STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	165575	A. BUILDING _____ B. WING _____	06/28/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MANORCARE HEALTH SERVICES-UTICA RIDGE	3800 COMMERCE BLVD DAVENPORT, IA 52807

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 000	INITIAL COMMENTS VKK 7/26/18 Correction date 7/25/18 & 6/29/18(G) The following deficiencies relate to the facility's annual health survey and investigation of complaint #76687. (See Code of Federal Regulations (42CFR) Part 483, Subpart B-C).	F 000		
F 561 SS=D	Self-Determination CFR(s): 483.10(f)(1)-(3)(8) §483.10(f) Self-determination. The resident has the right to and the facility must promote and facilitate resident self-determination through support of resident choice, including but not limited to the rights specified in paragraphs (f)(1) through (11) of this section. §483.10(f)(1) The resident has a right to choose activities, schedules (including sleeping and waking times), health care and providers of health care services consistent with his or her interests, assessments, and plan of care and other applicable provisions of this part. §483.10(f)(2) The resident has a right to make choices about aspects of his or her life in the facility that are significant to the resident. §483.10(f)(3) The resident has a right to interact with members of the community and participate in community activities both inside and outside the facility. §483.10(f)(8) The resident has a right to participate in other activities, including social, religious, and community activities that do not interfere with the rights of other residents in the	F 561		

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

Administrator — 07/16/2018

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.

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

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F 561	Continued From page 1 facility. This REQUIREMENT is not met as evidenced by: Based on observation, clinical record review, resident and staff interview, the facility failed to ensure one residents needs were met as they desired. (Resident # 309) The facility census was 110 residents. Findings include: 1. The Face Sheet for Resident # 309 dated 6/20/18, listed diagnosis of diabetes mellitus and pneumonia. The Care Plan dated 6/20/18, directed staff to assist with transfers and adjust toileting times to meet resident needs. During interview on 6/26/18 at 1:47 p.m., the resident reported putting on the call light to get up and use the toilet on the previous the night shift. The resident stated Staff directed him/her to go ahead and go in the bed. The resident continued to the report staff said that was why you have a brief on. The resident planned to discharge from the facility today. During interview on 6/27/18 at 12:00 p.m., Staff E Certified Nurses Aide, CNA reported when residents ask to go to the bathroom we are expected to take them to the toilet or if they want the bed pan, offer them the choice. We should never tell them to just go in their pants. During interview on 6/27/18 at 11:46 a.m., the Administrator stated when asked by a resident for staff help them to the toilet, staff are expected to	F 561		

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F 561	Continued From page 2 take the resident to the toilet. It is not expectable to tell a resident to go on their pants. During interview on 6/28/18 at 7:40 a.m., Staff F Director of Care Delivery (DCD) reported the expectation when a resident asks to go to the toilet, they are taken to the toilet. The facility provided the Admission packet titled ManorCare Health Services Utica Ridge Center Supplement undated, on page 4 listing the Resident's Rights at point # 1: Each Resident has the right to considerate and respectful care and to be treated with honesty, dignity, respect and with reasonable accommodation of individual needs except where the health, safety, or rights of the resident or other individuals in the facility would be endangered. During interview on 6/25/18 at 2:34 p.m., the resident revealed telling staff the other morning the desire to get up at 5:00 a.m. The resident reported staff responded saying "no, you need to wait till 6:00 a.m., to get up". During interview on 6/26/18 at 1:31 p.m., the resident reported turning the call light on early this morning on 6/26/18 to get up and staff said they would be back. The resident stated awhile later they put the light on again, staff came and got my roommate up. The resident stated having to be at work at 6:30 a.m., so it was routine to get up at 5:00 a.m. During interview on 6/27/18 at 12:00 p.m., Staff E Certified Nurses Aide, CNA reported if a resident wants to get up in the morning its his/her choice of the time to get up, yes if they want 5:00 a.m. they can get up at 5:00 a.m.	F 561		

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F 561	Continued From page 3 During interview on 6/27/18 at 11:47 a.m., the Administrator reported staff are expected to get the resident up out of bed when they ask, even at 4 or 5 a.m., it's their choice. Staff should never tell the resident to wait for the next shift.	F 561		
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 follow physician orders as directed for one of 21 residents reviewed. (Resident #78) The facility census was 110 residents. Findings include: The Minimum Data Set assessment dated 5/30/18, documented Resident #78 had diagnoses of cancer, stroke and kidney failure and required extensive assistance for personal hygiene, bed mobility and transfers. A nursing note entry dated 3/17/18 at 4:08 p.m., revealed the resident returned from the hospital and had a right below the knee amputation with an ace wrap dressing intact and dry. Hospital discharge instructions dated 3/17/18, lacked information regarding a dressing change.	F 658		

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F 658	Continued From page 4 A 3/20/18 physician order directed staff to " apply dry dressing to right below knee amputation, with compressive stump sock or ace wrap every 3 days, start on 3/21/18. The March 2018 TAR (Treatment Administration Record) lacked the above order. During interview on 6/27/18 at 3:00 p.m., Staff R, Registered Nurse stated when the resident returned after surgery for the amputation, there were orders the dressing was to remain in place for a certain amount of time. He stated the facility left the dressing in place for a longer period of time than it was supposed to be left on. He stated when they sent the resident out to the doctor's appointment, the physician mentioned the dressing was still on.	F 658		
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:	F 686		

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F 686	Continued From page 5 Based on observation, clinical record review and staff interview, the facility failed to provide interventions to prevent and care for pressure ulcers for two of seven residents reviewed with pressure ulcers. (Resident #54 & #197) The facility census was 110 residents. Findings: 1. The Minimum Data Set (MDS) assessment completed 5/30/18, documented Resident #54 had diagnoses of paraplegia, osteomyelitis and pressure ulcer of right buttock Stage III and required extensive staff assistance with most activities of daily living. The Stage III pressure ulcer measured 5.3 cm (centimeters) b 8.7 cm and depth of 0.1 cm. The care plan with the target date of 8/31/18 identified the resident with the problem of pressure wound to the right buttock related to impaired mobility, incontinence, Braden score of 14. It directed the staff to complete the following interventions: -Administer analgesia per physician orders (offer prior to treatment/therapy) -Administer treatment per physician orders -Diet and supplements per physician orders -Encourage and assist as needed to turn and reposition, use sassiest devices as needed -Follow up care with physician as ordered -Obtain labs as ordered and report results to physician -Pressure reducing surface on bed and wheelchair -Report evidence of infection such as purulent	F 686		

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F 686	Continued From page 6 drainage, swelling, localized heat, increased pain, etc. Notify physician as needed. -Use pillows and/or positioning devices as needed. A review of a pressure ulcer assessment completed in the electronic medical record on 5/25/18 at 1:57 p.m. identified the resident with a pressure wound to the right buttock with measurements of 6.0 cm by 9.0 cm by 0.1 cm. with no description of the appearance of the wound or surrounding skin edges. During observation on 6/25/18 at 11:16 a.m., the resident sat up in the chair in her room, talking on cell phone wearing non-skid shoes. At 12:18 p.m., the resident remained in the wheelchair wearing shoes to both feet. At 12:53 p.m., remained in the wheelchair in her room wearing shoes to both feet On 6/26/18 at 9:49 a.m., Staff L, registered nurse, RN and Staff X, certified nurse aide entered the resident's room to perform cares. Staff X removed the prevalon boots from the resident's feet. Staff L placed clean towel underneath the resident's gluteal folds, removed the dressing to the right gluteal fold which had moderate amount of serous drainage, the wound bed appeared large with red/pink granulation tissue, peri wound blanchable without odor, without tendon/muscle or bone exposed. The wound had no signs of infection noted. Staff L reported she needed to measure wound to area behind right ankle as it was a new area. The open area noted to the right Achilles appeared pale in color with scant amount of serous drainage. On 6/27/18 at 6:09 a.m., the resident was asleep	F 686		

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F 686	Continued From page 7 in bed lying on their back without prevalon boots on and wore only gripper socks to her feet. On 6/28/18 at 7:20 a.m., the resident laid in bed on her left side without prevalon boots on at this time and only gripper socks to her feet without her heels floated. A review of a skin alteration record which should not be used for pressure ulcers identified an open area to the backside of the right ankle first identified on 6/26/18 with measurements of length of 1.8 cm width of 0.8 cm and depth of 0 cm. The wound had pale, pink tissue, scant amount of serous drainage and the surrounding skin with maceration - skin softening related to fluid and no pain at the site. A review of the progress notes dated 5/25/18 at 2:13 p.m., documented the right buttock pressure ulcer measured 6.0 cm by 9.0 cm and depth of 0.1 cm. with a large amount of yellow serous drainage, wound bed large red/pink granulation tissue with margins that were well defined and rolled, that the periwound to be blanchable , without odor or exposed tendon, muscle or bone. Recommendations for air mattress, roho cushion to chair Assessments had been completed weekly. An assessment dated 6/26/18 at 7:41 p.m., documented the wound measured 4.6 cm by 5.0 cm and depth of 0.1 cm with a moderate amount of yellow serous drainage, large red/pink granulation tissue, margins well defined with periwound that was blanchable and no odor or exposed tendon, muscle or bone. During an interview on 6/27/18 at 12:40 p.m.,	F 686		

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F 686	Continued From page 8 Staff G, CNA reported the resident had an open area to her bottom, and was care planned to not allow her to sit for long periods of time, usually after meals, she is supposed to lay down in bed. During interview on 6/27/18 at 1:17 p.m., Staff H, CNA reported the resident had a pressure sore to her bottom and was to lay down in bed after meals. During interview on 6/27/18 at 1:47 p.m., Staff L, RN reported the resident had a pressure ulcer to her right buttocks on admission. There was two on her left gluteal fold which was more from shearing. She also had an open area to the right Achilles which developed after she was admitted. She was care planned to be repositioned, when in bed she should have the prafo boots on, and should not be wearing any shoes until the Achilles wound heals. During interview on 6/28/18 at 7:28 a.m., Staff R, RN, Unit manager reported when residents have an open area to the feet or Achilles, the expectation would be to suspend the heels, or put heel protectors on as ordered. Staff R reported the resident had complained about the heel protectors and would not keep them on and that should have been care planned. 2. The MDS assessment completed 6/1/18, documented Resident #197 had diagnoses of cancer, Non-Alzheimer's dementia and arthritis and required extensive staff assistance with most activities of daily living and had a Stage II pressure ulcer and one untraceable pressure ulcer.	F 686		

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F 686	Continued From page 9 The care plan with the target date of 9/2/18 identified the resident with the problem of pressure ulcers to the coccyx, right heel and right great toe and left great toe and directed the staff to: -Administer analgesics as needed -Daily body audit -Friction reducing transfer surface -Incontinence management -Pain evaluation prior to treatment -Pressure redistributing support surface -Repositioning during activities of daily living -Skin barrier It also identified the resident with the problem of being at risk for alteration in skin integrity and directed the staff to: Elevate the heels as able Encourage the resident to lay down and not sit up for long periods her chair to prevent more pressure to the coccyx. A review of the nursing admission assessment completed 5/25/18 at 6:46 p.m. had documentation the resident had one pressure ulcer to the coccyx. Physician progress notes dated 5/29/18 at 9:55 a.m., documented the resident had an untraceable pressure ulcer to her coccyx and a fluid filled blister on her right heel. Physician progress notes dated 6/1/18 at 8:45 a.m., documented the resident had an untraceable pressure ulcer to her coccyx and a fluid filled blister on her right heel. Progress notes dated 5/29/18 at 11:09 a.m., documented the coccyx wound without measurements was blanchable and erythemic,	F 686		

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F 686	Continued From page 10 without odor or appearance of tendon/muscle or bone. The left heel wound identified as Stage II measured 2.0 cm by 3.0 cm. Additional recommendations included heel protectors, floating heels on pillows while in bed. Assessments had been completed weekly. Progress notes dated 6/12/18 at 3:44 p.m., documented the residents left heel with measurements of 0.9 cm by 1.2 cm and depth of 0.1 cm. The wound had a small amount of serosanguinous drainage, the wound bed had large eschar and adherent slough noted with well-defined margins and blanchable, erythemic macerated periwound. No odors, tendon/muscle or bone exposed. It also identified the resident to have another new pressure ulcer to the left great toe with measurements of a length of 0.9 cm width of 0.9 cm and depth of 0.1 cm The wound had a large stable eschar with adherent slough noted, very small pink granulation noted around edges with well-defined margins and blanchable erythemic periwound. The wound to the coccyx had measurements with a length of 3.0 cm width of 2.0 cm and depth of 1.9 cm. The wound had a small amount of serosanguinous drainage, the wound bed had large adherent slough with small pink/pale granulation, margins had been well defined and the periwound blanchable. Progress notes date 6/26/18 at 8:21 p.m., documented the coccyx wound measured 2.5 cm by 1.6 cm and depth of 3.0 cm. The left heel wound measured 4.5 cm by 5.0 cm and depth of 0.1 cm. Observation on 6/26/18 at 6:21 a.m., Staff W, CNA removed the prevalon boots from resident's	F 686		

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F 686	Continued From page 11 feet. Staff W transferred the resident and provided peri care after toileting the resident. Staff W did not place prevalon boots on the resident's feet prior to placing the resident's feet on the metal foot pedals while the resident only had gripper socks to her feet. At 7:34 a.m., the resident was sitting in the wheelchair in the dining room without prevalon boots on feet which only had gripper socks on and resting directly on metal foot pedals. Still no air mattress on bed. At 8:54 a.m., the resident sat in her wheelchair wearing only gripper socks on both feet on foot pedals without heels floated. At 9:02 a.m., Staff W checked the resident's vital signs and did not place prevalon boots on the resident's feet which remained with only gripper socks and not floated. At 9:30 a.m., the resident remained in up in her wheelchair without prevalon boots and both feet resting directly on metal foot pedals wearing only gripper socks to both feet without heels floated. At 10:34 a.m., the resident remained in the wheelchair with no boots on as planned. At 12:52 p.m., the prevalon boots sat on top of the table at the foot of the resident's bed. Staff Y, RN entered the room, washed hands, donned gloves and placed a clean towel under the resident's hip. Staff Y used the correct technique to remove the dressings from the wound to the coccyx which appeared pale pink with a moderate amount purulent drainage. The surrounding skin did not have signs of infection. Staff Y removed her gloves, used hand sanitizer, donned new gloves and measured the wound with a length of 2.5 cm by 1.6 cm and a depth of 3.0 cm Staff Y removed gloves, used hand sanitizer, donned new gloves then measured the first tunneling located at 11:00 as 1.6 cm The wound	F 686		

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F 686	Continued From page 12 had a moderate amount of adherence slough in wound, the peri wound had been macerated, erythemic, but blanchable. Staff Y used the correct technique to cleanse the wound and dress it with hydrofoam. At 1:08 p.m., Staff Y used the correct technique to remove the dressing from the wound to the left great toe, cleanse the wound and measured it with a length of 0.9 cm width of 0.9 cm and depth of 0.1 cm with large adherence slough eschar noted and very small pink granulation noted. The peri wound was macerated and erythemic. Staff Y used the correct technique to apply a new silver alginate dressing and cover with a foam dressing. At 1:17 p.m., Staff Y used the correct technique to remove the dressing to the right great toe, cleanse the wound and measured it with a length of 0.9 cm width of 1.2 cm and depth of 0.1 cm. The wound had a large amount of adherence slough noted to wound, erythemic and the peri wound with some maceration. Staff Y used the correct technique to apply a new silver alginate dressing and cover with a foam dressing. At 1:25 p.m., Staff Y used the correct technique to remove the dressing to the right heel. The wound had large stable eschar noted to right heel, peri wound dry, slightly calloused, erythemic and blanchable without drainage. Staff Y measured the wound with a length of 4.3 cm width of 5.0 cm and depth of 0.1 cm. At 1:30 p.m., Staff Y used the correct technique to cleanse the wound and applied silver alginate, covered it with gauze and Kerlix and secured with tape and placed the prevalon boots to the resident's feet. During interview on 6/27/18 at 1:17 p.m., Staff H, CNA reported the resident had pressure ulcers to the coccyx and to her heels and care planned to	F 686		

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	165575	A. BUILDING _____ B. WING _____	06/28/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MANORCARE HEALTH SERVICES-UTICA RIDGE	3800 COMMERCE BLVD DAVENPORT, IA 52807

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F 686	Continued From page 13 have heel protector boots at all times, that she was to lay down after meals, elevate her feet and be repositioned every 2 hours. The only reason she would not have her heel protectors on would be if the aides forgot to place them on her. During interview on 6/27/18 at 1:39 p.m., Staff K, CNA reported the resident had been admitted with one large area to her coccyx and now had two open areas to each great toe and one open area to each heel. The right heel still had a black area. She was care planned for moon boots on her feet at all times, except during transfers or showers, lay her down after meals and after therapy and reposition her every 2 hours with a pillow underneath her coccyx. During interview on 6/27/18 at 1:47 p.m., Staff L, RN reported the resident had been admitted 3 weeks ago with open areas to both great toes, both heels and her sacrum. She is care planned to reposition frequently, should wear the prafo boots at all times. During interview on 6/28/18 at 7:28 a.m., Staff R, RN, unit manager reported the expectation for residents with open areas to the heels would be to suspend the heels, or put heel protectors on.	F 686		
F 688 SS=D	Increase/Prevent Decrease in ROM/Mobility CFR(s): 483.25(c)(1)-(3) §483.25(c) Mobility. §483.25(c)(1) The facility must ensure that a resident who enters the facility without limited range of motion does not experience reduction in range of motion unless the resident's clinical condition demonstrates that a reduction in range	F 688		

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F 688	Continued From page 14 of motion is unavoidable; and §483.25(c)(2) A resident with limited range of motion receives appropriate treatment and services to increase range of motion and/or to prevent further decrease in range of motion. §483.25(c)(3) A resident with limited mobility receives appropriate services, equipment, and assistance to maintain or improve mobility with the maximum practicable independence unless a reduction in mobility is demonstrably unavoidable. This REQUIREMENT is not met as evidenced by: Based on clinical record review, resident and staff interviews, the facility failed to complete regular range of motion exercises for one of 21 residents reviewed. (Resident #78) The facility census was 110 residents. Findings include:	F 688		
	1. The Minimum Data Set (MDS) assessment dated 3/22/18, documented Resident #53 had diagnoses that included heart disease, Alzheimer's and muscle weakness and required limited assistance for personal hygiene, extensive assistance for dressing, bed mobility, transfers, toilet use and bathing. The MDS indicated the resident did not walk during the review period and listed the resident's Brief Interview for Mental Status score as 13, indicating intact cognition. Record review revealed the facility lacked documentation the resident received assistance with a restorative program or range of motion (ROM).			

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F 688	Continued From page 15 The facility policy "Range of Motion: Active/Passive", dated 1/2011, stated the purpose of ROM was "to improve or maintain joint mobility and minimize potential of contractures". The policy directed staff to assist the resident with range of motion in the neck, shoulder, arms, and legs. During interview on 6/25/18 at 10:59 a.m., the resident stated the facility did not offer any opportunity for her to exercise. During interview on 627/18 at 11:30 a.m., Staff R, Registered Nurse, Unit Manager stated the facility used to have a restorative/ROM program in the past but there was not one currently. During interview on 6/27/18 at 4:59 p.m., the Director of Nursing stated they do not complete regular range of motion exercises for residents and anyone who has had a decline will be screened for therapy. During interview on 6/28/18 at 6:37 a.m., Staff J Certified Nurse Aide, stated the aides do not complete range of motion exercises with residents.	F 688		
F 812 SS=E	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		

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F 812	Continued From page 16 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 policy review and staff interview, the facility failed to ensure dietary staff restrained their hair under hairnets during food preparation. The facility census was 110 residents. Findings include: 1. During observation on 6/25/18 at 8:55 a.m. Staff C, Cook had a moderate amount of hair exposed at the forehead area while preparing pureed food. 2. During observation on 6/26/18 at 9:00 a.m., Staff D, Dietary Aide had hair exposed outside of the hair net while putting bread in waxed paper bags and preparing drinks for the noon meal. During observation on 6/26/18 at 9:00 a.m., the Certified Dietary Manager (CDM) had hair exposed outside her hair net while dishing red Jello and coleslaw into individual bowls and making vanilla pudding. During interview on 6/26/18 at 1:50 p.m., the CDM reported she would expect staff to have	F 812		

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F 812	Continued From page 17 their hair restrained under the hair nets. The Hair Restraints policy dated 4/07/06, documented that hair restraints are worn to keep hair away from food and to minimize touching or handling of hair during food production. Hair is considered to be a foreign object and hair restraints help to avoid hair from falling into food. The guidelines directed staff as follows; Hair restraints are worn by anyone in the kitchen. Hair restraints are worn in a manner that covers all hair including bangs and pony tails.	F 812		
F 880 SS=D	Infection Prevention & Control CFR(s): 483.80(a)(1)(2)(4)(e)(f) §483.80 Infection Control The facility must establish and maintain an infection prevention and control program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of communicable diseases and infections. §483.80(a) Infection prevention and control program. The facility must establish an infection prevention and control program (IPCP) that must include, at a minimum, the following elements: §483.80(a)(1) A system for preventing, identifying, reporting, investigating, and controlling infections and communicable diseases for all residents, staff, volunteers, visitors, and other individuals providing services under a contractual arrangement based upon the facility assessment conducted according to §483.70(e) and following accepted national standards;	F 880		

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F 880	Continued From page 18 §483.80(a)(2) Written standards, policies, and procedures for the program, which must include, but are not limited to: (i) A system of surveillance designed to identify possible communicable diseases or infections before they can spread to other persons in the facility; (ii) When and to whom possible incidents of communicable disease or infections should be reported; (iii) Standard and transmission-based precautions to be followed to prevent spread of infections; (iv)When and how isolation should be used for a resident; including but not limited to: (A) The type and duration of the isolation, depending upon the infectious agent or organism involved, and (B) A requirement that the isolation should be the least restrictive possible for the resident under the circumstances. (v) The circumstances under which the facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease; and (vi)The hand hygiene procedures to be followed by staff involved in direct resident contact. §483.80(a)(4) A system for recording incidents identified under the facility's IPCP and the corrective actions taken by the facility. §483.80(e) Linens. Personnel must handle, store, process, and transport linens so as to prevent the spread of infection. §483.80(f) Annual review.	F 880		

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F 880	Continued From page 19 The facility will conduct an annual review of its IPCP and update their program, as necessary. This REQUIREMENT is not met as evidenced by: Based on observation, clinical record review, facility policy review and staff interview, the facility failed to ensure the indwelling Foley catheter did not drag on the floor for one of three residents reviewed with catheters. (Resident #167) The facility census was 110 residents. Findings include: 1. The Minimum Data Set (MDS) assessment dated 6/15/18, documented Resident #167 had diagnoses that included benign prostatic hyperplasia, urinary tract infection with sepsis and congestive heart failure and had an indwelling catheter.	F 880		
	Observation on 6/25/18 at 2:59 p.m., revealed the resident in his room sitting in a wheelchair with the catheter hung under the seat of the wheelchair. The resident reported came from home with the catheter and noted the catheter tubing hanging down and on the floor and scraped upon the floor as the resident moved back and forth in his wheelchair. Observation on 6/26/18 at 11:06 a.m., revealed the resident coming down the hall propelling himself in his wheelchair with Therapy Staff next to him and with each step the catheter tubing moved the resident almost stepped on it and the tubing hit the floor each time the resident moved his feet.			

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F 880	Continued From page 20 Observation on 6/26/18 at 1:31 p.m., revealed Staff O, Certified Nurse Aide, CNA provided catheter cares. After completing cares, Staff O hooked the catheter bag under the seat of the resident's wheelchair noted the resident propelled himself out of the room and out into the hallway on the way to the Therapy Room with the catheter tubing dragging on the floor as he went down the hall. Observation on 6/26/18 at 2:55 p.m., revealed the resident in Therapy in his wheelchair talking to a Therapist and the catheter tubing hanging on the floor beneath his feet. Observation on 6/27/18 at 1:45 p.m., revealed the resident in his room sitting in his wheelchair and the catheter tubing hanging down, rubbing on the floor as he rocked back and forth in his wheelchair. During interview on 6/27/18 at 1:35 p.m., Staff N, CNA stated at no time should the tubing of an indwelling catheter drag along the floor. The tubing can be stepped on and pulled out. During interview on 6/27/18 at 1:50 p.m., Staff O, CNA reported the catheter tubing was not to touch the floor at any time. Staff O stated the catheter tubing was long and tried to keep it up off the floor for the resident. During interview on 6/27/18 at 5:11 p.m., the Director of Nursing stated staff should not allow the catheter tubing to drag on the ground/floor. Review of the Catheter Care: Indwelling Catheter Policy last revised on 4/2016 stated the purpose of the policy to recommend the steps of catheter	F 880		

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F 880	Continued From page 21 hygiene for patients with indwelling catheters. The policy noted to direct staff to check that tubing is not looped, kinked, clamped, or positioned above the level of the bladder and off the floor - place bag in catheter bag holder if appropriate.	F 880		

ManorCare Health Services -Utica Ridge
3800 Commerce Blvd.
Davenport, IA 52807

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F561

483.10(f) Self Determination

The resident has the right to and the facility must promote and facilitate resident self-determination through support of resident choice, including but not limited to the rights specified in paragraphs (f)(1) through (11) of this section. (1) The resident has a right to choose activities, schedules (including sleeping and waking times) health care providers of health care services consistent with his or her interests, assessments, and plan of care and other applicable provisions of this part. (2) The resident has a right to make choices about aspects of his or her life in the facility that are significant to the resident. (3) The resident has a right to interact with members of the community and participate in community activities both inside and outside the facility. (8) The resident has a right to participate in other activities, including social, religious, and community activities that do not interfere with the rights of other residents in the facility.

Corrective action taken for residents found to have been affected by deficient practice

-Resident discharged Day 1 of annual survey. Patient was interviewed and statements were taken from staff that provided care at the time of the complaints.

How the center will identify other residents having the potential to be affected by the same deficient practice

-Residents with specific requests to get up early would have the potential to be affected.

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

-Staff re-educated on resident rights and resident choices pertaining to getting up early and utilizing whatever toileting method the patient prefers at the time.

Quality Assurance Plan to monitor performance to make sure corrections are achieved

-DON/designee will complete random weekly audits x4 weeks

-Audit findings to be taken through Center's QAA.

Completion Date: 6/29/2018

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F658

483.21 (b)(3)(i) Services Provided Meet Professional Standards

Comprehensive care plans; the services provided or arranged by the facility as outlined by the comprehensive care plans, must meet the professional standards of quality.

Corrective action taken for residents found to have been affected by deficient practice

-Resident was assessed and appropriate treatment orders were put in place.

How the center will identify other residents having the potential to be affected by the same deficient practice

-Residents with new treatment orders have the potential to be affected.

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

-Nurse and Unit Manager educated at time of discovery.

Quality Assurance Plan to monitor performance to make sure corrections are achieved

-DON/designee will complete random daily order audits x 4 weeks to ensure treatment orders are being entered with the appropriate schedule.

-Audit findings to be taken through Center's QAA.

Completion Date: 7/25/2018

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F686

§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.

Corrective action taken for residents found to have been affected by deficient practice

-Resident #54 assessed, care plan reviewed and revised as indicated.

-Resident #197 assessed, care plan reviewed and revised as indicated.

How the center will identify other residents having the potential to be affected by the same deficient practice

-Residents in the facility with pressure ulcers have the potential to be affected

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

-Staff re-educated on skin practice guidelines specific to preventative interventions and following the plan of care. Education completed 6/29/18.

Quality Assurance Plan to monitor performance to make sure corrections are achieved

-DON/designee will complete random weekly audits x4 weeks to ensure preventative measures are in place and care planned interventions are followed.

-Audit findings to be taken through Center's QAA.

Completion Date: 6/29/2018

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F688

483.25 Mobility

The facility must ensure that a resident who enters the facility without limited range of motion does not experience reduction in range of motion unless the resident's clinical condition demonstrates that a reduction in range of motion is unavoidable; and a resident with limited range of motion receives appropriate treatment and services to increase range of motion and/or to prevent further decrease in range of motion. A resident with limited mobility receives appropriate services, equipment and assistance to maintain or improve mobility with the maximum practical independence unless a reduction in mobility is demonstrably unavoidable.

Corrective action taken for residents found to have been affected by deficient practice

-Resident #53 was identified, assessed and ROM addressed during daily ADL/Dressing/Toileting cares.

How the center will identify other residents having the potential to be affected by the same deficient practice

- Residents with a ROM/Mobility need were assessed and screened by therapy if appropriate and/or additional plans updated.

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

-Staff re-educated on ROM/Mobility during cares, ADLs, dressing and toileting (daily cares). Plans of care updated.

Quality Assurance Plan to monitor performance to make sure corrections are achieved

-DON/designee will complete random weekly audits to determine if appropriate treatment and services to increase range of motion and/or to prevent further decrease in range of motion.

-Audit findings to be taken through Center's QAA.

Completion Date: 7/25/2018

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F812 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 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.

Corrective action taken for residents found to have been affected by deficient practice

-No residents affected.

How the center will identify other residents having the potential to be affected by the same deficient practice

-Audit completed of meal service to ensure proper restraint of hair during food preparation.

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

-Staff re-educated on hair restraint policy and restraining hair during food preparation. Education completed on 6/29/2018.

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

-Dietary Manager/designee to complete random audits weekly x4 to ensure compliance of hair restraint during food preparation.

-Audit findings to be taken through Center's QAA.

Completion Date: 7/25/2018

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F880 Infection Control

483.80 (a)(1)(2)(4)(e)(f)

The facility must establish and maintain an infection prevention and control program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of communicable diseases and infections.

Corrective action taken for residents found to have been affected by deficient practice

-Resident #167 was assessed and new catheter bag was ordered and placed

How the center will identify other residents having the potential to be affected by the same deficient practice

-Residents in the facility with a foley catheter bag have the potential to be effected will be given a new catheter bag.

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

-Staff re-educated on infection control and the foley catheter policy

-New dignity bags ordered and placed

Quality Assurance Plan to monitor performance to make sure corrections are achieved

-DON/designee will complete random weekly audits x4 weeks to ensure foley tubing is not touching the floor

-Audit findings to be taken through Center's QAA.

Completion Date: 7/25/2018