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| F 000 | INITIAL COMMENTS<br><br>Correction date _____<br><br>The following deficiencies were identified during the facility's annual health survey and investigation conducted 5/30/17- 6/1/17<br><br>Complaint # 67833-C was substantiated, not specific to the allegation.<br><br>See the Code of Federal Regulations (42CFR) Part 483, Subpart B-C. | F 000 | | |
| F 225 SS=D | 483.12(a)(3)(4)(c)(1)-(4) INVESTIGATE/REPORT ALLEGATIONS/INDIVIDUALS<br><br>483.12(a) The facility must-<br><br>(3) Not employ or otherwise engage individuals who-<br><br>(i) Have been found guilty of abuse, neglect, exploitation, misappropriation of property, or mistreatment by a court of law;<br><br>(ii) Have had a finding entered into the State nurse aide registry concerning abuse, neglect, exploitation, mistreatment of residents or misappropriation of their property; or<br><br>(iii) Have a disciplinary action in effect against his or her professional license by a state licensure body as a result of a finding of abuse, neglect, exploitation, mistreatment of residents or misappropriation of resident property.<br><br>(4) Report to the State nurse aide registry or licensing authorities any knowledge it has of actions by a court of law against an employee, | F 225 | | |

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE 06/14/2017

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| F 225 | Continued From page 1<br>which would indicate unfitness for service as a nurse aide or other facility staff.<br><br>(c) In response to allegations of abuse, neglect, exploitation, or mistreatment, the facility must:<br><br>(1) Ensure that all alleged violations involving abuse, neglect, exploitation or mistreatment, including injuries of unknown source and misappropriation of resident property, are reported immediately, but not later than 2 hours after the allegation is made, if the events that cause the allegation involve abuse or result in serious bodily injury, or not later than 24 hours if the events that cause the allegation do not involve abuse and do not result in serious bodily injury, to the administrator of the facility and to other officials (including to the State Survey Agency and adult protective services where state law provides for jurisdiction in long-term care facilities) in accordance with State law through established procedures.<br><br>(2) Have evidence that all alleged violations are thoroughly investigated.<br><br>(3) Prevent further potential abuse, neglect, exploitation, or mistreatment while the investigation is in progress.<br><br>(4) Report the results of all investigations to the administrator or his or her designated representative and to other officials in accordance with State law, including to the State Survey Agency, within 5 working days of the incident, and if the alleged violation is verified appropriate corrective action must be taken.<br>This REQUIREMENT is not met as evidenced by: | F 225 | | |

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| F 225 | Continued From page 2<br>Based on clinical record review, staff interview and review of policy/procedures, the facility failed to investigate an injury of unknown origin for one of 10 current residents reviewed (Resident # 2). The facility reported a census of 43 residents.<br><br>Findings include:<br><br>1. The MDS (Minimum Data Set) assessment dated 6/22/16 documented Resident #2 had diagnoses that included hypertension, dementia, thyroid disorder, osteoporosis, vision impairment and a fall history. The MDS documented the resident the resident scored a 12 on the Brief Interview for Mental Status (BIMS) indicating moderately impaired memory and cognition. Resident #2 required the assistance of 1 staff member for bed mobility, transfers and walking and displayed impaired balance with all activities. The MDS documented the resident fell once without injury since the prior assessment.<br><br>An X-ray dated 8/24/16 documented the resident had a left toe non-displaced fracture. The clinical record lacked an incident report or any investigation of the resident's fracture.<br><br>On 5/31/17 at 2:10 p.m. the Director of Nursing (DON) stated she could not locate any investigation of the resident's injury. The DON agreed staff needed to investigate the cause of the unknown injury.<br><br>The facility's Dependent Adult Abuse Reporting policy and procedure dated 4/3/17 directed staff to investigate injuries of unknown origin immediately to rule out abuse. | F 225 | | |
| F 226 | 483.12(b)(1)-(3), 483.95(c)(1)-(3) | F 226 | | |

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| F 226 SS=D | Continued From page 3<br>DEVELOP/IMPLMENT ABUSE/NEGLECT, ETC POLICIES<br><br>483.12<br>(b) The facility must develop and implement written policies and procedures that:<br><br>(1) Prohibit and prevent abuse, neglect, and exploitation of residents and misappropriation of resident property,<br><br>(2) Establish policies and procedures to investigate any such allegations, and<br><br>(3) Include training as required at paragraph §483.95,<br><br>483.95<br>(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-<br><br>(c)(1) Activities that constitute abuse, neglect, exploitation, and misappropriation of resident property as set forth at § 483.12.<br><br>(c)(2) Procedures for reporting incidents of abuse, neglect, exploitation, or the misappropriation of resident property<br><br>(c)(3) Dementia management and resident abuse prevention.<br>This REQUIREMENT is not met as evidenced by:<br>Based on review of personnel records, staff interviews, and review of policy and procedures, the facility failed to obtain an abuse registry check | F 226 | | |

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| F 226 | Continued From page 4 | F 226 | | |

prior to hiring Staff G and failed to ensure staff completed an approved dependent adult abuse training course (Staff E). Ten personnel files were reviewed and the facility identified a census of 43 residents.

Findings include:

1. The form titled Employee New Hire Report, with a date range of 5/22/16 thru 5/30/17, identified a date of hire for Staff G, RN (Registered Nurse) as 7/21/16.

The personnel file for Staff G identified a Single Contact License & Background Check (SING) form with a completion date of 7/14/16 identified the results of a criminal background check but did not identify results of a dependent adult abuse history check. The SING form identified a possible hit on the Dependent Adult Abuse Registry and instructed the facility to initiate request for information from DHS (Department of Human Services).

The Request for Child and Dependent Adult Abuse Information, signed as requested 7/14/16, documented a signed response on 9/23/16. The response identified Staff G had no history of abuse.

In an interview on 6/1/17 at 9:40 a.m., the Human Resource Director confirmed the facility did not receive results from the abuse check prior to hiring Staff G.

The policy and procedure titled Dependent Adult Abuse Reporting, revised on 4/3/17, directed the following under the sub-title Team Member Screening and Training:

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| F 226 | Continued From page 5 | F 226 | | |

Point C1b. - A criminal background check will be conducted on all prospective team members as provided by Wesley Life's policy on criminal background checks. A significant finding on the background check will result in denied employment consistent with the criminal background check policy in accordance with State and Federal Regulations.

2. The Employee New Hire Report, with a date range of 5/22/16 through 5/30/17, documented a hire date of 8/25/16 for Staff E, Registered Nurse (RN).

Review of Staff E's employee file on 5/31/17 at 8:30 a.m., revealed the file lacked documentation of completion of an approved Dependent Adult Abuse Training for Mandatory Reporters course. At 10:00 a.m., the surveyor informed the Human Resource Director who confirmed the absence of the certificate.

In an interview on 6/1/17 at 9:40 a.m., the Human Resource Director stated she texted Staff E and said Staff E responded she remembered watching it (training). The Human Resource Director then provided a copy of a Certificate of Completion backdated 8/25/16 with the Human Resource Director's signature, signed as a witness on that day. The Human Resource Director stated she filled out the certificate on 5/31/17 after receiving Staff E's text message.

The facility's policy and procedure revised 4/3/17 titled Abuse Policy/Resident Protection Plan lacked any directions pertaining to staff attending or completing a 2 hour approved course for Dependent Adult Abuse training.

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| F 323 | Continued From page 6 | F 323 | | |
| F 323 SS=D | 483.25(d)(1)(2)(n)(1)-(3) FREE OF ACCIDENT HAZARDS/SUPERVISION/DEVICES<br><br>(d) Accidents.<br>The facility must ensure that -<br><br>(1) The resident environment remains as free from accident hazards as is possible; and<br><br>(2) Each resident receives adequate supervision and assistance devices to prevent accidents.<br><br>(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.<br><br>(1) Assess the resident for risk of entrapment from bed rails prior to installation.<br><br>(2) Review the risks and benefits of bed rails with the resident or resident representative and obtain informed consent prior to installation.<br><br>(3) Ensure that the bed's dimensions are appropriate for the resident's size and weight.<br>This REQUIREMENT is not met as evidenced by:<br>Based on clinical record review, observation, staff interview, and facility policy review, the facility failed to put appropriate interventions in place to prevent falls for 1 of 6 residents reviewed with a history of falls. (Resident #2). The facility reported a census of 43 residents.<br><br>Findings include: | F 323 | | |

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| F 323 | Continued From page 7 | F 323 | | |

The MDS (Minimum Data Set) assessment dated 6/22/16 documented Resident #2 had diagnoses that included hypertension, dementia, thyroid disorder, osteoporosis, vision impairment and a fall history. The MDS documented the resident the resident scored a 12 on the Brief Interview for Mental Status (BIMS) indicating mederately impaired memory and cognition. Resident #2 required the assistance of 1 staff member for bed mobility, transfers and walking and displayed impaired balance with all activities. The MDS documented the resident fell once without injury since the prior assessment.

The care plan dated 2/9/16 listed the resident as at risk for falls and directed to implement the following:

a. Two assist with a 4 wheeled walker;
b. Encourage appropriate non skid footwear to prevent slipping with transfers;
c. Assess orthostatic blood pressures per facility policy and consult the physician with concerns;
d. Monitor for adverse effects of medication that may increase the risk of falling;
e. Use 1/2 side rail to the head of bed as needed for bed mobility and positioning;
f. Keep bed brakes locked and keep the bed in low position;
g. Monitor for dizziness and encourage to rise slowly;
h. Place sign in room to use the call light.

The Resident Incident Report dated 7/23/16 at 2:00 a.m. documented the resident fell from the bed. The resident sustained no injury. Staff placed a personal alarm through the night but discontinued the alarm after the night shift. Staff failed to update the care plan to include

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| F 323 | Continued From page 8 | F 323 | | |

interventions to prevent further falls.

The Resident Incident Report dated 8/17/16 at 8:04 p.m. documented the resident fell in front of toilet. The resident did not sustain injury. Staff placed the resident across from the nurse's station. Staff failed to update the care plan to include interventions to prevent further falls.

The Resident Incident Report dated 9/3/16 at 6:20 p.m. documented the resident fell in the bathroom in front of the toilet. The resident sustained no injury. Staff failed to update the care plan to include interventions to prevent further falls.

The MDS assessment dated 9/21/16 documented the resident had a BIMS of 10 indicating moderate memory and cognitive impairment. The MDS documented the resident required the assistance of 1 staff member for bed mobility and walking and the assistance of 2 with walking. The assessment continued to document impaired balance with all activities. The MDS documented the resident had 2 falls without injury and 1 fall with injury since the prior assessment.

The MDS assessment dated 10/26/16 documented the resident had a BIMS of 9 indicating moderate cognitive impairment. The MDS documented the resident required the assistance of 1 staff with bed mobility, transfers, and walking. The resident continued to experience impaired balance and s/he had no falls since the prior assessment.

The care plan dated 10/26/17 and updated 4/5/17 listed the resident as at risk for falls and directed the following:

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| F 323 | Continued From page 9 | F 323 | | |

a. One assist with a 4 wheeled walker and gait belt;
b. It is okay to wear a shoe to the right foot and gripper sock to the left foot if having discomfort to left great toe;
c. Assist to wear appropriate non-skid footwear to prevent slipping with transfers;
d. Assess orthostatic blood pressures per facility policy and consult the physician with concerns;
e. Monitor for adverse effects of medication that may increase the risk of falling;
f. Use 1/2 side rail to the head of bed as needed for bed mobility and positioning;
g. Keep bed brakes locked and keep bed in lowest position;
h. Monitor for dizziness and encourage to rise slowly;
i. Place sign in room to use the call light.

On 3/19/17 staff updated the care plan to place a floor mat beside low bed to prevent injury.
On 4/24/17 staff updated the care plan to not leave the resident unattended in the bathroom.

The MDS assessment dated 1/25/17 documented the resident had a BIMS of 4 indicating severe cognitive and memory impairment. The resident required the assistance of 2 staff for bed mobility and transfers and the assistance of one staff member for walking. The MDS documented the resident had 1 fall without injury since the last assessment. The resident continued to have impaired balance.

The Resident Incident Report dated 1/23/17 at 1:30 p.m. documented the resident fell in the bathroom. The resident sustained no injury. Staff documented placing a sign on the resident's

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| F 323 | Continued From page 10 | F 323 | | |

walker directing him/her to use the call light, but the care plan failed to contain the intervention.

The Resident Incident Report dated 4/3/17 at 7:45 p.m. documented the resident fell from the bed. Staff reminded the resident to use the call light. The resident sustained no injury. Staff failed to update the care plan with interventions to prevent further falls.

The MDS dated 4/13/17 documented the resident had a BIMS of 3 indicating severe cognitive impairment. The MDS documented the resident required the assistance of 2 staff for transfers and the assistance of one staff member for bed mobility and walking. The MDS documented the resident had 2 falls without injury and 2 falls with injury since the last assessment. The resident continued to show impaired balance with all assessed activities.

The Resident Incident Report dated 4/24/17 at 2:00 p.m. documented the resident fell in the bathroom and did not sustain injury. Staff documented an intervention to stay with the resident in the bathroom, but did not update the resident's Care Plan with the intervention.

During an interview on 6/1/17 at 9:32 a.m. the Director of Nursing (DON) reviewed the resident's fall history and agreed the resident fell 5 times in the bathroom from 7/23/16 to 4/24/17 and staff did not put an appropriate interventions in place. The DON stated when a resident falls, an immediate intervention needed to be put in place then the interdisciplinary team will review the intervention and update the care plan.

The Accidents/Incident Investigation Policy and

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| F 323 | Continued From page 11<br>Procedure dated 5/6/13 instructed staff to complete an Incident Report for any accident or incident including injuries of unknown origin. The data on the report must include any corrective action and interventions must be initiated in a an attempt to prevent reoccurrence. | F 323 | | |
| F 371 SS=F | 483.60(i)(1)-(3) FOOD PROCURE, STORE/PREPARE/SERVE - SANITARY<br><br>(i)(1) - Procure food from sources approved or considered satisfactory by federal, state or local authorities.<br><br>(i) This may include food items obtained directly from local producers, subject to applicable State and local laws or regulations.<br><br>(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.<br><br>(iii) This provision does not preclude residents from consuming foods not procured by the facility.<br><br>(i)(2) - Store, prepare, distribute and serve food in accordance with professional standards for food service safety.<br><br>(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.<br>This REQUIREMENT is not met as evidenced by:<br>Based on observation, staff interview and review of the Food and Drug Administration (FDA) Food Code, the facility failed to seal, label, and date | F 371 | | |

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food items when opened, failed to properly use single-use gloves or change gloves between tasks and failed to designate dedicated handwashing only sinks so as to prevent the spread of food-bourne illness and disease. The facility reported a census of 43.

Findings include:

1. The initial tour of the main kitchen, with the Director of Culinary services present on 5/30/17 at 9:10 a.m., identified the walk-in freezer with contained the following items:
a. One bag of approximately 36 cookies not sealed or dated when opened;
b. 18 hamburger patties not sealed or dated when opened;
c. Six chicken breasts not sealed or dated when opened.

The Director of Culinary services stated she expected staff to cover, label, and date opened items.

2. Observation on 5/30/17 at 9:30 a.m., revealed Staff A, homemaker, cleaned off the dirty dishes from tables in the Magnolia dining area. Staff A wiped off tables with the same gloves worn after bussing the tables. Staff A then went to the clean linen basket, obtained clean placemats and linens and placed linens on the tables with soiled gloves. Staff A wore the same pair of single-use, disposable gloves during multiple tasks. Staff A failed to change her gloves and wash hands between different tasks.

3. Tour of the kitchenette connected between Magnolia and Juniper dining areas, on 5/30/17 at 11:35 a.m. revealed the following concerns:

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| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) | (X5) COMPLETION DATE |
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| F 371 | Continued From page 13<br>a. The Whirlpool stand up freezer contained one bag of approximately 40 waffles not sealed, labeled or dated<br>b. The Frigedaire stand up freezer contained 20 meat patties and a 10 pound box half full of sausage links not sealed;<br>c. The Amana upright freezer contained moderate amount of frost/ice build up, approximately 2 inches thick, covering the entire top and bottom shelves;<br>d. Juniper refrigerator/freezer contained bag of raspberries not sealed.<br><br>4. Observation on 5/30/17 at 12:10 p.m., revealed Staff A served the lunch meal in the Magnolia unit. Staff B rinsed her hands in the same sink used to rinse coffee pots. Staff A used no soap and donned gloves. Staff A then served plates of food to the tables, went to the next resident, placed her gloved hands on the resident's wheelchair, picked up dirty dishes and returned dishes to the sink. Staff A removed her gloves, wiped her hands on her backside, stated her hands felt sweaty and donned new gloves without washing her hands.<br><br>5. Observation on 5/31/17 at 8:16 a.m., revealed Staff B, homemaker, handled dirty dishes in the Magnolia kitchenette with gloves on. Staff B then opened a drawer to obtain a clean clothing protector. Staff B touched several clothing protectors with the same soiled gloves before choosing one. At 8:34 a.m., Staff B took a container of Med Pass supplement from Staff D, RN (Registered Nurse) with the same pair of soiled gloves and put the container in the refrigerator.<br><br>6. Observation on 5/31/17 at 11:53 a.m., revealed | F 371 | | |

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|---|---|---|---|
| | 165167 | A. BUILDING _____ B. WING _____ | 06/01/2017 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
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| F 371 | Continued From page 14 | F 371 | | |

the double sink next to the dishwasher in the Magnolia unit contained soapy water and dishes. Above the sink, a signed posted the steps for handwashing. Staff B wore a pair of gloves, served a plate of food, removed gloves, wiped their hands on their pants and donned new gloves without washing hands. Observation further revealed a cutting board with a used knife by the left side of the sink and a wet washcloth next to the cutting board during the meal service.

7. Observation on 5/31/17 at 12:06 p.m., revealed the Juniper kitchenette double sink with soapy water and dishes in the left side. Staff C, homemaker, washed her hands in the right side of the sink. Above the sink, a sign posted the steps for handwashing.

In an interview on 5/31/17 at 1:24 p.m., the Director of Culinary services acknowledged she expected staff to change gloves between tasks and wash hands when gloves changed. The Director of Culinary stated she had done competency training educating staff on gloving procedures and she started a QA (quality assurance) process for the issue prior to survey.

The Food Code, published by the FDA and considered a standard of practice for the food service industry, in the 2013 edition requires the following:
a. A container of refrigerated, ready to eat, potentially hazardous food prepared and packaged by a Food Processing plant shall be clearly marked, at the time the original container is opened in a food establishment, to indicate that date by which the food should be consumed
b. Packaged food shall be labeled
c. If used, single-use gloves shall be used for

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| F 371 | Continued From page 15<br>only one task such as working with ready-to-eat food or with raw animal food, used for no other purpose, and discarded when damaged or soiled, or when interruptions occur in the operation<br>d. A warewashing sink may not be used for handwashing<br>e. A handwashing sink may not be used for purposes other than handwashing | F 371 | | |
| F 499 SS=D | 483.70(f)(1)(2) EMPLOY QUALIFIED FT/PT/CONSULT PROFESSIONALS<br><br>(f) Staff qualifications.<br><br>(1) The facility must employ on a full-time, part-time or consultant basis those professionals necessary to carry out the provisions of these requirements.<br><br>(2) Professional staff must be licensed, certified, or registered in accordance with applicable State laws.<br>This REQUIREMENT is not met as evidenced by:<br>Based on employee file review, staff interview and facility record review, the facility failed to verify a nurse licensure for 1 of 4 nurse employee files reviewed (Staff F). The facility reported a census of 43 residents.<br><br>Findings include:<br><br>The Employee New Hire Report, with a date range of 5/22/16 thru 5/30/17 documented a hire date of 10/3/16 for Staff F, Licensed Practical Nurse (LPN).<br><br>Review of the personnel file for Staff F on 5/31/17 at 8:30 a.m. revealed it lacked verification of | F 499 | | |

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| F 499 | Continued From page 16 | F 499 | | |

nurse licensure.

The form titled Lookup Detail View printed 5/31/17 at 10:18 a.m. documented Staff F's license effective 9/1/16 and expired on 1/4/17. The form recorded Colorado nurse compact designation as single state. (Compact state license allow nurses to practice in multiple states with the same license. A designation of multi state is needed to practice in Iowa with another state license.)

In an interview on 6/1/17 at 9:40 a.m., the Human Resource Director confirmed Staff F's employee file lacked verification of nurse licensure prior to the survey. The Human Resource Director stated she ran a license verification for Staff F on 5/31/17 and provided a copy of the verification. The verification only verified a Colorado license that expired 1/4/17; the facility provided no verification of an Iowa license.

The facility's policy and procedure revised 4/3/17 titled Abuse Policy/Resident Protection Plan directed the following under the sub-title Team Member Screening and Training:
Point C1a. - Before new hires are permitted to work with residents, references provided by the prospective employee will be checked as well as appropriate Board Registrations and Certifications regarding the prospective team member's background. The Board of Nursing, Board of Nursing Home Administrator, and DCW (Direct Care Registry), as applicable, will be contacted regarding the prospective employee's background before permitted to work with residents.