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

PRINTED: 02/07/2018
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	165034	A. BUILDING _____ B. WING _____	01/30/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MANORCARE HEALTH SERVICES	201 WEST RIDGEWAY AVENUE WATERLOO, IA 50701

(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 ✓KAC 3/16/18	INITIAL COMMENTS Correction date 2/14/18 The following deficiencies relate to the facility's annual health survey and the investigation of complaint #73779. (See Code of Federal Regulations (42CFR) Part 483, Subpart B -C). Complaint #71952 & #71374 was not substantiated.	F 000		
F 688 SS=G	Increase/Prevent Decrease In ROM/Mobility CFR(s): 483.25(c)(1)-(3) §483.25(c) Mobility. §483.25(c)(1) The facility must ensure that a resident who enters the facility without limited range of motion does not experience reduction in range of motion unless the resident's clinical condition demonstrates that a reduction in range of motion is unavoidable; and §483.25(c)(2) A resident with limited range of motion receives appropriate treatment and services to increase range of motion and/or to prevent further decrease in range of motion. §483.25(c)(3) A resident with limited mobility receives appropriate services, equipment, and assistance to maintain or improve mobility with the maximum practicable independence unless a reduction in mobility is demonstrably unavoidable. This REQUIREMENT is not met as evidenced by: Based on observation, clinical record review, and interviews with staff and resident, the facility failed to ensure recommendations provided by a therapist were followed to maintain or prevent a decline in function for two of three residents	F 688		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Leann Miller — TITLE: Administrator — (X6) DATE: 02/07/2018

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 688	Continued From page 1 reviewed for activity of daily living abilities (Resident #6 & #5).The facility identified a census of 74 residents. Findings include: 1. The Minimum Data Set (MDS) assessment for Resident #6 dated 12/30/17, included diagnoses of heart failure and peripheral vascular disease. The MDS documented the resident required extensive assistance of two to walk in room and corridor. The MDS documented the resident had a Brief Interview for Mental Status (BIMS) score of 14 (cognitively intact). The MDS dated 6/29/17, documented the resident required supervision and set up to walk in room and corridor. A Therapy Discharge Communication form dated 9/8/17, included a directive for walk to dine with assistance of one with four wheeled walker three times a day. The MDS dated 9/29/17, documented the resident required extensive assistance of one to walk in room and corridor. The care plan revised 1/11/18, included a problem of activity of daily living self-care deficit related to physical limitations, history of subarachnoid hemorrhage and right orbital floor fracture status post fall. The problem included no interventions for a walk to dine program. Resident #6's clinical record review revealed no documentation of a walk to dine program initiated for the resident.	F 688		

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F 688	Continued From page 2 On 1/25/18 at 12:45 p.m., Staff I, Certified Nurse Aide, CNA and Staff J, Licensed Practical Nurse, LPN provided a list of residents on any kind of ambulation program. The list did not include Resident #6. During interview on 1/25/18 at 1:57 p.m., Resident #6 stated no one had provided routine assistance with ambulation regularly for two years. The resident stated staff had provided ambulation assistance in their room but not in the hall and they felt they had a decline because of it. The resident stated they had told facility staff they wanted to walk and had been told to walk in the room. Staff H, Physical Therapy Aide verified during interview on 1/29/18 at 7:45 a.m., the directive on the residents Therapy Discharge Communication sheet had been for walk to dine with assistance of one with a four wheeled walker three times a day. At 12:43 p.m., the facility Director of Nursing (DON) stated they had a concern with residents ambulating a while ago but it had been at least 6 months since they had reviewed it. On 1/30/17 at 7:40 a.m., the resident propelled themselves to the dining room in a wheelchair. At 7:45 a.m., the facility DON stated they had counseled staff the previous evening on walking residents who were to be on the walk to dine program. 2. The MDS for Resident #5 with a reference date of 12/29/17, documented diagnoses which included cerebrovascular accident (stroke), depression, muscle weakness, lack of	F 688		

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F 688	Continued From page 3 coordination, and weakness. The MDS further documented the resident required extensive assistance of one for bed mobility, transfer and toilet use, and supervision with set up assistance for meals. The MDS documented the Resident used a walker and wheelchair for mobility and walk in room and corridor did not occur. A document dated 11/8/17, titled Therapy Discharge Communication included a recommendation for the Resident to walk to dine with one person physical assist and walk from bed to bathroom with one person physical assist using forward wheeled walker twice a day. The document had been signed by the physical therapist with the signature of the nurse manager signed by DON. A physical therapy treatment note dated 11/8/17 documented the resident stated he had not ambulated with staff "never sees anyone". Physical therapy note dated 11/6/17 documented resident gait training with forward wheeled walker 150' with caregiver assist with cues to increase left foot clearance. When asked if he ambulates with staff he said no. PT educated he needs to ask staff 2x/day to ambulate with him. The care plan dated as initiated 8/20/17 and last revised on 9/15/17, included ADL (activities of daily living), Self-Care deficit as a focus area related to physical limitations, recent CVA with right sided weakness/hemi neglect and dysphagia. A goal was established that the resident will receive assistance necessary to meet ADL needs with a target date of 3/17/18. The care plan directed staff to transfer with: refer to Kardex. A document labeled Visual/Bedside Kardex	F 688		

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F 688	Continued From page 4 Report dated as printed on 1/29/18 directed: Ambulate in hallway twice daily as tolerated. In an interview on 1/23/18 at 2:45 p.m., the Physical Therapist (PT) stated that therapy was provided to patient under [Medicare] part A until 9/27/17 and then continued under part B until 11/8/17. Stated would expect the facility to proceed with recommendations from Physical Therapy after discharge from therapy services. In an interview on 1/23/18 at 3:45 p.m., Staff M, CNA, she reported being responsible to check and change patient throughout the shift, reposition patient with assist of 1 and gait belt (transfer assistance device) and assist resident to the dining room in wheelchair. Denied she routinely provided other cares for resident. In an interview on 1/24/18 at 1:32 p.m.,Staff F, CNA reported the cares she provide for patient are assist out of bed in the morning, take to dining room by wheelchair, check and change, and assist to the bathroom if requested. Staff F denied providing any walks or exercises. In an interview on 1/24/18 at 3:15 p.m., Resident #5 stated he had not walked today. In an interview on 1/25/18 at 9:20 a.m., Staff K, RN stated he worked in several areas of the building and had not witnessed Resident #5 being walked with staff since he had been in current room 12/1/17. In an interview on 1/25/18 at 11:00 a.m., DON confirmed they do not have restorative program after discharge from therapy. The DON confirmed recommendations go on CNA task Kardex. She	F 688		

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F 688	Continued From page 5 stated she expected staff to offer to walk resident and resident is not responsible to ask CNA's to walk them. She would expect the CNA to alert the charge nurse if a resident had refused/declined to participate in therapy recommendation. DON would expect RN to document and follow up with resident that does not participate.	F 688		
F 693 SS=D	Tube Feeding Mgmt/Restore Eating Skills CFR(s): 483.25(g)(4)(5) §483.25(g)(4)-(5) Enteral Nutrition (Includes naso-gastric and gastrostomy tubes, both percutaneous endoscopic gastrostomy and percutaneous endoscopic jejunostomy, and enteral fluids). Based on a resident's comprehensive assessment, the facility must ensure that a resident- §483.25(g)(4) A resident who has been able to eat enough alone or with assistance is not fed by enteral methods unless the resident's clinical condition demonstrates that enteral feeding was clinically indicated and consented to by the resident; and §483.25(g)(5) A resident who is fed by enteral means receives the appropriate treatment and services to restore, if possible, oral eating skills and to prevent complications of enteral feeding including but not limited to aspiration pneumonia, diarrhea, vomiting, dehydration, metabolic abnormalities, and nasal-pharyngeal ulcers. This REQUIREMENT is not met as evidenced by: Based on observation, clinical record review, facility policy review and staff interview, the facility failed to check gastrostomy tube placement prior to use and failed to ensure the head of the bed	F 693		

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F 693	Continued From page 6 was elevated during feedings for two residents with a gastrostomy tube. (Resident #1 & #69) The facility census was 74 residents. Findings include: Facility policy for enteral tubes directed residual volume checks for intermittent enteral feedings are performed once a day prior to hanging the first feeding, prior to medication administration through the tube and when clinically indicated. 1. The Minimum Data Set (MDS) assessment dated 12/28/17, documented Resident #1 had diagnoses that included Non-Alzheimer's dementia, Multiple Sclerosis and diabetes mellitus and required the extensive assistance for bed mobility and had a tube feeding. Observation on 1/23/28 at 11:25 a.m., revealed Staff L, Licensed Practical Nurse, LPN entered the residents room to administer medications. Staff L obtained a syringe from the bathroom and positioned the head of bed to a 45 degree angle. Staff L instilled 30 milliliter (ml) of tap water through a syringe and administered medications. Following the medication administration, Staff L flushed the feeding tube with 30 ml of tap water and reconnected the infusion pump. Under constant observation Staff L failed to check the resident's gastrostomy tube placement prior to giving the resident's medication and fluids. During interview on 8/27/15 at 9:54 a.m., the Director of Nursing, DON stated facility policy directed staff to confirm gastrostomy tube placement prior to use.	F 693		

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F 693	Continued From page 7 2. The MDS assessment dated 1/4/18, documented Resident #69 had diagnoses of hemiplegia/hemiparesis and dysphagia following a stroke and required extensive assistance for bed mobility and had a gastric feeding tube for nutrition. During observation on 1/24/18 at 2:30 p.m., Staff C, Registered Nurse, RN administered medications via the gastric tube without checking for placement of the gastric tube prior to use. During observation on 1/24/18 at 2:45 p.m., Staff C, RN, administered the resident's tube feeding and started the feeding via an infusion pump. The resident requested to be changed. Staff C activated the call light and put the head of the bed down flat without pausing or stopping the feeding pump. Staff entered immediately to provide incontinence care and when finished failed to elevate the head of the bed. During interview on 1/24/18 at 2:35 p.m., Staff C, RN stated placement of a gastric tube should be checked by auscultation (listening with a stethoscope) of the resident's stomach. Staff C stated she did not check it for placement as she has never had a problem with the resident's gastric tube before. Staff C admitted she had failed to check for correct placement before administering medications.	F 693		
F 758 SS=D	Free from Unnec Psychotropic Meds/PRN Use CFR(s): 483.45(c)(3)(e)(1)-(5) §483.45(e) Psychotropic Drugs. §483.45(c)(3) A psychotropic drug is any drug that	F 758		

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F 758	Continued From page 8 affects brain activities associated with mental processes and behavior. These drugs include, but are not limited to, drugs in the following categories: (i) Anti-psychotic; (ii) Anti-depressant; (iii) Anti-anxiety; and (iv) Hypnotic Based on a comprehensive assessment of a resident, the facility must ensure that--- §483.45(e)(1) Residents who have not used psychotropic drugs are not given these drugs unless the medication is necessary to treat a specific condition as diagnosed and documented in the clinical record; §483.45(e)(2) Residents who use psychotropic drugs receive gradual dose reductions, and behavioral interventions, unless clinically contraindicated, in an effort to discontinue these drugs; §483.45(e)(3) Residents do not receive psychotropic drugs pursuant to a PRN order unless that medication is necessary to treat a diagnosed specific condition that is documented in the clinical record; and §483.45(e)(4) PRN orders for psychotropic drugs are limited to 14 days. Except as provided in §483.45(e)(5), if the attending physician or prescribing practitioner believes that it is appropriate for the PRN order to be extended beyond 14 days, he or she should document their rationale in the resident's medical record and indicate the duration for the PRN order.	F 758		

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F 758	Continued From page 9 §483.45(e)(5) PRN orders for anti-psychotic drugs are limited to 14 days and cannot be renewed unless the attending physician or prescribing practitioner evaluates the resident for the appropriateness of that medication. This REQUIREMENT is not met as evidenced by: Based on clinical record review and staff interview, the facility failed to ensure one of five residents reviewed was free from unnecessary medications. (Resident #20) The facility census was 74 residents. Findings include: 1. The Minimum Data Set (MDS) assessment dated 1/12/18, documented Resident #20 had diagnoses of anxiety disorder and adjustment disorder and required extensive assistance for bed mobility and transfer. The care plan revised on 11/21/17, included a problem of at risk for adverse effects related to use of anti-depressant medication and use of anxiolytic medication. The problem included a goal of increase patients ability to fall asleep or maintain sleep through observation period. The problem included the following interventions: a. evaluate effectiveness and side effects of medications for possible decrease/elimination of psychotropic drugs b. notify physician of decline in activity of daily living ability or mood/behavior changes related to a dosage change c. provide patient teaching of risks and benefits	F 758		

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F 758	Continued From page 10 of medications as needed d. report to physician signs of adverse reaction such as decline in mental status, declines in positioning/ambulation ability, lethargy, complaints of dizziness, tremors, etc. The Medication Administration Record (MAR) for the month of December 2017, included the following as needed (prn) medication orders: a. Trazodone HCL (sedative) 50 milligrams (mg) one tablet by mouth as needed for insomnia. Give at bedtime as needed. b. Tylenol (for pain) 650 mg by mouth every 8 hours as needed for pain. c. Tizanidine HCL (Xanaflex) 2 mg by mouth every eight hours as needed for muscle spasms. d. Tramadol HCL (opioid pain medication) 50 mg by mouth every eight hours as needed for pain. A review of the MAR for the month of December 2017, revealed the resident received the prn Trazadone on the following dates: -25th at 12:11 a.m., also received prn Tizanidine at the same time. -31st at 12:11 a.m., also received prn Tylenol at the same time. A review of the MAR for the month of January 2018, revealed the resident received the prn Trazadone on the following dates:	F 758		

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F 758	Continued From page 11 -1st at 12:28 a.m., then received prn Tylenol and Tizanidine at 12:33 a.m.. -1st at 11:04 p.m., also received prn Tylenol and Tizanidine at the same time. -2nd at 9:47 p.m., also received the prn Tizanidine at the same time -4th at 11:49 p.m., also received the prn Tylenol and Tizanidine at the same time. -6th at 12:43 a.m., also received the prn Tizanidine at the same time, then received the prn Tylenol at 12:44 a.m. -6th at 9:17 p.m., also received the prn Tizanidine at the same time. -7th at 10:00 p.m., also received the prn Tizanidine at the same time. -9th at 12:27 a.m., then received the prn Tylenol and Tizanidine at 12:28 a.m. -14th at 12:36 a.m., then received the prn Tylenol and Tizanidine at 12:37 a.m. -18th at 8:52 p.m., after receiving the prn Tramadol at 8:51 p.m.. and the prn Tizanidine at 8:48 p.m.. -21st at 9:18 p.m., after having had the prn Tramadol at 9:17 p.m.. -24th at 12:14 a.m., also received the prn Tramadol at that time. A review of the monthly pharmacy review dated	F 758		

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F 758	Continued From page 12 1/1/18, revealed no irregularities identified. During interview on 1/25/18 at 9:44 a.m., the Director of Nursing (DON) stated they believed the resident may have requested the medications that way but it would be important to know so the facility could educate the resident and attempt pain medication prior to administering psychotropic's. On 1/25/18 at 10:30 a.m., the consultant pharmacist stated it would be important to review medications for irregularities such as pain medications given with psychotropic's and stated they did periodically do this with monthly medication reviews. The pharmacist stated they felt it would be important to attempt pain medications prior to administering psychotropic's. On 1/29/18 at 8:15 a.m., the director of nursing, DON stated the consultant pharmacist did not feel the need to eliminate the as needed psychotropic's after 14 days because it would be the lowest dose of a medication for the resident. The DON stated they had completed all of the medication audits for that. The DON stated the consultant pharmacist did not routinely review concerns related to polypharmacy with them. The DON verified the resident was currently on 14 routine medications and 8 as needed medications for a total of 22 medications	F 758		
F 804 SS=D	Nutritive Value/Appear, Palatable/Prefer Temp CFR(s): 483.60(d)(1)(2) §483.60(d) Food and drink Each resident receives and the facility provides- §483.60(d)(1) Food prepared by methods that	F 804		

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F 804	Continued From page 13 conserve nutritive value, flavor, and appearance; §483.60(d)(2) Food and drink that is palatable, attractive, and at a safe and appetizing temperature. This REQUIREMENT is not met as evidenced by: Based on observation, staff and resident interviews, the facility failed to ensure room trays were maintained at a palatable temperature for one meal observed. The facility census was 74 residents. Findings include: 1. The Minimum Data Set (MDS) assessment dated 12/22/17, documented Resident #54 as independent with eating after set up and had a Brief Interview for Mental Status (BIMS) score of 15, indicating intact cognition. During interview on 1/22/18 10:53 a.m., the resident stated they frequently ate in their room and the food was often cold because it sat in the hallway. During observation on 1/25/18 at 7:57 a.m., a dietary cart sat in the back hallway. At 8:23 a.m., three trays remained on the cart. At the time the surveyor asked Staff F, Certified Nurse Aide, CNA to check food temperatures on one of the trays. Staff F stated they did not have a thermometer available. At the time the Director of Nursing, DON went to the kitchen to get a thermometer. The DON returned with a thermometer and Staff F checked the temperature of the egg and sausage sandwich which registered at 124.7 degrees Fahrenheit (F). Staff F checked the hot cereal on the tray and	F 804		

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	165034	A. BUILDING _____ B. WING _____	01/30/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MANORCARE HEALTH SERVICES	201 WEST RIDGEWAY AVENUE WATERLOO, IA 50701

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F 804	Continued From page 14 found it to be at 132.4 degrees F. Staff F checked the temperature of a hot hard boiled egg and found it to be at 113.4 degrees F. The eggs tasted luke warm on the inside and cool on the outside and not palatable. At the time the Dietary Manager stated food held on hot carts should have been maintained at least 140 degrees. At 9:45 a.m., the Dietary Manager stated they had an issue with room tray temperatures back in October or November and audits were done. At the time the facility provided a breakfast food temperature log to show the temperatures were satisfactory at the time the trays were plated in the kitchen.	F 804		
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 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	F 880		

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F 880	Continued From page 15 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 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.	F 880		

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F 880	Continued From page 16 §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 observation and clinical record review, the facility failed to ensure staff utilized proper infection control technique when completing a dressing change for one of 15 residents reviewed. (Resident #26) The facility census was 74 residents. Findings include: 1. The minimum data set (MDS) assessment dated 11/26/17, documented Resident #26 had diagnoses of viral hepatitis and diabetes mellitus and required limited assistance for bed mobility and transfer. A physician progress note dated 1/24/17, included a history of present illness which documented the resident had been admitted to the facility on 8/19/17, from a local hospital due to an infected malodorous ulceration of the first, second and third digits on the right foot. Cultures revealed Staphylococcus Coagulase (bacteria) positive, and an extensive history of Methicillin Resistant Staphylococcus Aureus (antibiotic resistant bacteria) related infection to epidural abscess requiring extensive incision and drainage at one point. The note documented the resident currently had an odor noted from the right foot dressing and on dressing removal there had been extensive amount of necrotic tissue along the incision site. The diagnoses list included MRSA culture positive.	F 880		

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F 880	Continued From page 17 During observation on 1/29/18 at 10:00 a.m., Staff K, Licensed Practical Nurse, LPN completed a dressing change to the residents right foot. The dressing on the right foot had a visible area saturated with pink drainage. Staff K removed the old dressing with both hands, touching the area saturated with pink drainage with the left hand. Staff K used the same gloved hand to pick up a spray bottle of wound cleanser. Staff K then placed the bottle on the bedside table with the other supplies. Staff L, LPN then picked up the spray bottle with clean gloves and handed it to Staff K who sprayed wound cleanser on a 4 x 4 then placed the bottle back on the bedside table. Staff L assisted and used the gloved hand that touched the spray bottle to hold the residents bare leg. After completing the treatment Staff K picked up the spray bottle and took it to the hallway and placed it in a treatment cart with other residents supplies. Staff K did not sanitize the spray bottle and touched multiple items including the tray table, a medication cart and treatment cart. Upon completion of the observation the surveyor asked the facility Director of Nursing if she would have had Staff K do anything differently. The DON stated Staff K should have sanitized the spray bottle. The DON stated they had not been aware of any positive wound cultures.	F 880		
F 921 SS=D	Safe/Functional/Sanitary/Comfortable Environ CFR(s): 483.90(i) §483.90(i) Other Environmental Conditions The facility must provide a safe, functional, sanitary, and comfortable environment for residents, staff and the public. This REQUIREMENT is not met as evidenced by:	F 921		

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F 921	Continued From page 18 Based on observation, review of water temperature logs and staff interview, the facility failed to ensure comfortable water temperatures for bathing and personal care. The facility census was 74 residents Findings include: 1. During an audit of water temperatures on the Rehab Unit on 1/30/18 at 8:00 a.m., it was noted the initial water temperature in Room 209 was 116.1. At 8:07 a.m., the water temperature was 85.6. At 8:10 a.m., the initial water temperature in Room 202 was 105.8. At 8:12 a.m., the water temp was 84.0. At 8:15 a.m. the initial water temp in Room 208 was 84.7. At 8:17 a.m. it was 84.4. During interview at the time, the Maintenance Supervisor stated staff reported a couple of weeks ago they felt the water temperature in the shower room on the Rehab Unit was cooler. Stated he had been adjusting the recirculation gauge and was trying to keep the temperature around 110 degrees. Stated he had contacted the plumber and he will come tomorrow to make repairs.	F 921		

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F688
The facility strives to ensure that a resident with limited mobility receives appropriate services, equipment, and assistance to maintain or improve mobility with the maximum practicable independence unless a reduction in mobility is demonstrably unavoidable.

Corrective action taken for residents found to have been affected by deficient practice
Resident #6 is able to ambulate with limited assistance of 1 staff member and does so twice per day.
Resident #5 is able to ambulate with extensive assistance of 2 staff members and does so twice per day.

How the center will identify other residents having the potential to be affected by the same deficient practice.
Residents residing in the facility that are discharged from therapy with an ambulation program are at risk of being affected.

What changes will be put into place to ensure that the problem will be corrected and will not recur.
- Kardex's of residents residing in the facility will be reviewed for ambulation programs and referred to therapy if declines are noted.
- Certified Nursing Assistants will be educated on following the kardex for recommendations on ambulating patients.
- DON or designee will randomly audit the ambulation of 5 patients per week for 4 weeks.

Quality Assurance Plan to monitor performance to make sure corrections are achieved and are permanent.

Identified concerns shall be reviewed by the facility's QAA Committee.
Recommendations for further corrective action will be discussed and implemented to sustain compliance

Date when corrective action will be completed.

February 7, 2018

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F693
The facility strives to ensure that a resident who is fed by enteral means receives the appropriate treatment and services to restore, if possible, oral eating skills and to prevent complications of enteral feeding including but not limited to aspiration pneumonia, diarrhea, vomiting, dehydration, metabolic abnormalities, and nasal-pharyngeal ulcers.

Corrective action taken for residents found to have been affected by deficient practice
Resident #1 has not had any complications related to failure to check gastrostomy tube placement. Licensed nurses are checking placement prior to initiating medications into the gastrostomy tube.
Resident #69 has not had any complications related to failure to check gastrostomy tube placement or keeping the head of bed elevated during infusion of enteral feeding.
Licensed nurses are checking placement prior to initiating medications into gastrostomy tube, and nursing staff are ensuring that the head of bed is elevated during the infusion of enteral feeding.

How the center will identify other residents having the potential to be affected by the same deficient practice.
Residents residing in the facility that are receiving enteral feedings are at risk of being affected.

What changes will be put into place to ensure that the problem will be corrected and will not recur.

- Licensed nurses will be educated on checking placement of gastrostomy tubes per facility policy.
- Nursing staff will be educated on ensuring the head of bed is elevated during the infusion of enteral feedings for residents with such.
- DON or designee will randomly audit residents with enteral feedings 3 times per week for 4 weeks to ensure placement of gastrostomy tube is checked appropriately and head of bed is elevated during enteral feeding infusion.

Quality Assurance Plan to monitor performance to make sure corrections are achieved and are permanent.

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Identified concerns shall be reviewed by the facility's QAA Committee. Recommendations for further corrective action will be discussed and implemented to sustain compliance

Date when corrective action will be completed.

February 14, 2018

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F758
The facility strives to ensure that PRN orders for psychotropic drugs are limited to 14 days, unless the attending physician or prescribing practitioner believes that it is appropriate for the PRN order to be extended beyond the 14 days, and he or she documents their rationale in the resident's medical record and indicates the duration for the PRN order.

Corrective action taken for residents found to have been affected by deficient practice
Resident #20's PRN psychotropics were reviewed by the primary care provider.

How the center will identify other residents having the potential to be affected by the same deficient practice.
Residents residing in the facility that have orders for PRN psychotropics are at risk of being affected.

What changes will be put into place to ensure that the problem will be corrected and will not recur.

- An audit was conducted of patients with PRN psychotropics and recommendations sent to their primary care providers.
- The pharmacist completed a review of patients' medications for unnecessary medications.
- Licensed nurses were educated on the use of PRN psychotropics.
- DON or designee will audit PRN psychotropics weekly for 4 weeks.

Quality Assurance Plan to monitor performance to make sure corrections are achieved and are permanent.

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F804
The facility strives to ensure that each resident receives and the facility provides food and drink that is palatable, attractive, and at a safe and appetizing temperature.

Corrective action taken for residents found to have been affected by deficient practice
A new tray was obtained to replace the tray that was below temperature.

How the center will identify other residents having the potential to be affected by the same deficient practice.
Residents residing in the facility that receive room trays for meals are at risk of being affected.

What changes will be put into place to ensure that the problem will be corrected and will not recur.

- Room trays will be divided between front and back trolleys.
- Nursing staff will be educated on passing trays timely and shutting the trolley doors between passing trays to maintain temperature.
- DON or designee will randomly monitor room tray food temperatures 3 times per week for 4 weeks.

Quality Assurance Plan to monitor performance to make sure corrections are achieved and are permanent.

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F880
The facility strives to ensure that it has established and maintains 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 infection.

Corrective action taken for residents found to have been affected by deficient practice
Resident #26 has not had any adverse effects related to the contamination of the wound cleanser bottle.
The wound cleanser bottle that was contaminated was disposed of along with all items in the treatment cart it had touched.

How the center will identify other residents having the potential to be affected by the same deficient practice.
Residents residing in the facility that receive dressing changes for wounds are at risk of being affected.

What changes will be put into place to ensure that the problem will be corrected and will not recur.

- Licensed nursing staff were educated on proper dressing change procedure.
- DON or designee will randomly audit 3 dressing changes per week for 4 weeks.

Quality Assurance Plan to monitor performance to make sure corrections are achieved and are permanent.

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F921
The facility strives to ensure that it provides a safe, functional, sanitary, and comfortable environment for residents, staff, and the public.

Corrective action taken for residents found to have been affected by deficient practice
Young's Plumbing & Heating corrected the issue with the mixing valve for the hot water.

How the center will identify other residents having the potential to be affected by the same deficient practice.
Residents residing in the facility are at risk of being affected.

What changes will be put into place to ensure that the problem will be corrected and will not recur.

- Administrator or designee will randomly audit water temperatures in 3 rooms on each unit per week for 4 weeks.

Quality Assurance Plan to monitor performance to make sure corrections are achieved and are permanent.

Identified concerns shall be reviewed by the facility's QAA Committee.
Recommendations for further corrective action will be discussed and implemented to sustain compliance

Date when corrective action will be completed.

February 14, 2018