

PRINTED: 10/20/2017
FORM APPROVED
OMB NO. 0938-0391

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE		TITLE	(X6) DATE
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If continuation sheet Page 1 of 27

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

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 165253	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 10/09/2017
NAME OF PROVIDER OR SUPPLIER PANORA SPECIALTY CARE			STREET ADDRESS, CITY, STATE, ZIP CODE 805 EAST MAIN PANORA, IA 50216		
(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 167	Continued From page 1 areas of the facility that are prominent and accessible to the public. (iv) The facility shall not make available identifying information about complainants or residents. This REQUIREMENT is not met as evidenced by: Based on observation and group resident interviews, the facility failed to post the comprehensive survey results in a readily accessible place for residents, family members or visitors to view as desired. The facility reported a census of 44 at the time of the survey. Findings include: During a Group resident interview on 10/2/17 at 1:30 p.m. the 3 of the 3 residents in attendance stated they did not know the location of the survey results and did not know they could see a copy of the last survey results. An observation on 10/3/17 at 1:20 p.m. revealed a sign under the staffing sheet for the daily staff in the lobby by the front door. The surveyor lifted the staffing sheet to reveal the sign that informed the "Panora Specialty Care survey binder is located at the front nurses station. Please ask a staff member for assistance." Observation at 1:25 p.m. revealed the survey results kept on a shelf under the charts in the nurses station. Observation on 10/9/17 at 7:55 a.m. revealed the survey information sign still half covered up by the staffing sheet and the staffing sheet had to be moved to read the sign for the where about of the survey results.	F 167			

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F 252 F 252 SS=C	Continued From page 2 483.10(e)(2)(i)(1)(i)(ii) SAFE/CLEAN/COMFORTABLE/HOMELIKE ENVIRONMENT (e)(2) The right to retain and use personal possessions, including furnishings, and clothing, as space permits, unless to do so would infringe upon the rights or health and safety of other residents. §483.10(i) Safe environment. The resident has a right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely. The facility must provide- (i)(1) A safe, clean, comfortable, and homelike environment, allowing the resident to use his or her personal belongings to the extent possible. (i) This includes ensuring that the resident can receive care and services safely and that the physical layout of the facility maximizes resident independence and does not pose a safety risk. (ii) The facility shall exercise reasonable care for the protection of the resident's property from loss or theft. This REQUIREMENT is not met as evidenced by: Based on observation and staff interview, the facility failed to ensure a well-maintained and homelike environment for residents in the facility. The facility reported a census of 44 current residents. Findings include: During Environmental tour on 10/3/17 between	F 252 F 252			

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F 252	Continued From page 3 2:00 and 3:00 p.m. with the Facility Administrator and Environmental Services Supervisor present, observation revealed the following areas of concern: a. Rooms 109, 404, 406, 411, 415 and 100 hallway bath/shower door showed marred doors with missing paint. b. The 300 hall bathroom contained 4 cracked ceramic floor tiles and missing or cracked around the sink. The wallpaper in the room had a hole in it and loose edges from the floor to ceiling. c. A buildup of dirt around the base cove and in the dining room and activity room/assisted dining room. The front dining room middle air conditioner had a black substance that smeared when touch around the plug end. At the time of the environmental tour the Administrator agreed the areas did not appear homelike and agreed the areas needed fixed and cleaned.	F 252			
F 285 SS=D	483.20(e)(k)(1)-(4) PASRR REQUIREMENTS FOR MI & MR (e) Coordination. A facility must coordinate assessments with the pre-admission screening and resident review (PASARR) program under Medicaid in subpart C of this part to the maximum extent practicable to avoid duplicative testing and effort. Coordination includes: (1) Incorporating the recommendations from the PASARR level II determination and the PASARR evaluation report into a resident's assessment, care planning, and transitions of care.	F 285			

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F 285	Continued From page 4 (2) Referring all level II residents and all residents with newly evident or possible serious mental disorder, intellectual disability, or a related condition for level II resident review upon a significant change in status assessment. (k) Preadmission Screening for individuals with a mental disorder and individuals with intellectual disability. (1) A nursing facility must not admit, on or after January 1, 1989, any new residents with: (i) Mental disorder as defined in paragraph (k)(3)(i) of this section, unless the State mental health authority has determined, based on an independent physical and mental evaluation performed by a person or entity other than the State mental health authority, prior to admission, (A) That, because of the physical and mental condition of the individual, the individual requires the level of services provided by a nursing facility; and (B) If the individual requires such level of services, whether the individual requires specialized services; or (ii) Intellectual disability, as defined in paragraph (k)(3)(ii) of this section, unless the State intellectual disability or developmental disability authority has determined prior to admission- (A) That, because of the physical and mental condition of the individual, the individual requires the level of services provided by a nursing facility; and	F 285			

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F 285	Continued From page 5 (B) If the individual requires such level of services, whether the individual requires specialized services for intellectual disability. (2) Exceptions. For purposes of this section- (i) The preadmission screening program under paragraph(k)(1) of this section need not provide for determinations in the case of the readmission to a nursing facility of an individual who, after being admitted to the nursing facility, was transferred for care in a hospital. (ii) The State may choose not to apply the preadmission screening program under paragraph (k)(1) of this section to the admission to a nursing facility of an individual- (A) Who is admitted to the facility directly from a hospital after receiving acute inpatient care at the hospital, (B) Who requires nursing facility services for the condition for which the individual received care in the hospital, and (C) Whose attending physician has certified, before admission to the facility that the individual is likely to require less than 30 days of nursing facility services. (3) Definition. For purposes of this section- (i) An individual is considered to have a mental disorder if the individual has a serious mental disorder defined in 483.102(b)(1).	F 285			

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F 285	Continued From page 6 (ii) An individual is considered to have an intellectual disability if the individual has an intellectual disability as defined in §483.102(b)(3) or is a person with a related condition as described in 435.1010 of this chapter. (k)(4) A nursing facility must notify the state mental health authority or state intellectual disability authority, as applicable, promptly after a significant change in the mental or physical condition of a resident who has mental illness or intellectual disability for resident review. This REQUIREMENT is not met as evidenced by: Based on clinical record review and staff interviews the facility failed to obtain authorization for an additional period of time for placement and services according to the Preadmission Screening and Resident Review (PASRR) for 1 of 9 residents reviewed for level II PASRR's (Resident #7). The facility reported a census of 44 residents. Findings include: The Minimum Data Set (MDS) assessment dated 7/20/17 documented Resident #7 had diagnoses that included depression, anxiety disorder and manic depression (bipolar disease). The assessment documented Resident #7 felt down, depressed or hopeless about herself nearly half the time of every day. The resident's care plan dated 7/8/15 with a goal date of 11/3/17 documented problem areas for Resident #7 including a history of delusions and delusional thinking and episodes of verbal outbursts. The care plan instructed staff to assure the resident's safety and re-approach as needed	F 285			

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F 285	Continued From page 7 and to provide reality orientation. The care plan lacked identification of PASRR of needed specialized services. The Preadmission Screening and Resident Review (PASRR) Notice for Resident #7 dated 12/13/16 noted short-term nursing facility approval that included services or support. The PASRR recommended ongoing psychiatric services by a psychiatrist to evaluate response and effectiveness of psychotropic medication on target symptoms, modify medication orders and to evaluate ongoing need for additional behavioral health services. The PASRR expired 6/11/17 and the facility failed to obtain authorization for an additional period of time for placement and services. During interview on 10/5/17 at 12:10 p.m., the Social Worker/Activities Director acknowledged she would update the PASRR's in the system and take out the ones when residents discharged. The Social Worker/Activities Director stated that once the PASRR had been approved she would print it off and place the PASRR in the resident's chart. She and the Director of Nursing kept a calendar as to when a PASRR needed to be updated. The Social Worker/Activities Director stated she did not receive notice that Resident #7's PASRR needed to be updated.	F 285			
F 312 SS=D	483.24(a)(2) ADL CARE PROVIDED FOR DEPENDENT RESIDENTS (a)(2) A resident who is unable to carry out activities of daily living receives the necessary services to maintain good nutrition, grooming, and personal and oral hygiene. This REQUIREMENT is not met as evidenced	F 312			

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F 312	Continued From page 8 by: Based on clinical record review, observation, staff interview and facility policy review, the facility failed to ensure staff provided incontinence care in a manner to prevent infection and to provide complete incontinence care for hygiene for 1 of 5 incontinent residents reviewed (Resident #4). The facility reported a census of 44 residents. Findings included: 1. The Minimum Data Set (MDS) assessment dated 6/26/17 identified Resident #4 had diagnoses which included Non-Alzheimer's dementia, diabetes and cancer. The MDS indicated the resident required the assistance of two staff for bed mobility, transfers, toileting, and personal hygiene and that he experienced frequent incontinence. The resident's care plan dated 6/20/17 indicated he had frequent urine incontinence and required staff assistance for toileting. The care plan directed staff to provide the assistance of one with toilet use and perform pericare per facility protocol as needed. During observation on 10/3/17 at 9:38 a.m. revealed Staff C, Certified Nursing Assistant (CNA), and Staff D provided incontinence care for Resident #4 while the resident laid in bed. The Director of Nursing (DON) stood in the room and observed staff. Staff D reported Resident #4's brief was wet. Staff D removed the resident's brief, then took several disposable wipes, wadded the wipes up, and cleansed the groin area and penis front to back, folding the wipes as she cleansed each area. Staff D and Staff C rolled the resident onto his left side and tucked the	F 312			

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F 312	Continued From page 9 soiled incontinence brief under the resident. Staff D wadded up a couple disposable wipes and used the same disposable wipe to cleanse between the buttocks and then each buttock, without turning the wipe to a clean surface with each pass. Staff D used another disposable wipe to cleanse between the resident's legs. Staff D then changed her gloves and applied a clean brief. The staff failed to cleanse the resident's abdomen and hips, which came into contact with urine. During an interview 10/5/17 at 2:10 p.m., the DON reported the facility performed quarterly pericare audits with staff CNA's. The DON stated she expected staff to perform incontinence care according to the audit steps. The DON expected staff used a new disposable wipe to cleanse each area and cleanse the area from from front to back. An Incontinence Care/PeriCare Guideline, dated 1/15, recorded the following procedural steps: - Cleanse all soiled areas front to back using a clean area of cloth/wipe, turning the resident as necessary - Remove gloves - Wash hands An undated PeriCare Audit included the following procedural steps: - Washed all soiled areas front to back using clean parts of wash cloth each time - Turn resident to side - Cleanse buttocks and rectal areas - Remove gloves and wash hands - Make sure all areas that had contact with urine or stool cleansed including the thighs, abdomen, hips, back, etc.	F 312			

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F 323 SS=E	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: Based on observation, staff interviews and record review, the facility failed to ensure the facility provided appropriate interventions to ensure against hazards and failed to ensure maintenance of safe hot water temperatures to prevent potential injury to residents. The facility identified a census of 44 residents. Findings included:	F 323			

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F 323	Continued From page 11 1. During the initial tour of the facility on 10/2/17, between 9:08 to 9:42 a.m., random measurement of hot water temperatures revealed the following: Room 308 - a water temperature of 122 degrees Fahrenheit (F.) Room 312 - a water temperature of 129.2 degrees F. During the Environmental tour on 10/3/17 between 2:00 and 3:00 p.m. with the Administrator and Environmental Services Supervisor present, observation revealed the following: 100 Hallway bath/shower room - a water temperature of 127.3 degrees F. 300 Hallway bath/shower room - a water temperature of 131.7 degrees F. Room 312 - a water temperature of 130.6 degrees F. Review of documents titled Monday - Friday Daily Duties Form, from 7/13/17 until 10/3/17, revealed 138 documented water temperatures ranging 124 - 131 degrees F. While on environmental tour on 10/3/17 between 2:00 p.m. and 3:00 p.m. an interview with the Environmental Services Supervisor revealed he had not been aware of any issues with hot water temperatures. During a follow-up interview on 10/4/17 at 1:35 p.m., the Environmental Services Supervisor reported he adjusted the thermostat on the water heaters and rechecked water temperatures in several areas. At that time the Environmental Services Supervisor and surveyor measured the	F 323			

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F 323	Continued From page 12 water temperature in room 312 bathroom with the facility's thermometer and it recorded 125.3 degrees F. The Administrator identified 11 residents with cognitive impairment and independent mobility lived in the facility. 2. Observation during the Environmental tour on 10/3/17 between 2:00 and 3:00 p.m. with the Facility Administrator and Environmental Services Supervisor revealed the following chemicals stored behind an unlooked door in the hub of halls 400, 500, and 600. a. Eleven 8 ounce (oz) bottles of McKesson no rinse Perineal wash. The product's Material Safety Data Sheet (MSDS) directed to avoid eye contact and to get medical attention if ingested. b. Twenty 4 oz containers and seventeen 2 oz containers of Purell advanced instant hand sanitizer. The sanitizer's MSDS documented it a flammable liquid and vapor and it causes serious eye irritation. c. Fourteen 5 oz containers of Cavilon durable Barrier Cream. The product's MSDS warned to avoid eye contact and if swallowed, to rinse the mouth. d. Thirty five 4 oz containers of McKesson mouthwash. The mouthwash's MSDS warned to avoid eye contact and if ingestion occurred, to the rinse mouth immediately and drink plenty of water. At the time of the environmental tour the Administrator stated the door should be locked at all times. The facility protocol for Sanitary Conditions,	F 323			

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F 323	Continued From page 13 Housekeeping Policies section 2-9 March 2013 Edition recorded toxic items will be properly stored, labels and uses.	F 323			
F 353 SS=E	The Administrator identified 5 residents with cognitive impairment and independent mobility lived on facility halls 400, 500 and 600. 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 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	F 353			

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F 353	Continued From page 14 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 assessing, evaluating, planning and implementing resident care plans and responding to resident's needs. This REQUIREMENT is not met as evidenced by: Based on group resident interview, review of resident council minutes and resident and family interviews, the facility failed to ensure staff responded and answered residents' call lights within 15 minutes; and met residents needs in a timely manner for 3 of 3 residents during group interview and 3 of 10 current residents reviewed (Residents #10, # 1 and #9). The facility reported a census of 44 residents. Findings include: 1. During a group resident interview on 10/2/17 at 1:30 p.m., 3 of 3 residents reported when they placed the call light on, it took staff more than 15 minutes before they responded and provided assistance. The residents reported staff had longer response times on weekend, evening and night shifts. One resident reported she had waited 2 hours for staff assistance to go to the	F 353			

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F 353	Continued From page 15 bathroom. The resident reported she had placed call light on and waited. The resident reported she felt awful when she soiled her pants because she couldn't wait any longer. Another resident stated she had also wet herself while waiting for staff to come. This resident stated she kept time by a watch and felt demeaned and embarrassed about the incident. 2. Review of Resident Council Meeting minutes revealed the following concerns: a. 4/28/17 - call lights not answered timely and staff certified nursing assistants (CNA's) had a party in another resident's room on 4/26/17. b. 5/26/17 - call lights not answered timely. c. 6/30/17 - call light not answered timely on overnight shift. d. 7/17 - old business addressed the previous months concerns but call lights continued to be a problem between night shifts. e. 8/29/17 - CNA's talked on phone instead of assisting residents. f. 9/29/17 - CNA's still on phones instead of providing assistance to residents. It took an hour before call lights answered during the day and night time. 3. On 10/3/17 at 1:35 p.m., Resident #10's family member reported it took 45-60 minutes for staff to respond to the resident's needs and call lights. The family member reported when she visited the facility within the past week, Resident #10 sat in a wheelchair in soiled pants for 2 hours because staff were too busy and unable to assist. The family member reported the facility did not have enough staff to care for residents and staff told residents all of the time they had to wait, but then didn't come back. The family member reported the resident called her at home she couldn't get	F 353			

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F 353	Continued From page 16 any help. Review of Resident #10's MDS assessment of 8/15/17 revealed she required the assistance of one staff with transfers, toilet use and personal hygiene. 4. The MDS assessment dated 8/3/17 recorded Resident #1 had diagnoses that included heart failure, depression, muscle weakness and cellulitis in the left lower limb. The MDS documented the resident had a Brief Interview for Mental Status (BIMS) score of 15 out of 15, which indicated intact memory and cognition. The MDS documented the resident required the assistance of one staff for bed mobility, transfers, toilet use and personal hygiene. The care plan dated 1/14/16 recorded Resident #1 needed staff assistance with activities of daily living (ADL's) due to weakness. In an interview 10/2/17 at 3:45 p.m., Resident # 1 reported to took 20 minutes or longer before staff responded to her call light and provided assistance. Resident #1 reported this happened often. The resident reported she had wet and dirtied her pants while waiting for staff. The resident stated she felt degraded and embarrassed after that occurred. Resident #1 reported she looked at digital clock on dresser to tell how long it took for staff to respond. 5. Review of the MDS assessment dated 9/7/17 revealed Resident #9 had diagnoses that included heart failure, anxiety disorder, depression and chronic lung disease. The MDS documented the resident had a BIMS score of 15 out of 15 and that she required the assistance of	F 353			

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F 353	Continued From page 17 one staff with transfers, toilet use and personal hygiene. The care plan dated 5/24/17 identified resident had increased needs with ADL assistance and with an increased risk for falls. The care plan directed she needed the assistance of one staff with transfers, positioning and ambulation. During an interview 10/4/17 at 2:00 p.m., Resident #9 reported on the evening of 9/25/17, she told staff she needed to go to the bathroom. Staff verbally responded it would be a minute. The resident asked again for assistance to the bathroom and staff told her it would be a minute. The resident reported she wheeled herself in wheelchair to their room after 30 minutes and then fell in the bathroom when attempting to go to the bathroom by herself. The resident reported she pulled the call light in the bathroom but nobody came. The resident then used her cell phone and called the front desk, but nobody answered the phone. The resident then reported she hollered for help and a staff CNA came to check on her. The resident reported staff played on phones and texted a lot.	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.	F 371			

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F 371	Continued From page 18 (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, facility document review and staff interviews, dietary staff failed maintain dish machine temperatures or perform effective sanitation checks of the dish machine to reduce the risk of food borne illness. The facility reported a census of 44 residents. Findings include: Observation on 10/2/17 at 10:40 a.m. revealed the facility's low temperature dish machine had a wash cycle of 100 degrees Fahrenheit (F) and a rinse cycle of 114 degrees (F). The Dietary Manager ran the dish machine a second time, and the dish machine temperature gauge indicated a wash temperature at 114 degrees (F).	F 371			

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F 371	Continued From page 19 During interview at that time, the Dietary Manager reported she thought the water temperature should be 120 degrees (F). On the bulletin board near the dish machine, a sign documented the dish machine wash and rinse cycle temperatures needed to be at 120 (F) or above. If temperature is below 120, staff should run the dish machine until the temperature went up. Observation on 10/2/17 at 11:06 a.m. revealed the dish machine had a wash cycle temperature of 115 degrees (F). Observation on 10/4/17 at 1:20 p.m. revealed the dish machine had a wash cycle temperature of 100 degrees (F) and a rinse cycle temperature of 114 degrees (F). At 1:22 p.m., Staff E, dietary cook, loaded another rack of dishes and ran the dish machine again. The temperature gauge on the dish machine showed the wash cycle measured 100 degrees (F) and rinse cycle at 114 degrees (F). During an interview 10/4/17 at 1:24 p.m., Staff E reported she has had to run the dish machine a number of times in order for the machine to get up to the proper temperature. Staff E reported the wash and rinse cycles are supposed to be at least 120 degrees (F). Staff E stated when the dish machine temperatures not reading properly, she has been told to drain and refill the machine and recheck the temperature. Staff E acknowledged they had trouble with the dish machine and the company had serviced the machine came out a couple of weeks prior to the survey week. Staff E stated they wrote the temperatures in a log book and staff should	F 371			

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F 371	Continued From page 20 check the temperatures every day. During an interview 10/4/17 at 1:28 p.m., the Dietary Manager reported dish machine temperatures are recorded in a log book by staff every day. The Dietary Manager stated she expected dish machine wash and rinse cycles to be at 120 degrees (F). The Dietary Manager reported dish machine temperatures had been low lately, but the company had told them to drain the dish machine, refill the machine then recheck the temperature. Review of facility policy dated 2/16 titled General Dish Machine revealed mechanical dish machines will be checked prior to use to assure proper functioning and appropriate temperatures for cleaning and sanitization. Staff recorded the dish machine temperatures on the temperature log. Review of facility policy dated 2/16 titled Dish Machine Temperature Log revealed dishwashing staff needed to record dish machine temperatures for the wash and rinse cycle at each meal, and reported any problems with the dish machine to the food service manager. Review of documents titled "Dish Machine Temperature Log", dated 9/1 to 10/3/17 revealed the following: 1. Rinse temperature: a. 100 degrees (F) on 9/21 at lunchtime. b. 100 degrees (F) on 9/23 at lunch and dinnertime. c. 115 degrees (F) on 10/4 at breakfast. d. 114 degrees (F) on 10/4 at lunchtime.	F 371			

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F 371	Continued From page 21 2. Wash temperature: a. 118 degrees (F) on 10/4 at breakfast. b. 100 degrees (F) on 10/4 at lunchtime. 3. Wash and rinse temperatures blank on the following dates: Breakfast: 9/7, 9/8, 9/16, 9/17, 9/22, 9/25, 9/30 and 10/1. Lunch: 9/2, 9/3, 9/6, 9/7, 9/8, 9/16, 9/17, 9/22, 9/25, 9/30 and 10/1. Dinner: 9/2, 9/3, 9/5-9/17, 9/19-9/22, 9/25-9/29, 9/30, 10/1 and 10/3.	F 371			
F 431 SS=D	483.45(b)(2)(3)(g)(h) DRUG RECORDS, LABEL/STORE DRUGS & BIOLOGICALS The facility must provide routine and emergency drugs and biologicals to its residents, or obtain them under an agreement described in §483.70(g) of this part. The facility may permit unlicensed personnel to administer drugs if State law permits, but only under the general supervision of a licensed nurse. (a) Procedures. A facility must provide pharmaceutical services (including procedures that assure the accurate acquiring, receiving, dispensing, and administering of all drugs and biologicals) to meet the needs of each resident. (b) Service Consultation. The facility must employ or obtain the services of a licensed pharmacist who-- (2) Establishes a system of records of receipt and disposition of all controlled drugs in sufficient detail to enable an accurate reconciliation; and	F 431			

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F 431	Continued From page 22 (3) Determines that drug records are in order and that an account of all controlled drugs is maintained and periodically reconciled. (g) Labeling of Drugs and Biologicals. Drugs and biologicals used in the facility must be labeled in accordance with currently accepted professional principles, and include the appropriate accessory and cautionary instructions, and the expiration date when applicable. (h) Storage of Drugs and Biologicals. (1) In accordance with State and Federal laws, the facility must store all drugs and biologicals in locked compartments under proper temperature controls, and permit only authorized personnel to have access to the keys. (2) The facility must provide separately locked, permanently affixed compartments for storage of controlled drugs listed in Schedule II of the Comprehensive Drug Abuse Prevention and Control Act of 1976 and other drugs subject to abuse, except when the facility uses single unit package drug distribution systems in which the quantity stored is minimal and a missing dose can be readily detected. This REQUIREMENT is not met as evidenced by: Based on observation, clinical record review, facility policy review and staff interviews, the facility failed to ensure staff discarded an expired medication for one of 15 total residents reviewed (Resident #15). The facility reported a census of 44. Findings include:	F 431			

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F 431	Continued From page 23 Observation of the facility's medication carts with the Director of Nursing (DON) on 10/3/17 at 3:00 p.m. revealed Resident #15's Novolog (insulin) vial stored in the medication cart. The insulin vial showed an open date of 9/1/17. The DON acknowledged the insulin should be discarded 28 days after opening the vial. Nurses have a sheet in the front of the Medication Administration Records book that gives information on medication expiration dates. A review of the Resident # 15's Blood Sugar Record recorded she received Novolog 10 times from the vial during October. The facility's reference entitled Insulin Products documented Novolog insulin expired 28 days after opening the vial.	F 431			
F 469 SS=E	483.90(i)(4) MAINTAINS EFFECTIVE PEST CONTROL PROGRAM (i)(4) Maintain an effective pest control program so that the facility is free of pests and rodents. This REQUIREMENT is not met as evidenced by: Based on observation and resident and staff interview, the facility failed to ensure they maintained effective control of flies and other insects. The facility reported a census of 44 residents. Findings include: 1. Observations revealed flies in the the facility's kitchen: a. 10/2/17 at 8:30 a.m., a dead fly in a drawer with utensils in the kitchen. b. 10/2/17 at 10:40 a.m., flies flying around the	F 469			

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F 469	Continued From page 24 kitchen near the dish washing area. c. 10/2/17 at 11:30 a.m., a fly sat on the cap of a juice container on the beverage cart. d. 10/2/17 at 11:48 a.m., flies crawling and flying around the stove hood and food warming/steam cart. e. 10/2/17 at 11:59 a.m., flies crawling on the exterior surface of a fan and flying near the food serving area. f. 10/2/17 at 12:05 p.m., a fly landed on the food prep area, near the steam cart with food. During an interview and observation 10/2/17 at 12:25 p.m., Staff E, Dietary Cook, reported there had been a problem with flies in the kitchen over the past two months. Staff E stated the facility mounted a device on the wall in the kitchen to control fly population but the device didn't help much. Staff E showed the surveyor the device and plugged the device in. No indicator lights came on. When asked if the wall device should light up, Staff E stated she didn't know much about the device and didn't feel comfortable messing with it. During an interview 10/2/17 at 1:50 p.m., the Environmental Services/Maintenance Supervisor reported the insect light lit up when it worked, but he wasn't sure if the device had been broken or the bulb had burnt out. The Environmental Services/Maintenance Supervisor stated the facility used to have two devices to control insects but now had only one device, when the vendor took another device down during a service call. 2. Observation revealed flies and other insects in the nurse's station, dining rooms, hallway and on the medication cart on the following dates:	F 469			

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F 469	Continued From page 25 **10/2/17: a. At 3:05 p.m., flies on tables in the main dining room. b. At 3:10 p.m., flies landed on the countertop at the South Nurse's Station. **10/3/17: a. At 11:06 a.m., a bee flew around the medication cart and landed on the handle of a water pitcher that sat on the medication cart b. At 11:08 a.m., a bee flew in front of the surveyor and Staff B, Certified Medication Aide. Staff B waved her hand in air and attempted to move the bee away. **10/4/17 a. At 8:35 a.m., fly landed on the edge of a resident's cereal bowl in the main dining room. The resident waved a hand across the bowl in attempt to move the fly away from the food. The resident reported the flies had been a problem at the facility. 3. The Minimum Data Set (MDS) assessment dated 8/3/17 recorded Resident #1 had a Brief Interview for Mental Status (BIMS) score of 15 out of 15, which indicated intact memory and cognition. During interview 10/2/17 at 3:45 p.m., the resident reported the facility had a lot of bugs. 4. During a group resident interview on 10/2/17 at 1:30 p.m., 3 of 3 residents present reported the facility had a lot of crickets, spiders and flies. One resident stated the table in the dining room where she sat had a lot of flies and flies had been a chronic problem for at least 2 months. 4. During Environmental tour on 10/3/17 between 2:00 and 3:00 p.m. with the Facility Administrator	F 469			

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F 469	Continued From page 26 and Environmental Services Supervisor observation revealed crickets down the 100 and 400 hallway and numerous flies in the dining area and assisted dining room/activity room. At the time of the observation, the Administrator stated the facility had changed pest control companies to a local vendor to get a better response time.	F 469			

Panora Specialty Care

805 E. Main Street

Panora, IA 50216

Survey Exit Date 10/9/2017

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

F167 – All residents will have access to the most recent survey of the facility conducted by Federal or State surveyors. Ongoing monitoring of the survey results will become part of the facility QA process. This was completed by 10/30/2017.

F252- All residents will have a clean and homelike environment. Audits will be performed periodically for four weeks to ensure facility is clean and homelike. Ongoing monitoring will become part of the facility QA process. Items a, b and c will be completed by 10/30/2017.

F285- Facility will coordinate assessments with the PASRR for each resident. The director of nursing will monitor weekly to ensure compliance. Ongoing monitoring will become part of the facility QA process. This was completed by 10/30/2017.

F312- Resident #4, as well as all residents at the facility, who are unable to carry out activities of daily living will receive the necessary services to maintain good nutrition, grooming, and personal and oral hygiene. All appropriate staff at the facility have been re-educated as to the ADL needs of resident #4. Audits will be performed weekly for 4 weeks to ensure ADLs are being completed. Ongoing monitoring will become part of the facility QA process. This will be completed by 10/30/2017.

F323- Residents at the facility will have an environment that remains free from accident hazards as is possible; and each resident receives adequate supervision and assistance devices to prevent accident. QA team has been educated on safe hot water temperatures. All appropriate facility staff has been re-educated on the standard of maintaining harmful chemicals behind locked cabinets and doors. Audits will be performed weekly for 4 weeks to ensure compliance. Ongoing monitoring will become part of the facility QA process. This will be completed by 10/30/2017.

F353- All residents at the facility will have their needs met per their plan of care by sufficient numbers of staff. All staff will be re-educated to have call lights answered within 15 minutes or less. The facility will perform call light audits weekly for four weeks. Ongoing monitoring will become part of the facility QA process. This will be completed by 10/20/2017.

F371- Residents at the facility will have food procured from sources approved or considered satisfactory by Federal, State, or local authorities. All appropriate staff have been re-educated to the dish machine temperature to be at least 120 degrees (F). Audits will be performed weekly for four weeks. Ongoing monitoring will become part of the facility QA process. This will be completed by 10/30/2017.

F431- Residents at the facility will have their drugs labeled in accordance with currently accepted professional principles, and include the appropriate accessory and cautionary instructions, and the expiration date when applicable. All appropriate staff has been re-educated. Audits will be performed weekly for four weeks. Ongoing monitoring will become part of the facility QA process. This will be completed by 10/30/2017.

F469- The facility will maintain an effective pest control program so that the facility is free of pests and rodents. Audits will be performed weekly for four weeks. Ongoing monitoring will become part of the facility QA process. This will be completed by 10/30/2017.

Sincerely,

A handwritten signature in black ink, appearing to read 'Jana Cates', with a stylized, cursive script.

Jana Cates

Administrator