STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	165424	A. BUILDING _____ B. WING _____	C 04/24/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BETHANY LIFE	212 LAFAYETTE STREET STORY CITY, IA 50248

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F 000	INITIAL COMMENTS Correction date 5/11/2018 The following deficiencies relate to the investigation of complaint #74099, #74673 & #75137. (See Code of Federal Regulations (42CFR) Part 483, Subpart B-C).	F 000	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 these deficiencies were executed solely because provisions of State and Federal law require it.	
F 558 SS=D	Reasonable Accommodations Needs/Preferences CFR(s): 483.10(e)(3) §483.10(e)(3) The right to reside and receive services in the facility with reasonable accommodation of resident needs and preferences except when to do so would endanger the health or safety of the resident or other residents. This REQUIREMENT is not met as evidenced by: Based on observation, clinical record review and staff interviews, the facility failed to ensure one resident had a bathroom call light that accommodated their needs. (Resident #16) The facility census was 154 residents. Findings include: 1. A Minimum Data Set (MDS) assessment dated 2/22/18, assessed Resident #16 with highly impaired vision (object identification in question) and required total staff assistance with bed mobility, transfers and toileting. A care plan dated 3/7/18, identified the resident had diagnoses that included congenital non-progressive ataxia, muscular dystrophy and blindness. Daily notes dated 4/13/18 at 11:38 a.m.,	F 558	**Reasonable Accommodations Needs/ Preferences** Without waiving the foregoing statement, the facility states that with respect to the reasonable accommodations needs/ preferences. Resident #16 was provided a touch pad call light on 4/24/2016. **04/10/2018** Residents are assessed for call light use upon admission, quarterly with the MDS assessment and as needed. **04/10/2018** Staff were educated regarding residents' touch pad call light implementation on **4/24/2018.** Audits will be completed by the DON/or Designee periodically to ensure compliance. **Ongoing** Audit findings will be brought to the monthly QAPI meetings. **Ongoing**	5/11/2018

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

Betsy Warburton President/CEO 5/11/18 05/04/2018

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 558	Continued From page 1	F 558		

documented the resident was on the toilet from 10:00 a.m. until 11:38 a.m. and back to bed. The resident had a large BM (bowel movement) in the toilet. Staff reported the resident was not ready to get off the toilet after staff checked the resident every 15 minutes. The writer informed staff that 1.5 hours was too long to sit on the toilet. The resident had the call light in reach on the resident's lap. A skin assessment after the resident returned to bed was completed. The resident had 2 red areas on the right thigh that measured 4 centimeters (cm.) by 1.75 cm. and 9 cm. by 1 cm. The resident denied pain.

On 4/16/18 at 3:05 p.m. Staff D, licensed practical nurse, LPN stated she saw the resident on the toilet around 10 a.m. At 11:38 a.m., Staff D looked for the resident and found the resident still seated on the toilet slumped over with her arm hanging down. Staff D informed the aides that was unacceptable. Staff D stated the resident did not have a red ring on her bottom from sitting so long but she did have red areas on the right hip. The resident had the call light on her leg but Staff D doubted she could use it. The resident had limited hand dexterity and was unable to lift her hand.

On 4/17/18 at 10:33 a.m. Staff F, CNA stated she worked on 4/13/18 and assisted another CNA with placing the resident on the toilet. Staff F stated after about 10 minutes, she checked on the resident and the resident wanted to stay on the toilet. Staff F left the unit to assist with wellness class and cleaned up a resident after wellness class. After that she returned to the unit and the resident was just getting transferred off the toilet. Staff F thought she may have been gone an hour. Staff F thought the resident could

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F 558	Continued From page 2 not use the call cord and stated it was hanging down by the resident. On 4/19/18 at 8:54 a.m., Staff E, CNA stated she thought they placed the resident on the toilet at 10:15 a.m. and she checked the resident after 15 minutes and the resident was not ready for staff to assist her off the toilet. In another 15 minutes she checked the resident again and the resident was not ready. After that she took a break and transitioned to homemaker and did not check on the resident again. Staff CNA stated she did not know Staff F left the floor. She stated the resident was on the toilet too long. Observation on 4/16/18 at 12:43 p.m., revealed two staff transferred the resident to the toilet. There were no red areas observed on the resident's bottom or thighs. The resident sat in special chair over the toilet. Staff placed the call string across the resident's lap. The surveyor asked the resident to activate the call light and the resident stated she did not know where it was. On 4/17/18, occupational therapy (OT) evaluated the residents ability to utilize the call light during toileting. The resident was unable to demonstrate safe use of the call light and required total assistance to meet needs. OT recommended staff supervise the resident for toileting safety.	F 558		
F 607 SS=D	Develop/Implement Abuse/Neglect Policies CFR(s): 483.12(b)(1)-(3) §483.12(b) The facility must develop and implement written policies and procedures that: §483.12(b)(1) Prohibit and prevent abuse,	F 607	**Develop/Implement Abuse/Neglect Policies** Without waiving the foregoing statement, the facility states that with respect to the abuse policy. A QAPI plan of action was initiated on **4/19/2018.**	**5/11/2018**

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F 607	Continued From page 3 neglect, and exploitation of residents and misappropriation of resident property, §483.12(b)(2) Establish policies and procedures to investigate any such allegations, and §483.12(b)(3) Include training as required at paragraph §483.95, This REQUIREMENT is not met as evidenced by: Based on clinical record review, facility policy review and staff interview, the facility failed to report a possible abuse allegation and failed to separate the victim from the alleged perpetrator from the victim. The facility census was 154 residents. Findings include: 1. The Minimum Data Set (MDS) assessment dated 8/10/17, assessed Resident #7 with impaired long and short term memory and moderately impaired decision making skills and required extensive assistance for bed mobility, transfers, toileting, personal hygiene and bathing. The care tool dated 9/13/17, directed staff to transfer the resident with an EZ stand and 2 staff. Daily notes dated 9/13/17 at 1:40 p.m., documented Staff P went to the resident's room due to a laceration to the resident's right lower leg during a transfer from the bed to the wheelchair. Staff Q, CMA (certified medication aide) had a towel on the resident's leg and it was soaked with blood. Staff P notified the ARNP (advanced registered nurse practitioner) who told staff to continue applying pressure to the wound. Staff P grabbed a bag of ice and another towel and	F 607	Resident # 7 passed away on **5/1/2018.** Abuse policy was reviewed on **3/14/2018.** Staff were re-educated on the reporting guidelines and procedure on **3/14/2018** and several other dates. Director of Nursing/or Designee will complete periodic audits to ensure policy is being followed and that the facility is within standard compliance. **Ongoing** Audit findings will be brought to the monthly QAPI meetings. **Ongoing**	

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F 607	Continued From page 4	F 607		

elevated the right leg and applied pressure. Staff P called another nurse for assistance with the situation. After approximately 25 minutes the bleeding was minimal and Staff P completed an assessment of the wound. The right lower leg wound measured 11 centimeters (cm.) long and 2 cm. wide with skin unable to be approximated so staff continued to apply pressure. After the ARNP assessed the wound, the resident was transported to the ER (emergency room)

ED (emergency department) notes dated 9/14/17 revealed a 99 year old female arrived from the nursing home for evaluation of a right leg laceration. This was sustained when transferred by an aide. Her leg caught of the edge of the wheelchair and she sustained the laceration. There is a large gaping C-shaped flap like laceration deep into the subcutaneous tissue over the lateral right leg below the knee. This has a V-shaped component to the upper end of the laceration. Total length is 13 cm. There was a small amount of venous oozing. The ED report identified the the laceration as "extensive". Due to the resident's age of 99 and the large laceration she was a high risk for healing complications. The wound was closed with a total of 21 sutures.

On 4/9/18 at 12:10 p.m., Staff Q CMA (certified medication aide) stated she transferred the resident out of bed by herself and she pulled her foot up causing her leg to get caught on the wheelchair. The leg caught on the part where the pedals hooked into the wheelchair. Staff Q stated she knew the resident was a 2 person transfer but the other aide was busy giving a shower. She stated she was suspended for one day and coached regarding the incident. Staff Q stated the care tool said to use 2 staff. She used a gait belt.

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F 607	Continued From page 5 Staff Q said she didn't mean for the resident to get hurt. It was lunch time and she thought she could transfer her. Staff Q said she wanted the resident to get to her meal. On 4/10/18 at 11:15 a.m., the Administrator stated the facility did not report the incident to the State agency because a major injury form was signed and said "no major in jury". On 4/16/18 at 3:00 p.m., Staff Q stated she did work with the resident after the incident but rarely. Staff Q stated the last time was a couple weeks ago. Review of Resident #7's January 2018 MAR (medication administration record) revealed Staff Q signed she gave the resident a medication on 1/2/18. The schedule also identified she worked on the resident's household from 6 p.m. to 10 p.m. that day. Review of Resident #7's April 2018 MAR revealed Staff Q administered medications to the resident on 4/5/18. Facility policy identified they would report all allegations of resident neglect to the State Agency not later than 2 hours after the allegation is made, if the events that cause the allegation result in serious bodily injury or not later than 24 hours if the events that cause the allegation involve neglect but do not result in serious bodily injury. Facility policy regarding separation revealed the following: Following completion of the facility investigation, if the facility concludes that the allegations of resident abuse are unfounded, the	F 607		

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F 607	Continued From page 6 employee may be allowed to return to job duties involving resident contact but the employee must maintain separation and have no contact with the resident alleged to have been abused, by reassigning the accused employee to an area of the facility where no contact will be made between the accused employee and the resident alleged to have been abused.	F 607		
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 observation, record review and staff interviews, the facility failed to ensure that a resident with pressure ulcers received necessary treatment and services, consistent with professional standards of practice, to promote healing, prevent infection and prevent new ulcers from developing for 3 of 4 residents (Residents #2, #3 & #4) reviewed. Facility census was one hundred fifty-four (154) residents. Findings include:	F 686	**Tx/SVCS to prevent/heal Pressure Ulcer** Without waiving the foregoing statement, the facility states that with respect to the skin program. A QAPI plan of action was initiated on **4/3/2018.** Residents #2, 3, and 4 wounds were assessed by nursing for appropriate treatment on **4/4/2018** and **4/9/2018.** A head to toe skin assessment was completed on all residents in the facility. If issues were identified, appropriate interventions were put into place. **Completion date: 04/4/2018** Skin policy was reviewed and revised on **4/3/18.** **4/3/18** and **4/4/18** nurses were re-educated on households regarding skin policy. All nursing staff received education regarding skin protocol by **4/10/18.** Director of Nursing/or Designee will complete periodic audits to ensure skin protocol is being followed and is within standard compliance. **Ongoing** Audit findings will be brought to the monthly QAPI meetings. **Ongoing**	**5/11/2018**

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F 686	Continued From page 7 1. A Minimum Data Set (MDS) with assessment reference date of 3/8/18, assessed Resident #2 with impaired long and short term memory impairments. The resident had moderately impaired decision making ability. The resident had the following signs and symptoms of delirium: inattention and disorganized thinking. The resident had no behaviors identified including rejection of care. The resident required total staff assistance with bed mobility, transfers, dressing, toileting, personal hygiene and bathing. The resident did not ambulate and used a wheelchair for mobility. The resident was always incontinent if bowel and bladder. The resident had diagnoses that included: dementia and multiple sclerosis. The MDS identified the resident with 2 Stage 3 pressure sores. The largest pressure sore measured 5.2 centimeters (cm.) long by 3 cm. wide by 1 cm. deep. The MDS identified a Stage 3 pressure sore as 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 the tissue loss. May include undermining and tunneling. On 3/23/18 the right ischium measured 6.3 cm. by 3.5 cm. by 2 cm.. The area was described as a Stage 3 ulcer tunneling superior to wound opening with yellow slough notes to muscle level beneath dermal layer. On 3/30/18 the right ischium measurements were unchanged with greater than 2 cm., tunneling superior to the wound opening. On 4/10/18 the right ischium measured 6.2 cm. by 3.2 cm. by 1.6 cm. with 5 cm. of tunneling.	F 686		

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F 686	Continued From page 8 Skin sheets identified the coccyx measurement on 3/30/18 measured 3.1 cm. by 1.9 cm. by 0.2 cm. On 4/10/18 skin sheets revealed the coccyx measured 2.4 cm. by 1.5 cm. with depth of 0.4 cm. Daily notes revealed the resident admitted to Hospice on 3/1/18. Orders for treatment on that date were: pack sacrum and right ischial ulcers with Betadine moistened gauze and cover with gauze daily. Wound clinic orders dated 3/22/18 at 10:57 a.m. revealed orders for the right ischium was: Betadine moist gauze covered with "dressing of choice". April 2018 treatment administration records (TARs) identified the order for the area as: Betadine solution 10%. Apply Betadine moistened gauze to the sacrum/right ischial wound daily and as needed. Observation showed on 4/2/18 at 1:25 p.m. the resident eating in bed. Following the meal Staff B LPN (licensed practical nurse) completed pressure sore care to a deep right ischial wound and coccyx wound. Staff B soaked 2 by 2 gauze in Betadine and packed the wound with 3 2 by 2 Betadine soaked gauze pads into the ischial wound after cleansing with wound cleanser. Staff B then applied a tegaderm to the wound. Betadine seeped out from under the Tegaderm. Staff B then cleansed the coccyx wound and used gauze to wipe out the area. She then applied Betadine soaked gauze to the coccyx area and covered it with Mepilex border. Staff left the resident on her back in bed. The resident remained on her back in bed at 2:45 p.m., 3:55 p.m. and 4:50 p.m. The resident laid on an air mattress.	F 686		

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F 686	Continued From page 9 A 4/2/18 care tool directed staff to reposition the resident every 2 hours from side to side. Dietary progress notes dated 1/8/17 revealed the resident should receive super cereal and fortified potatoes. On 4/4/18 at 1210 p.m. the dietician stated the resident received fortified potatoes when mashed potatoes were on the menu. The resident should receive super cereal every morning. Observation on 4/4/18 at 9:45 a.m. showed the resident rolled up in bed feeding self. At 10 a.m. the resident was asleep with fork in hand. There was no super cereal on the tray. The tray contained biscuits and gravy and thickened water. At 10:08 a.m. staff entered the room to provide pericare. Observation showed the coccyx dressing rolled up and removed by Staff A CNA. The right ischial dressing was coming off and contained a date of 4/3/18. Review of the treatment administration record revealed Staff D LPN (licensed practical nurse) applied dressings to the pressure sores on the 2 p.m. to 10 p.m. shift on 4/4/18. On 4/10/18 at 2:50 p.m. Staff D stated there were no dressing on either pressure sore when she worked the afternoon/evening shift on 4/4/18. She reapplied the dressings around suppertime that night. (Meaning the dressing were off all day until suppertime) On 4/5/18 at 9:42 a.m. observation showed no dressings on the resident's bottom. At that time, Staff C CNA stated the dressings were off and in the bed with the resident when she saw the resident around 8 a.m.	F 686		

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F 686	Continued From page 10 Interdisciplinary team care plan notes dated 3/21/18 identified the intervention of fortified potatoes not super cereal. Resident care plan goals with review date of 3/21/18 revealed the goal of the resident would allow staff to turn her from side to side to relieve pressure. 2. A MDS with assessment reference date of 1/4/18, assessed Resident #3 with impaired long and short term memory and moderately impaired decision making skills. The resident had the following signs and symptoms of delirium: inattention and disorganized thinking. The resident did not have behavior symptoms identified. The resident required extensive assistance of 2 staff with bed mobility, transfers, dressing and personal hygiene. The resident was nonambulatory. The resident had diagnoses that included: Alzheimer's disease and urine retention. The MDS identified the resident at risk for pressure sores. The MDS did not identify pressure sores. A facility form dated 1/7/18 revealed the facility identified a 0.5 cm. by 2 cm. pressure area to the coccyx. A telephone order dated 1/15/18 identified an order for venalex to open area on coccyx daily and cover with Mepilex. Change Mepilex every 3 days. The most recent measurement of the coccyx was completed on 3/30/18. The area measured 3.1 cm. by 2.7 cm. with depth 0.1 cm. On 3/23/18 the area measured 3.4 cm. by 2.2 cm. The most recent order for the area was dated 2/9/18 that directed staff to apply Aquacel AG foam (3.2 by 3.2) to open area. Change every 2	F 686		

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F 686	Continued From page 11	F 686		

days. A clarification dated 2/15/18 revealed staff should discontinue the venalex treatment and apply Aquacel AG foam to open area on bottom after cleansing. Change every 2 days and cover with opsite (transparent) dressing.

Review of the 2/18 TAR showed a line through the Mepilex dressing. Review of the 3/18 TAR revealed the Mepilex was on the 3/18 TAR and signed for by staff. (even though it was discontinued).

Observation on 4/2/18 showed the last dressing was dated 3/30/18 (3 days). On 4/2/18 Staff B LPN applied Mepilex border and not the ordered Aquacel treatment.

The care tool dated 4/2/18 directed staff to ensure the resident used an alternating air mattress and equagel in the wheelchair. The care tool directed staff to reposition the resident every 2 hours and reposition off of coccyx.

Observation showed, on 4/2/18 at 12:03 p.m. the resident rolled up in bed. The resident laid on an air mattress which was set on "static" (not alternating air) normal pressure. At that time Staff A CNA (certified nurse aide) provided pericare to the resident. A large bandage dated 3/30/18 covered the resident's coccyx area. Staff A removed the dressing since it was coming off. Observation showed an open sore on the coccyx. At 12:50 p.m. of the same date Staff B LPN (licensed practical nurse) used wound cleanser to cleanse the coccyx wound, cleansed around the sore with skin prep and applied Mepilex border (and no Aquacel AG). The resident rated pain in her bottom at an "8" on a scale of 0 to 10 with 0 being no pain and 10 being the worst imaginable

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F 686	Continued From page 12 pain. After the treatment, staff covered the resident and rolled the head of the bed up. On the same date at 2:23 p.m., 2:45 p.m. 3:20 p.m. the resident remained on her back in bed on the static mattress. At 3:55 p.m. the resident was up in a wheelchair at the table in the dining room. Staff did not follow the Aquacel/opsite every 2 days orders to treat the coccyx or reposition every 2 hours per care tool. 3. A Minimum Data Set (MDS) with assessment reference date of 12/28/17, assessed Resident #4 with a brief interview for mental status (BIMS) score of "7" (severe cognitive impairment). The resident sometimes understood other and others sometimes understood the resident. The resident had the following signs and symptoms of delirium: inattention and disorganized thinking. The resident had no behavior symptoms. The resident required total staff assistance with bed mobility, eating and personal hygiene. The resident transferred once or twice a week with the assistance of 2 or more staff. The resident did not ambulate or use the toilet. The resident had functional range of motion limitations of one side of the upper and lower extremities. The resident was always incontinent of urine and frequently incontinent of bowel. The resident had diagnoses that included: Alzheimer's disease and fracture. The MDS identified the resident as at risk for pressure sores. The MDS identified one Stage 2 pressure sore. The MDS identified a pressure sore present on the prior assessment. The MDS defines a stage 2 pressure ulcer as a partial thickness loss of dermis presenting as a shallow open ulcer with red or pink wound bed, without slough.	F 686		

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F 686	Continued From page 13 A 1/14/18 Braden scale identified the resident with a score of 11 (high risk for pressure sores). Hospice notes dated 2/28/18 revealed staff informed Hospice that the resident still had a wound to the coccyx. Review of March 2019 treatments administration records (TARs) revealed an order for Aquacel AG foam ADH 4 by 4. Apply topically to open areas on bottom cover with Mepilex and change every 3 days. Staff last signed for the treatment on 3/11/18 and then staff wrote "repeat". The TAR did not identify further treatment to the area. Telephone orders identified the following order on 3/14/18 "discontinue aqua AG foam to coccyx. Mepilex to sacrum change every 3 days" The March and April 2018 TARs did not reflect the Meplilex order was carried out. There were no skin assessment records available regarding the coccyx since 11/30/17. On 11/30/17 a skin record identified a 0.6 centimeter (cm.) by 0.2 cm. dry scab on the coccyx. Observation: Observation showed on 4/2/18 at 12:02 p.m., 2:20 p.m., 2:45 p.m. 3:55 p.m. and 4:50 p.m. the resident in bed on her back. Observation on 4/3/18 at 8:42 a.m., 9:05 a.m. and 10:22 a.m. showed the resident on back in bed. On 4/3/18 at 9:05 a.m. observation showed the skin on the coccyx area red and fragile but not open. There was no dressing on the area. Staff provided pericare at this time. Staff did not apply periguard	F 686		

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F 686	Continued From page 14 with pericare. The resident laid on an air mattress when in bed. A care tool for CNAs did not contain a repositioning schedule for the resident. The care tool directed staff to apply periguard with all pericare. A resident care plan goals sheet with review date of 1/10/18 did not identify a repositioning plan. The corporate consultant stated on 4/9/18 at 10:18 a.m. stated the facility was aware there were issues with pressure sores. On 4/3/18 the facility did head to toe assessments on all residents and reviewed wound treatment orders for accuracy.	F 686		
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: Based on record review and staff interview, the facility failed to ensure that -the resident environment remained as free of accident hazards as possible; and each resident received adequate supervision and assistance devices to prevent accidents for 2 of 4 residents reviewed. (Resident #6 & #7) Facility census was one hundred fifty-four (154) residents.	F 689	**Free of accidents/hazards/supervision/ devices** Without waiving the foregoing statement, the facility states that with respect to accidents, hazards, supervision, and devices. QAPI action plan was instituted on **4/11/18** for review of falls and transfers. Resident #6 passed away on 3/6/18. Resident #7's fall interventions and documentation were reviewed for accuracy **4/11/18.** Staff were re-educated on the importance of following the resident care tools for fall interventions and appropriate transfers on **4/16/18.**	**5/11/2018**

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F 689	Continued From page 15 Findings include: 1. A Minimum Data Set with assessment reference date of 1/18/18, assessed Resident #6 with impaired short term memory and modified independence with decision making skills. The resident had no behavior symptoms identified. The resident required limited staff assistance with toileting and extensive staff assistance with bathing. The resident was frequently incontinent of bladder. The resident had diagnoses that included: diabetes and malignant neoplasm of the bone. The resident had one fall with injury since the previous assessment. A PT (physical therapy) progress and discharge summary dated 7/10/17 revealed the resident could ambulate safely with 4 wheeled walker and CGA (contact guard assistance) on even surfaces. The resident demonstrated a Tinette balance score of 6/16 and a gait score of 9/12 for a total balance and gait score of 15/28 which is high risk for falls. An incident report dated 12/2/17 at 5 a.m. identified an unwitnessed fall in the resident bathroom. The resident fell and hit her head on the bathroom door. The resident received a bump on the head. The incident report revealed the resident fell asleep on the toilet. Following the incident, staff instructed the resident to please call for assistance. A care tool dated 12/2/17 identified the resident was independent with a 4 wheeled walker. An incident report dated 2/14/18 at 12:45 a.m. revealed an unwitnessed fall in the resident's	F 689	Director of Nursing/or Designee will review all incident reports for appropriate interventions and documentation. **Ongoing** Audit findings will be brought to the monthly QAPI meetings. **Ongoing**	

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F 689	Continued From page 16	F 689		

room. Staff found the resident in a sitting position by the bed. The resident did not sustain injury. The report indicated the resident possibly fell out of bed. The resident stated a woman and baby kicked her out of bed. The report identified the resident with increased use of Morphine (narcotic) due to pain. The report also stated the resident was more confused lately. The root cause of the fall identified on the incident report was possible footwear and bed was very high for resident to get into and resident was always at the edge of the bed at all times. The report identified the facility may need to speak with the family about a lower bed easier to get into. The intervention was Hospice changed medication for better pain control. There was no evidence the facility approached the family about a lower bed. The care tool in place on 2/15/18 did not contain any changes in footwear for the resident.

An incident report dated 2/24/18 at 5:15 a.m. revealed an unwitnessed fall in the resident's room. A diagram identified the resident on the floor by the bed. When questioned, the resident said something about magazines. The resident's feet were bare and the call light was not in reach. Contributing factors revealed "footwear". The resident said she slid to the floor to look for her remote. The intervention following the incident was for the resident to call to ask for remote and have pendant call light available and pendant on body. Additional care tool changes/interventions was: suggest wrist pendant. Review of the 2/24/18 and 2/25/18 care tools showed no care tool changes following the incident.

Daily notes dated 3/2/18 at 2 a.m. revealed the resident was increasingly confused. A nurse walked by the resident's room and found the

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F 689	Continued From page 17 resident seated on the edge of the bed with no brief or pants on. The nurse asked the resident if she was Ok and she stated she didn't know what she was doing or why she was seated there. An incident report dated 3/4/18 at 9:15 a.m. revealed an unwitnessed fall in the resident room. The resident fell and hit the left eye possibly on the left corner of the bed frame. A diagram showed the resident on the floor at the foot of the bed. The resident was confused and had slippers on. The contributing factor was identified as "amount of assistance in effect". The resident appeared weak and didn't know why or how the fall occurred. The conclusion was that the resident took self to the bathroom and fell into the bed hitting her eye. After the incident, the family provided a lower bed. Daily notes dated 3/4/18 at 11 p.m. revealed staff found the resident on the floor at 9:15 a.m. facing the bed on her bottom. Staff observed an injury to the left eye. The pupil and iris were completely covered in blood. Staff placed an ice pack over the eye and the resident transported to the ER (emergency room). The resident returned to the facility (no time listed) with orders for an ice pack and multiple eye drops. The resident was to see an eye doctor in the morning. An ER after visit summary dated 3/4/18 identified the resident's eye injury as "hyphema". Hyphema care instructions identified it as bleeding between the colored part of the eye (iris) and the cornea. The cornea is the outer clear tissue that covers the iris and pupil. Hyphema is usually caused by a blunt injury to the face or eye. Because this is a serious injury, the resident will need to see an eye specialist right away.	F 689		

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F 689	Continued From page 18 Review of 3/5/18 nurses notes did not identify a visit to an eye specialist. On the same date at 6:40 p.m. the resident was unresponsive verbally and briefly opened eyes to voices. The resident expired on 3/6/18 at 9:40 p.m. A death certificate identified the immediate cause of death as respiratory failure due to breast cancer with metastases to the bone. Staff Interviews: On 4/9/18 at 12:56 p.m. Staff V CNA stated just she and Staff U LPN (licensed practical nurse) worked when the resident fell. She stated she heard the resident yell and found her on the floor. She got Staff U. The resident said she hit her eye on the corner of the bed. She said her foot got stuck when she tried to get out of the recliner. Her bed was kind of high and after the incident, she got a low bed. Her recliner was at the foot of the bed and there wasn't much room to walk in between. Her room was cluttered. Staff V didn't know if the resident wore a wrist pendant. On 4/8/18 at 3:47 p.m. Staff U LPN stated the resident was laying on the edge of the bed so he helped her into the recliner. 5 to 10 minutes later the resident was on the floor sitting on her bottom and facing the foot of the bed. Staff U stated he was shocked when he saw the resident's eye injury. The iris and pupil were completely covered with blood. The resident was confused and declining prior to the incident. Staff U sent the resident to ER and she returned with orders for multiple eye drops and an eye patch. She was supposed to see an eye specialist. On 4/12/18 at 11:50 a.m. Staff U stated he thought the resident's wrist pendant was next to her on a	F 689		

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F 689	Continued From page 19 table by the recliner. He stated the resident was forgetful and not good about asking for help. 2. A Minimum Data Set (MDS) with assessment reference date of 8/10/17, assessed Resident #7 with Impaired long and short term memory and moderately impaired decision making skills. She rarely understood verbal communication and was sometimes understood by staff with communication ability limited to making concrete requests. The resident had moderately impaired vision and could not read newspaper headlines but could identify objects. She had no behavior symptoms identified including no rejection of care identified. The resident required extensive assistance of 2 or more staff for bed mobility, transfers, toileting, personal hygiene and bathing. The resident did not ambulate. She had functional range of motion limitations of both upper and lower extremities. The resident was frequently incontinent of bowel and bladder. Resident #7 was 65 inches tall and weighed 118 pounds. A care tool dated 9/13/17 directed staff to transfer the resident with an EZ stand and 2 staff. Daily notes dated 9/13/17 at 1:40 p.m. and documented by Staff P RN (registered nurse) revealed at approximately 11:15 a.m. Staff P went to the resident's room due to a laceration to the resident's right lower leg during a transfer from the bed to the wheelchair. Staff Q CMA (certified medication aide) had a towel on the resident's leg and it was soaked with blood. Staff P notified the ARNP (advanced registered nurse practitioner) who told staff to continue applying pressure to the wound. Staff P grabbed a bag of ice and another	F 689		

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F 689	Continued From page 20	F 689		

towel and elevated the right leg and applied pressure. Staff P called another nurse for assistance with the situation. After approximately 25 minutes the bleeding was minimal and Staff P completed an assessment of the wound. The right lower leg wound measured 11 centimeters (cm.) long and 2 cm. wide with skin unable to be approximated so staff continued to apply pressure. After the ARNP assessed the wound, the resident was transported to the ER (emergency room)

ED (emergency department) notes dated 9/14/17 revealed a resident arrived from the nursing home for evaluation of a right leg laceration. This was sustained when transferred by an aide. Her leg caught of the edge of the wheelchair and she sustained the laceration. There is a large gaping C-shaped flap like laceration deep into the subcutaneous tissue over the lateral right leg below the knee. This has a V-shaped component to the upper end of the laceration. Total length is 13 cm. There was a small amount of venous oozing. The ED report identified the the laceration as "extensive". Due to the resident's age and the large laceration she was a high risk for healing complications. The wound was closed with a total of 21 sutures.

Observation:

On 4/10/18 at 1:15 p.m. observation showed 2 staff transfer the resident from the wheelchair to bed via Hoyer lift. Observation of the right outer leg shower a long black scab approximately 6 to 8 inches long. The resident did not respond to any questions asked about her right lower leg. She just smiled.

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F 689	Continued From page 21 Staff Interviews: An interview was conducted on 4/12/18 at 2:29 p.m. with Staff P RN. Staff P stated a nurse aide reported the incident to her. She was not sure who the CNA was but it was not Staff Q who was with the resident. During a transfer to the wheelchair, the resident must have caught her leg on something. Staff Q did not say how she transferred the resident-another aide told Staff P what happened. Staff Q transferred the resident by herself. Staff P found out at the end of the day and Staff Q was then taken to the office. When Staff P entered the room, she saw blood everywhere. There was a trail and then a pool of blood. The resident's leg had a big deep cut approximately 11 centimeters (cm.) long. The skin was sliced and hanging off. It could not be approximated (put back together). The resident went to the ER (emergency room) and received 21 stitches to close the wound. Staff P didn't know if there were complications after the injury. Staff P stated she did not know of anyone else transferring the resident improperly. On 4/22/18 at 6:13 p.m. Staff Y CNA stated she was getting a resident up and had told Staff Q she would be right back. When she returned, Staff Q transferred the resident by herself and cut her leg. Staff Y stated blood was everywhere and Staff Q put pressure on the wound. There was blood on the floor, and the resident's leg and foot. Staff Q told Staff Y-"You were in here with me weren't you" Staff Y stated she would not cover for Staff Q. She reported the information to management and they told Staff Y she didn't the right thing by not covering for Staff Q. Staff Y stated she was not aware of anyone else transferring the resident alone. Staff Y stated she	F 689		

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F 689	Continued From page 22 always used 2 to transfer the resident. On 4/24/18 at 10 a.m. Staff W RN and acting DON (director of nursing) stated she was told that Staff Q asked a staff to cover for her and the other staff said no. She stated then someone else took over the investigation. That person no longer works at Bethany. Staff W stated they couldn't find the investigation into the incident. On 4/9/18 at 12:10 p.m. Staff Q CMA (certified medication aide) stated she transferred the resident out of bed by herself and she pulled her foot up causing her leg to get caught on the wheelchair. The leg caught on the part where the pedals hooked into the wheelchair. Staff Q stated she knew the resident was a 2 person transfer but the other aide was busy giving a shower. She stated she was suspended for one day and coached regarding the incident. Staff Q stated the care tool said to use 2 staff. She used a gait belt. Staff Q said she didn't mean for the resident to get hurt. It was lunch time and she thought she could transfer her. Staff Q said she wanted the resident to get to her meal. On 4/10/18 at 1:40 p.m. Staff Q stated she had the care tool with her when the incident occurred and again said she knew the resident was not a 1 assist transfer and that she should have 2 for transfers. On 4/24/18 at 10:05 a.m. Staff Q denied asking Staff Y to say she assisted with the resident's transfer. Staff Q stated she told Staff Y not to lie. Staff Q didn't know why Staff Y would say that. Staff Q stated the DON and supervisor told her they spoke with a lawyer and Staff Q was told it wasn't reportable. They said they did their own investigation but now they cant find it.	F 689		

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F 689	Continued From page 23 On 4/10/18 at 11:15 a.m. the Administrator stated the facility did not report the incident to the State agency because a major injury form was signed and said "no major in jury".	F 689		
F 725 SS=E	Sufficient Nursing Staff CFR(s): 483.35(a)(1)(2) §483.35(a) Sufficient Staff. The facility must have sufficient nursing staff with the appropriate competencies and skills sets to provide nursing and related services to assure resident safety and attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident, as determined by resident assessments and individual plans of care and considering the number, acuity and diagnoses of the facility's resident population in accordance with the facility assessment required at §483.70(e). §483.35(a)(1) The facility must provide services by sufficient numbers of each of the following types of personnel on a 24-hour basis to provide nursing care to all residents in accordance with resident care plans: (i) Except when waived under paragraph (e) of this section, licensed nurses; and (ii) Other nursing personnel, including but not limited to nurse aides. §483.35(a)(2) Except when waived under paragraph (e) of this section, the facility must designate a licensed nurse to serve as a charge nurse on each tour of duty. This REQUIREMENT is not met as evidenced by: Based on observation, clinical record review, resident and staff interviews, the facility failed to	F 725	**Sufficient Nursing Staff** Without waiving the foregoing statement, the facility states that with respect to sufficient nursing staff. A QAPI plan of action was initiated for call lights, showers and toileting on **4/19/2018.** Residents #17, 19, 20 and 21 call light and toileting needs were addressed for timeliness. A facility audit was completed on call light times **4/11/2018.** Residents #3, 4, 7, 16, 22, 23, and 24 showers were assessed and addressed to meet the requirement of 2 showers in a week. MDS nurse audited and discovered that showers were completed but staff but did not do the documentation that showers had been completed **4/19/2018.** Staff were re-educated on answering call lights timely, addressing toileting needs timely, and offering/documenting showers twice weekly on **4/11/2018.** Audits were completed on **4/11/2018** for call light response times. Director of Nursing/or Designee will complete periodic audits to ensure call lights are answered timely, toileting needs are addressed timely, and showers are being offered and documented within standard compliance. **Ongoing** Audit findings will be brought to the monthly QAPI meetings. **Ongoing**	**5/11/2018**

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BETHANY LIFE	212 LAFAYETTE STREET STORY CITY, IA 50248

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F 725	Continued From page 24	F 725		

have sufficient nursing staff in place in order to answer resident call lights, provide showers and toileting for eight residents. The facility census was 154 residents.

Findings include:

1. The Minimum Data Set (MDS) assessment dated 3/22/18, assessed Resident #17 with a brief interview for mental status (BIMS) score of 15, indicating intact cognition and required total staff assistance with transfers, dressing, toileting and personal hygiene.

On 4/12/18 at 1:10 p.m., the resident stated the night before last she waited 30 minutes for the call light. She had a clock on the wall and could see the black hands on the clock. She wanted her fan turned on because she woke up roasting hot. No one came so she became furious and held the call button down and started yelling. Staff came in running and asked what the resident needed. The resident asked if the call light was working and staff replied it was working. The resident stated she had plenty of panic attacks due to heat and the fan not on.

A call light alarm activities report identified the following:

4/6/18 call light on at 12:12 p.m. and off at 12:36 p.m. (24 minutes)
4/6/18 call light on at 1:39 p.m. and off at 2:03 p.m. (24 minutes)
4/6/18 call light on at 9:39 p.m. and off 10:01 p.m. (22 minutes)
4/8/18 call light on at 4:18 p.m. and off 4:40 p.m. (22 minutes)
4/9/18 call light on at 7:38 p.m. and off 8 p.m. (22

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F 725	Continued From page 25 minutes) 4/10/18 call light on at 9:55 a.m. and off 10:12 a.m. (17 minutes) 4/11/18 call light on 1:32 a.m. and off at 1:55 a.m. (23 minutes) 4/11/18 call light on at 6:40 p.m. and off at 6:59 p.m. (19 minutes) 4/12/18 call light on at 8:01 a.m. and off at 8:32 a.m. (31 minutes) 2. The MDS assessment dated 3/1/18, assessed Resident #19 with a BIMS score of 12, indicating moderate cognitive impairment and required extensive staff assistance with bed mobility, transfers, dressing, toileting and personal hygiene. On 4/10/18 at 10:20 a.m., the resident stated sometimes it takes a long time for staff to answer the call light. It has taken an hour and the resident looked at his watch. The resident could not recall what he needed. Today he had his call light on and did not make it to the bathroom in time. A call light alarm activities report identified the following: 3/28/18 call light on at 5:59 p.m. and off at 6:37 p.m. (38 minutes) 3/29/18 call light on at 1:37 p.m. and off at 1:58 p.m. (21 minutes) 4/5/18 call light on at 5:06 p.m. and off at 5:39 p.m. (33 minutes) 4/6/18 pendant on at 6:24 p.m., call light on at 8:07 p.m. and off 8:11 p.m. (1 hour and 37 minutes since pendant activated) 4/9/18 call light on at 7:10 a.m. and off at 7:30 a.m. (20 minutes)	F 725		

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F 725	Continued From page 26 4/9/18 call light on at 6:59 p.m. and off at 7:18 p.m. (19 minutes) 3. The MDS assessment dated 1/11/18, assessed Resident #20 with a BIMS score of 13, indicating intact cognition and required limited assistance with transfers, ambulation, dressing, toileting and personal hygiene. On 4/10/18 at 1:35 p.m., the resident stated staff was slow. On Friday he had to wait an hour. He looked at a watch. He stated he had bowel accidents waiting for assistance in the past. A call light alarm activities report identified the following: 4/2/18 call light on at 4:31 p.m. and off at 5:04 p.m. (33 minutes) 4/6/18 call light on at 8:53 p.m. and off at 9:13 p.m. (20 minutes) 4/7/18 call light on at 8:10 a.m. and off at 8:36 a.m. (26 minutes) 4/9/18 call light on at 7:59 a.m. and off at 8:29 a.m. (30 minutes) 4. The MDS assessment dated 1/4/18, assessed Resident #21 with impaired long and short term memory. The resident required limited staff assistance with transfers and ambulation and extensive staff assistance with dressing and toileting. A care tool dated 4/2/18 revealed the resident required the assistance of one staff with ambulation. The care tool identified the resident as a fall risk and uses alarms due to self transfers.	F 725		

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F 725	Continued From page 27 On 4/2/18 at 10:22 a.m., the surveyor checked on an alarm that had sounded for several minutes. Observation showed the resident in the bathroom. The surveyor asked the resident if she went in the bathroom by herself and she stated she had. The alarm continued to beep. A therapy person walked by and there was a homemaker in the dining area that heard the alarm. The resident flushed the toilet and washed her hands and then walked back to the bed/chair by herself with a walker. After she was seated the alarm quit beeping. No staff ever arrived to check the alarm. 5. On 4/11/18 at 2:39 p.m., Staff S, certified nurse aide, CNA stated the facility needed more staff. Since the facility took away homemakers and had CNAs perform those duties it was very hard to get showers done. Staff S named 4 residents that had not received twice weekly showers: Resident #7, Resident #22, Resident #23 and Resident #24: Review of bath records: Resident #23 reviewed for baths since 1/1/8. One bath documented on 2/16/18. Resident #24 reviewed for baths since 1/1/18. The resident had one bath in January 2018: 1/13/18, four baths in February 2018: 2/7/18, 2/10/18, 2/17/18, 2/21/18, and 2 baths in March 2018: 3/7/18 and 3/28/18. There were no baths documented for April 2018. Resident #22 reviewed for baths since 1/1/18. The resident had one bath documented in January on 1/11/18. There were no baths documented for February 2018. There were 6 days between baths in April from 4/3/18 to 4/9/18.	F 725		

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F 725	Continued From page 28 Resident #7 reviewed for baths since 1/1/18. The resident did not receive a bath between 1/24/18 to 1/31/18 and 3/21/18 to 3/28/18. 6. While reviewing MDS information during the investigation, the surveyor noted the MDS's for Resident #3 (MDS date 1/4/18) , Resident #4 (MDS date 12/28/17) and Resident #16 (MDS date 2/22/18) had "8" in the MDS column for baths. On 4/19/18 at 10:50 a.m., the surveyor asked Staff X, MDS nurse why she coded "8" for baths. She stated she coded "8" because she could find no evidence of baths documented during the assessment reference period for those residents. 7. Resident council minutes revealed the following information: 10/26 17: Too little nursing/CNA staff to keep up with resident needs, especially during the evening 11/29/17 Still a concern there is too little staffing to meet resident needs. There are times when there is a single aide sometimes shared between 2 houses trying to take care of all the residents at a time of day when everyone has a major need, 2/19/18: Lost homemakers. Need more CNAs 3/18 Does not seem like there is enough help on the households, need more CNAs ever since the homemakers were sent to different tasks, because there is too much for them to do. 8. On 4/17/18 at 2:20 p.m., Staff T, CNA stated there has been a time or two staff did not complete baths but they try to make them up another time.	F 725		
F 802	Sufficient Dietary Support Personnel	F 802		

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F 802 SS=F	Continued From page 29 CFR(s): 483.60(a)(3)(b) §483.60(a) Staffing The facility must employ sufficient staff with the appropriate competencies and skills sets to carry out the functions of the food and nutrition service, taking into consideration resident assessments, individual plans of care and the number, acuity and diagnoses of the facility's resident population in accordance with the facility assessment required at §483.70(e). §483.60(a)(3) Support staff. The facility must provide sufficient support personnel to safely and effectively carry out the functions of the food and nutrition service. §483.60(b) A member of the Food and Nutrition Services staff must participate on the interdisciplinary team as required in § 483.21(b)(2)(ii). This REQUIREMENT is not met as evidenced by: Based on observation, resident council minutes review and staff interviews, the facility failed to employ sufficient staff with the appropriate competencies and skills sets to carry out the functions of the food and nutrition service for four of four households. The facility census was 154 residents. Findings include: 1. On 4/11/18 at 4:25 p.m., observation showed Staff J, certified nurse aide, CNA in the kitchen area on David's Place preparing food on the warmer burners for serving. At the time, the surveyor asked her if she received any training on temperature checks and other homemaker	F 802	**Sufficient Dietary Support Personnel** Without waiving the foregoing statement, the facility states that with respect to sufficient dietary support personnel. All homemakers and nursing staff were trained on food temperature and dishwasher temperature procedures on **4/10/18.** A skills fair is scheduled for **May 22 and 23, 2018** and training will be completed upon hire and annually. Director of Dietary Services/or Designee will complete periodic audits to ensure staff have clear knowledge on food and dishwasher temperature procedures. **Ongoing** Audit findings will be brought to the monthly QAPI meetings. **Ongoing**	**5/11/2018**

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F 802	Continued From page 30	F 802		

functions. Staff J stated she was kinda feeling her way around and she was not sure what to do. Staff J checked the soup temperature at 168 degrees. Staff J stated a lot of times they have a homemaker and she worked in dietary before and she had seen what the homemakers do when they were on the unit.

2. On 4/11/18 at 4:33 p.m., observation showed Staff K, licensed practical nurse, LPN in Julia's Place. Staff K stated she and the other 2 CNAs were working as homemakers in the kitchen that night. Staff K stated she had no training and had no idea what to do in the kitchen.
At 4:35 p.m., the surveyor spoke with the 2 CNAs on the unit. Both Staff L ,CNA and Staff M, CNA stated they had no training.

On 4/12/18 at 9:00 a.m., observation showed Staff I, homemaker working in Julia's Place. At that time, Staff N CNA stated the group last night did not even do the dishes. When the surveyor asked about the yellow folder for recording of dishwasher temperatures. Staff N stated he did not know there was a folder to write in and began asking the homemaker about procedures .

3. On 4/11/18 at 3:15 p.m., the director of dining services stated staff should check food and dishwasher temperatures every meal and food temperatures every meal. He stated there was a yellow folder for each house where staff should check dishwasher temperatures. The dishwasher wash cycle should be above 150 degrees and the rinse cycle should be above 180 degrees. He stated he was slowly getting staff trained.

4. On 4/12/18 at 8:25 a.m., the surveyor asked Staff A, CNA on Charlene's Place about food

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F 802	Continued From page 31 temperature checks. She stated it slipped her mind that day to check food temperatures. She stated no one showed staff anything when they transitioned to having CNAs work in the kitchen area as homemakers. 5. On 4/16 18 at 12:25 p.m., observation showed Staff O, CNA in the kitchen in Walker Place running the dishwasher which showed 141 degrees for the wash cycle. At that time Staff O stated she had no training and did not know what the temperature for the dishwashing machine should be. 6 On 4/11/18 at 2:39 p.m., Staff S, CNA stated they used have "homemakers" that performed the dietary duties on the unit, checking food and dishwasher temperatures etc. Staff S stated when homemakers were let go nursing staff was expected to perform those duties and they did not get any training 7. Resident council minutes from March 2018 revealed residents thought staff did not seemed trained on how to serve since the CNAs took over more of the food service roles which causes food to get out more slowly.	F 802		
F 812 SS=F	Food Procurement,Store/Prepare/Serve-Sanitary CFR(s): 483.60(i)(1)(2) §483.60(i) Food safety requirements. The facility must - §483.60(i)(1) - Procure food from sources approved or considered satisfactory by federal, state or local authorities. (i) This may include food items obtained directly from local producers, subject to applicable State	F 812	**Food Procurement Store/Prepare/Serve-Sanitary** Without waiving the foregoing statement, the facility states that with respect to food procurement, store/prepare/serve-sanitary. All homemakers and nursing staff were trained on food dishwasher temperature procedures on **4/10/18.** Training will be completed upon hire and annually.	**5/11/2018**

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F 812	Continued From page 32 and local laws or regulations. (ii) This provision does not prohibit or prevent facilities from using produce grown in facility gardens, subject to compliance with applicable safe growing and food-handling practices. (iii) This provision does not preclude residents from consuming foods not procured by the facility. §483.60(i)(2) - Store, prepare, distribute and serve food in accordance with professional standards for food service safety. This REQUIREMENT is not met as evidenced by: Based on observation, facility record review, facility policy review and staff interview, the facility failed to ensure the dishwasher wash and rinse cycle temperature was maintained as manufacturers recommendations directed for 4 of 4 households observed. The facility census was 154 residents. Findings include: 1. On 4/11/18 at 3:15 p.m., the director of dining services stated staff should check food and dishwasher temperatures every meal. He stated there was a yellow folder for each house where staff should document dishwasher temperatures. The dishwasher wash cycle should be above 150 degrees and the rinse cycle should be above 180 degrees. He stated he was slowly getting staff trained. a. Charlene's House review of 13 meals identified no food temperatures were taken for the meals between 4/8/18 and 4/12/18 at 8:25 a.m. b. Sansgaard food temperature checks from 4/8/18 through 4/12/18 breakfast revealed 5 out	F 812	Director of Dietary Services/or Designee will complete periodic audits to ensure staff have clear knowledge on food and dishwasher temperature procedures. **Ongoing** Audit findings will be brought to the monthly QAPI meetings. **Ongoing**	

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F 812	Continued From page 33 of 13 meals not checked for food temperatures. Review of Sansgaard dishwasher temperature checks revealed 23 out of 34 dishwasher checks not completed. Observation on Sansgaard on 4/12/18 at 9:33 a.m., revealed the initial temperature for the wash cycle of the dishwasher was 152 degrees then dropped to 144 for the rest of the cycle. The rinse was 175 degrees. At 9:54 a.m., the surveyor asked staff if they planned to run the dishes through again and staff stated yes. Observation of follow up rinse cycle was 181 degrees. c. Julia's Place food temperature checks from 4/8/18 through 4/12/18 breakfast revealed 8 out of 13 meals not checked for food temperatures. Review of Julia's Place dishwasher temperature checks revealed 20 out of 34 dishwasher checks not completed. Observation on 4/12/18 at 9:55 a.m., on Julia's Place revealed a wash cycle of 143 degrees and rinse 186 degrees. At the conclusion of the wash/rinse cycle, Staff I, homemaker began putting the dishes away. At that time the surveyor asked Staff I if she should run the dishes through again since the wash cycle was below 150 degrees. Staff I replied, "probably should" and rewashed the dishes. The wash cycle remained below 150 degrees at 144-145 degrees. Staff I stated she would let the machine sit awhile to see if the temperature wash cycle would rise. At 10:08 a.m., Staff I ran the dishes through with wash cycle 156 degrees and rinse 185 degrees. d. Ivy's Place food temperature checks from	F 812		

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F 812	Continued From page 34 4/8/18 through 4/12/18 breakfast revealed 8 out of 13 meals not checked for food temperatures. Review of Ivy's Place dishwasher temperature checks revealed 27 out of 33 dishwasher checks not completed.	F 812		