STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	165372	A. BUILDING _____ B. WING _____	11/02/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ELM CREST RETIREMENT COMMUNITY	2104 12TH STREET HARLAN, IA 51537

(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 Nov. 3, 2017 & Nov. 30, 2017. The following deficiencies relate to the facility's health survey and investigation of a self-report #69271-I. Investigation of facility-reported incident #69271-I resulted in deficiency. See the Code of Federal Regulations (42CFR) Part 483, Subpart B-C.	F 000		
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 by: Based on clinical record review, observation and staff interview the facility failed to provide complete incontinence care for 3 of 8 incontinent residents reviewed (Residents #3, #4 and #6). The facility reported a census of 63 residents. Findings include: 1. The Minimum Data Set (MDS) assessment dated 9/19/17 for Resident #3 identified diagnoses that included kyphosis, altered mental status and adjustment disorder with depressed mood. The MDS recorded the resident required the assistance of two staff for toilet use and the assistance of one staff with personal hygiene. The resident experienced frequent urinary and bowel incontinence.	F 312	See Attached	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Timothy J Maude	Administrator	11/24/2017 11/16/2017

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

POC accepted 11/27/17 KV

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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 by: Based on clinical record review, observation and staff interview the facility failed to provide complete incontinence care for 3 of 8 incontinent residents reviewed (Residents #3, #4 and #6). The facility reported a census of 63 residents. Findings include: 1. The Minimum Data Set (MDS) assessment dated 9/19/17 for Resident #3 identified diagnoses that included kyphosis, altered mental status and adjustment disorder with depressed mood. The MDS recorded the resident required the assistance of two staff for toilet use and the assistance of one staff with personal hygiene. The resident experienced frequent urinary and bowel incontinence.	F 312	See Attached	

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Timothy J Maude	Administrator 11/24/2017	11/16/2017

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

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F 312	Continued From page 1 The resident's care plan dated 7/4/17 documented she had a toileting deficit with frequent incontinence of urine and stool. The care plan instructed staff to offer, encourage or assist with perineal care when found wet. During an observation on 10/31/17 at 7:40 a.m. , Staff E and Staff F, both Certified Nurse's Aides, (CNAs) entered the resident's room, washed their hands and donned gloves. Staff E performed incontinence care with the resident lying in bed. Staff E cleansed under her abdominal fold, both leg creases and the central perineal area. Staff rolled Resident #3 to the left hip. Staff E removed a soiled incontinence brief from under the resident and cleansed her buttocks, buttocks crease and the back of the resident's thighs. Staff E failed to wash either hip after removing a saturated incontinence product from the resident. 2. The MDS assessment for Resident #4, dated 9/12/17, identified diagnoses that included arthritis, dementia, pain and a history of falling. The MDS recorded the resident required the assistance of two staff for toilet use and the assistance of one staff with personal hygiene. The assessment documented she experienced occasional incontinence of urine. The resident's care plan dated 6/24/17 documented she experienced occasional incontinence of the bladder and instructed staff to offer, encourage or assist with perineal care when found wet. During an observation on 10/30/17 at 1:30 p.m., Staff A, CNA, entered the resident's bathroom, washed her hands and donned gloves as	F 312		

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F 312	Continued From page 2 Resident #4 sat on the toilet. Staff A removed the resident's shoes, pants and soiled incontinence product. With the same gloved hands, Staff A applied a clean incontinence brief, pants and shoes. Staff A assisted the resident to stand using a gait belt and performed incontinence care on the resident's back perineal area. Staff A removed her gloves, pulled up the incontinence brief and pants and transferred Resident #4 back into the wheelchair. Staff A failed to wash the frontal perineal area, hips, inner thighs or buttocks after the resident experienced an incontinence episode. 3. According to the MDS assessment dated 10/17/17, Resident #6 had diagnoses that included hypertension, kidney disease, diabetes mellitus and Parkinson's disease. The MDS indicated Resident #6 required the assistance of 2 with toilet use and he experienced frequent urinary incontinence. Review of Resident #6's care plan, with a revision date of 10/22/17, revealed direction to assist with or provide perineal care when found wet or soiled. Staff should use pads and briefs as needed. During an observation on 10/31/17 at 8:14 a.m. Staff A and Staff G CNA assisted Resident #6 with incontinent cares. Both Staff A and G washed their hands and donned gloves and Staff G removed the blankets from Resident #6. Staff A unfastened the urine soiled incontinence brief and provided incontinence cares. Staff rolled Resident #6 to his left side and Staff A provided cares to his right buttocks and hip. Staff G obtained a pull up brief and pulled it up on his right side as Staff A removed her gloves, washed her hands and donned a new pair of gloves. Staff	F 312		

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F 312	Continued From page 3 A assisted to turn Resident #6 to his right side, and Staff G pulled up his brief without cleansing his right buttock and hip which came into contact with urine. During an interview on 11/2/17 at 7:57 a.m. the Director of Nursing (DON) stated the In-Service Coordinator had just completed competencies with staff on perineal care. The DON also stated her expectations are for staff to wash a resident's hips during incontinent cares.	F 312		
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	F 323	See Attached	

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F 323	Continued From page 4 appropriate for the resident's size and weight. This REQUIREMENT is not met as evidenced by: Based on record review and staff interviews and review of policy and procedures, the facility failed to provide adequate supervision to ensure against hazards during a wheelchair transfer (Resident #15). A staff person pushed Resident #15 in a wheelchair without the resident resting feet on the foot pedals. The staff member instructed the resident to lift feet during the transfer. The resident lowered her foot and propelled out of the wheelchair and onto the floor. This fall resulted in a fractured hip. The facility reported a census of 63 residents and the sample consisted of 10 residents reviewed. Findings include: 1. Resident #15 had a Minimum Data Set (MDS) assessment with a reference date of 5/16/17. Resident #15 had a Brief Interview for Mental Status (BIMS) score of 4. A score of 4 represented the resident had a severe cognitive behavior. The MDS indicated Resident #15 required extensive assistance of 2 or more people with bed mobility, transfer and toilet use. The MDS indicated the resident usually used a wheelchair. Resident #15 had diagnoses that included depression, muscle weakness, altered mental status and pain. The Care Plan dated 5/24/17 identified Resident #15 had a focus area with activity of daily living (ADL) deficit due to Alzheimer's disease and muscle weakness. The interventions included and directed the staff that the resident required extensive assist for wheelchair (wc) locomotion upon request and able to self-propel wc within facility. The Care Plan identified another focus for	F 323		

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F 323	Continued From page 5 a risk of falls. The interventions included and initated on 7/27/14, directed the staff to assure the resident's feet are placed on the wc pedals when staff pushed the resident in the wc. The Progress Notes, written by Staff I, Licensed Practical Nurse (LPN), dated 6/20/17 at 7:55 p.m. identified documentation regarding falls. The notes identified the Certified Nursing Assistant (CNA) was called to the room. Resident #15 was on the floor in front of her wc on her left side. The CNA reported she pushed the resident in a wc and out of the bathroom; had washed and put on pajamas. The note indicated the resident put a foot on the floor and she fell forward out of the wc and landed on her left side and hit head on the floor. The left leg rotated outward and resident grimaces and voiced pain with movement of her left leg. The staff assisted the resident up into her wc and then transferred with 2 staff assistance and a gait belt to the bed. The resident continued to complain of left hip pain in bed and transferred to the hospital emergency room (ER). Record review of the hospital History and Physical dated 6/20/17, identified Resident #15 came into the emergency room after she fell out of the wc. The reported indicated the resident's x-ray highly suspicious for an intertrochanteric hip fracture and referred to orthopedics (branch of medicine dealing with bone injuries). Record review of the Orthopedic Consultation dated 6/21/17 identified the x-ray showed a minimally displaced anterior intertrochanteric fracture of the left hip. Record review of the hospital Discharge	F 323		

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F 323	Continued From page 6	F 323		

Summary dated 6/26/17 indicated the resident status post fracture of left hip. The summary identified the resident has dementia and advanced age as well as renal insufficiency, hypothyroidism (low thyroid function) and hypertension (elevated blood pressure). The resident transferred back to the facility for comfort cares for end of life secondary to failure to thrive, poor intake and poor urine output.

A written statement by the Director of Nursing (DON) dated 6/23/17 identified Staff H, CNA stated she transferred Resident #15 into the wc with the gait belt and took her to the toilet with her feet on the pedals. After transferring resident back into the wc when finished, she turned the resident toward the beds. Staff H stated she did not put Resident #15's feet on the pedals. Staff H asked the resident to lift her feet and she did. They got as far as the first bed and she [the resident] started to lean forward and went to the floor. Staff H did not see the resident put her foot down [off of the foot pedals].

Review of the document titled Policy & Procedure for Transporting Residents in Wheelchair and Use of Wheelchair Pedals, dated 6/21/17, directed the staff to always use wheelchair pedals, if you are pushing a resident in a wheelchair. The policy also documented if the resident needs assistance, place pedals on the wheelchair and put their feet on the pedals.

On 10/31/17 at 2:00 p.m., Staff H CNA, was interviewed and stated she took Resident #15 to the bathroom using the wc. Staff H stated the foot pedals were locked in front of the wc but not down so the resident could use. Staff H confirmed the resident's feet were not on the wc

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F 323	Continued From page 7 pedals when she moved her out of the bathroom toward her bed. Staff H stated the resident held her feet up when being pushed but then dropped a foot to the floor and fell forward out of the wc. Staff H stated she should have flipped the foot pedals down as they were right there. On 11/2/17 at 7:55 a.m. the Director of Nursing was interviewed and stated her expectation for staff when pushing a wc is to use the foot pedals. Review of the Certificate Of Death, with a file date of 8/2/17, identified the date of death as 8/29/17. The physician listed the immediate cause of death as failure to thrive and the other significant condition listed is fall; hip fracture.	F 323		
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.	F 371	See Attached	

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F 371	Continued From page 8 (i)(3) Have a policy regarding use and storage of foods brought to residents by family and other visitors to ensure safe and sanitary storage, handling, and consumption. This REQUIREMENT is not met as evidenced by: Based on observation and staff interview the facility failed to ensure that resident food items were used prior to expiration/use by date, failed to ensure opened food items were properly stored and dated, failed to ensure cooking utensils were maintained in a sanitary manner, failed to ensure sanitary storage of a dry goods scoop, and failed to ensure food was served in a sanitary manner. The facility reported a census of 63 residents. Findings include: 1. During the initial Dietary Tour from 10:10 a.m. to 10:50 a.m. on 10/30/17, with the Consultant Dietician the following concerns were identified: a. An open, unsealed box of Cream of Rice Gluten Free cereal. b. Outdated food items: 2 white cake mixes with "use by" dates of 4/16, 2 angel food cake mixes with "use by" dates of 6/1/17. c. Multiple cooking utensils with cracked or melted handles and five spatulas with cracked rubber heads. d. A large measuring scoop lying in the sugar bin. e. Tongs used to place dinner rolls on the resident's plates sat on top of the dinner rolls allowing the area touched by the cook to come into contact with the dinner rolls. During the initial dietary tour the Dietician Consultant acknowledged the concerns identified.	F 371		

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F 371	Continued From page 9 In an interview with the Dietary Manager on 10/31/17 at 1:20 p.m., he stated the expectation is long handles should not be placed inside the dinner roll container with the handles touching the rolls. He instructed the cook to discard the rest of the dinner rolls after calling the issue to her attention.	F 371		
F 441 SS=E	483.80(a)(1)(2)(4)(e)(f) INFECTION CONTROL, PREVENT SPREAD, LINENS (a) Infection prevention and control program. 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	F 441	See Attached	

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F 441	Continued From page 10 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 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 clinical record review, observation, staff interview and facility policy review the facility	F 441		

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F 441	Continued From page 11 failed to utilize infection control techniques for 4 out of 13 current residents reviewed (Residents #2, #4, #5 and #6). The facility reported a census of 63 residents. Findings include: 1. The Minimum Data Set (MDS) assessment for Resident #2, dated 10/3/17, identified diagnoses of hypertension, diabetes and Alzheimer's disease. The MDS indicated the resident required extensive assistance of one staff for bed mobility, dressing, and toileting and the extensive assistance of two staff for transfers. During an observation on 10/31/17 at 6:35 a.m., Resident #2 sat on the toilet with a clean incontinence brief and pants on. Staff D, Certified Nurse's Aide, (CNA) finished dressing the resident, performed hand hygiene and donned gloves. Staff D assisted Resident #2 to stand and completed perineal care. Staff D then removed her gloves, pulled up the resident's incontinence brief and pants and transferred her to the wheelchair. Staff D assisted the resident in brushing her teeth, brushed the resident's hair, placed foot pedals on the wheelchair and pushed Resident #2 to the dining area. Staff D failed to perform hand hygiene after removing her gloves, before moving to a clean task from a dirty task and before exiting the resident's room. 2. The MDS assessment for Resident #4, dated 9/12/17, identified diagnoses that included arthritis, dementia, pain and a history of falling. The MDS recorded the resident required the assistance of two staff for toilet use and the assistance of one staff with personal hygiene. The assessment documented she experienced	F 441		

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F 441	Continued From page 12 occasional incontinence of urine. During observation on 10/30/17 at 1:30 p.m., Staff A, CNA, entered the resident's bathroom, washed her hands and donned gloves as Resident #4 sat on the toilet. Staff A removed the resident's shoes, pants and soiled incontinence product. With the same gloved hands, Staff A applied a clean incontinence brief, pants and shoes. Staff A assisted the resident to stand using a gait belt and performed incontinence care on the resident's back perineal area. Staff A removed her gloves, pulled up the incontinence brief and pants and transferred Resident #4 back into the wheelchair. The CNA pushed the resident's wheelchair back to the bedside and handed her the call light. Staff A failed to perform hand hygiene after glove removal and failed to change gloves when moving between dirty and clean tasks. 3. Resident #5's MDS assessment dated 10/17/17 identified diagnoses that included heart failure, dementia and Parkinson's disease. The MDS revealed the resident required the assistance of two staff for bed mobility, transfers, toilet use and personal hygiene. During an observation on 10/30/17 at 4 p.m., Staff B and Staff C, both CNA's, entered the resident's room and transferred him/her from the wheelchair to the toilet using a stand lift. Staff C donned gloves before she pulled down the resident's pants and underwear. Staff C removed her gloves and washed her hands. Staff C donned clean gloves and performed perineal care with disposable wipes, removed her gloves and pulled up the resident's underwear and pants. Staff B and Staff C transferred Resident #5 back	F 441		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	165372	A. BUILDING _____ B. WING _____	11/02/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ELM CREST RETIREMENT COMMUNITY	2104 12TH STREET HARLAN, IA 51537

(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 13 into the wheelchair using the stand lift. Staff C pushed the resident's wheelchair out to the dining area to participate in an activity before sanitizing her hands. Staff failed to perform hand hygiene after glove removal and when moving from dirty to clean tasks. 4. According to the MDS assessment dated 10/17/17, Resident #6 had diagnoses that included hypertension, kidney disease, diabetes mellitus and Parkinson's disease. The MDS indicated Resident #6 required the assistance of 2 with toilet use and he experienced frequent urinary incontinence. Review of Resident #6's care plan, with a revision date of 10/22/17, revealed direction to assist with or provide perineal care when found wet or soiled. Staff should use pads and briefs as needed. During an observation on 10/31/17 at 8:14 a.m. Staff A and Staff G CNA assisted Resident #6 with incontinent cares. Both Staff A and G washed their hands and donned gloves and Staff G removed the resident's blankets. Staff A obtained a new pair of pants, moved his wheelchair, obtained a new brief, went in to the bathroom to obtain a package of adult wipes, then unfastened the urine soiled incontinent brief. Staff A provided peri cares then proceeded to touch the side rail controller to raise the bed up. With the same gloved hands Staff A assisted Staff G to turn Resident #6 unto his left side. Staff completed incontinent cares to his right back side. Staff A then moved the trash can closer to her while wearing the same gloves and then finished with cares. Staff A failed to change her gloves in between dirty and clean tasks.	F 441		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	165372	A. BUILDING _____ B. WING _____	11/02/2017

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F 441	Continued From page 14 During an interview on 11/2/17 at 7:57 a.m. the Director of Nursing (DON) stated the In-Service Coordinator had just completed competencies with staff on hand washing. The DON also stated her expectations are for staff to complete proper hand hygiene between dirty and clean tasks. Review of the facility's policy and procedure for perineal care with a revision date of 1/8/14 revealed staff are to wash their hands and apply clean gloves after perineal cares. When staff are finished cleaning the front (peri area) change your gloves and wash hands or use hand sanitizer. Put on clean gloves and move to the back (rectal area) to finish. Remove soiled gloves then apply clean pad if indicated and adjust clothing as needed.	F 441		

Plan of Correction
Preparation of the Plan of Correction does not constitute admission or agreement by the provider of the truths 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 the federal and state law. Submission of the plan of correction shall not be construed as a waiver of this provider's right to contest any and all deficiencies, nor is such submission an admission that the facts are as alleged, or that any regulatory violation occurred.

The following is to be considered our Credible Allegation of Compliance.

F312 ADL Care Provided for Dependent Residents

Correct deficiency to individual:
Residents #3, 4, and 6 were checked and had perineal care given per our policy.

Protect res. in similar situation:
All residents have received perineal care given to them per our policy.

Measures/system prevent reoccur:
Nurses will receive re-education on our perineal care policy. Nurse Aides will receive re-education with return demonstration on our perineal care policy.

Monitor permanent solution:
DON or designee will audit three times weekly for 4 weeks. Then twice per week for the next 4 weeks. Audits will then continue for an additional four weeks at once a week. Results of audits will be taken to the monthly QAPI meeting and evaluated for compliance for next 3 monthly meetings.

Completion date of November 30, 2017.

F 333 Free of Accident, Hazards/Supervision/Devices

Correct Deficiency to Individual;
Resident is no longer in the facility. Staff CNA "H", who was transporting the resident was re-educated immediately by Nurse "I" on 6/20/2017.

Protect Residents in Similar Situations;
As nurses, CNAs and staff came on following shifts, they were re-educated and reviewed the Transporting of Residents policy or called in to be educated. Nurses and Nurse Aides were re-educated on facility policy for transportation of residents in a wheelchair, and all were completed by 6/30/2017. All staff had been re-educated on facility policy for transportation of residents in a wheelchair by 7/07/2017.

Measure/System to prevent reoccur;
Nurses, CNAs and All staff have been re-educated again on facility policy for transportation of residents in a wheelchair at our All Staff meeting on 7/13/2017, 8/10/2017, 9/14/2017 and 10/12/2017 as well as at our Team Time, 2X/day, the last week of June, and at various days each week in July and through August, September and October.

Monitor Permanent Solution;
Administrator and Director of Nursing/designee have done audits throughout the months of July, August and September observing residents being transported in wheelchairs. Results of audits have been taken to July, August, September and October QAPI meeting and will continue to be taken to the monthly QAPI meeting and evaluated for compliance at our next 2 meetings.

Completion Date of November 3, 2017

F371 Food Procure, Store/Prepare/Serve – Sanitary

Correct Deficiency to Individual;

a. Cream of rice was thrown out that same day, 10/30/2017.
b. The 2 White Cake mixes and the 2 Angel Food cake mixes were thrown out the same day, 10/30/2017
c. All the cooking utensils identified with affected areas were removed from facility the same day, 10/30/2017.
d. Measuring Scoop was removed from sugar bin the same day, 10/30/2017.
e. All Dinner rolls were thrown out, even those not touched by the Tongs, the same day, 10/31/2017.

Protect Residents in Similar Situations;
All food items will be stored, prepared, distributed and served under sanitary conditions. As dietary staff came on following shifts, they were re-educated and reviewed the proper food storage and proper utensil usage techniques and inspection to prevent contamination of food. The dietary manager has checked all kitchenware and dinnerware for excessive wear. Heavily worn items have been removed from service and replaced.

Measure/System to prevent reoccur;
All dietary staff were re-educated by November 30, 2017 with an educational in service conducted by the dietitian or dietary manager that included proper food storage and proper utensil use on techniques to prevent contamination of food. All Staff were educated on proper food storage, preparation and sanitary conditions of equipment at both Team Times 2X a day on various days of the week, starting 11/03/2017, and at the November All Staff on November 9th, 2017.

Monitor permanent solution:
Random audits by Dietary Manager, Dietician, Administrator or designee will be done for the following areas:

* Food Storage and Usage Dates,
* Kitchenware and dinnerware for excessive usage and unsanitary conditions,
* Meal prep and service for proper utensil use.

These audit will be performed 3X/week for 4 weeks, then 2X/week for the next 4 weeks and 1X/week for the final four weeks. Results of audits will be taken to the monthly QAPI meeting and evaluated for compliance at our next 3 meetings.

Completion Date of November 30, 2017

F 441 Infection Control, Prevent Spread, Linens

Correct deficiency to individual:

Residents #2, 4, 5 and 6 were checked and had perineal care given per our policy with proper infection control and glove usage per our policy and procedures effective November 3rd, 2017.

Protect res. in similar situation:

All residents have received perineal care per our policy and with proper infection control and glove usage per our policy and procedures effective November 3rd, 2017.

Measures/system prevent reoccur:

Nurses will receive re-education on Proper Infection Control and Glove Usage Policy and Procedure. Nurse Aides will receive re-education with return demonstration on our Policy and Procedure for Proper Infection Control and Glove Usage as well as our perineal care policy.

Monitor permanent solution:

DON or designee will audit three times weekly for 4 weeks. Then twice per week for the next 4 weeks. Audits will then continue an additional four weeks at once a week. Results of audits will be taken to the monthly QAPI meeting and evaluated for compliance for next 3 monthly meetings.

Completion date of November 30, 2017.

Administrator
11/24/2017