STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	165579	A. BUILDING _____ B. WING _____	11/15/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MAQUOKETA CARE CENTER	1202 GERMAN STREET MAQUOKETA, IA 52060

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 000	INITIAL COMMENTS VKK 12/17/18 Correction date 11/16/18 The following deficiencies relate to the facility's annual health survey and the investigation of incident 79665. (See Code Federal Regulations (42CFR) Part 483. Subpart B-C).	F 000	Submission of this "plan of correction" is not a legal admission that a deficiency exists or that the "statement of deficiencies" was correctly cited and is not to be construed as an admission of interest against the facility, the administrator, or any employees, agents, or other individuals who draft or may be discussed in this "plan of correction". Preparation and Execution of this response and Plan of Correction constitutes Maquoketa Care Center's requirement to submit credible allegation of compliance, and does not constitute an admission or agreement by this provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. All deficiencies were addressed and system changes implemented immediately upon discovery. All will be corrected by 11.16.2018.	
F 656 SS=D	Develop/Implement Comprehensive Care Plan CFR(s): 483.21(b)(1) §483.21(b) Comprehensive Care Plans §483.21(b)(1) The facility must develop and implement a comprehensive person-centered care plan for each resident, consistent with the resident rights set forth at §483.10(c)(2) and §483.10(c)(3), that includes measurable objectives and timeframes to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment. The comprehensive care plan must describe the following - (i) The services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §483.24, §483.25 or §483.40; and (ii) Any services that would otherwise be required under §483.24, §483.25 or §483.40 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(c)(6). (iii) Any specialized services or specialized rehabilitative services the nursing facility will provide as a result of PASARR recommendations. If a facility disagrees with the findings of the PASARR, it must indicate its rationale in the resident's medical record. (iv)In consultation with the resident and the resident's representative(s)-	F 656		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Sharon Enlinger | TITLE: Administrator | (X6) DATE: 12/14/2018

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F 656	Continued From page 1 (A) The resident's goals for admission and desired outcomes. (B) The resident's preference and potential for future discharge. Facilities must document whether the resident's desire to return to the community was assessed and any referrals to local contact agencies and/or other appropriate entities, for this purpose. (C) Discharge plans in the comprehensive care plan, as appropriate, in accordance with the requirements set forth in paragraph (c) of this section. This REQUIREMENT is not met as evidenced by: Based on clinical record review, facility policy review, resident and staff interview, the facility failed to develop a comprehensive person-centered care plan for one of 14 residents related to a toileting program. (Resident #10) The facility census was 35 residents. Finding include: 1. The Minimum Data Set (MDS) assessment dated 10/26/18, documented Resident #10 had diagnoses of hip fracture, non-Alzheimer's dementia and depression and required extensive assistance for toileting and was incontinent of urine and continent of bowel. The plan of care dated 9/20/18, indicated the resident required assistance with activities of daily living related to a fall. The care plan did not address the toileting needs of the resident. The Certified Nurse Aide (CNA) Documentation Survey Report for August 2018, toilet use indicated the assistance level for the resident was to be independent the majority of the time. The	F 656	**F656 Develop and Implement Comprehensive Care Plan** Maquoketa Care Center will continue to develop and implement comprehensive person-centered care plans for each resident. Re-Education and review of Comprehensive Care plan policy was completed by members of care plan nursing team immediately upon discovery. Resident #10 care plan was updated upon discovery to reflect current status. There was no resident harm indicated at time of observation. There were no negative outcomes related to this alleged deficiency noted. Care plan nursing team completed comprehensive review of all other resident care plans to reflect current status. Toileting care plans are initiated upon admission, and reviewed during quarterly and annual review as well as at time of significant change for compliance to ensure current status continues to be reflected.	

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F 656	Continued From page 2 assistance level changed to extensive to total assist of 1 to 2 staff as of 8/29/18 when the resident returned from the hospital following a hip fracture. The resident remained that level of assistance till approximately 11/5/18 when the resident became assist of 1 staff with a front wheeled walker in the resident's room. The resident was now limited assistance of 1 staff for toileting. During interview on 11/13/18 at 3:28 p.m., the resident stated they had urinary tract infections (UTI's) at times, and had for a few years now. The resident stated staff help them to go to the bathroom when needed or they come and ask I need to go. During interview on 11/15/18 at 10:37 a.m., Staff C, CNA stated they assist the resident to the bathroom to use the toilet and the resident will do her own cares and staff will follow up with the resident. During interview on 11/15/18 at 1:09 p.m., Staff C, CNA reported they try to toilet the resident every 2 hours, which was a usual "rule of thumb" for staff to follow. Staff C stated the resident does use her call light when she needs to use the toilet. Staff C explained the resident does wear a brief, but was continent more times than not. During interview on 11/15/18 at 3:15 p.m., the Director of Nursing (DON) stated they would expect the care plan to include a toileting program and include offering the restroom to the resident at least every 2 hours. During interview on 11/15/18 at 4:32 p.m., the DON and the Nurse Consultant presented a page	F 656	**F656 Continued** Care plan team has implemented a Triple Check Method of physician order review. This Triple Check review is done by a Management RN who audits all orders to make sure that Plan of Care has been updated as warranted prior to filing in the patient record. Triple Check order noting audit will be completed by D.O.N. / A.D.O.N. weekly on random orders for a month to monitor improvement. Additional retraining and individual re-teaching will be used if necessary. Results of the audit will be shared with the physician and pharmacist at QAPI meeting and areas identified as concerns will continue to be monitored to ensure corrective actions have been taken.	

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F 656	Continued From page 3 from a care plan the resident that showed the resident had a toileting program when returned from the hospital on 8/29/18. The care plan presented at the time showed the resident to be an assist x 2 with Bed Side Commode toileting or assist of x 1 with bedpan before and after meals and at bedtime, and as needed when the resident requests. The care plan identified the resident to be incontinent and wear incontinence briefs for dignity. The care plan directed the nursing staff to provide incontinence cares with each incontinent episode. The date for the care plan shown to be date initiated 8/29/18 and resolved date of 11/13/18. When the active care plan was reviewed with the DON and Nurse Consultant it was noted the active care plan did not reflect a toileting program for the resident. Both stated the care plan was lacking the current status of the resident and her toileting needs. Review of the Comprehensive Person-Centered Care Plans Policy revised 12/2016, states a comprehensive, person-centered care plan that includes measurable objectives and timetables to meet the resident's physical, psychosocial and functional needs is developed and implemented for each resident. Assessments of the residents are ongoing and care plans are revised as information about the residents and the residents' conditions change.	F 656		
F 657 SS=E	Care Plan Timing and Revision CFR(s): 483.21(b)(2)(i)-(iii) §483.21(b) Comprehensive Care Plans §483.21(b)(2) A comprehensive care plan must be- (i) Developed within 7 days after completion of	F 657		

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F 657	Continued From page 4 the comprehensive assessment. (ii) Prepared by an interdisciplinary team, that includes but is not limited to-- (A) The attending physician. (B) A registered nurse with responsibility for the resident. (C) A nurse aide with responsibility for the resident. (D) A member of food and nutrition services staff. (E) To the extent practicable, the participation of the resident and the resident's representative(s). An explanation must be included in a resident's medical record if the participation of the resident and their resident representative is determined not practicable for the development of the resident's care plan. (F) Other appropriate staff or professionals in disciplines as determined by the resident's needs or as requested by the resident. (iii)Reviewed and revised by the interdisciplinary team after each assessment, including both the comprehensive and quarterly review assessments. This REQUIREMENT is not met as evidenced by: Based on observation, clinical record review and staff interview, the facility failed to revise and update resident care plans for four of 14 residents reviewed. (Resident #4, #10, #13 & #14) The facility census was 35 residents. Findings include: 1. The Minimum Data Set (MDS) assessment dated 9/5/18, showed Resident #13 required extensive staff assistance with all cares, had impairment for range of motion on both the upper extremities and lower extremities.	F 657	**F657 Care Plan Timing and Revision** Maquoketa Care Center will continue to develop, revise and update comprehensive care plans. Resident care plans for residents #4, #10, #13, #14 as indicated were updated immediately upon discovery to reflect current status. There was no resident harm indicated at time of observation. There were no negative outcomes related to this alleged deficiency. Care plan nursing team completed comprehensive review of all other resident care plans to reflect current status. Care plans will continue to be reviewed during quarterly and annual review as well as at time of significant change for timely revision and continued compliance. Care plan team has implemented a Triple Check Method of physician orders and 24 hour summary report review.	

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F 657	Continued From page 5 The Resident's Occupational Therapy (OT) Report dated 9/14/18 showed the reason for referral to OT to evaluate and treat for left hand splint to address decreased PROM, prevent joint deformity, and maintain skin integrity. The report showed the resident would benefit from the use of a hand splint. The OT discharge note dated 11/6/17 showed the long term goal for the resident and Staff completed with demonstration of a good carryover of established wearing schedule (4 hours) for left hand splint to improve joint alignment and maintain good skin integrity. The Task for the Restorative Staff included to place a carrot fully inflated for 4 hours into the resident's left hand after Passive Range of Motion (PROM). After removing the carrot, check the resident's skin. This is to be completed 3 to 7 times a week. The Kardex used for the Nursing Aides, in the computer, failed to identify any carrot (splint) device to be placed into the resident's contracted left hand. There is no instruction under resident care nor any instruction who performs the placement, when they perform the task. The Care Plan updated 10/15/18, failed to identify measures taken for the resident's left hand contracture. Observation on 11/13/18 at 10:47 a.m., revealed Staff F, Certified Nursing Aide, CNA placed an air bottle-like (carrot) covered in a soft cushion into the residents left hand. Staff F reported the resident used it for the contracture in the resident's left hand.	F 657	**F657 Continued** This Triple Check review is done by a Management RN who audits physician orders and 24 hour report summary to make sure that Plan of Care has been updated as warranted. Triple Check noting audit will be completed by D.O.N. / A.D.O.N. weekly on random orders for a month to monitor improvement. Additional retraining and individual re-teaching will be used if necessary. Results of the audit will be shared with the physician and pharmacist at QAPI meeting and areas identified as concerns will continue to be monitored to ensure corrective actions have been taken.	

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F 657	Continued From page 6 Observation on 11/14/18 at 7:20 a.m., showed the resident up in the wheelchair with no carrot in the left hand. During interview on 11/15/18 at 7:05 a.m., Staff B, CNA/Restorative Aide reported the treatment for the resident included to put the carrot in the resident's left hand upon rising in the morning until 1:00 or 1:45 p.m., or around that time. The carrot was to be in place for 4 hours a day and can be placed by restorative or a CNA. During interview on 11/15/18 at 7:30 a.m. Staff C, CNA, reported as far as she knew restorative staff was suppose to place the carrot in the resident's hand. Staff C did not know when, how often or the times for that placement. During interview on 11/15/18 at 7:45 a.m., Staff D, Registered Nurse, acting MDS Coordinator, reported being unaware if the resident needed anything for the left hand contracture, and replied restorative would know that answer. Staff D noted if the resident was using something special, such as a splint, it should be care planned in the resident's record. 2. The MDS assessment dated 9/5/18, documented Resident #14 required extensive staff assistance for toileting, and had frequent bladder incontinence. A Physician Order Statement (POS) dated 11/6/18, directed staff to straight catherize the resident 3 times a day for urinary tract infection. The POS failed to identify the size, the type of catheter, and the method/procedure (clean or sterile) for the catherization.	F 657		

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F 657	Continued From page 7 The Medication Administration Record (MAR) dated 11/1/18 through 11/30/18 directed staff to straight catherize the resident 3 times a day for urinary tract infection. The MAR failed to identify the size, the type of catheter, and the method/procedure (clean or sterile) for the catherization. The Care Plan identified the resident required assistance with daily cares and had urine retention. An intervention included staff to provide straight catherizations 3 times a day. The Care Plan failed to identify the type, size of the catheter and the type of procedure to use for the catherization. Observation on 11/14/18 at 1:16 p.m., revealed Staff A, Licensed Practical Nurse, LPN provided catheter care utilizing a special (Coude) sterile, straight catheter. During interview on 11/14/18 at 2:41 p.m. Staff A reported checking with the Director of Nursing, who reported they did change the resident's catheter procedure to a sterile procedure, sometime back in October. The DON informed Staff A the change had been documented in a communication book. Staff A stated she did not usually work that Hall. She had checked with the resident's MAR, which only said to catherize the resident three times a day. 3. The Medication Administration Record (MAR) dated 11/18, documented Resident #4 had diagnosis of heart failure. A Physician order dated 10/17/18, directed staff to restart ace wraps.	F 657		

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F 657	Continued From page 8 The MAR dated 10/18, directed staff to apply ace wraps to bilateral lower extremities two times a day for edema. The MAR dated 11/18, directed staff to apply ace wraps to bilateral lower extremities two times a day for edema. During observation on 11/13/18 at 12:00 p.m., the resident's bilateral lower extremities were wrapped with ace wraps. During observation on 11/14/18 at 3:37 p.m., wraps to bilateral lower extremities was in place. The Care Plan with a target date of 2/6/19, lacked direction to staff about the ace wraps ordered by the Physician. During interview on 11/15/18 at 8:40 a.m., Staff A, LPN reported the ace wraps was not on the care plan. 4. The MDS assessment dated 10/26/18, documented Resident #10 had diagnoses of hip fracture, non-Alzheimer's dementia and depression received an antianxiety and antidepressant medication. The plan of care revised 9/10/18, indicated the resident was on an antidepressant and antianxiety medication related to depression and anxiety. The goals for the resident to be free from discomfort or adverse reactions related to antidepressant/anti-anxiety therapy, and take the lowest therapeutic dose of medication. Nursing Staff was directed to administer the antidepressant and antianxiety medications as ordered, monitor/document side effects and effectiveness and communicate with the	F 657		

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F 657	Continued From page 9 pharmacist and the physician regarding dose reduction of psychotropic medication, communicate with pharmacist/physician regarding therapeutic dose management, and consult pharmacist for monthly medication review. The care plan includes to educate the resident/family/caregivers about risks, benefits and the side effects of the antidepressant and antianxiety therapy. The care plan failed to show the individual behaviors the resident may display and what interventions the nursing staff should implement to assist the resident to lessen or cease the behavior. Review of the Certified Nurse Aide (CNA) Documentation Survey Report in the POC for August through November 2018 on behaviors marked for the resident showed frequent crying and yelling/screaming marked as behaviors the resident displayed. During interview on 11/15/18 at 1:11 p.m., Staff D, registered nurse, RN stated there was no particular behavior monitoring sheet for staff to utilize. Staff document in the progress notes or can go into the POC and document behaviors if seen. During an interview on 11/15/18 at 1:39 p.m., the DON they would expect the care plan to include what particular behaviors to look for on the resident listed and what interventions nursing staff may utilize to help the resident.	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	F 658		

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F 658	Continued From page 10 The services provided or arranged by the facility, as outlined by the comprehensive care plan, must- (i) Meet professional standards of quality. This REQUIREMENT is not met as evidenced by: Based on observation, clinical record review and staff interview, the facility failed to clarify a physician order for catheter care for one resident reviewed with a catheter. (Resident #14) The facility census was 35 residents. Findings include: 1. The Minimum Data Set (MDS) assessment dated 9/5/18, showed Resident #14 required extensive staff assistance for toileting and had frequent bladder incontinence and had diagnoses of dementia, neurogenic bladder and retention of urine. A Physician Order Statement (POS) dated 11/6/18, directed staff to straight catherize the resident 3 times a day for urinary tract infection. The POS failed to identify the size, the type, and the method of catherization (clean or sterile). The Medication Administration Record (MAR) dated 11/1/18 through 11/30/18 directed staff to straight catherize the resident 3 times a day for urinary tract infection. The MAR failed to identify the size, the type , and the procedure of catherization (clean or sterile). During interview on 11/14/18 at 2:15 p.m., Staff A, Licensed practical nurse, LPN reported they completed the straight catherization on the resident utilizing a special one (Coude catheter, due to the bent tip) that was sterile. Staff A	F 658	**F658 Services Meet Professional Standards / Comprehensive Care Plan** Maquoketa Care Center will continue to provide services that meet professional standards, and provide services as outlined by the comprehensive care plan. Resident #14 MAR and Physician catheter order was updated upon discovery to reflect current status. There was no resident harm indicated at time of observation. There were no negative outcomes related to this alleged deficiency. Re-Education and review of Physician catheter orders was completed by members of care plan and nursing team immediately upon discovery. Director of Nursing provided education 11.16.2018 to all active nurses regarding elements of physician catheter orders.	

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F 658	Continued From page 11 reported checking with the Director of Nursing (DON), who reported, they did change the resident's catheter procedure to a sterile procedure, sometime back in October. The DON informed Staff A the change was documented in a communication book. Staff A stated she did not usually work that Hall and had checked the resident's MAR, which only said to catherize the resident three times a day. During interview on 11/15/18 at 10:50 a.m., the DON reported reviewing the resident's frequent urinary tract infections and felt using a sterile method would be beneficial. The DON remarked she dropped the ball, and should have asked for a physician order. The physician order would have gone onto the resident's MAR's and therefore inform staff what to do and what catheter to use. The DON commented the written order to straight catherize the resident 3 times a day, lacked information of what size, type of catheter and the type of procedure to use for the catheterization.	F 658	**F658 Continued** Care plan team has implemented a Triple Check Method of physician order review. This Triple Check review is done by a Management RN who will audit to make sure that Physician catheter orders include size, type, and method of catheterization prior to filing in the patient record. Triple Check order noting audit will be completed by D.O.N. / A.D.O.N. weekly on catheter orders for a month to monitor improvement. Additional retraining and individual re-teaching will be used if necessary. Results of the audit will be shared with the physician and pharmacist at QAPI meeting and areas identified as concerns will continue to be monitored to ensure corrective actions have been taken.	
F 689 SS=G	Free of Accident Hazards/Supervision/Devices CFR(s): 483.25(d)(1)(2) §483.25(d) Accidents. The facility must ensure that - §483.25(d)(1) The resident environment remains as free of accident hazards as is possible; and §483.25(d)(2)Each resident receives adequate supervision and assistance devices to prevent accidents. This REQUIREMENT is not met as evidenced by: Based on clinical record review, staff and family interviews, the facility failed to provide adequate	F 689		

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MAQUOKETA CARE CENTER	1202 GERMAN STREET MAQUOKETA, IA 52060

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 689	Continued From page 12 supervision in the dining room to prevent accidents for one resident reviewed with a history of falls. (Resident #236) The facility census was 35 residents. Findings include: 1. The Minimum Data Set (MDS) assessment dated 9/26/18, documented Resident #236 had diagnoses of Non-Alzheimer's dementia, anxiety and depression and had a brief interview for mental status (BIMS) score of 9, indicating moderately impaired cognition. The MDS assessment indicated the resident required limited assistance of one with transfers and ambulation. The plan of care dated 9/7/17, directed the resident to be up independently with walker in the dining room and front lounge only. The resident was up with assistance of one staff, gait belt and walker throughout the rest of the facility. An incident/accident report dated 8/23/18, documented the resident was walking around a table in the dining room without her walker when she fell onto her bottom on the floor. The facility added an intervention to place sign on the walker to remind the resident to take the walker with her. An incident/accident investigation report dated 10/5/18, documented the resident was in the main dining room laying floor on her back with the walker in front of her. Staff added toilet with assistance to prevent further falling. A physician order sheet dated 10/4/18, directed the resident to be independent with front wheeled walker in the dining room and front lounge only,	F 689	**F689 Free of Accident Hazards/Supervision/Devices** Maquoketa Care Center will provide adequate supervision to protect resident against hazards from self, others, or elements in the environment. Statements were gathered by employees working at time of incident as well as visitor witness at time of incident. 10/22/2018 A comprehensive interdisciplinary review of this fall was completed by members of facility care plan and management team with collaboration of Primary Physician and Consultant Pharmacist. Collaboration was done with Pharmacy Consultant to review medication administration times and minimizing amount of medications passed around evening meal time, allowing more direct supervision at meals by charge nurse(s). 10/23/2018 IDT meeting held to discuss moving meal time back 30 minutes to allow for med-pass administration time change, and affect on all departments.	

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F 689	Continued From page 13 continue with assistance of one, gait belt and walker in other areas of the facility A fall screener completed on 10/10/18 and 7/17/18, documented an score of 80 for both assessments. Screen evaluated the history of falling, gait and mental status. The assessment stated the resident had history falls, gait was weak and mental status overestimated limits or forgets limits. Morse fall scoring: High Risk for 45 and higher. A Physical Therapy evaluation and plan of treatment completed 10/11/18, documented the resident was demonstrating both lower extremity/proximal weakness, balance deficits, and decline in functional mobility. The resident required cueing for safety with transfers and proper hand placement. The resident was able to navigate the hallway, room and bathroom using front wheeled walker with stand by assistance but required moderate assistance with toileting and maximum assistance with lower extremity dressing. Nurse progress notes dated 10/20/18 at 5:50 p.m., revealed a visitor came to the front nurse station to inform staff the resident was on the floor down the hallway. The nurse assessed the situation along with other nurse on duty. The floor was dry, hallway was well lit and the resident had the front wheeled walker with her. The resident was last seen in the Main Dining Room. The X-ray report from Finley Hospital dated 10/20/18 at 8:45 p.m., revealed a proximal right femoral fracture. During interview on 11/14/18 at 1:19 p.m., the	F 689	**F689 Free of Accident Hazards/Supervision/Devices** Maquoketa Care Center will provide adequate supervision to protect resident against hazards from self, others, or elements in the environment. Statements were gathered by employees working at time of incident as well as visitor witness at time of incident. 10/22/2018 A comprehensive interdisciplinary review of this fall was completed by members of facility care plan and management team with collaboration of Primary Physician and Consultant Pharmacist. Collaboration was done with Pharmacy Consultant to review medication administration times and minimizing amount of medications passed around evening meal time, allowing more direct supervision at meals by charge nurse(s). 10/23/2018 IDT meeting held to discuss moving meal time back 30 minutes to allow for med-pass administration time change, and affect on all departments.	

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F 689	Continued From page 14	F 689		

visitor who found the resident on the floor in the hallway states she walked from the main dining room to her husbands room that evening during the meal time and when she came out she saw the resident on the floor and told the nurse. She did not recall seeing the resident when she went into the room.

During interview on 11/14/18 at 2:19 p.m., Staff H, Certified Nurse Aide, CNA stated she did not witness the fall on 10/20/18. Staff H stated she was in the dining room feeding another resident when she heard someone yell the resident had fallen. The resident had been sitting at the first table when she was last saw her in the dining room. Staff H stated there was another CNA in the Dining room with her and two nurses were passing medication. Typically the resident would be up with one assistance but she must have got up and walked away without assistance the night of the fall.

During interview on 11/14/18 at 2:25 p.m., Staff I, Licensed Practical Nurse, LPN stated she saw the resident on 10/20/18 sitting at the table in the center first row eating her supper meal. Staff I left the dining room to use the restroom and was alerted to the fall by another staff member knocking on the door.

During interview on 11/14/18 at 2:38 p.m., Staff J, CNA stated she was in the dining room and heard someone say the resident had fallen. Staff J had she back to the hallway the resident had gone down.

During interview on 11/14/18 at 3:18 p.m., Staff K, CNA stated at the time of the fall she was at the back table feeding residents and heard the nurse

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F 689	Continued From page 15	F 689		

calling for help. Typically the resident would ask to go back to her room and she was an assist of one for ambulation. Staff K stated her back was turned to the rest of the dining room.

During interview on 11/14/18 at 3:26 p.m., Staff L, LPN stated a family member came and got her in the middle of supper time to notify her of the residents fall. There was a lot of people present and it was busy due to it being the supper hour. Staff L stated she was by the medication cart in the dining room area when she was notified. Staff L could not remember what she was doing and does not recall seeing the resident prior to the fall.

During interview on 11/14/18 at 4:04 p.m., Staff M, CNA stated she was out in the dining room feeding residents and went to a resident room to answer a call light and when coming back to the hallway the resident was on the floor. Staff M stated the resident was not in the hall when they left the dining room to go answer the call light.

During interview on 11/15/18 at 1:21 p.m., the Director of Nursing (DON) stated her expectation was to have staff in dining room to assist the resident and to place a gait belt on the resident and redirect the resident back to the common area with assistance. She was not sure how staff did not see the resident get up and leave the dining room.

During interview on 11/15/18 at 1:42 p.m., the Administrator was able to establish that when the visitor left the dining room the resident was not there and when the visitor came out of her husbands room the resident was on the floor. Based on staff statements no one was able to

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F 689	Continued From page 16 state they witnessed the resident leave the dining room. The Administrator expected staff to supervise the dining room and assist the residents as needed.	F 689	**F760 Residents Free of Significant Med Errors** Maquoketa Care Center will ensure that residents are free of significant medication errors.	
F 760 SS=D	Residents are Free of Significant Med Errors CFR(s): 483.45(f)(2) The facility must ensure that its- §483.45(f)(2) Residents are free of any significant medication errors. This REQUIREMENT is not met as evidenced by: Based on observation, clinical record review, facility policy review and staff interview, the facility failed to ensure professional nursing staff prime the Insulin Pen per the manufactures reconditions for one resident to ensure the correct dose was administered. (Resident # 14) The facility census was 35 residents. Findings include: 1. The Minimum Data Set (MDS) assessment dated 9/5/18, documented Resident #14 had diagnosis of diabetes mellitus. The Medication Administration Record (MAR) dated 11/18, directed staff to provide NovoLog 10 units subcutaneous three times a day. The Physician Order Sheet dated 11/6/18, directed staff to provide NovoLog insulin 10 units subcutaneous three times a day. During observation on 11/15/18 at 8:08 a.m., Staff D, registered nurse, RN removed the NovoLog Insulin pen from the medication cart and dialed the NovoLog insulin pen to the 10 units. Staff A	F 760	Maquoketa Care Center will ensure professional nursing staff administer Insulin Pen(s) per Mfg. recommendations. Resident #14 Insulin Pen was administered per mfg. recommendations, as insulin was not given until policy reviewed by RN prior to administration. There was no resident harm indicated at time of observation. There were no negative outcomes related to this alleged deficiency. Director of Nursing provided education 11.16.2018 to all active nurses regarding mfg. recommendations for insulin pen administration.	

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F 760	Continued From page 17 failed to prime the insulin pen before dialing up the ordered dose. During interview on 11/15/18 at 8:09 a.m., Staff D stated they never primed the insulin pen before administering insulin and expressed the need to review the policy. During interview on 11/15/18 at 8:21 a.m., Staff D called the pharmacy to clarify the need to prime the insulin pen before dialing up the dose of insulin for administration. Staff A confirmed the requirement of priming the insulin pen and further reported never receiving any education to prime insulin pens before now. During interview on 11/15/18 at 9:30 a.m., the Director of Nursing (DON) stated nurses were to prime the insulin pen before admiration. The DON report not providing education to the nurses on priming the insulin pens. The Facility provided a policy titled How to use you NovoLog FlexPen dated 2009, directing at step # 2 Do an air shot (prime the needle) 1. Dial 2 units. 2. Hold the syringe with the needle pointing up and tap the reservoir gently to move air bubbles to the top of the needle. 3. Press the push button on the top of the syringe as far as it will go until drop of insulin appears. The policy continues at step # 3 Dial up your dose	F 760	**F760 Continued** Care plan team has implemented a Triple Check Method of physician order review. This Triple Check review will be done by a Management RN who will audit to make sure that Physician insulin pen orders will include review of mfg. recommendations prior to filing in the patient record. Insulin Pen medication administration audit will be completed by D.O.N. / A.D.O.N. weekly on random shifts for a month to monitor performance improvement. Additional retraining and individual re-teaching will be used if necessary. Results of the audit will be shared with the physician and pharmacist at QAPI meeting and areas identified as concerns will continue to be monitored to ensure corrective actions have been taken.	
F 880 SS=D	Infection Prevention & Control CFR(s): 483.80(a)(1)(2)(4)(e)(f) §483.80 Infection Control The facility must establish and maintain an infection prevention and control program	F 880		

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F 880	Continued From page 18 designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of communicable diseases and infections. §483.80(a) Infection prevention and control program. The facility must establish an infection prevention and control program (IPCP) that must include, at a minimum, the following elements: §483.80(a)(1) A system for preventing, identifying, reporting, investigating, and controlling infections and communicable diseases for all residents, staff, volunteers, visitors, and other individuals providing services under a contractual arrangement based upon the facility assessment conducted according to §483.70(e) and following accepted national standards; §483.80(a)(2) Written standards, policies, and procedures for the program, which must include, but are not limited to: (i) A system of surveillance designed to identify possible communicable diseases or infections before they can spread to other persons in the facility; (ii) When and to whom possible incidents of communicable disease or infections should be reported; (iii) Standard and transmission-based precautions to be followed to prevent spread of infections; (iv)When and how isolation should be used for a resident; including but not limited to: (A) The type and duration of the isolation, depending upon the infectious agent or organism involved, and (B) A requirement that the isolation should be the	F 880	**F880 Infection Prevention and Control** Maquoketa Care Center has an infection prevention and control program that includes systems for preventing, identifying, reporting, investigating and controlling infections and communicable diseases for all residents. Resident #14 catheter order was reviewed, and physician order updated upon discovery to reflect current status. There was no resident harm indicated at time of observation. There were no negative outcomes related to this alleged deficiency noted. Staff (A) LPN was immediately re-educated after noted observation regarding catheterization proper catheter care procedures, and again after receipt of 2567 to review survey findings and receive individual counseling and review of infection control techniques and catheterization procedure.	

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F 880	Continued From page 19 least restrictive possible for the resident under the circumstances. (v) The circumstances under which the facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease; and (vi)The hand hygiene procedures to be followed by staff involved in direct resident contact. §483.80(a)(4) A system for recording incidents identified under the facility's IPCP and the corrective actions taken by the facility. §483.80(e) Linens. Personnel must handle, store, process, and transport linens so as to prevent the spread of infection. §483.80(f) Annual review. The facility will conduct an annual review of its IPCP and update their program, as necessary. This REQUIREMENT is not met as evidenced by: Based on observation, clinical record review and staff interview, the facility failed to provide proper catheter care for one resident reviewed with a catheter. (Resident #14) The facility census was 35 residents. Findings include: 1. The Minimum Data Set (MDS) assessment dated 9/5/18, showed Resident #14 had diagnoses of dementia, neurogenic bladder and retention of urine and required extensive assistance for toileting and had frequent bladder incontinence.	F 880	**F880 Continued** Director of Nursing provided education 11.16.2018 to all active nurses regarding catheter care and infection control procedures to be maintained. All staff Inservice Infection Control Updates education provided 11.23.2018 D.O.N / A.D.O.N will audit catheter care infection control techniques at random times and shifts to review and determine continued compliance. Additional retraining and individual re-teaching will be used if necessary. Results of the audit will be shared with the physician and pharmacist at QAPI meeting and areas identified as concerns will continue to be monitored to ensure corrective actions have been taken.	

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F 880	Continued From page 20 A Physician Order Statement (POS) dated 11/6/18, directed staff to straight catherize the resident 3 times a day for urinary tract infection. The POS failed to identify the size, the type of catheter, and the method/procedure (clean or sterile) for the catherization. Observation on 11/14/18 at 1:16 p.m., revealed Staff A, Licensed Practical Nurse, LPN entered the residents room, failed to cleanse hands but applied gloves and removed the resident's pants, touched the blanket and recovered the resident. Staff A washed hands and put on a pair of non-sterile gloves. Staff A took 2 by 2 inch gauze pads, poured Betadine solution on them and while gloved, uncovered the resident's peri area. Wearing the same gloves, Staff A cleansed the urethral site (with the Betadine gauzes) at the opening center using a circular downward motion. When completed Staff A re-covered the resident with the blanket. Staff A changed gloves, opened the plastic bag of the lubricant-KY-jelly, placed a squirt of the jelly on a paper barrier, and opened the Betadine to drop a squirt unto the KY-jelly. Staff A changed gloves (un-sterile) and opened the sterile catheter and rubbed the tip of the catheter into the mixture lubricating the catheter. Without changing gloves, Staff A moved the blanket off of the resident's peri area and touched the sterile catheter and inserted it into the resident's urethra site. During interview on 11/14/18 at 2:15 p.m., Staff A reported the straight catheter method was not a sterile procedure. The catheter was a special one (Coude catheter, due to the bent tip) that is sterile. During interview on 11/15/18 at 10:50 a.m., the	F 880		

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F 880	Continued From page 21 director of nursing, DON acknowledged Staff A did not keep the procedure clean or sterile. The DON remarked the Betadine solution should have not been mixed in with the KY-jelly, as Betadine was typically used topically.	F 880		