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
	165256	A. BUILDING _____ B. WING _____	09/20/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ELMWOOD CARE CENTRE	222 NORTH 15TH STREET ONAWA, IA 51040

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 000	INITIAL COMMENTS 10/5/18 557 Correction date 10/20/18 all others The following deficiencies result from the facility's annual health survey and complaint investigation. Complaints #70980-C, #71406-C, #75121-C, #76841-C, #77654-C, #77757-C, #77805-C and #78019-C were substantiated. See the Code of Federal Regulations (42CFR) Part 483, Subpart B-C.	F 000		
F 557 SS=E	Respect, Dignity/Right to have Prsnl Property CFR(s): 483.10(e)(2) §483.10(e) Respect and Dignity. The resident has a right to be treated with respect and dignity, including: §483.10(e)(2) The right to retain and use personal possessions, including furnishings, and clothing, as space permits, unless to do so would infringe upon the rights or health and safety of other residents. This REQUIREMENT is not met as evidenced by: Based on record review, resident and staff interviews. the facility failed to ensure the resident had a right to be treated with respect and dignity for 2 staff's interactions with residents. Staff C (former Administrator) raised his voice and did not speak appropriately to Resident #500 causing mental anguish. Staff D (CNA) had interactions with 5 residents that revealed a lack of kind and considerate care. The facility identified a census of 49 residents. Findings include:	F 557		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE 10/05/2018

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.

POC accepted 10/21/18 KK summary

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F 557	Continued From page 1 1. A Minimum Data Set (MDS) assessment dated 12/8/17 assessed Resident #500 with a brief interview for mental status (BIMS) score of "15" (no cognitive impairment). The resident had no delusions, hallucinations or behaviors identified. The resident required extensive staff assistance with bed mobility, transfers, dressing, toileting, personal hygiene and bathing. The resident admitted to the facility 9/8/17. The resident discharged from the facility 12/12/17. An incident reported by the facility regarding Staff C (former Administrator) occurred as follows: On 9/16/18 at 3:03 p.m. the resident stated he weighed 400 some pounds and measured 6'4" tall. He attempted to speak to Staff C about his bed, chair and diet. Staff C became rude and screamed and yelled at him. When asked how it made him feel, the resident stated he cried. It made him mad and upset. It made him feel terrible. A facility investigation summary (undated) revealed Staff B LPN (licensed practical nurse) stated Staff C raised his voice and with an authorative tone told Resident # 500 if he didn't want to be at the facility that he would 'call every frickin facility in the United States' for alternate placement for the resident. The investigation timeline revealed the incident occurred on 9/12/17. In a typed statement, Staff C stated he spoke to Resident # 500 in a raised direct voice telling the resident that he would not allow the resident to disrespect the staff and they would treat him with respect if he treated the staff with respect. Staff C stated he repeated the question 'what do you	F 557		

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F 557	Continued From page 2 want to do? several times to the resident because the resident didn't answer. Staff C then documented that he told the resident he would call every frickin place, even out of state, if that is what he wanted. Staff C told the resident he wanted the resident to be where ever the resident wanted to go. Staff C stated he spoke with a raised voice, direct with empathy. During interview on 9/18/18 at 9 a.m. Staff C stated stated he didn't recall raising his voice. He stated he had never cussed in front of a resident. He stated he told the resident if he didn't want to be here 'they would look everywhere. They would even look in places the resident didn't know about'. During interview on 9/18/18 at 8:42 a.m. Staff B stated Staff C raised his voice. She didn't think the situation was abusive because she felt the resident was manipulating Staff C and not letting Staff C talk. She stated Staff C was loud and not in a kind way that you would talk to a resident. During interview on 9/17/17 at 11:46 p.m. Staff A certified occupational therapy aide (COTA) stated she was outside the room when the incident occurred. Both the resident and Staff C sounded loud. She did not listen to what they said. During interview on 9/17/18 at 10:47 a.m. Resident #27 stated Staff C acted mean and everyone said he was mean. Review of Staff C's personnel file revealed no counseling or disciplinary actions in the file. The facility investigation identified that Staff C was told not to come to work beginning 9/13/17 until the facility investigation was complete.	F 557		

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F 557	Continued From page 3 On 9/19/18 at 9:26 a.m. the current Administrator stated they did not have a date when Staff C returned to work. A list of terminated staff revealed Staff C left employment voluntarily on 1/26/18. b. An additional incident involved Staff D certified nurse aide (CNA) and Resident #500: During interview on 9/16/18 at 3:03 p.m. the resident stated Staff D CNA was very rude. He stated he could not recall what she said. On 9/18/18 at 3:30 p.m. Staff D stated the resident made a racial slur to her. She told the resident he made his life style choices and how can she assist him when he weighs over 500 pounds. Staff D informed the resident she was 5'1" and 130 pounds so how could she help him? She stated she may have said the f-word to Resident # 36 and she apologized. She stated she told another resident (#27) that what the resident wanted wasn't important and she needed to provide care to another resident. She said Resident #27 needed her blanket adjusted. Staff D stated during the time she had kid custody issues and PTSD (post traumatic stress disorder). She stated she told residents she was on meds so she didn't choke anyone but she was just joking. A facility investigation dated 9/13/17 revealed Staff D told a resident the resident 's*** her pants and made a mess'. The resident involved felt upset because of what Staff D said. Resident #27 asked Staff D to assist her with repositioning and Staff D slammed the door and didn't help the	F 557		

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F 557	Continued From page 4 resident. Resident #501 also asked Staff D to assist her to the bathroom. Staff D stated she would not take the resident because she had already taken her 3000 times. Staff D did not assist her. Resident #501 stated she felt scared around Staff D. On 9/14/17 the facility investigation revealed Resident #28 stated Staff D was rude and disrespectful a time or 2. A facility investigation dated 8/27/17 revealed Staff D cursed at Resident # 36 when the resident tried to tell Staff D she couldn't eat cheese. During interview on 9/17/18 at 10:47 a.m. Resident #27 stated Staff D was snotty and wouldn't do what she asked her to. She stated Staff D informed the resident that Staff D had to be on medicine or she was mean. An employee coaching form dated 8/29/17 revealed Staff D used inappropriate language in front of a resident. Review of staff terminated from employment revealed Staff D's termination date as 10/2/17 for unsatisfactory performance.	F 557		
F 567 SS=B	Protection/Management of Personal Funds CFR(s): 483.10(f)(10(i)(ii) §483.10(f)(10) The resident has a right to manage his or her financial affairs. This includes the right to know, in advance, what charges a facility may impose against a resident's personal funds. (i) The facility must not require residents to deposit their personal funds with the facility. If a resident chooses to deposit personal funds with the facility, upon written authorization of a resident, the facility must act as a fiduciary of the resident's funds and hold, safeguard, manage, and account for the personal funds of the resident	F 567		

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F 567	Continued From page 5 deposited with the facility, as specified in this section. (ii) Deposit of Funds. (A) In general: Except as set out in paragraph (f)(l0)(ii)(B) of this section, the facility must deposit any residents' personal funds in excess of $100 in an interest bearing account (or accounts) that is separate from any of the facility's operating accounts, and that credits all interest earned on resident's funds to that account. (In pooled accounts, there must be a separate accounting for each resident's share.) The facility must maintain a resident's personal funds that do not exceed $100 in a non-interest bearing account, interest-bearing account, or petty cash fund. (B) Residents whose care is funded by Medicaid: The facility must deposit the residents' personal funds in excess of $50 in an interest bearing account (or accounts) that is separate from any of the facility's operating accounts, and that credits all interest earned on resident's funds to that account. (In pooled accounts, there must be a separate accounting for each resident's share.) The facility must maintain personal funds that do not exceed $50 in a noninterest bearing account, interest-bearing account, or petty cash fund. This REQUIREMENT is not met as evidenced by: Based on observation, record review and staff interview the facility failed to assure residents have access to personal funds on weekends for one out of one residents reviewed (Resident #8). The facility reported a census of 49. Findings include: The Minimum Data Set (MDS) assessment for Resident #8 dated 6/17/18 showed a Brief Interview for Mental Status (BIMS) of 15	F 567		

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F 567	Continued From page 6 indicating no cognitive impairment. The facility does not have a policy to address resident access to personal funds on the weekend. Interview with Resident #8 on 9/17/18 at 1:48 PM revealed he has personal funds in an account at the facility. Resident #8 stated he needs to request money prior to the weekend as he is not able access his personal funds from the facility over the weekend. In an interview with the Administrator on 9/19/18 at 3:44 PM stated residents do not have access to their personal funds over the weekend and the facility currently has no plan in place for residents to access their personal funds on the weekend.	F 567		
F 584 SS=E	Safe/Clean/Comfortable/Homelike Environment CFR(s): 483.10(i)(1)-(7) §483.10(i) Safe Environment. The resident has a right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely. The facility must provide- §483.10(i)(1) A safe, clean, comfortable, and homelike environment, allowing the resident to use his or her personal belongings to the extent possible. (i) This includes ensuring that the resident can receive care and services safely and that the physical layout of the facility maximizes resident independence and does not pose a safety risk. (ii) The facility shall exercise reasonable care for the protection of the resident's property from loss	F 584		

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F 584	Continued From page 7 or theft. §483.10(i)(2) Housekeeping and maintenance services necessary to maintain a sanitary, orderly, and comfortable interior; §483.10(i)(3) Clean bed and bath linens that are in good condition; §483.10(i)(4) Private closet space in each resident room, as specified in §483.90 (e)(2)(iv); §483.10(i)(5) Adequate and comfortable lighting levels in all areas; §483.10(i)(6) Comfortable and safe temperature levels. Facilities initially certified after October 1, 1990 must maintain a temperature range of 71 to 81°F; and §483.10(i)(7) For the maintenance of comfortable sound levels. This REQUIREMENT is not met as evidenced by: Based on observation, staff interview and facility policy review, the facility failed to maintain a clean resident environment. The facility reported a census of 49. Findings include: Observation on 9/19/18 at 9:33 AM revealed the following areas of concern: a. The hallway white ceiling tiles outside room 504 felt wet to touch and dark brown in color with black staining. b. The hallway white ceiling tiles outside room	F 584		

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F 584	Continued From page 8 508 stained black in color along the ceiling track. c. The hallway white ceiling tiles outside room 510 with circular stains dark brown in color and corrosion on ceiling tile metal grid. d. The hallway white ceiling tiles outside hallway 500 charting station in common resident space with circular stains dark brown in color with black areas. e. The hallway white ceiling tiles between 500 hall charting station and room 512 with circular stains dark brown in color. f. The hallway white ceiling tiles outside of room 514 with circular dark stains brown in color. g. The hallway white ceiling tiles outside of room 516 with circular stains brown in color with a black center. h. The hallway white ceiling tiles outside room 306 with circular stains dark brown in color. i. The return air vents across from 300 and 400 hall charting station with large amounts of dirt and dust buildup. During interview with the Administrator on 9/19/18 at 10:10 AM, he confirmed the tiles in the 300 and 500 hallways were stained and wet and should be replaced. The Administrator confirmed the dust buildup on return air vents across from 300 and 400 hall charting station. On 9/20/18 at 6:50 AM, the Administrator stated he has no policy to address how often to do preventative maintenance other than the computerized maintenance system.	F 584		

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F 584	Continued From page 9 Review of the Preventative Maintenance Work History report documented the facility cleaned the heating, ventilation and air conditioning units on 8/31/18.	F 584		
F 623 SS=B	Notice Requirements Before Transfer/Discharge CFR(s): 483.15(c)(3)-(6)(8) §483.15(c)(3) Notice before transfer. Before a facility transfers or discharges a resident, the facility must- (i) Notify the resident and the resident's representative(s) of the transfer or discharge and the reasons for the move in writing and in a language and manner they understand. The facility must send a copy of the notice to a representative of the Office of the State Long-Term Care Ombudsman. (ii) Record the reasons for the transfer or discharge in the resident's medical record in accordance with paragraph (c)(2) of this section; and (iii) Include in the notice the items described in paragraph (c)(5) of this section. §483.15(c)(4) Timing of the notice. (i) Except as specified in paragraphs (c)(4)(ii) and (c)(8) of this section, the notice of transfer or discharge required under this section must be made by the facility at least 30 days before the resident is transferred or discharged. (ii) Notice must be made as soon as practicable before transfer or discharge when- (A) The safety of individuals in the facility would be endangered under paragraph (c)(1)(i)(C) of this section; (B) The health of individuals in the facility would be endangered, under paragraph (c)(1)(i)(D) of	F 623		

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F 623	Continued From page 10 this section; (C) The resident's health improves sufficiently to allow a more immediate transfer or discharge, under paragraph (c)(1)(i)(B) of this section; (D) An immediate transfer or discharge is required by the resident's urgent medical needs, under paragraph (c)(1)(i)(A) of this section; or (E) A resident has not resided in the facility for 30 days. §483.15(c)(5) Contents of the notice. The written notice specified in paragraph (c)(3) of this section must include the following: (i) The reason for transfer or discharge; (ii) The effective date of transfer or discharge; (iii) The location to which the resident is transferred or discharged; (iv) A statement of the resident's appeal rights, including the name, address (mailing and email), and telephone number of the entity which receives such requests; and information on how to obtain an appeal form and assistance in completing the form and submitting the appeal hearing request; (v) The name, address (mailing and email) and telephone number of the Office of the State Long-Term Care Ombudsman; (vi) For nursing facility residents with intellectual and developmental disabilities or related disabilities, the mailing and email address and telephone number of the agency responsible for the protection and advocacy of individuals with developmental disabilities established under Part C of the Developmental Disabilities Assistance and Bill of Rights Act of 2000 (Pub. L. 106-402, codified at 42 U.S.C. 15001 et seq.); and (vii) For nursing facility residents with a mental disorder or related disabilities, the mailing and	F 623		

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F 623	Continued From page 11 email address and telephone number of the agency responsible for the protection and advocacy of individuals with a mental disorder established under the Protection and Advocacy for Mentally Ill Individuals Act. §483.15(c)(6) Changes to the notice. If the information in the notice changes prior to effecting the transfer or discharge, the facility must update the recipients of the notice as soon as practicable once the updated information becomes available. §483.15(c)(8) Notice in advance of facility closure In the case of facility closure, the individual who is the administrator of the facility must provide written notification prior to the impending closure to the State Survey Agency, the Office of the State Long-Term Care Ombudsman, residents of the facility, and the resident representatives, as well as the plan for the transfer and adequate relocation of the residents, as required at § 483.70(l). This REQUIREMENT is not met as evidenced by: Based on clinical record review and staff interview, the facility failed to send a notice of discharge to the Office of the State Long-Term Care Ombudsman for 3 of 15 residents reviewed (#36, #38 & #12). The facility reported a census of 49. Findings include: 1. Review of a Nurse's Progress Note dated 7/5/18 for Resident #23 documented the resident was transferred to the emergency room and admitted to the hospital. A Nurse's Progress Note dated 7/10/18 indicated the resident	F 623		

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F 623	Continued From page 12 returned to the facility at 2:30 P.M. that date. Documentation of notification of the Ombudsmen is absent from the resident's health record. During an interview with the Administrator on 9/19/18 at 4:20 P.M. he stated he just learned on 9/11/18 that the facility needed to send the State Ombudsmen notification of any discharges each month. The Administrator stated he emailed all August discharges to the Ombudsmen on 9/19/18 and will continue to do so monthly going forward. 2. Record review for Resident #36 revealed no documentation of discharge notice sent to the Office of the State Long-Term Care Ombudsman for a hospital discharge 6/22/18. In an interview with the Administrator on 9/18/18 at 3:08 PM stated the facility did not notify the Office of the State Long-Term Care Ombudsman for Resident #36 hospital discharge on 6/22/18. 3. Record review for Resident #38 revealed no documentation of discharge notice sent to the Office of the State Long-Term Care Ombudsman for a hospital discharge 7/23/18. In an interview with the Administrator on 9/19/18 at 1:35 PM stated the facility did not notify the Office of the State Long-Term Care Ombudsman for Resident #38 hospital discharge on 7/23/18.	F 623		
F 625 SS=B	Notice of Bed Hold Policy Before/Upon Trnsfr CFR(s): 483.15(d)(1)(2) §483.15(d) Notice of bed-hold policy and return- §483.15(d)(1) Notice before transfer. Before a nursing facility transfers a resident to a hospital or	F 625		

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F 625	Continued From page 13 the resident goes on therapeutic leave, the nursing facility must provide written information to the resident or resident representative that specifies- (i) The duration of the state bed-hold policy, if any, during which the resident is permitted to return and resume residence in the nursing facility; (ii) The reserve bed payment policy in the state plan, under § 447.40 of this chapter, if any; (iii) The nursing facility's policies regarding bed-hold periods, which must be consistent with paragraph (e)(1) of this section, permitting a resident to return; and (iv) The information specified in paragraph (e)(1) of this section. §483.15(d)(2) Bed-hold notice upon transfer. At the time of transfer of a resident for hospitalization or therapeutic leave, a nursing facility must provide to the resident and the resident representative written notice which specifies the duration of the bed-hold policy described in paragraph (d)(1) of this section. This REQUIREMENT is not met as evidenced by: Based on record review and staff interview the facility failed to provide written information to the resident or resident representative prior to hospital transfer of the facility's bed hold policy for 3 of 15 residents reviewed (#36, #38 and #12). The facility reported a census of 49. Findings include: 1. Review of a Nurse's Progress Note dated 7/5/18 for Resident #23 documented the resident transferred to the emergency room and admitted to the hospital. A Nurse's Progress Note dated	F 625		

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F 625	Continued From page 14 7/10/18 indicated the resident returned to the facility at 2:30 P.M. on that date. Documentation of notification of the Ombudsmen is absent from the resident's health record. During an interview with the Administrator on 9/19/18 at 4:20 P.M., he stated he just learned on 9/11/18 that the facility needed to send the State Ombudsmen notification of any discharges each month. The Administrator stated he emailed all August discharges to the Ombudsmen on 9/19/18 and will continue to do so monthly going forward. 2. Review of Resident #36's clinical record revealed no documentation of bed hold policy review with resident or resident representative prior to hospital discharge 6/22/18. In an interview with the Administrator on 9/18/18 at 4:28 PM, he stated staff did not review the bed hold policy with Resident #36 prior to hospital discharge 6/22/18. 3. Record review for resident #38 revealed no documentation of bed hold policy review with resident or resident representative prior to hospital discharge 7/23/18. On 9/19/18 at 1:35 PM, the Administrator stated staff did not review the bed hold policy with Resident #38 prior to hospital discharge 7/23/18.	F 625		
F 644 SS=E	Coordination of PASARR and Assessments CFR(s): 483.20(e)(1)(2) §483.20(e) Coordination. A facility must coordinate assessments with the pre-admission screening and resident review (PASARR) program under Medicaid in subpart C	F 644		

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F 644	Continued From page 15 of this part to the maximum extent practicable to avoid duplicative testing and effort. Coordination includes: §483.20(e)(1)Incorporating the recommendations from the PASARR level II determination and the PASARR evaluation report into a resident's assessment, care planning, and transitions of care. §483.20(e)(2) Referring all level II residents and all residents with newly evident or possible serious mental disorder, intellectual disability, or a related condition for level II resident review upon a significant change in status assessment. This REQUIREMENT is not met as evidenced by: Based on clinical record review and staff interviews, the facility failed to refer residents with a newly evident or possible serious mental disorder for review upon a significant change in mental health status or incorporate identified specialized services into plan of care for 4 of 8 residents identified for review of PASARR (Pre Admission Screening and Resident Review) (Residents #8 ,#38, #10 and #35). The facility reported a census of 49 residents. Findings include: 1. Resident #8's PASARR dated 1/5/16 listed a diagnosis of cognitive disorder and symptoms of delusions, self-care issues, depression and anxiety. No psychotropic medications identified. The Psychiatric Telehealth Progress Note dated 8/16/18 listed the resident's diagnoses as primary insomnia, post traumatic stress disorder (PTSD), other specified depressive episodes and	F 644		

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F 644	Continued From page 16 generalized anxiety disorder The resident's most recent MDS (Minimum Data Set) assessment dated 6/17/18 listed mental health diagnoses as PTSD, anxiety and mental disorder not otherwise specified. The resident's Medication Review Report dated 9/19/18 listed mental health medications as Primidone for anxiety, Sertraline for mental disorder not otherwise specified and Trazodone for PTSD. Interview with Director of Nursing on 9/18/18 at 4:08 PM confirmed a new PASARR should have been submitted for review on resident #8. 2. Resident #38 PASARR dated 7/20/18 listed identified the need for specialized services of individual therapy by a licensed behavioral health professional. The resident's care plan with initiation date of 8/15/18 failed to address specialized services identified on current PASARR. Interview with Director of Nursing on 9/18/18 at 4:08 PM confirmed PASARR identified specialized services not addressed on resident #38's care plan. 3. The MDS assessment dated 6/19/18 documented Resident # 10's Brief Interview for Mental Status (BIMS) score of 4, indicating severe cognitive impairment. The MDS identified Resident # 10's diagnoses included Alzheimer's disease, dementia, generalized anxiety disorder, major depressive disorder, generalized muscle weakness and difficulty in walking.	F 644		

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F 644	Continued From page 17 Resident # 10 had a PASRR Notice of Nursing Facility Approval dated 3/8/18 with PASRR-Identified Services and Supports. However, the care plan did not address all of the identified services except for Telehealth. Resident # 10's record lacked documentation showing the start date, frequency and duration of the services. The care plan showed Resident # 10 admitted on 3/22/18. 4. Resident #35 PASARR dated 6/14/18 listed identified specialized services for behavioral health. The care plan with an initiation date of 6/14/18 failed to address or incorporate specialized services identified on the current PASARR. During an interview with the Consultant Registered Nurse (RN) on 9/18/18 at 2:20 p.m. she identified the MDS Coordinator, no longer employed at the facility, as responsible for completing the PASSAR care plans. The Consultant acknowledged the ASCEND recommendations are not addressed in the resident's plan of care.	F 644		
F 655 SS=D	Baseline Care Plan CFR(s): 483.21(a)(1)-(3) §483.21 Comprehensive Person-Centered Care Planning §483.21(a) Baseline Care Plans §483.21(a)(1) The facility must develop and implement a baseline care plan for each resident that includes the instructions needed to provide effective and person-centered care of the resident that meet professional standards of quality care. The baseline care plan must- (i) Be developed within 48 hours of a resident's admission.	F 655		

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F 655	Continued From page 18 (ii) Include the minimum healthcare information necessary to properly care for a resident including, but not limited to- (A) Initial goals based on admission orders. (B) Physician orders. (C) Dietary orders. (D) Therapy services. (E) Social services. (F) PASARR recommendation, if applicable. §483.21(a)(2) The facility may develop a comprehensive care plan in place of the baseline care plan if the comprehensive care plan- (i) Is developed within 48 hours of the resident's admission. (ii) Meets the requirements set forth in paragraph (b) of this section (excepting paragraph (b)(2)(i) of this section). §483.21(a)(3) The facility must provide the resident and their representative with a summary of the baseline care plan that includes but is not limited to: (i) The initial goals of the resident. (ii) A summary of the resident's medications and dietary instructions. (iii) Any services and treatments to be administered by the facility and personnel acting on behalf of the facility. (iv) Any updated information based on the details of the comprehensive care plan, as necessary. This REQUIREMENT is not met as evidenced by: Based on clinical record review and resident and staff interviews, the facility failed to develop and review a baseline care plan within the first 48 hours of admission for 1 of 15 residents reviewed (Resident #38). The facility reported a census of 49.	F 655		

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F 655	Continued From page 19 Findings include: 1. The Minimum Data Set (MDS) assessment dated 8/10/18 for Resident #38 showed a Brief Interview for Mental Status (BIMS) of 11, indicating moderately impaired cognition. Review of initial care plan for Resident #38 with an effective date of 7/21/18 showed only dietary order information. The initial care plan showed no review signature of the resident and/or his representative. Review of resident documentation showed no review of 48 hour care plan with resident or resident representative. During an interview with Resident #38 on 9/17/18 at 2:32 PM, he stated the facility did not review a plan of care with him and it went unsaid what the facility would do for him. Interview with Director of Nursing on 9/19/18 at 12:26 PM revealed the facility did not complete the 48 hour care plan for Resident #38 and they did not review the care plan with the resident.	F 655		
F 657 SS=D	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.	F 657		

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F 657	Continued From page 20 (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). 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 clinical record review, observation and staff interview, the facility failed to review and revise the resident's comprehensive plan of care for one of 15 residents reviewed (#4). The facility reported a census of 49 residents. Findings include: 1. The Minimum Data Set (MDS) assessment dated 6/11/18 for Resident #4 listed diagnoses of arthritis, non-Alzheimer's dementia and difficulty walking. The MDS identified the resident required the assistance of one staff person for bed mobility, dressing, transfers, toilet use and personal hygiene. The MDS identified the resident as being frequently incontinent of bowel and bladder. A Brief Interview for Mental Status score of 4 indicated moderate cognitive impairment for decision-making.	F 657		

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F 657	Continued From page 21 During an observation on 9/19/18 at 6:52 A.M. , Staff I, Certified Nurse's Aide (CNA), placed a gait belt on the resident and assisted him to transfer from the bed to the wheelchair. The CNA stated it was shower day. Staff I transported the resident to the shower room in the wheelchair with foot pedals in place and resident covered for dignity. During an observation of the transfer from the wheelchair into the shower chair, the CNA again used a gait belt and assisted the resident to stand up while he held on to the side of the whirlpool bathtub and transfer to the shower chair. The Director of Nursing (DON) was also present in the shower room observing. Observation of the resident's activity level throughout the survey period revealed the resident to be independently mobile in a manual wheelchair and he would often sit by the front door or windows and look outside. Resident #4 attended the activities that were offered and sat in the wheelchair drinking coffee in the main dining area with other residents. Review of a care plan last revised on 1/13/16 revealed a Focus area of potential for falls related to impaired decision-making/safety judgement secondary to dementia progression and history of CVA (stroke). A Goal with a target date of 6/20/18 was that resident would have no falls through review date. An intervention with a revision date of 1/13/16 directed to monitor for unsteady transfers and assist as needed. Review of a focus area regarding resident having frequent urinary incontinence with a revision date of 7/14/17 included an intervention (last revised 1/13/16) to check frequently for incontinence and provide peri care after each incontinent episode	F 657		

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F 657	Continued From page 22 and PRN. A care plan focus area regarding ADL (activities of daily living) self-care performance last revised on 11/16/15, included interventions of: resident requires limited assistance of one for bed mobility, ambulation, toileting and dressing, and resident required supervision/set-up for transfers. Both interventions had revision dates of 10/7/17. On 9/19/18 at 3:56 P.M. upon request to observe toilet use and incontinence cares for Resident #4, the DON stated the resident is independent with toilet use and transfers. The DON stated the MDS/Care Plan Coordinator resigned in August and the care plan did not get changed to reflect the resident's independence.	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 clinical record review, observation and staff interview, the facility failed to provide services that met professional standards for medication administration. Staff E did not sign out medications immediately following administering them or administer them according to the medication administration record (MAR) for 3 of 15 residents reviewed (Residents #150, #25, #23). The facility identified a census of 49 residents.	F 658		

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F 658	Continued From page 23 Findings include: On 9/17/18 at 7:20 p.m., a check of resident medications on the 500 hall revealed the following concerns: Review of Resident #150's September 2018 medication administration record (MAR) recorded a 9 p.m. order for Alprazolam (antianxiety) 1 milligram (mg.) at 9 p.m. The resident's Alprazolam card in the narcotic supply showed one missing. The Alprazolam tablet was not signed out of the narcotic supply or on the MAR. At that time, Staff E RN (registered nurse) stated she gave the Alprazolam to the resident around 7 p.m. because she goes to bed early. She just hadn't signed anything yet. Review of 9/17/18 medication administration audit revealed Staff E signed the MAR for administering the Alprazolam at 8:09 p.m. (after the surveyor left facility) Review of Resident #25's September 2018 MAR revealed the resident had a bedtime order for Alprazolam 0.25 mg. The resident's Alprazolam card in the narcotic supply showed one missing and was not signed out of the narcotic supply. The MAR identified Staff E administered the drug at 6:17 p.m. At that time, Staff E RN confirmed she did not yet sign the Alprazolam out of the narcotic supply. Review of Resident #23's September 2018 MAR revealed the resident had an order for clonazepam (for anxiety) at 9 p.m. The resident's clonazepam card in the narcotic supply showed one missing, but it had not been signed out of the narcotic supply or on the MAR. At that time, Staff E RN (registered nurse) stated she gave the clonazepam to the resident early because the	F 658		

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F 658	Continued From page 24 resident's daughter requested it. She did not sign it out of the narcotic supply or MAR yet. Review of 9/17/18 medication administration audit revealed Staff E signed the MAR for administering the Alprazolam at 8:07 p.m. (after the surveyor left the facility) Review of medication administration audit for 9/17/18 revealed Staff E signed she administered 3 resident's medications at 8:10 p.m. (3 residents in 1 minute), signed that she administered 1 resident's medications at 8:07 p.m., 2 at 8:08 p.m. and 3 at 8:10 p.m. (6 residents in 3 minutes), another resident's medications at 8:23 p.m. and 3 resident's medications at 8:24 p.m. (4 residents in 2 minutes) On 9/18/18 at 1:20 p.m. when questioned about administering 3 resident's medications in 1 minute, 6 residents in 3 minutes and 4 residents in 2 minutes, Staff E stated no, she could not have given all those in that short of time. If she gives medications and doesn't sign them out at the time, then she may sign a few out at once. On 9/18/18 at 2:36 p.m. the DON stated she she gives the narcotic and comes back and signs it out if the MAR and narcotic supply right away. Review of the facility medication administration manual did not identify when staff should sign out medications after administering them.	F 658		
F 677 SS=B	ADL Care Provided for Dependent Residents CFR(s): 483.24(a)(2) §483.24(a)(2) A resident who is unable to carry out activities of daily living receives the necessary services to maintain good nutrition, grooming, and	F 677		

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F 677	Continued From page 25 personal and oral hygiene; This REQUIREMENT is not met as evidenced by: Based on clinical record review and staff interview, the facility failed to ensure that a resident who is unable to carry out activities of daily living receives the necessary services to maintain good nutrition, grooming, and personal and oral hygiene for 1 of 15 residents reviewed (# 48). The facility identified a census of 49 residents. Findings include: 1. A Minimum Data Set (MDS) assessment dated 8/20/18 recorded Resident #48 with a brief interview for mental status (BIMS) score of 5, indicating severe cognitive impairment. The resident required limited staff assistance with toilet use, personal hygiene and extensive assistance with bathing. The resident had frequent incontinence of urine. She entered the facility on 7/23/18 and discharged on 8/26/18. Review of the resident's bath record identified she received a bath on 7/25/18, 8/1/18, 8/11/18 and 8/25/18. The bath record indicated the resident refused baths on 8/4/18 and 8/18/18. On 9/18/18 at 2:36 p.m. the DON (Director of Nursing) stated the resident had 2 baths scheduled for the week on Wednesdays and Saturdays.	F 677		
F 684 SS=D	Quality of Care CFR(s): 483.25 § 483.25 Quality of care Quality of care is a fundamental principle that	F 684		

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F 684	Continued From page 26 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 by: Based on record review and staff interview, the facility failed to ensure that residents received treatment and care in accordance with professional standards of practice, the comprehensive person-centered care plan, and the residents' choices for 1 of 15 sampled residents (#48). The facility identified a census of 49 current residents. Findings include: 1. A Minimum Data Set (MDS) with assessment dated 8/20/18 recorded Resident #48 with a brief interview for mental status (BIMS) score of "5" (severe cognitive impairment). The resident required limited staff assistance with toileting, personal hygiene and extensive assistance with bathing. The resident had frequent incontinence of urine. A Hospital History and Physical dated 7/11/18 identified the resident admitted to the hospital with sepsis and urinary tract infection (UTI). Nursing progress notes dated 7/23/18 at 4:39 p.m. revealed the resident admitted to the facility for skilled care. Nurses progress notes dated 8/12/18 at 7:53 p.m. revealed Resident #48 had occasional back pain. Nurses progress notes dated 8/14/18 at 2:27 p.m.	F 684		

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(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 684	Continued From page 27 revealed the resident complained of frequent back pain. Nursing progress notes dated 8/16/18 at 9:35 a.m. revealed clinic staff called and stated the resident's daughter called asking to check a UA (urinanalysis) due to the resident experiencing back pain. The facility documented the resident had no complaints of pain or discomfort. On 8/17/18 at 2:30 a.m. a nurse documented placement of a collection hat in the resident's bathroom to collect a urine sample in the morning. A laboratory report dated 8/16/18 identified the facility collected a urine sample at 6 p.m. and the lab received the sample at 8:15 p.m. The preliminary resulted measured over 100,000 gram negative rods (indicating infection). A facsimile (fax) to the facility received on 8/17/18 at 9:12 a.m. revealed the physician ordered Nitrofurantoin (antibiotic) 100 mg. twice a day for 10 days. On 8/17/18 at 4 p.m. the resident's temperature measured 100 degrees. Review of the August 2018 medication administration record (MAR) identified the facility did not start the antibiotic until that evening. On 9/18/18 at 11:29 a.m., when asked why the resident did not received the antibiotic sooner, the DON (Director of nursing) stated the fax probably sat on the fax machine and the nurse noted it at 12:40 p.m.	F 684		
F 689 SS=D	Free of Accident Hazards/Supervision/Devices CFR(s): 483.25(d)(1)(2) §483.25(d) Accidents. The facility must ensure that -	F 689		

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F 689	Continued From page 28 §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 clinical record review, staff and family interviews and facility policy review, the facility did not ensure adequate supervision and appropriate interventions to prevent falls for 1 of 4 residents (# 10) reviewed for accidents. The facility reported a census of 49 residents at the time of the survey. Findings include: 1. The Minimum Data Set (MDS) assessment dated 6/19/18 documented Resident #10 had diagnoses that included Alzheimer's disease, dementia, anxiety, low back pain and other chronic pain. The assessment documented she had Brief Interview for Mental Status score of 4, indicating severely impaired memory and cognition. The MDS documented she required the assistance of one with transfers, walking and toilet use, had impaired balance with transitions and while walking and had no falls since admission or the previous assessment. The assessment did not document that Resident #10 experienced behavioral symptoms. Resident #10 entered the facility on 3/22/18. The Order Summary Report (OSR) printed on 9/19/18, showed Resident # 10 received medications with side effects that may include dizziness, tiredness, fatigue and drowsiness such as Risperdal (antipsychotic), Ativan (anti-anxiety)	F 689		

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F 689	Continued From page 29 and Zoloft (anti-depressant). The care plan initiated on 4/20/18 identified Resident # 10's risk for falls related to impaired cognitive function and poor safety awareness. The interventions listed in the care plan included putting the call light within reach and encouraging Resident # 10 to use it for assistance, putting colored tape on her call string, making sure Resident # 10 wore non-skid footwear when walking, keeping needed items within reach and anticipating her needs. Progress Notes and Post Fall assessments documented that Resident # 10 experienced falls as follows: a. On 7/14/18, a progress note entry documented staff assisted the resident assisted up into a wheelchair via mechanical lift and 2 staff. The resident had no injuries. The Post Fall Assessment documented the fall occurred at 10 AM and staff had last assisted the resident to use the bathroom at 7:30 AM. Staff documented sitting the resident at the nursing station with the nurse as the immediate intervention. The facility did not conduct root-cause analysis of the incident in order to prevent additional falls. b. On 7/16/18 at 6:39 AM, a note documented a certified nursing assistant (CNA) notified the nurse Resident #10 slipped out of her recliner chair and found sitting on her buttocks with her back to the chair. The resident did not receive injury. The Post Fall Assessment documented staff put	F 689		

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the resident's walker right next to her (she required the help of one with walking) and fastened her call light so it can't fall off (the resident had severely impaired memory and cognition).

c. On 8/28/18 at 6:59 PM, a progress note indicated Resident # 10 fell when her husband tried to help her to the recliner from wheelchair.

d. On 9/8/18 at 5:50 PM, a progress note indicated Resident # 10 fell in her room while her husband tried transferring her. Staff educated her husband not to transfer Resident # 10 and to ask for staff assistance (the second documented transfer by her husband). Resident # 10 incurred a 1 centimeter (cm) X 2 cm skin tear on the right lower leg.

e. On 9/12/18, an untimed progress note documented Resident # 10 fell in her room; found in front of the recliner. She stated she slid out of the chair. Staff assessment revealed no injury and they brought her out to the dining room so she could be watched. No documentation could be found regarding analysis of the fall causes and whether current interventions remained appropriate.

During interview on 9/18/18 at 9:07 AM, Resident #10's family member stated she fell when her husband tried to assist with transfers; the husband liked helping with cares and transfers.

During interview on 9/19/18 at 2:21 PM, the Director of Nursing (DON) reported that all of Resident # 10's falls occurred when Resident # 10's husband tried transferring her either from recliner to chair or chair to recliner (the

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F 689	Continued From page 31 documentation identified family transfers occurred with 2 of the 5 falls listed above). The DON further stated she could not prevent what respective family members want to do with residents. However, the DON also acknowledged that it was facility's responsibility to provide safe cares for all residents.	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 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	F 690		

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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 clinical record review, observation, staff interview and facility policy review, the facility failed to utilize proper infection control techniques during catheter care for 2 out of 2 residents reviewed with indwelling catheters (#27, #12). The facility reported a census of 49 residents.

Findings include:

1. A Minimum Data Set (MDS) assessment dated 7/23/18 for Resident #27 listed diagnoses of paraplegia, urinary tract infection in the last 30 days and obstructive uropathy (obstruction of the urinary system). The MDS identified the resident required the assistance of two staff for bed mobility and transfers and the assistance of one staff for toileting and personal hygiene. The MDS documented the resident was frequently incontinent of bowels and had an indwelling catheter for urinary elimination. A Brief Interview for Mental Status (BIMS) scored 12 which indicated mild cognitive impairment for decision making.

During an observation of morning cares/catheter care on 9/19/18 at 9:45 AM, by Staff F, Certified Nurse's Aide (CNA), she washed her hands, donned gloves and cleansed down both leg creases and across abdomen, down central pubic area front to back motion, turning cloth to clean area with each wipe. The CNA then cleansed the

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central urethral area using the same area of the washcloth for two wipes near urethral opening and catheter insertion point. The resident was rolled to the right hip, left buttock was cleansed with one wipe, and buttocks crease one wipe, front to back motion, CNA turning the wash cloth with each wipe. Wearing the same gloves, the CNA placed a clean incontinence product under the resident and rolled the resident to the left hip to pull the incontinence brief the rest of the way under the buttocks. Staff F did not cleanse the right buttock. The CNA removed her gloves, washed hands, donned new gloves. Staff F picked up a used washcloth out of the "dirty" bag and washed the catheter tubing from the urethra to the connection port of the bedside bag. Wearing the same gloves, she disconnected the bedside bag, cleaned the connection port with an alcohol swab and connected the leg bag to the catheter tubing, then secured the leg bag to the resident's upper thigh. Staff F took the bedside catheter bag to the resident's bathroom, emptied it into the toilet and flushed the bag with water directly from the faucet without using a cup other device to pour the water in. The bedside bag was placed in a trash bag to store in the bathroom. The CNA removed her gloves, flushed the toilet, washed hands, donned gloves and returned to the bedside to complete cares. The resident washed her face and armpits and applied deodorant independently. Staff F assisted the resident to get a shirt on and placed a lift sling under the resident. The CNA gathered trash and dirty linen and left to get a mechanical lift and another person to assist with transfer. She returned with the Director of Nursing (DON) and a lift. The DON and CNA washed their hands and donned gloves. The resident was transferred to the wheelchair. The resident completed oral care

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F 690	Continued From page 34 and hair brushing independently. The DON pushed the lift out into the hallway and returned to wash her hands. The CNA washed her hands and both exited the room. During an interview with Staff F on 9/19/18 at 10:15 a.m., she stated she goes by the markings on the catheter bag for measurement of urine output instead of using a graduate to empty the catheter. A review of the clinical records reveals Resident #27 has been treated for urinary tract infections in December 2017, February 2018, March 2018, July 2018 and September 2018. All urinary tract infections except for February were caused by Escherichia coli (bacteria found in intestinal tract and stools) and Klebsiella pneumonae (bacteria found in the intestines). In February the resident received treatment for a urinary tract infection caused by Escherichia coli and Streptococcus salivarius (bacteria commonly found in human mouth and intestinal tract). A review of the care plan with a revision date of 12/1/16, documented the resident has a self care performance deficit related to paraplegia. Interventions identified she has a Foley catheter and directed to empty the bag every shift and as needed, provide catheter cares every shift and as needed, the resident is incontinent of bowel and provide perineal care after each incontinent episode and as needed. 2. The MDS assessment dated 6/25/18 for Resident #12 listed diagnoses of morbid obesity and diabetes mellitus. The MDS identified the resident required extensive assistance of two staff for bed mobility, transfers, toileting and	F 690		

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F 690	Continued From page 35	F 690		

personal hygiene. The MDS documented the resident was continent of bowels and has an indwelling catheter for urinary elimination. The resident had a Brief Interview for Mental Status (BIMS) score of 14 which indicated no cognitive impairment.

During an observation of morning cares on 9/19/18 from 10:25 A.M. to 11:00 A.M. Staff F washed her hands, donned gloves. The resident removed her own gown. Staff F washed the resident's upper body, removed her gloves, washed hands, donned new gloves. The resident put her own shirt on. The CNA applied slacks and edema wear to bilateral lower legs, removed gloves, washed hands. Donned gloves, cleansed under abdominal fold, down both leg creases and down central pubic area using a front to back motion and turning the cloth to a clean area with each wipe. The CNA did not secure the catheter tubing near urethra as she cleansed down the tubing with a washcloth, causing the catheter tubing to be pulled taut as she wiped downward. Wearing the same gloves, the CNA unhooked the catheter bag from the bed side, slid it through the pant leg and hung it back on the bedside. The resident rolled to the right hip, and Staff F cleansed the ischial folds and made one swipe up the buttocks crease. Continuing with the same gloves on, she pulled the resident's slacks up onto the left hip and rolled the resident back onto a visibly soiled comply pad lying underneath her. Still wearing the same gloves from providing perineal care, the CNA touched an afghan, a comforter and a sheet while looking for a lift sling. The CNA returned to the bedside, completed pulling up the resident's slacks onto the right hip, gathered the trash and linen, removed her gloves and exited the room to get a sling, a lift and

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F 690	Continued From page 36 second person to assist her with the transfer. The CNA returned with a lift sling, a mechanical lift and the Director of Nursing (DON) to assist her. Staff F, emptied the bedside catheter urine collection bag, using a barrier under the graduate on the floor, and cleaned the catheter port with alcohol. Staff F dumped the graduate in the toilet and rinsed it with water. Placed the graduate in a trash bag in bathroom to store. The CNA removed her gloves, washed her hands and donned gloves. Transferred resident from the bed to the recliner with the DON's assistance. A review of the clinical record reveals resident has been treated for urinary tract infections in July 2018 and August 2018. Bacteria present both times were klebsiella pneumoniae and proteus mirabilis. The resident was hospitalized 7/5/18 to 7/10/18 with diagnosis of urinary tract infection and elevated white blood count (usually indicates an infectious process in progress). A review of the care plan, with a revision date of 3/29/18, a focus area identifies that resident has an indwelling catheter and a goal is to have no urinary tract infections with a target date of 9/20/18. The care plan also identifies the resident requires extensive assistance of two staff for personal hygiene. Review of a document labeled Nursing Procedure Manual-Catheter Care with a date of 1/13, it states the purpose of catheter care is to provide safe and proper care of resident/patient with an indwelling catheter by evaluating elimination status, minimizing risk of bladder infection, and maintaining skin integrity. Steps included in the provision of catheter care are to hold and support catheter to avoid traction or unnecessary	F 690		

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F 690	Continued From page 37 movement and to gently cleanse the urethral/catheter juncture. During an interview with the DON on 9/19/18 at 11:00 A.M. , The DON stated staff are taught to change gloves and wash hands when going from dirty areas to areas that are considered "clean" and they are taught to complete catheter care by cleaning "away" from the body. The DON stated the CNA's are audited at least annually on their competency skills and both she and the Assistant Director of Nursing (ADON) frequently work the floor alongside the CNA's so are continuously auditing them that way. The DON acknowledged the soiled comply pad should have been removed from under the resident prior to being rolled back over with clean clothes on. The DON stated this resident should be a two-person always for hygiene needs. (Res. is morbidly obese). The DON stated they usually have two CNA's assigned to the 500 hall but they had a CNA not show up today and had to assign two of the three CNA's to the 300 hall for a shower that takes two hours to complete. Stated she called for an agency nurse at 6:30 a.m. but did not get any sent here as it was too late when she called. The DON stated facility nursing staff are taught to wash resident's from front to back and the difference in clean vs. dirty areas. During an interview with Staff F on 9/20/18 at 11:30 a.m. , she stated she has been taught to change gloves and wash hands after going from a "dirty" area to a "clean" area on resident. States she was taught to wash catheter tubing from the point of entry downward. Acknowledged she was aware of the need to rotate the washcloth or incontinence wipe to a clean area with each wipe to cleanse resident.	F 690		

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F 730 SS=D	Nurse Aide Peform Review-12 hr/yr In-Service CFR(s): 483.35(d)(7) §483.35(d)(7) Regular in-service education. The facility must complete a performance review of every nurse aide at least once every 12 months, and must provide regular in-service education based on the outcome of these reviews. In-service training must comply with the requirements of §483.95(g). This REQUIREMENT is not met as evidenced by: Based on facility document reviews and staff interview, the facility failed to ensure completion of required competency in-service trainings for 3 of 3 certified nursing assistants reviewed (Staff F, Staff K, and Staff L). The facility defied a census of 49 residents. Findings include: Review of the facility's In-Service Calendar indicated staff completion of 2-3 topics each month with at least 30-minute time, unless otherwise indicated. The calendar listed planned topics for each month. The calendar also directed Certified Nurse Aides (CNAs) to receive a minimum of 12 hours of in-service education annually and documentation of attendance. The facility's documentation of in-service trainings (In-Service/Training form) for the last 12 months requested (September 2017 through August 2018), revealed that the facility conducted in-service trainings for 6 topics as follows: My Innerview/Safe Lifting Techniques and Resident Transfers (7/24/18), Nursing Expectations/Roles, Pain Management and Comfort Promotion (8/15/17), Prevention Skin Care & Wound Care, Prevention of Pressure Ulcers (10/5/17),	F 730		

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F 730	Continued From page 39 Restorative Program, Infusion Pump from Omnicare, Residents' Rights, Customer Service, Wash Clothes, Needle Sticks (2/27/18), Bloodborne Pathogens, OSHA, MDS, Linens, HIPPA/Social Media, Briefs in Laundry, VS When Skilled, Wash Clothes/Air tanks shut off, Needle Sticks, Handwashing (3/22/18), Dealing with Residents Behaviors (5/30/18). These in-service trainings were completed for total of 4 hours. Review of employee records and training for CNAs showed the following: 1. Staff F's employment profile showed a hire date of 12/29/86. The in-service training records for 12 months showed that Staff F completed 4 hours for the above-listed topics conducted. 2. Staff K's employment profile showed hire date of 7/14/16. The in-service training records for 12 months showed that completed 1 hour for 1 topic. 3. Staff L's employment profile showed hire date of 12/29/86. The in-service training records for 12 months showed that completed 1.5 hours for 2 topics. On 9/19/18 at 1:42 PM, the Director of Nursing (DON) verified that there had only been 4 hours of in-service trainings conducted at the facility, and also verified the lack of trainings for the above-named CNAs. The DON stated expectations for nurse aides to complete a minimum of 12 hours annual in-service trainings.	F 730		
F 758 SS=B	Free from Unnec Psychotropic Meds/PRN Use CFR(s): 483.45(c)(3)(e)(1)-(5) §483.45(e) Psychotropic Drugs.	F 758		

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(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 758	Continued From page 40 §483.45(c)(3) A psychotropic drug is any drug that affects brain activities associated with mental processes and behavior. These drugs include, but are not limited to, drugs in the following categories: (i) Anti-psychotic; (ii) Anti-depressant; (iii) Anti-anxiety; and (iv) Hypnotic Based on a comprehensive assessment of a resident, the facility must ensure that--- §483.45(e)(1) Residents who have not used psychotropic drugs are not given these drugs unless the medication is necessary to treat a specific condition as diagnosed and documented in the clinical record; §483.45(e)(2) Residents who use psychotropic drugs receive gradual dose reductions, and behavioral interventions, unless clinically contraindicated, in an effort to discontinue these drugs; §483.45(e)(3) Residents do not receive psychotropic drugs pursuant to a PRN order unless that medication is necessary to treat a diagnosed specific condition that is documented in the clinical record; and §483.45(e)(4) PRN orders for psychotropic drugs are limited to 14 days. Except as provided in §483.45(e)(5), if the attending physician or prescribing practitioner believes that it is appropriate for the PRN order to be extended beyond 14 days, he or she should document their rationale in the resident's medical record and	F 758		

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F 758	Continued From page 41 indicate the duration for the PRN order. §483.45(e)(5) PRN orders for anti-psychotic drugs are limited to 14 days and cannot be renewed unless the attending physician or prescribing practitioner evaluates the resident for the appropriateness of that medication. This REQUIREMENT is not met as evidenced by: Based on clinical record review and staff interview, the facility failed to assure as needed (prn) psychotropic medications were only ordered for 14 days unless the physician wrote a rationale for continuing the medication for 2 of 5 residents reviewed (Residents #38 & #10). The facility reported a census of 49 residents. Findings include: 1. According to the Minimum Data Set (MDS) assessment dated 8/10/18, Resident #38 scored 11 on the Brief Interview for Mental Status (BIMS) indicating moderate cognitive impairment. Resident #38's diagnoses included depression, post traumatic stress disorder and insomnia due to a medical condition. The Order Summary Report for Resident #38 showed Temazepam (sedative-hypnotic) capsule 15 mg give one capsule by mouth as needed for insomnia at bedtime ordered 7/27/18 with no end date. The Medication Administration Record (MAR) for the months of July and August 2018 showed PRN Temazepam ordered on 7/27/18 and discontinued on 8/27/18. The resident did not receive the medication from 7/27 to 8/27/18 according the MAR.	F 758		

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F 758	Continued From page 42 The Pharmacy Consultation Report dated 8/23/18 recorded the resident had PRN order for sedative hypnotic which has been in place for greater than 14 days without a stop date and to discontinue PRN Temazepam. Medical provider accepted pharmacist recommendation to discontinue PRN Temazepam 8/27/18. During interview with Director of Nursing (DON) on 9/19/18 at 9:30 AM, she confirmed Resident #38 had an order for PRN Temazepam in place from 7/27/18 until 8/27/18 without a stop date. 2. The MDS assessment dated 6/19/18 documented Resident #10 had a BIMS score of 4, indicating severe cognitive impairment. The Order Summary Report (OSR) printed on 9/19/18, showed Resident # 10 had an order for anti-anxiety medication, Lorazepam tablet 0.5 milligrams (mg) by mouth as needed for increased anxiety, with an order and start date of 6/30/18. Review of consultant pharmacist's Consultation Report dated 8/23/18 documented Resident # 10 had an order for an anxiolytic, Ativan 0.5 mg by mouth (PO) every 4-6 hours PRN, which had been in place for longer than 14 days without a stop date. The Consultation Report recommended the prescriber document the indication for use, duration for therapy and rationale for the extended time period. The physician's response declined the recommendation and offered the rationale of psychoses [sic], no dose reduction or discontinuation and signed on 8/27/18. There lacked duration of therapy and reason for the	F 758		

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F 758	Continued From page 43 continuation of use. On 9/18/18 at 9:30 AM, the Assistant DON (ADON) verified she wrote a comment 'last PRN dose 7/13, please discontinue' on the same pharmacy Consultation Report form dated 8/23/18, in reference to the Ativan 0.5 mg PRN medication. The ADON stated she wrote the comment with the intent to inform the physician that Resident # 10 did not need and had not used the medication for a long time. The ADON also reported that Resident # 10 only used the Ativan PRN medication once (7/13/18) since 6/30/18. The facility's policy number 9.1, titled, Medication Regimen Review (MRR), dated 12/1/07, showed under procedure # 7 the facility the physician/prescriber or other responsible parties and the DON to act upon the recommendations contained in the MRR. The procedure also directed facility to encourage physician/prescriber to provide an explanation for recommendations rejected.	F 758		
F 812 SS=E	Food Procurement,Store/Prepare/Serve-Sanitary CFR(s): 483.60(i)(1)(2) §483.60(i) Food safety requirements. The facility must - §483.60(i)(1) - Procure food from sources approved or considered satisfactory by federal, state or local authorities. (i) This may include food items obtained directly from local producers, subject to applicable State 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	F 812		

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F 812	Continued From page 44 safe growing and food-handling practices. (iii) This provision does not preclude residents from consuming foods not procured by the facility. §483.60(i)(2) - Store, prepare, distribute and serve food in accordance with professional standards for food service safety. This REQUIREMENT is not met as evidenced by: Based on observation, staff interview and facility policy review, the facility failed to maintain the overhead exhaust fans and ice machine in a clean and sanitary condition. The facility reported a census of 49. Findings include: Observation on 9/17/18 at 11:23 AM showed a large amount of dust build up on exhaust fans above the food preparation table. Observation on 9/17/18 at 11:55 showed the ice machine with a large amount of mineral deposits on the grate, delivery chute and plastic shroud behind the delivery chute. Entire area around ice delivery chute is white in color. Observation on 9/19/18 at 10:05 AM showed exhaust fans above the food preparation table continued to have a large amount of dust build up and the ice machine continued to show a large amount of mineral deposits on grate, delivery chute and shroud behind the delivery chute. The Facility Preventative Maintenance work history report documented staff conducted preventative maintenance on the exhaust fans via inspection and cleaning last on 8/31/18. The ice machine's preventative maintenance documented	F 812		

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F 812	Continued From page 45 for 8/31/18 included to de-lime as necessary. In an interview on 9/19/18 at 10:10 AM, the Administrator stated the ice machine should not have lime buildup and should be cleaned or have the plastic and rack replaced if it could not be cleaned. Th Administrator confirmed the large amount of dust build up on the exhaust fans in the kitchen and stated it should be cleaned. On 9/20/18 at 6:50 AM, the Administrator stated he has no policy to address how often to do preventative maintenance other than the computerized preventative maintenance program.	F 812		
F 838 SS=D	Facility Assessment CFR(s): 483.70(e)(1)-(3) §483.70(e) Facility assessment. The facility must conduct and document a facility-wide assessment to determine what resources are necessary to care for its residents competently during both day-to-day operations and emergencies. The facility must review and update that assessment, as necessary, and at least annually. The facility must also review and update this assessment whenever there is, or the facility plans for, any change that would require a substantial modification to any part of this assessment. The facility assessment must address or include: §483.70(e)(1) The facility's resident population, including, but not limited to, (i) Both the number of residents and the facility's resident capacity; (ii) The care required by the resident population considering the types of diseases, conditions, physical and cognitive disabilities, overall acuity,	F 838		

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F 838	Continued From page 46 and other pertinent facts that are present within that population; (iii) The staff competencies that are necessary to provide the level and types of care needed for the resident population; (iv) The physical environment, equipment, services, and other physical plant considerations that are necessary to care for this population; and (v) Any ethnic, cultural, or religious factors that may potentially affect the care provided by the facility, including, but not limited to, activities and food and nutrition services. §483.70(e)(2) The facility's resources, including but not limited to, (i) All buildings and/or other physical structures and vehicles; (ii) Equipment (medical and non- medical); (iii) Services provided, such as physical therapy, pharmacy, and specific rehabilitation therapies; (iv) All personnel, including managers, staff (both employees and those who provide services under contract), and volunteers, as well as their education and/or training and any competencies related to resident care; (v) Contracts, memorandums of understanding, or other agreements with third parties to provide services or equipment to the facility during both normal operations and emergencies; and (vi) Health information technology resources, such as systems for electronically managing patient records and electronically sharing information with other organizations. §483.70(e)(3) A facility-based and community-based risk assessment, utilizing an all-hazards approach. This REQUIREMENT is not met as evidenced by:	F 838		

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F 838	Continued From page 47 Based on facility document reviews and staff interview, the facility failed to conduct a facility assessment in order to determine appropriate and necessary resources to meet the needs of residents placed under its care. The facility identified a census of 49 residents. Findings include: During the entrance conference on 9/17/18 at 10:30 AM, the team requested documentation of facility assessment from the Administrator. Review of the facility's Quality Assurance and Performance Improvement (QAPI) policy, dated 2/15, and QAPI plan documentation lacked information to indicate staff completed of a facility-wide assessment and where action plans or projects should be based on that facility assessment. During interview on 9/19/18 at 3:04 PM, the Administrator reported that he just found out the facility did not conduct a facility-wide assessment and they could not provide documentation. On 9/20/18 at 10:08 AM, the Administrator acknowledged the need to conduct the facility-wide assessment in the soonest time possible time.	F 838		
F 881 SS=D	Antibiotic Stewardship Program CFR(s): 483.80(a)(3) §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:	F 881		

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F 881	Continued From page 48 §483.80(a)(3) An antibiotic stewardship program that includes antibiotic use protocols and a system to monitor antibiotic use. This REQUIREMENT is not met as evidenced by: Based on facility document review and staff interview, the facility failed to ensure implementation of antibiotic stewardship program. The facility identified a census of 49 residents. Findings include: The facility policy titled, Antibiotic Stewardship, dated 3/2017 directed and identified the individuals accountable for the antibiotic stewardship activities included the Medical Director, Director of Nursing (DON), consultant Pharmacist, and an Infection preventionist. The procedure instructed that the antibiotic stewardship activities will be supported by the facility administrative team. On 9/20/18 at 8:25 AM, the DON and Assistant ADON stated the facility did not implement the antibiotic stewardship policy. The DON stated that the doctor will order antibiotics when the residents ask for it. The ADON stated that in June, the facility treated 4 residents with antibiotics even though they really did not have urinary tract infections. The ADON also reported that residents would be started on antibiotics once they complain or report symptoms of urinary tract infections (UTI) to physicians during rounds. The facility's infection log (Monthly Line Listing Report) for the last 3 months showed the following: for the month of 6/18, there 9 infection cases without culture results and all treated with antibiotics including 4 cases of UTI, there were no	F 881		

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F 881	Continued From page 49 infections logged for the month of 7/18, and for the month of 8/18, all 9 infection cases were started and treated with antibiotics before culture results were in, including 5 UTIs. The facility's Annual Nosocomial Infection Rate Summary, indicated a total of 4 infection cases and 0 UTI for 6/18, even though there were 9 infection cases treated with antibiotics as documented in the infection log above and for 8/18, there were 6 infection cases where only one was UTI, even though 9 cases were treated with antibiotics as recorded in the infection log above. The ADON stated on 9/20/18 at 8:25 AM, she did not count or include in the report UTI cases where culture results came back as negative. On 9/20/18 at 9:06 AM, the Administrator acknowledged that the facility Quality Assurance(QA) committee did not talk about antibiotic stewardship and stated plan to get everybody on board about implementing the program.	F 881		
F 925 SS=D	Maintains Effective Pest Control Program CFR(s): 483.90(i)(4) §483.90(i)(4) Maintain an effective pest control program so that the facility is free of pests and rodents. This REQUIREMENT is not met as evidenced by: Based on clinical record review, observation and resident and staff interviews, the facility failed to maintain an effective pest control program so that the facility is free of pests and rodents. The facility identified a census of 49 residents. Findings include:	F 925		

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F 925	Continued From page 50 1. A Minimum Data Set (MDS) assessment dated 8/6/18 assessed Resident # 33 with a brief interview for mental status (BIMS) score of 14 (no cognitive or memory impairment). The resident showed independence with transfers and ambulation. He required limited staff assistance with dressing, supervision with toileting and personal hygiene and extensive assistance with bathing. He was occasionally incontinent of bowel. Observation on 9/17/18 at 10:33 a.m. showed the resident laying in bed. The resident denied a problem with bugs. However, observation revealed at least 5 flies buzzing the resident and his roommate. An open large Styrofoam glass sat on the resident's bedside table filled with a red substance that the resident identified as juice. A large black bag and smaller white bag of empty pop cans sat in the room. On 9/17/18 at 1:22 p.m. Staff E RN (Registered Nurse) stated maybe a month ago she thought she observed a cock roach in the room but it moved so fast, she wasn't sure. 2. The MDS assessment dated 7/29/18 assessed Resident # 28 with a BIMS score of 15 (no cognitive or memory impairment) On 9/18/18 at 8:10 a.m. the resident stated the flies bother her because they keep coming around her face. She stated the fly issue had been going on most of the summer. 3. The MDS of 7/23/18 documented Resident #27 had a BIMS score of 12 (moderate cognitive and memory impairment).	F 925		

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F 925	Continued From page 51 On 9/17/18 at 10:47 a.m. Resident #27 stated yesterday, she had 2 big spiders and a worm in her room. She screamed and a staff heard her and killed one of the spiders and the worm.	F 925		

F-557 Respect, Dignity/Right to have personal property

No immediate action possible.

Staff in-serviced on 10/5/18 related to Resident Right's including Respect and Dignity by DON/Administrator.

Resident Right's are reviewed with staff upon hire and annually.

Activity Director will review Resident Right's related to Dignity and respect during resident council monthly x3 months. Administrator will review Guardian Angel rounds at least 5 times a week on ongoing basis, related to respect and dignity.

Activity coordinator will report finding of the above monitoring systems to facility Quality Assurance program monthly x3 months.

Then review/assess for need to continue. The plan will reviewed and revised as indicated and staff will be re-educated as needed.

F567

Weekend RTA Policy to be written in accordance with F567 and put into place by 10/20/2018.

Administrator to conduct weekly audits for 8 weeks to ensure resident access to personal funds are available on the weekend in accordance with F567.

F584

Hallway white ceiling tiles outside rooms 510, 512, 514, 516, 306, and hallway 500 charting station were replaced on 10/03/2018.

Environmental services to do daily walkthrough of facility to monitor for any yellowing ceiling tiles which will be replaced upon identification.

To prevent re-occurrence ceiling tiles will be added to a monthly PM schedule to ensure no leaks or discoloration.

Administrator to perform weekly audits of ceiling tiles weekly for 8 weeks to ensure compliance with F584. The results of these audits to be reviewed during QAPI committee meeting for 90 days.

The return air vents across from 300 and 400 hall charting station were cleaned of all dirt and dust buildup on 10/05/2018.

Air vents have been added to weekly PM schedule to prevent re-occurrence.

Administrator to perform weekly audits of ceiling tiles weekly for 8 weeks to ensure compliance with F584. The results of these audits to be reviewed during QAPI committee meeting for 90 days.

F623

On 9/19/2018, The administrator provided a list of 30 day's worth of discharges to the office of the state long term care ombudsman and will continue to do so monthly.

On 10/12/2018, the Regional Clinical Nurse Consultant provided in-service/education to the facility Department Supervisors, related to the requirements and expectations of providing notice of resident transfers to the office of the State Long Term Care Ombudsman on a monthly basis and notice to the same office immediately upon a forced discharge.

Administrator or designee will be responsible for notification of resident transfers and discharges to the Ombudsman office monthly.

The Administrator will monitor monthly to ensure continued compliance for of monthly ombudsman notification of discharges.

The administrator or designee will report findings of the above monitoring systems monthly times 3 months through the facility Quality Assurance Program, then review/assess for need to continue. The plan will be reviewed and revised as indicated and staff will be re-educated as needed.

F625 Notice of bed hold policy before/upon transfer

No immediate action possible for resident's number 36 and 38 due to is historical.

Any resident's of the facility can be affected.

On 10/9/18 the Regional Clinical Nurse Consultant provided in-service/education to the facility Department Supervisors, related to the requirements and expectations of providing bed hold notice policy to the resident or resident representative upon transfer to the hospital.

The Director of Nursing will review hospital transfers at least 5 days a week to ensure that the bed hold policy was provided to the resident and/or resident's representative upon transfer. If it is identified by the Director of Nursing that the bed hold was not provided due to unforeseen circumstances, she will ensure the bed hold notice is provided within 24 hours.

The Director of Nursing and/or designee will report finding of the above monitoring system monthly times 3 months to the facility Quality Assurance Program. Then review/assess for need to continue. The plan will reviewed and revised as indicated and staff will be re-educated as needed.

F-644 Coordination of PASARR and assessments

Resident #8- New PASSAR being submitted for review.

Resident #38- Careplan will be updated to include PASSAR identified specialized services.

Resident #10- Careplan will be updated to include start date/frequency and duration of services.

Resident #35- Careplan will be updated to include start date/frequency and duration of services.

Director of Nursing/Designee will complete audit of current resident's of facility to identify those who have Level II PASSAR's.

Director of Nursing will review careplans of current resident's who were identified by previous audit for Level II PASSAR discrepancies, correction and completion.

DON/Designee will monitor careplans and MDS weekly for 3 months for completeness of PASSAR recommendations to ensure continuous compliance for Resident #8, 38,10,and 35 and other like resident's of the facility.

Director of Nursing will report finding of above monitoring system monthly for 3 months through the facility Quality Assurance program, then review the need for continuation of plan. Review and revise as indicated.

F655 Baseline Care plan

Immediate action not possible due to it is historical.

New admission resident's could be affected.

On October 9, 2018 the Regional Nurse Consultant provided in-service to Director of Nursing, Administrator and Department Supervisors related to the requirements and expectations of providing the resident and their representative with a summary of the baseline care plan.

The Director of Nursing will educate/explain the requirements and expectations of providing the resident and/or their representative with a summary of the baseline care plan within 72 hours of admit.

The Director of Nursing or designee will follow up 48 hours after each new admission to verify that the baseline care plan is completed and that the summary is scheduled to be provided to the resident and/or their representative within 72 hours of admission. This will continue on and ongoing basis to ensure that resident 38 and other newly admitted resident's receive the baseline care plan summary timely.

The Director of Nursing or designee will report findings of the above monitoring systems monthly times 3 months through the facility Quality Assurance Program, then review/assess the need to continue. The plan will be reviewed and revised as indicated and staff will be re-educated as needed.

F 657 Care Plan Timing and Revision

On 10/8/18 Director of Nursing updated Resident #4 care plan to reflect current toileting needs.

Current resident's could be affected.

The Director of Nursing/Designee will initiate a system to review and revise care plans of current resident's by 10/15/18. System will continue over the next 90 days to ensure continuous compliance for resident #4 and other resident's of the facility.

Director of Nursing/Designee will report findings of above monitoring system monthly for 3 months through the facilities Quality Assurance program. The team will review and asses the need for continuance.

The plan will be reviewed and revised as indicated and staff re-educated as needed.

F 658 Professional Standards

On 9/20/18 the DON did a coaching with staff E RN related to the requirements and expectations of medication administration, including that medications are to be signed out directly after administering them.

Current residents can be affected.

The DON or designee will complete medication pass observations of the licensed nurses and medication aides 2 times weekly for 6 weeks, to verify that medications are administered and signed out directly afterward, to ensure compliance for resident #150, 25, 23 and other residents of the facility.

The Director of Nursing and or designee will report findings of above monitoring system(s) monthly times three months through the facility Quality Assurance Program, then review/assess for need to continue. The plan will be reviewed and revised as indicated and staff will be re-educated as needed.

F 677 ADL Care provided for Dependent Residents

No immediate action possible

Current resident's can be affected.

Director of Nursing/Designee will complete audit related to bathing preferences 5 times a week to identify other resident's who might not want to receive showers as scheduled. Nurse aides will offer shower 2 times during their shift and if resident continues to refuse then the Charge Nurse will interview the resident for reason of denial or ask if shower can be rescheduled per resident wishes. Charge Nurse is then to document in resident chart if resident continues to refuse.

Audit on bathing will be completed 5 times a week during morning clinical meeting.

All findings of audit will be discussed at Quality Assurance meeting and staff re-educated as needed.

F684 Quality of Care

No immediate action possible for resident #48 due to historical.

Current resident's can be affected

Any resident of the facility that has order for antibiotic whether written or verbal will have it initiated within the time frame of standard of practice.

Director of Nursing/Designee will review orders every morning in clinical meeting 5 times week for continuous compliance for current resident's of the facility.

Director of Nursing/Designee will report findings of audit to facility Quality Assurance program for compliance monthly for 3 months. Then review and asses for need to continue. The plan will be reviewed and revised as indicated. Staff will re-educated as needed.

F 689 Free of Accident Hazards/Supervision/Devices

Resident #10 care plan updated with appropriate interventions to prevent falls.

Current resident's can be affected.

Director of Nursing and clinical team will review falls 5 days week on an ongoing basis during clinical meeting to collect and organize the facts surrounding the fall to help facilitate methods in placing interventions on care plan that are a realistic goal for the resident for prevention of further falls.

Findings of above monitoring systems will be reported by Director of Nursing/Designee through the facility Quality Assurance program monthly x 3 months. Review/assess need to continue. The plan will be reviewed and revised as indicted and staff will be re-educated as needed.

F690 Catheter Care

On 9/20/18 The Director of Nursing did a coaching with staff related to Policy and Procedure for catheter care.

Resident's with indwelling catheter's can be affected.

The Director of Nursing will provide education/reminders to the staff by 10/15/18 related to policy and procedure for catheter care.

The Director of Nursing/Designee will observe provision of catheter care by 3 random nursing staff members weekly times 6 weeks. The Director of Nursing/Designee will initiate on 10/15/18 and complete competency checks for catheter care on current CNA's by October 31, 2018.

The Director of Nursing/Designee will report findings to above monitoring system monthly times 3 months through the facility Quality Assurance program, then review/assess for need to continue. The plan will be reviewed and revised as indicated and staff will be re-educated as needed.

F-730 Nurse Aide Performance Review/12 hour per year

No immediate action possible.

The Administrator will provide in-service to CNA's related to requirement and expectations for 12 in-service hours annually provided by the facility.

The Administrator/Designee will devise a system to track in-service hours on all certified nursing assistants to ensure requirements are met.

Administrator will report finding of above monitoring system to facilities Quality Assurance program.

F-758 Free from Unnec Psychotropic Meds/PRN Use

On August 27th, 2018 resident #38 PRN psychotropic medication was discontinued due to non-use. On 9/20/18 resident #10 PRN psychotropic was discontinued due to non-use.

Current resident's who receive PRN psychotropic medications can be affected.

Director of Nursing/Designee will review medication orders every morning in clinical meeting 5 times/week to ensure continuous compliance for resident's who receive PRN psychotropic medication. Nursing staff will be in-serviced on 10/16/18 on the regulatory rules and expectations that PRN psychotropic medications are limited to 14 days.

Director of Nursing/Designee will report findings of above monitoring system to facility Quality Assurance program for 3 months. Review/assess need to continue. Re-educate staff as needed.

F812

Exhaust fans above food preparation table were cleaned on 10/05/2018.

Exhaust fans in kitchen will be placed on a weekly PM schedule to prevent re-occurrence. Administrator to perform weekly audits of kitchen exhaust fans weekly for 8 weeks to ensure compliance with F812. The results of these audits to be reviewed during QAPI committee meeting for 90 days.

Lime remover ordered on 10/10/2018 to remove all mineral deposits on the grate, delivery chute, and plastic shroud behind the delivery chute.

All mineral deposit to be removed from ice machine to comply with F812 by November 15th, 2018.

Ice machine de-liming and cleaning to be added to monthly PM schedule to prevent re-occurrence.

Administrator to perform weekly audits of ice machine weekly for 8 weeks to ensure compliance with F812. The results of these audits to be reviewed during QAPI committee meeting for 90 days.

F838

Administrator and IDT to meet weekly to develop a plan to complete the Facility Assessment by 10/20/18. Facility will complete the Facility Assessment by 11/25/2018. Upon completion, facility assessment to be reviewed at QAPI Committee meetings for 90 days to ensure complete and up-to-date. Administrator to review/revise facility assessment annually thereafter.

F 881 Antibiotic Stewardship

The Regional Nurse Consultant in-serviced DON and ADON related to the Antibiotic Stewardship program.

Current resident's of the facility have the potential of being affected.

October 16th, 2018, the DON/Designee will provide in-service education related to antibiotic use, which will include the McGeers criteria and communication with the physician.

DON/Designee will review physician orders, 5 days a week, to review any new antibiotic orders, review antibiotic logs to verify the antibiotic has been logged or filled and completed as required and to verify criteria has been met.

DON/Designee is to report findings of the above to the facility Quality Assurance program monthly times 3 months then review and assess for need to continue. The plan will be reviewed and revised as indicated and staff will be re-educated as needed.

F925

On 9/19/2018, Ecolab pest control spray resident rooms #33, #28, and #27 for pests. On 10/12/2018, Resident #33 was educated not keep empty pop cans in his room and provided a space outside facility.

On 10/16/2018, an all staff in-service will be held and staff will be educated on facility's Pest Control Policy. Facility to monitor presence of pests at least 5 days a week and notify Environmental Supervisor. Ecolab pest control to visit and spray for pests and monthly log of visits to be kept.

Administrator to perform weekly audits of Pest Control Log to ensure timely visit are completed for 8 weeks to ensure compliance with F925. The results of these audits to be reviewed during QAPI committee meeting for 90 days.

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
	IA0445	A. BUILDING: _____ B. WING _____	09/20/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ELMWOOD CARE CENTRE	222 NORTH 15TH STREET ONAWA, IA 51040

(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
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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 facility record review and staff interview, the facility failed to ensure submission of residents to the Iowa Department of Veterans Affairs (V.A.) for potential benefits eligibility for 2 of 14 residents reviewed who had been admitted to the facility in the past year (Residents #503 and Resident # 38). The facility reported a census of 49 residents. Findings include: The facility reported a total of 88 residents admitted from 9/1/17 to 9/19/18, where 22 residents had been submitted to the VA for benefits eligibility. Seven random resident reviews revealed the facility screened Resident # 503 on 11/7/17 and determined the resident was a veteran's spouse. A second set of seven random resident reviews showed that the facility screened and determined that Resident # 38 was a veteran, as documented in an undated Resident Eligibility VA form. The facility provided an Iowa Department of Veterans Affairs Resident Eligibility form that showed neither Resident # 503 nor Resident # 38 had been submitted to the VA for potential benefits eligibility. During an interview on 9/20/18 at 10:15 AM, the	L1093		

DEPARTMENT OF INSPECTIONS AND APPEALS

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L1093	Continued From page 2 Administrator verified the facility did not submit Resident # 503's and Resident # 38's names to the Veterans Affairs for possible eligibility for benefits.	L1093		

L1093

Resident #38 and Resident #50 are both discharged from facility.

All current residents were audited for veteran status on 10/12/2018, and positive responses for veteran status to be entered into the VA eligibility portal.

Veteran status to be asked on all new admissions and if a positive response is recorded, will be submitted to VA eligibility portal within 30 days.

All new admissions will be audited weekly by Administrator or designee for 8 weeks to ensure ongoing compliance with L1093. The results of these audits to be reviewed during QAPI committee meeting for 90 days.