STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	165006	A. BUILDING _____ B. WING _____	08/24/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
IOWA JEWISH SENIOR LIFE CENTER	900 POLK BOULEVARD DES MOINES, IA 50312

(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 8-25-17 The following deficiency result from the facility's annual health survey. See the Code of Federal Regulations (42CFR) Part 483, Subpart B-C.	F 000		
F 323 SS=G	483.25(d)(1)(2)(n)(1)-(3) FREE OF ACCIDENT HAZARDS/SUPERVISION/DEVICES (d) Accidents. The facility must ensure that - (1) The resident environment remains as free from accident hazards as is possible; and (2) Each resident receives adequate supervision and assistance devices to prevent accidents. (n) - Bed Rails. The facility must attempt to use appropriate alternatives prior to installing a side or bed rail. If a bed or side rail is used, the facility must ensure correct installation, use, and maintenance of bed rails, including but not limited to the following elements. (1) Assess the resident for risk of entrapment from bed rails prior to installation. (2) Review the risks and benefits of bed rails with the resident or resident representative and obtain informed consent prior to installation. (3) Ensure that the bed's dimensions are appropriate for the resident's size and weight. This REQUIREMENT is not met as evidenced by:	F 323	See Attached	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Ronald Cerka	Executive Director	9-13-17

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	165006	A. BUILDING _____ B. WING _____	08/24/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
IOWA JEWISH SENIOR LIFE CENTER	900 POLK BOULEVARD DES MOINES, IA 50312

(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 323	Continued From page 1 Based on record review and staff interview, the facility failed to provide adequate supervision to Resident #7 in order to prevent falls. The sample consisted of 5 residents and the facility identified a census of 54 residents. Findings include: 1. Resident #7 had a quarterly MDS (Minimum Data Set) assessment with a reference date of 5/9/17. The MDS indicated the resident had diagnoses that included Alzheimer's disease, anxiety disorder, and history of falling, delusional disorders, restlessness and agitation. The MDS recorded Resident #7's Brief Interview for Mental Status (BIMS) a score of 3. A score of 3 represented the resident had cognitive impairments. The MDS recorded the resident required extensive assistance of one staff member for bed mobility, transfers, dressing, hygiene and required total assistance of two staff members for toilet use. The MDS indicated the resident not steady and only able to stabilize with staff assistance when moving from seated to standing position, walking, moving on and off the toilet and surface to surface transfers during the 7 day look back period. According to the annual MDS assessment with a reference date of 8/2/17, Resident #7's BIMS a score of 3, indicating severe cognitive impairment. The MDS recorded that Resident #7 required limited assistance of one staff member for transfers, walking and required total assistance for dressing, hygiene and toilet use. The MDS also recorded the Resident had not been steady and only able to stabilize with staff assistance when moving from seated to standing position, walking, moving on and off the toilet and	F 323		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	165006	A. BUILDING _____ B. WING _____	08/24/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
IOWA JEWISH SENIOR LIFE CENTER	900 POLK BOULEVARD DES MOINES, IA 50312

(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 323	Continued From page 2 surface to surface transfers during of the 7 day lookback period. Resident #7's Care Plan included a problem of impaired physical mobility with potential for injury related to a fractured right hip after a fall and Alzheimer's dementia with poor regards for safety. The Care Plan recorded approaches if fall occurs , assess for injury and notify doctor as needed, intervene with unsafe decision making, and staff should anticipate and provide his/her needs. Update to the Resident #7's Care Plan dated 7/17/17 indicated the resident had fallen in the bathroom during evening cares and received a laceration to the forehead and sent to emergency room and received sutures to his/her forehead. The Nurse's Note dated 5/13/17 recorded the Certified Nursing Aide (CNA) heard someone exclaim "Oooh" and went down the hall to find Resident #7 sitting on the floor mat. A fax to the physician dated 5/13/17 reported Resident #7 crawled or slipped out of the bed and on to the floor mat. The Care Plan dated 5/15/17 identified an update that the staff found the resident sitting on the floor mat next to the bed. The intervention directed staff to place a noodle device on the edge of the bed and change the mattress to a winged mattress. The Nurse's Note dated 6/10/17 [during the 2 P.M. to 10 P.M. shift] but recorded at 10:00 p.m. recorded the staff found the resident on the floor in the lounge with a laceration to the right side of	F 323		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	165006	A. BUILDING _____ B. WING _____	08/24/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
IOWA JEWISH SENIOR LIFE CENTER	900 POLK BOULEVARD DES MOINES, IA 50312

(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 323	Continued From page 3 his/her face and transferred to the hospital emergency room. The resident returned to the facility from the hospital at 7:50 P.M. The 6/10/17 CT head impression recorded a nondisplaced right nasal bone fracture and right supraorbital lateral laceration. The Care Plan identified an update on 6/10/17. The Care Plan indicated the resident had a right eye laceration due to a fall and had been sent to the emergency room and sutures placed. The Care Plan dated 6/12/17 referred to the 6/10/17 Nurse's Note and an intervention to educate the staff if the resident in the lounge area, then someone must be present. The Nurse's Note dated 7/17/17 recorded Resident #7 to be sent to the hospital emergency room. The facility Resident Incident/Accident Report recorded the CNA assisted Resident #7 with evening cares when the CNA turned to grab gloves and Resident #7 fell face first, with an open area on the right side of the forehead. The Nurse's Note dated 7/18/17 recorded Resident #7 returned from the hospital with 14 stiches on the Y shaped laceration. The Nurse's Note dated 7/19/17 recorded Resident #7 noted to be throwing up and received a new order to send to the hospital emergency room. The transfer form identified the recent fell with a head injury and with emesis and fixed pupils now. The note indicated the physician directed the nurse to send the resident to the	F 323		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	165006	A. BUILDING _____ B. WING _____	08/24/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
IOWA JEWISH SENIOR LIFE CENTER	900 POLK BOULEVARD DES MOINES, IA 50312

(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 323	Continued From page 4 hospital emergency room. On 8/23/17 at 2:58p.m. Staff B, CNA, was interviewed and stated he sat the resident on the toilet to do evening cares and removed the resident's clothing. Staff B explained he turned his back to the resident to wash his hands and obtain a wash cloth. Staff B acknowledged with his back to the resident, the resident stood up and fell. A fax to the physician on 8/14/17 reported shortly after assisting the resident to bed, found the resident lying on side and in a fetal position on the floor at the foot of the bed. The resident had no apparent injuries noted. A fax to the physician dated 8/16/17 reported Resident #7 sat in the lounge in a wheelchair, stood up and fell on his/her left side. The Care Plan dated 8/16/17 indicated the resident had fallen on 8/14/16 and an intervention added to keep the Resident #7 up until 8:00 p.m. and to use a body pillow in bed on the right side to prevent the resident from self- transferring. The resident's Care Plan identified an update on 8/17/17. The Care Plan indicated the resident had fallen 8/16/17 and received a new order for occupational therapy to make an evaluation for wheelchair placement.	F 323		
F 353 SS=E	483.35(a)(1)-(4) SUFFICIENT 24-HR NURSING STAFF PER CARE PLANS 483.35 Nursing Services The facility must have sufficient nursing staff with the appropriate competencies and skills sets to	F 353	See Attached	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	165006	A. BUILDING _____ B. WING _____	08/24/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
IOWA JEWISH SENIOR LIFE CENTER	900 POLK BOULEVARD DES MOINES, IA 50312

(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 353	Continued From page 5 provide nursing and related services to assure resident safety and attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident, as determined by resident assessments and individual plans of care and considering the number, acuity and diagnoses of the facility's resident population in accordance with the facility assessment required at §483.70(e). [As linked to Facility Assessment, §483.70(e), will be implemented beginning November 28, 2017 (Phase 2)] (a) Sufficient Staff. (a)(1) The facility must provide services by sufficient numbers of each of the following types of personnel on a 24-hour basis to provide nursing care to all residents in accordance with resident care plans: (i) Except when waived under paragraph (e) of this section, licensed nurses; and (ii) Other nursing personnel, including but not limited to nurse aides. (a)(2) Except when waived under paragraph (e) of this section, the facility must designate a licensed nurse to serve as a charge nurse on each tour of duty. (a)(3) The facility must ensure that licensed nurses have the specific competencies and skill sets necessary to care for residents' needs, as identified through resident assessments, and described in the plan of care. (a)(4) Providing care includes but is not limited to	F 353		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	165006	A. BUILDING _____ B. WING _____	08/24/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
IOWA JEWISH SENIOR LIFE CENTER	900 POLK BOULEVARD DES MOINES, IA 50312

(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 353	Continued From page 6 assessing, evaluating, planning and implementing resident care plans and responding to resident's needs. This REQUIREMENT is not met as evidenced by: Based on review of resident council minutes and resident interview, the facility failed to ensure that call lights were responded to within 15 minutes. The facility census was 54 residents. Findings include: 1. Review of Resident Council Meeting minutes revealed the following concerns: a. 6/6/17 documented there were concerns raised regarding call light answering etiquette and timing. b. 7/11/17 documented the residents requested more attention to call lights. c. 8/1/17 documented resident comments regarding call light wait times, the wait is longer at night. During group interview completed 8/22/17 at 2:00 p.m. 5 of 5 residents present stated the response to call lights was often longer than 15 minutes and could be as long as 30 minutes to one hour. 2. The Minimum Data Set (MDS) assessment dated 7/18/17 recorded Resident #3 had diagnoses that included diabetes, polyneuropathy (numbness and weakness), lymphedema (edema in arms and legs), and heart failure. The MDS documented the resident had a Brief Interview for Mental Status (BIMS) score of 15 out of 15, which indicated an intact cognition. The MDS documented the resident required extensive assistance of 1 staff for transfers, bed mobility, and toileting.	F 353		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	165006	A. BUILDING _____ B. WING _____	08/24/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
IOWA JEWISH SENIOR LIFE CENTER	900 POLK BOULEVARD DES MOINES, IA 50312

(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 353	Continued From page 7 During an interview on 8/22/17 at 8:15 a.m., Resident #3 reported when he/she placed call light on, it took up to 50 minutes for staff to respond. The resident reported he/she had a clock to know the amount of time it took staff to respond. The resident stated 50 minutes seemed too long when he/she needed something or had to go to the bathroom. The resident also reported when staff took him/her to the bathroom, he/she had sat an extended period of time on the toilet before staff returned to assist. 3. The MDS assessment dated 8/7/17 recorded Resident #10 had diagnoses that included cerebrovascular accident (stroke), hemiplegia (paralysis on one side of the body), peripheral vascular disease, arthritis, a collapsed lumbar vertebrae (lower part of the spine), and reduced mobility. The MDS documented the resident had a BIMS score of 14 out of 15, which indicated intact cognition. The MDS documented the resident dependent on staff for transfers and toileting, and required extensive assistance of 2 staff for bed mobility. The MDS revealed the resident had impaired range of motion to the upper and lower extremity on one side. In an interview on 8/21/17 at 10:30 a.m., Resident #10 reported he/she had waited 60 minutes over the weekend before staff answered the call light and provided assistance. The resident reported he/she had a clock on the wall and tracked the amount of time it took for staff to respond. The resident reported the longer response times happened all of the time, no specific day of the week or time of day. The resident also stated he/she sat in the dining room for an extended period of time before staff took him/her to room or another area. The resident reported he/she	F 353		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	165006	A. BUILDING _____ B. WING _____	08/24/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
IOWA JEWISH SENIOR LIFE CENTER	900 POLK BOULEVARD DES MOINES, IA 50312

(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 353	Continued From page 8 frequently had to wait more than 20 minutes for assistance.	F 353		
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, the facility failed to serve food in accordance with professional standards for food safety. The facility reported a census of 54 residents. Findings include:	F 371		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	165006	A. BUILDING _____ B. WING _____	08/24/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
IOWA JEWISH SENIOR LIFE CENTER	900 POLK BOULEVARD DES MOINES, IA 50312

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 371	Continued From page 9 1. During observation of food service preparation and serving on 8/22/17 for the noon meal service, several ladles and scoops were placed on the top of the steam table lids. Staff A repeatedly used the scoops and ladles and placed them back on the soiled service until the dietary supervisor placed clean tin foil on the lids for the implements to be placed. 2. Continued observation revealed Staff A touched several inanimate soiled objects with her gloved right hand then placed a bun on a plate to serve, put meat on the bun with a scoop, placed the top of the bun and pushed it into place with the soiled gloved hand. 3. Observation on 8/22/17 from 12:25 p.m. to 12:38 p.m. revealed Staff A, Dietary Cook, assigned to serve lunch in the Memory Care Unit. During observations Staff A wore a glove on her right hand and touched a variety surfaces with the gloved right hand including, but not limited to, menu slips (handled by residents and staff), handles of utensils, and used the gloved hand to place the top part of buns on sandwiches served to 5 of 13 residents. The 2013 Food Code, published by the Food and Drug Administration and considered a standard of practice for the food service industry requires single-use gloves be used for only one task, such as working with ready-to-eat food and used for no other purpose and discarded when damaged or soiled or when interruptions occur in the operation.	F 371		

State survey 2567 Responses

Iowa Jewish Senior Life Center

F00- Completion date- 8-25-17

Preparation and/or execution of this Plan of Correction does not constitute admission or agreement by the provider the truth of the facts alleged or conclusions set forth in this statement of Deficiencies. The Plan of Correction is prepared and or executed solely because it is required by the provisions of federal and state law.

F323 (G) Free of Accident Hazards/Supervision/ Devices

This facility denies that the alleged facts as set forth constitute a deficiency under Federal and State law.

The preparation of the following plan of correction for this deficiency does not constitute and should not be interpreted as an admission nor an agreement by the facility of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction prepared for this deficiency was executed solely because provisions of the State and Federal law require it.

With respect to resident # 7 and all other similarly situated residents, the facility will provide adequate supervision to prevent avoidable accidents with injury.

Staff education was done with all staff. Review of all fall risk patients was done immediately. Fall risk patients will be monitored on an ongoing basis by the DON/Designee for one month and Quarterly at QA meetings.

F 353 (E) Sufficient 24-hr Nursing Staff per Care Plans

This facility denies that the alleged fact as set forth constitute a deficiency under Federal and State law.

The preparation of the following plan of correction for this deficiency does not constitute and should not be interpreted as an admission nor agreement by the facility of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of Correction prepared for this deficiency was executed solely because provisions of the State and Federal law require it.

With respect to residents number # 3 and # 10 and all other similarly situated residents the facility will provide adequate call light response. Staff Education was done with all staff. Facility will do random call light audits by both Nursing and non-nursing personnel to assure call lights are answered promptly with

the 15 minute time frame. Monitoring of the call lights will be done on a random daily basis and reviewed weekly and at Resident Council meetings held. The DON/designee will review compliance on a weekly basis for one month and then quarterly at QA meetings for two meetings.

F-371 (E) Food Procure, Store, Prepare/ Serve

The Facility denies that the alleged fact as set forth constitute a deficiency under Federal and State Law.

The preparation of the following plan of correction for this deficiency does not constitute and should not be interpreted as an admission nor agreement by the facility of the truth of the facts alleged or conclusions set forth in the Statement of deficiencies. The plan of correction prepared for this deficiency was executed solely because provisions of the State and Federal law required it.

Staff A and all other dietary staff have been Educated on proper food handling with Utensils, barriers and glove usage when applicable. Monitored by the Food Services Supervisor/ designee on a random basis and weekly for one month and then quarterly at QA meeting for two meetings.

F323 (G) Free of Accident Hazards/Supervision/ Devices

This facility denies that the alleged facts as set forth constitute a deficiency under Federal and State law.

The preparation of the following plan of correction for this deficiency does not constitute and should not be interpreted as an admission nor an agreement by the facility of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction prepared for this deficiency was executed solely because provisions of the State and Federal law require it.

With respect to resident # 7 and all other similarly situated residents, the facility will provide adequate supervision to prevent avoidable accidents with injury.

Staff education was done with all staff. Review of all fall risk patients was done immediately. Fall risk patients will be monitored on an ongoing basis by the DON/Designee for one month and Quarterly at QA meetings.