STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	165474	A. BUILDING _____ B. WING _____	C 03/06/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE AMBASSADOR SIDNEY INC	115 MAIN STREET SIDNEY, IA 51652

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F 000	INITIAL COMMENTS Correction date 4/26/18 The following deficiencies were identified during investigation of complaints #70750-C, #71269-C and #71728-C and facility-reported incidents #71244-I and #71352-I. See Code of Federal Regulations (42CFR) Part 483, Subpart B-C.	F 000		
F 655 SS=D	Baseline Care Plan CFR(s): 483.21(a)(1)-(3) §483.21 Comprehensive Person-Centered Care Planning §483.21(a) Baseline Care Plans §483.21(a)(1) The facility must develop and implement a baseline care plan for each resident that includes the instructions needed to provide effective and person-centered care of the resident that meet professional standards of quality care. The baseline care plan must- (i) Be developed within 48 hours of a resident's admission. (ii) Include the minimum healthcare information necessary to properly care for a resident including, but not limited to- (A) Initial goals based on admission orders. (B) Physician orders. (C) Dietary orders. (D) Therapy services. (E) Social services. (F) PASARR recommendation, if applicable. §483.21(a)(2) The facility may develop a comprehensive care plan in place of the baseline care plan if the comprehensive care plan- (i) Is developed within 48 hours of the resident's	F 655		

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

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F 655	Continued From page 1 admission. (ii) Meets the requirements set forth in paragraph (b) of this section (excepting paragraph (b)(2)(i) of this section). §483.21(a)(3) The facility must provide the resident and their representative with a summary of the baseline care plan that includes but is not limited to: (i) The initial goals of the resident. (ii) A summary of the resident's medications and dietary instructions. (iii) Any services and treatments to be administered by the facility and personnel acting on behalf of the facility. (iv) Any updated information based on the details of the comprehensive care plan, as necessary. This REQUIREMENT is not met as evidenced by: Based on clinical record reviews, facility policy review and interview, the facility failed to develop a baseline care plan to inform staff of the resident's individual care needs within 48 hours of admission for 1 of 2 closed resident records sampled (Resident #3. The facility identified a census of 44. Findings include: 1. The Medicare 5 day/discharge Minimum Data Set (MDS) assessment dated 9/17/17 documented diagnoses that included anemia, hip fracture of the left femur, constipation and dysphagia for Resident #3. The same MDS documented the resident admitted to the facility for Medicare A skilled services on 9/15/17. He required the assistance of 2 for transfers, bed mobility, dressing, hygiene and toilet use. The resident did not walk and depended upon staff for	F 655		

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F 655	Continued From page 2	F 655		

wheelchair mobility. The assessment documented he fell in the last month prior to admission, suffered a fracture prior to admission and fell once without injury, once with a non-major injury and a third time with major injury since admission to the facility.

The resident's clinical record had no initial care plan to direct staff on the resident's individualized care needs.

The Resident Progress Notes dated 9/15/17 at 12:30 PM documented the resident as alert and oriented to person, place and time and he admitted to the facility for strengthening and care of his hip fracture. The resident received blood thinning medication, required assistance of one and use of a gait belt for transfers and was touch-toe weight bearing on the left leg. The resident could not take tub baths or whirlpools due to the hip fracture and he wore TED (antiembolism) hose.

The Resident Progress Notes dated 9/16/17 at 2:27 PM documented the resident had 6 staples intact to 1 incision on the left hip, 5 intact staples to a second left hip incision and 3 staples intact to a third incision on the left hip.

An Event Report completed by Staff D, registered nurse (RN), on 9/17/17 at 6:01 AM documented the resident got out of bed and staff found the resident on the floor on his knees at 5:53 AM without injury. Staff placed a bed alarm. Review of the Resident Progress Notes revealed no documentation that staff were educated on the use of a bed alarm.

Review of the Resident Progress Notes dated

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F 655	Continued From page 3 9/17/17 at 4:50 PM documented the staff found the resident on the floor at 7:30 AM. The resident denied falling to the left side and Staff E, RN, documented no new injury upon assessment. Staff E documented she instructed the resident and his spouse about the use of the call light to alert staff and she informed the resident's son an alarm had been placed to remind the resident to use the call light for assistance with getting up. The Resident Progress Notes entry dated 9/17/17 at 7:13 PM documented the resident self-transferred to the bathroom and fell in front of the bed. Staff E contacted the on-call physician regarding this fall. The Resident Progress Notes Entry dated 9/18/17 at 12:24 AM documented the mobile x-ray report documented an impacted fracture of the right femoral neck. The resident transferred to the hospital by ambulance after physician notification of the x-ray results. The Care Plans-Baseline Initial Care Plan policy dated 8/2017 directed the following procedure: 1. To assure the resident's immediate care need are met and maintained, a baseline care plan will be developed within 48 hours of the resident's admission. 2. The Interdisciplinary Team will review the healthcare practitioner's orders (e.g. dietary needs, medications routine treatments, etc) and implement a baseline care plan to meet the resident's immediate needs including, but not limited to: a. initial goals based on admission orders b. physician orders c. dietary orders d. therapy services	F 655		

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F 655	Continued From page 4 e. social service and, f. PASARR recommendations (if applicable) g. build on the resident's/patient's strengths During interview on 2/16/18 at 10:05 AM the Director of Nursing (DON) stated Staff D documented placement of a bed alarm as an intervention for the fall that occurred on 9/17/17 at 5:53 AM. During investigation of the fall she found out the bed alarm had not actually been implemented because the resident was already in bed so Staff D placed the alarm and pad on the resident's bedside table. When the DON interviewed Staff E for the subsequent falls she determined the bed alarm had not been implemented by other staff on duty throughout the day and the alarm remained on the resident's bedside table. The DON stated Staff D received disciplinary action for failing to implement the bed alarm at the time she documented it's use and also for failing to complete a baseline care plan for Resident #3 within 48 hours of admission to educate staff to resident-specific care needs.	F 655		
F 658 SS=D	Services Provided Meet Professional Standards CFR(s): 483.21(b)(3)(i) §483.21(b)(3) Comprehensive Care Plans The services provided or arranged by the facility, as outlined by the comprehensive care plan, must- (i) Meet professional standards of quality. This REQUIREMENT is not met as evidenced by: Based on clinical record review and staff interview, the facility failed to assure resident medications available for administration for the next scheduled dose on the day of admission as well as to follow physician orders as written for	F 658		

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F 658	Continued From page 5 one of two discharged residents reviewed (Resident # 5). The facility identified a census of 44. Finding include: The Problem List printed 8/30/17 documented Resident #5 had diagnoses that included angina, asthma, chronic kidney disease, congestive heart failure, chronic lung disease, coronary artery disease, diabetes and hypertension. The Transfer Form dated 9/1/17 documented the resident had a left ankle hardware removal and a tibio-talo-calcaneal arthrodesis (leg bone) surgery. 1. The Admission Observation Form documented the resident admitted to the facility on 9/1/17 at 8:20 AM. The Transfer Form documented medication orders that included the following, along with the last time medication administered: a. Eliquis (blood-thinning medication) 2.5 milligrams (mg) 2 times daily (BID) with the last administered dose on 8/31/17 at 9:00 PM; b. Gabapentin (medication used for treating nerve pain) 400 mg at noon with last administered dose on 8/31/17 at 12 noon; c. Imdur (medication for treatment of angina) 60 mg daily with last administered dose on 8/31/17 at 9:00 AM; d. Singulair (medication for the treatment of asthma) 10 mg daily with last administered dose on 8/31/17 at 9:00 AM. Review of the resident's Medication Administration Record (MAR) revealed he following: a. No administration of Eliquis until 8:00 AM on	F 658		

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F 658	Continued From page 6 9/2/17; staff documented both ordered doses were not administered on 9/1/17 as they were "not available"; b. No Gabapentin administered at noon on 9/1/17 and documented as "not available"; c. Isorsobide mononitrate (Imdur) not administered on 9/1/17; d. Singulair (montelukast) not administered on 9/1/17. During interview on 2/16/18 at 1:27 PM, the facility's pharmacist stated the pharmacy can deliver medications to the facility at any time of the day or night as long as the facility sends the orders to them. He further stated the facility should have contacted the physician for direction for administration of medications outside the facility's assigned medication administration times on the day of admission. The facility's Nursing 2016 Drug Handbook directed the following regarding administration of Eliquis: If the patient doesn't take the dose at the scheduled time, he should take the dose as soon as possible on the same day, then resume twice daily administration. 2. The Transfer Form dated 9/1/17 directed staff to administer CeleBREX (a nonsteroidal anti-inflammatory medication) 100 mg BID. The facility faxed the orders on the Transfer From to the resident's primary care physician for approval. The facility received the faxed orders back from the primary care physician at 4:56 PM on 9/1/17; the physician noted to not administer the CeleBREX while the resident received Eliquis. Review of the September MAR revealed staff administered the CeleBREX on 9/1/17 at 6:00 PM. The resident refused the scheduled 7:00 AM	F 658		

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F 658	Continued From page 7 dose on 9/2/17. 3. The Transfer Form dated 9/1/17 directed staff administer to Symbicort (used for the treatment of lung disease) 2 puffs every 12 hours as needed (PRN); the order documented the resident did not receive this medication while in the hospital. Review of the MAR for September, 2017 revealed staff incorrectly transcribed the order and scheduled Symbicort to be administered BID at 7:00 AM and 2:30 PM (7 1/2 hours apart) and staff administered the Symbicort at 7:00 AM and 2:30 PM on 9/1/17.	F 658		
F 677 SS=E	ADL Care Provided for Dependent Residents CFR(s): 483.24(a)(2) §483.24(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 reviews, observation and interviews, the facility failed to assure all resident bathed according to their preference for 4 of 4 current residents sampled (Residents #1, #2, #4 and #6) and failed to provide complete incontinence care for 2 of 4 sampled residents (Residents #1 and #2). The facility identified a census of 44. Findings include: 1. The Minimum Data Set (MDS) assessment dated 11/28/17 recorded Resident #1 had diagnoses that included Non-Alzheimer's dementia, diabetes mellitus and cancer. The	F 677		

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F 677	Continued From page 8 same MDS documented the resident required the assistance of two with toilet use, bathing and transfers and the assistance of one with personal hygiene. The resident experienced incontinence of bladder and bowel. The care plan problems dated 12/8/17 recorded the resident had a self-care deficit and the identified the resident required the assistance of one with bathing and assistance of 2 for transfer to and from the bath. The care plan also documented a problem of urinary and bowel incontinence and directed staff to check and change the resident frequently and to provide perineal care when incontinent. Observation of the resident's room on 2/16/18 at 9:31 AM revealed a sign on the resident's wall which indicated the resident's bath days are Monday and Thursday. Review of the resident's bathing record 9/1/17 through 2/16/18 revealed the resident received only 4 baths in September. Observation on 2/15/18 at 11:00 AM with the facility's nursing consultant present revealed Staff A and B, certified nursing assistants (CNA's) transferred the resident to the toilet with the use of a sit-stand lift. Staff B removed a urine-saturated brief from the resident and lowered her to sit on the toilet. After the resident used the toilet, staff raised her from the toilet with the lift and Staff A cleansed the resident's glutteal crease, removed her gloves, washed her hands and then placed a clean brief on the resident. Observation revealed staff failed to cleanse the resident's frontal perineal area and buttocks skin that had been exposed to the wet brief.	F 677		

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F 677	Continued From page 9 2. The MDS assessment dated 7/25/17 for Resident #2 documented diagnoses that included anemia, peripheral vascular disease, generalized muscle weakness and seizure disorder. The same assessment documented she required the assistance of two with bed mobility, bathing and toilet use and the assistance of one with personal hygiene. The care plan problem dated 1/31/18 identified a self-care deficit which instructed to provide the assistance of one with bathing and the assistance of two for transfer to and from the bath. The care plan also identified a problem with bladder incontinence and it directed staff to assist the resident to the toilet and to complete perineal care and change the resident's brief when incontinent. Observation of the resident's room on 2/15/18 at 10:53 AM revealed a sign which indicated the resident's bath days as Sunday and Wednesday. Review of the resident's bathing records for 9/1/17 through 2/15/18 revealed the resident received 5 baths in September and 6 baths in January, 2018. Observation on 2/15/18 at 9:21 AM with the nursing consultant present revealed Staff A and C, CNA, assisted the resident to the toilet. Staff A removed the resident's brief and confirmed it was soiled with urine. After toilet use, Staff C cleansed the resident's gluteal crease, buttocks and hips, changed her gloves and applied a clean brief. Observation revealed Staff C failed to cleanse the resident's frontal perineal skin exposed to the soiled brief.	F 677		

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F 677	Continued From page 10 The facility's Perineal Care Policy dated 1/2015 directed the following: Point #7. wash perineal area with disposable wipes of soap and water. Point #8. Wash from pubic area to perineum, rinse and dry. Use only front to back motions. Always cleanse the anal area LAST. 3. The MDS assessment dated 11/28/17 documented the pertinent diagnosis of Parkinson's disease for Resident #4. The same assessment documented he required the assistance of two with transfers and bathing. The care plan problem dated 12/8/17 identified a self-care deficit and directed the resident required the assistance of one with bathing and the assistance of two to transfer to and from the bath. Observation of the resident's room on 2/16/18 at 2:45 PM revealed a sign which indicated the resident's bath days as Monday and Friday. Review of the resident's bathing records for 9/1/17 though 2/16/18 revealed the resident received 6 baths in September and 7 baths in January, 2018. 4. The MDS assessment dated 1/9/18 documented diagnoses that included bipolar disorder, psychotic disorder and Non-Alzheimer's dementia for Resident #6. The same MDS documented the resident required the assistance of one with bathing. The care plan problem dated 7/14/17 identified a self-care deficit and directed the resident required the assistance of one with bathing.	F 677		

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F 677	Continued From page 11 Observation of the resident's room on 2/16/18 at 10:52 AM revealed a sign which indicated the resident's bath days as Wednesday and Sunday. Review of the resident's bathing records for 9/1/17 though 2/16/18 revealed the following: a. No bath between 9/13 and 9/26 (12 days), no bath between 10/1 and 10/8 (6 days), no bath between 11/30 and 12/6 (5 days), 12/11 and 12/17 (5 days), 12/20 and 12/27 (6 days), no bath between 12/27/17 and 1/3/18 (6 days), no bath between 1/5 and 1/12 (6 days), no bath between 1/16 and 1/23 (6 days) and no bath between 1/26 and 2/2 (6 days). During interview on 2/16/18 at 1056 AM, the Director of Nursing (DON) stated she had identified an issue with resident bathing in September, 2017 as the facility had a staffing issue and could not utilize temporary staff. She further stated the facility added six staff members in January, 2018 so she can now schedule a full-time bath aide which she implemented on 2/1/18.	F 677		
F 689 SS=G	Free of Accident Hazards/Supervision/Devices CFR(s): 483.25(d)(1)(2) §483.25(d) Accidents. The facility must ensure that - §483.25(d)(1) The resident environment remains as free of accident hazards as is possible; and §483.25(d)(2)Each resident receives adequate supervision and assistance devices to prevent accidents. This REQUIREMENT is not met as evidenced by:	F 689		

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F 689	Continued From page 12 Based on clinical record review and staff interviews, the facility failed to provide adequate nursing supervision as planned by the use of personal safety alarms which resulted in further falls, one which resulted in fracture, for 1 of 2 discharged residents reviewed (Resident # 3). The facility identified a census of 44. Findings include: 1. The Medicare 5 day/discharge Minimum Data Set (MDS) assessment dated 9/17/17 documented diagnoses that included anemia, hip fracture of the left femur, constipation and dysphagia for Resident #3. The same MDS documented the resident admitted to the facility for Medicare A skilled services on 9/15/17. He required the assistance of 2 for transfers, bed mobility, dressing, hygiene and toilet use. The resident did not walk and depended upon staff for wheelchair mobility. The assessment documented he fell in the last month prior to admission, suffered a fracture prior to admission and fell once without injury, once with a non-major injury and a third time with major injury since admission to the facility. The facility did not develop an initial care plan to direct staff on the resident's individualized care needs. The Resident Progress Notes dated 9/15/17 at 12:30 PM documented the resident as alert and oriented to person, place and time and he admitted to the facility for strengthening and care for his hip fracture. The resident currently received blood thinning medication, transferred with the assistance of one and a gait belt for transfers, had touch-toe weight bearing on the left	F 689		

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F 689	Continued From page 13	F 689		

leg and could not take tub baths or whirlpools due to the hip fracture.

The resident's Fall Risk Assessment, dated 9/15/17 and completed by the Director of Nursing (DON), documented a score of 9 (ten or above represents a high risk for falls).

The Resident Progress Notes dated 9/16/17 at 2:27 PM documented Resident #3 had six intact staples to an incision on the left hip, five intact staples to a second left hip incision and three intact staples to a third incision on his left hip.

An Event Report completed by Staff D, Registered Nurse (RN), on 9/17/17 at 6:01 AM documented Resident #3 got out of bed and was found on his knees on the floor at 5:53 AM. Staff D noted no resident injury and documented she placed a bed alarm on the resident's bed. Review of the Resident Progress Notes revealed no entry regarding this event completed by Staff D.

Review of the Resident Progress Notes dated 9/17/17 at 4:50 PM documented the resident found on the floor at 7:30 AM and he denied falling to the left side. Staff E, RN, documented no new injuries upon a check of the resident. Staff E recorded she instructed the resident and his spouse on the use of the call light to alert staff and she informed the resident's son an alarm had been placed to remind Resident #3 to use the call light for assistance with getting up.

The Resident Progress Notes entry dated 9/17/17 at 4:53 PM documented the resident's son reported Resident #3 had increased discomfort in the right hip and lower leg. Staff E contacted the

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	165474	A. BUILDING _____ B. WING _____	C 03/06/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE AMBASSADOR SIDNEY INC	115 MAIN STREET SIDNEY, IA 51652

(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 689	Continued From page 14 on-call physician. The Resident Progress Notes entry dated 9/17/17 at 7:13 PM documented the resident self-transferred to the bathroom and fell in front of his bed. Three staff assisted him off the floor, the resident denied pain or discomfort and moved without difficulty. Staff E contacted the on-call physician regarding this fall. A mobile X-ray arrived at the facility at 11:58 PM and obtained an X-ray of the resident's right hip. An entry dated 9/18/17 at 12:24 AM documented Resident #3 had a impacted fracture of the right femoral neck (right hip fracture). The resident transferred to the hospital by ambulance after physician notification of the x-ray results. During interview on 2/16/18 at 10:05 AM, the DON stated Staff D documented placement of a bed alarm as an intervention for the fall that occurred on 9/17/17 at 5:53 AM. During investigation of the fall, the DON found out the bed alarm had not actually been implemented because the resident was already in bed. Staff D placed the alarm and pad on the resident's bedside table instead. When the DON interviewed Staff E for the subsequent falls she determined the bed alarm had not been implemented by other staff throughout the day and the alarm remained on the resident's bedside table. The DON stated Staff D received disciplinary action for failing to implement the bed alarm at the time she documented it's use.	F 689		

Plan of Correction

The Ambassador Sidney **Survey Date:** 03/06/2018

115 Main Street, Sidney, Iowa 51652 **PROVIDER #:** 165474

COMPLETION

TAG	STATEMENT OF COMPLIANCE:	DATE:
F 655	**CORRECTION TO RESIDENT AFFECTED:** 1. Implemented Q shift safety device checks on Resident # 3 on 9/30/17 and daily safety device checks on all residents on 9/22/17. 2. Disciplined RN on 9/21/17 for not completing baseline care plan and for not putting intervention into place. 3. Education began on 9/14/17 to nursing staff regarding timeliness of completing the baseline care plan and checking safety devices daily Q shift. 4. DCS or designee began auditing for the completion of baseline care plan weekly on 9/22/17. 5. Resident was discharged to an assisted living facility on 12/22/17. **FACILITY INTERVENTIONS:** 1. Nursing education began on 3/17/18 regarding baseline care plan being completed within 48 hours of admission. Education will be completed by 3/26/18 on all nursing staff except those on leave. Those staff members will complete the education prior to returning to work. 2. DCS or designee to audit new admission within 48 hours to ensure baseline care plan completed. Education will be completed by 3/26/18 for all nursing staff except those on leave. Those staff members will complete the education prior to returning to work. **Monitoring System:** 1. DCS or designee will audit all new admissions ongoing within 48 hours of admit to ensure baseline care plan completed. 2. Administrator or designee will monitor audits weekly x 2 months and results will be taken to monthly QAPI meetings to ensure effectiveness.	12/22/17 3/26/18 3/26/18

F 658	**CORRECTION TO RESIDENT AFFECTED:** 1. Resident # 5 discharged AMA on 9/1/17. **FACILITY INTERVENTIONS:** 1. Facility developed time ranges for specific medications to be administered according to manufacturer directions. These time ranges updated in EMAR system, staff education began 3/17/18 regarding this updated process and will be completed by 3/26/18 on all staff except those on leave. Those staff members will be educated prior to returning to work. Penn Drug pharmacist and pharmacy staff educated to this change on 3/22/18. 2. Nursing education to begin 3/17/18 on double checking and second noting all admission orders after the pharmacy has entered them and notifying physician with any questions or changes. If physician faxes any additional orders, these to be faxed to pharmacy and second noted that same shift. Staff also educated to utilize the admission check list to ensure completion of admission orders. This education will be completed by 3/26/18 for all nurses except those on leave and that will be completed prior to them returning to work. 3. Education of nurses, and medication aides started 3/17/18 regarding medication availability. If a medication is not available the facility staff must call the pharmacy and if the pharmacy cannot obtain the medication, a nurse must notify the physician for further instruction and this will be documented in the medical record. Education will be completed by 3/26/18 for all nurses and medication aides except for the staff on leave and they will complete the education prior to returning to work. 4. DCS has placed a 2-tiered bin at the nurse's station. The top bin for any orders that need to be taken off/noted. The bottom bin for all orders that need a second nurse to review for accuracy and second note them. Education to nurses started on 3/17/18 to check both bins throughout their shift and have cleared the bins by the end of their shift. Education will be completed by 3/26/18 for all nurses except those on leave and they will complete education prior to returning to work. 5. Facility will Review all current resident's orders for accurate administration times and notify pharmacy of any discrepancies in EMAR and stickers on cards, so items may be corrected. This will be completed by 3/26/18. **MONITORING SYSTEM:** 1. DCS or designee will audit all admission orders within 24 hours of admission for accurate administration times, second noting, medication availability, pharmacy and/or physician notification,	3/26/18 3/26/18 3/26/18 3/26/18 3/26/18

	and administration of meds as ordered. Audits will be ongoing. Any further concerns will be addressed with staff. This information will be reviewed at monthly QAPI meetings. 2. DCS or designee will audit new medication orders for significant med changes to ensure proper time assignment weekly ongoing. These audits will be reviewed in QAPI meetings monthly.	

F 677	**CORRECTION TO RESIDENT AFFECTED:** 1. Resident # 4 expired on 2/21/18. 2. Residents #1, # 2 and # 6 (or POA) interviewed 3/15/18 and bathing choices identified and baths scheduled accordingly and care plans updated. 3. Staff education began 3/17/18 regarding resident bathing choices, offering alternate days if refusals, and documenting any changes made to schedule in progress notes. 4. Facility has trained additional staff to work as bath aides. Training to be completed by 3/26/18. **FACILITY INTERVENTIONS:** 3. Facility completely rearranged the bath schedule on 3/15/18 to accommodate resident choices and added an additional bath aide, 1- 2 days per week to ensure baths are being completed. Care plans have been updated to reflect these changes. Education regarding this will be completed by 3/26/18 on all nursing staff except those on leave. Those staff members will complete the education prior to returning to work. **MONITORING SYSTEM:** 1. DCS or designee will audit bathing documentation to ensure that 2 baths are completed weekly. This will be done weekly x 3 months then monthly ongoing. Results will be reviewed at QAPI meetings monthly.	3/15/18 3/26/18 3/26/18
F 677	**CORRECTION TO RESIDENT AFFECTED:** 1. Residents #1 and # 2 care plans reviewed to ensure incontinent cares have been addressed based on assessment. 2. Staff members listed on the deficiency statement were educated and competency tested by 3/26/18. **FACILITY INTERVENTIONS:** 4. Staff education began on 3/17/18 on how to complete peri-care/incontinent care on residents who utilize toilet and are incontinent when toileted. To be completed by 3/26/18 on all nursing staff except those on leave. Those staff members will complete the education prior to returning to work. **MONITORING SYSTEM:** 1. DCS or designee to audit resident #1 and # 2 twice a week x 4 weeks, then random audits weekly x 3 months. Results will be reviewed at QAPI monthly.	3/19/18 3/26/18 3/26/18

F 689	**CORRECTION TO RESIDENT AFFECTED:** 1. Resident # 3 had a baseline care plan completed on 9/18/17. Staff member was disciplined for failure to complete baseline care plan and not putting an alarm in place on 9/21/17. 2. Resident was placed on daily monitoring of safety devices on 9/22/17 and changed to Q shift monitoring of safety devices on 9/30/17. Care plan was updated to reflect those changes. 3. Resident discharged to an assisted living facility on 12/22/17. **FACILITY INTERVENTIONS:** 5. Facility began Q shift monitoring of safety devices on all residents with safety devices on 3/13/18. Care plans were updated to reflect the changes. 6. Nurses will begin doing Q 2-hour rounds utilizing a "rounding tool" to ensure interventions in place and resident needs are being met per care plan. 7. Facility implemented on 3/12/18 charge nurse presence in dining room during meal times to monitor safety. 8. All nursing education started 3/17/18 regarding baseline care plan timeliness and safety devices being checked Q shift by medication aides/nurses; nurses doing Q 2-hour rounds to ensure resident interventions are in place and staff are following resident's plan of care, and nurse monitoring the dining room during meals. Education will be completed by 3/26/18 on all nursing staff except those on leave. Those staff members will complete the education prior to returning to work. **MONITORING SYSTEM:** 1. DCS or designee to review Q shift device monitoring sheets and Q 2-hour "rounds tool" to ensure completion, these are to be monitored throughout each week and ongoing. This information will be taken to monthly QAPI meetings for review. 2. DCS or designee to do weekly rounds x 2 months at various times to ensure interventions are being followed and charge nurses are rounding, then monthly ongoing. Any concerns will be addressed with staff and monitoring will be increased if needed. Results will be reviewed at QAPI monthly for effectiveness. 3. All falls reviewed in daily meeting Monday thru Friday by department heads to ensure appropriateness of interventions, root cause analysis and any other concerns. This is an ongoing process and will continue.	3/26/18 3/26/18