

PRINTED: 04/03/2019
FORM APPROVED
OMB NO. 0938-0391

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X8) DATE

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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CENTERS FOR MEDICARE & MEDICAID SERVICES

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 165165	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 03/13/2019
NAME OF PROVIDER OR SUPPLIER NORTHCREST SPECIALTY CARE			STREET ADDRESS, CITY, STATE, ZIP CODE 2001 HEATH STREET WATERLOO, IA 50703		
(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 578	Continued From page 1 time of admission and is unable to receive information or articulate whether or not he or she has executed an advance directive, the facility may give advance directive information to the individual's resident representative in accordance with State Law. (v) The facility is not relieved of its obligation to provide this information to the individual once he or she is able to receive such information. Follow-up procedures must be in place to provide the information to the individual directly at the appropriate time. This REQUIREMENT is not met as evidenced by: Based on clinical record review and staff interview, the facility failed to correctly document the resident's Advanced Directive status for one of eighteen residents reviewed. (Resident #74) The facility census was 89 residents. Findings include: Review of the clinical record for Resident #74 revealed an Iowa Physician Orders for Scope of Treatment (IPOST) dated 3/4/2015. The IPOST documented medical interventions for comfort measures only and DNR (Do Not Attempt Resuscitation). Review of a document labeled Cardiopulmonary Resuscitation/DNR Order Declaration Form dated 2/12/2019, documented I DO NOT WANT CPR. The care plan dated 2/12/2019, documented a focus area for Advanced Directives with an intervention of resident being a FULL CODE (desiring cardiopulmonary resuscitation). During interview on 3/11/19 at 4:05 p.m., the	F 578			

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F 578	Continued From page 2	F 578			
F 623 SS=B	Director of Nursing (DON) stated her expectation would be for advanced directives to match the residents IPOST and care plan. Notice Requirements Before Transfer/Discharge CFR(s): 483.15(c)(3)-(6)(8) §483.15(c)(3) Notice before transfer. Before a facility transfers or discharges a resident, the facility must- (i) Notify the resident and the resident's representative(s) of the transfer or discharge and the reasons for the move in writing and in a language and manner they understand. The facility must send a copy of the notice to a representative of the Office of the State Long-Term Care Ombudsman. (ii) Record the reasons for the transfer or discharge in the resident's medical record in accordance with paragraph (c)(2) of this section; and (iii) Include in the notice the items described in paragraph (c)(5) of this section. §483.15(c)(4) Timing of the notice. (i) Except as specified in paragraphs (c)(4)(ii) and (c)(8) of this section, the notice of transfer or discharge required under this section must be made by the facility at least 30 days before the resident is transferred or discharged. (ii) Notice must be made as soon as practicable before transfer or discharge when- (A) The safety of individuals in the facility would be endangered under paragraph (c)(1)(i)(C) of this section; (B) The health of individuals in the facility would be endangered, under paragraph (c)(1)(i)(D) of this section; (C) The resident's health improves sufficiently to	F 623			

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

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F 623	Continued From page 4 advocacy of individuals with a mental disorder established under the Protection and Advocacy for Mentally Ill Individuals Act. §483.15(c)(6) Changes to the notice. If the information in the notice changes prior to effecting the transfer or discharge, the facility must update the recipients of the notice as soon as practicable once the updated information becomes available. §483.15(c)(8) Notice in advance of facility closure In the case of facility closure, the individual who is the administrator of the facility must provide written notification prior to the impending closure to the State Survey Agency, the Office of the State Long-Term Care Ombudsman, residents of the facility, and the resident representatives, as well as the plan for the transfer and adequate relocation of the residents, as required at § 483.70(l). This REQUIREMENT is not met as evidenced by: Based on clinical record review and staff interview, the facility failed to notify the Ombudsman of the hospitalization for three of nine residents reviewed. (Resident #8, #30 & #4) The facility census was 89 residents. Findings include: 1. The Minimum Data Set (MDS) assessment dated 12/17/18, documented Resident #8 had diagnoses of heart failure, diabetes mellitus and congestive heart failure. Nurse Progress Notes dated 2/19/18 at 10:49 a.m., documented an order to send the resident out via ambulance.	F 623			

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F 623	Continued From page 5 Nurse Progress Notes dated 2/19/18 at 2:56 p.m., documented the resident was admitted with pneumonia, sepsis, and acute respiratory failure. Documentation of notification of the Ombudsmen was absent from the residents health record. Nurse Progress Note dated 7/19/18 at 12:39 p.m., documented the resident was transported via ambulance to the Emergency Room. Nurse Progress Notes dated 7/19/18 at 3:44 p.m., documented the resident was admitted to the hospital for pneumonia. Documentation of notification of the Ombudsmen was absent from the residents health record. During interview on 3/12/19 at 3:20 p.m., the Social Worker revealed she was using the wrong form. She acknowledged the Ombudsmen was not updated of the residents discharges to the hospital on 2/19/18 and 7/19/18. 2. The Minimum Data Set (MDS) assessment dated 12/27/18, documented Resident #30 had diagnoses of hypertension, Parkinson's disease and Diabetes Mellitus. Progress notes dated 2/11/2019, documented the resident was admitted to the hospital. Documentation of notification of the Ombudsman was absent from the resident's medical record. During interview on 3/11/19 at 4:49 p.m., the social worker confirmed the Ombudsman was not notified of resident's admission to the hospital. 3. The Minimum Data Set (MDS) assessment dated 11/30/18, documented Resident #4 had diagnoses of neurogenic bladder, septicemia and	F 623			

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F 623	Continued From page 6 multiple sclerosis. Nurse progress notes documented the resident was hospitalized 11/21/17, 2/2/18, 3/29/18, 6/27/18, 7/20/18, 8/6/18, 9/7/18, 10/25/18, and 11/16/18. During review of the Ombudsman notification list for the dates of each hospital admission/transfer out of facility revealed the resident's name was not documented on the monthly notification list. During interview on 3/11/19 at 1:40 p.m., the Social Worker stated the bed hold notification was not completed as resident is a complicated case, has a lot of equipment in his room, and they have always held his bed.	F 623			
F 625 SS=B	Notice of Bed Hold Policy Before/Upon Trnsfr CFR(s): 483.15(d)(1)(2) §483.15(d) Notice of bed-hold policy and return- §483.15(d)(1) Notice before transfer. Before a nursing facility transfers a resident to a hospital or 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			

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F 625	Continued From page 7 (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 clinical record review, facility policy review and staff interview, the facility failed to notify the resident or resident representative of the bed hold for hospitalization for two of nine residents reviewed (Resident #8 & #4) The facility census was 89 residents. Findings include: 1. The Minimum Data Set (MDS) assessment dated 12/17/18, documented Resident #8 had diagnoses of heart failure, diabetes mellitus and congestive heart failure. Nurse Progress Notes dated 2/19/18 at 10:49 a.m., documented an order to send the resident out via ambulance. Nurse Progress Notes dated 2/19/18 at 2:56 p.m., documented the resident was admitted with pneumonia, sepsis, and acute respiratory failure. Documentation of notification of the Ombudsmen was absent from the residents health record. Nurse Progress Note dated 7/19/18 at 12:39 p.m., documented the resident was transported via ambulance to the Emergency Room.	F 625			

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F 625	Continued From page 8 Nurse Progress Notes dated 7/19/18 at 3:44 p.m., documented the resident was admitted to the hospital for pneumonia. Documentation of notification of the Ombudsmen was absent from the residents health record. Documentation of notification of resident or their representative regarding the bed hold was absent from the residents health record for 2/19/18 and 7/19/18 admission to the hospital. During interview on 3/12/19 at 3:40 p.m., the Director of Nursing, DON stated the facility sends the bed hold with the resident to the hospital. She stated the nurses are to chart in the progress notes the resident was aware of the bed hold. During interview on 3/12/19 at 4:10 p.m., the Social Worker revealed she was unable to locate any nurse's note or evaluations, regarding bed hold for 2/19/18 and 7/19/18 discharges. 3. The Minimum Data Set (MDS) assessment dated 11/30/18, documented Resident #4 had diagnoses of neurogenic bladder, septicemia and multiple sclerosis. Nurse progress notes documented the resident was hospitalized 11/21/17, 2/2/18, 3/29/18, 6/27/18, 7/20/18, 8/6/18, 9/7/18, 10/25/18, and 11/16/18. Documentation in the resident's health record failed to identify notification of the resident or the resident's representative of the facility bed hold policy for 8 out of the 9 hospitalizations. A review of the facility Bed Hold Policy with revision date of 3/14/17 directs Care Initiatives	F 625			

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F 625	Continued From page 9 agrees to hold the bed of any resident upon the return of a signed bed hold agreement. Each time a resident goes out of the building, a new bed hold agreement will be sent with the transferring resident.	F 625			
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)- (A) The resident's goals for admission and desired outcomes.	F 656			

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F 656	Continued From page 10 (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 observation, clinical record review and staff interview, the facility failed to ensure the care plan was followed for one of twenty-one residents reviewed. (Resident #65) The facility census was 89 residents. Findings Include: 1. The Minimum Data Set (MDS) assessment dated 1/30/19, documented Resident #65 had diagnoses of non-Alzheimer's dementia and legal blindness and required total assistance of two for bed mobility and transfer. The care plan updated 8/30/18, included a problem of potential for nutritional risk related to blindness, diabetes mellitus, depression and dementia, need for assist at meals. The problem included an intervention of when assisting resident at meals, speak loudly and tell resident what eating. On 3/11/19 at 6:10 p.m., the resident sat in a geri-chair in the dining room. Staff J, Certified Nurse Aide, CNA fed the resident numerous spoonfuls of pudding alternated with chicken noodle soup. Staff J failed to tell the resident what	F 656			

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F 656	Continued From page 11 they were being fed. On 3/12/19 at 7:55 a.m., the resident sat in a geri-chair at the table in the dining room, Staff K, CNA sat beside resident and fed hot cereal alternated with yogurt by the spoonful repeatedly and failed to tell the resident what they had been feeding them. The care plan also included a problem of potential for pressure ulcers and skin breakdown related to diabetes, incontinence, impaired mobility. Chronic reddened areas to abdominal folds. History of a recurrent open area on right buttock related to incontinence. History of pressure ulcer to right heel and bilateral buttocks. The problem included the following interventions: -Heel couch to bed to suspend heels as tolerated -Tubi-grips on upper extremities as tolerated -Right hand palm posey when out of bed as tolerated On 3/11/19 at 5:43 p.m., the resident laid in bed with no tubi-grips on bilateral upper arms and no heel couch on the bed to float heels. At 6:10 p.m., as the resident sat in a geri-chair for supper observation revealed no palm protector to the right hand. On 3/12/19 at 8:34 a.m., Staff K, CNA and Staff M, CNA positioned the resident in bed with no heel couch to float heels. The resident had no tubi-grips on the bilateral upper arms. A 9:16 a.m., the resident remained in bed with no	F 656			

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F 656	Continued From page 12 heel couch on the bed to float heels and no tubi-grips to the arms. The care plan also included a problem of resident requires assistance with activity of daily living related to impaired vision/blindness, dementia, tremors, and ataxia. The problem included an intervention to assist resident to remain in upright position for one hour after meals. On 3/12/19 at 8:31 a.m., Staff M finished assisting the resident with breakfast. At 8:34 a.m., Staff M and Staff K transferred the resident to bed without allowing the resident to sit up for an hour after breakfast as directed. The resident had no palm posey in the right hand as planned. At 1:35 p.m., Staff M stated they thought the resident had not worn tubi-grips on the arms for several months because they caused the resident to have blisters. Staff M stated they laid the resident down after meals because they thought it had been the family preference. Staff M stated they had not used the heel couch or palm posey for months and had not been aware it had been on the care plan. On 3/13/19 at 10:00 a.m., the DON stated they would expect staff to follow the plan of care.	F 656			
F 658 SS=D	Services Provided Meet Professional Standards CFR(s): 483.21(b)(3)(i) §483.21(b)(3) Comprehensive Care Plans The services provided or arranged by the facility, as outlined by the comprehensive care plan, must- (i) Meet professional standards of quality. This REQUIREMENT is not met as evidenced	F 658			

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F 658	Continued From page 13 by: Based on observation, clinical record review, staff and resident interviews, the facility failed to follow physician orders for three of 22 residents reviewed (Resident #21, 65 & 77). The facility census was 89 residents. Findings include: 1. Resident #21's Minimum Data Set (MDS) assessment dated 12/21/18, showed the resident had heart failure, respiratory failure and chronic peripheral venous insufficiency. The Physician Order Statement (POS) directed staff on 1/10/19 to apply bilateral tubi-grip size F, then black Velcro compression wraps. Staff were to apply the black wrap to the ankles first, then to the resident's calf. Tighten the compression wraps from the bottom up, attaching the Velcro in rotation from side to side. Staff were to apply these every day and evening shift related to the resident's lymphedema. The Care Plan with a revision on 1/10/19 showed the resident had bilateral lower extremity edema related to Congestive heart failure (CHF), venous insufficiency and lymphedema. Interventions for this problem included to apply bilateral lower extremity compression wraps per physician orders as tolerated. During interview on 03/11/19 at 7:23 a.m., the resident reported getting both feet wrapped every morning and removed every night. Observation on 3/11/19 at 7:32 a.m. showed Staff C, Certified Nursing Aide (CNA), came in to apply	F 658			

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F 658	Continued From page 14 the tubi-grips and compression wraps. Staff C did not open the closet to refer to the diagrams posted on the inside door which Occupational Therapy (OT) had hung for staff to refer to in the compression wraps application. Staff C applied the tubi-grips to the residents's legs, applied the black compression wraps. The black compression wraps had Velcro pads that would alternate (criss-cross) over the other. There were 2 pieces involved for the application, one for ankle area and one for the calf area. Staff C applied the black compression wrap to the resident's calf first, then applied the ankle wrap last. She applied the resident's other leg's compression wrap in the same manner, calf first and the lower one second, instead of the other way around. During interview on 3/12/19 at 11:45 a.m., Occupational Therapy staff reported the compression wraps should be applied with the lower ankle wrap first and the calf wrap on last. The application is important in order to obtain the graded compression effect, which is from the distal (farthest away from the main body area) to the proximal area (nearest to the main body area). Staff I did not remember what staff member received the instructions from her. During interview on 3/12/19 at 2:40 p.m., the Director of Nursing (DON), Consultant RN and Assistant Director of Nursing (ADON), discussed the situation. The DON was surprised to hear staff did not apply the compression wraps correctly. 2. The Minimum Data Set (MDS) assessment dated 1/30/19, documented Resident #65 had diagnoses of non-Alzheimer's dementia and legal	F 658			

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F 658	Continued From page 15 blindness and required total assistance of two for bed mobility and transfer. A physician order summary report included an order dated 4/29/17, for daily range of motion and massage to the residents hands every day shift. The care plan updated 9/21/18, included a problem of restorative program for range of motion. The problem included an interventions for passive range of motion upper extremity exercises, ten second holds all planes 3 times per week. A restorative sheet for the month of March 2019 revealed the resident had received range of motion exercises to bilateral upper extremities three times per week. On 3/10/19 at 3:06 p.m., the resident laid in bed. Observation revealed both hands in a tightly contracted/flexed position. On 3/12/19 at 9:16 a.m., Staff L, Restorative Aide entered the residents room. The resident laid in bed and Staff L stated the resident had been very contracted. Staff L stated range of motion was routinely completed for the resident three times per week. Staff L failed to do any massage or range of motion to the residents right hand, and failed to complete any massage to the residents left hand. On 3/13/19 at 10:00 a.m., the DON stated they did not know why hand massage and daily range of motion had been on the physician order sheet. 3. The MDS assessment dated 2/16/19,	F 658			

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F 658	Continued From page 16 documented Resident #77 had diagnoses of chronic systolic congestive heart failure and required extensive assistance of one for bed mobility and transfer. The care plan updated 1/23/19, included a problem of altered respiratory status/difficulty breathing secondary to congestive heart failure/pneumonia. A physician order summary included an order dated 1/24/19, for a daily weight and notify provider of weight gain greater than 3 pounds per day or 5 pounds per week. Clinical record review revealed the following weight changes with no physician notification: -2/9 to 2/10/19, weight change of 225 to 228 pounds, three pound gain -2/15 to 2/16/19, weight change of 214 to 219 pounds, five pound gain -3/4 to 3/6/19, weight change of 208 to 211 pounds, three pound gain Record review revealed no weight completed on 3/5/19. The Assistant Director of Nursing stated on 3/12/19 at 10:30 a.m., the nurses should have notified the physician when the weight changes occurred and did not.	F 658			
F 684 SS=D	Quality of Care CFR(s): 483.25	F 684			

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F 684	Continued From page 17 § 483.25 Quality of care Quality of care is a fundamental principle that applies to all treatment and care provided to facility residents. Based on the comprehensive assessment of a resident, the facility must ensure that residents receive treatment and care in accordance with professional standards of practice, the comprehensive person-centered care plan, and the residents' choices. This REQUIREMENT is not met as evidenced by: Based on observation, clinical record review and staff interview, the facility failed to ensure timely assessments and interventions were completed for areas of altered skin integrity for one of one resident with non-pressure skin concerns. The facility census was 89 residents. Findings Include: The Minimum Data Set (MDS) assessment dated 1/21/19, documented Resident #51 had diagnoses of diabetes mellitus and contusion of left lower leg and required extensive assistance of two for bed mobility and total assistance of two for transfer. The care plan updated 2/4/19, included a problem of potential for pressure ulcers and other skin breakdown related to diabetes, impaired mobility and incontinence. The problem included an intervention to monitor skin with baths and cares. Report any reddened or open areas to nurse and physician. On 3/10/19 at 1:44 p.m., observation revealed dark purple bruises covering a large area on the residents bilateral posterior hands, as well as a tear covered with a dark scab on each hand. At	F 684			

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F 684	Continued From page 18 the time the resident stated the bruises on bilateral hands had been from when staff turned the resident from side to side, some of them used the residents hands instead of shoulders to turn. Clinical record review revealed no documentation of an assessment of the residents hands or new interventions to prevent further damage to the residents skin. On 3/11/19 at 4:44 p.m., the Director of Nursing entered the resident room to assess the residents hands. The DON stated they were unaware of any issues with the residents' hands. At 4:50 p.m., the DON verified no one had assessed the residents hands and should have.	F 684			
F 686 SS=G	Treatment/Svcs to Prevent/Heal Pressure Ulcer CFR(s): 483.25(b)(1)(i)(ii) §483.25(b) Skin Integrity §483.25(b)(1) Pressure ulcers. Based on the comprehensive assessment of a resident, the facility must ensure that- (i) A resident receives care, consistent with professional standards of practice, to prevent pressure ulcers and does not develop pressure ulcers unless the individual's clinical condition demonstrates that they were unavoidable; and (ii) A resident with pressure ulcers receives necessary treatment and services, consistent with professional standards of practice, to promote healing, prevent infection and prevent new ulcers from developing. This REQUIREMENT is not met as evidenced by: Northcrest Soecialty F686 G Exit date: 3/13/19	F 686			

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F 686	Continued From page 19 Based on observation, staff interview and clinical record review the facility failed to prevent the development of pressure ulcers for 1 of 2 residents reviewed. The resident developed 3 pressure ulcers areas after returning from the hospital with surgery for a fractured hip. (Resident #68) The facility identified a census of 89 residents. Findings include: 1. The Minimum Data Set (MDS) assessment for Resident #68 dated 1/3/19 documented admission after an acute hospital stay and included diagnoses of diabetes, muscle weakness and dementia. The MDS documented the resident required limited staff assistance with transfers, bed mobility and ambulation with no skin concerns for pressure ulcers or injuries. The MDS documented a weight of 120 pounds. A Skin Evaluation for Non-Pressure form dated 1/6/19 showed no skin concerns except for the incision to the left closed fractured hip. A Progress Note dated 1/6/19 upon return to the facility documented the resident had no pressure areas. The Braden Scale for Predicting Pressure Sore Risks dated 1/6/19 documented the resident scored a 17 (at risk for developing pressure sores). The MDS assessment dated 2/7/19 included diagnoses of diabetes, dementia, hip fracture, schizophrenia, muscle wasting and atrophy of the	F 686			

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F 686	Continued From page 20 left thigh. The MDS documented the resident required extensive assistance of two for bed mobility and extensive assistance of one for transfer, and had a Brief Interview for Mental Status score of 3 (severe memory loss). The assessment showed the resident had weight loss of 5% or more not prescribed by the physician and had 3 unstagable pressure ulcers. The MDS identified the following descriptions of pressure ulcers: -Stage I is an intact skin with non-blanchable redness of a localized area usually over a bony prominence. Darkly pigmented skin may not have a visible blanching; in dark skin tones only it may appear with persistent blue or purple hues. -Stage II is partial thickness loss of dermis presenting as a shallow open ulcer with a red or pink wound bed, without slough. May also present as an intact or open/ruptured blister. -Stage III Full thickness tissue loss. Subcutaneous fat may be visible but bone, tendon or muscle is not exposed. Slough may be present but does not obscure the depth of tissue loss. May include undermining and tunneling. -Stage IV is full thickness tissue loss with exposed bone, tendon or muscle. Slough or eschar may be present on some parts of the wound bed. Often includes undermining and tunneling. The Care Plan updated 1/10/19 (after the findings of the pressure ulcers) included a focus area of increased potential for pressure	F 686			

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F 686	Continued From page 21 ulcers and other skin breakdown related to diabetes, incontinence and impaired mobility, with pressure injuries to the coccyx and bilateral heels on 1/10/19. The problem included the following interventions: - gel overlay mattress on bed (11/08/2018). - pressure reducing cushion in wheelchair (1/09/2019). - keep heels elevated when in bed (1/10/2019). - Prafo boots to bilateral feet at all times (1/10/2019). - Treatments per physician orders (1/10/2019). A Non-Pressure Skin Evaluation dated 1/10/19 showed a new injury on the right big toe which had fluid serous intact blister to the front and bottom. The measurement showed 3.3 centimeters (cm) in length and 2.5 cm in width. A Pressure Injury Evaluation dated 1/10/19 showed a pressure ulcer to the lower coccyx with the wound bed clean. The measurements showed 0.5 cm in length x 0.5 cm in width and no depth, documenting the area as a stage II pressure ulcer. The report showed the resident's mattress upgraded to an air mattress and a gel cushioned to the wheelchair. The report also showed the resident had not experienced pain related to the pressure injury. A Pressure Injury Evaluation dated 1/10/19 showed a pressure ulcer to the resident's upper coccyx, showing 50 percent (%) with eschar and 50% with white and gray tissue to the wound bed.	F 686			

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F 686	Continued From page 22 The measurements showed 0.8 cm in length x 0.5 cm in width and 0.1 cm in depth, documented as unstageable. The report also showed the resident had not experienced pain related to the pressure injury. A Pressure Injury Evaluation dated 1/10/19 showed a pressure ulcer to the resident's left heel described as an intact blood blister present. The measurements showed 6.5 cm in length x 4.5 cm in width and 0 depth, documented as unstageable. Staff initiated Prafo boot (heel protectors) and a pillow under both legs. The report also showed the resident had experienced pain related to the pressure injury. A Pressure Injury Evaluation dated 1/10/19 showed a pressure ulcer to the resident's right heel described as an area with purple discoloration, soft and boggy to the touch with depth unknown but skin intact. The measurements showed 4.3 cm in length x 2 cm in width and 0 depth (unknown), documented as suspected deep tissue injury. Staff initiated Prafo boot and a pillow under both legs. The report also showed the resident had not experienced pain related to the pressure injury. On 03/11/19 at 8:35 a.m., staff toileted the resident. Observation revealed a small intact dry Mepilex dressing covering the resident's coccyx. During observation on 3/11/19 at 10:49 a.m. Staff D, Licensed Practical Nurse (LPN) performed the prescribed treatment to the resident's heels. The right heel showed dark brown eschar on the bottom toward the outer side of the foot. The area appeared to be the size of a nickel touching into another eschar which appeared the size of a	F 686			

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F 686	Continued From page 23 dime. The left foot had a large dark brown area on the entire bottom of the heel. Staff D stated they thought the pressure sores started from shoes. Staff O, Registered Nurse (RN) also observing, stated they showed as blisters in the beginning. Staff O then stated the resident's coccyx was nearly healed with the dressing change due for change on the evening shift. Progress Notes revealed the following: - 1/6/19 at 9:47 p.m.: the resident returned to the facility, resting in bed. - 1/7/19 at 2:17 a.m.: no concerns at the night shift. - 1/8/19 at 8:44 a.m.: the resident came out for breakfast, lost another pound and remains extremely passive. - 1/8/19 at 8:47 p.m.: the resident stayed in bed and refused to come out for supper, seems very weak and will continue to monitor. - 1/9/19 at 8:20 p.m.: resting quietly tonight. - 1/10/19 at 9:07 a.m.: the resident rested in bed and got ready for breakfast when Staff noted 2 open areas to the resident's coccyx and placed a Mepilex dressing at the site. - 1/10/19 at 11:39 a.m.: Nurse was called to room this a.m., noted 2 small openings on the coccyx. Areas are present over coccyx (upper aspect is unstageable and lower aspect is stage 2). Area cleansed and mepilex border applied. Assistant Director of Nursing (ADON)/RN manager were notified. Further assessment completed. Resident	F 686			

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F 686	Continued From page 24 was checked for other skin alterations and noted blister to left heel and deep tissue injury to right heel. Resident also has serous fluid filled blister to top of right great toe. Resident had complained of pain to left heel when asked, but unable to rate. Had eyes closed and relaxed posture while lying in bed. Meplex border applied. Gel mattress overlay replaced with air mattress. Prafo boots applied to bilateral feet and pillow underneath lower legs. Also upgraded resident wheel chair cushion to an equi-gel cushion. See pressure ulcer and skin evaluation. IMPACT was notified and requested consult for further wound management On 3/12/19 at 9:20 a.m. Staff D, Licensed Practical Nurse (LPN), stated they usually work the residents hall. Staff D reported the nurse doing a re-admission should make sure to check the residents skin, especially their heels when coming back from the hospital. They have had problems with resident's developing pressure ulcers when returning from the hospital. Staff D stated she did not re-admit this resident and did not remember if the resident had an air mattress on the bed before the residents went to the hospital. Staff D stated she would not automatically put on heel protectors either. She reported being acutely aware of the necessity to check resident's heels when returning to the facility. She noted if the heels are soft and spongy that is a problem starting and would place preventative measures right away. If the resident's heels are intact and firm then there probably isn't a concern at that time. On 3/12/19 at 2:10 p.m. the Director of Nursing (DON), the Consultant RN, and the ADON discussed the situation during an interview. The	F 686			

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F 686	Continued From page 25 ADON stated staff reported an opening on the resident's coccyx on 1/10/19 and she went to assess the resident. While doing that she felt the need to also assess the resident's heels. The ADON found pressure areas on the resident's heels. The DON remarked the resident had been on a repositioning schedule for the nurse aides. They all agreed the care plan showed interventions added after the pressure ulcers were identified. They did not know if the resident had the heels floated while bed, prior findings to the pressure areas, but probably didn't, as no documentation found including this prevention. The RN Consultant commented floating the resident's heels should have been implemented, if anything, right after returning from the hospital. They all verified the resident had diabetes, a small build, limited mobility after surgery and at risk to develop pressure areas. The ADON noted the area on the big toe founded as a vascular injury, as it did not display signs of a pressure area as the resident had not ambulated and did not wear shoes. The facility's policy dated 1/2015 for Prevention of Pressure Ulcers documented the purpose: to promote good skin integrity, to relieve pressure, restore circulation and promote skin protection in the affected area. The guidelines in this Policy included the following: - reposition the resident routinely and position with pads and pillows to protect bony prominence's and maintain proper alignment. - use elbow and/or heel foot protectors if needed.	F 686			

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F 686	Continued From page 26	F 686			
F 690	NOTE: any reddened area that remains red longer than 30 minutes after pressure is relieved is at high risk for a pressure sore to develop.				
SS=D	Bowel/Bladder Incontinence, Catheter, UTI CFR(s): 483.25(e)(1)-(3)	F 690			
	§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 receives appropriate treatment and services to				

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F 690	Continued From page 27 restore as much normal bowel function as possible. This REQUIREMENT is not met as evidenced by: Based on observation, clinical record review and staff interview, the facility failed to complete catheter cares as ordered for one of four residents reviewed with a catheter. (Resident # 77) The facility census was 89 residents. Findings include: The Minimum Data Set (MDS) assessment dated 2/16/19, documented Resident #77 had diagnoses of septicemia, retention of urine and acute cystitis and required extensive assistance of one for bed mobility and transfer. A hospital discharge summary documented the resident had been discharged from the hospital 1/23/19, with diagnosis of acute cystitis, acute kidney injury and severe sepsis. A physician order sheet included an order for Foley cares every shift for sepsis protocol dated 1/24/19. The care plan updated 3/1/19, included a problem of Foley catheter related to urinary retention. The problem included an intervention for catheter care every shift and as needed or per physician order. On 3/12/19 at 9:37 a.m., the resident sat in their room in a wheel chair. Staff K, Certified Nurse Aide, CNA and Staff M, CNA emptied the residents catheter drainage bag. At that time Staff M stated that would be the extent of catheter cares for the day shift.	F 690			

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F 690	Continued From page 28 At 1:44 p.m., Staff K stated day shift completed no other catheter care for the resident. Staff K stated the night shift routinely did the actual cleansing of the catheter, perineal area and insertion site. At 2:30 p.m., the Director of Nursing stated they had just done a skills check and all staff knew catheter cares were to be completed every shift.	F 690			
F 725 SS=E	Sufficient Nursing Staff CFR(s): 483.35(a)(1)(2) §483.35(a) Sufficient Staff. The facility must have sufficient nursing staff with the appropriate competencies and skills sets to provide nursing and related services to assure resident safety and attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident, as determined by resident assessments and individual plans of care and considering the number, acuity and diagnoses of the facility's resident population in accordance with the facility assessment required at §483.70(e). §483.35(a)(1) The facility must provide services by sufficient numbers of each of the following types of personnel on a 24-hour basis to provide nursing care to all residents in accordance with resident care plans: (i) Except when waived under paragraph (e) of this section, licensed nurses; and (ii) Other nursing personnel, including but not limited to nurse aides. §483.35(a)(2) Except when waived under paragraph (e) of this section, the facility must designate a licensed nurse to serve as a charge	F 725			

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F 725	Continued From page 29 nurse on each tour of duty. This REQUIREMENT is not met as evidenced by: Based on clinical record review, resident, family and staff interviews, the facility failed to answer resident call lights in a timely manner in order to meet resident needs. The facility census was 89 residents. Findings include: 1. On 3/10/19 at 10:55 a.m., Resident # 71 reported feeling short of staff and usually had to wait over 15 minutes for the call lights to be answered. The resident reported it was usually 20 minutes or more. The resident commented they are very busy and this hall had many residents requiring a lot of care, so staff end up rushing. 2. On 3/10/19 at 10:25 a.m., Resident # 58's spouse reported call lights are usually answered in 20 minutes or more. The spouse reported it happens usually in the mornings and at supertime, when staff are busy. The spouse felt they are short staffed and rushed. 3. The minimum data set (MDS) assessment dated 12/24/18, documented Resident #25 had diagnoses of orthostatic hypotension and cerebral palsy and had a Brief Interview for Mental Status score of 15, indicating intact cognition. During interview on 3/11/19 at 4:51 p.m., the resident stated call light response time had frequently been a problem. The resident stated the problem had been their need for two assistance and that was why it frequently takes	F 725			

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F 725	Continued From page 30 staff longer than 15 minutes to answer call lights. The resident stated it had happened most recently within the past few days. 4. The Minimum Data Set (MDS) completed on 1/15/19, documented Resident #38 had diagnoses of aphasia (inability to speak) and cerebrovascular accident (stroke) During interview on 3/10/19 at 11:36 a.m., the resident's family stated it takes a while to get someone to answer the call lights especially around meal times. The family member did not have specific dates or times but stated it was too long when a person needs help. 5. The MDS assessment completed on 1/21/19, documented Resident #83 had diagnoses of heart failure, multiple sclerosis, and chronic obstructive pulmonary disease (COPD) and had a BIMS score of 13, indicating mild cognitive impairment. During interview on 3/11/19 at 7:27 a.m., the resident stated sometimes it takes a while to get her call light answered. She was unable to provide specific dates or times but stated when she can not breathe it feels like forever. During interview on 3/12/19 at 10:45 a.m., the Director of Nursing (DON) stated her expectation would be that all call lights are answered in less than 15 minutes. The DON stated she feels they are adequately staffed but they have a high acuity level with the resident's currently living in the facility. 6. During Resident Council meeting on 3/11/19 at 11:00 a.m., three of five residents verbalized concern of response time to call lights.	F 725			

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F 812 SS=E	Food Procurement,Store/Prepare/Serve-Sanitary CFR(s): 483.60(l)(1)(2) §483.60(l) Food safety requirements. The facility must - §483.60(l)(1) - Procure food from sources approved or considered satisfactory by federal, state or local authorities. (i) This may include food items obtained directly from local producers, subject to applicable State and local laws or regulations. (ii) This provision does not prohibit or prevent facilities from using produce grown in facility gardens, subject to compliance with applicable safe growing and food-handling practices. (iii) This provision does not preclude residents from consuming foods not procured by the facility. §483.60(l)(2) - Store, prepare, distribute and serve food in accordance with professional standards for food service safety. This REQUIREMENT is not met as evidenced by: Based on observation, facility policy review and staff interviews, the facility failed to ensure dietary staff followed proper sanitizing recommendations when disinfecting the food prep area in the main kitchen area. The facility census was 89 residents. Findings include: 1. Observation on 11/10/19 at 9:44 a.m., of the main Kitchen area revealed a red sanitizer bucket used for sanitizing the food prep areas, work surfaces and small equipment. Staff A tested the PH level with a strip of Hydrion tester. The strip failed to change color to the appropriate level showing the sanitized water to be effective. Staff	F 812			

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F 812	Continued From page 32 A said the strip should read 200 parts per million (ppm) or even a higher reading. She also reported the the red bucket gets changed every shift, 3 times a day. The color of the (Hydriion) strip should change from orange to green, which marks the level of 200 ppm, indicating the sanitizing effects. Staff A acknowledged not knowing how often the water should be changed. Observation on 3/11/19 at 12:25 p.m., the Dietary Service Manager checked the red bucket. She noted the water cold to touch and said it probably would not reach the appropriate PH level. The sanitizer bucket did not change colors on the strip, indicating the bucket did not sanitize or disinfect the food prep areas. She noted staff were just using the bucket for cleansing the food preps areas. The Dietary Supervisor reported the color of the (Hydriion) PH strip should change from orange to green to show 200 ppm to indicate the sanitizing effects for cleaning. She also reported she had informed the staff many times the red bucket needed to be changed about every 2 hours. Record review of the Cleaning Instructions dated 2/2016 showed the Policy of all kitchen areas and equipment shall be maintained in a sanitary manner and be free of buildup of food, grease, or other soil. Detailed instructions for cleaning each piece of equipment shall be available to every employee. In Procedure #6 (part c) it showed the red bucket of quaternary solution will be maintained in the Dietary Department and utilized to sanitize small equipment and work surfaces with warm detergent. This solution is to be tested to register 200 ppm with a qualified test strip often and changed every 2 to 4 hours as needed to ensure it registers at 200 ppm.	F 812			

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F 838 SS=C	Facility Assessment CFR(s): 483.70(e)(1)-(3) §483.70(e) Facility assessment. The facility must conduct and document a facility-wide assessment to determine what resources are necessary to care for its residents competently during both day-to-day operations and emergencies. The facility must review and update that assessment, as necessary, and at least annually. The facility must also review and update this assessment whenever there is, or the facility plans for, any change that would require a substantial modification to any part of this assessment. The facility assessment must address or include: §483.70(e)(1) The facility's resident population, including, but not limited to, (i) Both the number of residents and the facility's resident capacity; (ii) The care required by the resident population considering the types of diseases, conditions, physical and cognitive disabilities, overall acuity, and other pertinent facts that are present within that population; (iii) The staff competencies that are necessary to provide the level and types of care needed for the resident population; (iv) The physical environment, equipment, services, and other physical plant considerations that are necessary to care for this population; and (v) Any ethnic, cultural, or religious factors that may potentially affect the care provided by the facility, including, but not limited to, activities and food and nutrition services. §483.70(e)(2) The facility's resources, including but not limited to, (i) All buildings and/or other physical structures	F 838			

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F 838	Continued From page 34 and vehicles; (ii) Equipment (medical and non- medical); (iii) Services provided, such as physical therapy, pharmacy, and specific rehabilitation therapies; (iv) All personnel, including managers, staff (both employees and those who provide services under contract), and volunteers, as well as their education and/or training and any competencies related to resident care; (v) Contracts, memorandums of understanding, or other agreements with third parties to provide services or equipment to the facility during both normal operations and emergencies; and (vi) Health information technology resources, such as systems for electronically managing patient records and electronically sharing information with other organizations. §483.70(e)(3) A facility-based and community-based risk assessment, utilizing an all-hazards approach. This REQUIREMENT is not met as evidenced by: Based on review of the Facility Assessment and staff interview, the facility failed to complete a thorough evaluation of their needs and services. The facility census was 89 residents. Findings include: A review of the Facility Assessment on 3/11/19 at 3:30 p.m., revealed a two page document that listed the number of residents with specific diagnoses, a list of equipment needed, a list of facility staff and education levels and facility third party agreements. The Facility Assessment does not evaluate the resident population and identify resources needed to provide the necessary person-centered care and services the residents	F 838			

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F 838	Continued From page 35 require. During interview on 3/12/19 at 3:00 p.m., the Administrator and Consultant Nurse acknowledged the assessment was not thorough and complete. She stated the facility will be working on expanding and individualizing the information to identify the specific resident and staffing needs. On 3/12/19 at 4:54 p.m., the Director of Nursing stated they knew what equipment the facility had and how much assistance each residents needed. The DON stated the facility assessment was completed by the former administrator and it did not include all resources and services provided to residents. The DON stated the facility was aware the facility assessment had not been complete.	F 838			

1) F578

Advance Directives

The facility denies that the alleged facts as set forth constitute a deficiency under interpretations of Federal and/or State law. Preparation and/or execution of this plan of correction does not constitute an admission or agreement by this provider of the truth of the facts alleged or conclusions set forth in this statement of deficiencies. The plan of correction is prepared and/or executed solely because it is required by the provision of federal and/or state law.

This is my credible allegation of compliance to F578. This allegation does not constitute guilt but that the facility is in compliance to F578.

In regards to Resident #74 and any similar situated resident. Resident #74 Care Plan has been Corrected to say see CPR Declaration. All current residents' care plans were audited to ensure that code status declaration form was accurate and care plans updated to say "see code status declaration."

Staff educated on date: 3/19/2019 concerning Advance Directives protocol
Social Services and Nurse Management will complete random audits to ensure Advance Directive, IPOST and Care Plan match

2) F623

Ombudsman

The facility denies that the alleged facts as set forth constitute a deficiency under interpretations of Federal and/or State law. Preparation and/or execution of this plan of correction does not constitute an admission or agreement by this provider of the truth of the facts alleged or conclusions set forth in this statement of deficiencies. The plan of correction is prepared and/or executed solely because it is required by the provision of federal and/or state law.

This is my credible allegation of compliance to F623. This allegation does not constitute guilt but that the facility is in compliance to F623.

In regards to resident # 8, 30, and 4 and any similar situated resident

Staff educated on date: 3/19/2019 concerning reporting of discharges and transfers to the Office of the State Long-Term Care Ombudsman

Administrator will monitor and conduct routine audits for compliance. Concerns noted will be addressed immediately

3) F625

Bed Hold

The facility denies that the alleged facts as set forth constitute a deficiency under interpretations of Federal and/or State law. Preparation and/or execution of this plan of correction does not constitute an admission or agreement by this provider of the truth of the facts alleged or conclusions set forth in this statement of deficiencies. The plan of correction is prepared and/or executed solely because it is required by the provision of federal and/or state law.

This is my credible allegation of compliance to F625. This allegation does not constitute guilt but that the facility is in compliance to F625.

In regards to resident #8 and #4 and any similar situated resident

Staff educated on date: 3/19/2019 concerning the Bed Hold protocol.

Nursing management and social services will monitor and conduct routine audits for compliance, any concerns will be brought to Daily QA for discussion and resolution

4) F656

Care Plan

The facility denies that the alleged facts as set forth constitute a deficiency under interpretations of Federal and/or State law. Preparation and/or execution of this plan of correction does not constitute an admission or agreement by this provider of the truth of the facts alleged or conclusions set forth in this statement of deficiencies. The plan of correction is prepared and/or executed solely because it is required by the provision of federal and/or state law.

This is my credible allegation of compliance to F656. This allegation does not constitute guilt but that the facility is in compliance to F656.

In regard to resident #65 and any similar situated resident

Staff educated on date: 3/14/2019, 3/19/2019, and 3/20/2019 on following the care plan.

Resident #65, therapy services were enlisted with new recommendations received. The plan of care has been updated to reflect current recommendations.

Care plans will be monitored via routine audits by director of nursing/designee, any concerns will be addressed immediately

5) F658

Following MD Orders

The facility denies that the alleged facts as set forth constitute a deficiency under interpretations of Federal and/or State law. Preparation and/or execution of this plan of correction does not constitute an admission or agreement by this provider of the truth of the facts alleged or conclusions set forth in this statement of deficiencies. The plan of correction is prepared and/or executed solely because it is required by the provision of federal and/or state law.

This is my credible allegation of compliance to F658. This allegation does not constitute guilt but that the facility is in compliance to F658.

In regards to Resident #21, #65, #77 and any similar situated resident

Resident #21, nurses are now donning and doffing black Velcro compression wraps. Education was completed on 3/20/2019 for nurses concerning following MD orders.

Resident #65 picked up under Part B therapy services to review current restorative recommendations. New recommendations have been received and implemented.

Resident #77, nursing staff educated on proper procedure for weight monitoring and doctor notification on 3/14/2019 and 3/20/2019.

DON/designee monitoring MD orders routinely for compliance

6) F684

Quality of Care

The facility denies that the alleged facts as set forth constitute a deficiency under interpretations of Federal and/or State law. Preparation and/or execution of this plan of correction does not constitute an admission or agreement by this provider of the truth of the facts alleged or conclusions set forth in this statement of deficiencies. The plan of correction is prepared and/or executed solely because it is required by the provision of federal and/or state law.

This is my credible allegation of compliance to F684. This allegation does not constitute guilt but that the facility is in compliance to F684.

In regard to Resident # 51 and any similar resident, nurses completed skin checks on all current residents. In regard to resident #51 immediate skin evaluation was completed and geri-sleeves were applied to BUE.

DON/designee will complete routine audits to ensure that skin evaluations are being completed per protocol.

7) F686

Pressure Ulcer

The facility denies that the alleged facts as set forth constitute a deficiency under interpretations of Federal and/or State law. Preparation and/or execution of this plan of correction does not constitute an admission or agreement by this provider of the truth of the facts alleged or conclusions set forth in this statement of deficiencies. The plan of correction is prepared and/or executed solely because it is required by the provision of federal and/or state law.

This is my credible allegation of compliance to F686. This allegation does not constitute guilt but that the facility is in compliance to F686.

Resident #68 staff education on 3/14/2019, 3/19/2019, and 3/20/2019 was completed regarding pressure ulcer prevention in regard to resident # 68 and similar situated resident.

Resident #68 has healed pressure areas to her coccyx on 3/23/2019.

All residents with a Braden score of 18 or less have been identified and preventative interventions are in place. For all new admissions/readmissions/change in conditions are discussed in morning QA to ensure all preventative measures were implemented per protocol

QA team will conduct routine audits on residents with current pressure reduction interventions checking for compliance.

8) F690

Catheter Care

The facility denies that the alleged facts as set forth constitute a deficiency under interpretations of Federal and/or State law. Preparation and/or execution of this plan of correction does not constitute an admission or agreement by this provider of the truth of the facts alleged or conclusions set forth in this statement of deficiencies. The plan of correction is prepared and/or executed solely because it is required by the provision of federal and/or state law.

This is my credible allegation of compliance to F690. This allegation does not constitute guilt but that the facility is in compliance to F690.

Resident #77 staff educated on proper catheter care protocol. Audits completed on routine basis by DON/Designee. Staff K and staff M were audited along with the rest of the CNA staff to ensure catheter care protocol is being followed

9) F725

Call Lights

The facility denies that the alleged facts as set forth constitute a deficiency under interpretations of Federal and/or State law. Preparation and/or execution of this plan of correction does not constitute an admission or agreement by this provider of the truth of the facts alleged or conclusions set forth in this statement of deficiencies. The plan of correction is prepared and/or executed solely because it is required by the provision of federal and/or state law.

This is my credible allegation of compliance to F725. This allegation does not constitute guilt but that the facility is in compliance to F725.

Staff has been educated on call light answering protocol on 3/14/2019, 3/19/2019, and 3/20/2019.

Routine resident interviews are being completed by management for call light response satisfaction. Call lights are being audited for compliance. Concerns are being brought to daily QA for discussion and resolution.

10) F812

Food Procurement, Store/Prepare/Serve-Sanitary

The facility denies that the alleged facts as set forth constitute a deficiency under interpretations of Federal and/or State law. Preparation and/or execution of this plan of correction does not constitute an admission or agreement by this provider of the truth of the facts alleged or conclusions set forth in this statement of deficiencies. The plan of correction is prepared and/or executed solely because it is required by the provision of federal and/or state law.

This is my credible allegation of compliance to F812. This allegation does not constitute guilt but that the facility is in compliance to F812.

Staff has been reeducated concerning proper kitchen sanitation on 3/12/19.

Random audits will be conducted and brought to QA weekly to ensure protocol is being followed.

11) F838

Facility Assessment

The facility denies that the alleged facts as set forth constitute a deficiency under interpretations of Federal and/or State law. Preparation and/or execution of this plan of correction does not constitute an admission or agreement by this provider of the truth of the facts alleged or conclusions set forth in this statement of deficiencies. The plan of correction is prepared and/or executed solely because it is required by the provision of federal and/or state law.

This is my credible allegation of compliance to F838. This allegation does not constitute guilt but that the facility is in compliance to F838.

NorthCrest continues to review and update the facility assessment. The facility will continues to assess the needs of its resident's population and the resources required to provide the care and service the resident's need.