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
	165198	A. BUILDING _____ B. WING _____	04/27/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
IOWA CITY REHAB & HEALTH CARE	3661 ROCHESTER AVENUE IOWA CITY, IA 52245

(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 Amended F329 scope/severity on October 3, 2017 after CMS review. Correction date 5/5/17 The following deficiencies relate to the recertification survey and investigation of Complaint #67627-C conducted 4/24 - 4/27/17. Complaint #67627-C was substantiated. See Code of Federal Regulations (42CFR) Part 483, Subpart B-C.	F 000		
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	F 309		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE: Administrator | (X6) DATE: 05/25/2017

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.

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F 309	Continued From page 1 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 record review and interview, the facility failed to assess the dialysis access site for 1 of 1 residents on dialysis (Resident #11) and failed to assess and document a change in condition for 1 of 9 residents sampled (Resident #2). The facility census included 67 residents. Findings include: 1. The MDS(Minimum Data Set) assessment tool, dated 3/23/17, listed diagnoses for Resident #11 included diabetes mellitus, depression, and end stage renal disease. The MDS stated the resident required supervision assistance of 1 staff for eating, extensive assistance of 1 staff for bed mobility, transfers, dressing, and personal hygiene, extensive assistance of 2 staff for toilet use, and depended totally on 1 staff for bathing. The MDS listed the resident's BIMS(Brief Interview for Mental Status) score as 15 out of 15, indicating intact cognition. The care plan, initiated 7/21/16, stated the resident required dialysis and directed staff to	F 309		

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F 309	Continued From page 2 monitor for signs/symptoms of infection at the dialysis access site. A 4/26/17 telephone order per the dialysis clinic directed staff to keep gauze and tegaderm in place over the port, monitor for localized redness, swelling, pain, or excess drainage on gauze every shift. The resident's April 2016 MAR(Medication Administration Record) lacked documentation of assessments of the resident's dialysis access site. During an interview on 4/26/17 at 11:31 a.m., the Director of Nursing stated the nurses should be assessing the dialysis port. She stated there should be a place on the MAR(Medication Administration Record) for the nurses to chart this. 2. The MDS assessment tool, dated 2/21/17, listed diagnoses for Resident #2 included diabetes, depression, and mild intellectual disability. The MDS stated the resident required extensive assistance of 2 staff for bed mobility, transfers, dressing, toilet use, and personal hygiene and depended totally on 1 staff for bathing. The MDS listed the resident's BIMS score as 14 out of 15, indicating intact cognition. The April 2016 MAR displayed an order for Gentamycin Sulfate Solution 0.3 %(an antibiotic), 1 drop in both eyes 5 times a day for infected left eye for 7 days. The MAR indicated the resident received the eye drops from 4/13/17-4/20/17. A 4/13/17 9:37 a.m. nursing note stated the facility received a telephone order for Gentamycin	F 309		

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F 309	Continued From page 3 0.3% eye drops 1 drop to both eyes every 4 hours while awake. Review of nursing notes 4/1/17-4/26/17 revealed the facility lacked documentation of assessments of the resident's eye. The facility lacked documentation as to why the resident required the antibiotic or the condition of the resident's eye both before and after the administration of the Gentamycin. During an interview on 4/27/17 at 9:39 a.m., the Director of Nursing stated she would expect the nurses to document and assess the eye.	F 309		
F 314 SS=D	483.25(b)(1) TREATMENT/SVCS TO PREVENT/HEAL PRESSURE SORES (b) Skin Integrity - (1) Pressure ulcers. Based on the comprehensive assessment of a resident, the facility must ensure that- (i) A resident receives care, consistent with professional standards of practice, to prevent pressure ulcers and does not develop pressure ulcers unless the individual's clinical condition demonstrates that they were unavoidable; and (ii) A resident with pressure ulcers receives necessary treatment and services, consistent with professional standards of practice, to promote healing, prevent infection and prevent new ulcers from developing. This REQUIREMENT is not met as evidenced by: Based on observation, record review, and interview, the facility failed to properly assess and	F 314		

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F 314	Continued From page 4 treat 1 of 6 residents with pressure ulcers (Resident #1). The facility reported a census of 67 residents. Findings: 1. The MDS(Minimum Data Set) assessment tool, dated 4/4/17, listed diagnoses for Resident #1 included schizophrenia, weakness, and delirium. The MDS stated the resident required supervised assistance for walking and eating, limited assistance of 1 staff for toilet use and personal hygiene, and extensive assistance of 1 staff for bathing. The MDS listed the resident's BIMS(Brief Interview for Mental Status) score as 6 out of 15, indicating severely impaired cognition. During an observation on 4/24/17 at 12:37 p.m., Staff F RN(Registered Nurse) assisted the resident in the bathroom. Staff F removed the resident's incontinent brief and noted the resident had an open area on the left buttock which was yellow in color on the inside with pink edges. No dressing present on the open area at this time. Staff F stated to the resident she needed to go get the resident's "Band-Aid". The resident pulled his/her pants up and Staff F left the resident's room. Staff F did not immediately return to the room and the resident walked out to the nursing station. At 1:00 p.m., Staff F stated she was ready to complete the dressing and re-entered the resident's room with the resident. The resident laid in bed on the left side and Staff F measured the area on the left buttock as 0.7 cm(centimeters) x 0.7 cm. She then cleansed the area with saline and placed an Exuderm LP Hydrocolloid wound dressing(a dressing used to promote wound healing) on the area.	F 314		

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F 314	Continued From page 5 The resident's Skin Grid For Pressure Ulcers stated the facility discovered a Stage 2 pressure ulcer on 4/5/17 on the left buttock with measurements of 1.8 cm x 1 cm x 0.1 cm(length x width x depth). The sheet listed the wound's 4/12/17 measurements as 0.6 cm x 0.8 cm x 0 cm. The April 2017 TAR(Treatment Administration Record) displayed a 4/24/17 order for Exuderm dressing 1 time a day every 3 days. The record lacked documentation the resident received a treatment during the time period of 4/5/17-4/23/17. Progress notes during the period of 4/5/17-4/23/17 lacked documentation of physician notification of the pressure ulcer or a treatment order. The facility also lacked wound measurements for the time period of 4/12/17-4/24/17. The care plan, dated 4/17/17, stated the resident had one pressure ulcer at a Stage 2 with a goal for the resident to show signs of healing and remain free from infection. The care plan directed staff to assess/record/monitor the wound healing weekly and report improvements and decline to the provider. The facility Skin Care and Wound Management Treatment Protocol for Stage 2 Pressure Ulcers, dated 9/11, defined a Stage 2 pressure ulcer as a partial thickness loss of dermis presenting as a shallow open ulcer with a red pink wound bed, without slough. The policy directed staff to obtain an order for a treatment, measure the wound no less than weekly, and verify interventions in	F 314		

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F 314	Continued From page 6 place. During an interview on 4/26/17 at 9:03 a.m., Staff F stated she first saw the resident's wound "about a week ago". She stated there wasn't a dressing in place at that time and no treatment orders until she phoned the provider on 4/24/17 to obtain the order for the Exuderm dressing. She stated she would have expected a dressing order to be in place prior to this. Staff F stated the nurse in charge of wounds was "overwhelmed" and Staff F stated she(Staff F) was "embarrassed" there was no order in place. During an interview on 4/27/17 at 9:39 a.m., the Director of Nursing stated the facility had skin issues and she would create a document for the staff indicating expectations for wounds. She stated the family and physician should be notified of the wound and a treatment should be in place. She stated skin assessments should be done daily and measurements should be done weekly. She stated if there was no improvement in the wound, the treatment should be changed.	F 314		
F 329 SS=D	483.45(d)(e)(1)-(2) DRUG REGIMEN IS FREE FROM UNNECESSARY DRUGS 483.45(d) Unnecessary Drugs-General. Each resident's drug regimen must be free from unnecessary drugs. An unnecessary drug is any drug when used--- (1) In excessive dose (including duplicate drug therapy); or (2) For excessive duration; or (3) Without adequate monitoring; or	F 329		

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F 329	Continued From page 7 (4) Without adequate indications for its use; or (5) In the presence of adverse consequences which indicate the dose should be reduced or discontinued; or (6) Any combinations of the reasons stated in paragraphs (d)(1) through (5) of this section. 483.45(e) Psychotropic Drugs. Based on a comprehensive assessment of a resident, the facility must ensure that-- (1) Residents who have not used psychotropic drugs are not given these drugs unless the medication is necessary to treat a specific condition as diagnosed and documented in the clinical record; (2) Residents who use psychotropic drugs receive gradual dose reductions, and behavioral interventions, unless clinically contraindicated, in an effort to discontinue these drugs; This REQUIREMENT is not met as evidenced by: I. Based on record review, facility policy and staff interviews, the facility failed to administer Coumadin (blood thinner) medications as ordered by the physician for 1 of 2 residents reviewed (Resident #9). Record review identified staff administered Coumadin/Warfarin Sodium medication incorrectly to Resident #9 for multiple days. Resident #9 required treatment with Vitamin K for anticoagulation reversal to address his/her elevated INR (International Normalized Ratio) level. The facility reported a census of 67	F 329		

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F 329	Continued From page 8 residents. Findings Include: Record review of Minimum Data Set (MDS) for resident #9 dated 3/4/17 reveals a Diagnoses Atrial Fibrillation, Hip Fracture, Schizophrenia and Diabetes. Resident #9 scored 14 out of 15 on the Brief Interview for Mental Status (BIMS) cognitive test, indicating he/she cognitively intact. The resident's care plan dated 2/13/17 revealed he/she required the used of warfarin medication and would have no complications from anticoagulant therapy. Staff will administer medications as ordered. The signed [physician's] Order Summary Report dated 4/11/17 documented an order for 10 milligrams (mg) of Warfarin Sodium Tablet (Coumadin) administered in the evening every Monday and Thursday for unspecified Atrial Fibrillation. The order called for 7.5 milligrams (mg) of Coumadin administered in the evening every Sunday, Tuesday, Wednesday, Friday and Saturday. Record review of Resident #9's Medication Administration Record for April 2017 revealed both 10 mg of Coumadin and 7.5 mg of Coumadin had been administered (signed out) for Monday 4/17/17 and Tuesday 4/18/17. (Resident #9's physician's order called for 10 mg of Coumadin on Monday 4/17/17; and called for 7.5 mg of Coumadin on Tuesday (4/18/17.) The MAR and Progress Notes dated 4/19/17	F 329		

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F 329	Continued From page 9 identified the correct dose of Coumadin had been administered on 4/19/17 by Staff H, Registered Nurse. The MAR for Thursday 4/20/17, Friday 4/21/17, Saturday 4/22/17 and Sunday 4/23/17 revealed staff administered both the 10 mg of Coumadin and the 7.5 mg of Coumadin daily. (The MAR showed Resident #9 received 17.5 mg of Coumadin daily from 4/20/17- to 4/23/17.) The State surveyor noticed the Coumadin medication errors on the MARs on 4/24/17. On 4/24/17 at 12:45 p.m. an interviewed with Staff F, Registered Nurse (RN) and Assistant Director of Nursing (ADON) about dose of Coumadin medication currently being administered. Staff F (RN) verified the wrong dose of medication had been administered with nurses. Staff F stated the medication error[s] related to data entry in the electronic Medication Administration Record. She contacted the physician and received order to check Resident #9's International Normalized Ration (INR). The Progress Notes written by Staff F dated 4/24/17 at 4:29 p.m., revealed the following: On 4/16/17, the [Coumadin] order accidently changed in MAR to give both Coumadin does daily, 10 mgs ordered for Monday and Thursdays and 7.5 mg Coumadin the other five days [Tuesday, Wednesday, Friday, Saturday and Sunday]. The error[s] brought to nurses attention, and lab results were obtained for INR, with the results at 6.4. (Resident #9's prior INR laboratory results dated 4/4/17 revealed a therapeutic level of 2.4.) [A therapeutic INR range is normally under 4.] The same progress notes identified the physician ordered 5 mg of Vitamin K1 Solution	F 329		

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F 329	Continued From page 10 subcutaneously and to hold the Coumadin and daily check the resident's INR. Progress Notes dated 4/25/17 revealed Resident #9 INR's at 4.0 and the physician was notified. Interview with Staff G, (RN) 4/25/17 at 7:40 a.m., admitted she gave 17.5 mg Coumadin that was on electronic medication administration record (EMAR) on 4/22/17. When asked whether if she questioned the large dose of medication, Staff G responded, yes and stated she gave it anyways. Interview with Staff H, (RN) 4/25/17 at 10:50 AM did verify that only gave the 7.5 mg dose of Coumadin on 4/19/17 which was the correct dose, stated did not notify anyone that EMAR was incorrect. Interview with Director of Nursing (DON) 4/25/17 at 7:30 a.m., regarding Coumadin medication administered to Resident #9, she stated the Assistant DON had entered the order wrong into the computer system: The DON stated the nurses administering the medication should have questioned the dosage and the pharmacy label did not match the eMAR. The DON reported all other Coumadin orders were verified. The facility provided guidelines for medication administration dated 1/13. Policy/Procedure to verify medication administration according to physician's orders. Staff should verify the pharmacy label on the drug and the manufacturer's identification system matches the MAR. If there is a discrepancy, check the original physician's order and notify the pharmacy; do not give the medication until clarified.	F 329		

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F 329	Continued From page 11 II. Based on record review, staff interview and policy review, the facility nursing staff failed to implement non-pharmacological interventions prior administration of as needed (PRN) antianxiety medications on 3 of 3 residents reviewed (Residents #3, #5, and #6). The facility reported a census of 67 residents. Findings Include: 1. Resident #5's Minimum Data Set (MDS) 30-day assessment completed 3/30/17 had documentation of the following diagnoses to include: schizophrenia, chronic obstructive pulmonary disease (COPD), and hypertension (high blood pressure). It also identified the resident as cognitively intact with a Brief Interview for Mental Status (BIMS) score of 14 out of 15, required extensive assistance of 1 to 2 staff with most activities of daily living. The care plan with the revision date of 4/25/17 identified the resident with a mood disorder and a goal that the resident will have improved mood state (Specify: happier, calmer appearance, no signs or symptoms of depression, anxiety or sadness). The nursing staff directed to administer medications as ordered, assist the resident to identify strengths, positive coping skills and the Certified Nurse Aide (CNA) to reinforce these. Monitor/record/report to the doctor mood patterns, signs and symptoms of depression, anxiety, sad mood as per facility behavior monitoring protocols. Review of the Medication Administration Record (MAR) for March 2017 displayed an order for	F 329		

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F 329	Continued From page 12 Resident #5 of lorazepam (an antianxiety medication) 1 milligram, 1 tablet by mouth every 6 hours as needed (PRN) for anxiety. Noted the order date to be 3/2/2107 on the resident's admit date. Further review of the MAR shown the PRN lorazepam recorded to be given to the resident 19 times in the month with no non-pharmacological interventions documented as attempted prior administration. Review of the Progress Notes for the resident in that time frame also revealed lack of documentation any non-pharmacological interventions attempted prior the medication given and nothing charted that the resident requested the PRN antianxiety medication at those times. Review of the MAR for April 2017 displayed the same order for Resident #5 of lorazepam (an antianxiety medication) 1 milligram, 1 tablet by mouth every 6 hours as needed (PRN) for anxiety. Further review of the MAR indicated the staff administered the PRN lorazepam to the resident 13 times in the month between the dates of 4/1/17 to 4/24/17 without non-pharmacological interventions attempted prior administration. Review of the Progress Notes for the resident in that time frame revealed lack of documentation of non-pharmacological interventions attempted prior the administration of medication and staff failed to charted the resident requested the PRN antianxiety medication at those times. 2. Resident #6's Minimum Data Set (MDS) admission assessment completed 2/10/17 had documentation of the following diagnoses to include: anxiety, paraplegia and depression. It also identified the resident as cognitively intact	F 329		

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F 329	Continued From page 13 with a Brief Interview for Mental Status (BIMS) score of 15 out of 15, required extensive assistance of 1 to 2 staff with most activities of daily living. The care plan with the revision date of 2/18/17 identified the resident with a goal of the resident to remain free of signs and symptoms of distress, depression, anxiety or sad mood. The nursing staff directed to administer medications as ordered and monitor/document side effects and effectiveness. Also to monitor document/report to the nurse or doctor signs /symptoms of depression, anxiety, repetitive anxious or health-related complaints. The resident needs time to talk and encourage the resident to express feelings. Review of the MAR for February 2017 displayed an order for Resident #6 of diazepam (an antianxiety medication) 5 milligram, 1 tablet by mouth every 6 hours as needed (PRN) for anxiety. Noted the order date to be 2/3/2107 on the resident's admit date. Further review of the MAR revealed the staff administered PRN diazepam given to the resident 11 times in the month without no non-pharmacological interventions documented prior to administration. Review of the Progress Notes for the resident in that time frame also revealed lack of documentation of non-pharmacological interventions attempted prior the medication given and also nothing charted that the resident requested the PRN antianxiety medication at those times. Review of the MAR for March 2017 displayed the same order for Resident #6 of diazepam (an antianxiety medication) 5 milligram, 1 tablet by	F 329		

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F 329	Continued From page 14 mouth every 6 hours as needed (PRN) for anxiety. Further review of the MAR showed the staff administered PRN diazepam to the resident 23 times in the month without no non-pharmacological interventions documented prior to administration. Review of the Progress Notes for the resident in that time frame revealed lack of documentation of non-pharmacological interventions attempted prior the medication given and also nothing charted that the resident requested the PRN antianxiety medication at those times. Review of the MAR for April 2017 displayed the same order for Resident #6 of diazepam (an antianxiety medication) 5 milligram, 1 tablet by mouth every 6 hours as needed (PRN) for anxiety. Further review of the MAR showed the PRN diazepam recorded given to the resident 7 times in the month between the dates of 4/1/17 to 4/25/17 with no non-pharmacological interventions documented as attempted prior administration. Review of the Progress Notes for the resident in that time frame lack documentation of non-pharmacological interventions attempted prior the medication given and also nothing charted that the resident requested the PRN antianxiety medication at those times. During an interview on 4/26/17 at 2:16 p.m., Staff E, Licensed Practical Nurse reported prior to administering a PRN antianxiety medication to a resident interventions should be attempted such as giving the resident a snack, reposition the resident, offer toileting or just talk to the resident. Staff E demonstrated how the PRN medications are checked off and charted on in the facility's computer system when given.	F 329		

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F 329	Continued From page 15 Review of the Medication Management Policy dated 5/14 stated the resident/patient's medication regimen is managed and monitored to promote and/or maintain his/her highest practicable, mental, physical, and psychosocial; well being. The nursing staff directed to verify indications for the use of medications are documented in the resident/patient medical record and include medication related goals, parameters for monitoring resident/patient condition in the care plan to include non-pharmacological interventions as indicated. 3. The MDS assessment tool, dated 1/29/17, listed diagnoses for Resident #3 included depression and schizophrenia. The MDS stated the resident required extensive assistance of 1 staff for personal hygiene and bathing and extensive assistance of 2 staff for bed mobility, transfers, and toilet use. The MDS listed the resident's BIMS(Brief Interview for Mental Status) score as 14 out of 15, indicating intact cognition. The April 2017 MAR(Medication Administration Record) displayed an order for lorazepam(a medication used to treat anxiety) 0.5 mg(milligrams), 1 tablet by mouth every 8 hours as needed. The record indicated the resident received the medication 14 times during the period of 4/2/17-4/24/17. The facility lacked documentation during the period of 4/2/17-4/24/17 of non-pharmacological interventions attempted prior to the administration of the as needed lorazepam. During an interview on 4/25/17 at 2:44 p.m., the Director of Nursing stated she expected the nurses to attempt and chart 2-3	F 329		

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F 329	Continued From page 16 non-pharmacological interventions prior to the administration of as needed anti-anxiety medications.	F 329		
F 364 SS=E	483.60(d)(1)(2) NUTRITIVE VALUE/APPEAR, PALATABLE/PREFER TEMP (d) Food and drink Each resident receives and the facility provides- (d)(1) Food prepared by methods that conserve nutritive value, flavor, and appearance; (d)(2) Food and drink that is palatable, attractive, and at a safe and appetizing temperature; This REQUIREMENT is not met as evidenced by: Based on observation, record review, and interview, the facility failed to maintain adequate hot holding temperatures for 1 of 1 meals observed. The facility reported a census of 67 residents. Findings included: 1. During the group interview on 4/24/17 at 1:45 p.m., 2 out of 5 interviewable residents stated the food was sometimes not hot enough. The residents stated this could happen during any meal. During an observation of the noon meal service on 4/25/17, Staff C Cook obtained the following food temperatures prior to the food service: a. Hash browns---196.5 degrees Fahrenheit at 11:05 a.m. b. Green beans---184 degrees Fahrenheit at	F 364		

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F 364	Continued From page 17 11:22 a.m. c. Pork ribs(also used for ground pork)---171.1 degrees Fahrenheit at 11:28 a.m. During an observation on 4/25/17 at 11:50 a.m., Staff A CNA(Certified Nursing Assistant) and Staff B CNA began delivering room trays. After the staff delivered the last room tray, the surveyor obtained the following temperatures at 12:05 p.m.: a. Hash browns---110 degrees Fahrenheit b. Green beans---129 degrees Fahrenheit c. Pork ribs---112 degrees Fahrenheit Staff C began serving the West Dining Room at 11:48 a.m. the staff took the steam table to the East Dining Room and began serving at 12:21 p.m. Staff C stated he served the last resident tray at 12:38 p.m. The surveyor then immediately requested a test tray and Staff C obtained the following food temperatures: a. Hash browns---110 degrees Fahrenheit at 12:40 p.m. b. Green beans---100 degrees Fahrenheit at 12:40 p.m. c. Pork ribs---100 degrees Fahrenheit at 12:40 p.m. d. Ground pork ribs--- 90 degrees Fahrenheit at 12:40 p.m. At this time the surveyor tasted the food and found it lukewarm. The facility Sanitation and Food Production policy, dated June 2015, directed the facility to serve hot foods above 140 degrees Fahrenheit. During an interview on 4/25/17 at 12:45 p.m., the Administrator stated she would put a plan in place to help maintain food temperatures.	F 364		

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F 364	Continued From page 18 During an interview on 4/25/17 at 2:21 p.m., the facility Dietician Consultant stated hot holding temperatures should be a minimum of 165 degrees Fahrenheit.	F 364		
F 371 SS=E	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. (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, record review, and interview, the facility failed to maintain adequate kitchen sanitation and failed to assure sanitary food handling practices. The facility reported a	F 371		

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F 371	Continued From page 19 census of 67 residents. Findings include: The initial kitchen tour on 4/24/17 at 9:30 a.m. revealed the following concerns: a. A sticky red substance on the floor of the Unit 1 refrigerator b. A flaky white substance on the outside of the ice machine c. Crumbs and shreds of cheese on the floor of the Unit 5 refrigerator d. A red substance covering boxes and the floor inside the Unit 4 freezer e. Brown and white flakes covering the top of the dishwashing machine During an observation on 4/25/17 at 11:25 a.m., Staff D Cook wore gloves and touched plate lids with her gloved right hand. With the same gloves, Staff D then touched bread she then placed on resident plates. During an observation on 4/25/17 at 12:13 p.m., Staff C Cook wore gloves and opened a plastic bread bag. With the same gloves Staff C touched bread he then placed into a container for the resident's lunch. During an observation on 4/25/17 at 12:26 p.m., the Administrator wore a glove on the right hand and touched the bottoms of plates. With the same gloved hand, she picked up bread and placed it on resident plates. Kitchen observations on 4/25/17 at 12:48 p.m. revealed the following concerns: a. Crumbs underneath the steam table b. Brown drips on the outside of the cupboards	F 371		

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

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F 371	Continued From page 20 near the steam table c. Thick greasy dust particles on the vents above the dishwashing area d. Brown splatters on the cupboard next to the dishwasher e. Brown and white flakes covering the top of the dishwashing machine f. Crumbs and a yellow substance on a metal shelf under the silverware holder g. Dust particles on the fire suppression system above the stove burners h. Large chunks of a yellow substance and red splatters on the underside of the Kitchenaide blender i. Splatters on all of the inside walls of the microwave j. Crumbs on a metal shelf under metal cookie sheets The facility Nutrition Services Manual Sanitation policy, dated 06/2015, directed staff to wear gloves when handling food and to remove the gloves and wash hands before proceeding to the next task. The facility undated Daily Cleaning Schedule directed staff to clean the following: refrigerator, range, steam table, milk cooler. The undated, facility Weekly Cleaning Schedule directed staff to clean the following: range tops, mixer, microwave, refrigerators, freezers, cabinets, and vent hoods. During an interview during the kitchen tour on 4/25/17 at 12:48 p.m., the Dietary Manager acknowledged there was dust on the vents and fire suppression systems and stated she would look into the cleaning schedule.	F 371		

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F 371	Continued From page 21 During an interview on 4/25/17 at 2:21 p.m. the facilty Dietician Consultant stated tongs would be a better option for the staff to use in order to minimize cross contamination with food handling.	F 371		
F 465 SS=E	483.90(i)(5) SAFE/FUNCTIONAL/SANITARY/COMFORTABLE ENVIRON (i) Other Environmental Conditions The facility must provide a safe, functional, sanitary, and comfortable environment for residents, staff and the public. (5) Establish policies, in accordance with applicable Federal, State, and local laws and regulations, regarding smoking, smoking areas, and smoking safety that also take into account non-smoking residents. This REQUIREMENT is not met as evidenced by: Based on observation, environmental tour, and staff interview, the facility failed to maintain cleanliness of fans, air vents, and light fixtures. The facility reported a census of 67. Findings include: 1. Observation during the environmental tour conducted on 4/26/17 at 9:00 a.m., with the Maintenance Supervisor and the Administrator present, revealed the following: a. 45 of 48 ceiling lights in the east hallway, center hallway, west hallway, and 2 dining room areas, with visible debris, dirt, and dead bugs in the light fixtures. b. Several ceiling air vents on the east hallway,	F 465		

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F 465	Continued From page 22 center hallway, west hallway, and 2 dining room areas with visible build up of dust balls, debris, grime, and filaments; the approximate measurements - one 1 foot by 1 foot grate, one 1 foot by 2 feet grate, four 1 foot by 3 feet grates, and two 2 feet by 2 feet grates. In an interview on 4/27/17 at 8:45 a.m., the Maintenance Supervisor responded the vents are cleaned as needed and not on a schedule. The Maintenance Supervisor stated the vents probably were cleaned approximately 2 years ago, but stated the facility filters need changed monthly as the vents in ceiling lead straight into a crawl space. The Maintenance Supervisor stated the housekeeping staff are responsible for having the light fixtures cleaned and he would have them start cleaning them; he did not know if the housekeepers had a schedule for cleaning the fixtures. 2. During observations of personal cares with a resident residing on the east hallway on 4/24/17 at 12:13 p.m., 4/25/16 at 7:12 a.m. and 4/26/17 at 7:00 a.m. noted a 20 inch box fan setting on a folding chair in the room turned on, running, and blowing on the resident. Further observation of the fan revealed the grates of the fan with dirt/grime, dust and filaments blowing off the grate 1/2 to 2 inches long. During an interview on 4/26/17 at 1:35 p.m., the Maintenance Supervisor notified of the dirty box fan in a resident's room in the east hall way. The Maintenance Supervisor then went to the room and looked at the fan. He/she reported had spoken with the resident to find out where the fan came from as not a facility one. The resident reported a staff brought the fan in , but could not'	F 465		

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F 465	Continued From page 23 remember who it was. The Maintenance Supervisor stated not sure if there is a policy in place in regards to residents' fans. He/she reported would have housekeeping clean the fan.	F 465		

This plan of correction does not constitute an admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. This plan of correction is prepared solely because it is required by State and Federal Law.

F309

Date of compliance for this is: 5/11/2017

It is the facility practice to provide services for residents to maintain their well-being.

#1- Resident # 11 dialysis access site was assessed and documented.
Resident #2 no longer on antibiotic.
#2- Residents audited for assessment completion.

#3- Education in the form of a nurses meeting was completed on 5/11/17 to re-educate on assessment and intervention practices. The Director of Nursing or designee will conduct audits to ensure assessments have been completed per policy a minimum of 3 times per week for 4 week and randomly thereafter.

#4- The Director of Nursing or designee will report progress related to this plan of correction for a minimum of 3 months to the QAPI committee for tracking/trending to ensure compliance is achieved.

F314

Date of compliance for this is: 5/11/2017

It is the facility practice to assess and treat residents for skin impairment.

#1-For resident #1, wound treatment orders were obtained on 4/26/17.

#2- For all residents a skin assessment was completed on 5/9/2017 to ensure potential skin issues have been addressed.

#3- Education in the form of a nurses meeting was completed on 5/11/2017 to re-educate on skin assessment practices. The Director of Nursing or designee will conduct audits to ensure assessments have been completed per policy a minimum of 3 times per week for 4 week and randomly thereafter.

#4- The Director of Nursing and/or designee will report progress related to this plan of correction for a minimum of 3 months to the QAPI committee for tracking/trending to ensure compliance is achieved.

F329

Date of compliance for this is: 5/11/2017

It is the facility practice to ensure residents are free from unnecessary drugs.

#1- For resident #9 physician was immediately notified and new orders obtained.

For residents #5,#6 and #3 PRN medications were reviewed.

#2- For all residents a PRN medication documentation assessment was completed.

#3- Education in the form of a nurses meeting was completed on 5/11/17 to re-educate on non-pharmacological interventions. The Director of Nursing or designee will conduct audits to ensure assessments have been completed per policy a minimum of 3 times per week for 4 week and randomly thereafter.

#4- The Director of Nursing or designee will report progress related to this plan of correction for a minimum of 3 months to the QAPI committee for tracking/trending to ensure compliance is achieved.

F364

Date of compliance for this is: 5/9/2017

It is the facility practice to ensure food is served at the appropriate temp.

#1 for the food temperatures identified in the 2567 statement of deficiencies, the Steam table was relocated to where it can be plugged in to maintain temperatures. New hot plates were purchased to adequately maintain room tray temperatures.

#2-for other food temperatures the Steam table was relocated to where it can be plugged in to maintain temperatures. New hot plates were purchased to better maintain room tray temperatures

#3- The Dietary supervisor or designee will conduct audits to ensure appropriate temperatures are maintained per policy a minimum of 3 times per week for 4 week and randomly thereafter.

#4- The Dietary supervisor or designee will report progress related to this plan of correction for a minimum of 3 months to the QAPI committee for tracking/trending to ensure compliance is achieved.

F371

Date of compliance for this is: 5/9/2017

It is the facility practice to ensure food is prepared and served appropriately.

#1- all areas identified in the 2567 statement of deficiencies were addressed on 05-05-2017

#2- an audit of kitchen sanitation was conducted on 05-08-2017 by the Administrator. Any additional concerns identified were addressed.

#3- A dietary meeting was held by the dietary manager on 5/3/17 to review appropriate gloving/serving techniques and kitchen sanitation. The Dietary supervisor or designee will conduct audits to ensure appropriate sanitation is maintained per policy a minimum of 3 times per week for 4 week and randomly thereafter.

#4- The Dietary supervisor or designee will report progress related to this plan of correction for a minimum of 3 months to the QAPI committee for tracking/trending to ensure compliance is achieved.

F465

Date of compliance for this is: 5/5/2017

It is the facility practice to ensure a safe, comfortable environment.

#1-a. Ceiling lights were cleaned by maintenance supervisor.
b. vents were cleaned by maintenance supervisor.
c. fax in resident room was cleaned by housekeeping staff.

#2- All ceiling lights, vents and fans were audited for cleanliness.

#3- The Administrator or designee will conduct audits to ensure assessments have been completed per policy a minimum of 3 times per week for 4 week and randomly thereafter.

#4- The Administrator or designee will report progress related to this plan of correction for a minimum of 3 months to the QAPI committee for tracking/trending to ensure compliance is achieved.