STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	165256	A. BUILDING _____ B. WING _____	06/08/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ELMWOOD CARE CENTRE	222 NORTH 15TH STREET ONAWA, IA 51040

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 000	INITIAL COMMENTS Correction date 06/20/2017 The following deficiencies were identified during the facility's annual licensure and certification survey. Complaint #68542-C was not substantiated. See Code of Federal Regulations (45 CFR) Part 483, Subpart B.	F 000		
F 156 SS=C	483.10(d)(3)(g)(1)(4)(5)(13)(16)-(18) NOTICE OF RIGHTS, RULES, SERVICES, CHARGES (d)(3) The facility must ensure that each resident remains informed of the name, specialty, and way of contacting the physician and other primary care professionals responsible for his or her care. §483.10(g) Information and Communication. (1) The resident has the right to be informed of his or her rights and of all rules and regulations governing resident conduct and responsibilities during his or her stay in the facility. (g)(4) The resident has the right to receive notices orally (meaning spoken) and in writing (including Braille) in a format and a language he or she understands, including: (i) Required notices as specified in this section. The facility must furnish to each resident a written description of legal rights which includes - (A) A description of the manner of protecting personal funds, under paragraph (f)(10) of this section;	F 156		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Laura Sachs — TITLE: Administrator — (X6) DATE: 06/20/2017

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.

POC accepted 7/5/17 VV

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F 156	Continued From page 1 (B) A description of the requirements and procedures for establishing eligibility for Medicaid, including the right to request an assessment of resources under section 1924(c) of the Social Security Act. (C) A list of names, addresses (mailing and email), and telephone numbers of all pertinent State regulatory and informational agencies, resident advocacy groups such as the State Survey Agency, the State licensure office, the State Long-Term Care Ombudsman program, the protection and advocacy agency, adult protective services where state law provides for jurisdiction in long-term care facilities, the local contact agency for information about returning to the community and the Medicaid Fraud Control Unit; and (D) A statement that the resident may file a complaint with the State Survey Agency concerning any suspected violation of state or federal nursing facility regulations, including but not limited to resident abuse, neglect, exploitation, misappropriation of resident property in the facility, non-compliance with the advance directives requirements and requests for information regarding returning to the community. (ii) Information and contact information for State and local advocacy organizations including but not limited to the State Survey Agency, the State Long-Term Care Ombudsman program (established under section 712 of the Older Americans Act of 1965, as amended 2016 (42 U.S.C. 3001 et seq) and the protection and advocacy system (as designated by the state, and as established under the Developmental	F 156		

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F 156	Continued From page 2 Disabilities Assistance and Bill of Rights Act of 2000 (42 U.S.C. 15001 et seq.) [§483.10(g)(4)(ii) will be implemented beginning November 28, 2017 (Phase 2)] (iii) Information regarding Medicare and Medicaid eligibility and coverage; [§483.10(g)(4)(iii) will be implemented beginning November 28, 2017 (Phase 2)] (iv) Contact information for the Aging and Disability Resource Center (established under Section 202(a)(20)(B)(iii) of the Older Americans Act); or other No Wrong Door Program; [§483.10(g)(4)(iv) will be implemented beginning November 28, 2017 (Phase 2)] (v) Contact information for the Medicaid Fraud Control Unit; and [§483.10(g)(4)(v) will be implemented beginning November 28, 2017 (Phase 2)] (vi) Information and contact information for filing grievances or complaints concerning any suspected violation of state or federal nursing facility regulations, including but not limited to resident abuse, neglect, exploitation, misappropriation of resident property in the facility, non-compliance with the advance directives requirements and requests for information regarding returning to the community. (g)(5) The facility must post, in a form and manner accessible and understandable to residents, resident representatives: (i) A list of names, addresses (mailing and email), and telephone numbers of all pertinent State	F 156		

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F 156	Continued From page 3 agencies and advocacy groups, such as the State Survey Agency, the State licensure office, adult protective services where state law provides for jurisdiction in long-term care facilities, the Office of the State Long-Term Care Ombudsman program, the protection and advocacy network, home and community based service programs, and the Medicaid Fraud Control Unit; and (ii) A statement that the resident may file a complaint with the State Survey Agency concerning any suspected violation of state or federal nursing facility regulation, including but not limited to resident abuse, neglect, exploitation, misappropriation of resident property in the facility, and non-compliance with the advanced directives requirements (42 CFR part 489 subpart I) and requests for information regarding returning to the community. (g)(13) The facility must display in the facility written information, and provide to residents and applicants for admission, oral and written information about how to apply for and use Medicare and Medicaid benefits, and how to receive refunds for previous payments covered by such benefits. (g)(16) The facility must provide a notice of rights and services to the resident prior to or upon admission and during the resident's stay. (i) The facility must inform the resident both orally and in writing in a language that the resident understands of his or her rights and all rules and regulations governing resident conduct and responsibilities during the stay in the facility.	F 156		

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F 156	Continued From page 4 (ii) The facility must also provide the resident with the State-developed notice of Medicaid rights and obligations, if any. (iii) Receipt of such information, and any amendments to it, must be acknowledged in writing; (g)(17) The facility must-- (i) Inform each Medicaid-eligible resident, in writing, at the time of admission to the nursing facility and when the resident becomes eligible for Medicaid of- (A) The items and services that are included in nursing facility services under the State plan and for which the resident may not be charged; (B) Those other items and services that the facility offers and for which the resident may be charged, and the amount of charges for those services; and (ii) Inform each Medicaid-eligible resident when changes are made to the items and services specified in paragraphs (g)(17)(i)(A) and (B) of this section. (g)(18) The facility must inform each resident before, or at the time of admission, and periodically during the resident's stay, of services available in the facility and of charges for those services, including any charges for services not covered under Medicare/ Medicaid or by the facility's per diem rate. (i) Where changes in coverage are made to items	F 156		

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F 156	Continued From page 5 and services covered by Medicare and/or by the Medicaid State plan, the facility must provide notice to residents of the change as soon as is reasonably possible. (ii) Where changes are made to charges for other items and services that the facility offers, the facility must inform the resident in writing at least 60 days prior to implementation of the change. (iii) If a resident dies or is hospitalized or is transferred and does not return to the facility, the facility must refund to the resident, resident representative, or estate, as applicable, any deposit or charges already paid, less the facility's per diem rate, for the days the resident actually resided or reserved or retained a bed in the facility, regardless of any minimum stay or discharge notice requirements. (iv) The facility must refund to the resident or resident representative any and all refunds due the resident within 30 days from the resident's date of discharge from the facility. v) The terms of an admission contract by or on behalf of an individual seeking admission to the facility must not conflict with the requirements of these regulations. This REQUIREMENT is not met as evidenced by: Based on facility record review and staff interview, the facility failed to adequately inform 3 of 3 residents reviewed of their appeal rights following discharge from skilled services (Residents #13, #14, and #15). The facility reported a census of 46 residents. Findings include:	F 156		

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F 156	Continued From page 6 1. A list of Skilled Admissions and Discharges documented Resident #13 received Medicare Skilled Services 12/9/16 to 3/17/17. Review of a Skilled Nursing Facility Advance Beneficiary Notice (SNFABN) dated 3/13/17 revealed no documentation that the facility designated the resident's or representative's the option to appeal discharge from skilled services. 2. A list of Skilled Admissions and Discharges documented Resident #14 received Medicare Skilled Services 1/13/17 to 4/27/17. Review of a Notice of Exclusions from Medicare Benefits Skilled Nursing Facility (NEMB-SNF) form dated 4/25/17 revealed no documentation that the facility designated the resident's or representative's the option to appeal discharge from skilled services. 3. A list of Skilled Admissions and Discharges documented Resident #15 received Medicare Skilled Services 2/23/17 to 4/19/17. Review of a NEMB-SNF form dated 4/14/17 revealed no documentation that the facility designated the resident's or representative's the option to appeal the discharge from skilled services. During interview on 6/6/17 at 1:05 PM with the Social Services Director, she stated that the three residents did not want to continue on skilled services, but acknowledged the resident's wishes were not documented on the forms.	F 156		
F 226 SS=D	483.12(b)(1)-(3), 483.95(c)(1)-(3) DEVELOP/IMPLMENT ABUSE/NEGLECT, ETC POLICIES 483.12	F 226		

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F 226	Continued From page 7	F 226		

(b) The facility must develop and implement written policies and procedures that:

(1) Prohibit and prevent abuse, neglect, and exploitation of residents and misappropriation of resident property,

(2) Establish policies and procedures to investigate any such allegations, and

(3) Include training as required at paragraph §483.95,

483.95
(c) Abuse, neglect, and exploitation. In addition to the freedom from abuse, neglect, and exploitation requirements in § 483.12, facilities must also provide training to their staff that at a minimum educates staff on-

(c)(1) Activities that constitute abuse, neglect, exploitation, and misappropriation of resident property as set forth at § 483.12.

(c)(2) Procedures for reporting incidents of abuse, neglect, exploitation, or the misappropriation of resident property

(c)(3) Dementia management and resident abuse prevention.
This REQUIREMENT is not met as evidenced by:
Based on employee file review, policy review and staff interview, the facility failed to timely obtain criminal and abuse background check prior to hire for 1 of 5 employees. The facility identified a census of 46 residents.

Findings include:

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F 226	Continued From page 8 1. Record review for the facility new hires since last survey revealed the Administrator's date of hire as 2/6/17. Review of the Administrator's employee file revealed a Single Contact License and Background Check for criminal and abuse completed on 6/5/17. The form showed no abuse or criminal history record for the Administrator. An interview 6/7/17 at 9:00 a.m. with the Administrator revealed his/her unawareness of the criminal background check not completed by the corporate office upon hire. The Administrator reported the immediate need to have a background check completed on 6/5/17 and completed the process. The Abuse Prevention Program and Reporting Policy dated 4/17 identified employees would be screened and trained to prevent abuse. The policy revealed all potential employees would be screened prior to hire for a history of abuse, neglect, etc. and the screening consisted of criminal and abuse registry checks.	F 226		
F 315 SS=D	483.25(e)(1)-(3) NO CATHETER, PREVENT UTI, RESTORE BLADDER (e) Incontinence. (1) The facility must ensure that resident who is continent of bladder and bowel on admission receives services and assistance to maintain continence unless his or her clinical condition is or becomes such that continence is not possible to maintain. (2)For a resident with urinary incontinence, based on the resident's comprehensive assessment, the facility must ensure that-	F 315		

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(i) A resident who enters the facility without an indwelling catheter is not catheterized unless the resident's clinical condition demonstrates that catheterization was necessary;

(ii) A resident who enters the facility with an indwelling catheter or subsequently receives one is assessed for removal of the catheter as soon as possible unless the resident's clinical condition demonstrates that catheterization is necessary and

(iii) A resident who is incontinent of bladder receives appropriate treatment and services to prevent urinary tract infections and to restore continence to the extent possible.

(3) For a resident with fecal incontinence, based on the resident's comprehensive assessment, the facility must ensure that a resident who is incontinent of bowel receives appropriate treatment and services to restore as much normal bowel function as possible.
This REQUIREMENT is not met as evidenced by:
Based on clinical record review, observation, facility policy review and staff interview, the facility failed to ensure storage of urinary catheter bags to minimize the chance for urinary tract infections for 2 of 4 residents selected for review (Residents #1 and #4). The facility identified a census of 46 residents.

Findings include:

1. According to the Minimum Data Set (MDS) assessment dated 5/22/17, Resident #1 had a diagnoses of obstructive uropathy (which

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F 315	Continued From page 10 impacts drainage of urine). The MDS documented the resident as alert and orientated with a Brief Interview for Mental Status (BIMS) score of 15. The assessment documented Resident #1 required the assistance of 2 staff with transfers and toilet use, the assistance of one with personal hygiene and that s/he required an indwelling urinary catheter. The resident's Individual Resident Care Plan revised on 6/5/16 documented s/he had an deficit with Activities of Daily Living self care and instructed staff to provide catheter care every shift and as needed. Observation on 6/6/17 at 3 p.m. revealed the resident positioned in a recliner with the hook of the drainage bag for the urinary catheter hung on the edge of the full waste basket. Observation on 6/7/17 at 9:50 a.m. revealed the resident's indwelling catheter tubing hung below the catheter drainage bag, not allowing for down drainage. 2. According to the MDS assessment dated 5/9/17, Resident #4 had diagnoses that included end stage renal disease, diabetes mellitus, anxiety, depression and chronic lung disease. The MDS documented the resident had a BIMS score of 15. The assessment MDS documented the resident required limited assistance of two or more staff for mobility and toilet use. The resident's Individual Resident Care Plan dated 6/2/17 documented the resident had a Foley (urinary) catheter. Observation on 6/6/17, at 10:40 a.m. revealed the	F 315		

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F 315	Continued From page 11 resident positioned in his/her recliner and the resident's catheter bag hanging on a waste basket next to his/her recliner. Observation on 6/7/17, at 8 a.m. revealed the resident up in the recliner with the catheter drainage bag hung on the waste basket. Point #18 of the facility's Catheter Care procedure, dated 1/13, directed staff to hang the drainage bag on the bed frame, not on the bed rails. An interview with the Director of Nursing 6/7/17 at 4 p.m. revealed the need to position a catheter drainage bag on proper areas, not waste baskets.	F 315		
F 363 SS=B	483.60(c)(1)-(7) MENUS MEET RES NEEDS/PREP IN ADVANCE/FOLLOWED (c) Menus and nutritional adequacy. Menus must- (c)(1) Meet the nutritional needs of residents in accordance with established national guidelines.; (c)(2) Be prepared in advance; (c)(3) Be followed; (c)(4) Reflect, based on a facility's reasonable efforts, the religious, cultural and ethnic needs of the resident population, as well as input received from residents and resident groups; (c)(5) Be updated periodically; (c)(6) Be reviewed by the facility's dietitian or	F 363		

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F 363	Continued From page 12 other clinically qualified nutrition professional for nutritional adequacy; and (c)(7) Nothing in this paragraph should be construed to limit the resident's right to make personal dietary choices. This REQUIREMENT is not met as evidenced by: Based on facility menu review, observation and staff interview, the facility failed to followed the planned menu for 4 residents who had orders for pureed diets of 17 current residents reviewed (Residents #6, #16, #17, #18). The facility identified a census of 46 residents. Findings include: 1. Review of the facility's Week 1 noon meal menu for 6/6/17 revealed that residents with pureed diet orders should receive one serving of pureed bread and margarine. Observation on 6/6/17 at 11:30 a.m. revealed Staff B, Cook, prepared 4 residents their physician ordered pureed menu items. Observation revealed at the end of the meal service the 4 residents did not receive a serving of bread and margarine. Interview after observation of the pureed process and the meal service with Staff B, Cook, revealed she had not pureed the bread requirement on the menu in the vegetables, meat or by itself.	F 363		
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	F 371		

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F 371	Continued From page 13 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, and staff interview. the facility failed to ensure the staff restrained their hair in the kitchen. The facility identified a census of 46 residents. Findings include: 1. Observation 6/6/17 at 12 noon until 12:45 p.m. (during meal service), revealed Staff A, Medical Records entered the kitchen area 5 times without wearing a hair net. An interview with Staff B, Cook, after the meal service, revealed the need and expectation for staff to have his/her hair covered when in the kitchen area.	F 371		

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ELMWOOD CARE CENTRE	222 NORTH 15TH STREET ONAWA, IA 51040

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F 371	Continued From page 14 An interview 6/7/17 at 10:00 a.m. with Staff A revealed she had assisted with the meal service for years. Staff A stated she had not worn a hair net before.	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, the facility failed to maintain clean and sanitized cabinets in the kitchen and in the medication supply rooms. The facility identified a census of 46 residents. Findings include: 1. Observation 6/6/17 at 9:30 a.m. revealed white painted cabinets in the 500 hall medication supply room with black dirt and grime on the exterior and interior surfaces. Observation of the front medication supply area on 6/7/17 at 7:00 a.m. revealed cabinet surfaces not able to be sanitized, worn and a marred surface with a grime like feel when touched. The sink basin area and under the sink cabinet	F 465		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	165256	A. BUILDING _____ B. WING _____	06/08/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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F 465	Continued From page 15 revealed marred and missing wood surfaces with a green mold and mildew like discoloration around the sink bowl and the side of the cabinet. Observation revealed both medication supply room cabinets housed stock medication and medical supplies for resident use. 2. Observation 6/6/17 at 11:35 a.m. revealed 12, white kitchen cabinet doors were soiled a black color about the handles and edges, worn to the wood surface and not sanitizable. Observation revealed when opened cooking spices, bowls and cooking bowls stacked on worn shelves that had crumbs, dust and grime buildup in the corners and along the edges.	F 465		

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

Date of compliance and all insufficiencies will be completed by June 20, 2017.

F-156

It is the practice of Elmwood Care Centre to inform residents and their responsible parties of their appeal rights following a discharge from skilled services.

1. For resident #13, 14 and 15, the Social Services Designee was educated on 06/08/2017.
2. For similar residents, education was completed with staff on 06/08/2017 reviewing the policy and documentation requirements for completion of the Advance Beneficiary Notices.
3. The Administrator and/or Designee will conduct weekly audits of Advance Beneficiary Notices served for 6 weeks and randomly thereafter.
4. Findings of audits will be reviewed with monthly QAPI committee for tracking/trending for a minimum of 3 months or until compliance is achieved.

F226

It is the practice of Elmwood Care Centre to complete a background check on all new employees prior to hire.

1. A background check for the Administrator was completed 6/5/2017.
2. For similar employees, employee's files were reviewed to ensure background checks were completed prior to hire and education was done with staff on 6/8/2017 on the review of the abuse policy and ensuring background checks are completed prior to hire.
3. The Administrator and/or Designee will complete an audit on new hires to ensure that the background check is completed prior to the hire of the employee for 6 weeks and randomly thereafter.
4. Findings of audits will be reviewed with monthly QAPI committee for tracking/trending for a minimum of 3 months or until compliance is achieved.

F315

It is the practice of Elmwood Care Centre to hang the catheter bag on appropriate designated areas and to be positioned correctly.

1. For resident #1 and #4, education was completed with staff on 06/07/2017 on Patient Rights/Dignity, and the catheter care policies.
2. For similar residents, education was completed with staff on 06/07/2017 on Patient Rights/Dignity, and the catheter care policies.
3. The Director of Nursing and/or Designee will conduct audits 3 times per week of residents with a catheter to ensure the catheter drainage bag is positioned correctly to allow drainage and to ensure the bag is hung in appropriate area. The Director of Nursing and/or Designee will conduct audits 3 times per week of residents with a catheter to ensure proper placement and positioning of the catheter bag. Each audit will be completed for 6 weeks, and randomly thereafter.
4. Findings of audits will be reviewed with monthly QAPI committee for tracking/trending for a minimum of 3 months or until compliance is achieved.

F363

It is the practice of Elmwood Care Centre to follow the pureed diet menu as written and to prepare the pureed meals per those menus.

1. For concern identified related to puree diet, the staff member who prepared the puree was re-educated on 6/8/2017 on the correct way to prepare a pureed meal and the importance of following the written menu.
2. For similar diet orders, dietary staff were educated on 6/8/2017 on the correct way to prepare a pureed meal and the importance of following the menu.
3. The Dietary Supervisor and/or Designee will complete an audit 3 times weekly to ensure that the pureed menu is being followed and the meal is being prepared correctly for 6 weeks and randomly thereafter.
4. Findings of audits will be reviewed with monthly QAPI committed for tracking/trending for a minimum of 3 months or until compliance is achieved.

F371

It is the practice of Elmwood Care Centre for all staff to restrain their hair while in the kitchen and keep it covered by wearing hair nets for hair and/or beard/mustache nets if they have facial hair.

1. For the sanitation concern, staff were re-educated on the need to cover hair when entering the kitchen on 6/8/2017.
2. For similar sanitation concerns, an education was done with staff on 6/8/2017 on the expectation that hair nets need to be worn when entering the kitchen and they are not to

be removed until after leaving the kitchen. This education also covered facial hair and the expectation that beard/mustache nets must be worn on anyone who has facial hair.

3. The Administrator and/or Designee will complete an audit 2 times weekly to ensure the expectation of use of hair/beard nets is being followed for 6 weeks and then randomly thereafter.
4. Findings of audits will be reviewed with monthly QAPI committed for tracking/trending for a minimum of 3 months or until compliance is achieved.

F465

It is the practice of Elmwood Care Centre to provide a safe, functional, sanitary and comfortable environment for residents, staff and the public which includes maintaining clean and sanitized surfaces including kitchen and med room cabinets.

1. For the environmental concerns noted, bids are being collected to order and replace the cabinets in the kitchen, in the 500 hall medication room and in the front medication room.
2. For similar environmental concerns, an education was provided to staff on 6/8/2017 to inform Maintenance staff when a surface has become uncleanable so the concern can be addressed.
3. The Administrator and/or Designee will complete an audit weekly to identify uncleanable surfaces and to ensure the uncleanable surfaces are being addressed. The Administrator and/or Designee will audit this weekly for 6 six weeks and then randomly thereafter.
4. Findings of audits will be reviewed with monthly QAPI committed for tracking/trending for a minimum of 3 months or until compliance is achieved.