheimer's Dementia, muscle weakness, unspecified osteoporosis, and depression. The resident's care plan with a goal date of 04/07/14 noted the resident at risk for falls, and would try to move on own. The resident had a non-healed fractured hip, and contractures to both knees. The care plan instructed staff the resident required transfer with the assist of two staff using a fireman lift or a Hoyer lift, the resident used a geri-chair propelled by staff for mobility, required a low bed with floor mat beside the bed, sensor alarms to the bed, recliner, wheelchair, geri-chair and a floor alarm. The care plan contained a notation dated 12/27/13 that reminded staff to use an alarm to all surfaces the resident is on and on 03/02/14 a notation indicated the resident had fallen, with the staff member involved counseled. During the initial tour of the facility on 03/10/14 at	F 323	After each accident the interdisciplinary team reviews the report, makes sure the plan of care is being followed, makes new intervention recommendations and notifies staff as to such. This is done on a weekly basis. During the course of the facility investigation process, if staff is found to be at fault for not following the plan of care, disciplinary action will be taken as necessary. Completion date 04-18-14	

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F 323	Continued From page 15 11:00 a.m. it had been noted that Resident #7 had a large light purple/yellowish bruise that covered the right side of the forehead from the temporal area to the mid forehead. The MDS coordinator accompanying the surveyor on tour noted the resident had fallen from bed striking his/her head. Review of the incident report for the fall during the survey noted on 03/02/14 at 6:55 a.m. the charge nurse she had been summoned to the resident's room by the emergency call light and found the resident laying on the floor on his/her back in the middle of the room. The nurse documented the CNA (certified nursing assistant stated she had left the resident in the bed for a brief moment to step across the hall to get help. The bed had been left in the high position with the floor mat and floor mat alarm pushed under the bed. The bed alarm had been sounding. The nurse documented the resident had received a 3.3 centimeter (cm) by 4.4 cm hematoma to the mid-forehead with light purple bruising to the center. A 2.6 cm by 1 cm skin tear noted to the right posterior forearm. The nurse documented the area had been cleansed with normal saline and steri strips applied. The resident complained of pain to his/her head. The staff applied an icepack. The nurse documented no other injuries were noted and the resident assisted off the floor by two staff. The nurse documented the physician had been notified as well as the resident's family. At 6:45 p.m. the staff documented the resident continued to have a slight hematoma to the forehead, the dressing intact to the right forearm with purple bruising noted to the area. On 03/03/14 at 6:50 a.m. the staff noted the forehead to have dark purple bruising with the forearm dressing intact. At 9:00 p.m. the staff noted the	F 323		

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F 323	Continued From page 16	F 323		

resident's condition remained unchanged. On 03/09/14 the staff noted the resident continued to have a purple to yellow bruising noted to the forehead with a scabbed area to the right posterior forearm, with the resident denied pain or discomfort to the areas.

On 03/11/14 at 3:30 p.m. the facility director of nursing (DON) stated that the facility fall investigation of the incident started when Staff F, CNA notified her that she had left the resident unattended in the bed to summon assistance from another staff to transfer the resident. Staff F admitted that she had left the bed in a high position and had pushed the floor mat and floor mat alarm under the bed while providing cares. Staff F stated she had only left the resident for a minute and heard the bed alarm sounding. Another staff who had been coming down the hall heard the alarm at the same time and both rushed into the room to find the resident on the floor. The DON stated that since the facility knew exactly what had happened with the CNA admitting what she had failed to do correctly, the facility handled the discipline by placing a write up notice in the staff's employee file. The DON stated the incident did not get reported because they feel the incident to be handled appropriately.

Interview with Staff F, CNA on 03/12/14 at 7:15 a.m. regarding the fall on 03/02/14, Staff F stated she and another CNA had been getting the resident ready for the day, and after getting the resident's clothes out, the other CNA stepped out of the room to assist another resident. Staff F stated she had placed the bed up to about thigh height, and slid the floor mat and alarm under the bed as she got the resident dressed. After dressing the resident, Staff F stated she did not

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F 323	Continued From page 17 put the resident's bed back down or pull out the floor mat prior to stepping out of the room to summon help. She stated she heard the bed alarm go off and rushed back into the resident's room with another CNA where the found Resident #7 laying face up on the floor. Staff F stated the other CNA pulled the emergency alarm to summon the nurse who came in to assess the resident. Staff A stated that after the resident had been assessed, they placed an icepack on his/her forehead, the nurse cleaned and put steri-strips on the skin tear. The staff then placed a gait belt around the resident's waist and assisted him/her from the floor. Staff F stated she called the DON and told her what had happened, and the DON stated she would notify the administrator. Staff F stated the next day was given a discipline notice which she accepted because she realized she was incorrect in her care for Resident #7.	F 323		
F 363 SS=E	483.35(c) MENUS MEET RES NEEDS/PREP IN ADVANCE/FOLLOWED Menus must meet the nutritional needs of residents in accordance with the recommended dietary allowances of the Food and Nutrition Board of the National Research Council, National Academy of Sciences; be prepared in advance; and be followed. This REQUIREMENT is not met as evidenced by: Based on resident record review, observations, and staff interview, the facility failed to follow the menu as written and did not consistently provide the approved portion sizes determined appropriate and approved by the facility dietician	F 363		

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F 363	Continued From page 18 to ensure the residents received nutritional, balanced meals according to the meal plan. This occurred for 52 of 52 residents receiving regular diets. The facility reported a resident census of 56 at the time of the survey. Findings include: The approved menu for the lunch meal on 3/11/14 included the following food items and serving portion sizes for the regular diet: 1 each Italian Chicken Breast 1/2 cup Parsley-Butter Potato 1/2 cup diced Beets 1 slice White/Wheat Bread 1 ea. Margarine 1 Sq. Strawberry Peach Gelatin 1/2 cup Bread Pudding with/Raisins 8 oz Whole Milk Observation made on 3/11/14 at 11:55 a.m. revealed Staff A, Cook, placed all food items into the hot cart in preparation to serve the noon meal. Staff A placed serving scoops into the food items and identified the correct serving scoops for all food items except she placed a serving spoon into the potatoes and alternate vegetable of mixed beans. The menu stated to use 1/2 cup for the potato and 1/2 cup for the alternate vegetable. At 12:20 p.m. Staff A finished serving the noon meal. When asked how she knew what portion serving scoops to use she stated she looked at the spread sheet for the meal which indicated the portion size for each food item and she selected the scoop/serving size based on that. When asked what serving scoop she needed to use for the alternate vegetable she stated 1/2 cup the	F 363	Dietary Supervisor discussed the serving size and utensils with her staff after the meal that day. She also had an in-service on 3-24-14 and although we did not have the 2567 at that time, portion control was one of the topics addressed. Dietary in-service to be held on 04-15-14. The specific items on the 2567 will be discussed in detail as well as the plan of correction for each deficiency. Dietary Supervisor and/or her designee will monitor serving portions and utensils used, at randomly chosen meals on a weekly basis. This will be documented and kept as part of facility QA process. Completion date 04-18-14	

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F 363	Continued From page 19 same as the diced beets She also verified she had not used a 1/2 cup scoop for the potatoes.	F 363		
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: Based on resident record review and observation, the facility failed to puree foods for residents on this specific diet in a manner that retained the desired consistency, palatability, and desired appearance of the food items served for 4 of 4 pureed diets. The facility reported a resident census of 56 at the time of the survey. Findings include: The menu for the noon meal on 3/11/14 for the puree/Regular diets included 1/4 cup Italian Chicken breast, 1/2 cup Parsley Butter Potato, 3/8 cup Diced Beets, 1/4 cup Puree White/Wheat bread, 1 each Margarine, 3/8 cup Puree Strawberry Peach Gelatin, 1/2 cup Puree Bread Pudding with Raisins and 8 oz Whole Milk. Observation revealed on 3/11/14 at 10:45 a.m., Staff A, Cook, measured 4 servings of 1/2 cup potatoes into the blender and warmed 1/2 pint whole milk in the microwave. Staff A added the warm milk as she blended the potato mixture until the desired consistency The total volume	F 364	In this instance with the pureed potatoes, residents received more than the ½ cup serving, temperature was a non issue, we can only surmise from the description on the alleged deficient practice that the surveyor had an issue with the consistency of the pureed potatoes. Although the survey notes that Staff poured the thin "pudding like" potato mixture into a steam care container. The recipe also called for the potatoes to be pudding like consistency. In future practice if the pureed product is not the correct consistency then either thickener or liquid will be added to obtain the proper consistency. Thickeners may include instant potato flakes, commercial thickeners or other approved items. Liquids may include milk, broth, juice or gravies.	

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F 364	Continued From page 20 measured 20 cz on the side of the blender container used. Staff A poured the thin pudding-like potato mixture into a steam cart container, covered it with foil, and placed it back into the oven. Observation revealed on 3/11/14 at 12:05 p.m. Staff A scooped up the last serving of puree potatoes which had a thin film present on the bottom of the pan that resembled a piece of wax paper, initially attempted to get it off of the bottom of the serving scoop and then ended up serving it to the resident. According to the recipe for the puree Parsley Butter Potatoes provided by the consulting Dietician on 3/13/14 at 3:25 p.m., it directed to add liquid as needed, blend until smooth adding additional liquid/thickener as needed to obtain a pudding like consistency	F 364	A dietary in-service will be held on 04-15-14, the use of thickeners/liquids to pureed foods will be addressed and proper instruction to staff given. Dietary staff responsible for pureeing will be audited on their puree technique and following the recipe(s). This will be done by the Dietary Supervisor and documented for QA purposes. Completion date 04-18-15	
F 365 SS=E	483.35(d)(3) FOOD IN FORM TO MEET INDIVIDUAL NEEDS Each resident receives and the facility provides food prepared in a form designed to meet individual needs This REQUIREMENT is not met as evidenced by: Based on resident record review, observation, and staff interview, the facility failed to prepare the pureed diets according to the recipes provided to ensure the residents received the maximum nutritional value and flavor from the foods prepared and served in this manner. This occurred for 4 of 4 puree diets served. The facility reported a resident census of 56 at the	F 365		

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F 365	Continued From page 21 time of the survey. Findings include: The noon meal menu for lunch service on 3/11/14 for the puree/Regular diet included the following food items: 1/4 cup Italian Chicken breast 1/2 cup Parsley Butter Potato 3/8 cup diced Beets 1/4 cup White/Wheat Bread 1 ea Margarine 3/8 cup Strawberry peach Gelatin 1/2 cup Bread Pudding with Raisins The current resident/diet report received from the Dietary Supervisor on 3/10/14 at 11:10 a.m. revealed 4 of 56 residents received puree diets. Observation on 3/11/14 at 11:00 a.m. revealed Staff A, Cook, removed 4 chicken breasts from the pan, placed them into the blender, added 4 slices of buttered bread, and stated she would begin to add warm milk to the chicken/bread mixture until the desired consistency. The meat/bread mixture did not blend easily in the blender. Once Staff A determined the mixture to be the desired consistency, she placed the meat mixture into a hot cart container without measuring the total volume blended, covered it with foil, and returned the pan to the oven. Observation on 3/11/14 at 11:10 a.m. revealed Staff B, Dietary Aide, removed 4 squares of Strawberry Peach Gelatin pre-cut and placed them into the blender until the desired consistency achieved. Staff B then poured the mixture equally into 4 plastic dessert cups without	F 365	Currently once a food is pureed in the blender the measurement is taken from the blender container which has measurements in ounces. Instead dietary staff will pour the pureed food into a standard measuring cup to measure total volume of pureed product. Menu will be referenced for appropriate serving portion and scoop size. Dietary staff will be educated to this practice at the in-service on 04-15-14. Dietary Supervisor will continue to monitor to correctness as well as utilizing consulting dietician. Completion date 04-18-14	

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F 365	Continued From page 22 first measuring the total liquid volume or using the scoop size of 3/8 cup according to the menu. Observation revealed on 3/11/14 at 11:55 a.m. Staff A placed a 1/2 cup scoop in the puree potatoes, a 3/8 cup scoop for the puree beets, and a 2 oz scoop for the puree chicken. At 12:25 p.m. Staff A had minimal amounts of the puree chicken, beets, and potatoes left in the hot cart containers. During the findings conference with the facility on 3/13/14 at 3:15 p.m., the administrator stated the facility used a measurement grid for determining the correct portion sizes for the puree diets and the puree recipes used factored into the recipe the addition of the liquids or thickeners for desired consistency. The administrator stated the consulting dietician could provide the recipes and answer any additional questions as she remained at the facility. At 3:45 p.m. the consulting dietician provided the following recipes for the puree chicken breast, potatoes, beets, and Strawberry peach gelatin salad. The Italian Chicken Breast recipe for puree read as follows: Serving size 1/4 cup recipe yields for 5 each = 2/3 cup with the addition of 2% reduced fat milk. Instructions: Step 1 NOTE: The serving size as shown on this recipe and on the diet spreadsheet is an estimate. The fluid amount if listed in the recipe is also an estimate that is based on industry standards. To get the actual serving size, puree the number of portions needed, adding adequate liquid if needed to achieve desired consistency as appropriate for resident (	F 365		

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F 365	Continued From page 23 replacing the liquid shown if desired), then divide the total amount equally by the number of portions pureed. WASH HANDS BEFORE BEGINNING PREPARATION. SANITIZE ALL SURFACES AND EQUIPMENT. Place prepared recipe portion(s) along with liquid into a blender or food processor. Blend until smooth adding additional liquid/thickener needed to obtain a pudding - like consistency. Serve #16 dipper = 2 oz meat Discard unused portion(s) Note: If gravy/sauce is served on the menu, it may be used in place of milk and additional gravy may be served over pureed meat if desired. The recipe did not direct adding the bread to the chicken. The recipe for the Puree Strawberry Peach Gelatin Serving size = 3/8 cup provided for 5 servings = 5 squares of the gelatin. Instructions: Step #1 NOTE: The serving size as shown on this recipe and on the diet spreadsheet is an estimate. the fluid amount if listed in the recipe is also an estimate that is based on industry standards. to get the actual serving size, puree the number of portions needed, adding adequate liquid if needed to achieve desired consistency as appropriate for resident (replacing the liquid shown if desired), then divide the total amount equally by the number of portions pureed. WASH HANDS BEFORE BEGINNING PREPARATION. SANITIZE ALL SURFACES AND EQUIPMENT. Place number of prepared recipe portions into blender or food processor. Blend until smooth, adding liquid/thickener if needed to reach a	F 365		

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F 365	Continued From page 24 pudding-like consistency. Serving dipper = #10 = 2/5 cup Discard unused portion(s)	F 365		
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 consistently monitor prepared food items and liquids kept in the refrigerators and freezers to ensure they discarded them on or prior to the dates identified as acceptable or specifically indicated on the product. The facility reported a resident census of 56 at the time of the survey. Findings include: 1. During the initial Dietary tour conducted on 3/10/14 at 9:50 a.m., the following items contained in the kitchen refrigerators and freezers surpassed the acceptable dates as indicated by the date of use or preparation labeled on the food/liquid product:	F 371	Each of the items listed were discarded upon discovery. Pitchers of liquids such as ice tea, juice, lemonade, etc. will be labeled as to the date is was put in the pitcher for use. It will not be kept for more than 5 days. It will then be discarded. The apple juice referenced was left in the its original container which had a "use by date" from the manufacturer. This date had not been reached at the time of the survey. Again it will be labeled as to the date it was opened and be kept no more than 5 days after opening. The birthday cupcakes were in a freezer bag and stored in the freezer. According to HACCP Reference Book frozen baked goods may be kept 4-9 months. We were within this time frame. This was shown to the surveyor at the time of the survey. We will now discard any frozen baked goods at the 4 month mark.	

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F 371	Continued From page 25 Maximum Refrigerator: Pitcher of Ice Tea dated 2/17/14 Container of thickened Apple Juice - not dated when originally opened. E-State Refrigerator, freezer section: A bag of 8 muffins dated 10/23/13. The Dietary Supervisor explained these were Birthday muffins given to individual residents on their birthdays. In this same refrigerator a container of used oil dated 8/23/13 for a fry daddy In the refrigerator on the Green Hall, a pitcher of apple juice dated 2/22/14. An interview conducted with the Dietary Supervisor on 3/10/14 at 10:10 a.m. revealed she generally kept prepared juices in the pitchers 3-5 days and then discarded them. When asked how long she would typically keep the Birthday muffins found in the freezer she stated probably a couple of months.	F 371	Cooking oil will be discarded after each use and fresh oil used when using the fry daddy for special events/ foods for the residents. These protocols will be addressed with dietary staff at the in-service on 04-15-14. Dietary staff will be monitored for proper protocol use by Dietary Supervisor. Completion date 04-18-14	
F 431 SS=E	483.60(b), (d), (e) DRUG RECORDS, LABEL/STORE DRUGS & BIOLOGICALS The facility must employ or obtain the services of a licensed pharmacist who establishes a system of records of receipt and disposition of all controlled drugs in sufficient detail to enable an accurate reconciliation; and determines that drug records are in order and that an account of all controlled drugs is maintained and periodically reconciled. Drugs and biologicals used in the facility must be	F 431		

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F 431	Continued From page 26 labeled in accordance with currently accepted professional principles, and include the appropriate accessory and cautionary instructions, and the expiration date when applicable. In accordance with State and Federal laws, the facility must store all drugs and biologicals in locked compartments under proper temperature controls, and permit only authorized personnel to have access to the keys. The facility must provide separately locked, permanently affixed compartments for storage of controlled drugs listed in Schedule II of the Comprehensive Drug Abuse Prevention and Control Act of 1976 and other drugs subject to abuse, except when the facility uses single unit package drug distribution systems in which the quantity stored is minimal and a missing dose can be readily detected This REQUIREMENT is not met as evidenced by: Based on observation and staff interview, the facility failed to label pharmacological drugs with the date opened and and discard after expiration date. The facility reported a census of 56 residents. Findings include: During observation on 03/13/14 at 10:10 a.m. of the medications cart and medication room it was noted: The medication cart for the Pink and Blue hallways contained:	F 431		

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F 431	Continued From page 27 1. A large bottle (400 count) of multivitamin dispensed to Resident #16 that contained approximately 100 tablets that had an expiration date of 02/14. The medication cart for the Green hallway contained: 4. A bottle of Tussin (cough medication) with approximately 3/4 of liquid left that had been dispensed to Resident #5 on 12/21/12 with no open date marked on the bottle. The pharmacy had noted no refills after 12/21/13. 5. Two bottles of MGP Generlac (laxative that is used to rid the body of excess ammonia)10mg/5ml, (milligrams/milliliter) one almost full bottle dispensed on 09/21/12 with no opened date marked on the bottle, the second dispensed on 11/07/12 with no opened date marked on the bottle. The pharmacy had noted may refill until 09/21/13 During the medication cart checks the facility MDS coordinator registered nurse, confirmed staff failed to label the medications with the open dates.	F 431	The bottle of multivitamins were 13 days past the expiration date were immediately disposed of. A new bottle was ordered from pharmacy to replace. The two medication carts were then inspected for any additional expired medications, over the counter or prescription. None were found by facility staff. Random audits will be conducted by the DON and/or her designee. These audits will be documented and kept as part of the facility QA process. A staff nurse will be assigned to conduct a monthly inspection of the medication carts to assure that there are no expired medications present and open dates are present. This too will be documented and kept for QA.	
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	F 441	Completion date 04-18-14	

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F 441	Continued From page 28 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. (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 resident record review, observations, and staff interviews, the facility failed to demonstrate consistent infection control practices through hand washing and gloving techniques utilized during resident cares in an effort to minimize the risk of transmission of potentially harmful infections or disease processes to the	F 441	The facility Director of Nursing spoke to the staff involved in the noted observations at the time of the survey. In addition glove use and hand washing was addressed at a nursing staff in-service on 04-04-14. Proper use of gloves and hand washing protocols were reviewed with nursing staff members. The DON and/or her designee will continue to address this at future nursing staff in-services. Infection control audits will be done directly related to proper glove usage and proper hand washing. These audits will done during the course of routine direct cares with residents, such as oral care, peri care, catheter care etc. Random audits will also be done. Documentation of audits will be kept as part of the facility QA process. Completion date 04-18-14	

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residents This occurred for 9 of 9 residents reviewed (Residents # 2, 3, 4, 5, 6, 7, 8, 10, and 11) The facility reported a resident census of 56 at the time of the survey.

Findings include:

1. A quarterly MDS (Minimum Data Set Assessment Tool) dated 1/29/14 identified Resident #2 with the following diagnoses of peripheral vascular disease, diabetes, Non-Alzheimer's Dementia, hypothyroidism, glaucoma, insomnia, dysphagia, and carcinoma in situ of prostate The resident scored 2/15 on the Brief Interview for Mental Status indicative of both memory and cognitive impairment related to daily decision making skills. The MDS coded the resident as totally dependent upon staff for bed mobility, transfers, dressing, toileting needs, personal hygiene, and bathing. The MDS identified the resident always incontinent of bowel and bladder function

The resident care plan reviewed on 2/5/14 identified the resident as incontinent and directed staff the resident wore a flex incontinent brief which staff needed to check and change around mealtimes and as needed. The care plan also directed staff to provide pericare after incontinent episodes.

An observation made on 3/11/14 at 9:00 a.m. revealed both Staff H, CNA (Certified Nursing Assistant), and Staff I, CNA, washed their hands upon entering the resident's room. Staff H and Staff I donned gloves and removed the resident's outer pants and dry incontinent brief. The resident began to void. Staff I rolled the resident onto the right side. The resident continued to

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void on the white cloth pad under the resident. Staff H changed gloves and placed a blue chux under the resident. Staff H began to cleanse the groin area, the penis, and scrotum as the resident continued to void. Staff I assisted the resident to turn onto the right side as Staff H cleansed the peri-rectal area, buttocks, lower back, and hips. Staff H changed gloves and cleansed the front area again. Staff I placed the clean incontinent brief under the resident and secured it in place as the resident continued to lay on the soiled cloth pad. Staff H then placed a clean white cloth pad under the resident and as Staff I assisted the resident to roll from side to side, Staff H removed the soiled cloth pad. While continuing to wear the same gloves, Staff H donned the bilateral heel protectors, covered the resident with a blanket, lowered the bed to the floor, and then bagged up the soiled linen and garbage and exited the room. Staff I removed her gloves but did not wash hands prior to exiting the room. Neither Staff H or Staff I used any sanitizer between glove changes during the procedure.

An observation made on 3/11/14 at 9:45 a.m. revealed Staff J, RN (Registered Nurse), prepared clean work area for supplied to change heel dressing. Staff J donned gloves and with a scissor, cut off the old kling dressing and placed the scissors back on the clean work area without sanitizing the scissors after use. After cleansing the wound and the application of Santyl and Bacitracin, Staff J cut the Allvyn dressing with the soiled scissors and secured it in place with the kling wrap and secured with tape. Staff J did not date or initial the dressing change. Staff J then placed the soiled scissors back into the drawer of the treatment cart.

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2. A quarterly MDS dated 2/26/14 identified Resident #3 with the following diagnoses of diabetes, cerebrovascular accident, anxiety, depression, Schizophrenia, carcinoma in situ of prostate, and mild intellectual disabilities. The resident scored 10/15 on the Brief Interview for Mental Status indicative of both memory and cognitive impairment related to daily decision making skills. The MDS coded the resident required extensive staff assistance with bed mobility, transfers, dressing, toileting needs, personal hygiene, and bathing. The MDS indicated the resident frequently incontinent of both bowel and bladder function.

The resident care plan indicated the resident required staff assistance with all activities of daily living.

An observation made on 3/11/14 at 6:40 a.m. revealed Staff C, CNA, prepared a wet washcloth for the resident to wash hands and face. Staff C donned gloves and with a gloved hand turned on the water faucet and wet the washcloth. Staff C then turned off the faucet with the same gloved hand and proceeded to wash the residents eyes, face, and hands. Staff D, CNA, washed her hands after removed her gloves, combed the resident's hair, and assisted Staff C ambulate the resident with a walker out of the room and down the hallway. Neither Staff C or Staff D washed their hands prior to exiting the resident's room.

3. A quarterly MDS dated 1/22/14 identified Resident #4 with the following diagnoses of peripheral vascular disease, diabetes, Non-Alzheimer's Dementia, anxiety, depression, manic depression, unspecified heart disease, malignant neoplasm of prostate, hypothyroidism,

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and generalized pain. The MDS coded the resident with both short and long term memory loss and severely impaired cognitive function related to daily decision making skills. The MDS coded the resident required extensive staff assistance with bed mobility, transfers, dressing, toilet use, personal hygiene, and bathing. The MDS coded the resident as always incontinent of both bowel and bladder function.

The resident care plan reviewed on 1/28/14 identified the resident as often incontinent of bowel and bladder and wore an incontinent brief and required staff assistance with toileting need and incontinence care.

An observation made on 3/11/14 at 8:40 a.m. revealed Staff C and Staff D performed incontinence care for Resident #4. Staff D donned the clean incontinent brief, secured it in place and pulled up the resident's outer pants. While continuing to wear the same gloves, Staff D covered the resident with a blanket, offered the resident a drink of water, raised the head of the bed, and placed the resident's call light within reach before she removed her gloves and washed her hands. Staff C exited the resident's room without washing her hands.

4. An annual MDS dated 2/12/14 identified Resident #10 with the following diagnoses of peripheral vascular disease, Non-Alzheimer's Dementia, nutritional deficiency, and syncope with collapse. The resident scored 3/15 on the Brief Interview for Mental Status indicative of both memory and cognitive impairment related to daily decision making skills. The MDS coded the resident required limited staff assistance with bed mobility, transfers, and toileting needs, and

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F 441	Continued From page 33 required extensive staff assistance for personal cleansing. The MDS coded the resident as frequently incontinent of bladder and always continent of bowel function. An observation made on 3/13/14 at 6:50 a.m. revealed Staff F, CNA, and Staff D entered the resident's room without first washing their hands. Staff F aroused the resident and donned the gait belt while Staff D washed her hands. Staff F assisted the resident to ambulate into the bathroom with the walker. Staff F then washed her hands and donned gloves. Staff F performed incontinence care to the peri-area, changed gloves, and cleansed the peri-rectal area, buttocks, lower back, and bilateral hips. Staff F and Staff D changes gloves and Staff D secured the clean incontinent brief in place and both CNAs removed their gloves prior to assisting the resident ambulate back to the recliner chair Staff D and Staff F washed their hands Staff F assisted the resident to donn clean outer pants. Staff D applied a gaitbelt as she assisted the resident to stand as Staff F pulled up the clean pants The resident again sat down in the recliner chair as Staff D removed the gait belt and gave the resident the call light. Staff D covered the resident with a blanket and assisted the resident take sips of water. Staff D placed the chair alarm box behind the chair on the floor. Staff D and Staff F exited the resident's room without washing their hands. The facility policy for Hand Washing with no date of origin identified as it's purpose: 1. Medical Asepsis to control infection 2. To reduce transmission of organisms from resident to resident 3. to reduce transmission of organisms from	F 441		

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F 441	Continued From page 34 nursing staff to resident 4. to reduce transmission of organisms from resident to nursing staff General Instructions: 1. Hands should be thoroughly washed before and after providing resident care 2. Proper hand washing techniques must be followed at all times The facility policy for use of Hand Cleaner (Antiseptic) with no date or origin identified as it's purpose: 1. To cleanse hands between resident contacts 2. To prevent the spread of infection. NOTE. This procedure is to be used when hand washing facilities are not readily available. Hands should be washed with soap and water after direct resident contact such as administration of eye drops, ear drops, peri care, oral care. An interview conducted during the facility findings exit on 3/13/14 at 3:20 p.m. with the DON revealed she did not expect her nursing staff to use hand sanitizer in between glove changes during the provision of resident care. She also stated she would only expect her staff to change their gloves if visibly soiled or if deemed appropriate based on the type of care the staff provided at the time. 5. A quarterly MDS (Minimum Data Set) with a reference date of 11/27/13 indicated Resident #5 with a BIMS (brief interview for mental status) score of 8 which indicated the resident to have moderate cognitive impairment. The MDS indicated the resident to exhibit behaviors of	F 441		

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inattention and disorganized thinking. The MDS indicated the resident required extensive staff assistance for bed mobility, transfers, ambulating, toilet use and personal hygiene. The MDS indicated the resident's diagnoses included hypertension, peripheral vascular disease, other fracture, dementia, history of falls, unspecified osteoporosis, anxiety and depression.

The resident's care plan with a target date of 05/08/14 indicated the resident required extensive staff assistance with dressing and grooming, often incontinent of urine, required staff assistance for pericare after incontinent episodes and required a flex brief. A handwritten note dated 03/03/14 indicated that the staff may check and change the resident while using the mechanical lift for transfers.

Observation on 03/10/14 at 2:55 p.m. revealed Staff C and Staff H, certified nursing assistants (CNA) entered the resident's room to get the resident up for an activity. The resident had been observed lying in the bed with eyes closed. The staff washed their hands and donned gloves. Staff H, picked up a package of disposable wipes and proceeded to pull a few wipes out of the package, grabbed hold of the resident's bed with one gloved hand and pulled the bed away from the wall, stepped behind the bed with the package and loose wipes in her hands. Staff C pulled the resident's pants down, unfastened the resident's urine soaked flex brief and tucked between the resident's legs. Staff H handed one disposable wipe to Staff C who proceeded to cleanse the resident, folding the wipe after cleaning the right groin, then left groin, folding wipe and cleaning the perianea from the front to the back. Without changing gloves, Staff C

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pushed on the resident's shoulder and hip to position the resident to the left side. Staff H handed Staff C another wipe. Staff C cleansed the resident's right hip and inner buttock, folded the wipe and cleaned inner left buttock, pulled the soiled brief out from under the resident. Staff C removed gloves . picked up a new flex brief and placed under the resident, rolled the resident onto the flex brief, fastened the strap of the brief around the resident's waist and secured the brief. Staff C and H pulled the resident's pants up and rolled the resident back and forth to position on a lift sling. Staff H, without removing her gloves and washing hands, exited the room to obtained a mechanical lift, then removed her gloves and washed her hands. After transferring the resident from the bed to a wheelchair with the lift, the staff combed the resident's hair, offered and provided a drink of water and propelled the resident to the dining room for the afternoon activity. The staff did not wash hands prior to exiting the room.

Observations on 03/11/14 at 10:15 a.m. revealed Staff C, Staff L and Staff K, all CNAs entered the resident's room to transfer the resident back to bed from the wheelchair to use the bedpan, utilizing the mechanical lift. After transferring the resident into the bed Staff C exited the room with the mechanical lift. Staff C did not wash hands prior to leaving the room. The resident told the staff he/she needed to use the toilet. The Staff informed the resident they would get him/her the bed pan. Staff L washed her hands and donned gloves and pulled down the resident's clothing, unfastened a flex brief, stating the resident had been incontinent. Staff L removed the wet brief and placed it into the garbage. Staff K with gloved hands, obtained a fracture bedpan wrapped in a plastic bag from the cabinet and removed the

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(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 441	Continued From page 37	F 441		

plastic bag. The staff rolled the resident from side to side and placed the bedpan under the resident. The staff covered the resident with a blanket. Staff L, without removing gloves, exited the room to obtain a clean brief. When returned to the room, Staff L removed the gloves and washed her hands and donned clean gloves. The staff rolled the resident to the right side as Staff L removed the bedpan from the resident, Placed the clean brief under the resident, then placed the bedpan back into the bag and placed it on the floor. Staff K donned new gloves, obtained a package of disposable wipes, removed a couple of wipes from the package and handed the package to Staff L, (who had the same gloves on). Staff K proceeded cleaning the the resident's right hip and inner buttock, new wipe and cleansed rectal area wiping from the coccyx area down toward the perineum (wrong direction), obtained new wipe and repeated going down toward the perineum. Staff L instructed Staff K to wipe up on the hip. Staff L assisted the resident to turn on his/her back. Staff K obtained a clean wipe and started to clean the perineum until stopped and asked to change her gloves. Staff K removed her gloves, washed her hands, donned new gloves and proceeded to clean the perineum using the appropriate technique. After completing the perineum Staff K removed her gloves and washed her hands. Staff L fastened the brief which had been placed under the resident after the bedpan had been removed and prior to the pericare. Staff L then removed her gloves. The staff replaced the resident's slacks, positioned the resident in the bed for comfort and covered the resident, placed the call light string so resident could reach it, washed hands and exited the room.

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	165562	A. BUILDING _____ B. WING _____	03/13/2014

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MONRDE CARE CENTER	120 NORTH THIRTEENTH STREET ALBIA, IA 52531

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6. A quarterly MDS (Minimum Data Set) with a reference date of 2/19/14 indicated Resident #8 with a BIMS (brief interview for mental status) score of 11 which indicated the resident to have moderate cognitive impairment. The MDS indicated the resident to exhibit behaviors of inattention and disorganized thinking. The MDS indicated the resident required limited staff assistance for bed mobility, transfers, ambulating, toilet use and personal hygiene. The resident's diagnoses included kyphosis, heart disease, unspecified osteoporosis, generalized muscle weakness, hypertension, chronic airway obstruction and anxiety .

The resident's care plan with a target date of 05/24/14 indicated the resident required staff assistance with dressing and grooming, is incontinent of urine, required staff assistance for pericare after incontinent episodes and required a flex brief

Observation on 03/10/14 at 4:45 p.m. revealed Staff M and Staff N entered the resident's room to take the resident to the bathroom. The staff washed hands and donned gloves. The staff assisted the resident to sit up on the side of bed then stand with the walker, pulled down the resident's pants. Staff N checked the resident's brief for incontinence, stated the brief had been damp. Staff N removed the brief and discarded in the garbage. Staff M opened a package of wipes and removed a wipe from the package and handed to Staff N. Staff N proceeded providing incontinency care, cleaned the right groin, folded the wipe, cleaned the left groin, folded wipe again and cleaned down the middle. Staff N removed her gloves, donned new gloves, did not wash or sanitize hands. Staff M handed Staff N the

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	165562	A. BUILDING _____ B. WING _____	03/13/2014

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second wipe. Staff N reached between the resident's legs and wiped the genitals from the front up the back, folded the wipe and repeated. Staff N asked for another wipe and repeated wiping the perineum in the same manner. Staff N removed her gloves, and donned new gloves. The staff assisted the resident to sit on the side of the bed (with bare bottom), pulled a clean brief over the resident's legs and pulled the brief up. The staff assisted the resident to stand with the walker and pulled up the brief and pants. The resident ambulated to the dining room with the walker per self.

7. A quarterly MDS (Minimum Data Set) with a reference date of 01/15/14 indicated Resident #11 with a BIMS (brief interview for mental status) score of 1 which indicated the resident to have severe cognitive impairment. The MDS indicated the resident to exhibit behaviors of inattention and disorganized thinking. The MDS indicated the resident required extensive staff assistance for dressing, toilet use and personal hygiene. The MDS indicated the resident's diagnoses included hypertension, and Alzheimer's Disease.

The resident's care plan with a target date of 04/21/14 indicated the resident required extensive staff assistance with dressing, toileting grooming, sometimes incontinent of urine, required staff assistance for pericare after incontinent episodes and required a flex brief.

Observation on 03/12/14 at 4:05 p.m. Staff P and Staff M propelled the resident to his/her bedroom to use the bathroom. Staff P placed a gaitbelt around the resident to and assisted the resident ambulate to the bathroom. The staff pulled on gloves in the bathroom. Did not wash hands prior

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	165562	A. BUILDING _____ B. WING _____	03/13/2014

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F 441	Continued From page 40	F 441		

to entering the bathroom. Staff P pulled the resident's jeans down, removed the resident's urine soaked brief, placed in the garbage, assisted the resident to sit on the toilet. Staff M removed a package of wipes from the bathroom towel rack. Staff P asked if the resident if he/she needed to pee. The resident tried to pull up his/her jeans, with Staff P pulling them back down wearing the soiled gloves. Staff M pulled several wet wipes from the package and handed to Staff P. Staff P proceeded to provide pericare with resident sitting on the toilet, cleansing across the suprapubis, new wipe, cleansed right groin, then left groin. Staff P reached between the resident's legs and cleaned the genitals wiping from the front toward the back. Staff P assisted the resident to stand by holding onto the gaitbelt with the soiled gloves, the resident continued to attempts to pull up jeans as Staff P pulling them back down reassuring the resident that she was almost finished Staff M handed Staff P another wipe and Staff P cleansed the residents hips and buttocks using new wipe for each swipe Staff P then cleaned the anal area. Staff P touched the resident's the resident's sweater, jeans and the toilet bars with her soiled gloves. Staff M started to place the clean brief on the resident, dropping it to the floor. Staff M removed one glove, going to the dresser and obtained a clean flex brief. Staff M brought the brief to the bathroom. Staff P continued to hold onto the resident with soiled gloves. Staff M proceeded to hold onto the gaitbelt. Staff P removed the soiled gloves and placed the clean brief on the resident, pulled up the resident's jeans and ambulated the resident to the bedroom and assisted back into the wheelchair. Staff P washed her hands and assisted the resident over to the sink and assisted to wash his/her hands.

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F 514 SS=B	483.75(l)(1) RES RECORDS-COMPLETE/ACCURATE/ACCESSIBLE The facility must maintain clinical records on each resident in accordance with accepted professional standards and practices that are complete; accurately documented; readily accessible; and systematically organized. The clinical record must contain sufficient information to identify the resident; a record of the resident's assessments; the plan of care and services provided; the results of any preadmission screening conducted by the State; and progress notes. This REQUIREMENT is not met as evidenced by: Based on resident record review and staff interview, the facility failed to to document disposition of medications and belongings following a resident's death for 1 of 2 residents reviewed (Resident # 13). The facility reported a resident census of 56 at the time of the survey. Findings include: The resident admission record indicated Resident #13 admitted to the facility on 12/13/2010 with the diagnoses of diabetes, chronic pain, osteoporosis, generative disc disease, senile dementia, congestive heart failure, peripheral vascular disease, depression, anxiety, and heart disease. A Record of Death completed by Staff J, RN (Registered Nurse) on 2/16/14 revealed the resident passed away at 11 00 a.m. Nursing note documentation dated 2/16/14 from	F 514	Once it was identified, the medical record nurse did chart that indeed the pharmacy had picked up the medicine and personal belongings had been picked up by the deceased resident's family. Prior to any closed chart being filed, the medical record nurse will double check the chart for the appropriate final documentation. This nurse has been instructed as such by the Administrator and the DON. A checklist will be developed to identify what items will are required to close the chart prior to filing. The medical record nurse will complete and sign the checklist and give to the DON for QA reporting. Completion date 04-18-14	

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F 514	Continued From page 42 10:45 a.m. to 1:15 p.m. did not indicate the disposition of the resident medications or the personal belongings at the time of death. The last documentation in the nurse's notes was dated 2/16/14. An interview conducted on 3/13/14 at 1:15 p.m. with the DON (Director of Nursing) revealed this information would be documented in the nursing notes at the time of death or discharge from the facility. The DON verified Resident #13 medical record did not contain this information required	F 514		

DEPARTMENT OF INSPECTIONS AND APPEALS

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	IA0495	A. BUILDING: _____ B. WING _____	03/13/2014

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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 record review and staff interview, the facility failed to report an accident which required admission to a higher level of care for treatment	N 101	HEALTH FACILITIES APR 18 2014	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Shelley B

TITLE: Administrator

(X6) DATE: 4-17-14

DEPARTMENT OF INSPECTIONS AND APPEALS

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N 101	Continued From page 1 (Resident #10). The facility reported a census of 56 residents and the sample consisted of 14 residents. 1. Resident #10 had an annual MDS (Minimum Data Set) assessment with a reference date of 4/24/13. The assessment identified the resident with the following diagnoses: Non-Alzheimer's Dementia, orthostatic hypotension, peripheral vascular disease and a fracture. The resident scored 10/15 on the Brief Interview for Mental Status (BIMS). A score of 10 reflected the resident had a moderate cognitive impairment. The MDS coded the resident with no moods or behaviors present. The MDS reflected the resident required limited staff assistance for bed mobility, transfers, ambulation both in and out of the room, dressing, toileting needs, personal hygiene, and required extensive staff assistance for bathing. The MDS identified the resident with functional limitation in range of motion on one side for the upper extremity. The MDS noted the resident with 2 falls with no injuries and 1 fall with an injury, although not major since the previous assessment. The resident care plan reviewed on 2/20/13 identified the resident with a history of syncopal (fainting) episodes which placed the resident at risk for falls. The care plan interventions included and directed staff to ensure the resident ' s glasses were on, assist with activities of daily living as needed, will attend rehabilitation 5 - 7 times each week, assist as needed with toileting, ambulate with walker and I assist, Dycem (to prevent sliding) to the recliner chair seat, check orthostatic blood pressure readings twice a month, and medicate for pain as needed or requested. Review of the nursing note dated 6/10/13 at 8:35	N 101	Upon discussion with the state surveyors regarding reporting requirements, the DON and Administrator did refer to chapter 50.7 for specific definitions. The facility legal counsel was also contacted for clarification on reporting requirements. In the event that a resident has an accident or a fall that may meet the requirements of reporting, the interdisciplinary team will review the decision for reporting determination. The major injury report will also be examined and determined if it is applicable in each case. If found to be a reportable incident, facility will do such within the time limits and constraints of the law. Completion date 04-14-18	

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N 101	Continued From page 2 p.m revealed the nurse was summoned to the resident's room per the CNA (Certified Nursing Assistant) and the LPN (Licensed Practical Nurse). The LPN stated she heard the resident fall in the room. The nurse entered the room. and found the resident in the doorway flat on back. The resident stated he/she fell onto the left hip which appeared shortened and externally rotated. The resident could not move leg upon request and complained of tenderness over the left hip joint when palpated. The staff placed the resident onto a back board for safety. phoned the physician, and requested transport per ambulance to a local hospital. A nursing note dated 6/10/13 at 10:40 a.m., reflected the family notified the facility that the resident had sustained a left hip fracture and the resident would have surgery to pin the hip within the next day or two A diagnostic Radiology report dated 6/10/13 of the left hip gave the following impression: Acute fracture involving the left femoral neck. The resident returned to the facility on 6/14/13 following surgical repair of the hip (hemiarthroplasty) On 3/13/14 at 11.20 a.m. the DDN (Director of Nursing) was interviewed and stated she thought the alarm had sounded at the time of the fall. The DON stated the nursing staff tended to be more prone to document if an alarm didn't sound. The DON confirmed she had not reported the fall with injury to the Department of Inspections and Appeals and had not had the resident's physician complete a major injury determination form following the fall.	N 101		