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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	165578	A. BUILDING _____ B. WING _____	06/19/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PREMIER ESTATES OF MUSCATINE	3440 MULBERRY AVENUE MUSCATINE, IA 52761

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F 000	INITIAL COMMENTS Correction Date 8/5/18 ✓ JM The following deficiencies are the result of the annual survey and investigation of 76285-C, 76296-C, 75749-I, 76649-C and 75532-C conducted 6/11/18-6/19/18. Complaint 75532-C was not substantiated. Complaints 76285-C, 76649-C and 76296-C were substantiated. Facility reported incident 75749-I was substantiated.	F 000		
F 645 SS=D	Amended 8/29/18 JKM, RN PASARR Screening for MD & ID CFR(s): 483.20(k)(1)-(3) §483.20(k) Preadmission Screening for individuals with a mental disorder and individuals with intellectual disability. §483.20(k)(1) A nursing facility must not admit, on or after January 1, 1989, any new residents with: (i) Mental disorder as defined in paragraph (k)(3)(i) of this section, unless the State mental health authority has determined, based on an independent physical and mental evaluation performed by a person or entity other than the State mental health authority, prior to admission, (A) That, because of the physical and mental condition of the individual, the individual requires the level of services provided by a nursing facility; and (B) If the individual requires such level of services, whether the individual requires specialized services; or (ii) Intellectual disability, as defined in paragraph (k)(3)(ii) of this section, unless the State	F 645		

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

Administrator — 08/02/2018

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 645	Continued From page 1 intellectual disability or developmental disability authority has determined prior to admission- (A) That, because of the physical and mental condition of the individual, the individual requires the level of services provided by a nursing facility; and (B) If the individual requires such level of services, whether the individual requires specialized services for intellectual disability. §483.20(k)(2) Exceptions. For purposes of this section- (i)The preadmission screening program under paragraph(k)(1) of this section need not provide for determinations in the case of the readmission to a nursing facility of an individual who, after being admitted to the nursing facility, was transferred for care in a hospital. (ii) The State may choose not to apply the preadmission screening program under paragraph (k)(1) of this section to the admission to a nursing facility of an individual- (A) Who is admitted to the facility directly from a hospital after receiving acute inpatient care at the hospital, (B) Who requires nursing facility services for the condition for which the individual received care in the hospital, and (C) Whose attending physician has certified, before admission to the facility that the individual is likely to require less than 30 days of nursing facility services. §483.20(k)(3) Definition. For purposes of this section- (i) An individual is considered to have a mental disorder if the individual has a serious mental disorder defined in 483.102(b)(1).	F 645		

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F 645	Continued From page 2 (ii) An individual is considered to have an intellectual disability if the individual has an intellectual disability as defined in §483.102(b)(3) or is a person with a related condition as described in 435.1010 of this chapter. This REQUIREMENT is not met as evidenced by: Based on record review and interview, the facility failed to keep a current PASRR (Preadmission Screening and Resident Review) in the chart and document services carried out on the plan of care for 1 of 7 residents reviewed for PASRR requirements (Resident #35). The facility reported a census of 63 residents. Findings: 1. Record review revealed Resident #35's PASRR, dated 6/5/17, stated because of the resident's medical needs, PASRR was not required unless the nursing home stay exceeded 30 days. At the time of the survey on 6/11/18, the resident's record contained no current PASRR. Upon surveyor request, the facility printed a current PASRR for the resident, dated 3/20/18. The PASRR listed diagnoses for the resident included Major Depressive Disorder and Generalized Anxiety Disorder. The PASRR identified the following specialized and rehabilitative services required: a. Ongoing psychiatric services by a psychiatrist to evaluate response and effectiveness of psychotropic medications on target symptoms, modify medication orders, and to evaluate ongoing need for additional behavioral health	F 645		

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F 645	Continued From page 3 services. b. Obtain archived psychiatric records to clarify history and to provide to treating physicians. The resident's current care plan did not reflect the above recommendations as part of the resident's plan of care. The facility policy "Resident/Family Care and Services" stated the facility screened residents before admission to determine whether they had a mental illness and if the facility was able to meet the specialized needs of the resident. During an interview on 6/14/18 at 11:37 a.m., the (DON)Director of Nursing stated the staff member who completed PASRR Level 2 care plans was no longer at the facility and they were in the process of hiring someone to train in this area.	F 645		
F 657 SS=E	Care Plan Timing and Revision CFR(s): 483.21(b)(2)(i)-(iii) §483.21(b) Comprehensive Care Plans §483.21(b)(2) A comprehensive care plan must be- (i) Developed within 7 days after completion of the comprehensive assessment. (ii) Prepared by an interdisciplinary team, that includes but is not limited to-- (A) The attending physician. (B) A registered nurse with responsibility for the resident. (C) A nurse aide with responsibility for the resident. (D) A member of food and nutrition services staff. (E) To the extent practicable, the participation of the resident and the resident's representative(s).	F 657		

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F 657	Continued From page 4 An explanation must be included in a resident's medical record if the participation of the resident and their resident representative is determined not practicable for the development of the resident's care plan. (F) Other appropriate staff or professionals in disciplines as determined by the resident's needs or as requested by the resident. (iii)Reviewed and revised by the interdisciplinary team after each assessment, including both the comprehensive and quarterly review assessments. This REQUIREMENT is not met as evidenced by: Based on observation, record review, and staff interviews, the facility failed to provide adequate interventions on the care plan for Resident # 13, # 73 (seizures), # 9, # 53 (nonpharmacological interventions prior to psychotropic use), and # 273 (swallowing issue). The resident sample included 16 residents. The facility reported a census of 63. Findings include: 1. The Quarterly Minimum Data Set (MDS) with an assessment reference date of 03/29/2018 revealed Resident # 13 demonstrated severe memory and decision making abilities. Facility staff provided total care for the resident. Diagnoses included aphasia, quadriplegia, traumatic brain injury, and a seizure disorder/epilepsy. The June Medication Administration Record contained an order for Carbamazeprine 100 milligrams in 5 milliliter (ration 100/5). The resident would receive 10 milliliter through the gastrointestinal feeding tube twice a day. The	F 657		

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F 657	Continued From page 5 prescribed medication is for prevention of convulsions and seizures related to the traumatic brain injury and epilepsy. The plan of care with a revision date of 04/09/2018 failed to address Resident # 13's convulsion/seizure condition. Resident # 13's diagnoses included seizures and convulsions when admitted to the facility. On 06/12/2018, a medical record nursing note with a time of 9:02 AM, documented Resident # 13 demonstrated twitching of the entire body and mucous from the mouth since before 7:00 AM. Approximately 07:10 AM, the resident went into seizures lasting 20 to 30 seconds. The Physician was notified and the ambulance called. At 7:30 A.M., the ambulance arrived. Resident # 13 began to seizure again. In a medical record update on 6/12/2018 12:50, an emergency room nurse reported Resident # 13 would be transferred to another hospital for a urinary tract infection and an infiltrate of the left lung. Resident # 13 seized twice more, but stabilized with medication. During an interview on 06/18/18 11:21 AM, the Director of Nursing stated the care plan should have contained interventions for seizure activity. DON agreed that anyone with a seizure disorder should have it on their care plan. 2. The Quarterly MDS dated 05/01/2018 coded Resident # 73's long and short term memory recall as good with only minor deficits. Resident # 73 required very limited assistance from staff for care and remained independent for mobility. Diagnoses included hemiplegia, traumatic brain	F 657		

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F 657	Continued From page 6 injury, and a mental disorder with behaviors. On 03/30/2018, during a teleconference for Resident # 73's psychiatric conditions, a review of medications being administered to the resident included Keppra 750 milligrams twice a day. The medication assisted in controlling seizures and/or convulsions caused by the traumatic brain injury. The plan of care failed to have any interventions or assessments to direct the nursing staff care when a seizure or convulsion would occur. 3. Resident #9's MDS dated 3/20/18 had documentation of the following diagnoses: aphasia, anxiety disorder and psychotic disorder. It also identified the resident as severely cognitively impaired and required extensive staff assist with all activities of daily living. A review of June 2018 MAR revealed orders for Lorazepam concentrate 2 mg (milligrams) per ml (milliliter), 0.25 ml by mouth every 2 hours as needed for anxiousness until 9/1/18. A review of the care plan with the target date of 9/13/18 identified use of PRN (give as needed) anti-anxiety medications (Lorazepam) and directed the staff to give PRN anti-anxiety medications as ordered by the physician. The care plan failed to direct staff to attempt and document non-pharmacological interventions prior to the administration of the medications. 4. Resident #53's Minimum Data Set quarterly assessment completed 5/19/18 had documentation of the following diagnoses: pneumonia, Non-Alzheimer's dementia and muscle weakness, had a BIMS score of 1 out 15 and	F 657		

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F 657	Continued From page 7 required extensive staff assistance with most activities of daily living. A review of the June 2018 MAR and nurse's notes had documentation of the following order: Lorazepam concentrate 2 mg/ml give 0.25 ml orally every 4 hours as needed for anxiety. A dose administered on 6/13/18 at 00:03 a.m. did not have documentation of non-pharmacological interventions attempted prior to the dose given. A review of the care plan with the target date of 9/10/18 identified the resident with the problem of use of anti-anxiety medications (Lorazepam) however no interventions to attempt non-pharmacological interventions prior to the administration of the PRN anti-anxiety medications. A review of the facility policy titled: care plan development with the original date of August 2015 had documentation of the following: Comprehensive care plans are designed to: *Include identified resident needs and strengths *Include risk factors associated with needs *The care plan will be reviewed and revised as needed, when a significant change in condition is noted, when outcomes were not achieved or when outcomes are completed, at least every 92 days. *All team members are responsible for reporting any changes to the resident's condition to the primary/charge nurse and of any goals or objectives not being met. 6. A Certificate of Death form, dated 5/11/18, indicated Resident #273 passed away 5/5/18 at 4:28 a.m. and listed the immediate cause of	F 657		

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F 657	Continued From page 8	F 657		

death as acute hypoxic (relating to low oxygen) respiratory failure due to or as a consequence of cardiac arrest and acute respiratory arrest and listed the underlying cause as aspiration (a condition in which food or liquid is breathed into the airway) with the significant condition of anoxic encephalopathy (a condition in which the brain did not receive enough oxygen).

The MDS dated 3/18/18, listed diagnoses for Resident #273 that included seizure disorder, traumatic brain injury, and dysphagia (difficulty swallowing). The MDS stated the resident required extensive assistance of 1 staff for eating, and extensive assistance of 2 staff for bed mobility, transfers, dressing, toilet use, and personal hygiene. The MDS listed the resident's cognition as severely impaired.

A Speech Therapy Plan of Treatment, dated 1/23/18, stated the resident's referral to Speech Therapy was due to a swallowing assessment required for a chronic cough and staff reported the resident coughed at times when hurrying to swallow food.

A Speech Therapy Discharge Summary, dated 2/15/18, stated the resident received Speech Therapy services from 1/19/18-2/15/18 for dysphagia therapy. The discharge recommendations directed staff to cue the resident to decrease oral residue and to check for clearance before offering another bite.

A Progress Note entry, dated 5/3/18 at 12:48 p.m., documented the resident was at lunch eating at 12:10 p.m. and another nurse yelled the resident was choking. The resident was attempting to get food out as well as trying to get

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F 657	Continued From page 9	F 657		

the air in. The nurse (writer) began to rub his back vigorously due to not being able to get positioned to perform the Heimlich maneuver because of the wheelchair. Food began coming out of his mouth and his lips turned blue. The staff repositioned the resident onto the floor, turned him on the side and pulled food from his mouth. Another staff member dialed 911 and a PA (Physician's Assistant) who was present took over the code. The Emergency Medical Technicians arrived and took the resident to the hospital.

A hospital report stated the resident admitted to the emergency department on 5/3/18 at 12:53 p.m. and listed the reason for the visit as respiratory and cardiac arrest and listed the diagnosis of asphyxiation due to food.

A Progress Note, dated 5/6/18 at 1:23 a.m., stated the resident passed away on 5/5/18 at 4:30 a.m.

The facility Week 1 lunch menu for Thursday (the day of the choking incident) listed the entree of Polish Sausage.

A care plan entry, initiated 12/14/17, stated the resident required assistance at meals and was unable to feed self. An entry dated 11/24/17 revealed the resident required total assistance to eat in the assisted dining room. The care plan did not include information regarding the resident eating rapidly or special direction to encourage the resident to eat more slowly. The care plan did not include information regarding the resident's swallowing difficulties or any special instructions for staff that assisted the resident with meals.

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F 657	Continued From page 10 During an interview on 6/13/18 at 1:00 p.m.,the DON stated she would search for a policy related to what to do if a resident choked but did not believe they had one. During an interview on 6/14/18 at approximately 11:00 a.m., the Director of Nursing stated the facility updated care plans on the evening of 6/13/18 to include information regarding special instructions for feeding assistance.	F 657		
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 observation, record review, and interview, the facility failed to follow professional standards when facility staff failed to observe ingestion of medications for 1 of 5 residents reviewed during the medication pass observations (Resident #57). The facility reported a census of 63 residents. Findings: 1. The MDS (Minimum Data Set) assessment tool, dated 5/18/18, listed diagnoses for Resident #57 that included heart failure, depression, and muscle weakness. The MDS stated the resident totally depended on 2 staff for bed mobility, transfers, dressing, toilet use, personal hygiene, and bathing, and revealed the resident displayed	F 658		

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F 658	Continued From page 11 intact cognition. During an observation on 6/11/18 at 11:44 a.m., the resident lay in bed and Staff K, CMA entered the room and handed the resident a medication cup containing Ferrous Sulfate (iron) 325 mg (milligrams) 1 tablet, Culturelle (a probiotic) 1 capsule, Furosemide (a diuretic) 40 mg 1 tablet, and Oxycodone-Acetaminophen (a narcotic pain reliever) 5-325 mg 1 tablet. Staff K exited the room and closed the door as the resident began taking the medications. The CMA failed to remain at the resident's bedside to ensure the resident took all of the medications. The June 2018 MAR (Medication Administration Record) displayed the following orders: a. Ferrous Sulfate 325 mg 1 tablet daily b. Culturelle 1 tablet twice daily c. Furosemide 40 mg twice daily d. Oxycodone-Acetaminophen 5-325 mg 1 tablet every 6 hours An undated care plan entry documented the resident experienced an ADL (Activities for Daily Living) self care performance deficit and directed staff to administer medications as ordered. The facility policy "Medication Administration," dated 1/13, directed staff to remain with the resident until the resident consumed all medication. During an interview on 6/14/18 at 11:37 a.m., the Director of Nursing stated staff should ensure residents ingested their medications.	F 658		
F 661	Discharge Summary	F 661		

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F 661 SS=D	Continued From page 12 CFR(s): 483.21(c)(2)(i)-(iv) §483.21(c)(2) Discharge Summary When the facility anticipates discharge, a resident must have a discharge summary that includes, but is not limited to, the following: (i) A recapitulation of the resident's stay that includes, but is not limited to, diagnoses, course of illness/treatment or therapy, and pertinent lab, radiology, and consultation results. (ii) A final summary of the resident's status to include items in paragraph (b)(1) of §483.20, at the time of the discharge that is available for release to authorized persons and agencies, with the consent of the resident or resident's representative. (iii) Reconciliation of all pre-discharge medications with the resident's post-discharge medications (both prescribed and over-the-counter). (iv) A post-discharge plan of care that is developed with the participation of the resident and, with the resident's consent, the resident representative(s), which will assist the resident to adjust to his or her new living environment. The post-discharge plan of care must indicate where the individual plans to reside, any arrangements that have been made for the resident's follow up care and any post-discharge medical and non-medical services. This REQUIREMENT is not met as evidenced by: Based on record review and interview, the facility failed to complete a recapitulation of a resident's stay for 1 of 1 residents reviewed that discharged to another facility (Resident #272). The facility reported a census of 63 residents. Findings include:	F 661		

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F 661	Continued From page 13 1. The MDS (Minimum Data Set) assessment tool, dated 4/5/18, listed diagnoses for Resident #272 that included diabetes, stroke, anxiety, and depression and documented the resident displayed intact cognition. A Progress Note entry dated 4/9/18, documented the resident discharged to another facility. Record review revealed the facility lacked a recapitulation of the resident's stay including the resident's diagnoses, course of illness/treatment or therapy, and a post-discharge plan of care. During an interview on 6/18/18 at 12:59 p.m., the DON (Director of Nursing) reported she could not locate a recapitulation of the resident's stay. She stated ideally, all department heads should participate in completing the form. She stated in the future the forms would be completed via the facility's electronic charting system.	F 661		
F 678 SS=D	Cardio-Pulmonary Resuscitation (CPR) CFR(s): 483.24(a)(3) §483.24(a)(3) Personnel provide basic life support, including CPR, to a resident requiring such emergency care prior to the arrival of emergency medical personnel and subject to related physician orders and the resident's advance directives. This REQUIREMENT is not met as evidenced by: Based on record review and interview, the facility failed to possess a current code status for 1 resident during an episode of choking (Resident #273) and 1 of 22 residents reviewed in the standard sample (Resident #39). The facility	F 678		

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	165578	A. BUILDING _____ B. WING _____	06/19/2018

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F 678	Continued From page 14 reported a census of 63 residents. Findings: 1. A Certificate of Death form, dated 5/11/18, indicated Resident #273 passed away 5/5/18 at 4:28 a.m. and listed the immediate cause of death as acute hypoxic(relating to low oxygen) respiratory failure due to or as a consequence of cardiac arrest and acute respiratory arrest and listed the underlying cause as aspiration (a condition in which food or liquid is breathed into the airway) with the significant condition of anoxic encephalopathy (a condition in which the brain did not receive enough oxygen). The MDS (Minimum Data Set) assessment tool, dated 3/18/18, listed diagnoses for Resident #273 that included seizure disorder, traumatic brain injury, and dysphagia(difficulty swallowing). The MDS stated the resident required extensive assistance of 1 staff for eating, and extensive assistance of 2 staff for bed mobility, transfers, dressing, toilet use, and personal hygiene. The MDS listed the resident's cognition as severely impaired. A Progress Note entry, dated 5/3/18 at 12:48 p.m., stated the resident was at lunch eating at 12:10 p.m. and another nurse yelled the resident was choking. The resident attempted to get food out as well as tried to get air in. The nurse(writer) began to rub his back vigorously due to not being able to get positioned to perform the Heimlich maneuver because of the wheelchair. Food began coming out of the mouth and his/her lips turned blue. The staff lifted the resident onto the floor, turned him/her on the side and pulled food from the mouth. Another staff member dialed 911	F 678		

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F 678	Continued From page 15 and a PA (Physician's Assistant) who was present took over the code. The EMTS s(Emergency Medical Technician's) arrived and the resident transferred to the hospital. A hospital report stated the resident admitted to the emergency department on 5/3/18 at 12:53 p.m. and listed the reason for the visit as respiratory and cardiac arrest and listed the diagnosis of asphyxiation due to food. The report stated the resident ate a hot dog, started choking, and staff performed the Heimlich that resulted in removal of the hot dog. EMS(Emergency Medical Services) arrived and provided CPR (Cardiopulmonary Resuscitation) for a total of 25 minutes and the resident subsequently transferred to the emergency room. A Progress Note, dated 5/6/18 at 1:23 a.m., revealed the resident passed away on 5/5/18 at 4:30 a.m. During an interview on 6/12/18 at 3:13 p.m., Staff E LPN stated when the PA took over the code she noted the crash cart did not contain an ambu bag (a bag used to ventilate during CPR) or a suction machine. She reported the computer listed the resident as Do Not Resuscitate (DNR), but they could not locate the signed document. Someone tried to contact the resident's spouse in the midst of the situation to ascertain the resident's code status. During an interview on 6/12/18 at 5:57 p.m., Staff R LPN stated she was near the fish tank of the 500 Hall when the PA took over until the ambulance arrived. Staff R heard the DON (Director of Nursing) tell the ambulance crew she reached the resident's spouse via telephone and	F 678		

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F 678	Continued From page 16 the resident was DNR. During an interview on 6/12/18 at 2:22 p.m., The Physician's Assistant (Staff Q) stated on the day the resident choked, she was in an office and heard someone call for help. The resident was near the fish tank in his/her wheelchair. His skin was blue and he was not moving any air. She stated one of the PTA s(Physical Therapy Assistants) had started the Heimlich and they moved him to the floor when she arrived. Staff Q gave instructions for a crash cart. She stated there was a delay in getting the ambu bag because it was not on the crash cart. She stated in the course of trying to assist the resident, the facility could not locate the resident's code status. During an interview on 6/13/18 at 6:50 a.m., the DON stated when she got back from lunch on 5/3/18 the resident was unresponsive on the floor by the 500 Hall being assisted by other staff. She stated at the time of the incident, there was not an ambu bag on the crash cart and reported during the incident they were not 100% sure of the resident's code status. The electronic record documented the resident requested DNR, but they could not find the signed document and stated they never did find it after the incident. She reported during the incident staff called the resident's spouse to inquire as to the resident's code status and the spouse informed them his status was DNR. She stated the facility was trying to figure out a system where staff would know what the resident's code status was without having to go to the chart. 2. Record review on 6/13/18 at 2:00 p.m. revealed neither the resident's hard chart nor the	F 678		

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F 678	Continued From page 17 facility's electronic record contained a code status for Resident #39. During an observation on 6/14/18 at approximately 10:00 a.m., the crash cart in the dining room contained an updated list of all resident's code statuses. A document, dated 6/14/18, signed by the physician and the resident's guardian, documented Resident #39 requested Full Code status, indicating the resident wanted staff to attempt resuscitation in an instance that required it. The facility policy "Advance Directives/Iowa", dated 02/15, instructed staff a living will provided specific instructions to health care providers about particular kinds of health care treatment an individual would or would not want to prolong life. During an interview on 6/14/18 at approximately 11:00 a.m., the Director of Nursing stated the facility now had 100% of residents' code statuses signed.	F 678		
F 684 SS=J	Quality of Care CFR(s): 483.25 § 483.25 Quality of care Quality of care is a fundamental principle that applies to all treatment and care provided to facility residents. Based on the comprehensive assessment of a resident, the facility must ensure that residents receive treatment and care in accordance with professional standards of practice, the comprehensive person-centered care plan, and the residents' choices. This REQUIREMENT is not met as evidenced	F 684		

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F 684	Continued From page 18 by: Based on record review and interview, the facility failed to properly monitor/assist a resident with a history of swallowing difficulties and failed to carry out appropriate procedures to assist a choking resident (Resident #273). A licensed nurse was not in the dining room during the lunch meal as the Director of Nursing had instructed and the care plan failed to identify and communicate Resident #273's eating and swallowing difficulties. The care plan failed to direct staff to cut the resident's food into bite-sized pieces, and cue the resident to swallow the food in his mouth before they offered him another bite. When the resident choked on a large piece of Polish Sausage, facility staff also failed to administer the Heimlich Maneuver in the dining room in a timely manner; instead, staff left the room to summon a nurse, wheeled the resident down the hall in his wheelchair, and had therapy staff perform the Heimlich. In addition, when the resident became unresponsive, CPR was initiated but the facility failed to have a system to rapidly communicate the resident's code status to staff. This failure necessitated a phone call to the resident's spouse to ascertain the resident's wishes while other staff administered CPR. The facility sent the resident to the emergency room via ambulance, and he passed away at the hospital. These findings constitute an Immediate Jeopardy (IJ) to the resident's health and safety. The sample consisted of 25 residents. The facility identified a census of 63 residents. Findings Include: 1. A Certificate of Death form, dated 5/11/18, indicated Resident #273 passed away 5/5/18 at	F 684		

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F 684	Continued From page 19 4:28 a.m. and listed the immediate cause of death as acute hypoxic (relating to low oxygen) respiratory failure due to or as a consequence of cardiac arrest and acute respiratory arrest and listed the underlying cause as aspiration (a condition in which food or liquid is breathed into the airway) with the significant condition of anoxic encephalopathy (a condition in which the brain did not receive enough oxygen). According to the MDS (Minimum Data Set) assessment tool dated 3/18/18, Resident #273 had diagnoses that included seizure disorder, traumatic brain injury, and dysphagia (difficulty swallowing). The MDS documented the resident required extensive assist of 1 staff for eating, and extensive assist of 2 staff for bed mobility, transfers, dressing, toilet use, and personal hygiene. The MDS listed the resident's cognition as severely impaired. During an observation on 6/13/18 at 9:00 a.m., it was 92 steps from the fish tank in the 500 Hall to the ADR (Assisted Dining Room) and 48 steps from the front charting room to the ADR. A Speech Therapy Plan of Treatment, dated 1/23/18, documented the resident's referral to Speech Therapy was due to a swallowing assessment required for a chronic cough and staff reported the resident coughed at times when hurrying to swallow food. A Speech Therapy Discharge Summary, dated 2/15/18, documented the resident received Speech Therapy services from 1/19/18-2/15/18 for dysphagia therapy. The discharge recommendations directed staff to cue the resident to decrease oral residue and to check for	F 684		

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F 684	Continued From page 20 clearance before offering another bite. A Progress Note entry, dated 5/3/18 at 12:48 p.m., documented the resident eating lunch at 12:10 p.m. and another nurse yelled the resident was choking. The resident was attempting to get food out as well as trying to get the air in. The writer (a nurse) began to rub his back vigorously due to not being able to get positioned to perform the Heimlich maneuver because of the wheelchair, and food began coming out of the resident's mouth and his lips turned blue. The staff lifted the resident onto the floor, turned him on the side and pulled food from his mouth. Another staff member dialed 911 and a PA (Physician's Assistant) who was present took over the code. The EMTs (Emergency Medical Technicians) arrived and transferred to the hospital via ambulance. A hospital report documented the resident admitted to the emergency department on 5/3/18 at 12:53 p.m. due to respiratory and cardiac arrest and listed the diagnosis as asphyxiation due to food. The report revealed the resident ate a hot dog and started choking. Staff performed the Heimlich which resulted in the removal of the hot dog. EMS (Emergency Medical Services) arrived and provided CPR (Cardiopulmonary Resuscitation) for a total of 25 minutes and then subsequently transferred the resident to the emergency room. A Progress Note entry, dated 5/4/18 at 12:45 p.m., documented the resident was in ICU (Intensive Care) and was on a ventilator. A Progress Note, dated 5/6/18 at 1:23 a.m., revealed the resident passed away on 5/5/18 at	F 684		

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F 684	Continued From page 21 4:30 a.m. According to the facility's week 1 lunch menu for Thursday (the day of the choking incident), the entree that day was Polish Sausage. A care plan entry, initiated 12/14/17, documented the resident required assistance at meals and was unable to feed himself. An entry dated 11/24/17 revealed the resident required total staff assist to eat and ate in the assisted dining room. The care plan did not include information regarding the resident eating rapidly or special direction to encourage the resident to eat more slowly. The care plan did not include information regarding the resident's swallowing difficulties or any special instructions for staff assisting the resident with meals. During an interview on 6/12/18 at 1:55 p.m., Staff D CNA (Certified Nursing Assistant) stated she was feeding another resident while Staff A fed Resident #273. She stated the residents were eating "whole sausage" and the resident began coughing like he was choking. She stated there was no nurse in the dining room at the time, so another CNA ran and summoned the nurse. Staff E LPN (Licensed Practical Nurse) entered and pushed the resident out of the dining room to the 500 Hall near the fish tank; Staff Q, PA (Physician's Assistant) directed them to place the resident on the floor. Staff Q then provided chest compressions while Staff D called 911. Staff D stated the resident ate quickly and reported there was supposed to be a nurse in the dining room at all times. During an interview on 6/12/18 at 3:01 p.m., Staff A stated she was feeding the resident on the day	F 684		

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F 684	Continued From page 22 he choked. She stated the resident took a bite of sausage and then wanted milk, so she gave it to him. She then saw the resident was choking. Another CNA went to summon the nurse (Staff E) who was outside the dining room at the medication cart and Staff E came in and wheeled the resident to the 500 Hall near the fish tank. Staff A did not see anyone initiate the Heimlich maneuver in the dining room. She stated the resident was not able to feed himself, so staff cut up the food and fed him. During an interview on 6/13/18 at 10:31 a.m., Staff A stated she cut up the resident's Polish sausage and gave him a bite on the day of the choking. During an interview on 6/12/18 at 3:13 p.m., Staff E LPN stated she was in the charting room with the door open when a CNA came out of the dining room and called for her. When she arrived in the dining room, the resident had air exchange but food was hanging out of his mouth. She pulled some food out of his mouth, wheeled the resident away and started running with him in his wheelchair and yelling for help with Staff D accompanying them. When they arrived at the fish tank near the 500 Hall, they ran into Staff R LPN. Staff E stated she needed help and this was the reason she moved the resident out of the dining room and down to the 500 Hall looking for another nurse. A therapy staff member arrived and began doing the Heimlich and Staff Q PA (Physician's Assistant) moved the resident to the floor and continued the Heimlich. Staff E reported the crash cart did not have a suction machine on it or an ambu bag (a bag used to ventilate during CPR). She stated the computer listed the resident as a DNR (Do Not Resuscitate) but they	F 684		

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F 684	Continued From page 23 could not locate the signed document, so someone tried to contact the resident's spouse in the midst of the situation to ascertain the resident's code status. Staff E reported there was no nurse in the dining room when the resident choked, although the 500 Hall nurse (Staff R) was supposed to be in the dining room. During an interview on 6/12/18 at 5:57 p.m., Staff R LPN stated when she was near the fish tank of the 500 Hall, she looked up and saw Staff E, LPN and Staff D, CNA wheeling the resident toward her. They leaned the resident forward and some food came out. Staff Q, PA arrived and instructed them to place the resident on the floor; Staff Q took over until the ambulance arrived. Staff R heard the DON (Director of Nursing) tell the ambulance crew she got a hold of the resident's spouse and the resident was DNR. Staff R stated she witnessed a large piece of hot dog come out of the resident's mouth during the incident. Staff R stated at the time the resident choked, it was her understanding Staff E was in the dining room. She stated the Friday before the incident the DON told her to get to the dining room during meals, but it was difficult for her to do so due to having to pass medications and complete blood sugars. During an interview on 6/12/18 at 2:22 p.m., Staff Q PA stated on the day the resident choked, she was in an office and heard someone call out for help. The resident was near the fish tank in his wheelchair. His skin was blue and he was not moving any air. She stated one of the PTAs (Physical Therapy Assistants) had attempted the Heimlich maneuver and they moved the resident to the floor when she arrived. Staff Q requested a crash cart, but there was a delay in getting the	F 684		

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F 684	Continued From page 24 ambu bag because it was not on the cart. She reported she suctioned the resident and retrieved a large piece of Polish sausage. Staff Q commented the piece of meat was larger than an average bite and estimated it was 1-1.5 inches in length. She reported in the course of trying to assist the resident, the facility could not locate the resident's code status. Staff Q stated staff should have initiated the Heimlich maneuver immediately in the dining room because transferring a resident could lodge the piece of food in the throat even more. During an interview on 6/13/18 at 6:50 a.m., the DON stated when she got back from lunch on 5/3/18, the resident was unresponsive on the floor by the 500 Hall being assisted by other staff. She stated at the time of the incident, there was not an ambu bag on the crash cart and during the incident they were not 100% sure of the resident's code status. The electronic record indicated the resident was DNR, but they could not find the signed document. She reported they never did find it (the signed documented) after the incident. She stated staff called the resident's spouse during the emergency to inquire as to the resident's code status and the spouse informed them he was DNR. She stated the facility was trying to figure out a system where staff would know the resident's code status without having to go to the chart. She stated when staff fed residents they should cut up food in the appropriate sized bites and stated there should be a nurse in the dining room at all times; if a resident choked, staff should attempt to resolve the situation where the resident was located. During an interview on 6/13/18 at 1:00 p.m., the DON stated she would search for a policy related	F 684		

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F 684	Continued From page 25 to what to do if a resident choked, but did not believe they had one. On 6/14/18, the facility abated the Immediate Jeopardy by implementing the following: 1. The Director of Nursing completed an audit of each resident's Code Status. 2. Facility staff completed an audit of the Code Carts to ensure all carts contained an adequate amount and type of supplies required in the event one of the residents suffered a cardiac arrest and or experienced a choking incident. 3. The Care Plan Coordinator conducted an audit of residents' care plans to validate each resident's care plan reflected the current needs of each resident. 4. All nursing staff were reeducated by the Director of Nursing regarding the requirements of immediately providing first aid including the Heimlich Maneuver. 5. All nursing staff were educated by the Director of Nursing regarding the requirements of maintaining the Code Carts in a fully stocked manner for immediate access to supplies in case of an emergency. 6. All nursing staff were educated by the Director of Nursing regarding the requirements of immediately calling for assistance in the event of an emergency and that assistance will be rendered at the place of occurrence. 7. All nursing staff were educated by the Director of Nursing regarding the elements of the facility's	F 684		

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F 684	Continued From page 26 CPR policy. 8. All nursing staff were educated by the Director of Nursing regarding the requirements to assist resident with cutting foods to a size that is manageable by residents. 9. Licensed nursing staff were educated by the Director of Nursing regarding the requirement to maintain care plans to reflect the most current feeding assistance needs of the residents. 10. All therapy staff were educated regarding the requirement to complete therapy communication sheets with changes in resident care needs. 11. All staff were reeducated regarding the facility's policy for abuse. 12. All education began on 6/13/14 and continued until all staff were reeducated. The facility did not permit any staff to work prior to receiving all training required to abate the IJ. 13. The Director of Nursing placed a roster of resident wishes regarding CPR and stocked an additional Code Cart in the dining room for immediate use in the event of an emergency. II. Based on record review and interview, the facility failed to provide treatment and care in accordance with professional standards for 1 of 25 residents reviewed. The facility identified a census of 63 residents. Findings include: quality of care to promote the resident's highest According to the MDS dated 5/19/18, Resident #53 had diagnoses that included: non-Alzheimer's	F 684		

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	165578	A. BUILDING _____ B. WING _____	06/19/2018

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F 684	Continued From page 27 dementia, metabolic encephalopathy and constipation. The MDS documented the resident displayed cognitive impairment and required extensive staff assist with most activities of daily living. A review of the care plan for February 2018 revealed no documentation of the potential for constipation with interventions if the resident did not have a BM (bowel movement) for more than 3 days. A review of nurse's notes revealed the following entries: a. On 2/4/2018 at 11:55 p.m., Nurse assessed res for left leg pain related to deep vein thrombosis (blood clot). The resident appeared upset, displayed facial grimacing and stated pain was 2 or 3 on numeric scale and presented as infrequent, sharp, shooting pain to LLE (left lower extremity). The nurse documented a bruise across the resident's lower abdomen which measured 27 centimeters (cm) by 7 cm, perhaps from gait belt across abdomen. The resident complained of pain upon palpation of abdomen. The nurse notified the physician, who ordered an abdominal x-ray. b. On 2/5/2018 at 07:07 a.m., staff called the physician's office to notify of new symptoms of pain and edema (swelling) to the resident's leg c. On 2/6/2018 at 00:40 a.m. Staff received fax regarding AND (abdominal) X-ray results. The physician's assistant asked if the resident continued with abdominal pain and also asked about bowels. The resident had last bowel movement on 2/1/18, so the physician assistant ordered staff to give Bisacodyl suppository now and if no results in 4 hours, give enema	F 684		

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F 684	Continued From page 28 tomorrow. Staff administered suppository, awaited results, and passed information on to next shift. d. On 2/6/2018 at 00:58 a.m. abdominal X-ray results: portable image of the abdomen demonstrated gaseous distention of multiple loops of bowel throughout the abdomen with moderate volume stool in the colon. e. On 2/6/2018 at 05:43 a.m. The resident did not have results with suppository, gave enema with results of formed soft medium BM. A review of February 2018 MARs revealed the following: a. 2/7/18 Miralax ordered daily b. FeSo4 (iron supplement) 325 mg(milligrams) twice daily c. Senna S 8.6 mg 2 tablets twice daily d. Dulcolax suppository 10 mg once daily as needed for constipation - only one dose signed out on 2/1/18 e. Fleets enema one application once daily as needed for constipation - no doses signed out as given f. Senna Tabs 8.6 mg one tablet once every 8 hours as needed for constipation - no doses signed out as given During an interview on 6/18/18 at 8:33 a.m., Staff L, LPN reported if the resident had no bowel movement for more than 3 days, try least invasive interventions first, such as pushing fluids, then utilize standing order for Milk of Magnesia (MOM) and Bisacodyl suppository as the facility protocol. By day 3, assess bowel sounds, give suppository and if the suppository doesn't work, notify physician for additional orders.	F 684		

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F 684	Continued From page 29 In an interview on 6/18/18 at 8:58 a.m., Staff F, LPN reported the facility protocol if the resident has not had a bowel movement for more than 3 days is to push fluids and initiate MOM. If MOM ineffective, repeat the MOM the following shift. If the second dose is ineffective, notify doctor via facsimile. During an interview on 6/18/18 at 9:07, Staff M, LPN reported the facility protocol if the resident has not had a bowel movement for more than 3 days: start with MOM on the third day, there is a section on the dashboard area (under the section with EMARs which will show alerts, i.e.: dietary intakes, if the resident has not had a BM for more than 3 days.) All nurses are educated to check the dashboard report at the beginning of the shift. The night shift nurse will usually tell first shift of residents that have gone for more than 3 days. In an interview on 6/18/18 at 2:26 p.m. Staff J, LPN reported the facility protocol: if resident has not had a bowel movement for more than 3 days is to initiate standing orders, listen to their bowel sounds, palpate their abdomen, ask the CNAs when the last BM was and if it has been 3 days, give MOM first, if ineffective, give Bisacodyl suppository. Staff J stated if the Bisacodyl suppository is ineffective, then give Fleets enema and if that is ineffective, call the prescriber and ask for their recommendations. She also reported Resident #53 had problems with constipation and had required MOM because she was on the 3 day list several times. Staff J stated the 3 day list is on our dashboard which means the resident did not have any documented BMs for 3 days. The nurses are to review the dashboards each shift. If a laxative is given, nurses should be checking for effectiveness at	F 684		

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F 684	Continued From page 30	F 684		

least every shift. Staff J reported if the resident had a BM, this would be documented in the nurse's notes and not necessarily if they did not have one. They should also check for bowel sounds, abdominal distention, decreased appetite.

During an interview on 6/19/18 at 8:08 a.m., the director of nursing reported the facility protocol: if the resident had no BM for more than 3 days, staff placed the resident on the BM list. The nurses should ask the resident if she/he had a BM if they're cognitively aware and if they have, the nurse will document in the progress notes the day the resident had a BM. If they have not had a BM for 3 days, on the 3rd day, the facility had a standing order kept in the shift guides in each station at each hall. The nurse should start with MOM and if that doesn't work, give a Dulcolax suppository and if that doesn't work, give a Fleets enema. If that doesn't work, the DON reported,we notify the doctor for further orders. She also reported that Resident #53 had chronic problems with her bowels. This problem should have been passed on in report. Shift reports are verbal and they are supposed to use 24 hour worksheets for nurses that don't work every day so they can get a picture of what has been going on with the past 2 weeks. The DON stated the facility kept a copy of the worksheets, but unable to produce a copy for the first week of February 2018. She also reported the incident could have been prevented with better communication and follow-up. The DON added, if Resident #53 did have the history of constipation, I would not necessarily have expected the bowel protocol to be on her MAR because she had other interventions in place, such as the Dulcolax and the Senna PRN

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F 684	Continued From page 31 A facility form titled: standards of practice directed: The below orders may be initiated by a nurse unless to do so is contraindicated by a resident's medical condition/history or allergies. Nurses must write the order, place it in the chart, notify the physician of use of standing orders. a. Milk of magnesia 30 cc (cubic centimeters) daily as needed for constipation. b. Bisacodyl suppository 10 mg daily as needed for constipation. c. Fleets enema one bottle daily as needed for constipation A review of the facility policy titled: bowel intervention policy with revised date of 8/10/17 had documentation of the following: All residents noted to have gone 3 days without a bowel movement, will receive the most non-invasive intervention they have ordered or allowed to take. This may include, but is not limited to Milk of Magnesia, Bisacodyl tablets or prune juice. The third shift nurse will run the "no BM" reports and perform and abdominal assessment on indicated residents. Documentation of the findings are to be documented. This will be included in their report to the first shift nurse. The first shift nurse will begin the first intervention, will receive a suppository starting on day 4 by the third shift nurse at 6:00 a.m. If the resident does not have results following a suppository intervention or the resident refuses any intervention, the physician must be called for further instructions. If the resident does not have a current PRN medication for bowel intervention, one must be written from	F 684		

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F 684	Continued From page 32 the facility standing orders.	F 684		
F 686 SS=D	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 interview, the facility failed to provide complete weekly pressure ulcer (Resident #23 and #42) and failed to prevent pressure ulcer from developing and/or worsening for one of three residents reviewed (Resident #42). The facility reported a census of 63 residents. Findings include: The MDS identified the following descriptions of pressure ulcers: *Stage I is an intact skin with non-blanchable redness of a localized area usually over a bony prominence. Darkly pigmented skin may not have a visible blanching; in dark skin tones only it	F 686		

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F 686	Continued From page 33 may appear with persistent blue or purple hues. *Stage II is partial thickness loss of dermis presenting as a shallow open ulcer with a red or pink wound bed, without slough. May also present as an intact or open/ruptured blister. *Stage III Full thickness tissue loss. Subcutaneous fat may be visible but bone, tendon or muscle is not exposed. Slough may be present but does not obscure the depth of tissue loss. May include undermining and tunneling. *Stage IV is full thickness tissue loss with exposed bone, tendon or muscle. Slough or eschar may be present on some parts of the wound bed. Often includes undermining and tunneling. 1. Resident #23's Minimum Data Set admission assessment completed 4/6/18 did not have documentation of any active diagnoses and revealed the resident displayed intact cognition. The MDS documented the resident required limited staff assistance with most activities of daily living and had 4 (four) Stage 4 pressure ulcers. A review of the attending note on the history and physical report dictated by the physician on 3/27/18 revealed the resident had been treated at another long term care facility for coccygeal osteomyelitis and for acute encephalopathy (a disease in which the functioning of the brain is affected by some agent or condition such as viral infection or toxins in the blood) along with acute kidney injury.	F 686		

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F 686	Continued From page 34 The care plan with the target date of 9/5/18 identified the resident admitted to the facility with 5 pressure ulcers present and directed staff to: a. Assess/record/monitor wound healing weekly. b. Measure length, width and depth where possible. c. Assess and document status of wound perimeter, wound bed and healing progress d. Report improvements and declines to the physician A review of the skin grid for all pressure skin impairments revealed the following: LEFT CALF *Date identified: 5/16/18 *Not present on admission *Length (L)= 1.1 cm Width (W)=1 cm Depth (D)= no documentation *Assessment included documentation of no drainage, wound bed color to be red, no odor, tissue type, wound red color and odor all marked with a zero. *The next assessment completed 13 days later was dated 5/29/18 with L= 5.4 cm W=2.7 cm No documentation of depth. The only narrative documentation of "scant yellow drainage" . COCCYX *Date identified 4/4/18 *Are present upon admission *Initial measurements L=4 cm W= 5.5 D= 3 cm, no odor, drainage, color of wound bed - red/pink, no odor, the number zero had been marked for tissue type, wound bed color and odor. The physician and responsible party had been notified	F 686		

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F 686	Continued From page 35 on 4/4/18. The form contained no documentation to show staff notified the dietician. No assessments had been documented until 14 days later on 4/18/18 with measurements of L=5 cm W=5.7 cm D=1 cm and the appearance of wound had not been documented. No assessments had been documented until 14 days later on 5/2/18 with measurements of L=5.2 W=4.2 D=0.9 only documentation of appearance "open" and no other documentation regarding drainage, tissue type, wound bed or presence of odor. 5/9/18 Measurements documented L=5.5 cm W=4.1 cm D=0.8 cm only documentation of appearance "open" and no other documentation regarding drainage, tissue type, wound bed or presence of odor. 5/16/18 Measurements documented L=5.7 W=5 D=1 only documentation of appearance "open" no other documentation regarding drainage, tissue type, wound bed or presence of odor. The next assessment 13 days later on 5/29/18 L=4.9 W=3 D=0.8 scant yellow drainage, no other documentation regarding tissue type, wound bed or presence of odor. No further assessments had been documented on the form after 5/29/18 for 14 days. A review of the skin/wound notes in the electronic medical record revealed: a. 6/1/18 4:00 p.m. sacral area wound about 8 to 10 cm diameter, left leg wound measures 3 x 5	F 686		

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F 686	Continued From page 36 cm 1 cm depth noted without signs of infection. b. 6/5/18 10:29 a.m. open area to the inner left calf measuring 3.5 cm x 3 cm with scant yellow/clear drainage, an open area to the coccyx measuring 4.4 cm x 4 cm with a depth of 0.8 cm and a pin point area red to the bottom of the left buttock measuring 0.1 cm x 0.1 cm. All treatments completed at this time. 2. Resident #42's MDS completed 5/3/18 contained documentation of the following diagnoses: heart failure, peripheral vascular disease and diabetes mellitus and identified the resident displayed intact cognition. The MDS revealed Resident # 42 required extensive staff assistance with most activities of daily living and documented the resident had no pressure ulcers. The care plan with a target date of 9/5/18 identified the resident as at risk for impaired skin integrity and directed staff to assess her skin with daily cares, treatments, bi-weekly showers, weekly skin sweeps and as needed, and alert her nurse to any significant changes. During an observation of incontinence care on 6/12/18 at 11:53 a.m., Staff B, CNA and Staff H, CNA entered the resident's room. While staff provided incontinence care, further observation revealed dime sized areas located in each gluteal fold without redness or drainage noted. A review of the skin grid for other skin impairments had documentation of the following: *Date identified: 5/9/18 *Area not present upon admission Site: both buttocks	F 686		

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F 686	Continued From page 37 No initial measurements documented 6/5/18 only one measurement documented length (8 cm x 1 cm) with no documentation of depth. The resident had "multiple scabbed areas" with no documentation of color of wound bed, presence of odor, tissue type or wound bed color. 6/12/18 left measurement length 0.9 cm x width 0.3 cm no depth documented. "Both areas now open with scant bleeding" no documentation of color of wound bed, presence of odor, tissue type or wound bed color. A review of the skin/wound notes revealed the following entries: a. 5/9/18 10:12 a.m. skin sweep completed. Resident has peeling flaky skin to both buttocks b. 6/5/18 1:12 p.m. skin sweep completed. No new issues noted. Resident had an area on the right buttock measuring 8 cm by 1 cm. The area is pin not open at this time and has some scratches. c. 6/12/18 2:41 p.m. skin sweep completed. Resident had an open area to the left buttock measuring 0.9 cm by 0.3 cm with scant bleeding as well as an open area to the right buttock measuring 1 cm by 0.7 cm During an interview on 6/13/18 at 11:29 a.m., Staff E, LPN reported she came in twice a week to look at skin, the floor nurses had the responsibility to look at the wounds, assess and measure if it's day for the resident's skin sweep to be done and if she had not completed an assessment. It will populate on the computerized TAR (treatment administration record). She also reported she had not attended any official training specific to wounds.	F 686		

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F 686	Continued From page 38 In an interview on 6/13/18 at 12:02 p.m., Staff F, LPN reported Staff E had been the skin nurse and completed the measurements, and that all nurses should complete a skin sweep once a week which should document length, width and depth of pressure areas. Staff L reported the appearance of the wound should include any signs of infection, any odor. During an in interview on 6/13/18 at 12:15 p.m., the director of nursing (DON) reported Staff E was not the wound nurse, however, she came in one or two days a week to complete skin sweeps on high risk residents or residents with existing skin issues. The DON verified Staff E had not had any formal training in wound care and reported staff should complete skin sweeps weekly. Wounds should be assessed weekly and should include measurements, any odor, drainage, appearance of the wound, if any pain or any changes in the wound. The DON stated these should be documented on the pink pressure ulcer grid (skin grid for all pressure skin impairments) with one wound per sheet. A review of the Skin Care and Wound Management policy dated June 2015 directed staff to: a. Monitor pressure ulcer daily and document any complications or changes. Monitoring to include, but not limited to: b. Evaluation of ulcer, if no dressing present c. Status of dressing if present d. Status of area surrounding ulcer observable without removing dressing e. Complications, such as increasing area of tissue ulceration or soft tissue infection f. Pain and pain management if needed	F 686		

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F 686	Continued From page 39 g. Document daily monitoring on the treatment record. Document an complications/changes, as indicated in the progress note.	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 observation, record review, staff interviews, and facility procedures, the facility failed to provide adequate nursing supervision, assistance devices, and individualized interventions for Resident # 47 after multiple falls which culminated in a fall and hip fracture. The facility reported a census of 63 residents. Findings include: 1. The Significant change Minimum Data Set (MDS) assessment tool dated 05/04/2018 indicated Resident # 47 demonstrated both long and short term memory deficits with severely impaired decision-making abilities. The MDS documented Resident # 47 required limited assist of one staff for ambulation (walking) and toilet use. The MDS also documented the resident experienced bowel and bladder and had diagnoses that included cerebral vascular accident (stroke), non-Alzheimer's dementia, and anxiety.	F 689		

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	165578	A. BUILDING _____ B. WING _____	06/19/2018

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PREMIER ESTATES OF MUSCATINE	3440 MULBERRY AVENUE MUSCATINE, IA 52761

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 689	Continued From page 40 The plan of care with a revision date of 12/19/2016 documented Resident # 47 as at risk for falls The plan documented the need for 2 staff to assist with transfers (12/19/16 and revised on 06/11/18), provide a low bed, body pillows (05/30/18), and clear pathways and call light (12/19/16). The care plan also directed staff to place a fall mat at bedside (05/30/18), and provide correct fitting shoes (04/24/18). The plan failed to provide any assistance with ambulation. The May 2018 Medication Administration Record recorded an order for Clonazepam 0.5 milligrams twice a day. The medication is for anxiety and has side effects of dizziness, lack of coordination, and increased sleepiness. From the beginning of February 2018 until the fall and fracture on May 26, 2018, Resident # 47 fell 15 times. a. 02/05/18 (10:00 PM) found sitting on the floor by couch yelling for help. b. The resident fell 8 times between February and May 2018; each time staff found the resident on the floor at the end of her bed. The fall on 05/26/18 resulted in a left hip fracture. c. 03/30/18 (5:24 PM) found on floor by station 1. d. 04/24/18 (2:28 P.M.) resident fell on face in hall. e. 05/01/18 (12:49 PM) ambulating in hall with sister and fell on the floor. 05/03/18 (9:40 PM) found on floor in 500 hall. 05/07/18 (2:45 PM) found on floor in 300 hall. 05/26/18 (12:15 A.M.) fall by bed and fall with fracture at 12:53 A.M. The facility failed to consistently identify	F 689		

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F 689	Continued From page 41 appropriate interventions with each fall in order to prevent more falls from occurring. During an interview on 06/18/18 at 11:32 AM, Staff O, LPN (Licensed Practical Nurse) reported working the night of 05/26/2018 when Resident # 47 fell and fractured her left hip. Resident # 47 fell around 12:15 AM without any injuries found. Staff P, CNA (Certified Nursing Assistant) and Staff O placed the resident back in bed. Staff O stated it was not unusual for this resident to be up at night. Staff O noticed for the last 2 months Resident # 47 seemed to be slowly declining in stability when ambulating. Sometimes she would allow you to help her and other times she could be combative. Around 12:15 AM, Resident # 47's roommate came out into the hall and told staff the resident had fallen. Staff O and Staff P entered and found Resident # 47 on the floor at bedside with her legs out in front of her, holding her knee. The resident batted at the nurse to go away. Resident # 47 did not complain of any pain, so Staff P and Staff O helped the resident back to bed. Around 12:50 AM, the roommate came out again and said Resident #47 was on the floor. Staff O examined the resident who was not in pain until moved, then she complained of severe pain. The nurse called Hospice, the resident's daughter, and the ambulance. On 06/12/18 at 11:54 AM, the Director of Nursing stated had Resident # 47 incurred several falls prior to the hip fracture on 05/26/18. The DON stated this resident ambulated around the facility prior to the last fall. The DON stated this resident's dementia is advanced. She verbalized that interventions were put into place after each fall. A review of the plan of care revealed it failed to contain consistent, individualized interventions	F 689		

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F 689	Continued From page 42 for every fall situation. On 06/13/18 at 02:29 PM, Staff P (Certified Nursing Assistant) verbalized being on duty the night Resident # 47 fell and fractured the left hip. She stated she worked 100/200 and part of 300 hall that night and when she made rounds, Resident # 47 was asleep in her bed. Staff P reported sometime after midnight, Resident # 40's roommate came out in the hall and said the resident was on the floor. Staff P called the nurse, went into resident's room and found her on the floor by the bed. Staff O checked the resident, found no injuries, and assisted her back in bed. Staff P stated the resident did not want to be bothered and yelled, "get away, get away," but a short time later, the roommate came out told us Resident # 47 was on the floor again. This time Staff O checked and found the resident in pain when moved, she called the ambulance. When asked, Staff P verbalized the night shift helped Resident # 47 to the bathroom when she needed to go and they didn't use a mat by her bed. The facility Fall Risk Reduction & Management dated 12/2015 directed nursing staff to identify risk factors for falls and injuries, implement individualized interventions to minimize the fall risk, address the underlying causes, and evaluate the effectiveness of the interventions put in place.	F 689		
F 690 SS=D	Bowel/Bladder Incontinence, Catheter, UTI CFR(s): 483.25(e)(1)-(3) §483.25(e) Incontinence. §483.25(e)(1) The facility must ensure that resident who is continent of bladder and bowel on	F 690		

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F 690	Continued From page 43 admission receives services and assistance to maintain continence unless his or her clinical condition is or becomes such that continence is not possible to maintain. §483.25(e)(2)For a resident with urinary incontinence, based on the resident's comprehensive assessment, the facility must ensure that- (i) A resident who enters the facility without an indwelling catheter is not catheterized unless the resident's clinical condition demonstrates that catheterization was necessary; (ii) A resident who enters the facility with an indwelling catheter or subsequently receives one is assessed for removal of the catheter as soon as possible unless the resident's clinical condition demonstrates that catheterization is necessary; and (iii) A resident who is incontinent of bladder receives appropriate treatment and services to prevent urinary tract infections and to restore continence to the extent possible. §483.25(e)(3) For a resident with fecal incontinence, based on the resident's comprehensive assessment, the facility must ensure that a resident who is incontinent of bowel receives appropriate treatment and services to restore as much normal bowel function as possible. This REQUIREMENT is not met as evidenced by: Based on observation, record review and staff interviews, it was determined the facility failed to provide complete incontinence care for two of seven residents observed in the standard sample (Residents #9 and #53). The facility reported a census of 63 residents.	F 690		

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F 690	Continued From page 44 Findings include: 1. Resident #9's Minimum Data Set quarterly assessment completed 3/20/18 had documentation of the following diagnoses: diabetes mellitus, non-Alzheimer's dementia and acute kidney failure. It also documented the resident required extensive staff assistance with all activities of daily living, was occasionally incontinent of bladder and bowel, and displayed cognitive impairment. BIMS (brief interview for mental status) score of 0 out of 15, The care plan with the target date of 9/13/18 identified the resident displayed self-care deficits, was incontinent of bladder/bowels and directed staff to check and change her frequently and provide incontinence care as needed. She utilized incontinence products and was dependent on staff to change these as needed. During an observation 6/11/18 at 11:16 a.m., Staff AC, CNA and Staff G, CNA entered the resident's room, transferred the resident from wheelchair to bed via mechanical lift, and provided incontinence care. The resident had been incontinent of a large amount of stool, and when they provided incontinence care, they failed to turn the resident to the other side to cleanse the right outer hip before they secured the new incontinent brief into place. A review of a urine culture report completed 6/3/18 revealed greater than 100,000 CFU (colony forming units) of Escherichia Coli (a bacteria found in the intestines of humans)	F 690		

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F 690	Continued From page 45 A review of a physician order dated 6/4/18 revealed an order for levofloxacin 250 mg one tablet by mouth two times daily for 7 days for the diagnosis of urinary tract infection. 2. Resident #53's Minimum Data Set quarterly assessment completed 5/19/18 had documentation of the following diagnoses: non-Alzheimer's dementia, acute kidney failure, and metabolic encephalopathy. It also identified the resident as cognitively impaired, frequently incontinent of bladder, and always incontinent of bowel. The MDS revealed the resident required extensive staff assistance with most activities of daily living. The care plan with the target date of 9/10/18 identified the resident displayed a self-care performance deficit related to dementia and documented the resident had been occasionally incontinent of bowels and frequently incontinent of urine, and required staff assistance to transfer to/from the toilet wash their hands, and adjust clothing. During an observation of incontinence cares on 6/12/18 at 8:54 a.m., Staff D, CNA and Staff H, CNA entered the resident's room and assisted the resident to transfer from wheelchair to bed. At 8:57 a.m., staff provided incontinence care, but failed to turn the resident to the right side to cleanse the other hip before they both secured the new incontinent brief into place. A review of positive urine culture reports revealed the resident had a history of urinary tract infections by the following: 8/14/17 culture findings greater than 100,000	F 690		

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F 690	Continued From page 46 CFU (colony forming units which estimates the number of bacteria cells in a sample) of Enterococcus faecium vancomycin resistant enterococci 9/7/17 culture findings greater than 100,000 CFU streptococcus mitis A review of the infection notes revealed the following entries: 8/19/17 9:57 a.m. remains on antibiotic for VRE (Vancomycin resistant Enterococcus) in urine with no adverse reactions 9/15/17 5:17 a.m. resident continues on antibiotics for UTI (urinary tract infection) 9/30/17 5:17 a.m. resident continues antibiotic therapy for UTI with no signs of adverse effects noted 10/3/17 5:31 a.m. resident is on post day one after antibiotic therapy for UTI During an interview on 6/13/18 at 10:30 a.m., Staff A, CNA reported when providing incontinence care to a female resident in bed after a bowel movement, she would wash the vaginal area first, turn the resident on one side, wash them up, tuck the brief underneath them, depending on the resident, may have to roll on the other side to get the brief out from underneath them. In an interview on 6/13/18 at 10:41 a.m. Staff B, CNA reported when providing incontinence care to a female resident in bed after a bowel movement, she would wash the vaginal area first, roll her over to one side, start cleaning her, change surface of the cloth with each wipe, rinse, dry off, then pull the brief out, put a new brief on, change gloves.	F 690		

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F 690	Continued From page 47 During an interview on 6/13/18 11:15 a.m., Staff D, CNA reported when providing incontinence care to a female resident in bed after a bowel movement, she would wash the vaginal area first, turn her over to her side, clean her bottom off using soapy washcloth, rinse, dry, remove the incontinent brief and throw it away, change gloves, put the clean brief under the resident and put it on her. In an interview on 6/13/18 at 12:15 p.m., the director of nursing reported when providing incontinence care to a female resident in bed after a bowel movement, she would expect staff to wash the vaginal area first, turn her side, clean her bottom, roll her over to the next side and clean her other side. A review of the facility policy titled: perineal care with the revised date of April 2013 had documentation of the following procedure: Wash hands and apply gloves Cover the resident with a blanket or sheet, exposing only the genitalia area if assisting resident in bed Use a clean wash cloth/wipe and rinse thoroughly from front to back Pat the area dry with a bath towel Apply ordered creams or ointments Clean, rinse and dry the anal area, starting at the posterior vaginal opening and wiping from front to back Assist resident with incontinent brief, underwear, appropriate garments Remove gloves, wash hands	F 690		
F 692	Nutrition/Hydration Status Maintenance	F 692		

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F 692 SS=D	Continued From page 48 CFR(s): 483.25(g)(1)-(3) §483.25(g) Assisted nutrition and hydration. (Includes naso-gastric and gastrostomy tubes, both percutaneous endoscopic gastrostomy and percutaneous endoscopic jejunostomy, and enteral fluids). Based on a resident's comprehensive assessment, the facility must ensure that a resident- §483.25(g)(1) Maintains acceptable parameters of nutritional status, such as usual body weight or desirable body weight range and electrolyte balance, unless the resident's clinical condition demonstrates that this is not possible or resident preferences indicate otherwise; §483.25(g)(2) Is offered sufficient fluid intake to maintain proper hydration and health; §483.25(g)(3) Is offered a therapeutic diet when there is a nutritional problem and the health care provider orders a therapeutic diet. This REQUIREMENT is not met as evidenced by: Based on observation, record review, and staff interviews, the facility failed to assess Resident # 9 for a diagnosis of dehydration and failed to effectively address Resident # 47's continued significant weight loss. The resident sample included 25 residents. The facility reported a census of 63 residents. Findings include: 1. The Significant change Minimum Data Set (MDS) with an assessment reference date of 05/04/2018 indicated Resident # 47 demonstrated both long and short term memory	F 692		

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F 692	Continued From page 49 deficits with severely impaired decision-making abilities. Resident # 47 required the extensive assistance of a staff member for assistance with meals. Diagnoses included a cerebral vascular accident, Non-Alzheimer's Dementia, anxiety, and dysphasia. The plan of care with a revision date of 12/19/2016 documented Resident # 47 as unable to feed herself and required staff to provide cues for swallowing and safety. The care plan noted Resident # 47 had dentures but did not wear them. and physicians' orders included Boost Breeze and Magic Cup supplements. The plan directed staff to monitor the resident's weight according to physician's orders. The May 2018 Medication Administration Record (MAR) contained an order for Magic Cup (a nutritional supplement) initiated on 03/29/2018. On the MAR, staff recorded the resident's Magic Cup intake 16 of 27 days, which left 11 days that staff failed to enter an intake percentage. The MAR also contained an order for Boost Breeze (a nutritional supplement) initiated 04/14/2018. Staff documented the supplement as given 25 of 27 days. Staff documented the resident's weight in the computer as follows: a. 3/3/18 = 142 lbs. b. 4/2/18 = 134. lbs. c. 5/2/18 = 126 lbs. d. 6/1/18 = 137 lbs. e. 6/12/18 = 130 lbs. The Dietician documented as follows:	F 692		

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F 692	Continued From page 50 In May 2018 documented Resident # 47 triggered for a significant weight change of -5.65% x 1 month, -14.50% x 3 month, -16.58% x 6 month based on May monthly wt of 126.8 lbs. The current weight of 120 lbs. is a loss of an additional 6 pounds. Resident # 47 received a a pureed diet, but spit out food and refused to eat. She continued to receive 240 ml Boost Breeze three times a day and magic cup as 2:00 PM snack. The Dietician Recommended the facility serve the resident ice cream at lunch and dinner. On 5/3/2018 09:50, Resident # 47 admitted to hospice, however weight loss continued. A 5/2/18 weight of 126.8 lbs. lbs. triggered for significant wt change of -5.65% x 1 month, -14.50% x 3 month, -16.58% x 6 month. Resident continued with very poor intakes, refused to eat at meals, and spit food out. The Dietician noted the resident had an order for 240 ml boost breeze three times a day as well as magic cup every day for PM snack, as well as the resident's fall on 5/1/18 and increased lethargy. The Dietician documented the Director of Nursing verbalized the intent to move the resident to an assisted dining table. Resident's dementia diagnosis affects intakes; will continue to monitor and honor any food requests as able. a. 3/10/18 = 142 lbs. b. 3/17 = 134 lbs. c. 3/21 = 133.4 lbs. d. 3/24 = 130.7 lbs. e. 3/26 = 130 lbs. The Dietician documented the resident triggered for significant weight change of -12.52% x 6 months based on March monthly weight of 142.6	F 692		

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F 692	Continued From page 51 lbs. Weight as of 3/2/18 was 133.4., and has had 9 lb. weight loss since start of month. Resident on regular diet, however due to dentition issues, downgrade requested to mechanical soft until resident received new dentures (Had appointment for for 4/18/18. The resident to be moved to assisted dining table. Resident receives 120 milliliter boost breeze twice a day and is accepted according to the Medication Administration Record documentation. a. 6/6/2018 = 130.4 lbs b. 6/2/2018 = 137.0 lbs c. 5/2/2018 = 126.8 lbs d. 4/2/2018 = 134.4 lbs e. 3/10/2018 = 142.0 lbs The Dietician documented from 03/10/2018 to 06/12/2018 the resident down another 12 pounds (8%). The dentures continued to be an issue and the appointment for new dentures continued to be delayed until the middle of July. The facility canceled the April 18, 2018 appointment and continued to delay treatment that increased the risk significant continual weight loss. In an interview on 6/14/18, the Dietician stated she had found the weights of the resident inaccurate several times. The Dietician reported she could not confirm that the nurses actually stayed with the resident and made sure she took all the supplements. The Dietician also reported the resident had different interventions for supplements, and she did not know if the resident used teeth at all. An observation on 6/14/18 at 12:23 PM revealed Resident# 47 sat at an assisted table in the dining room for lunch. A nursing assistant sat between	F 692		

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F 692	Continued From page 52	F 692		

the resident and another resident, assisting both with the meal. Resident # 47 ate two bites of vanilla ice cream, but refused the pureed green beans, roast beef, mashed potatoes with gravy, dinner roll and strawberry shortcake. She also refused the chocolate milk and water. The nursing assistant asked the resident if she would eat something else and the resident declined. Resident # 47 did not have any dentures. The nursing assistant then assisted the other residents, but did not offer any hand held foods or try to offer food on a spoon to the resident.

During an observation of cares on 06/12/18 at 01:10, Staff D and Staff N stated the resident would not wear her teeth. The aides searched the resident's room and were unable to find the teeth. Both stated the resident would tell them the dentures belonged to someone else.

2. Resident #9's Minimum Data Set quarterly assessment completed 3/20/18 had documentation of the following diagnoses: diabetes mellitus, Non-Alzheimer's dementia and acute kidney failure. It also identified the resident to be cognitively impaired with a BIMS (brief interview for mental status) score of 0 out of 15, required extensive staff assistance with all activities of daily living and occasionally incontinent of bladder and bowel.

The care plan with the target date of 9/13/18 identified the resident with the problem of being at risk for an alteration in fluid and electrolyte balance related to diuretic therapy and directed staff to:
Administer medications as ordered
Encourage the intake of fluids at meals
Monitor/assess the resident for signs and symptoms of dehydration, intervene as needed,

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F 692	Continued From page 53 document and alert the physician to any significant findings. A review of nurse's notes revealed the following: a. 12/8/17 12:00 p.m. call received from the physician's assistant with lab results indicating acute renal failure and to send to ER. Call placed to daughter and informed of new order. Transported to ER via ambulance b. 12/9/17 00:58 a.m., received call from the hospital, resident admitted to hospital for dehydration and acute renal failure c. 12/12/17 4:19 p.m. resident arrived back at this facility at 2:15 p.m. Her family was here with her at arrival. Resident came with medication orders, hospice referral. Will follow up when more information available related to hospice. A review of the history and physical report dictated by the hospital physician on 12/8/17 at 5:00 p.m. revealed the following: *Diagnosis: dehydration with hypernatremia (high sodium level) and acute cystitis (bladder infection) *Sodium: 167 (normal level 135 - 145 meQ/L millequivelents per liter) *BUN (a test for kidney function): 75 (normal level 7 - 20 mg/dL milligrams per deciliter) *Creatinine (a test for kidney function): 2.41 (normal level 0.5 - 1.1 mg/dL) *Plan: intravenous fluid hydration, intravenous Cefriazone (antibiotic) for urinary tract infection During an interview on 6/18/18 at 8:33 a.m., Staff L, LPN reported the facility protocol to prevent the residents from being admitted to the hospital with dehydration was staff should always be push	F 692		

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F 692	Continued From page 54 fluids. There were a few residents where this popped up on the MARs (medication administration records) to remind staff to push fluids, and most of the aides know they are supposed to do so. In an interview on 6/18/18 at 8:58 a.m., Staff F, LPN reported the facility protocol to prevent the residents from being admitted to the hospital with dehydration is the staff should push fluids throughout every shift. The aides are aware of this as they are the ones that mostly do it. During an interview on 6/18/18 at 9:07 a.m., Staff M, LPN reported the facility protocol to prevent the residents from being admitted to the hospital with dehydration is the staff should definitely increase fluids and offer the residents plenty of water. Each shift, staff refilled the water pitchers with fresh ice water. The aides and nurses should offer whenever they go into the residents' rooms. In an interview on 6/19/18 at 8:08 a.m. the director of nursing reported she would expect staff to prevent residents from being admitted to the hospital for dehydration by offering the resident a drink at least 3 times a day when they pass ice and each time they go into the room. She commented our physician assistant is very good about checking lab results and followed up on residents who have low results.	F 692		
F 732 SS=B	Posted Nurse Staffing Information CFR(s): 483.35(g)(1)-(4) §483.35(g) Nurse Staffing Information. §483.35(g)(1) Data requirements. The facility must post the following information on a daily	F 732		

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F 732	Continued From page 55 basis: (i) Facility name. (ii) The current date. (iii) The total number and the actual hours worked by the following categories of licensed and unlicensed nursing staff directly responsible for resident care per shift: (A) Registered nurses. (B) Licensed practical nurses or licensed vocational nurses (as defined under State law). (C) Certified nurse aides. (iv) Resident census. §483.35(g)(2) Posting requirements. (i) The facility must post the nurse staffing data specified in paragraph (g)(1) of this section on a daily basis at the beginning of each shift. (ii) Data must be posted as follows: (A) Clear and readable format. (B) In a prominent place readily accessible to residents and visitors. §483.35(g)(3) Public access to posted nurse staffing data. The facility must, upon oral or written request, make nurse staffing data available to the public for review at a cost not to exceed the community standard. §483.35(g)(4) Facility data retention requirements. The facility must maintain the posted daily nurse staffing data for a minimum of 18 months, or as required by State law, whichever is greater. This REQUIREMENT is not met as evidenced by: Based on observation and staff interviews, the facility failed to post the hours of daily nursing staff for public and resident information. The facility reported a census of 63 residents.	F 732		

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F 732	Continued From page 56 Findings: Observations throughout the facility on June 11-14, 18-19 2018 revealed the absence of the daily staffing posting. The facility failed to post in a public place, visible to all, and in a readable design, an up-to-date information sheet of the staff working each day that reflected all paid nursing hours and the names of those working that day. In an interview on 06/19/18 at 12:23 PM, the Director of Nursing stated she did not have a daily staff posting.	F 732		
F 757 SS=D	Drug Regimen is Free from Unnecessary Drugs CFR(s): 483.45(d)(1)-(6) §483.45(d) Unnecessary Drugs-General. Each resident's drug regimen must be free from unnecessary drugs. An unnecessary drug is any drug when used- §483.45(d)(1) In excessive dose (including duplicate drug therapy); or §483.45(d)(2) For excessive duration; or §483.45(d)(3) Without adequate monitoring; or §483.45(d)(4) Without adequate indications for its use; or §483.45(d)(5) In the presence of adverse consequences which indicate the dose should be reduced or discontinued; or §483.45(d)(6) Any combinations of the reasons	F 757		

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F 757	Continued From page 57 stated in paragraphs (d)(1) through (5) of this section. This REQUIREMENT is not met as evidenced by: Based on record review and staff interviews, the facility failed to document non-pharmacological interventions implemented prior to the administration of PRN (given as needed) anti-anxiety medications for 3 of 3 residents reviewed for unnecessary medications (Residents #9, #36 and #53). The facility reported a census of 63 residents. Findings include: 1. Resident #9's MDS dated 3/20/18 had documentation of the following diagnoses: aphasia, anxiety disorder and psychotic disorder. It also identified the resident as severely cognitively impaired and required extensive staff assist with all activities of daily living. A review of June 2018 MAR revealed orders for Lorazepam concentrate 2 mg (milligrams) per ml (milliliter), 0.25 ml by mouth every 2 hours as needed for anxiousness until 9/1/18. The MAR showed staff gave the medication on June 10 at 11:23 a.m. and June 12 at 11:30 p.m. without documentation of attempts of non-pharmacological interventions prior to administering Lorazepam. A review of the nurse's notes revealed no documentation of any attempts of non-pharmacological interventions prior to the dose given on 6/10/18 at 11:30 p.m. A review of the care plan with the target date of 9/13/18 identified use of PRN (give as needed)	F 757		

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F 757	Continued From page 58 anti-anxiety medications (Lorazepam) and directed the staff to give PRN anti-anxiety medications as ordered by the physician. The care plan failed to direct staff to attempt and document non-pharmacological interventions prior to the administration of the medications. 2. Resident #36's MDS admission assessment completed 4/18/18 contained no active diagnoses in the last 7 days. The MDS documented the resident displayed moderately impaired cognition and remained independent for all activities of daily living. A review of the June 2018 MARs and nurse's notes revealed documentation on the following doses given for Lorazepam 0.5 mg PO Q 12 hours PRN anxiety: June 1 at 1:57 p.m. no documentation of non-pharmacological interventions attempted prior to giving PRN June 2 at 3:47 a.m. no documentation June 3 at 9:51 a.m. "PRN given after all interventions" June 7 at 00:01 a.m. - no documentation June 9 at 00:04 a.m. - no documentation June 11 at 10:25 a.m. - no documentation of non-pharmacological interventions attempted prior to administration A review of the May 2018 MARs and nurse's notes revealed documentation on the following doses given for Lorazepam 0.5 mg PO Q 12 hours PRN anxiety: May 13 at 8:52 p.m. no documentation of non-pharmacological interventions attempted May 17 at 3:00 p.m. no documentation of	F 757		

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F 757	Continued From page 59 non-pharmacological interventions attempted May 20 at 6:32 a.m. no documentation of non-pharmacological interventions attempted May 21 at 10:11 a.m. no documentation of non-pharmacological interventions attempted May 22 at 8:29 p.m. staff documented they offered the resident an ice pack for complaint of swollen gums May 25 at 10:09 a.m. no documentation of non-pharmacological interventions attempted May 26 at 3:33 p.m. no documentation of non-pharmacological interventions attempted May 28 at 7:14 a.m. no documentation of non-pharmacological interventions attempted May 30 at 7:48 no documentation of non-pharmacological interventions attempted A review of the MARs and current care plan revealed no interventions to address the need to attempt non-pharmalogical interventions prior to the administration of the anti-anxiety medication. 3. Resident #53's MDS quarterly assessment completed 5/19/18 had documentation of the following diagnoses: pneumonia, Non-Alzheimer's dementia and muscle weakness, had a BIMS score of 1 out 15 and required extensive staff assistance with most activities of daily living. A review of the June 2018 MAR had documentation of the following order: Lorazepam concentrate 2 mg/ml give 0.25 ml orally every 4 hours as needed for anxiety. A dose administered on 6/13/18 at 00:03 a.m. did not have documentation of non-pharmacological interventions attempted prior to administering the med. A review of the care plan revealed no	F 757		

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F 757	Continued From page 60 documentation to address the resident's anxiety and the need to attempt non-pharmacological interventions prior to the administration of the PRN anti-anxiety medications. During an interview on 6/18/18 at 8:33 a.m. Staff L, LPN reported prior to the administration of PRN anti-anxiety medication, nurses should attempt at least 3 interventions such as taking the resident to the restroom, repositioning, offer them a drink or a snack, or 1:1 time spent with them. Staff L stated nurses should document this in the progress notes, but Staff L reported she sometimes forgot to do this. In an interview on 6/18/18 at 8:58 a.m., Staff F, LPN reported prior to the administration of PRN anti-anxiety medication, nurses should document in the progress notes at least 3 interventions such as take the resident to the restroom, offer a snack, or spend 1:1 time with them. She reported she did not always remember to document the interventions. During an interview on 6/18/18 at 9:07 a.m., Staff M, LPN reported prior to the administration of PRN anti-anxiety medication, nurses should try to redirect the resident. Staff M reported staff could also sit down and talk with them regarding the cause of anxiety (excess stimulation, the roommate, etc.) and find comfort for those issues, then chart the intervention in the nurse's notes. During an interview on 6/19/18 at 8:08 a.m., the DON (director of nursing) reported prior to the administration of PRN anti-anxiety medication, she expected nurses to document 3 interventions such as offer them a drink, reposition them, offer	F 757		

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F 757	Continued From page 61 to take them to the restroom, and if behaviors continue to escalate, provide one on one time with them. The DON states nurses should chart on the MAR, which should populate into the nurse's notes. The DON said there should be a reminder on the MAR to attempt the 3 interventions and should be part of the order; the nurse that put in the order should enter that reminder.	F 757		
F 790 SS=D	Routine/Emergency Dental Srvcs in SNFs CFR(s): 483.55(a)(1)-(5) §483.55 Dental services. The facility must assist residents in obtaining routine and 24-hour emergency dental care. §483.55(a) Skilled Nursing Facilities A facility- §483.55(a)(1) Must provide or obtain from an outside resource, in accordance with with §483.70(g) of this part, routine and emergency dental services to meet the needs of each resident; §483.55(a)(2) May charge a Medicare resident an additional amount for routine and emergency dental services; §483.55(a)(3) Must have a policy identifying those circumstances when the loss or damage of dentures is the facility's responsibility and may not charge a resident for the loss or damage of dentures determined in accordance with facility policy to be the facility's responsibility; §483.55(a)(4) Must if necessary or if requested, assist the resident;	F 790		

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F 790	Continued From page 62 (i) In making appointments; and (ii) By arranging for transportation to and from the dental services location; and §483.55(a)(5) Must promptly, within 3 days, refer residents with lost or damaged dentures for dental services. If a referral does not occur within 3 days, the facility must provide documentation of what they did to ensure the resident could still eat and drink adequately while awaiting dental services and the extenuating circumstances that led to the delay. This REQUIREMENT is not met as evidenced by: Based on observation, record review, and staff interview, the facility failed to provide dental service in a timely manner and failed to document or have a policy for dental services (Resident # 47). The sample consisted of 16 residents. The facility reported a census of 63 residents. Findings include: 1. A Minimum Data Set (MDS) dated 05/04/2018 indicated Resident # 47 had diagnoses that included a cerebral vascular accident, non-Alzheimer's dementia, anxiety, and dysphasia. The MDS documented the resident demonstrated both long and short term memory deficits with severely impaired decision-making abilities and required extensive assist of one staff for dining. The MDS documented Resident # 47 experienced a weight loss and consumed a mechanically altered diet. The dental portion of the documentation noted the lack of any natural teeth.	F 790		

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F 790	Continued From page 63 The plan of care with a revision date of 12/19/2016 documented Resident # 47 received a pureed diet and could not feed herself; this required staff to provide cues for swallowing and safety. The care plan noted Resident # 47 had dentures, but did not wear them. A medical record progress note dated 4/18/2018 at 2:55 PM documented the Administrator spoke to Resident # 47's guardian and asked if the dental appointment scheduled that day could be canceled due to the bad weather. During an interview on 06/13/18 01:34 PM, the DON reported the resident had an appointment for Iowa City back in March for the dentist, but canceled it due to snow. The DON stated the facility tried to take the resident to a dentist in town after that, but the dentist would not have anything to do with the case. The Administrator told the surveyor the dentist could not get the resident to open her mouth, but could not locate documentation that verified this. During an interview on 06/19/18 at 09:59 AM, the Administrator the facility has no written policy, they have just been replacing dentures and hearing aids as of last November. The Dental note of 08/14/2017 documented the dentist voiced uncertainty about Resident # 47 tolerating dentures. The dentist thought it might be best for the resident not to go through the denture process if she could eat without dentures. During an observation of breakfast on 06/13/18 at 8:38 AM , Resident # 47 consumed a couple of mouthfuls of hot cereal, but would not eat the	F 790		

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F 790	Continued From page 64 scrabbled eggs or drink the chocolate milk. In an interview at that time, Staff D and Staff K (Certified Nursing Assistants), both reported the resident refused to wear her teeth. Resident # 47 then stated they were not her teeth and she will not wear someone else's teeth.	F 790		
F 803 SS=E	Menus Meet Resident Nds/Prep in Adv/Followed CFR(s): 483.60(c)(1)-(7) §483.60(c) Menus and nutritional adequacy. Menus must- §483.60(c)(1) Meet the nutritional needs of residents in accordance with established national guidelines.; §483.60(c)(2) Be prepared in advance; §483.60(c)(3) Be followed; §483.60(c)(4) Reflect, based on a facility's reasonable efforts, the religious, cultural and ethnic needs of the resident population, as well as input received from residents and resident groups; §483.60(c)(5) Be updated periodically; §483.60(c)(6) Be reviewed by the facility's dietitian or other clinically qualified nutrition professional for nutritional adequacy; and §483.60(c)(7) Nothing in this paragraph should be construed to limit the resident's right to make personal dietary choices. This REQUIREMENT is not met as evidenced by: Based on observation and staff interview, the	F 803		

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F 803	Continued From page 65 facility failed to obtain the Dietician's signature on menu changes prior to serving a substitute meal. In addition, 8 residents interviewed complained of no menu posting prior to the meals (Resident #9,#23,#42, #53, #68,# 57, # 67, # 37). The facility reported a census of 63 residents. Findings include: 1. On 06/12/18 at 08:12 AM, the Dietary Supervisor (DS) voiced needing to change concerning the menu for Tuesday because they were unable to obtain the baked ziti. The DS stated the baked ziti scheduled about one time a cycle (4 week menu rotation). The Dietary Supervisor verbalized being unable to purchase the baked ziti and needed to substitute each time it came up in the menu cycle. He stated the first time this happened, he had the Dietician sign off before they served the meal and since then she signs off on the substitute meal as being adequate when she comes in later in on Thursday. 2. During an interview on 6/11/18 at 3:30 p.m., Resident #57 stated the menu the facility provided did not match the food served. 3. During an interview on 6/11/18 at 4:26 p.m., Resident #67 stated the facility had no menu available for residents. 4. During an interview on 6/12/18 at 10:06 a.m., Resident #37 stated the facility did not have menus posted so the residents could see what they were having for meals. 5. Observations during lunch on 6/11/18	F 803		

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F 803	Continued From page 66	F 803		

(Monday) revealed the facility served ham. Observation during breakfast on 6/12/18 at approximately 9:00 a.m. revealed a "Week 4" menu posted in the main dining room. The menu listed Monday's lunch as meatloaf. No other menu was present in the dining room. Subsequent kitchen review revealed the current menu week was "Week 1".

6. Resident #9's MDS dated 5/20/18 contained documentation of the following diagnoses: aphasia, diabetes mellitus, and non-Alzheimer's dementia. It also identified the resident as cognitively impaired and documented the resident required extensive staff assistance with all activities of daily living.

The care plan identified the resident as at nutritional risk related to anticipated weight loss and hospice level of care and directed staff to provide and serve diet as ordered.

During an observation on 6/11/18 at 12:00 p.m. the resident's daughter fed the resident pureed ham, sweet potatoes and cooked broccoli.

An observation of the menu posted in the main dining room on 6/11/18 listed the following as lunch for that day: meat loaf, mashed potatoes, peas and carrots.

7. Resident #23's MDS admission assessment completed 4/6/18 revealed no active diagnoses in the past 7 days and identified the resident displayed intact cognition. The MDS documented the resident required extensive staff assistance with moving in bed.

A review of the care plan with the target date of 9/5/18 identified the resident as at nutritional risk

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F 803	Continued From page 67 related to anticipated weight loss, decline on hospice level of care, and directed staff to provide and serve diet as ordered. During an observation on 6/11/18 at 12:22 p.m., the resident had a room tray with ham, sweet potatoes, cooked broccoli, one glass each of milk, apple juice and one cup of coffee. An observation of the menu posted in the main dining room on 6/11/18 listed the following as lunch for that day: meat loaf, mashed potatoes, peas and carrots. 8. Resident #42's MDS dated 5/3/18 documented the resident had the following diagnoses: anemia, heart failure, and diabetes mellitus and identified the resident displayed intact cognition. The MDS documented the resident required extensive staff assistance with transferring out of bed, dressing, toilet use, and personal hygiene. A review of the care plan with the target date of 9/5/18 identified the resident as at risk for hypo/hyperglycemia related to diabetic diagnosis. The care plan directed staff to monitor compliance with diet and document any problems. During an observation on 6/11/18 12:27 p.m. the resident sat up in bed with a lunch tray in front of her which consisted of ham, sweet potatoes, cooked broccoli, canned pineapple, one glass of iced tea, and a dinner roll. An observation of menu posted in main dining room on 6/11/18 had documentation meal served for lunch should have included meat loaf, mashed potatoes, peas and carrots.	F 803		

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F 803	Continued From page 68 An observation of the menu posted in the main dining room on 6/11/18 listed the following as lunch for that day: meat loaf, mashed potatoes, peas and carrots. 9. Resident #53's MDS dated 5/19/18 had documentation of the following diagnoses: pneumonia, non-Alzheimer's dementia, and metabolic encephalopathy. It also documented the resident displayed severe cognitive impairment and identified the resident required extensive staff assist with all activities of daily living. A review of the care plan with the target date of 8/16/18 identified the resident as at nutritional risk related to previous medical history of encephalopathy. The care plan directed staff to encourage fluids due to constipation and to provide and serve diet as ordered. During an observation on 6/11/18 at 11:58 a.m., the resident fed herself ham, sweet potatoes, cooked broccoli, one cup of canned pears, one glass each of apple juice and milk. An observation of the menu posted in the main dining room on 6/11/18 listed the following as lunch for that day: meat loaf, mashed potatoes, peas and carrots. 10. Resident #68's MDS completed 5/29/18 had documentation of the following diagnoses: hypertension, generalized muscle weakness, and adult failure to thrive. It also identified the resident displayed intact cognition and required limited staff assistance with most activities of daily living.	F 803		

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F 803	Continued From page 69 A review of the care plan with the target date of 8/3/18 had documentation of the following: Problem: at nutritional risk related to history of adult failure to thrive Interventions: provide and serve diet as ordered. During an observation on 6/11/18 at 12:21 p.m., Staff D, CNA served the resident a tray with ham, a dinner roll, sweet potatoes, a cup of tomato soup, a glass of apple juice, a carton of milk and a bowl of canned pears. An observation of the menu posted in the main dining room on 6/11/18 listed the following as lunch for that day: meat loaf, mashed potatoes, peas and carrots.	F 803		
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 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	F 812		

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F 812	Continued From page 70 serve food in accordance with professional standards for food service safety. This REQUIREMENT is not met as evidenced by: Based on observation, staff interview, and facility policy, the facility failed to prevent contamination of baked goods by placing the commercially packaged plastic hamburger bun container on top of the tray of rolls during meal service. The facility reported a census of 63 residents. Findings include: During an observation of the service for the noon meal on June 11, 2018 at 11:23 A.M., Staff A (dietary cook) placed the plastic container of commercially packaged hamburger buns on top of a 36 by 24 inch baking sheet full of fresh baked rolls. The plastic bag remained on top of the rolls until the service ended at 12:20 P.M. The dietary cook retrieved the plastic bag of hamburger buns from a plastic tub under the counter of a kitchen work area. The plastic tub contained other bags of chips and other plastic bags of food items. During an interview on 06/14/18 at 1:03 PM, this Surveyor related the issue of the hamburger buns being placed on top of the baked rolls and asked if this was acceptable. The Dietary Manager and the Dietician both agree this was a sanitation issue and should not have been done. On 06/19/18 at 11:07 AM, the Dietary Supervisor could not find a kitchen policy for cross-contamination or sanitation in the kitchen.	F 812		
F 843 SS=D	Transfer Agreement CFR(s): 483.70(j)(1)(2)	F 843		

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F 843	Continued From page 71 §483.70(j) Transfer agreement. §483.70(j)(1) In accordance with section 1861(l) of the Act, the facility (other than a nursing facility which is located in a State on an Indian reservation) must have in effect a written transfer agreement with one or more hospitals approved for participation under the Medicare and Medicaid programs that reasonably assures that- (i) Residents will be transferred from the facility to the hospital, and ensured of timely admission to the hospital when transfer is medically appropriate as determined by the attending physician or, in an emergency situation, by another practitioner in accordance with facility policy and consistent with state law; and (ii) Medical and other information needed for care and treatment of residents and, when the transferring facility deems it appropriate, for determining whether such residents can receive appropriate services or receive services in a less restrictive setting than either the facility or the hospital, or reintegrated into the community will be exchanged between the providers, including but not limited to the information required under §483.15(c)(2)(iii). §483.70(j)(2) The facility is considered to have a transfer agreement in effect if the facility has attempted in good faith to enter into an agreement with a hospital sufficiently close to the facility to make transfer feasible. This REQUIREMENT is not met as evidenced by: Based on record review and interview, the facility failed to have a current transfer agreement with the hospital. The facility reported a census of 63 residents.	F 843		

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F 843	Continued From page 72 Findings: 1. A transfer agreement with the local hospital listed a review date of 3/24/11. The facility lacked documentation of a current transfer agreement. During an interview on 6/19/18 at 11:30 a.m., the Administrator stated the facility did not have a current transfer agreement with the hospital and the last one they had was when the facility changed hands. He stated he faxed the hospital and was awaiting a current agreement.	F 843		
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 73 §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 74 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, record review, and interview, the facility failed to practice adequate infection control measures for 1 of 5 residents observed during medication pass (Resident #3), 2 of 9 residents observed during perineal cares (Residents #37 and #42), and for 1 of 2 residents observed during a dressing change (Resident#23). The facility reported a census of 63 residents. Findings include: 1. The MDS (Minimum Data Set) assessment tool, dated 3/8/18, listed diagnoses for Resident #3 that included anxiety, depression, and muscle weakness and listed the resident's BIMS (Brief Interview for Mental Status) score as 14 out of 15, indicating intact cognition. During an observation on 6/11/18 at 11:37 a.m., Staff K CMA (Certified Medication Aide) attempted to obtain 2 Acetaminophen 500 mg (milligram) tablets from a stock bottle by pouring the tablets into the lid of the bottle. She poured more than 2 tablets into the lid and touched 2 tablets with her bare fingers to keep them in the lid while she poured the extras back into the bottle. Staff K then delivered the medications to the Resident #3 and the resident took the medication. The facility policy "Medication Administration", dated 1/13, directed staff to avoid touching medication with their fingers.	F 880		

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F 880	Continued From page 75 During an interview on 6/14/18 at 11:37 a.m., the DON (Director of Nursing) stated staff should avoid touching medications with their bare hands. 2. The MDS assessment tool, dated 4/21/18, listed diagnoses for Resident #37 that included cerebral palsy, diabetes, and abscess of the buttock. The MDS stated the resident required extensive assistance of 1 staff for personal hygiene and dressing, extensive assistance of 2 staff for bed mobility, transfers, and toilet use, and depended totally on 1 staff for bathing. The MDS listed the resident's BIMS score as 13 out of 15, indicating intact cognition. During an observation on 6/12/18 at 9:02 a.m., Staff N CNA (Certified Nursing Assistant) and Staff G CNA assisted the resident with perineal cares while the resident lay in bed, and then covered the resident with a blanket. Several brown spots of dried fecal material were present on the underside of the blanket. After cares, the surveyor showed this to the DON and she changed the blanket after acknowledging the presence of feces. The care plan, 5/15/18, stated the resident had a boil on the upper posterior thigh positive for MRSA(methicillin-resistant staphylococcus aureus). The facility policy "Bed Making", dated 1/13, directed staff to remove and dispose of soiled linens. During an interview on 6/14/18 at 11:37 a.m., the DON stated she expected staff to do a thorough check of linens and change them if needed. 3. Resident #23's MDS completed 4/6/18 did not	F 880		

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F 880	Continued From page 76 have documentation of any active diagnoses. It also identified the resident as cognitively aware with a BIMS (brief interview for mental status) score of 15 out of 15, required limited staff assistance with most activities of daily living and had 4 (four) stage 4 pressure ulcers. A review of the attending note on the history and physical report dictated by the physician on 3/27/18 revealed the resident had been treated at another long term care facility for coccygeal osteomyelitis and for acute encephalopathy (a disease in which the functioning of the brain is affected by some agent or condition such as viral infection or toxins in the blood) along with acute kidney injury. The care plan with the target date of 9/5/18 identified the resident had 5 pressure ulcers present upon admission and directed staff to monitor dressings as ordered, ensure they are intact and adhering, and report loose dressing to the charge nurse. a. Observation on 6/12/18 12:11 p.m., revealed Staff E, and LPN, Staff F, LPN entered the room, washed their hands, and donned gloves. Staff E used scissors to cut through the telfa dressing on left lower leg, but failed to disinfect scissors afterward. The wound to the left calf contained a moderate amount of serosanguinous drainage without redness noted to the surrounding skin. Staff E cleansed wound using correct technique with Skin Integrity, then removed gloves, used hand sanitizer, and donned new gloves. b. At 12:15 p.m. Staff E used the correct technique to complete the wound care to the wound on the left lower leg. At 12:18 p.m. Staff E removed the dressing to wound in the coccyx	F 880		

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F 880	Continued From page 77 area which Staff E reported was the wound that measured 4.1 x 4.3 x 0.1 cm. Staff E changed gloves, used hand sanitizer, donned new gloves, and used skin integrity spray to cleanse wound using correct technique. c. At 12:22 p.m. Staff E then poured H-Chlor 12 into a plastic cup, then placed kerlix dressing which she had cut previous dressing with (and did not disinfect afterward) then packed H-chlor soaked kerlix into wound, covered with an ABD dressing over the wound, and taped it into place with paper tape. d. At 12:25 p.m. Staff E changed gloves and used alcohol to disinfect the scissors. During an interview on 6/13/18 at 11:29 a.m. Staff E, LPN reported nurses should disinfect the scissors after using it on one wound. In an interview on 6/13/18 at 12:02 p.m., Staff F, LPN (Staff F) reported nurses should clean the scissors with an alcohol wipe or bleach wipes after each dressing change. During an interview on 6/13/18 at 12:15 p.m., the director of nursing reported nurses should disinfect the scissors after each dressing change. A review of the facility policy titled: dressing change with the revised date of January 2013 revealed: Purpose: to prevent contamination of a wound, to protect adjacent skin surfaces from irritation due to wound drainage, to promote wound healing Procedure: 1. Wash hands and apply gloves 2. Remove soiled dressing	F 880		

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F 880	Continued From page 78 3. Observe amount, color, and odor of drainage and condition of wound bed or incision. 4. Place soiled dressing and gloves in plastic bag 5. Remove gloves and wash hands 6. Set up supplies 7. Apply gloves 8. Pour sterile solution over gauze pads/cotton tipped applicators while holding gauze/applicators over plastic bag, or pour solution into basin 9. Cleanse wound with gauze/applicators from center outward using spiral motion and gentle pressure. Discard used supplies into plastic bag. Use new gauze/applicators each time wound is cleansed from center outward 10. Document the following: 11. Date and time of dressing change 12. Amount of drainage, color and odor 13. Any unusual appearance of wound or peril-wound area 14. Complaints of pain or discomfort 15. Resident response to procedure 4. Resident #42's MDS completed 5/3/18 had documentation of the following diagnoses: heart failure, peripheral vascular disease and diabetes mellitus. It also identified the resident as cognitively intact with a BIMS score of 15 out of 15, required extensive staff assistance with most activities of daily living and was occasionally incontinent of bladder. The care plan with the target date of 9/5/18 identified the resident with the problem of self-care deficits related to left below the knee amputation and occasionally incontinent of urine. The care plan directed staff to assist and transfer the resident from bed utilizing the slide board to the commode with the drop down arm, assist to use the bedpan when she is in her wheelchair per	F 880		

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F 880	Continued From page 79 her preference utilizing the mechanical lift, assist on the bedpan at night, change her incontinence products, and provide per care as needed. During an observation of peri care on 6/12/18 at 11:53 a.m., Staff B, CNA and Staff H, CNA entered the resident's room, washed their hands, and donned gloves. Staff had placed a wash basin with water on a clean towel on top of overbed table. Staff B used the correct technique to cleanse the perineal area, removed gloves, used hand sanitizer and donned new gloves. The resident's buttocks contained dime sized areas noted to each gluteal fold, but no redness or drainage noted to the areas. Staff B used the correct technique to cleanse rectal crease then emptied the washbasin into the sink. During an interview on 6/13/18 at 10:30 a.m. Staff A, CNA reported after using a wash basin for cares, staff should empty the water into the toilet. In an interview on 6/13/18 at 10:41 a.m., Staff B, CNA reported after using a wash basin for cares, staff should empty the water into the toilet. During an interview on 6/13/18 at 11:08 a.m., Staff C, CNA reported after using a wash basin for cares, staff should empty the water into the toilet or in the soiled utility room. In an interview on 6/19/18 at 8:08 a.m., the director of nursing reported she would expect staff to empty the washbasin used for incontinence cares into the toilet.	F 880		
F 908 SS=F	Essential Equipment, Safe Operating Condition CFR(s): 483.90(d)(2)	F 908		

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F 908	Continued From page 80 §483.90(d)(2) Maintain all mechanical, electrical, and patient care equipment in safe operating condition. This REQUIREMENT is not met as evidenced by: Based on observation, staff interview, and cleaning schedules, the facility failed to maintain the kitchen environment and equipment in a clean and sanitary manner. The facility reported a census of 63 residents. Findings: During the kitchen tour on 06/11/2018 at 9:15 AM, the areas of concern found: *A small amount of carbon build up on bottom of 6 baking pans. *The walk-in refrigerator fans contained dark brown debris on both covers. *The Sunfire stove burners (6 burners) had a built up of black grease debris. *The edge of the grill showed 1 to 1 1/2 inch of build-up of grease. * Both ovens showed rusty surface areas and the right oven showed a build-up of grease around 3 sides of the insides of the door. *The lids of the flour, brown and white sugar bins all contained greasy residue. *1 stainless steel work table brace contained grimy yellow food debris. *The vent above the dishwasher has grimy black debris on all the panel louvers. The Healthcare Service Group training for new hires on Cleaning and Sanitizing inform dietary employee on the purpose of proper sanitation and sanitizing which is: for resident safety in the healthcare	F 908		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	165578	A. BUILDING _____ B. WING _____	06/19/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PREMIER ESTATES OF MUSCATINE	3440 MULBERRY AVENUE MUSCATINE, IA 52761

(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 908	Continued From page 81 environment as a top priority and be ongoing in the kitchen to prevent harm. The Dietary staff are directed to clean any surface that comes into contact with food after each use. The untitled cleaning schedules for January and February 2018 direct the dietary staff to clean work tables including their legs, wipe the stove top down from front to back and inside the ovens. 06/14/2018 at 2:20 PM, the Dietary Supervisor verbalized not being able to find cleaning schedules for March, April, and May. The cleaning schedule marked 06/11 with no year, listed oven cleaning, prep tables, walk-in cooler, but failed to include the stove top, fan vents in the walk-in refrigerator, the grill, food bins, vents above the dishwasher, and carbon on baking pans.	F 908		

DEPARTMENT OF INSPECTIONS AND APPEALS

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	701074	A. BUILDING: _____ B. WING _____	06/19/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PREMIER ESTATES OF MUSCATINE	3440 MULBERRY AVENUE MUSCATINE, IA 52761

(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) COMPLETE DATE
L1093	58.12(1)l Admission, transfer, and discharge 58.12(135C) Admission, transfer, and discharge. 58.12(1) General admission policies. l. For all residents residing in a health care facility receiving reimbursement through the medical assistance program under Iowa Code chapter 249A on July 1, 2003, and all others subsequently admitted, the facility shall collect and report information regarding the resident's eligibility or potential eligibility for benefits through the Federal Department of Veterans Affairs as requested by the Iowa commission on Veterans Affairs. The facility shall collect and report the information on forms and by the procedures prescribed by the Iowa commissions on veterans affairs. Where appropriate, the facility may also report such information to the Iowa department of human services. In the event that a resident is unable to assist the facility in obtaining the information, the facility shall seek the requested information from the resident's family members or responsible party. For all new admissions, the facility shall collect and report the required information regarding the resident's eligibility or potential eligibility to the Iowa commission on veterans affairs within 30 days of the resident's admission. For residents residing in the facility as of July 1, 2003, and prior to May 5, 2004, the facility shall collect and report the required information regarding the resident' s eligibility or potential eligibility to the Iowa commission on veterans affairs within 90 days after May 5, 2004. If a resident is eligible for benefits through the federal Department of Affairs or other third-party payor, the facility shall seek reimbursement from such benefits to the maximum extent available before seeking reimbursement from the medical	L1093		

DEPARTMENT OF INSPECTIONS AND APPEALS

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	701074	A. BUILDING: _____ B. WING _____	06/19/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PREMIER ESTATES OF MUSCATINE	3440 MULBERRY AVENUE MUSCATINE, IA 52761

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L1093	Continued From page 1 assistance program established under Iowa Code chapter 249A. The provisions of this paragraph shall not apply to the admission of an individual as a resident to a state mental health institute for acute psychiatric care or to the admission of an individual to the Iowa Veterans Home. (II,III) This Statute is not met as evidenced by: Based on record review and interview, the facility failed to enter into the Iowa Department of Veteran's Affairs website veteran statuses for 4 of 4 veterans admitted within the survey year (Residents #6, #55, #62, #68). The facility reported a census of 63 residents. Findings: 1. The Admission Record for Resident #6 listed an admission date of 8/3/17. The facility's Iowa Department of Veteran's Affairs(VA) Resident Eligibility list indicated the facility entered the resident's veteran status on 6/12/18, during the survey week. 2. The Admission Record for Resident #55 listed an admission date of 8/7/17. The facility's Iowa Department of Veteran's Affairs Resident Eligibility list indicated the facility entered the resident's veteran status on 6/12/18, during the survey week. 3. The Admission Record for Resident #62 listed an admission date of 6/12/17. The facility's Iowa Department of Veteran's Affairs Resident Eligibility list indicated the facility entered the resident's veteran status on 6/12/18, during the survey week.	L1093		

DEPARTMENT OF INSPECTIONS AND APPEALS

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	701074	A. BUILDING: _____ B. WING _____	06/19/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PREMIER ESTATES OF MUSCATINE	3440 MULBERRY AVENUE MUSCATINE, IA 52761

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L1093	Continued From page 2 4. The Admission Record for Resident #68 listed an admission date of 4/30/18. The facility's Iowa Department of Veteran's Affairs Resident Eligibility list indicated the facility entered the resident's veteran status on 6/12/18, during the survey week. During an interview on 6/11/18 at 2:00 p.m., the Administrator stated the former Social Worker carried out the task of entering veteran statuses into the Veteran's Affairs website and stated since she left, he didn't believe anyone carried out the task. During an interview on 6/18/18 at 12:30 p.m., the Administrator stated he was now completing VA Eligibility assessments upon admission.	L1093		

This plan of correction does not constitute an admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. This plan of correction is prepared solely because it is required by State and Federal Law.
Please accept Premier Estates Credible Allegation of Compliance for Premier Estates of Muscatine's annual survey and investigation if 76285-C, 76296-C, 75749-I and 75532-C conducted 06/11/2018-06/19/2018

F645

1. Resident #35's care plan for psychosocial needs was reviewed and revised to reflect current needs by the care plan coordinator. The PASRR for resident #35 was filed in the active medical record by the medical records department.
2. An audit of resident medical records was completed by the medical records department to validate required documentation is filed in the medical record as required. An audit of resident care plans was completed by the care plan coordinator to validate care plans reflect current psychosocial needs with revisions completed as required.
3. The Interdisciplinary Team was re-educated by the Director of Nursing regarding the requirement to maintain the PASRR in the active medical record. The Interdisciplinary Team was re-educated regarding the requirement to maintain the care plan to reflect current needs of the residents.
4. Audits will be completed of 10 resident medical records weekly for 4 weeks and monthly for 2 months to validate the care plan continues to reflect current resident psychosocial needs and that the PASRR is filed as required. Results of these audits will be brought to the monthly QA meeting for review and recommendations for 3 months and as needed. The Director of Nursing is responsible for ongoing compliance.
5. Date of Compliance: 8/5/18

F657

1. Resident #9 and resident #53's care plans have been reviewed and revised by the care plan coordinator. Residents #13, 73, and 273 have been discharged from the center.
2. An audit of resident care plans was completed by the Interdisciplinary Team to validate care plans are comprehensive and reflect the current needs of the residents. Revisions to the plans of care will be completed as needed.
3. The Interdisciplinary Team will be re-educated by the Director of Nursing regarding the requirement to maintain comprehensive care plans to reflect the current needs of the residents.
4. Audits will be completed by the Director of Nursing/designee of 10 random resident care plans weekly for 4 weeks and monthly for 2 months to validate staff continue to maintain resident care plans as required. Results of these audits will be brought to the monthly QA meeting for 3 months and as needed. The Director of Nursing is responsible for ongoing compliance.
5. Date of Compliance:08/05/20/18

F658

1. Staff member K was re-educated regarding the rights of medication administration by the Director of Nursing.

1. The identified areas requiring cleaning and maintenance in the kitchen were addressed by the Dietary Manager.
2. An observational sanitation audit of the kitchen will be completed by the Administrator to validate dietary staff maintain the kitchen in a sanitary manner. Corrections will be completed as needed.
3. Dietary staff will be re-educated by the Administrator regarding to maintain the kitchen in a sanitary manner.
4. Observational sanitation audits of the kitchen will be completed weekly for 4 weeks and monthly for 2 months to validate kitchen staff continue to maintain the kitchen in a sanitary manner. Results of these audits will be brought to the monthly QA meeting for review and recommendations. The Administrator is responsible for ongoing compliance.
5. Date of Compliance:08/05/18

L1093

1. Residents #6, #55, #62, #68 were entered into the VA Website during the survey by the Administrator.
2. We have entered all VA residents into the VA website since the survey and will continue to enter all VA residents.
3. We have hired a new S.S. Director which has been educated on how to enter the information on every VA resident that enters the facility.
4. The Administrator will monitor for compliance on a monthly basis for 3 months along with the QA Team.
5. Date of Compliance:08/05/18

2. Observational audits of Licensed Nurses and Certified Medication Aides will be completed by the Assistant Director of Nursing to validate staff administer medications as required. Re-education will be immediately provided as needed.
3. Licensed Nursing and Certified Medication Aides will be re-educated regarding the process for medication administration by the Assistant Director of Nursing.
4. 4 observational audits of medication administration will be completed by the Assistant Director of Nursing for 4 weeks and then monthly for 2 months to validate licensed nurses and certified medication aides continue to administer medications as required. Results of these audits will be brought to the monthly QA meeting for 3 months and as needed. The Assistant Director of Nursing is responsible for ongoing compliance.
5. Date of Compliance:08/05/18

F661

1. Resident #272's discharge summary was completed by the Licensed Nurse.
2. An audit of the last 30 days of resident discharges was completed by the Assistant Director of Nursing to validate a discharge summary is documented as required.
3. The Interdisciplinary Team was re-educated by the Director of Nursing regarding the requirements of completing a discharge summary.
4. Audits of residents that discharge from the center will be completed weekly for 4 weeks and monthly for 2 months to validate discharge summaries continue to be completed as required. Results of these audits will be brought to the monthly QA meeting for review and recommendations for 3 months and as needed. The Assistant Director of Nursing is responsible for ongoing compliance.
5. Date of Compliance:08/05/18

F678

1. The code status for Resident #39 was obtained and documented in the medical record on 6/13/18 by the Licensed Nurse. Resident #273 was discharged from this center.
2. An audit of resident code status was completed by the Director of Nursing/designee to validate current code status was documented in the medical record as required. Corrections were made as needed.
3. The Interdisciplinary Team and the Nursing staff were re-educated by the Director of Nursing regarding the requirement to maintain the current code status in the medical record.
4. An audit of resident code status will be completed weekly for 12 weeks to validate staff continue to maintain the current code status in the medical record as required. Results of these audits will be brought to the monthly QA meeting for review and recommendations. The Director of Nursing is responsible for ongoing compliance.
5. Date of Compliance:08/05/18

F684

1. Assistance was provided to Resident #273 by the Licensed Nurse. Resident #273 was transferred to the Emergency Room for evaluation and treatment.
2. An audit of resident code status was completed on 6/13 by the Director of Nursing. Code cart audits were completed on 6/13/18 to validate supplies were immediately available to staff. An audit of resident care plans for feeding assistance was completed by the Care Plan Coordinator to validate care plans reflect current needs of the residents. An audit of CNA Kardex was completed by the the Care Plan Coordinator to validate the Kardex reflects currents feeding assistance needs of the residents.

An audit of the last 30 days of therapy recommendations was completed by the Care Plan Coordinator to validate therapy communications are communicated as required.

3. All nursing staff will be re-educated by the Director of Nursing regarding the requirements of immediately providing first aide including Heimlich. All nursing staff will be re-educated by the Director of Nursing regarding the requirements of maintaining the code carts in a fully stocked manner for immediate access to supplies in the event of an emergency. All nursing staff will be re-educated by the Director of Nursing regarding the requirements of immediately calling for assistance in the event of an emergency and that assistance will be rendered at the place of occurrence. All nursing staff will be re-educated by the Director of Nursing regarding the elements of the facility's CPR policy. All nursing staff will be re-educated by the Director of Nursing regarding the requirement to assist residents with cutting foods to a size that is manageable by residents. Licensed Nursing staff will be re-educated by the Director of Nursing regarding the requirement to maintain care plans to reflect the feeding assistance needs of the residents. All therapy staff will be re-educated regarding the requirement to complete therapy communication sheets with changes in resident care needs. All staff will be re-educated regarding the facility's policy for abuse by the Administrator beginning 6/13/18. All education will begin on 6/13/18 and continue until all staff have been re-educated. Staff will not work without first receiving the above education. An additional code cart will be stocked for immediate use in the dining room. This will be completed immediately by the Director of Nursing or her designee. A roster of resident wishes regarding CPR will be developed and placed in the dining room for immediate accessibility by the Director of Nursing on 6/13/18 and will be maintained with changes.
4. Audits will be completed daily for 7 days, 3 times weekly for 3 weeks and weekly for 2 months to validate staff continue to follow the policy for CPR, provide immediate emergency assistance, maintain the code carts in a fully supplied manner, maintain a roster of resident CPR wishes and assist residents with cutting foods as required. Audits will be completed daily for 7 days, 3 times weekly for 3 weeks and weekly for 2 months to validate care plans continue to reflect feeding assistance needs of residents and that the therapy department continues to complete therapy communication sheets as required. Results of these audits will be brought to the monthly QAPI meeting for 3 months and as needed. The Director of Nursing is responsible for ongoing compliance.
5. Date of Compliance: 07/27/2018

F686

1. Resident #23's wounds were assessed by the Licensed Nurse and treatment changes were obtained by the provider. Resident #42's wounds were assessed by the Licensed Nurse and treatment changes were obtained from the provider.
2. An audit of residents with wounds was completed by the Director of Nursing/designee to validate wounds are assessed as required with corresponding documentation. Assessments were completed as needed.
3. Licensed Nursing staff were re-educated by the Director of Nursing regarding the requirements to assess and document wounds and the requirement to seek alternate treatment for wounds not showing signs of healing.
4. Weekly audits of wound care documentation will be completed for 12 weeks to validate licensed nursing staff continue to to assess and document wound care as required. Results of these audits will be brought to the monthly QA meeting for 3 months and as needed. The Director of Nursing is responsible for ongoing compliance.
5. Date of Compliance:08/05/18

F689

1. Resident #47's plan of care for falls was reviewed and revised by the Interdisciplinary Team to reflect current interventions to minimize falls.
2. An audit of the last 30 days of falls was completed to validate the plan of care includes individualized interventions to minimize the residents risk for falls. An observational audit of fall interventions will be completed to validate staff are following the fall plan of care for residents at risk for falls.
3. Staff have been re-educated regarding the requirements of fall prevention including supervision, preventative individualized interventions, and assistive devices to minimize falls.
4. An audit care plans of residents sustaining falls will be completed weekly for 4 weeks and monthly for 2 months to validate staff continue to implement surging supervision, individualized care plan interventions and assistive devices to minimize falls. These audits will be completed by the Directer of Nursing. An observational audit of fall care plan interventions will be completed weekly for 4 weeks and monthly for 2 months to validate staff continue to follow the plan of care to minimize falls. Results of these audits will be brought to the monthly QA meeting for 3 months and as needed. The Director of Nursing is responsible for ongoing compliance.
5. Date of Compliance:08/27/18

F690

1. Resident #9 and Resident #53 were provided complete incontinence care by the nursing staff.
2. An observational audit of resident incontinence care was completed by the Nurse Management team to validate direct care staff are completely cleaning each resident as required.
3. Nursing staff have been re-educated regarding the requirement to provide complete incontinence care with residents by the Director of Nursing.
4. An observational audit of 5 instances of incontinence care per week will need completed weekly for 4 weeks and monthly for 2 months to validate direct care staff continue to provide complete incontinence care as required. Results of these audits will be brought to the monthly QA meeting for 3 months and as needed. The Director of Nursing is responsible for ongoing compliance.
5. Date of Compliance:08/05/18

F692

1. Resident #47 was evaluated by the Registered Dietician regarding changes in weight with revisions to the plan of care implemented as required. Resident #9's hydration status was evaluated by the Interdisciplinary Team with changes to the plan of care implemented as needed.
2. An audit of residents nutrition and hydration status was completed by the Interdisciplinary Team to validate care plans reflect interventions to address weight changes and dehydration.
3. Nursing staff have been re-educated by the Director not Nursing regarding the requirement to implement interventions to address weight changes and dehydration. This education included assisting residents with meals, offering hydration and documenting intakes of supplementation.
4. Audits will be completed weekly for 4 weeks and monthly for 2 months by the Director of Nursing/designee to validate staff continue to implement interventions to address weight changes and dehydration as well as document intakes of supplements. Results of these audits will be brought to the monthly QA meeting for review and recommendations for 3 months and as needed. The Director of Nursing is responsible for ongoing compliance.
5. Date of Compliance:08/15/18

F732

1. Daily staffing will be posted in a manner that is accessible to the public.

2. An audit of daily staffing posting will be completed by the Administrator to validate staffing is posted as required.
3. Staff have been re-educated by the Administrator regarding the requirement to post staffing in a manner that is accessible to the public.
4. An audit will be conducted weekly for 4 weeks and monthly for 2 months by the Administrator to validate staff continue to post staffing as required. The results of these audits will be brought to the monthly QA meeting for 3 months and as needed. The Administrator is responsible for ongoing compliance
5. Date of Compliance:08/05/18

F757

1. Residents #9, 36, and 53 have been assessed by the licensed nurse with no change of condition identified.
2. An audit of residents receiving anti-anxiety medications on an as needed basis will be completed by the Director of Nursing/designee to validate staff are implementing non pharmacological interventions per the plan of care prior to the administration of anti-anxiety medications.
3. Licensed Nursing staff and certified medication aides will be re-educated by the Director of Nursing regarding the requirement to attempt non pharmacological interventions per the plan of care prior to the administration of anti-anxiety medications.
4. An audit of residents with orders for as needed anti-anxiety medications will be completed weekly for 4 weeks and monthly for 2 months to validate staff continue to attempt non-pharmacological interventions per the plan of care prior to the administration of anti-anxiety medications as required. Results of these audits will be brought to the monthly QA meeting for review and recommendation for 3 months and as needed. The Director of Nursing is responsible for ongoing compliance.
5. Date of Compliance:08/05/18

F790

1. Resident #47 was evaluated by the Dentist is not considered a candidate for dentures at this time. Documentation of dental services was entered into the resident medical record.
2. An audit of residents need for dental services was completed by the Social Service director to identify residents that may need dental services. Assistance with dental services will be provided if needed.
3. Social service and nursing staff will be re-educated by the Administrator regarding the requirement to assist residents in obtaining dental services as required.
4. Audits of residents need for dental services will be completed weekly for 4 weeks and monthly for 2 months to validate staff continue to assist residents with dental services as required. Results of these audits will be brought to the monthly QA meeting for 3 months and as needed. The Administrator is responsible for ongoing compliance.
5. Date of Compliance:08/05/18

F803

1. The menu substitute was reviewed and approved by the Registered Dietician. The menus will be posted prior to meals in a manner accessible to residents
2. An audit of the last 30 days of menu compliance and substitute approval will be completed by the Administrator to validate the Certified Dietary Manager obtains Dietician approval prior to menu substitutes. An audit of menu posting will be completed by the Administrator to validate menus are posted as required. Corrections will be made as needed.
3. The dietary staff will be re-educated by the Registered Dietician regarding the requirement to follow menus, post menus and obtain dietician approval prior to menu substitutes.

4. A weekly audit by the Administrator will be completed for 4 weeks then monthly for 2 months to validate the dietary staff continue to follow menus, obtain approval for menu substitutes and post menus as required. Results of these audits will be brought to the monthly QA meeting for review and recommendations. The Administrator is responsible for ongoing compliance.
5. Date of Compliance:08/05/18

F812

1. Dietary staff will store foods in a manner to prevent cross contamination.
2. An observational audit of food storage will be completed by the Administrator to validate dietary staff are storing foods in a manner to prevent cross contamination. Concerns identified will be addressed as needed
3. Dietary staff have been re-educated regarding the requirement to store food in a manner to prevent cross contamination by the Registered Dietician
4. An observational audit will be completed weekly for 4 weeks and monthly for 2 months to validate dietary staff continue to store food in a manner to prevent cross contamination. Results of these audits will be brought to the monthly QA meeting for review and recommendations. The Administrator is responsible for ongoing compliance
5. Date of Compliance:08/05/18

F843

1. A transfer agreement will be maintained in a current status with a local hospital
2. An audit of requirement transfer agreement documentation was completed by the Administrator and is current.
3. The managers have been re-educated regarding the requirement to maintain a current transfer agreement.
4. An audit will be conducted quarterly by the Administrator to validate current transfer agreement documentation remains in place as required. Results of this audit will be brought to the QA meeting for review and recommendation The Administrator is responsible for ongoing compliance
5. Date of Compliance:08/05/18

F880

1. Residents 3, 37, 42 and 23 were assessed by the Licensed Nurse for signs of infection with no change of condition identified .
2. An observational audit of infection control practices was completed by the Director of Nursing to validate staff are observing required infection control practices to prevent the spread of infection.
3. Nursing staff will be re-educated regarding the requirements to maintain infection control practices to prevent the spread of infection. This education will include cleaning scissors after each use, disposing of water after care and medication handling.
4. Observational audits of infection control practices will be completed weekly for 4 weeks and monthly for 2 months to validate staff continue to maintain infection control practices to prevent the spread of infection. Results of these audits will be brought to the monthly QA meeting for review and recommendations. The Director of Nursing is responsible for ongoing compliance
5. Date of Compliance:08/05/18

F908

1. The identified areas requiring cleaning and maintenance in the kitchen were addressed by the Dietary Manager.
2. An observational sanitation audit of the kitchen will be completed by the Administrator to validate dietary staff maintain the kitchen in a sanitary manner. Corrections will be completed as needed.
3. Dietary staff will be re-educated by the Administrator regarding to maintain the kitchen in a sanitary manner.
4. Observational sanitation audits of the kitchen will be completed weekly for 4 weeks and monthly for 2 months to validate kitchen staff continue to maintain the kitchen in a sanitary manner. Results of these audits will be brought to the monthly QA meeting for review and recommendations. The Administrator is responsible for ongoing compliance.
5. Date of Compliance:08/05/18

L1093

1. Residents #6, #55, #62, #68 were entered into the VA Website during the survey by the Administrator.
2. We have entered all VA residents into the VA website since the survey and will continue to enter all VA residents.
3. We have hired a new S.S. Director which has been educated on how to enter the information on every VA resident that enters the facility.
4. The Administrator will monitor for compliance on a monthly basis for 3 months along with the QA Team.
5. Date of Compliance:08/05/18