STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	165230	A. BUILDING _____ B. WING _____	08/30/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
OAKLAND MANOR	737 NORTH HIGHWAY OAKLAND, IA 51560

(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 9/27/17 The following deficiencies relate to the annual recertification and state licensure survey. See code of Federal Regulations (42CFR) Part 482, Subpart B-C.	F 000		
F 156 SS=D	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; (B) A description of the requirements and procedures for establishing eligibility for Medicaid, including the right to request an assessment of	F 156		

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

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 10/1/17 VKimmis

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	165230	A. BUILDING _____ B. WING _____	08/30/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
OAKLAND MANOR	737 NORTH HIGHWAY OAKLAND, IA 51560

(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 156	Continued From page 1 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 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	F 156		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	165230	A. BUILDING _____ B. WING _____	08/30/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
OAKLAND MANOR	737 NORTH HIGHWAY OAKLAND, IA 51560

(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 156	Continued From page 2 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 agencies and advocacy groups, such as the State Survey Agency, the State licensure office, adult protective services where state law provides for	F 156		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	165230	A. BUILDING _____ B. WING _____	08/30/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
OAKLAND MANOR	737 NORTH HIGHWAY OAKLAND, IA 51560

(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 156	Continued From page 3 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. (ii) The facility must also provide the resident with the State-developed notice of Medicaid rights and obligations, if any.	F 156		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	165230	A. BUILDING _____ B. WING _____	08/30/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
OAKLAND MANOR	737 NORTH HIGHWAY OAKLAND, IA 51560

(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 156	Continued From page 4 (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 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	F 156		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	165230	A. BUILDING _____ B. WING _____	08/30/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
OAKLAND MANOR	737 NORTH HIGHWAY OAKLAND, IA 51560

(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 156	Continued From page 5 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 clinical record review and staff interview, the facility failed to adequately inform 1 of 3 sampled residents of their appeal rights prior to discharge from skilled services (Residents #13) in the required timeframe. The facility reported a census of 48 residents. Findings include: The facility administrator provided an undated list entitled 'Admissions Did Not Use 100 Skilled	F 156		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	165230	A. BUILDING _____ B. WING _____	08/30/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
OAKLAND MANOR	737 NORTH HIGHWAY OAKLAND, IA 51560

(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 156	Continued From page 6 Days'. The list indicated Resident #13 received Medicare Skilled Services 2/2/17 to 3/8/17. The resident's record contained form CMS 10123 'Notice of Medicare Non-Coverage' signed and dated by the resident's representative on 3/7/17, which did not allow for a timely appeal. An interview with the Office Manager on 8/29/17 at 10:18 a.m. revealed no other notification found to allow for a 2 day notification. She stated that usually notifies resident representatives by phone that the coverage will end but she did not write on Resident #13's form this time. The Office Manager could not confirm notification as done in a timely fashion.	F 156		
F 226 SS=D	483.12(b)(1)-(3), 483.95(c)(1)-(3) DEVELOP/IMPLMENT ABUSE/NEGLECT, ETC POLICIES 483.12 (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	F 226		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	165230	A. BUILDING _____ B. WING _____	08/30/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
OAKLAND MANOR	737 NORTH HIGHWAY OAKLAND, IA 51560

(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 226	Continued From page 7 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 record review and staff interview, the facility failed to complete a criminal background check 30 days before the hire date (Staff B). The sample consisted of 5 residents and the facility reported a census of 48 residents. Findings include: Review of the new employee hire list, identified Staff B, Certified Nursing Assistant (CNA) had a date of hire as 1/4/17. Review of the Single Contact License and Background Check indicated a criminal background history and abuse checks were completed on 10/27/16. The facility did not have a background check 30 days before the hire date of 1/4/17. On 8/29/17 at 11:08 a.m. the Office Manager (OM) was interviewed and stated they [the facility] started the hiring process in October of 2016 but Staff B did not start working until January of 2017. The OM stated she didn't know what the time frame was for getting the criminal background checks completed.	F 226		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	165230	A. BUILDING _____ B. WING _____	08/30/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
OAKLAND MANOR	737 NORTH HIGHWAY OAKLAND, IA 51560

(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 279 SS=D	483.20(d);483.21(b)(1) DEVELOP COMPREHENSIVE CARE PLANS 483.20 (d) Use. A facility must maintain all resident assessments completed within the previous 15 months in the resident's active record and use the results of the assessments to develop, review and revise the resident's comprehensive care plan. 483.21 (b) Comprehensive Care Plans (1) The facility must develop and implement a comprehensive person-centered care plan for each resident, consistent with the resident rights set forth at §483.10(c)(2) and §483.10(c)(3), that includes measurable objectives and timeframes to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment. The comprehensive care plan must describe the following - (i) The services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §483.24, §483.25 or §483.40; and (ii) Any services that would otherwise be required under §483.24, §483.25 or §483.40 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(c)(6). (iii) Any specialized services or specialized rehabilitative services the nursing facility will provide as a result of PASARR recommendations. If a facility disagrees with the	F 279		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	165230	A. BUILDING _____ B. WING _____	08/30/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
OAKLAND MANOR	737 NORTH HIGHWAY OAKLAND, IA 51560

(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 279	Continued From page 9 findings of the PASARR, it must indicate its rationale in the resident's medical record. (iv)In consultation with the resident and the resident's representative (s)- (A) The resident's goals for admission and desired outcomes. (B) The resident's preference and potential for future discharge. Facilities must document whether the resident's desire to return to the community was assessed and any referrals to local contact agencies and/or other appropriate entities, for this purpose. (C) Discharge plans in the comprehensive care plan, as appropriate, in accordance with the requirements set forth in paragraph (c) of this section. This REQUIREMENT is not met as evidenced by: Based on clinical record review and staff interview, the facility failed to develop comprehensive care plans for 3 of 5 sampled residents who received psychotropic medications (Residents #7, #8 and #9). The facility reported a census of 48 residents. Findings include: 1. According to the Minimum Data Set (MDS) assessment dated 8/11/17, Resident #7 had a Brief Interview Mental Status (BIMS) score of 11 indicating moderate cognitive impairment. The assessment documented Resident #7 had diagnoses that included anxiety and depression. The MDS indicated Resident #7 received daily antianxiety and antidepressant	F 279		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	165230	A. BUILDING _____ B. WING _____	08/30/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
OAKLAND MANOR	737 NORTH HIGHWAY OAKLAND, IA 51560

(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 279	Continued From page 10 medications during the assessment period. Review of Resident #7's care plan, with a revision date of 7/6/16, indicated Resident #7 had signs and symptoms of depression and anxiety and received Celexa (an antidepressant) and clonzapam (antianxiety medication) to manage his/her symptoms. The care plan directed staff to observe and report to the doctor any adverse effects, but did not list specific adverse effects to report. Review of the Medication Administration Record (MAR) for August 2017 listed the resident's physician ordered administration of Celexa 40 milligrams (mg) every morning and clonazepam 0.5 mg twice a day. 2. According to the MDS assessment dated 6/5/17, Resident #8 had severely impaired cognitive skills for daily decision making. The MDS listed the resident had diagnoses that included Non-Alzheimer's dementia, anxiety, depression, schizophrenia and lack of coordination. The assessment documented Resident #8 received daily antipsychotic, antianxiety and antidepressant medications. Review of Resident #8's care plan, with a revision date of 8/29/16, indicated Resident #8 takes psychotropic medications related to anxiety, depression, dementia, psychotic symptoms and schizoaffective bipolar disorder. The care plan documented a goal that Resident #8 would have no side effects from psychotropic medications. The care plan instructed staff to observe for effectiveness and adverse side effects from the psychotropic medications, but did not document which specific side effects to observe for.	F 279		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	165230	A. BUILDING _____ B. WING _____	08/30/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
OAKLAND MANOR	737 NORTH HIGHWAY OAKLAND, IA 51560

(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 279	Continued From page 11 The MAR for August 2017 listed that Resident #8's physician ordered administration of Zoloft (an antidepressant) 125 mg every day, Zyprexa (an antipsychotic) 5 mg every day and Lorazepam 0.25 mg (an antianxiety) three times a day. 3. According to the MDS assessment dated 5/31/17, Resident #9 had a BIMS score of 11. The assessment recorded that Resident #9 had diagnoses that included Non-Alzheimer's dementia, anxiety, depression and manic depression. The MDS indicated Resident #9 received daily antipsychotic and antidepressant medications during the assessment period. Review of Resident #9's care plan, revised on 7/26/17, indicated Resident #9 with the potential to demonstrate verbally abusive behaviors related to mental illness or a diagnosis of bipolar disorder. The care plan directed staff to evaluate for side effects of the medications, but did not identify the side effects to observe for. Review of the MAR for August 2017 revealed Resident #9's physician ordered administration of Seroquel 50 mg (an antipsychotic) every night and Sertraline 100 mg (antidepressant) daily at bed time.	F 279		
F 282 SS=D	483.21(b)(3)(ii) SERVICES BY QUALIFIED PERSONS/PER CARE PLAN (b)(3) Comprehensive Care Plans The services provided or arranged by the facility, as outlined by the comprehensive care plan, must-	F 282		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	165230	A. BUILDING _____ B. WING _____	08/30/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
OAKLAND MANOR	737 NORTH HIGHWAY OAKLAND, IA 51560

(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 282	Continued From page 12 (ii) Be provided by qualified persons in accordance with each resident's written plan of care. This REQUIREMENT is not met as evidenced by: Based on clinical record review and staff interview, the facility failed to provide one to one interaction as directed by the care plan for 1 of 11 current residents reviewed (Resident #2). The facility reported a census of 48 residents. Findings include: The Minimum Data Set (MDS) assessment, dated 7/12/17, documented Resident #2 with severely impaired cognitive skills for daily decision making. The MDS recorded Resident #2 required the assistance of 2 with bed mobility, transfers and toilet use and the assistance of one with eating. Resident #2 had diagnoses that included cerebral palsy (poor muscle coordination), infection with a multidrug-resistant organism, seizure disorder, respiratory failure and dependence on a ventilator (to assist breathing). The MDS also documented the resident received oxygen therapy, suctioning and tracheostomy care. The care plan dated 11/1/16 documented a focus area of dependence on staff and an intervention to provide 1 x 1's (personal interactions) on a weekly basis to provide socialization. An interview with the Activity Director on 8/29/17 at 10:08 a.m. revealed she has not been writing down the 1 x 1's and indicated she got behind and could not do this. She could not provide documentation of 1 x 1 visits with the resident.	F 282		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	165230	A. BUILDING _____ B. WING _____	08/30/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
OAKLAND MANOR	737 NORTH HIGHWAY OAKLAND, IA 51560

(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 282	Continued From page 13 An interview with the Director of Nursing (DON) on 8/30/17 at 10:10 a.m. revealed the expectation that all staff follow care plan interventions.	F 282		
F 367 SS=D	483.60(e)(1)(2) THERAPEUTIC DIET PRESCRIBED BY PHYSICIAN (e) Therapeutic Diets (e)(1) Therapeutic diets must be prescribed by the attending physician. (e)(2) The attending physician may delegate to a registered or licensed dietitian the task of prescribing a resident's diet, including a therapeutic diet, to the extent allowed by State law. This REQUIREMENT is not met as evidenced by: Based on observation, record review, and staff interview the facility failed to serve the planned meat portions for 1 of 44 residents (#5) served during lunch. The facility reported a census of 48 residents. Findings include: According to the Minimum Data Set (MDS) assessment dated 6/21/17, Resident #5 scored a 15 on the Brief Interview of Mental Status (BIMS) indicating no cognitive or memory impairment. The MDS indicated Resident #5 required set up and supervision while eating. The MDS indicated Resident #5 had diagnoses that included anemia, diabetes mellitus, severe and chronic kidney disease, dependence on renal dialysis and hyperlipidemia. Review of Resident #5's care plan, revised	F 367		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	165230	A. BUILDING _____ B. WING _____	08/30/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
OAKLAND MANOR	737 NORTH HIGHWAY OAKLAND, IA 51560

(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 367	Continued From page 14 3/30/17, revealed Resident #5 had a nutritional problem related to a wound, diabetes and recent weight gain. The care plan instructed to serve the resident's diet as ordered providing double egg and double whole meats. Resident #5 fed him/herself. Review of the resident's Medication Review Report dated 6/28/17 revealed the physician ordered a no added salt, high protein diet. During observation of meal service on 8/28/17 at 12:02 p.m., Staff A Cook served lunch. Staff A prepared Resident #5's plate with one serving of smothered steak. Once staff served the plate, interview with Staff A revealed the resident should received double meat portions but he forgot about it. Staff A then served another smothered steak to Resident #5. During interview on 8/29/17 at 1:45 p.m. the Dietary Manager stated they always give Resident #5 double meat portions because s/he needs the extra protein.	F 367		
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	F 371		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	165230	A. BUILDING _____ B. WING _____	08/30/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
OAKLAND MANOR	737 NORTH HIGHWAY OAKLAND, IA 51560

(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 15 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 dispose of milk that had expired. The facility reported a census of 48 residents. Findings include: During initial tour of the kitchen on 8/27/17 at 10:15 a.m., observation revealed 3, 1-gallon containers of whole milk cartons in the True refrigerator with expiration dates of 8/27/17. Observation on 8/28/17 at 11:52 a.m. revealed 2, 1-gallon containers whole milk cartons in the True refrigerator with an expiration date of 8/27/17. During interview on 8/29/17 at 1:45 p.m. the Dietary Manager stated the milk delivery guy usually rotates and discards any expired milk.	F 371		
F 441 SS=D	483.80(a)(1)(2)(4)(e)(f) INFECTION CONTROL, PREVENT SPREAD, LINENS (a) Infection prevention and control program.	F 441		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	165230	A. BUILDING _____ B. WING _____	08/30/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
OAKLAND MANOR	737 NORTH HIGHWAY OAKLAND, IA 51560

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 441	Continued From page 16 The facility must establish an infection prevention and control program (IPCP) that must include, at a minimum, the following elements: (1) A system for preventing, identifying, reporting, investigating, and controlling infections and communicable diseases for all residents, staff, volunteers, visitors, and other individuals providing services under a contractual arrangement based upon the facility assessment conducted according to §483.70(e) and following accepted national standards (facility assessment implementation is Phase 2); (2) Written standards, policies, and procedures for the program, which must include, but are not limited to: (i) A system of surveillance designed to identify possible communicable diseases or infections before they can spread to other persons in the facility; (ii) When and to whom possible incidents of communicable disease or infections should be reported; (iii) Standard and transmission-based precautions to be followed to prevent spread of infections; (iv) When and how isolation should be used for a resident; including but not limited to: (A) The type and duration of the isolation, depending upon the infectious agent or organism involved, and (B) A requirement that the isolation should be the	F 441		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	165230	A. BUILDING _____ B. WING _____	08/30/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
OAKLAND MANOR	737 NORTH HIGHWAY OAKLAND, IA 51560

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 441	Continued From page 17 least restrictive possible for the resident under the circumstances. (v) The circumstances under which the facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease; and (vi) The hand hygiene procedures to be followed by staff involved in direct resident contact. (4) A system for recording incidents identified under the facility's IPCP and the corrective actions taken by the facility. (e) Linens. Personnel must handle, store, process, and transport linens so as to prevent the spread of infection. (f) Annual review. The facility will conduct an annual review of its IPCP and update their program, as necessary. This REQUIREMENT is not met as evidenced by: Based on observation, record review and staff interviews, the facility failed to promote good handwashing technique for 1 of 7 residents reviewed (Resident #2). The facility reported a census of 48 residents. Findings include: The Minimum Data Set (MDS) assessment, dated 7/12/17, documented Resident #2 had severely impaired cognitive skills for daily decision making. The MDS recorded Resident #2 required the assistance of 2 with bed mobility, transfers and toilet use and the assistance of one	F 441		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	165230	A. BUILDING _____ B. WING _____	08/30/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
OAKLAND MANOR	737 NORTH HIGHWAY OAKLAND, IA 51560

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 441	Continued From page 18 with eating. Resident #2 had diagnoses that included cerebral palsy (poor muscle coordination), infection with a multidrug-resistant organism, seizure disorder, respiratory failure and dependence on a ventilator (to assist breathing). The MDS also documented Resident #2 received oxygen therapy, suctioning and tracheostomy care. The care plan dated of 2/8/16 revealed Resident #2 as ventilator dependent related to chronic respiratory failure. The care plan instructed to maintain the ventilator settings as recommended by R.T. (Respiratory Therapist). An observation on 8/29/17 at 8:54 a.m. revealed the R.T. manager preparing to enter the resident's room. She picked up a glove off the floor, gowned, donned gloves and entered the resident's room. She put some items away and then removed her gloves. The R.T. manager applied fresh gloves, began suctioning resident and removed his/her dressing. She then removed her gloves again and donned fresh gloves to cleanse around the tracheostomy stoma site (surgical airway for breathing) and apparatus. She removed her gloves again and donned gloves to change the strap that held the tracheostomy apparatus in place. The R.T. manger then removed her gloves again and donned fresh gloves to place dressing around stoma site and change inner cannula of the tracheostomy. She did not wash her hands or use hand sanitizer at any time prior to entering the resident's room and when moving from clean to soiled tasks. The R.T. manager washed her hands only before leaving the room. An interview with the Director of Nursing (DON)	F 441		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	165230	A. BUILDING _____ B. WING _____	08/30/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
OAKLAND MANOR	737 NORTH HIGHWAY OAKLAND, IA 51560

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 441	Continued From page 19 on 8/29/17 at 1:30 p.m. revealed she expected staff to wash or sanitize their hands after each glove removal, going from dirty to clean tasks, upon entering the room and prior to leaving the room. Review of the facility's Handwashing policy and procedure, dated 2/16, revealed instruction that staff should wash their hands with soap and water (hand hygiene) before applying and after removing gloves, after handling items potentially contaminated with blood, body fluids or secretions and before moving from a contaminated body site to a clean body site during resident care.	F 441		

Submission of the response and plan of correction is not a legal admission that a deficiency exists or that this statement of deficiency was correctly cited and is also not to be construed as an admission of interest against the facility, the Executive Director, or other associates, agents, or other individuals who draft or may be discussed in this response and plan of correction. Preparation and submission of this plan of correction does not constitute an admission or agreement of any kind by the facility of the truth of any fact alleged or the correctness of any conclusion set forth in these allegations by the survey agency.

Compliance Date Set: 9/27/17

F 156 Notice of Rights, Rules, Services, Charges

How the corrective action will be accomplished for those residents found to have been affected by the deficient practices:

No residents had a negative outcome because of this deficient practice. Resident 13 was discharged from services and ABN notice was signed on 3-7-17, day of discharge from services.

How the facility will identify other residents having the potential to be affected by the same deficient practice:

The facility recognizes that all residents receiving Medicare benefits could be affected by the deficient practice with reviewing the current payor source of stay.

What measures will be put into place or what systemic changes will be made to ensure the deficient practice will not reoccur:

Education was provided to BOM, ADON, DON, MDS Coordinator, Administrator and Social services on the use of the ABN form and Generic Denial notice form and the required notification period by the Regional Resident Assessment Coordinator. The MDS Coordinator and/or designees will be responsible to provide resident and Resident Representative the Beneficiary notice per the required notification time. All communication to resident and/or Resident Representative will be documented.

How will the facility monitor its corrective actions:

The BOM and/or designee will do random audits weekly to assure compliance and will report audit findings to the QAPI Committee monthly for 2 months and as needed thereafter.

F 226 Develop/Implement Abuse/Neglect, ETC Policies

How the corrective action will be accomplished for those residents found to have been affected by the deficient practices:

No residents had a negative outcome because of this deficient practice. Employee B Background check was immediately processed on 8-30-2017 with no adverse actions noted on background check.

How the facility will identify other residents having the potential to be affected by the same deficient practice:

The facility recognizes that all residents have the potential to be affected by this deficient practice.

What measures will be put into place or what systemic changes will be made to ensure the deficient practice will not reoccur:

All current Employee background checks have been audited by BOM to assure all necessary background checks have been completed within the required timeline as required by federal and state laws.

Education was provided to the BOM by Administrator on the Federal and Iowa Law requirements of Background checks.

How will the facility monitor its corrective actions:

The BOM and/or designee will do random audits weekly to assure compliance. The BOM and/or designee will report audit findings to the QAPI committee for 2 months and as needed thereafter.

F 279 Develop Comprehensive Care Plan

How the corrective action will be accomplished for those residents found to have been affected by the deficient practices:

No residents had a negative outcome because of this deficient practice. Resident 7,8 & 9, all have had care plan reviewed and updated to include side effects of anti-psychotic medications.

How the facility will identify other residents having the potential to be affected by the same deficient practice:

The facility recognizes that any resident prescribed anti- psychotic medications have the potential to be affected by this deficient practice.

What measures will be put into place or what systemic changes will be made to ensure the deficient practice will not reoccur:

All current residents identified to have an anti-psychotic medication was audited to assure Care plan was updated to include medication side effects.

The MDS Coordinator, Social Service Designee, DON and ADON were education on how to develop a Care plan by the Regional Resident Assessment Coordinator on 9-7-2017.

The pharmacy consultant provided an anti-psychotic medication list with side effects to the Social Service Designee, MDS Coordinator, DON and ADON.

How will the facility monitor its corrective actions:

The Social Service Designee and/or designee will do random audits weekly to assure compliance on side effects a part of Care Plans. The Administrator and/or Designee will report audit findings to the QAPI committee for 2 months and as needed thereafter.

F 282 Services by Qualified persons/per care plan

How the corrective action will be accomplished for those residents found to have been affected by the deficient practices:

No residents had a negative outcome because of this deficient practice. Resident #2 had care plan reviewed and followed to include documentation of 1:1 interactions.

How the facility will identify other residents having the potential to be affected by the same deficient practice:

The facility recognizes that any resident care planned for 1:1 interactions have the potential to be affected by this deficient practice.

What measures will be put into place or what systemic changes will be made to ensure the deficient practice will not reoccur:

All current residents identified to have 1:1's were audited to assure Care plan was updated to include 1:1 interactions.

The Activity Director was education on how to determine 1:1 interactions are beneficial and warranted on 8-30-2017.

The Activity Director was educated on the importance of effective documentation of completed interactions.

How will the facility monitor its corrective actions:

The Administrator and/or designee will do random audits weekly to assure compliance with care plan interventions for 1:1 interactions are followed. The Activity Director and/or Designee will report audit findings to the QAPI committee for 2 months and as needed thereafter.

F 367 Therapeutic Diet Prescribed by Physician

How the corrective action will be accomplished for those residents found to have been affected by the deficient practices:

No residents had a negative outcome because of this deficient practice. Resident #5 diet order was reviewed to ensure transcribed correctly and dietary department documentation accurate.

How the facility will identify other residents having the potential to be affected by the same deficient practice:

The facility recognizes that any resident prescribed therapeutic diet have the potential to be affected by this deficient practice.

What measures will be put into place or what systemic changes will be made to ensure the deficient practice will not reoccur:

All current residents identified to have therapeutic diet were audited to assure dietary sheet noted the proper diet.

The Registered Dietician will provide an in-service on importance of dietary compliance to dietary manager and dietary staff.

How will the facility monitor its corrective actions:

The Dietary Manager and/or designee will do random audits weekly to assure compliance with diets as prescribed being followed. The Administrator and/or Designee will report audit findings to the QAPI committee for 2 months and as needed thereafter.

F371 Dietary Sanitation

How the corrective action will be accomplished for those residents found to have been affected by the deficient practices:

No residents had a negative outcome because of this deficient practice. The Expired product was removed on 8-29-2017 by the Dietary Manager.

How the facility will identify other residents having the potential to be affected by the same deficient practice:

The facility recognizes that all residents have the potential to be affected by this deficient practice.

What measures will be put into place or what systemic changes will be made to ensure the deficient practice will not reoccur:

All Dietary staff and Dietary Manager have been educated by the Registered Dietician on safe food procurement practices and used by dates of products. The Dietary manager has set a system to assure rotating of stock is completed.

The milk vendor was notified to assure no expired product is delivered to facility.

How will the facility monitor its corrective actions:

The Dietary Manager and/or designee will do random audits weekly to assure no expired products are in rotation. The Dietary Manager and/or Designee will report audit findings to the QAPI committee for 2 months and as needed thereafter.

F441 Infection Control

How the corrective action will be accomplished for those residents found to have been affected by the deficient practices:

No residents had a negative outcome because of this deficient practice. RT Manager has been educated on the proper handwashing techniques.

How the facility will identify other residents having the potential to be affected by the same deficient practice:

The facility recognizes that all residents have the potential to be affected by this deficient practice.

What measures will be put into place or what systemic changes will be made to ensure the deficient practice will not reoccur:

RT manager was educated with return demonstration on proper handwashing techniques on 8-29-2017 and reviewed on 9-06-2017.

All nursing staff was educated on proper handwashing techniques by 9-15-2017 and scheduled to review on 9-25-2017.

How will the facility monitor its corrective actions:

The DON and/or designee will do random audits weekly to assure compliance with proper handwashing techniques. The DON and/or Designee will report audit findings to the QAPI committee for 2 months and as needed thereafter.