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
	165191	A. BUILDING _____ B. WING _____	01/31/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOOD SAMARITAN SOCIETY - RED OAK	201 ALIX AVENUE RED OAK, IA 51566

(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 Correction date 2/22/19 The following deficiencies relate to the facility's health survey. Complaint #74209-C was not substantiated. Incident #79187-I was not substantiated. See the Code of Federal Regulations (42CFR) Part 483, Subpart B-C.	F 000	Preparation and execution of this response and plan of correction does not constitute an admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because it is required by the provisions of federal and state law. For the purposes of any allegation that the center is not in substantial compliance with federal requirements of participation, this response and plan of correction constitutes the center's allegation of compliance in accordance with section 7305 of the State Operations Manual (SOM)	
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.	F 623		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Christy Travis RN — TITLE: Administrator — (X6) DATE: 2/21/2019

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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F 623	Continued From page 1 (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 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	F 623		

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F 623	Continued From page 2 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 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 record review and interview the facility failed to notify the ombudsman of a transfer to the hospital for one of three residents (Resident #30). The facility reported a census of 53 residents. Findings include	F 623	**F 623** Correction to affected individuals: Individual #30 was not affected due to facility's failure to notify the ombudsman of a transfer (return anticipated) to the hospital. Director of Social Services notified our Ombudsman, via email, regarding resident #30's discharge return anticipated on 09/4/2018 and return on 09/13/2018. The facility recognizes the importance of notifying Office of the State Long-Term Care Ombudsman of all residents transferred or discharged from facility. Measures put in place to ensure ombudsman is notified of all transfers and discharges. Director of Social Services' (DSS) monthly Notice of Transfer Form (NOTF) to Office of the State Long-Term Care Ombudsman will be double checked by the Director of Nursing (DON) to ensure list of residents transferred or discharged is reconciled, prior to delivery	

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F 623	Continued From page 3 1. The Minimum Data Set assessment printed on 1/30/19 recorded Resident #30 had a discharge return anticipated on 9/4/18. The clinical census document printed 1/30/19 indicated the resident had a no-pay hospital leave on 9/4/18 and returned on 9/13/18. In an interview on 1/29/19 at 2:40 p.m., the Director of Nursing (DON) noted and verified the September 2018 Notice of Transfer Form to Long Term Care Ombudsman lacked Resident #30's transfer to the hospital. An interview on 1/30/19 at 2:30 p.m., the Social Service Director verified the resident was not on the transfer form to the Ombudsman.	F 623	Monitor performance Focus Audit: DON will audit monthly x3 months for completeness of NOTF. The results of these audits will be reported to the Quality Assurance Performance Improvement (QAPI) Committee for review and recommendation. The QAPI Committee will determine further auditing needs. Correction Date: 2/22/2019	
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 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	F 625	**F 625** Correction to affected individuals: Individuals #30 and #51 were not affected due to facility's lack of GSS's Procedure: *Bed-Hold* not being initiated. The facility recognizes the importance of initiating the Notice of Bed Hold Policy to all residents that are being transferred or discharged from the facility to another facility.	

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F 625	Continued From page 4 (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 interview the facility failed to provide notice to the resident and/or representative of the bed hold policy prior to and upon transfer to the hospital for two of three resident reviewed (Residents #30, #51). The facility reported a census of 53 residents. Findings include: 1. The clinical Minimum Data Set (MDS) document printed 1/30/19 indicated that Resident # 30 had a discharge return anticipated on 9/4/18. The clinical census document printed 1/30/19 revealed the resident had a no-pay hospital leave on 9/4/18 and returned on 9/13/18. The clinical record lacked a bed hold given to the resident and or her representative. 2. The clinical MDS document printed 1/30/19 indicated that Resident #51 had a discharge return anticipated on 1/3/19. The clinical census document printed 1/30/19 revealed the resident had a no pay hospital leave on 1/3/19 and returned 1/7/19.	F 625	Measures put into place to ensure *Notice of Bed-Hold Policy* are initiated according to GSS' Procedure: *Bed-Hold*. 1/31/2019, Director of Social Services (DSS) received education regarding the importance obtaining a "timely" bed-hold for all residents per GSS's Procedure: *Bed-Hold*, and the *Notice of Bed-Hold Policy (GSS#273-IA)*. Monitor performance Focus Audit = The Business Office Manager (or designee) will audit *Bed-Hold* procedure compliance, weekly x 3 weeks and monthly x3 months The results of these audits will be reported to the Quality Assurance Performance Improvement (QAPI) Committee for review and recommendation. The QAPI Committee will determine further auditing needs. Correction Date: 2/22/2019	

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F 625	Continued From page 5 A document titled Notice of Bed-Hold Policy signed and dated by Resident #51's financial responsible party on 1/9/19 two days after the resident returned from the hospital. A document titled Procedure Bed-Hold revised on 12/16 directs staff to provide the Notice of Bed Hold policy upon admission, the social worker or designated individual will obtain the resident's or responsible party's signature on the admission acknowledgment page of the admission agreement. Upon transfer the social worker or designated individual will provide the Notice of Bed hold policy to the resident and/or responsible party, which specified the duration of the bed-hold policy under the state plan. The social worker or designated individual will explain the notice of bed hold policy and answer any questions. In case of emergency transfer, the resident's copy of the notice of bed hold policy is sent with the other papers accompanying the resident to the hospital. The family member or legal representative, if any, is provided with the notice of bed hold policy within 24 hours of transfer. The notice of bed hold policy should be mailed if family does not come in to the location to receive a copy. The charge nurse is responsible for completion of notification procedures if the transfer occurs at a time the social worker is not at the location. The social worker or designated individual will contact resident/responsible party to inquire regarding their decision for holding a bed. In an interview on 1/30/19 at 2:30 p.m., the Social Service Director stated she didn't provide a bed for Resident #30 for the discharge on 9/4/18. She acknowledged Resident #51's bed hold as signed two days after the resident returned from the	F 625		

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F 625	Continued From page 6 hospital. She stated there is no process for doing the bed holds and she does them if she remembers or if the business office tells her they need one.	F 625		
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 incontinence, based on the resident's comprehensive assessment, the facility must ensure that a resident who is incontinent of bowel	F 690		

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F 690	Continued From page 7 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, resident interview, observation, staff interview, and facility record review, the facility failed to provide incontinence care in a manner to reduce the risk of developing urinary tract infections (UTIs) for one resident with a history of infections and failed to complete bladder & bowel assessments for the incontinent resident in an effort to maintain or reduce the frequency of incontinence out of seven residents reviewed for UTIs or bladder & bowel assessments (Resident #1). The facility reported a census of 53 residents. Findings include: The Minimum Data Set (MDS) assessment dated 7/11/18 for Resident #1 recorded the resident experienced frequent episodes of bladder incontinence and continent of bowel. The MDS assessment dated 10/10/18 for Resident #1 recorded the resident experienced frequent episodes of bladder incontinence and occasional episodes of bowel incontinence. The MDS assessment dated 1/16/19 for Resident #1 identified a Brief Interview for Mental Status (BIMS) score of 11 without signs/symptoms of delirium. A score of 11 indicated moderate cognitive impairment. The MDS revealed the resident required the extensive physical assistance of 1 person for transfers, toileting, and personal hygiene. The MDS recorded the resident experienced occasional episodes of	F 690		

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F 690	Continued From page 8	F 690		

bladder incontinence and occasional episodes of bowel incontinence. The MDS documented diagnoses that included UTI in the last 30 days, hemiplegia (weakness on one side of the body), and history of malignant neoplasm of prostate (prostate cancer).

The care plan focus area revised 6/21/18 identified an ADL (Activities of Daily Living) self care performance deficit related to left sided hemiplegia/hip fracture evidenced by decreased mobility and left sided weakness. The care plan intervention revised 11/7/18 informed staff the resident required the assistance of 1 staff person to complete peri-cares as allows and the resident wore incontinence products. The care plan focus areas revised 7/20/18 identified bladder incontinence related to dementia and physical limitations evidenced by frequently incontinent of urine and the potential for a urinary tract infection.

The Progress Notes dated 1/2/19 at 10:36 a.m. documented the resident continued on antibiotic treatment for UTI and awaited culture results.

The Progress Notes dated 1/5/19 at 2:02 p.m. documented the resident continued with a poor appetite, required the sit to stand (mechanical lift) for transfers, and continued to be lethargic.

The Progress Notes dated 1/7/19 at 10:37 a.m. documented a request for a doctor appointment per family request.

The Progress Notes dated 1/7/19 at 11:07 a.m. documented an order received to send the resident to the ER (Emergency Room) for evaluation.

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F 690	Continued From page 9 The Progress Notes dated 1/14/19 at 2:24 p.m. documented the resident returned to the facility at 11:30 a.m. that day and continued on antibiotic treatment related to a fungal UTI. The Progress Notes dated 1/21/19 at 9:36 a.m. documented the resident completed antibiotic treatment for UTI on 1/19/19 and would continue on Cipro (a different antibiotic treatment) 250 mg (milligrams) every Monday and Friday prophylactically related to recurrent UTI. The Progress Notes dated 1/22/19 at 9:54 a.m. documented the resident returned from a doctor's appointment with a new order to obtain a UA. The Progress Notes dated 1/24/19 at 12:38 p.m. documented the UA results returned with no new orders. The Progress Notes dated 1/25/19 at 2:38 p.m. documented the urine culture results showed no growth on day one or two. In an interview on 1/28/19 at 2:34 p.m., Resident #1 stated he had a current UTI, he took pills to treat it, and the symptoms felt better when he took the pills. Resident #1 stated he got recurrent UTIs and thought it was a problem from years ago. Resident #1 responded he was not sure what kind of incontinency he had but the staff took him to the bathroom regularly as it was a long standing problem. Observation on 1/20/19 at 2:00 p.m. revealed Staff C, Certified Nurse Aide (CNA), and Staff D, CNA, assisted Resident #1 to the toilet. Resident #1 audibly voided urine and bowel movement into the toilet. With gloved hands, Staff C assisted	F 690	**F 690** Correction to affected individual: A Bowel and Bladder Assessment was completed on 2/18/2019 for resident #1. Measures taken to ensure problem does not occur: 1. Peri-care coaching has been occurring with staff by the Nursing Staff Development Coordinator (NSDC). 2. Staff completed education from In The Know titled, *Handling Incontinence of Bowel and Bladder*. This training has a knowledge validation post-test. Skills validation will be completed by 4/30/2019. 3. All residents will have a Bowel and Bladder Assessment completed with their quarterly MDS assessment.	

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F 690	Continued From page 10 the resident to stand to the grab bar. Staff C wiped the resident's buttocks with visible loose feces present in moderate amount. Staff C used several wipes to cleanse the buttocks area. With the same contaminated gloves, Staff C wiped the resident's front groin region. Without changing the gloves, Staff C cleansed the penis coming in contact with an opening to the body. Staff C removed her gloves, pulled up the resident's pants, grasped the gait belt during assistance with transfer back to the wheelchair, and then washed her hands. In an interview on 1/30/19 at 2:10 p.m., the Director of Nursing, (DON) reported Staff C is a new employee to the facility and brand new CNA five months prior. The DON commented the Staff Development Assistant trained staff and worked with Staff C. The DON stated when Staff C went slowly she provided cares good but at times the CNA did not listen when she did worked fast. The DON expected staff to start incontinence cares in the front and proceed to the back as well as wash hands after removal of gloves. On 1/30/19 at 2:25 p.m., the DON reported Staff Development Assistant had not yet reached the point of checking off staff but rather worked with them only in the coaching phase. The clinical record lacked documentation of a Bladder & Bowel Incontinence Assessment to assess the resident for type and frequency of incontinence. The facility procedure titled Perineal Care revised 10/17 included the following documentation: Purpose - To prevent infection and odors in the perineal	F 690	Monitor performance • Focus audits will be done to ensure all residents have a bowel and bladder assessment completed with their quarterly MDS assessment. Audits will be done weekly for 3 weeks and monthly for 3 months. • Focus audits of observational peri-care will be done to ensure that peri-care is being performed according to policy and procedure. Audits will be done weekly for 3 weeks and monthly for 3 months. The results of these audits will be reported to the Quality Assurance Performance Improvement (QAPI) Committee for review and recommendation. The QAPI Committee will determine further auditing needs. Correction date: 2/22/19	

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F 690	Continued From page 11 area To promote good perineal hygiene To observe perineal area Procedure - For Males - a. Grasp penis gently with one hand and wash. Begin at meatus (opening to the body) and wash in a circular motion toward the base of the penis. v. If resident is not circumcised, draw foreskin back. Be sure entire penis is washed. Rinse thoroughly. Be careful to replace the foreskin to normal position. c. Wash scrotum. Lift scrotum and wash perineum. d. With a new washcloth, remake mitt and rinse area just washed. e. Pat dry with towel. Reposition foreskin if necessary. Point 7. Turn resident (both male and female) on side to wash, rinse and dry anal area. After removing soiled gloves, use hand sanitizer or wash with soap and water to cleanse hands. Put on clean gloves to put on clean pad and/or clothing.	F 690		
F 692 SS=G	Nutrition/Hydration Status Maintenance CFR(s): 483.25(g)(1)-(3) §483.25(g) Assisted nutrition and hydration. (Includes naso-gastric and gastrostomy tubes, both percutaneous endoscopic gastrostomy and percutaneous endoscopic jejunostomy, and enteral fluids). Based on a resident's comprehensive assessment, the facility must ensure that a resident- §483.25(g)(1) Maintains acceptable parameters of nutritional status, such as usual body weight or desirable body weight range and electrolyte balance, unless the resident's clinical condition	F 692		

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F 692	Continued From page 12 demonstrates that this is not possible or resident preferences indicate otherwise; §483.25(g)(2) Is offered sufficient fluid intake to maintain proper hydration and health; §483.25(g)(3) Is offered a therapeutic diet when there is a nutritional problem and the health care provider orders a therapeutic diet. This REQUIREMENT is not met as evidenced by: Based on clinical record review, observation, and staff interview, the facility failed to initiate a dietician recommendation for dietary supplement for two residents with a weight loss of greater than 9 % in one month (Residents #44 and #46) out of three residents reviewed for nutrition. The facility reported a census of 53 residents. Findings include: 1. The admission Minimum Data Set (MDS) assessment dated 1/6/19 for Resident #44 identified a Brief Interview for Mental Status (BIMS) score of 3 without signs/symptoms of delirium. A score of 03 indicated severe cognitive impairment. The MDS revealed the resident independent with no setup help needed from staff for eating. The MDS documented diagnoses that included Crohn's disease (a chronic inflammatory bowel disease that affects the lining of the digestive tract), diabetes, other fracture, and non-Alzheimer's dementia. The MDS recorded a weight of 105.0 lbs (pounds). The assessment documented she entered the facility on 12/31/18. The care plan focus area dated 12/31/18 identified an ADL (Activities of Daily Living) self care deficit related to dementia and cast to right	F 692		

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F 692	Continued From page 13 arm. The care plan informed staff Resident #44 could hold a cup, feed herself, and eat finger foods independently. The care plan focus area revised 1/2/19 identified a potential nutritional problem related to a decline in cognitive ability. The care plan focus area revised 1/8/19 identified impaired cognitive function related to dementia evidenced by forgetfulness and need for cues or reminders. The Progress Notes dated 1/16/19 at 11:45 a.m. documented a care conference held that included discussion of the resident's eating habits and her current weight with the resident's family. The Progress Notes dated 1/17/19 at 11:11 a.m. documented a Nutritional Status Dietician Assessment. The assessment recorded the resident ate 50% of meals independently with no chewing or swallowing problems. The assessment documented the resident's current body weight measured 97.0 lbs, her ideal body weight would be 100 lbs, and an admission weight 105 lbs. The Dietician wrote Resident #44 was at risk for impaired nutritional status related to dementia. The assessment documented interventions to maintain her weight or gain, maintain skin integrity, improve the resident's oral intake to greater than 50% of all meals and continue diet as ordered. The Dietician recommended that staff start a house supplement 90 ml (milliliters) TID (3 times a day), weigh as ordered, and report weight/appetite changes to RD (Registered Dietician). The Progress Notes dated 1/17/19 at 12:30 p.m. documented a weight warning of a 7.6% weight loss and to see the RD assessment dated 1/17/19.	F 692	**F 692** Correction to affected individuals: Resident # 44: PCP faxed on 1/31/19 regarding residents weight and Registered Dietician (RD) recommending 90 ml of house supplement to be given TID. PCP faxed back on the same day with the orders to give the house supplement. Resident has been receiving the house supplement as ordered. Resident # 46: PCP faxed on 1/31/19 with weights and RD recommendations for boost pudding TID with meals. PCP ordered a 7 day trial of the boost pudding and questioned if the weights were correct. PCP related that he had been here on rounds and it was reported to him that the residents weight was 116 pounds on that day. Resident received the 7 day trial of the boost pudding.	

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F 692	Continued From page 14 The Weights and Vitals Summary dated 1/30/19 recorded the following weight measurements for Resident #44: 12/31/18 - 105.0 lbs; 1/11/19 - 97.0 lbs; 1/18/19 - 96.0 lbs; 1/25/19 - 95.5 lbs. Comparison of the starting weight of 105.0 lbs with the ending 95.5 lbs showed a weight loss of 9.05% in one month. The clinical record lacked documentation that staff provided the resident's house supplement 90 mls TID. Observation on 1/29/19 at 4:43 p.m. revealed the resident walked independently into the dining room following her husband to the table, greeting others and socializing. At the time of the observation, the Director of Nursing (DON) reported the resident as very social and on the go since she arrived to the facility. In an interview on 1/30/19 at 2:25 p.m., the DON acknowledged she expected the nursing staff to document the administration and consumption of house supplements on the EMAR (Electronic Medication Administration Record). Review of the EMAR revealed no administration of supplements. At 4:15 p.m., the DON stated the dietician's recommendations from the 1/17/19 assessment were not passed on to anyone and therefore the recommendations got missed. The DON reported Resident #44 did not receive the house supplement 90 mls TID as recommended. 2. The admission MDS assessment dated 1/9/19 for Resident #46 identified a BIMS score of 02	F 692	Measures put into place to ensure problem does not occur: 1. On 1/31/19 Director of Nursing (DON) met with Certified Dietary Manager (CDM) to discuss initiating weight meetings with the RD when she is in the facility. On 2/8/19 the RD and the interdisciplinary team (IDT) consisting of MDS/CarePlan Coordinator, CDM, and DON met and discuss resident's weights and RD's recommendations. It was determined that the RD will write her recommendations on the Dietary Consultant Form and submit form to the IDT. The DON will then fax the RD recommendations to PCPs to obtain approval/order. It has been discussed that when the new RD becomes more familiar with GSS-RO resident, the RD will fax her/his recommendations and updates directly to the PCPs for approval/order. 2. New admissions to the facility will have a 3 consecutive day weight check added to the TAR at admission.	

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F 692	Continued From page 15 with continuous signs of disorganized thinking. A score of 02 indicated severe cognitive impairment. The MDS revealed the resident independent with no setup help needed from staff for eating. The MDS documented diagnoses that included thyroid disorder, Non-Alzheimer's dementia, and malnutrition. The MDS recorded a weight of 122.0 lbs . The care plan focus area revised 1/3/19 identified an ADL self care performance deficit related to dementia and right hip fracture/post-op right hip hemiarthroplasty (surgical hip joint replacement). The care plan informed staff the resident could hold a cup, feed himself, and eat finger foods independently. The care plan focus area dated 1/3/19 identified a nutritional problem or potential problem related to poor nutrition evidenced by weight loss. The care plan intervention dated 1/11/19 informed staff Resident #46 had an order for medical nutritional supplement and to see the EMAR. The care plan focus area dated 1/22/19 identified impaired cognitive function related to dementia evidenced by pleasantly confused and forgetful with need for cues or reminders The Progress Notes dated 1/17/19 at 11:28 a.m. documented a Nutritional Status Dietician Assessment. The assessment recorded Resident #46 ate 50% of meals independently with no chewing or swallowing problems. The assessment documented his current body weight measured 105.0 lbs, a usual body weight of 117 lbs, and an admission weight of 122 lbs. The Dietician wrote the resident underweight status as evidenced by a BMI (Body Mass Index) of 16. The assessment documented interventions included to gain weight, improve his oral intake to greater than 75% of meals, Improve skin integrity	F 692	Monitor performance: Focus Audits will be done: • To ensure all new admissions have a 3 consecutive day weight added to the TAR on admission. Audits will be done weekly for 3 weeks, and monthly for 3 months. • To ensure RD recommendations are followed through and PCP is notified of all RD recommendations. Audits will be done weekly for 3 weeks and monthly for 3 months. • To ensure a weekly review of residents' weights for discrepancies. Audits will be done weekly for 3 weeks and monthly for 3 months. The results of these audits will be reported to the Quality Assurance Performance Improvement (QAPI) Committee for review and recommendation. The QAPI Committee will determine further auditing needs. Correction Date: 2/11/2019	

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F 692	Continued From page 16 and continue diet and nutritional supplements. The Dietician recommended that staff administer Ensure pudding TID with meals, weigh as ordered, and report weight/appetite changes to RD. The Progress Notes dated 1/17/19 at 12:29 p.m. documented a weight warning of a 14% weight loss and to see the RD assessment dated 1/17/19. The Weights and Vitals Summary dated 1/31/19 recorded the following weight measurements for Resident #44: 1/2/18 - 122.1 lbs; 1/11/19 - 105.0 lbs; 1/18/19 - 106.0 lbs; 1/25/19 - 110.0 lbs. Comparison of the starting weight of 122.1 lbs with the ending 110.0 lbs showed a weight loss of 9.91% in less than one month. The clinical record lacked documentation that staff provided the resident's Ensure pudding TID following the dietician's assessment and recommendation on 1/7/19. Observation on 1/28/19 at 1:02 p.m. revealed Resident #46 appeared very thin with the outline of his rib cage visible as he laid in bed. Observation on 1/29/19 at 4:38 p.m. revealed Resident #46 self propelled into the dining room for supper and conversed with his wife to tell her where they sat and to prepare for supper. At the time of the observation the DON stated she thought the resident's admission weight was an error as the resident looked no different that day than the day he came; very thin. The DON said	F 692		

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F 692	Continued From page 17 the resident had been eating 50% or more of meals and doing pretty good. The DON thought Resident #46 had started on a supplement. The DON reported he just snacked throughout the day for meals at home and since being in the facility had been very active and social, on the move. The DON said the resident had snacks in his room as well. In an interview on 1/30/19 at 4:15 p.m., the DON confirmed the dietician's recommendations from the 1/17/19 assessment did not get passed on to anyone and therefore the recommendations got missed. The DON reported the resident did not receive the ensure pudding TID with meals as recommended.	F 692		
F 759 SS=D	Free of Medication Error Rts 5 Prcnt or More CFR(s): 483.45(f)(1) §483.45(f) Medication Errors. The facility must ensure that its- §483.45(f)(1) Medication error rates are not 5 percent or greater; This REQUIREMENT is not met as evidenced by: Based on observation, clinical record review and staff interview the facility failed to remain free of a medication administration error rate of 5% or greater. During an observation of 27 medications administered, six errors occurred, resulting in an error rate of 22.2%. The facility reported a census of 53 residents. Findings include: During an observation on 1/30/19 at 8:08 AM Staff B Certified Medication Administrator (CMA)	F 759	**F759** Correction to affected individual: On 1/30/2019 an order was obtained for resident # 53 to crush and cocktail medications with applesauce and pudding as resident needs.	

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F 759	Continued From page 18 administrated Resident #53's medications. Staff B crushed the following medications: Potassium Chloride 20 milliequivalents (meq) 1 tablet, Prednisone (steroid) 5 milligrams (mg) 1 tablet, Metroprolol (high blood pressure) 25 mg 1 tablet, Multivitamin 1 tablet, Verapamil (high blood pressure) 240 mg, Vitamin B-12 1000 microgram (mcg) together and put them in the medication cup with the remaining capsules. Staff B them placed a scoop of applesauce in the medication cup with the crushed medications and capsules then administrated them to Resident #53. Review of Resident #53's Electronic Health Record (EHR) revealed the following orders: -Prednisone 5 mg twice a day; -Metroprolol 25 mg twice a day; -Potassium Chloride 20 meq twice a day; -Vitamin B-12 1000 mcg every morning; -Verapamil 240 mg every morning; -Multivitamin every morning. Review of Resident #53's EHR revealed no order to crush and cocktail the medications together. During interview on 1/30/19 at 2:20 PM the Director of Nursing (DON) stated the resident asked Staff B to crush her medications this morning, so Staff B did. The DON stated they could not find an order to have her medications crushed and cocktailed together. On 1/30/19 at 3:35 PM the DON stated she would have expected them to get an order to crush the medications prior to doing so. She stated the resident had no issues since she came in to the facility, so they were unsure why she requested medications to be crushed this morning. The DON then provided an order to have the	F 759	Measures put into place to ensure problem does not occur: 1. On 1/31/19 the Administrator talked with Staff B (CMA) about needing to make sure that we have a doctor's order to crush and cocktail any medications. If there is a question about crushing medications for a resident the CMA should go to the charge nurse to be sure of the orders prior to crushing medications. 2. Education = RNs, LPNs and CMAs will complete the Omnicare self-study titled *Medication Pass Fundamentals Part 2: The 7 Rights, 3 Way Check, Basics of Preparing and Administering: Oral, Ophthalmic, Otic and Nasal Medications, Common Errors...* (included in this self-study an insert from SOM r/t F759 *Crushing Medications and Crushing Oral Medications*). A facility created Knowledge Validation Post-test accompanies Omnicare self-study and is to be completed by 2/18/2019. 3. The facility is notifying PCP of residents to ensure that a crush and cocktail order is in effect when appropriate.	

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F 759	Continued From page 19 medications crushed and put in applesauce or pudding that was obtained today.	F 759	Monitor performance: Focus Audits: • To ensure no medications are crushed without an order from the PCP, audits will be completed weekly x3 weeks and monthly x3 months. • To ensure medications are delivered to the resident in the proper form according to PCP orders, audits will be completed weekly x3 weeks and monthly x3 months. The results of these audits will be reported to the Quality Assurance Performance Improvement (QAPI) Committee for review and recommendation. The QAPI Committee will determine further auditing needs. Correction date: 2/22/19	
F 880 SS=E	Infection Prevention & Control CFR(s): 483.80(a)(1)(2)(4)(e)(f) §483.80 Infection Control The facility must establish and maintain an infection prevention and control program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of communicable diseases and infections. §483.80(a) Infection prevention and control program. The facility must establish an infection prevention and control program (IPCP) that must include, at a minimum, the following elements: §483.80(a)(1) A system for preventing, identifying, reporting, investigating, and controlling infections and communicable diseases for all residents, staff, volunteers, visitors, and other individuals providing services under a contractual arrangement based upon the facility assessment conducted according to §483.70(e) and following accepted national standards; §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;	F 880		

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F 880	Continued From page 20 (iii) Standard and transmission-based precautions to be followed to prevent spread of infections; (iv)When and how isolation should be used for a resident; including but not limited to: (A) The type and duration of the isolation, depending upon the infectious agent or organism involved, and (B) A requirement that the isolation should be the least restrictive possible for the resident under the circumstances. (v) The circumstances under which the facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease; and (vi)The hand hygiene procedures to be followed by staff involved in direct resident contact. §483.80(a)(4) A system for recording incidents identified under the facility's IPCP and the corrective actions taken by the facility. §483.80(e) Linens. Personnel must handle, store, process, and transport linens so as to prevent the spread of infection. §483.80(f) Annual review. 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 clinical record review, observation, staff interview, and facility record review, the facility failed to ensure staff performed infection control measures during incontinence, medication administration and respiratory treatments for three of 19 total residents reviewed (#33, #41 and #25). The facility reported a census of 53	F 880	F 880 Correction to affected individuals. Remediation of involved nursing staff. • Staff A, RN = Infection prevention and control discussion completed 1/31/2019, with follow-up 2/20/2019. • Staff C, CNA = Resigned 2/4/2019 prior to scheduled remediation meeting with DON. • Staff D, CNA = Infection prevention and control discussion completed 2/20/2019. The facility recognizes that all residents have the potential to be affected by the same deficient practices.	

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F 880	Continued From page 21 residents. Findings include: 1. The Minimum Data Set (MDS) assessment dated 12/12/18 for Resident #33 identified a Brief Interview for Mental Status (BIMS) score of 03. A score of 03 indicated severely impaired cognition. The MDS revealed the resident required the extensive assistance of two with transfers, toilet use, and one person for personal hygiene. The MDS recorded the resident experienced frequent episodes of bladder and bowel incontinence. The MDS documented diagnoses that included Non-Alzheimer's dementia and unspecified disorder of kidney and ureter. The care plan focus area revised 11/16/16 identified the potential for a urinary tract infection related to the resident being resistive to cares at times and incontinent. The care plan focus area revised 11/30/18 identified an ADL (Activities of Daily Living) self care performance deficit related to arthritis, obesity, and non-compliance with cares, walker or assistance to maintain safety. The care plan intervention revised 1/8/19 informed staff the resident transferred to the toilet with the extensive assist of one or two staff if able to use the sit to stand (mechanical lift) and wore incontinence products. Observation on 1/30/19 at 9:38 a.m. revealed Staff D, Certified Nurse Aide (CNA), and Staff C, CNA, assisted Resident #33 to transfer to the toilet. Staff D and Staff C used a sit to stand mechanical lift to transfer the resident from the wheelchair to the toilet. With gloved hands, Staff C removed a soiled incontinence brief and placed it in the trash. With the same contaminated	F 880	Measures put into place to ensure that the deficient practices do not recur include the following: 1. DON, in concert with Nursing Staff Development Coordinator (NSDC), will review the existing Infection Prevention and Control Policies regarding proper Hand-Hygiene during incontinent care, medication administration, respiratory treatments, and resident care equipment. 2. Staff care practices related to infection prevention will be audited monthly by Nursing Leadership Team, according to a calendar developed by DON and NSDC. 3. Education = RNs, LPNs and CMAs will complete the Omnicare self-study titled *Medication Pass Fundamentals Part 2: The 7 Rights, 3 Way Check, Basics of Preparing and Administering: Oral, Ophthalmic, Otic and Nasal Medications, Common Errors*...(this self-study includes appropriate hand-hygiene during medication administration). A facility created Knowledge Validation Post-test accompanies Omnicare self-study and is to be completed by 2/18/2019.	

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F 880	Continued From page 22 gloves, Staff C pushed the control buttons on the mechanical lift to lower the resident onto the toilet. Staff C then removed her gloves but did not wash or sanitize her hands. Staff C proceeded to make the resident's bed and Staff D informed her she should have washed her hands. Staff C responded the incontinent brief removed was lightly soiled with urine. Staff C returned to the bathroom and washed her hands. After providing incontinence cares, staff assisted the resident to transfer back to her wheelchair. Staff D placed the mechanical lift back out in the hallway but staff failed to sanitize the lift buttons and handles that Staff C touched with contaminated gloves. In an interview on 1/30/19 at 2:10 p.m., the Director of Nursing, (DON), acknowledged she expected staff to wash hands after removal of gloves. The facility procedure titled Hand Hygiene and Handwashing revised 1/18 included the following documentation: Background - Regular handwashing with soap and warm not hot water is one of the best ways to remove germs, avoid getting sick and prevent the spread of germs to others. Patient Care - The goal is to prevent the spread of infection between residents. Handwashing and changing gloves occurs after care is delivered to prevent the spread of organisms to other residents. Sanitizers are used in patient care areas. Procedure - During Patient Care Point 1. Wash hands with plain soap and water or with anti-microbial soap and water.	F 880	4. Education = RNs, LPNs, CNAs, CMAs will be re-educated regarding infection prevention and control (IPC) as related to: appropriate hand-hygiene during, peri-care, and resident care equipment. Education will consist of Knowledge Validation completed by 3/15/2019 and Skills Validation and completed by April 30, 2019. Monitor performance • Focus Audit = Completion of Omnicare self-study and knowledge validation post-test by 2/18/2019. • Focus Audit = Completion of IPC Knowledge Validation Post-test by 3/15/2019. • Focus Audit = Completion of IPC Skills Validation (which will include hand-hygiene r/t medication administration for RNs, LPN, and CMAs) by 4/30/2019. The results of these audits will be reported to the Quality Assurance Performance Improvement (QAPI) Committee for review and recommendation. The QAPI Committee will determine further auditing needs. Correction Date: 2/22/2019	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	165191	A. BUILDING _____ B. WING _____	01/31/2019

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F 880	Continued From page 23 a. If hands are visibly soiled b. If hands are visibly contaminated with blood or body fluids c. Before eating d. After using the restroom e. When a build-up of emollients (moisturizers such as ointments, lotions or creams) is felt on hands (usually after five to 10 applications of a gel) Point 2. If hands are not visibly soiled or contaminated with blood or body fluids, use an alcohol-based hand rub for routinely cleaning hands. a. Before having direct contact with residents, patients and children b. After having direct contact with another person's skin c. After having contact with body fluids, wounds or broken skin d. After touching equipment or furniture near the resident/patient e. After removing gloves 3. Alternatively, hands may be washed with an anti-microbial soap and water in clinical situations described above. 2. During an observation on 1/30/19 at 8:00 AM Staff A Registered Nurse (RN) administered Resident # 33's medications. Staff A used a pill cutter to cut a Potassium tablet in half. Once she placed the pill into the cutter, Staff A used her fingers to place the pill on the cutter to line up with the cutting blade. Staff A then removed a Lopressor (treat high blood pressure) tablet from the pill cassette and it dropped on the medication cart, she picked it up said "sorry," placed it in the medication cup and administered Resident #33's medications. Review of Resident #33's Electronic Health	F 880		

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

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F 880	Continued From page 24 Record (EHR) revealed the following orders: -Lopressor 50 milligrams (mg) twice a day -Potassium Tablet 20 milliequvilants (meq) twice a day 2. During an observation on 1/30/19 at 11:03 AM Staff A administered Resident #41's insulin without gloves. After she left Resident #41's room she went to the medication cart: touched the computer, medication cart. Staff A then went to Resident #40's room and administered his nasal spray and nebulizer treatment. Staff A cleansed the nasal spray tip with alcohol wipes, handled the computer to chart, then went to Resident #27's doorway and set up her supplies to obtain his blood sugar level. She removed a Sani-wipe (sanitizing wipe), the put the glucometer on the cart then went to assist a resident that fell. Staff A did not wear gloves while administering insulin and failed to perform proper hand hygiene between tasks during this medication administration observation. Review of Resident #41's EHR revealed the following order: -Novolog (insulin aspart) per sliding scale 3. During an observation on 1/30/19 at 11:34 AM Staff A administered Resident #25's insulin without gloves then went back to her medication cart used the computer without performing proper hand hygiene. Review of Resident #25 EHR revealed the following order: -Novolog 8 units (u) During interview on 1/30/19 at 2:39 PM the Director of Nursing (DON) stated staff should	F 880		

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F 880	Continued From page 25 have worn gloves while giving insulin and should have washed their hands between tasks. During a staff interview on 1/30/19 at 3:36 PM the DON stated staff should have obtained a new pill and are expected to not touch medications during administration. Review of the facility's Hand Hygiene and Handwashing Procedure with a revised date of 1/2018 revealed staff is to use alcohol-based hand rub before having direct contact with residents, after having direct contact with another person's skin.	F 880		