STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	165145	A. BUILDING _____ B. WING _____	04/13/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
EMBASSY HEALTHCARE COMMUNITY	206 PORT NEAL ROAD SERGEANT BLUFF, IA 51054

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F 000	INITIAL COMMENTS Correction date 5/7/17 overall 4/27/17 ~~5/8/17~~ F323 per facility The following deficiencies were identified during the facility's annual survey and investigation of facility-reported incident # 66670-I and complaint # 66333-C. See Code of Federal Regulations (45 CFR) Part 483, Subpart B-C.	F 000		
F 278 SS=D	483.20(g)-(j) ASSESSMENT ACCURACY/COORDINATION/CERTIFIED (g) Accuracy of Assessments. The assessment must accurately reflect the resident's status. (h) Coordination A registered nurse must conduct or coordinate each assessment with the appropriate participation of health professionals. (i) Certification (1) A registered nurse must sign and certify that the assessment is completed. (2) Each individual who completes a portion of the assessment must sign and certify the accuracy of that portion of the assessment. (j) Penalty for Falsification (1) Under Medicare and Medicaid, an individual who willfully and knowingly- (i) Certifies a material and false statement in a resident assessment is subject to a civil money penalty of not more than $1,000 for each assessment; or	F 278		

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

Director 5-5-17

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 278	Continued From page 1 (ii) Causes another individual to certify a material and false statement in a resident assessment is subject to a civil money penalty or not more than $5,000 for each assessment. (2) Clinical disagreement does not constitute a material and false statement. This REQUIREMENT is not met as evidenced by: Based on staff interview and record review, the facility failed to completely and accurately complete all assessments on the Minimum Data Set assessment tool for for 2 of 13 current residents reviewed (Residents #6 and #10). The facility reported a census of 46. Findings include: 1. Review of Resident #6's admission Minimum Data Set (MDS) assessment dated 2/26/17 revealed an admission date of 2/13/17. An RN (Registered Nurse) signed the assessment as complete on 3/6/17. The MDS contained no completed assessments on the resident's cognitive status, mood/behavior, psychosocial, balance, range of motion, bathing and pain. 2. The MDS assessment dated 2/15/17 recorded that nursing staff documented the following sections of Resident #10's MDS as not assessed: Section G- Activities of Daily Living- bed mobility, transfer, walk in room, walk in corridor, locomotion on unit, locomotion off unit, dressing, eating, toilet use, personal hygiene and balance during transfers. Section H - Bladder and Bowel- urinary continence and bowel continence.	F 278		

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F 278	Continued From page 2 An RN signed the assessment as complete on 2/28/17. During interview on 4/12/17 at 10:00, the facility's MDS Registered Nurse/RN stated he began employment as the MDS Coordinator on 2/28/17. He stated he noted the resident's MDS had not been completed by the previous MDS Coordinator and the resident's MDS to still be open on 3/1/17. The MDS Coordinator confirmed he documented the areas above as not assessed because he had not been here at the time and had not been the nurse who completed the assessments during the assessment period ending 2/15/17. Review of a facility policy and procedure for MDS with an effective date of 11/22/16, included the following: It is the policy to insure the timeliness and accuracy of all MDS. This will be done following the guidelines laid out in the RAI (Resident Assessment Instrument) Manual. The departments of the facility will be assigned certain sections of the MDS and the information obtained through the assessment process and the MDS will be used to create and update the care plan.	F 278		
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	F 309		

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F 309	Continued From page 3 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, 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 clinical record review, observations and staff interviews, the facility failed to assure timely intervention for residents with adverse changes of condition for 2 of 11 current residents sampled (Residents #1 and 2). The facility identified a census of 46. Findings include: 1. The Minimum Data Set (MDS) assessment dated 1/29/17 documented diagnoses that	F 309		

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F 309	Continued From page 4 included chronic obstructive pulmonary disease, artherosclerotic heart disease, history of deep vein thrombosis and hypertension for Resident #1. The same MDS documented the resident required the assistance of one with transfers, personal hygiene, dressing and toilet use. The assessment documented s/he had moisture associated skin damage at the time of the assessment. The resident's care plan problem initiated 7/3/14 and revised on 3/14/16 identified the resident at risk for skin breakdown due to impaired mobility and directed staff to monitor the resident's skin for breakdown during cares and to report to the physician as needed. The Progress Notes dated 3/4/17 at 8:56 PM, completed by Staff G, Licensed Practical Nurse (LPN), documented the resident's skin of the frontal genital area appeared raw. Staff G documented she cleansed the area, dusted it with stomahesive power and applied a thin layer of Calmoseptine ointment. The resident's clinical record failed to contain documentation of physician notification of the resident's skin condition. During interview on 3/24/17 at 3:40 PM Staff G stated she sent a fax notification to the physician on 3/4/17 regarding the resident's skin condition changes. During interview on 4/11/17 at 10:30 AM, the Director of Nursing (DON) stated she could not locate the physician fax sent by Staff G. The Non-Pressure Skin Condition Report dated 3/4/17 documented Staff G documented the area as bright red in color with the surrounding tissue macerated. The same Non-Pressure Skin	F 309		

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F 309	Continued From page 5 Condition Report documented assessments done on the following dates: 3/10/17 - the surrounding skin color as pink/bright red and the surrounding tissue macerated. 3/18/17 - the surrounding skin color as bright red with surrounding tissue macerated and edematous; the progress had deteriorated. 3/24/17 - the area as macerated with redness. 3/31/17 - the area was pink with maceration. 4/6/17 - an excoriated inner perineal area with a yeast-like odor and the surrounding skin color pink/bright red. Review of the resident's clinical record revealed a physician order dated 4/6/17 which directed staff to apply Nystop powder (an antifungal treatment) to the resident's perineal area two times a day for excoriated skin and to apply Calmoseptine ointment on top of the Nystop powder two times a day. Review of the Medication Administration Records (MAR) for March and April, 2017 revealed no treatment to the resident's perineal area initiated until 4/6/17 although it had been initially observed 33 days earlier on 3/4/17. 2. The MDS assessment dated 3/8/17 documented diagnoses that included Alzheimer's disease, diabetes mellitus and cerebral infarction for Resident #2. The same MDS documented the resident transferred, walked, used the toilet and performed personal hygiene activities with supervision. The assessment documented the resident as continent of bowel. The care plan problem dated 4/14/16 identified the resident as independent with toilet use, continent of bowel and incontinent of bladder at	F 309		

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F 309	Continued From page 6 times and for staff to assist the resident as needed. The care plan did not identify any history or active Clostridium difficile infection. The Progress Notes dated 1/25/17 at 2:24 PM documented the resident passed a large amount of odiferous stool with mucous. The facility requested and received an order to perform a stool culture. The Progress Notes dated 1/25/17 at 8:34 PM documented the resident's stool culture tested positive for Clostridium difficile. The Progress Notes entry dated 1/26/17 at 9:24 AM documented the facility received an order for Flagyl (an antibiotic) 500 milligrams (mg) three times a day (TID) for 10 days. A fax sent to the physician on 2/14/17 documented the resident continued to have loose stools with the odor indicative of Clostridium difficile infection. The fax also documented the resident completed antibiotic therapy on 2/7/17. Review of the same fax revealed the facility did not obtain a response from the physician until 3/7/17 at which time the physician ordered another stool culture for Clostridium difficile and directed to administer 1 packet of Banatrol+ (a supplement used to control diarrhea) daily. The Progress Notes dated 3/8/17 at 11:03 AM documented the lab notified the facility the resident's stool culture tested positive for Clostridium difficile. The Provider notes dated 3/9/17 documented the resident as Clostridium difficile positive with completion of antibiotic and clinically improving. This note also documented to await addition of Banatrol and if unresponsive, the practitioner will consider an additional course of antibiotic.	F 309		

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F 312	Continued From page 7	F 312		
F 312 SS=D	483.24(a)(2) ADL CARE PROVIDED FOR DEPENDENT RESIDENTS (a)(2) 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 clinical record review, staff and resident interview, facility policy review and observation, the facility failed to provide bathing assistance for 2 of 11 current residents reviewed (Residents #6 and #9). The facility reported a census of 46 residents. Findings Include: 1. According to the Minimum Data Set (MDS) assessment dated 2/26/17, Resident #6's diagnoses included coronary artery disease, heart failure, hypertension, peripheral vascular disease, neurogenic bladder, diabetes mellitus, chronic lung disease, early onset cerebellar ataxia, old myocardial infarction, cardiomyopathy and chronic pain. The MDS documented a Brief Interview for Mental Status (BIMS) score of 10 indicating moderate cognitive impairment. The assessment documented the resident required the assistance of two with toilet use and the assistance of one with personal hygiene. The MDS documented the resident entered the facility on 2/13/17. Review of the care dated 2/16/17 revealed a focus on dressing, grooming and bathing. The care plan documented the the resident needed the extensive assistance of one with bathing.	F 312		

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F 312	Continued From page 8 Review of facility forms identified as bathing records revealed the following dates documenting when the resident received a bath: a. 2/16/17; b. 2/22/17; c. 2/26/17; d. 3/5/17 (the resident refused and no documentation of another offer); e. 3/14/17; f. 3/21/17; g. 3/29/17; h. 4/5/17. During an interview with Resident #6 on 4/11/17 at 9:10 AM, the resident needed a shave and stated s/he would like to receive a bath more than one time per week. 2. According to the MDS assessment dated 3/15/17, Resident #9's diagnoses included anemia, hypertension, neurogenic bladder, Non-Alzheimer's disease, multiple sclerosis (MS), seizure disorder, respiratory failure, athrosclerotic heart disease and depression. The MDS documented a BIMS score of 7 indicating severe cognitive impairment. The assessment documented the resident required the assistance of two with bed mobility and transfers, the assistance of one with personal hygiene and displayed total dependence on staff in order to bathe. Review of the resident's care plan dated 3/30/17 revealed a focus on a risk for falls due to MS and seizure disorder. The care plan instructed staff to set up and assist with daily hygiene cares. Review of facility forms identified as bathing	F 312		

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F 312	Continued From page 9 records revealed the following dates documenting when the resident received a bath: a. 2/3/17; b. 2/6/17; c. 2/11/17; d. 2/25/17; e. 3/6/17; f. 3/13/17 (hospitalized 3/10/17-3/13/17); g. 3/18/17; h. 3/22/17; i. 3/25/17; j. 3/29/17; k. 4/5/17. During an interview with the Director of Nursing (DON) on 4/12/17 at 8:59 AM, she stated that she would expect residents to receive more than one bath per week. She stated the facility has a designated bath aide. She stated when the bath aide is off, another certified nursing assistant (CNA) is assigned give baths. Review of a facility policy entitled Shower/Tub Bath, revised 1/14, revealed the purpose of the bathing/showering procedure was to promote cleanliness, provide comfort to the resident and to observe the condition of the resident's skin.	F 312		
F 323 SS=G	483.25(d)(1)(2)(n)(1)-(3) FREE OF ACCIDENT HAZARDS/SUPERVISION/DEVICES (d) Accidents. The facility must ensure that - (1) The resident environment remains as free from accident hazards as is possible; and (2) Each resident receives adequate supervision	F 323		

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F 323	Continued From page 10 and assistance devices to prevent accidents. (n) - Bed Rails. The facility must attempt to use appropriate alternatives prior to installing a side or bed rail. If a bed or side rail is used, the facility must ensure correct installation, use, and maintenance of bed rails, including but not limited to the following elements. (1) Assess the resident for risk of entrapment from bed rails prior to installation. (2) Review the risks and benefits of bed rails with the resident or resident representative and obtain informed consent prior to installation. (3) Ensure that the bed's dimensions are appropriate for the resident's size and weight. This REQUIREMENT is not met as evidenced by: Based on clinical record review, facility policy review and interviews, the facility failed to provide adequate supervision to protect one (1) of eight (8) residents reviewed for falls (Resident #1). The facility identified a census of 46 residents. Finding include: 1. The Minimum Data Set (MDS) dated 1/29/17 documented diagnoses that included aural vertigo, chronic obstructive pulmonary disease and hypertension for Resident #1. The MDS documented the resident required extensive assistance of one staff for completion of transfer and toileting. Resident #1 was not steady and only able to stabilize with staff assistance when: moving on/off the toilet, when moving from a seated to standing positon, and during surface to	F 323		

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F 323	Continued From page 11 surface transfer (transfer between chair and bed or wheelchair). Resident #1 Brief Interview of Mental Status (BIMS) revealed a score of 14 which indicated intact cognitive skills. Resident #1 utilized a wheelchair for mobility and had no falls in the previous 90 days. The Hospitalist History and Physical dated 9/15/16 documented the additional diagnoses of legal blindness in left eye which affects the resident's balance and a closed comminuted fracture of the shaft of the right femur after a fall in the facility on 9/15/16. The care plan problem initiated 2/2/17 identified the resident with impaired mobility due to a fracture and required assistance of 1 for transfers. The care plan identified staff should supervise Resident #1 at all time while in the restroom. The Incident report dated 2/20/17 at 18:45 (6:45 PM) documented the resident found sitting on the floor of the bathroom facing the toilet and leaning against the wall with the resident's left leg bent and under the resident's right leg which had a brace in place. The resident's left knee and thigh looked swollen and the resident experienced pain when the leg touched or moved. Staff called 911 and the resident transferred to the hospital after ambulance personnel administered morphine (a narcotic pain medication) to the resident. The Progress Notes entry dated 2/20/17 at 21:23 (9:23 PM) documented the resident admitted to the hospital for treatment of a left distal femur fracture.	F 323		

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F 323	Continued From page 12 The Hospital History and Physical dated 2/20/17 at 11:55 p.m., revealed Resident #1 had hip pain after a fall at the nursing home and had been brought to the emergency room. Previous to this fall, Resident #1 had a right femur fracture that was surgically repaired and the resident had been in the nursing home for rehab and strengthening. The resident reported he/she is wheelchair bound. The resident denied any dizziness, lightheadedness or any chest pain. Upon the physician examination, the resident's left leg was in knee immobilizer and rated his/her pain at 7 out of 10 (ten being the highest); and his/her right leg in a brace. The resident reported receiving initial pain medication which helped, however now the pain resumed. The assessment revealed the resident had a closed fracture of the distal end of the left femur and a displaced peri-prosthetic fracture [on the right]. A progress notes dated 2/27/17 at 10:52 p.m. revealed Resident #1 returned to the nursing home and had a surgical incision to his/her left hip with 38 staples and a bilateral knee braces. Resident #1 is non-weight bearing an up only 1 hour at time. A Witness Statement from Staff E dated 2/20/17 at 7:45 p.m. regarding the incident revealed Resident #1 had been hanging on to the bar in the bathroom after he/she got up from the toilet. The resident had been leaving to the left side and Staff E went to his/her back side then the resident went down. The resident reported he/she was tired from therapy. During interview on 3/24/17 at 11:59 AM, Staff F, certified nursing assistant(CNA) stated she had been assigned to train Staff E, CNA, when the	F 323		

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F 323	Continued From page 13 incident occurred. She stated she assisted the resident's roommate and Staff E assisted Resident #1 in the bathroom. Staff F stated she did not use a gait belt to transfer residents, had never been issued one and no one educated her on how and when to use it. She felt she had not been trained properly and should have not been training new staff. Staff F stated she told the Administrator, Director of Nursing (DON) and the person in charge of scheduling staff about her concern with lack of training and no one did anything for her. Staff F stated she did not instruct Staff E to use a gait belt. Review of the personnel file for Staff F revealed the DON documented Staff F completed transfer belt competency on 1/26/17. During interview on 3/24/17 at 11:53 AM, Staff E stated Staff F assisted her to transfer Resident #1 to the toilet at the time of the incident. Staff E stated normally 1 staff would assist to transfer Resident #1. Staff E stated Staff F then assisted Resident #1's roommate while she stayed in the bathroom with Resident #1. Staff E stated she assisted the resident to pull of his/her pants and pivot to the wheelchair when the resident stated he/she's was going down. Staff E stated she thinks the resident's legs straddled the toilet but the resident's left leg looked bent in an abnormal way. Staff E stated she had ahold of Resident #1's shirt and pants from the back. Staff E stated she did not use a gait belt when transferring Resident #1 and did not know she should have used one, nor did she have one available. Staff E stated she never witnessed any other staff member use a gait belt unless state surveyors or corporate staff were present in the facility.	F 323		

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F 323	Continued From page 14 She stated she had worked for 2 month as a personal assistant to residents prior to becoming certified and witnessed other staff transfer Resident #1 in the same manner. During interview on 4/11/17 at 10:40 a.m., Staff H, CNA, stated a gait belt is issued to staff upon hire and to use it anytime you have to provide hands-on assistance to residents for transfers or ambulation. During interview on 3/23/17 at 3:50 PM, the Administrator stated Staff F never told him about her perceived lack of training. If she had, he would have provided more training time for her. The Administrator stated Staff E self-terminated after the incident and Staff F had been terminated by the facility. The facility's Transfer-Ambulation With a Transfer Belt policy revised in August, 2015 directed the following: POLICY: If is the policy of this facility that all associated utilize a transfer (gait) belts with resident during transfers ambulation and gait training. PURPOSE: The gait belt provides a firm grasping surface for the staff person and protects the resident from accidental trauma to the skin. It gives the resident a sense of security as it is tightened. The belt also allows the staff person to gradually lower a resident to the floor (if necessary) without injuring self or the resident. The procedure included step by step instructions for staff including the following : place the gait belt around the resident's waist, properly tighten the belt, bring the resident to a standing positon, grasp the belt to the resident's side while assisting him/her to stand.	F 323		

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F 323	Continued From page 15 If ambulating, walk slightly behind and to one side of the resident while holding on to the [gait] belt. If the resident starts to fall, draw the resident close to your body using the gait belt and slowly lower the resident to the floor.	F 323		
F 441 SS=D	483.80(a)(1)(2)(4)(e)(f) INFECTION CONTROL, PREVENT SPREAD, LINENS (a) Infection prevention and control program. The facility must establish an infection prevention and control program (IPCP) that must include, at a minimum, the following elements: (1) A system for preventing, identifying, reporting, investigating, and controlling infections and communicable diseases for all residents, staff, volunteers, visitors, and other individuals providing services under a contractual arrangement based upon the facility assessment conducted according to §483.70(e) and following accepted national standards (facility assessment implementation is Phase 2); (2) Written standards, policies, and procedures for the program, which must include, but are not limited to: (i) A system of surveillance designed to identify possible communicable diseases or infections before they can spread to other persons in the facility; (ii) When and to whom possible incidents of communicable disease or infections should be reported; (iii) Standard and transmission-based precautions	F 441		

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F 441	Continued From page 16 to be followed to prevent spread of infections; (iv) When and how isolation should be used for a resident; including but not limited to: (A) The type and duration of the isolation, depending upon the infectious agent or organism involved, and (B) A requirement that the isolation should be the least restrictive possible for the resident under the circumstances. (v) The circumstances under which 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; and (vi) The hand hygiene procedures to be followed by staff involved in direct resident contact. (4) A system for recording incidents identified under the facility's IPCP and the corrective actions taken by the facility. (e) Linens. Personnel must handle, store, process, and transport linens so as to prevent the spread of infection. (f) Annual review. The facility will conduct an annual review of its IPCP and update their program, as necessary. This REQUIREMENT is not met as evidenced by: Based on clinical and facility record reviews, observations and staff interviews, the facility failed to maintain an infection control program to provide a safe and sanitary environment to assist in development and transmission of disease and	F 441		

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F 441	Continued From page 17 infection. Additionally, the facility failed to assure staff adhered to infection control policies and procedures per accepted professional standards during cares of 2 of 11 current residents sampled (Residents #2 and #5). The facility identified a census of 46. . Findings include: 1. The Minimum Data Set (MDS) assessment dated 3/8/17 documented diagnoses that included Alzheimer's disease, diabetes mellitus and cerebral infarction for Resident #2. The same MDS documented the resident transferred, walked, used the toilet and performed personal hygiene activities with supervision. The assessment documented the resident as continent of bowel. The care plan problem dated 4/14/16 identified the resident as independent with toilet use, continent of bowel and incontinent of bladder at times and for staff to assist the resident as needed. The care plan did not identify any history or active Clostridium difficile infection. The Progress Notes dated 1/25/17 at 2:24 PM documented the resident passed a large amount of odiferous stool with mucous. The facility requested and received an order to perform a stool culture. The Progress Notes dated 1/25/17 at 8:34 PM documented the resident's stool culture tested positive for Clostridium difficile. The Progress Notes entry dated 1/26/17 at 9:24 AM documented the facility received an order for Flagyl (an antibiotic) 500 milligrams (mg) three times a day (TID) for 10 days.	F 441		

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F 441	Continued From page 18 A fax sent to the physician on 2/14/17 documented the resident continued to have loose stools with the odor indicative of Clostridium difficile infection. The fax also documented the resident completed antibiotic therapy on 2/7/17. Review of the same fax revealed the facility did not obtain a response from the physician until 3/7/17 at which time the physician ordered another stool culture for Clostridium difficile and directed to administer 1 packet of Banatrol+ (a supplement used to control diarrhea) daily. The Progress Notes dated 3/8/17 at 11:03 AM documented the lab notified the facility that Resident #2's stool culture tested positive for Clostridium difficile. The Provider notes dated 3/9/17 documented the resident as Clostridium difficile positive with completion of antibiotic and clinically improving. This note also documented to await addition of Banatrol and if unresponsive, the practitioner will consider an additional course of antibiotic. Observation on 4/10/17 at 2:50 PM revealed BM (bowel movement) soiled wash cloths in the bathroom sink, and 2 pair of soiled slacks hanging on the towel racks. The BM on the cloths, toilet riser and slacks had a foul odor and yellow in color. Staff J washed her hands in the sink which contained the soiled washcloths after she removed them and placed them in the isolation linen barrel in the resident's room. Observation on 4/10/17 at 3:00 PM revealed Staff J, CNA (certified nursing assistant)/CMA (certified medication aide) entered the resident's room and cleaned the sink with Micro-Kill bleach wipes because Staff J stated the resident has a Clostridium difficile infection. After wiping the all	F 441		

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F 441	Continued From page 19 the soiled areas with the bleach wipe Staff J washed her hands and left the room. The label of the Micro-Kill beach wipes directed the following: A 3-minute contact time is required to kill Clostridium difficile spores and to re-apply as necessary to ensure that the surface remains white the entire time. Observation revealed Staff J did not thoroughly wipe the sink with the Micro-Kill bleach wipe after she washed her hands or monitor the sink to assure 3 minutes of continual wet contact time. Observation on 4/11/17 at 8:15 AM revealed 3 pairs of soiled pants on the rack in the bathroom and a pair of underwear soiled with malodorous yellow, loose BM (bowel movement) on the floor in front of the toilet. An observation at 8:30 AM revealed the soiled underwear from the floor now sat in the dry bathroom sink. Observation of the resident revealed s/he put on a pair of the soiled pants previously observed hanging on the bathroom towel rack. Observation at 9:20 AM revealed the resident walked in the hallway outside his/her room. The resident wore the same soiled pants observed earlier. The resident stated s/he had just finished eating breakfast. Observation of the resident's door at 11:40 AM revealed no signage to direct staff and/or visitors to check with the charge nurse prior to entry of the room. During interview on 4/11/17 at 8:50 AM the Director of Nursing (DON) stated the resident had not had a negative Clostridium difficile culture but s/he had not been symptomatic. The DON stated staff are still to use isolation precautions and the resident to remain in a private room. The facility's Clostridium Difficile policy, revised	F 441		

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F 441	Continued From page 20 11/16, documented the following: Description: Clostridium difficile is a spore forming bacterium that causes diarrhea and more serious intestinal conditions such as colitis, sepsis, and rarely death. Symptoms of C. diff disease include watery diarrhea, fever, loss of appetite, nausea, abdominal pain/tenderness. Disease usually follows administration of antibiotics. During interview on 4/11/17 at 10:30 AM Staff D, CNA stated the resident has frequent loose foul stools with mucous, like the type with Clostridium difficile. When asked if Staff D had reported this finding to the nurses, she replied they already know the resident has Clostridium difficile. During interview on 4/11/17 at 10:40 AM, Staff H, CNA stated the resident has episodes of foul loose stools and some formed stools. She stated the resident usually does pretty well with personal hygiene when incontinent of bowel and will ask for assistance when needed. Staff H stated she did not know if the resident washes his/her hands after personal hygiene but she has the resident wash his/her hands after she performs care. Review of the Progress Notes for Resident #2 revealed no documentation of continued symptoms of Clostridium difficile infection as noted by the CNA staff. 2. During record review and interview on 4/11/7 at 8:45 AM the DON provided a Monthly Infection Rates By Site list for January and February, 2017. The report documented three residents identified with Clostridium difficile infection in January, 2017 and no residents infected in February, 2017. During interview the DON stated the report only	F 441		

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F 441	Continued From page 21 tracks new infections, so existing infections do not carry over into the preceding month even if the resident still has an infection. The DON agreed the calculation of the facility's health acquired infection rate was inaccurate because of failure to carry over continuing infections. The DON stated that she and the MDS Coordinator reviewed infections daily during Quality Assurance Performance in Improvement (QAPI) meeting and reviewed the infection report monthly with the facility's Medical Director. The DON stated all documentation regarding the facility's infection control program would be part of their QAPI program. Review of the facility's Infection Prevention Program Overview revised 11/16 documented the following: I. Goals A. Decrease the risk of infection to residents/patients and personnel. B. Prevent, to the extent possible, the onset and spread of infection. Monitor for kinds of infection control outbreaks and cross-contamination. D. Monitor for occurrence of infection and implement appropriate control measures. E. Identify and correct problems relating to infection prevention practices. F. Maintain compliance with state and federal regulations and standards of practice relating to infection prevention and control The Major Activities Of The Program Are: A. Surveillance of infections with implementation of prevention of infections and control measures. There is ongoing monitoring and identifying infectious and communicable diseases among residents, personnel, visitors and others providing services at the facility; subsequent documentation	F 441		

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F 441	Continued From page 22 and investigation of infections that occur. Analysis of data is done ongoing and documentation is completed and reported to the Infection Prevention Committee. 3. According to a Diagnosis list dated 4/11/17, Resident #5's diagnoses included quadriplegia (paralysis of both arms and legs), gonococcal (bacteria that causes gonorrhea) genitourinary (organ system of the reproduction organs and urinary system) infections, muscular sclerosis, neuromuscular dysfunction of the bladder and urinary tract infection. Resident #5's 3/27/17 MDS assessment documented the resident had a BIMS score of 7, indicating severely impaired memory and cognition. The resident required the assistance of 2 staff with bed mobility, toilet use and dressing. The MDS revealed the resident required the use of a indwelling urinary catheter. A Braden Scale Assessment for Predicting Pressure Sore Risk form dated 3/18/17 identified the resident at high risk with a score of 12. A Patient Discharge Instructions form, dated 3/18/17, included the following orders: a) Irrigate the resident's left ischium (lower back area of the hip) ulcer with 1/2 strength peroxide and normal saline, rinse with normal saline, pack the wound with Dakins (an antiseptic that kills bacteria and viruses) solution moist gauze and cover with dry dressing. b) Mepilex border dressing to the right Ischium every other day. Review of Resident #5's Non-Pressure Skin Condition Report forms revealed the following	F 441		

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F 441	Continued From page 23 assessments: a. 3/27/17 - Left Ischium - 6. 1 centimeter (cm) by 2.5 cm open area with depth of 0.3 cm. Staff documented a small amount of serosanguinous dressing and a slight odor. b. 4/1/17 - Right Ischium - Staff assessed the area as old scar tissue and the area as not open. Observation on 4/10/17 at 1:05 P.M., revealed the resident sat in a wheelchair (w/c) in his/her room with a purple colored blanket over his/her lap and legs. Ongoing observation revealed Staff A, CNA and Staff B, CNA, transferred the resident from his/her w/c to his/her bed via a Hoyer lift (a mechanical lift) and full body sling, rolled the resident from side to side, removed the sling and Staff A placed the sling on the floor. Closer observation of the Hoyer sling on the floor revealed the same purple blanket that covered the resident's lap and legs lay directly on the floor as well. Staff A then removed the resident's heel protectors, brief and pants. At 1:10 P.M., Staff A picked up the purple blanket off of the floor, placed the blanket over the resident's waist and legs and directly on top of a portion of the resident's urinary catheter that rested on top of the resident's left leg. At 1:15 P.M., Staff B, placed the Hoyer lift sling that had been on the floor into a plastic bag. Ongoing observation revealed Staff A and Staff B prepared to perform Resident #5's perineal cares. While the resident lay on his/her back, Staff A cleansed the resident's anterior perineal area Staff A and Staff B rolled the resident to his/her left side and Staff B reported the 2 dressings on the resident's right and left ischiums as wet. Staff A left the room to report the wet dressings to a nurse. At 1:20 P.M., Staff C, Licensed Practical Nurse	F 441		

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F 441	Continued From page 24 (LPN) entered the resident's room, assessed the resident and questioned if the resident's urinary catheter leaked. Staff C gathered supplies to flush the resident's catheter patency. Staff C used normal saline in a 60 cc syringe, flushed the resident's catheter tubing and repeated a flush with 60 cc of normal saline. Staff C reported the normal saline came out of the resident's catheter tubing faster than she instilled the flush and noted the catheter needed to be changed. Staff C left the room to obtain a urinary catheter insertion kit and Staff A and Staff B rolled the resident on to his/her back. At 1:25 P.M., Staff C re-entered the room, washed her hands, donned gloves, deflated the bulb on the end of the catheter and removed the non-functioning urinary catheter. Staff A and Staff B rolled the resident to his/her left side and observation revealed the resident's bottom bed sheet as highly saturated with fluid (and the resident's exposed buttocks with dressings on each ischium, lay directly on the highly saturated sheet. The bed sheet became saturated after Staff C flushed the resident's non-functioning urinary catheter. Because the catheter did not function, the saline flush and other contents of the resident's bladder and catheter tubing saturated the resident's bed sheet. At 1:30 P.M., ongoing observation revealed Staff C inserted a new urinary catheter. Staff C next prepared to change the resident's dressings on both buttocks due to the dressings being wet. Staff C used hand sanitizer, donned gloves, removed the packing from the resident's left ischium ulcer and placed new gauze, soaked in Dakins solution, into the left ischium ulcer. Staff C placed new dressings to cover both the areas on the left and right ischiums. Observation revealed the dressings failed to adhere to the resident's skin and Staff C stated the dressing	F 441		

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F 441	Continued From page 25 had not adhered due to the resident's skin being wet. Observation revealed neither Staff A or Staff B cleansed the resident's buttock areas after exposure to the saturated wet sheets prior to the dressing changes and Staff C failed to cleanse the resident's buttock or areas under the wet dressings, prior to the newly packed gauze and/or dressing changes. Staff C reported she needed to replace the newly changed dressings due to non-adherence. Staff C obtained new Mepilex dressings, used hand sanitizer, donned gloves, placed skin prep around both ischium areas that required dressings and placed new dressings over the resident's right and left ischium areas. Staff C again failed to cleanse the resident's buttock areas and or the ischium areas under the dressings. Ongoing observation at 1:40 P.M., revealed Staff A rolled the resident to his/her back, positioned again on the saturated wet bed sheet, exposed the resident's bare buttock areas and dressings to the saturated wet bed sheet. Ongoing observation revealed Staff B washed her hands, donned gloves and repeated the resident's anterior perineal care. Staff A rolled the resident to his/her left side and Staff B cleansed the buttock area around the resident's dressing on his/her right buttock and hip. Staff B tucked 1/2 of the wet bed sheet under the resident's left buttock, wiped the wet mattress of with a perineal wipe (an Aloetouch personal cleansing cloth) and dried that part of the mattress with a towel. Staff A rolled the resident to his/her right side and cleansed the buttock around the resident's dressing on his/her left buttock and hip. Staff B tucked the other half of the resident's wet bed sheet under the resident, wiped the wet mattress off with a perineal wipe and dried that part of the mattress with a towel. Staff A then placed a clean bed sheet under the resident.	F 441		

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EMBASSY HEALTHCARE COMMUNITY	206 PORT NEAL ROAD SERGEANT BLUFF, IA 51054

(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 26 During interview on 4/11/17 at 12:40 P.M., the facility's Environmental Supervisor stated at the times a resident's mattress is wet with urine, staff needed to use either Microkill Bleach Germicidal Wipes or Virex #265 (disinfectant cleanser). During interview on 4/12/17 at 8:35 A.M., Staff B reported she placed the resident's Hoyer sling into a plastic bag because the sling had been directly on the floor. Staff B stated she did not know the resident's blanket was also on the floor. During interview on 4/12/17 at 10:50 A.M., the DON confirmed she expected staff to not place a blanket that lied directly on the floor immediately over a resident. The DON stated she expected staff to remove the saturated wet sheet, prior to cleansing the resident's buttocks and/or performing a dressing change and she expected staff to wash a resident's mattress off with Micro-Kill disinfectant wipes if wet with urine. A facility policy for Cleaning Resident Equipment, revised 9/15, included a purpose to ensure all resident equipment be sanitized using an EPA (Environmental Protection Agency) approved guidelines to assist in the prevention of spread of infection. The policy included a plan for all mattresses to be wiped down using an EPA approved disinfectant.	F 441		

Embassy Healthcare Community Plan of Correction

5/7/2017

F278 Assessment Accuracy/Coordination/Certified

Immediate Corrective Action

Department heads responsible for MDS completion have been educated on the policy for timely completion of MDS for Resident #6 and resident #10.

Action as it Applies to Others

Department heads respobsible for MDS completion have been educated on the policy for timely completion of all MDS's.

Recurrence will be prevented by

The department heads have been educated on timeliness and accuracy of all MDS following the guidelines of the RAI manual.

The correction will be monitored by

The DON or designee will monitor for accurate and complete MDS completion; following the RAI guidelines weekly. These audits will be reported to the QAPI committee monthly and the QAPI committee will determine how long to continue audits.

F309 Provide Care/Services for Highest Well Being

Immediate Corrective Action

The physician has been notified of resident #1's frontal genital skin breakdown. A wound ARNP rounded on the resident and provided an updated treatment for the area and a skin assessment is being completed weekly by a licensed nurse.

Resident #2's physician gave order that resident's c.diff infection is dormant on 4/28/2017.

Action as it Applies to Others

Licensed nurses have been educated on notifying physician of assessments outside of normal limits and obtaining orders to treat.

Recurrence Will be Prevented by

Licensed nurses have been educated to notify physician of assessments outside of normal limits, timely and obtain orders to treat.

The Correction Will be Monitored by

Weekly audits of nurses progress notes will be conducted for appropriate interventions and notification of physician by DON or designee. These audits will be reported to the QAPI committee monthly and the QAPI committee will determine how long to continue these audits.

F312 ADL Care Provided for Dependent Residents

Immediate Corrective Action

Resident #6 and Resident #9 are receiving baths weekly according to facility policy.

Action as it Applies to Others

Residents at Embassy are receiving baths according to facility policy

Recurrence will be Prevented by

The bathing aides have been educated on timely and appropriate documentation of completed baths. The baths will be completed according to the bathing schedule, unless otherwise requested by the resident.

The Correction Will be Monitored by

Weekly audits of the bathing schedule will be conducted by DON or designee to monitor for completion of baths according to facility policy. These audits will be reported to the QAPI committee monthly and the QAPI committee will determine how long to continue these audits.

F323 Free of Accident Hazards/Supervision/Devices

Immediate Corrective Action

Resident #1 was sent to the hospital on 2/20/2017 and admitted with a distal left femur and peri-prosthetic fracture.

Action as it Applies to Other

Staff F was terminated was terminated and staff E self-terminated.

Recurrence will be Prevented by

Direct care givers were re-educated on the transfer/gait belt policy

The Correction Will be Monitored by

Transfer audits will be completed weekly by DON or designee to monitor for gait belt usage. These audits will be reported to the QAPI committee monthly and the QAPI committee will determine how long to continue these audits.

F441 Infection Control, Prevent Spread, Linens

Immediate Corrective Action

Resident #2's bathroom surfaces were cleaned with bleach wipes. Resident #2 received a shower at 0940 on 4/11/2017 and was not wearing the soiled pants. Resident #2's physician wrote an order on 4/28/2017 that the c.diff infection is dormant.

Resident #5's blanket was washed appropriately, dressings were changed and clean, mattress was cleaned with micro-kill disinfectant wipes and linens were changes.

Action as it Applies to Others

Resident's with an active MDRO have appropriate signage on their door to alert staff according to facility policy. Staff were educated on clean linens and dressings during incontinent care.

Recurrence Will be Prevented by

Staff are educated on infection control with incontinence care and MDRO's.

The Correction will be Monitored by

The DON or designee will conduct weekly peri-care audits. These audits will be reported to the QAPI committee monthly and the QAPI committee will determine how long to continue these audits.