STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	165592	A. BUILDING _____ B. WING _____	04/13/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PLEASANT MANOR CARE CENTER	413 NORTH BROADWAY STREET MOUNT PLEASANT, IA 52641

(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 4-27-17 The following deficiencies relate to the facility's annual health survey and investigation of Complaint #64673 and Incident #65085. See Code of Federal Regulations (42CFR) Part 483, Subpart B-C.	F 000		
F 157 SS=D	483.10(g)(14) NOTIFY OF CHANGES (INJURY/DECLINE/ROOM, ETC) (g)(14) Notification of Changes. (i) A facility must immediately inform the resident; consult with the resident's physician; and notify, consistent with his or her authority, the resident representative(s) when there is- (A) An accident involving the resident which results in injury and has the potential for requiring physician intervention; (B) A significant change in the resident's physical, mental, or psychosocial status (that is, a deterioration in health, mental, or psychosocial status in either life-threatening conditions or clinical complications); (C) A need to alter treatment significantly (that is, a need to discontinue an existing form of treatment due to adverse consequences, or to commence a new form of treatment); or (D) A decision to transfer or discharge the resident from the facility as specified in §483.15(c)(1)(ii).	F 157		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Marcia R Johnson RN Admin — TITLE: Administrator — (X6) DATE: 4/27/2017

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.

P Campbell 4/27/17

Plan of Correction for Pleasant Manor Care Center, Mount Pleasant Iowa Provider # IA0937

F 000 Accept the following corrections as the facilities credible allegation of compliance.

F 157

4/11/2017 – 4/13/2017: Bedside Blood Glucose Monitoring Policy and Procedure revised to include requiring staff to obtain an order from the provider indicating parameters of blood sugar results the provider is to be notified. Orders for provider notification were obtained on all residents with bedside blood glucose testing orders. Documentation in the electronic medical record was modified so an alert is triggered when a blood glucose result is entered that requires provider notification. Staff was educated on the new process.

Floor nurses will monitor blood glucose readings in the electronic record alerts every shift to assure all blood sugars out of ordered parameters are reported.

The Director of Nursing or designee will monitor orders for blood glucose parameters on all residents with bedside blood glucose testing, blood glucose results and provider notification daily. On 4/12/2017 an alert was appropriately triggered with a bedside blood glucose result requiring provider notification. The provider was notified and orders received.

The QA committee will monitor monthly for 3 months, quarterly for 1 year for further recommendations and compliance.

results and provider notification daily. On 4/12/2017 an alert was appropriately triggered with a bedside blood glucose result requiring provider notification. The provider was notified and orders received.

The QA committee will monitor monthly for 3 months, quarterly for 1 year for further recommendations and compliance.

F 363

On 04/13/17 A detailed Policy and Procedure for the Puree Process was created. Staff was educated on the new procedure.

Audits will be performed weekly for 3 weeks monthly for 3 months and quarterly thereafter to assure compliance with margarine/butter being added prior to pureeing.

The QA committee will monitor the results of the audits for further recommendations and compliance.

F371

On 04/12/17 and 04/13/17 all 4 freezers and the milk cooler were defrosted and cleaned.

On 04/17/17 a new cleaning schedule was developed that directs staff when to clean the refrigerators and freezers and when to defrost the freezers.

Audits will be performed weekly for 4 weeks and monthly thereafter to assure compliance with cleaning and defrosting of freezers.

The QA committee will monitor the results of all audits for further recommendations and compliance.

F 226

A new hire procedure was created including results of criminal record check and dependent adult/child abuse registry check. The Office Manager and Administrator must sign off on criminal record check and dependent adult/child abuse registry paper work to assure everything is completed prior to new hires starting work.

The Policy and Procedure "Abuse Prevention, identification, investigation, and reporting" does state the facility will conduct a criminal record check and dependent adult/child abuse registry check on all personnel.

All reports that are received from the DHS will be maintained in the employee files.

Compliance to the revised procedure will be monitored with random audits of employee files by the office manager monthly for 3 months and quarterly thereafter.

The QA committee will monitor quarterly ongoing for continued compliance.

F 309

4/11/2017 – 4/13/2017: Bedside Blood Glucose Monitoring Policy and Procedure revised to include requiring staff to obtain an order from the provider indicating parameters of blood sugar results the provider is to be notified. Orders for provider notification were obtained on all residents with bedside blood glucose testing orders. Documentation in the electronic medical record was modified so an alert is triggered when a blood glucose result is entered that requires provider notification. Staff was educated on the new process.

Floor nurses will monitor blood glucose readings in the electronic record alerts every shift to assure all blood sugars out of ordered parameters are reported.

The Director of Nursing or designee will monitor orders for blood glucose parameters on all residents with bedside blood glucose testing, blood glucose

Plan of Correction for Pleasant Manor Care Center, Mount Pleasant Iowa Provider # IA0937

Accept the following corrections as the facilities credible allegation of compliance.

Tag L 1093 Admission, transfer, and discharge

All Veterans at Pleasant Manor were placed into the Iowa Department of Veterans Affairs (IDVA) data base on 04/11/2017.

A new policy and procedure was developed on 04/11/2017 regarding Veterans Eligibility. IDVA web site will be printed off monthly and kept on file for future reference.

Audits of Resident files will be performed monthly for 3 months quarterly for 1 year.

The QA committee will monitor the results of the audits for further recommendations and compliance.

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	165592	A. BUILDING _____ B. WING _____	04/13/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PLEASANT MANOR CARE CENTER	413 NORTH BROADWAY STREET MOUNT PLEASANT, IA 52641

(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 157	Continued From page 1 (ii) When making notification under paragraph (g)(14)(i) of this section, the facility must ensure that all pertinent information specified in §483.15(c)(2) is available and provided upon request to the physician. (iii) The facility must also promptly notify the resident and the resident representative, if any, when there is- (A) A change in room or roommate assignment as specified in §483.10(e)(6); or (B) A change in resident rights under Federal or State law or regulations as specified in paragraph (e)(10) of this section. (iv) The facility must record and periodically update the address (mailing and email) and phone number of the resident representative(s). This REQUIREMENT is not met as evidenced by: Based on record review and interview, the facility failed to notify the physician following a change in condition for 1 of 10 residents (Resident #5). The facility reported a census of 32 residents. Findings include: 1. The Minimum Data Set (MDS) assessment tool dated 2/16/17 listed diagnoses for Resident #5 which included diabetes mellitus, non-Alzheimer's dementia, and long term use of insulin. According to the MDS, the resident required supervision and setup assistance for eating, extensive assistance of 1 staff for personal hygiene, and extensive assistance of 2 staff for bed mobility, transfers, walking, dressing, toilet use, and bathing. The resident's Brief	F 157		

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	165592	A. BUILDING _____ B. WING _____	04/13/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PLEASANT MANOR CARE CENTER	413 NORTH BROADWAY STREET MOUNT PLEASANT, IA 52641

(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 157	Continued From page 2	F 157		

Interview for Mental Status (BIMS) score was 3 out of 15, indicating severely impaired cognition.

A physician communication sheet, dated 3/1/17, documented the facility informed the physician the resident's blood sugars for the month of February ranged from the mid to high 400s. The physician directed the staff to increase the resident's Levemir (medication to treat high blood sugar) to 15 units in the morning and 10 units in the evening.

The resident's current Physician's Order Sheet (POS), dated 3/29/17, directed staff to notify the physician if blood sugars exceeded 350 mg/dl(milligrams/deciliter).

The resident's Weights and Vitals Summary for the period of 3/1/17-4/12/17 revealed the following blood sugars on the following dates exceeding 350 mg/dl:

3/1/17	370
3/1/17	600
3/2/17	488
3/3/17	444
3/5/17	446
3/6/17	442
3/7/17	374
3/12/17	555
3/16/17	460
3/17/17	357
3/19/17	449
3/20/17	425
3/22/17	499
3/26/17	406
3/30/17	390
4/1/17	353
4/2/17	440
4/4/17	373

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	165592	A. BUILDING _____ B. WING _____	04/13/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PLEASANT MANOR CARE CENTER	413 NORTH BROADWAY STREET MOUNT PLEASANT, IA 52641

(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 157	Continued From page 3 4/5/17 446 4/6/17 494 4/7/17 455 4/8/17 399 4/8/17 510 4/9/17 470 4/10/17 480 4/11/17 376 A 4/8/17 5:21 p.m. nursing progress note entry documented the nurse showed the resident his/her blood sugar of 510 and resident stated he/she ate ice cream and cake earlier and he/she felt fine. The entry lacked any additional follow-up or assessments. The facility lacked any additional documentation for the period of 3/1/17-4/10/17 of physician notification of blood sugars over 350 mg/dl or any follow-up assessments of the resident following the high blood sugars. A 4/11/17 11:39 a.m. nursing progress note entry document the facility informed the physician of the resident's recent blood sugars in the 300-400's. A physician's order, dated 4/11/17, revealed an order for Levemir 20 units in the morning. The facility policy and procedure "Bedside Blood Glucose Monitoring", dated 4/11/17, directed nurses to complete assessments and notify the resident's provider and family as appropriate if the resident's blood sugar was out of the ordered parameters. During an interview on 4/11/17 at 10:33 a.m., the Director of Nursing stated staff should notify the	F 157		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	165592	A. BUILDING _____ B. WING _____	04/13/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PLEASANT MANOR CARE CENTER	413 NORTH BROADWAY STREET MOUNT PLEASANT, IA 52641

(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 157	Continued From page 4 physician if blood sugars exceeded the 300's-400's and should make a note of whether the resident just ate. During an interview on 4/13/17 at 9:15 a.m., the Director of Nursing provided their new policy on blood sugar management. She stated the facility began implementing the policy.	F 157		
F 226 SS=D	483.12(b)(1)-(3), 483.95(c)(1)-(3) DEVELOP/IMPLMENT ABUSE/NEGLECT, ETC POLICIES 483.12 (b) The facility must develop and implement written policies and procedures that: (1) Prohibit and prevent abuse, neglect, and exploitation of residents and misappropriation of resident property, (2) Establish policies and procedures to investigate any such allegations, and (3) Include training as required at paragraph §483.95, 483.95 (c) Abuse, neglect, and exploitation. In addition to the freedom from abuse, neglect, and exploitation requirements in § 483.12, facilities must also provide training to their staff that at a minimum educates staff on- (c)(1) Activities that constitute abuse, neglect, exploitation, and misappropriation of resident property as set forth at § 483.12. (c)(2) Procedures for reporting incidents of abuse,	F 226		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	165592	A. BUILDING _____ B. WING _____	04/13/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PLEASANT MANOR CARE CENTER	413 NORTH BROADWAY STREET MOUNT PLEASANT, IA 52641

(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 226	Continued From page 5 neglect, exploitation, or the misappropriation of resident property (c)(3) Dementia management and resident abuse prevention. This REQUIREMENT is not met as evidenced by: Based on employee files, interview, and policy review, the facility failed to obtain the required background check prior to employment for 1 of 5 employee files reviewed. The facility reported a census of 32 residents. Findings include; Review of the employee file for Staff B (Housekeeping) revealed a SING (Single Contact License and Background Check) completed on 5/2/16. Staff B had no abuse history identified on the SING but required further research of his/her criminal history. The facility received the results of Staff B's criminal record on 5/2/16 and requested an evaluation on 5/4/16 from the Department of Human Services (DHS). The facility new hire list revealed a hire date for Staff B on 5/4/16. On 5/9/16 the facility received the Record Check Evaluation results allowing Staff B to work at the facility (5 days after Staff B had been hired to work). During an interview on 4/12/17 at 10:00 a.m., the Administrator confirmed Staff B worked in the facility prior to the completion of the Record Check Evaluation. She did not have any further information regarding this as she was not employed at the facility at this time. During an interview on 4/12/17 at approximately	F 226		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	165592	A. BUILDING _____ B. WING _____	04/13/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PLEASANT MANOR CARE CENTER	413 NORTH BROADWAY STREET MOUNT PLEASANT, IA 52641

(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 226	Continued From page 6 11:00 a.m., the Administrator stated she could not locate Staff B's criminal history record in the file. The facility policy and procedure "Abuse Prevention, Identification, Investigation, and Reporting", revised 4/5/17, stated the facility would conduct a criminal record check and dependent adult/child abuse registry check on all prospective employees and other individuals engaged to provide services to residents prior to hire.	F 226		
F 309 SS=D	483.24, 483.25(k)(l) PROVIDE CARE/SERVICES FOR HIGHEST WELL BEING 483.24 Quality of life Quality of life is a fundamental principle that applies to all care and services provided to facility residents. Each resident must receive and the facility must provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being, consistent with the resident's comprehensive assessment and plan of care. 483.25 Quality of care Quality of care is a fundamental principle that applies to all treatment and care provided to facility residents. Based on the comprehensive assessment of a resident, the facility must ensure that residents receive treatment and care in accordance with professional standards of practice, the comprehensive person-centered care plan, and the residents' choices, including but not limited to the following: (k) Pain Management. The facility must ensure that pain management is provided to residents who require such services,	F 309		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	165592	A. BUILDING _____ B. WING _____	04/13/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PLEASANT MANOR CARE CENTER	413 NORTH BROADWAY STREET MOUNT PLEASANT, IA 52641

(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 309	Continued From page 7 consistent with professional standards of practice, the comprehensive person-centered care plan, and the residents' goals and preferences. (l) Dialysis. The facility must ensure that residents who require dialysis receive such services, consistent with professional standards of practice, the comprehensive person-centered care plan, and the residents' goals and preferences. This REQUIREMENT is not met as evidenced by: Based on record review and interview, the facility failed to properly assess 1 of 10 residents following a change in condition(Resident #5). The facility reported a census of 32 residents. Findings include: 1. The Minimum Data Set (MDS) assessment tool dated 2/16/17 listed diagnoses for Resident #5 to include diabetes mellitus, non-Alzheimer's dementia, and long term use of insulin. The MDS stated the resident required supervision and setup assistance for eating, extensive assistance of 1 staff for personal hygiene, and extensive assistance of 2 staff for bed mobility, transfers, walking, dressing, toilet use, and bathing. The resident's Brief Interview for Mental Status (BIMS) score was 3 out of 15, indicating severely impaired cognition. A physician communication sheet, dated 3/1/17, documented the facility informed the physician the resident's blood sugars for the month of February ranged from the mid to high 400s. The physician directed the staff to increase the resident's Levemir (medication to treat high blood sugar) to 15 units in the morning and 10 units in	F 309		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	165592	A. BUILDING _____ B. WING _____	04/13/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PLEASANT MANOR CARE CENTER	413 NORTH BROADWAY STREET MOUNT PLEASANT, IA 52641

(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 309	Continued From page 8	F 309		

the evening.

The resident's current Physician's Order Sheet (POS), dated 3/29/17, directed staff to notify the physician if blood sugars exceeded 350 mg/dl (milligrams/deciliter).

The resident's Weights and Vitals Summary for the period of 3/1/17-4/12/17 revealed the following blood sugars on the following dates exceeding 350 (mg/dl):

3/1/17	370
3/1/17	600
3/2/17	488
3/3/17	444
3/5/17	446
3/6/17	442
3/7/17	374
3/12/17	555
3/16/17	460
3/17/17	357
3/19/17	449
3/20/17	425
3/22/17	499
3/26/17	406
3/30/17	390
4/1/17	353
4/2/17	440
4/4/17	373
4/5/17	446
4/6/17	494
4/7/17	455
4/8/17	399
4/8/17	510
4/9/17	470
4/10/17	480
4/11/17	376

A 4/8/17 5:21 p.m. nursing progress note entry

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	165592	A. BUILDING _____ B. WING _____	04/13/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PLEASANT MANOR CARE CENTER	413 NORTH BROADWAY STREET MOUNT PLEASANT, IA 52641

(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 309	Continued From page 9 documented the nurse showed the resident his/her blood sugar of 510 and resident stated he/she ate ice cream and cake earlier and he/she felt fine. The entry lacked any additional follow-up or assessments. The facility lacked any additional documentation for the period of 3/1/17-4/10/17 of physician notification of blood sugars over 350 mg/dl or any follow-up assessments of the resident following the high blood sugars. A 4/11/17 11:39 a.m. nursing progress note entry documented the facility informed the physician of the resident's recent blood sugars in the 300-400's. A physician's order dated 4/11/17 revealed an order for Levemir 20 units in the morning. The facility policy and procedure "Bedside Blood Glucose Monitoring", dated 4/11/17, directed nurses to complete assessments and notify the resident's provider and family as appropriate if the resident's blood sugar was out of the ordered parameters. During an interview on 4/11/17 at 10:33 a.m., the Director of Nursing stated staff should notify the physician if blood sugars exceeded the 300's-400's and should make a note of whether the resident just ate. During an interview on 4/13/17 at 9:15 a.m., the Director of Nursing provided their new policy on blood sugar management. She stated the facility began implementing the policy.	F 309		
F 363	483.60(c)(1)-(7) MENUS MEET RES	F 363		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	165592	A. BUILDING _____ B. WING _____	04/13/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PLEASANT MANOR CARE CENTER	413 NORTH BROADWAY STREET MOUNT PLEASANT, IA 52641

(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 363 SS=D	Continued From page 10 NEEDS/PREP IN ADVANCE/FOLLOWED (c) Menus and nutritional adequacy. Menus must- (c)(1) Meet the nutritional needs of residents in accordance with established national guidelines.; (c)(2) Be prepared in advance; (c)(3) Be followed; (c)(4) Reflect, based on a facility's reasonable efforts, the religious, cultural and ethnic needs of the resident population, as well as input received from residents and resident groups; (c)(5) Be updated periodically; (c)(6) Be reviewed by the facility's dietitian or other clinically qualified nutrition professional for nutritional adequacy; and (c)(7) Nothing in this paragraph should be construed to limit the resident's right to make personal dietary choices. This REQUIREMENT is not met as evidenced by: Based on observation, staff interview, and facility policy, the facility failed to include margarine in the 5 pureed portions of asparagus to ensure the same nutritional equivalents as for regular diets was maintained. The facility reported a census of 32 residents. Findings include: During an observation of the kitchen and the	F 363		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	165592	A. BUILDING _____ B. WING _____	04/13/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PLEASANT MANOR CARE CENTER	413 NORTH BROADWAY STREET MOUNT PLEASANT, IA 52641

(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 363	Continued From page 11 puree process on 04/11/2017 at 9:43 A.M., Staff A, Cook, placed five - 4 ounce ladles of asparagus into the blender with 2 and 1/2 slices of bread. The bread failed to have any margarine spread as called for on the meal menu. When Staff A completed the puree process, she failed to add any margarine to the mixture. On 04/13/17 at 9:15 A.M. the Dietary Manager assisting this facility agreed Staff A needed to add the margarine to the mixture either as buttered bread or in bulk to the mixture. The undated Martin Brothers Puree process guide directed dietary staff to add the appropriate liquid of nutritive value and flavor to obtain the desired consistency (margarine) when preparing the pureed diets.	F 363		
F 371 SS=D	483.60(i)(1)-(3) FOOD PROCURE, STORE/PREPARE/SERVE - SANITARY (i)(1) - Procure food from sources approved or considered satisfactory by federal, state or local authorities. (i) This may include food items obtained directly from local producers, subject to applicable State and local laws or regulations. (ii) This provision does not prohibit or prevent facilities from using produce grown in facility gardens, subject to compliance with applicable safe growing and food-handling practices. (iii) This provision does not preclude residents from consuming foods not procured by the facility.	F 371		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	165592	A. BUILDING _____ B. WING _____	04/13/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PLEASANT MANOR CARE CENTER	413 NORTH BROADWAY STREET MOUNT PLEASANT, IA 52641

(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 371	Continued From page 12 (i)(2) - Store, prepare, distribute and serve food in accordance with professional standards for food service safety. (i)(3) Have a policy regarding use and storage of foods brought to residents by family and other visitors to ensure safe and sanitary storage, handling, and consumption. This REQUIREMENT is not met as evidenced by: Based on observation, staff interviews, and cleaning schedules, the facility failed to maintain the kitchen freezers in a frost free condition and failed to follow their cleaning policy. The facility reported a census of 32 residents. Findings: During the initial tour of the facility kitchen on 04/10/17 at 09:00 A.M., the following concerns were observed: 9:05 A.M. - A white upright General Electric Freezer display 1/2 inch thick frost on 4 shelves. Temperature 0 degrees. 9:10 A.M. - A white Amana upright freezer displayed 1/4 inch thick frost on all 4 shelves. Temperature 5 degrees 9:20 A.M. - A white general Electric freezer for meat displayed a 1/2 inched build up of frost on all sides. Temperature 0 degrees. 9:25 A.M. - The milk chest cooler displayed a large area of frost/ice build up in the back left corner of the chest. The area covered 1 to 1 1/2 foot by 3 inches thick. Temperature 38 degrees. During an interview on 04/13/2017 at 9:15 A.M., the Dietary Supervisor (DS) overseeing the kitchen at this time, verbalized Staff A should	F 371		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	165592	A. BUILDING _____ B. WING _____	04/13/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PLEASANT MANOR CARE CENTER	413 NORTH BROADWAY STREET MOUNT PLEASANT, IA 52641

(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 371	Continued From page 13 have added the margarine to the asparagus or buttered the bread she added to the asparagus. The DS also verbalized visualizing the frost build up in the different freezers. The March 2017 cleaning schedules for the kitchen documented the various freezers received a cleaning for the week of March 27, 2017 on: S freezer (inside/out) cleaned once. NW freezer (inside/out) cleaned once. milk cooler in the garage cleaned once. Freezer in the garage (meat) cleaned once. Defrosting of the freezers no documented.	F 371		

DEPARTMENT OF INSPECTIONS AND APPEALS

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	IA0937	A. BUILDING: _____ B. WING _____	04/13/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PLEASANT MANOR CARE CENTER	413 NORTH BROADWAY STREET MOUNT PLEASANT, IA 52641

(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) COMPLETE DATE
L1093	58.12(1)l Admission, transfer, and discharge 58.12(135C) Admission, transfer, and discharge. 58.12(1) General admission policies. l. For all residents residing in a health care facility receiving reimbursement through the medical assistance program under Iowa Code chapter 249A on July 1, 2003, and all others subsequently admitted, the facility shall collect and report information regarding the resident's eligibility or potential eligibility for benefits through the Federal Department of Veterans Affairs as requested by the Iowa commission on Veterans Affairs. The facility shall collect and report the information on forms and by the procedures prescribed by the Iowa commissions on veterans affairs. Where appropriate, the facility may also report such information to the Iowa department of human services. In the event that a resident is unable to assist the facility in obtaining the information, the facility shall seek the requested information from the resident's family members or responsible party. For all new admissions, the facility shall collect and report the required information regarding the resident's eligibility or potential eligibility to the Iowa commission on veterans affairs within 30 days of the resident's admission. For residents residing in the facility as of July 1, 2003, and prior to May 5, 2004, the facility shall collect and report the required information regarding the resident' s eligibility or potential eligibility to the Iowa commission on veterans affairs within 90 days after May 5, 2004. If a resident is eligible for benefits through the federal Department of Affairs or other third-party payor, the facility shall seek reimbursement from such benefits to the maximum extent available before seeking reimbursement from the medical	L1093		

DEPARTMENT OF INSPECTIONS AND APPEALS

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	IA0937	A. BUILDING: _____ B. WING _____	04/13/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PLEASANT MANOR CARE CENTER	413 NORTH BROADWAY STREET MOUNT PLEASANT, IA 52641

(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) COMPLETE DATE
L1093	Continued From page 1 assistance program established under Iowa Code chapter 249A. The provisions of this paragraph shall not apply to the admission of an individual as a resident to a state mental health institute for acute psychiatric care or to the admission of an individual to the Iowa Veterans Home. (II,III) This Statute is not met as evidenced by: Based on record review for admitting a resident to the nursing facility, one of the requirements expected is a review of military service within the first 30 days. The facility failed to submit veterans names to the Iowa Department of Veterans Affairs for eligibility of benefits for 11 residents admitted since 3/17/16. The facility reported a census of 32 residents. Findings include: During the initial meeting with the Administrator on April 11, 2017 at 9:05 A.M., when asked for the Iowa Veterans reporting sheet for the past survey year, the Administrator admitted the facility did not complete the reporting process for veterans eligibility of benefits. On 04/12/2017, the facility did report 6 out of 11 residents who were veterans to the Iowa Department of Affairs. The facility asked all admissions their veteran status, but did not report them to the Iowa Department of Veterans Affairs. The new Policy and Procedure for Veteran Benefit Documentation dated 04/11/2017 directed the business office representative to complete the "Veteran Eligibility" form within 30 days of admission for all admissions and enter the data into the Iowa Department of Veterans Affairs. All	L1093		

DEPARTMENT OF INSPECTIONS AND APPEALS

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	IA0937	A. BUILDING: _____ B. WING _____	04/13/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PLEASANT MANOR CARE CENTER	413 NORTH BROADWAY STREET MOUNT PLEASANT, IA 52641

(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) COMPLETE DATE
L1093	Continued From page 2 records would be maintained by the facility.	L1093		