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	165368	A. BUILDING _____ B. WING _____	01/09/2018

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LITTLE FLOWER HAVEN	736 HIGHWAY 37 EARLING, IA 51530

(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 1/23/18 amm 2/6/18 The following deficiencies result from the facility's annual health survey. See the Code of Federal Regulations (42CFR) Part 483, Subpart B-C.	F 000	See Attached Plan of Correction	
F 583 SS=D	Personal Privacy/Confidentiality of Records CFR(s): 483.10(h)(1)-(3)(i)(ii) §483.10(h) Privacy and Confidentiality. The resident has a right to personal privacy and confidentiality of his or her personal and medical records. §483.10(h)(i) Personal privacy includes accommodations, medical treatment, written and telephone communications, personal care, visits, and meetings of family and resident groups, but this does not require the facility to provide a private room for each resident. §483.10(h)(2) The facility must respect the residents right to personal privacy, including the right to privacy in his or her oral (that is, spoken), written, and electronic communications, including the right to send and promptly receive unopened mail and other letters, packages and other materials delivered to the facility for the resident, including those delivered through a means other than a postal service. §483.10(h)(3) The resident has a right to secure and confidential personal and medical records. (i) The resident has the right to refuse the release of personal and medical records except as provided at §483.70(i)(2) or other applicable	F 583		2/6/18

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

[signature] | Asst. Adm. | 1/26/18

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 1/29/18 VK

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F 583	Continued From page 1 federal or state laws. (ii) The facility must allow representatives of the Office of the State Long-Term Care Ombudsman to examine a resident's medical, social, and administrative records in accordance with State law. This REQUIREMENT is not met as evidenced by: Based on clinical record review, observation, staff interview and facility policy review, the facility failed to provide privacy during incontinent cares for 1 of 2 residents (Resident #30) observed for incontinent cares. The facility reported a census of 38 residents. Findings include: According to the Minimum Data Set (MDS) assessment dated 12/5/17, Resident #30 had severely impaired cognitive skills for daily decision making. The MDS listed the following diagnoses: cerebral palsy, traumatic brain injury and urinary incontinence. The MDS indicated Resident #30 required the assistance of 2 staff with bed mobility, transfers and toilet use and the assistance of one with dressing and personal hygiene. Resident #30 always experienced incontinence of both urine and bowel. Review of the care plan with a revision date of 12/13/17 revealed Resident #30 required the assistance of two with a Hoyer (mechanical) lift with all transfers. The care plan also instructed staff to provide incontinent cares after each incontinent episode. Observation on 1/2/18 at 11:17 a.m. revealed Staff A Certified Nursing Assistant (CNA) and Staff B CNA performed incontinent cares for	F 583		

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F 000	INITIAL COMMENTS Correction date 2/6/18 The following deficiencies result from the facility's annual health survey. See the Code of Federal Regulations (42CFR) Part 483, Subpart B-C.	F 000		
F 583 SS=D	Personal Privacy/Confidentiality of Records CFR(s): 483.10(h)(1)-(3)(i)(ii) §483.10(h) Privacy and Confidentiality. The resident has a right to personal privacy and confidentiality of his or her personal and medical records. §483.10(h)(l) Personal privacy includes accommodations, medical treatment, written and telephone communications, personal care, visits, and meetings of family and resident groups, but this does not require the facility to provide a private room for each resident. §483.10(h)(2) The facility must respect the residents right to personal privacy, including the right to privacy in his or her oral (that is, spoken), written, and electronic communications, including the right to send and promptly receive unopened mail and other letters, packages and other materials delivered to the facility for the resident, including those delivered through a means other than a postal service. §483.10(h)(3) The resident has a right to secure and confidential personal and medical records. (i) The resident has the right to refuse the release of personal and medical records except as provided at §483.70(i)(2) or other applicable	F 583		

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POC aa

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F 583	Continued From page 2 Resident #30 but failed to pull the curtains to his windows closed. The curtains were left open during the entire incontinent cares. The observation revealed Resident #30's window faces the Middle Hall windows. During interview on 1/8/18 at 2:31 p.m. the Assistant Director of Nursing (ADON) stated staff always pull the curtains closed during cares and staff know they are supposed to close the curtains before cares. Review of the facility's Incontinent Care policy, dated 11/14, revealed instruction to explain the procedure to the resident and then provide privacy.	F 583		
F 686 SS=G	Treatment/Svcs to Prevent/Heal Pressure Ulcer CFR(s): 483.25(b)(1)(i)(ii) §483.25(b) Skin Integrity §483.25(b)(1) Pressure ulcers. Based on the comprehensive assessment of a resident, the facility must ensure that- (i) A resident receives care, consistent with professional standards of practice, to prevent pressure ulcers and does not develop pressure ulcers unless the individual's clinical condition demonstrates that they were unavoidable; and (ii) A resident with pressure ulcers receives necessary treatment and services, consistent with professional standards of practice, to promote healing, prevent infection and prevent new ulcers from developing. This REQUIREMENT is not met as evidenced by: Based on record review, observation, staff interviews and review of policy and procedures, the facility failed to implement preventive	F 686		

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F 686	Continued From page 3 measures to relieve pressure on a resident's bilateral heels to prevent the development of an avoidable suspected deep tissue injury pressure sores (Resident #37). The sample consisted of 1 resident with pressure ulcers and the facility reported a census of 38 residents. Findings include: The MDS (Minimum Data Set) assessment identifies the definition of pressure ulcers: Stage I is an intact skin with non-blanchable redness of a localized area usually over a bony prominence. Darkly pigmented skin may not have a visible blanching; in dark skin tones only it may appear with persistent blue or purple hues. Stage II is partial thickness loss of dermis presenting as a shallow open ulcer with a red or pink wound bed, without slough. May also present as an intact or open/ruptured blister. Stage III Full thickness tissue loss. Subcutaneous fat may be visible but bone, tendon or muscle is not exposed. Slough may be present but does not obscure the depth of tissue loss. May include undermining and tunneling. Stage IV is full thickness tissue loss with exposed bone, tendon or muscle. Slough or eschar may be present on some parts of the wound bed. Often includes undermining and tunneling. Unstageable Ulcer: inability to see the wound bed. Other staging considerations include: Deep Tissue Pressure Injury (DTPI): Persistent	F 686		

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F 686	Continued From page 4 non-blanchable deep red, maroon or purple discoloration. Intact skin with localized area of persistent non-blanchable deep red, maroon, purple discoloration due to damage of underlying soft tissue. This area may be preceded by tissue that is painful, firm, mushy, boggy, warmer or cooler as compared to adjacent tissue. These changes often precede skin color changes and discoloration may appear differently in darkly pigmented skin. This injury results from intense and/or prolonged pressure and shear forces at the bone-muscle interface. 1. Resident #37 had a MDS (Minimum Data Set) assessment with a reference date of 12/14/17, due to a significant change in condition. The MDS identified the resident had a Brief Interview for Mental Status (BIMS) score of 8 with no signs or symptoms of delirium. A score of 8 indicated the resident had a moderately cognitive impairment. The MDS indicated the resident as dependent upon 2 staff persons for physical assistance with bed mobility and transfers. The MDS documented impairment with range of motion on both sides of the lower extremities. The MDS reflected the resident used a wheel chair. The MDS identified diagnoses that included hypertension (elevated blood pressure), diabetes mellitus, arthritis, non-Alzheimer's dementia, chronic pain, and history of malignant neoplasm of the breast. The MDS recorded the resident at risk for pressure ulcers but did not have any pressure ulcers at the time of the assessment. The Care Plan problem area dated 10/25/17 identified the resident at risk for pressure ulcers related to frequently incontinent. The Care Plan approaches dated 10/25/17 instructed staff to	F 686		

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F 686	Continued From page 5 provide assist as needed with bed mobility and transfers; Braden assessment quarterly (skin assessment tool); and report any signs of skin breakdown (sore, tender, red, or broken areas). The Care Plan problem area dated 10/25/17 identified the resident at risk for falls and directed staff to provide the resident with safety device/appliance wheelchair. The revision dated 12/4/17 identified the use of a Geri chair (reclining wheelchair with elevated foot rest). The Braden Scale for Predicting Pressure Sore Risk dated 10/17/17 identified a score of 17. A score of greater than 16 indicated the resident not at increased risk for skin breakdown. The Braden Scale for Predicting Pressure Sore Risk dated 12/14/17 identified a score of 14. A score of 13 or 14 indicated the resident at moderate risk for skin breakdown. The Non-Pressure Ulcer Skin Condition Record dated 12/17/17 documented an area on the resident's left heel first observed 12/17/17. The record documented an origin from Geri chair positioning and a treatment plan of skin prep, moon boots (soft foam) until healed. The record identified the following measurements and skin condition assessments: a. 12/17/17 - 2.7 centimeters (cm) by 1.9 cm, surrounding skin color red b. 12/23/17 - 2.9 cm by 4.7 cm, surrounding skin color pink c. 12/29/17 - 3.2 cm by 3.3 cm, surrounding skin color pink d. 1/6/18 - 3.1 cm by 3.4 cm, surrounding skin color red, progress deteriorated with middle of area boggy.	F 686		

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F 686	Continued From page 6 The Non-Pressure Ulcer Skin Condition Record dated 12/17/17 documented an area on the resident's right heel first observed 12/17/17. The record documented an origin from Geri chair positioning and a treatment plan of skin prep, moon boots until healed. The record identified the following measurements and skin condition assessments: a. 12/17/17 - 2.7 cm by 1.8 cm, surrounding skin color red b. 12/23/17 - 3.3 cm by 4.0 cm, surrounding skin color pink c. 12/29/17 - 3.3 cm by 5.0 cm, surrounding skin color pink d. 1/6/18 - 2.5 cm by 4.5 cm, surrounding skin color red, progress deteriorated with middle of area boggy. The Client Coordination Note report dated 12/18/17 from the resident's hospice Registered Nurse (RN) Case Manager, Staff C, documented staff reported the resident's heels appeared to be breaking down. Staff C wrote she ordered optifoam (foam barrier to protect skin) and bed with air mattress. The Client Coordination Note report dated 12/18/17 documented staff applied skin prep to bilateral heels, used boots and floating heels to prevent skin breakdown. The Client Coordination Note report dated 1/4/18 documented the resident's heels becoming soft and Staff C instructed the facility to remove the boots and float heels only and continue with skin prep. The Care Plan revised 12/20/17, continued to identify a problem area of pressure ulcer risk	F 686		

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related to frequently incontinent. The Care Plan did not reflect any changes to the previous interventions or addition of new interventions. The Care Plan lacked documentation to identify the presence of actual pressure sores on the heels.

The Interdisciplinary Care Plan Conference Record dated 12/20/17 documented skin under areas reviewed. The comments section of the form identified the use of an air mattress and heel protectors as the heels had areas and hospice services.

The Narrative Notes identified the following:

On 12/5/17 at 9:00 a.m. the resident is now in Geri chair due to fall and the resident's son reported that the day before, the resident would continuously lean forward when seated in the Geri chair.

On 12/10/17 at 12:20 p.m. the resident transferred with a Hoyer lift (mechanical lift) and the assistance of 2 staff persons. The note recorded the resident utilized a Geri chair for locomotion throughout the facility and staff propelled the chair.

The Narrative Notes lacked any entries for the dates of 12/15/17 thru 12/17/17.

On 12/18/17 at 9:10 p.m. a new bed and air mattress provided by hospice, the resident rested in bed, and bilateral heels floated with a body pillow.

On 12/21/17, noted each of the resident's heels red.

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F 686	Continued From page 8 On 12/26/17 at 10:00 a.m. staff noted an increased redness to the resident's bilateral heels, heels floated to alleviate pressure, and the resident encouraged to sit in a recliner to provide feet some relief from sitting on Geri chair. The entry recorded the resident declined stating she didn't like that chair. On 1/7/18 at 8:38 a.m. the resident had areas to each heel, skin prep applied BID (2 times a day), and heels floated at all times. On 12/1/17 thru 1/6/18 the record lacked documentation to show skin prep treatment applied to the bilateral heels as a nursing order. The December 2017 and January 2018 Treatment Flowsheets lacked documentation of completion of the skin prep per nursing order. Observation on 1/2/18 at 11:32 a.m. revealed Resident #37 wore heel protectors on both heels. Staff D, Certified Nurse Aide (CNA), stated sores were present on both of the resident's heels. Clinical record review on 1/4/18 at 9:32 a.m. revealed no physician ordered treatment orders found. Observation on 1/4/18 at 9:45 a.m. revealed Staff G, Licensed Practical Nurse (LPN), completed a treatment to the resident's bilateral heel pressure ulcers. Staff G applied skin prep (protective barrier) to both heels. The bottom of the left heel observed with approximate 2 inch by 1 inch dark purple circular area. Staff G commented the center soft the day before but more firm at time of observation. Staff G reported the previous week	F 686		

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the area measured about 4 cm by 3 cm. The tissue surrounding the pressure area appeared normal flesh tone with no break in skin. The bottom of the right heel observed with approximate 1.5 inch by 1 inch dark purple circular area with center of the area flesh tone in color. Resident #37 denied pain to the areas. Staff G stated the top portion of the circular area felt boggy and the other areas firm. Staff G confirmed the skin prep not listed on the TAR (Treatment Administration Record). Staff G stated the skin prep a nursing order and the treatment completed BID (2 times a day). Staff G reported Hospice aware the heels degrading as she talked to them the other day and Hospice okayed the continued use of skin prep. Staff G stated she would need to look at the skin sheet to see how long the treatment had been going but she thought approximately a month. Staff G said the use of skin prep only documented on the skin sheets. Staff G stated the treatment originated from a fax to the doctor. Staff G commented it could be a slow process for the resident's doctor to answer faxes.

On 1/8/18 at 1:26 p.m., the Director of Nursing, DON, was interviewed and stated no physician had seen the heel pressure areas. The DON stated the resident's hospice nurse, Staff C, saw the areas on the heels and relayed the information to the doctor.

On 1/8/18 at 3:17 p.m., Staff C, Hospice nurse, was interviewed and stated she first became aware of the heel pressure areas a couple weeks prior. Staff C stated the facility sent the forms to notify hospice and she notified the doctor. Staff C stated she and her office could not find the forms so she asked the facility to resend the form the

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previous week. Staff C said the doctor told them to make sure the heels did not breakdown further. Staff C stated she wanted the facility to treat the areas with skin prep and told the facility to float the heels. Staff C commented prior to first finding out about the pressure sores she did complete full nursing assessments of the resident and did not observe any skin issues. Staff C stated the resident's transfer status had been and remained a Hoyer lift with the resident not being able to reposition herself. Staff C stated in her professional opinion, the resident's legs contracting, the resident had poor nutrition, and co-morbidities contributed to the development of the pressure areas. Staff C said she ordered a new bed for the resident and told the facility to stop using the boots the previous week (week of 1/2/18). Staff C commented she wanted the facility to float heels only as the boots caused the resident to sweat and get restless. Staff C did not know if she had a lot of documentation of the pressure areas but she would attempt to fax her records to the facility as the facility did not have the hospice notes as of the interview.

On 1/8/18 at 4:15 p.m., Staff E, CNA, was interviewed and stated the resident's decline came on fast. Staff E reported until the previous week, the resident got up for meals. Staff E stated when Resident #37 up in a regular wheelchair, she propelled herself up and down the halls. Staff E reported after the resident had an accident falling out of the wheelchair, her condition declined and she could not reposition herself.

On 1/8/18 at 4:20 p.m., Staff F, CNA, reported she worked for the facility for 1/1/2 years during the 2 p.m. to 10 p.m. shift. Staff F stated

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Resident #37 used to move good in a regular wheelchair and would wheel herself around. Staff F stated the resident started declining after she fell from a wheel chair leading to the resident using a Geri chair instead. Staff F reported the resident became completely different and couldn't move her arms much and could move her legs only a little bit.

On 1/8/18 at 4:25 p.m., Staff G, Licensed Practical Nurse, was interviewed and reported she worked for the facility as a nurse since 2012 and worked the 6 a.m. to 2 p.m. shift, filling other shifts as needed. Staff G stated prior to Resident #37 falling from a wheelchair, Resident #37 self-propelled throughout the facility, attempted to feed herself, and could move her legs a little bit. Staff G stated for the last couple of months the resident's arthritic pain became unbearable. Staff G stated the resident began leaning forward in a regular wheel chair that resulted in a fall. Kayla stated the facility changed the resident's chair to a Geri chair. Staff G responded she believed the Geri chair contributed to Resident #37's heel pressure areas. Staff G stated Resident #37's legs contracted and Staff G commented she could see Resident #37's heels pressed down into the Geri chair. Staff G reported they did not float the resident's heels or use heel protectors until after the pressure areas developed. Staff G stated Staff H, LPN, found the pressure areas on the heels and implemented floating heels, protector boots, and skin prep to the heels 2 times a day as a nursing order. Staff G reported they worked closely with the mobile wound clinic who recommended skin prep the best treatment. Staff G stated they completed the skin prep treatment as a nursing order and did not document anywhere when completed; they just

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LITTLE FLOWER HAVEN	736 HIGHWAY 37 EARLING, IA 51530

(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 686	Continued From page 12 did the treatment 2 times a day. Staff G commented the resident's decline and pressure sore development happened fast. A facility policy and procedures titled Pressure Ulcer, Care and Prevention (not dated) included and directed the staff to do the following: Purpose: To prevent and treat further breakdown of pressure sores. Equipment: Point 3. Heel protector Procedure: Point 5. Use pressure reducing devices to relieve pressure. Point 9. Use elbow and heel protectors if needed. Treatment: Treatment of pressure ulcers will vary depending on the orders of the attending physician. The nurse is responsible for carrying out the treatment as ordered by the attending physician and for implementing measures to prevent pressure ulcers.	F 686		
F 880 SS=D	Infection Prevention & Control CFR(s): 483.80(a)(1)(2)(4)(e)(f) §483.80 Infection Control The facility must establish and maintain an infection prevention and control program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of communicable diseases and infections. §483.80(a) Infection prevention and control	F 880		

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F 880	Continued From page 13 program. The facility must establish an infection prevention and control program (IPCP) that must include, at a minimum, the following elements: §483.80(a)(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; §483.80(a)(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 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	F 880		

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F 880	Continued From page 14 contact will transmit the disease; and (vi)The hand hygiene procedures to be followed by staff involved in direct resident contact. §483.80(a)(4) A system for recording incidents identified under the facility's IPCP and the corrective actions taken by the facility. §483.80(e) Linens. Personnel must handle, store, process, and transport linens so as to prevent the spread of infection. §483.80(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, observations, record review, staff interview, and facility policy the facility failed to utilize proper infection control techniques during incontinent cares for 1 of 2 residents (Resident #30) observed for incontinent cares. The facility reported a census of 38 residents. Findings include: According to the Minimum Data Set (MDS) assessment dated 12/5/17, Resident #30 had severely impaired cognitive skills for daily decision making. The MDS listed the following diagnoses: cerebral palsy, traumatic brain injury and urinary incontinence. The MDS indicated Resident #30 required the assistance of 2 staff with bed mobility, transfers and toilet use and the assistance of one with dressing and personal hygiene. Resident #30 always experienced incontinence of both urine and bowel.	F 880		

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F 880	Continued From page 15 Review of the care plan with a revision date of 12/13/17 revealed staff instruction to provide incontinent cares after each incontinent episode. Observation on 1/2/18 at 11:17 a.m. revealed Staff A Certified Nursing Assistant (CNA) had completed peri-cares, removed her gloves, washed her hands and donned a new pair gloves. Staff A proceeded to complete cares to Resident #30's back side. While wearing the same gloves, Staff A touched the resident's pillows, assisted with turning him to his left side, pulled blankets over him and then removed her gloves. Staff A failed to remove her gloves, perform hand hygiene and don a new pair of gloves after completing incontinent cares. During interview on 1/8/18 at 2:32 p.m. the Assistant Director of Nursing (ADON) stated she would expect staff to change their gloves between tasks and not to touch resident's items with dirty gloves. Review of the facility's Incontinent Care policy, dated 11/04, revealed instruction to cleanse the rectal area thoroughly, rinse and pat dry, remove gloves, wash hands and put on clean gloves. The policy also directed to put on clean gloves and adjust sheets and clean linens.	F 880		

F583(D)

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

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

Without waiving the foregoing statement, the facility states that with respect to Residents #30, and all other similarly situated residents, the facility has re-educated staff regarding assuring compliance with the facility policies regarding maintaining privacy during the providing of incontinency cares, by assuring that curtains on any outside windows are closed before any personal cares are provided. The Director of Nursing and/or her designated representative will monitor for compliance through the facility's quality assurance program on a monthly basis. This deficiency will be corrected on or before 02/06/2018

F 686(G)

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

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

Without waiving the foregoing statement, the facility states that with respect to Resident #37, and all other similarly situated residents, the facility has reviewed its protocol relating to assessing and identifying residents at risk for development of pressure areas, and implementation of interventions in the care plan to assist in preventing the development of avoidable pressure areas. Nursing staff will be re-educated regarding compliance with the facility's Pressure Ulcer, Care and Prevention policy relating to implementation of use of interventions to prevent the development of avoidable pressure areas. The Director of Nursing and/or her designated representative will monitor for compliance through the facility's quality assurance program on a monthly basis. All corrections will be made by 01/23/2018.

F880(D)

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

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

Without waiving the foregoing statement, the facility states that with respect to Resident #30, and all other similarly situated residents, the facility has re-educated staff regarding assuring compliance with the facility policies regarding maintaining infection control techniques during incontinence care and changing gloves between tasks.

The Director of Nursing and/or her designated representative will monitor for compliance through the facility's quality assurance program on a monthly basis. This deficiency will be corrected on or before 02/06/2018.