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	165299	A. BUILDING _____ B. WING _____	C 03/20/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CRESTVIEW ACRES	1486 GRAND MARION, IA 52302

(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	F 000		
	Plan of Correction 05/22/19			
	The following deficiencies relate to investigation of complaints #81371, #81373, #81520, #81707, #81810, #81787, #81812 and #81833 and facility reported incidents #81930, #81941 and #81990. Complaints #81371, #81520, #81707, #81810, #81787 and #81833 were substantiated. Complaints #81373 and #81812 were not substantiated. Facility reported incidents #81930 and #81990 were substantiated. Facility reported incident #81941 was not substantiated.			
F 584 SS=D	Safe/Clean/Comfortable/Homelike Environment CFR(s): 483.10(i)(1)-(7) §483.10(i) Safe Environment. The resident has a right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely. The facility must provide- §483.10(i)(1) A safe, clean, comfortable, and homelike environment, allowing the resident to use his or her personal belongings to the extent possible. (i) This includes ensuring that the resident can receive care and services safely and that the physical layout of the facility maximizes resident independence and does not pose a safety risk. (ii) The facility shall exercise reasonable care for	F 584		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Marla Walden | TITLE: Administrator | (X6) DATE: 050319

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 584	Continued From page 1 the protection of the resident's property from loss or theft. §483.10(i)(2) Housekeeping and maintenance services necessary to maintain a sanitary, orderly, and comfortable interior; §483.10(i)(3) Clean bed and bath linens that are in good condition; §483.10(i)(4) Private closet space in each resident room, as specified in §483.90 (e)(2)(iv); §483.10(i)(5) Adequate and comfortable lighting levels in all areas; §483.10(i)(6) Comfortable and safe temperature levels. Facilities initially certified after October 1, 1990 must maintain a temperature range of 71 to 81°F; and §483.10(i)(7) For the maintenance of comfortable sound levels. This REQUIREMENT is not met as evidenced by: Based on observations and interviews the facility failed to supply adequate linens to perform resident cares 3 of 12 days of the survey. The facility reported a census of 85 residents. Findings included: During an environmental tour on 3/10/19 at 9:50 a.m., with Staff J (Licensed Practical Nurse) present, revealed the 300/400 Hall linen closet had no washcloths and no hand towels available. At 9:58 a.m., the 400 Hall linen cart had 1 white washcloth, 8 blue washcloths and 6 hand towels available. The 300 Hall linen cart had 1 hand	F 584		

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F 584	Continued From page 2	F 584		

towel and no washcloths available. The 100 Hall linen cart had no washcloths and 6 hand towels available. The Laundry Room had 8 hand towels and no washcloths available.

Observation on 3/10/19 at 10:08 a.m. revealed Staff D (Housekeeping/Laundry) removed 4 blue washcloths, 8 white washcloths and 5 hand towels from the dryer. Staff D placed them on a cart for the nursing staff to use.

During an interview on 3/11/19 at 8:53 a.m. Staff G (Nurses Aide) indicated at this time of the morning the facility does not have any washcloths or hand towels available on the 300 and 400 Hall clean linen cart or in the linen closet. Staff G reported she used bath towels for resident cares this morning. Staff G stated they do not have any staff working in the laundry this morning to wash the soiled linens.

Observation on 3/11/19 at 8:56 a.m. revealed the 400 Hall linen cart had no washcloths, 2 hand towels and 9 bath towels available for the staff. Observation of the 300 Hall linen cart revealed no washcloths, no hand towels and 2 bath towels available for the staff.

Observation on 3/11/19 at 9:00 a.m. revealed the Laundry Room had 1 washcloth, no hand towels and 8 bath towels available.

During an observation and interview on 3/11/19 at 9:01 a.m. with Staff H (Agency Nurse Aide) revealed the 100 Hall linen cart had no washcloths, no hand towels and no bath towels available. Staff H reported they do not have the key to the linen closet so they must walk to the other end of the building to get linens to complete

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F 584	Continued From page 3 resident cares. Observation on 3/12/19 at 7:05 a.m. revealed the 100 and 300 Hall linen carts had no washcloths available. The 400 Hall had 8 washcloths available. During an interview on 3/13/19 at 1:00 p.m. Staff I (Housekeeping/Laundry Supervisor) reported she recently placed an order but only half of the order was approved for purchase.	F 584		
F 600 SS=D	Free from Abuse and Neglect CFR(s): 483.12(a)(1) §483.12 Freedom from Abuse, Neglect, and Exploitation The resident has the right to be free from abuse, neglect, misappropriation of resident property, and exploitation as defined in this subpart. This includes but is not limited to freedom from corporal punishment, involuntary seclusion and any physical or chemical restraint not required to treat the resident's medical symptoms. §483.12(a) The facility must- §483.12(a)(1) Not use verbal, mental, sexual, or physical abuse, corporal punishment, or involuntary seclusion; This REQUIREMENT is not met as evidenced by: Based on clinical record review, observations and interviews the facility failed to ensure resident's right to be free from abuse for 1 of 1 of 23 sampled (Resident #17). The facility reported a census of 85. Findings include:	F 600		

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F 600	Continued From page 4 The Minimum Data Set (MDS) assessment dated 2/12/19 revealed Resident #16 had diagnoses of cancer, renal insufficiency, dementia, anxiety and Werinckies Encephalopathy (acute neurological condition). The MDS dated 2/12/19 revealed Resident #16 independent with transfers and toilet use and required extensive assistance of 1 staff with dressing. Resident #16 used a wheelchair for mobility. Resident #16 had moderate cognitive impairments. Review of Resident #16's care plan dated 3/26/18 revealed the resident can exhibit inappropriate behaviors toward other residents, the staff should continue to monitor and report incidents to administration. Review of an incident report dated 3/18/19 revealed the staff found Resident #17 cornered in the hallway by Resident #16 near exit door 5 on the CCDI unit. Resident #16 had one hand in Resident #17's shirt fondling her left breast and his other hand in the resident's pants, the staff separated the residents and placed them on 15 minute checks. Review of the MDS dated 12/4/18 revealed Resident #17 had diagnoses of included Alzheimer's, Dementia and psychotic disorder. The resident required limited assistance of 1 staff for transfers, walking, and extensive assistance of 1 staff for dressing and eating, the resident does not use a mobility device and resides on the locked dementia unit of the facility. Resident #17 had severe cognitive impairments.	F 600		

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F 600	Continued From page 5 Review of Resident #17's care plan last revised on 10/30/17 revealed the resident ambulates independently about the unit. The resident has formed a relationship with another male peer on he unit and it has been approved by the resident's spouse that they may sit next to each other and hold hands, that male peer no longer resides on the unit since Feb. 2019. Review of an incident report written on 3/18/19 revealed Resident #16 had Resident #17 cornered by exit door 5 on the locked CCDI unit on 3/13/19 at 5:30 p.m. Resident #16 was found fondling Resident #17 in a sexual manner. The staff immediately separated the residents. Both resident were placed on 15 minute checks. Review of Nursing Note for Resident #17 created on 3/19/19 at 10:03 a.m. with an effective date of 3/13/19 at 5:00 p.m., Staff G stated she was alerted by another nurse aide on the unit that she witnessed Resident #16 had Resident #17 cornered against the wall in an alcove of the unit by exit door 5. The staff reported the male resident unbuttoned Resident #17's shirt and was touching the resident's left breast and had his other hand down the resident's pants. Resident #16 told the staff when confronted "I didn't do anything she didn't like, look at her she loves it". During an interview on 3/18/19 at 2:15 p.m. Staff S (Nurse Aide) stated she was the staff that witnessed the incident between the residents. She was walking a resident down the hall towards the dining room and noted Resident #17 with her back to exit door 5 and Resident #16 facing the resident. Both of the residents were laughing and giggling. Resident #16 had unbuttoned Resident	F 600		

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F 600	Continued From page 6 #17's shirt and was fondling her breast and his other hand was down her pants but couldn't tell if it was under her brief. Staff S told the resident to stop, covered up Resident #17 and removed both of the residents. Staff S stated Resident #16 has made nasty comments to another aide in the past, sexual in context and has been known to make advances towards another aide. During an interview on 3/18/19 at 2:30 p.m., the Director of Nurses stated Staff L (Licensed Practical Nurse) failed to assess both residents and failed to chart the incident and will be returning to the facility to complete the paper work. During an interview on 3/18/19 at 10:15 a.m. Staff G (Nurse Aide) stated she has not known Resident #16 to make gestures towards other but he has made verbal, sexual comments to the female aides. During an interview on 3/18/19 at 10:58 a.m. Staff (Licensed Practical Nurse) stated he worked the evening of 3/18/19 and responsible for the unit, he stated he failed to assess both residents on 3/13/19. Review of an undated Abuse Policy provided to the surveyor on 3/5/19 failed to contain information on the handling of resident to resident abuse.	F 600		
F 677 SS=D	ADL Care Provided for Dependent Residents CFR(s): 483.24(a)(2) §483.24(a)(2) A resident who is unable to carry out activities of daily living receives the necessary services to maintain good nutrition, grooming, and	F 677		

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F 677	Continued From page 7 personal and oral hygiene; This REQUIREMENT is not met as evidenced by: Based on clinical record review and interviews the facility failed to provide bathing for 3 of 16 sampled (Resident #9, 11, 13). The facility reported a census of 85 residents. Findings include: 1. Review of Resident #9's Minimum Data Set dated 1/15/19 revealed the resident had diagnoses which included stroke, paralysis and dementia. The resident required limited assistance of 1 staff for personal hygiene and required physical help for bathing. The resident had a BIMS score of 4. The Care Plan dated 8/7/17 revealed Resident #9 totally dependent on 1 staff to provide 2 showers a week. Review of the January and February 2019 bath records revealed the staff provided the resident 4 baths in January and 1 bath in February. 2. Review of Resident # 11's Minimum Data Set dated 1/16/19 revealed the resident had diagnoses which included stroke and dementia. The resident required extensive assistance of 2 staff for toilet use and total dependence on staff for personal hygiene and bathing. The resident had a BIMS score of 1. The Care Plan dated 11/10/18 revealed Resident #11 totally dependent on staff for bathing twice a week.	F 677		

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F 677	Continued From page 8 Review of the January and February 2019 bath records revealed the staff provided the 4 baths in January and 6 baths in February. 3. Review of Resident #13 Minimum Data Set dated 1/29/19 the resident had diagnoses which included paraplegia, concussion, edema of cervical spinal cord and cognitive communication deficit. The resident required extensive assistance of 2 staff for personal hygiene and had total dependence on the staff for bathing. The resident could not participate in the BIMS testing. The Care Plan dated 1/23/19 directed the staff to provide 2 baths weekly and as needed. Review of the January and February 2019 bath records revealed the staff provided 4 baths in January and 6 baths in February. During an interview on 3/19/19 at 1:50 p.m. Staff X (Nurse Aide) stated she almost always completes her assigned baths but feels the agency staff and the evening shift do not do their showers as assigned. Staff X stated it is hard to get baths done when you do not have enough staff.	F 677		
F 678 SS=K	Cardio-Pulmonary Resuscitation (CPR) CFR(s): 483.24(a)(3) §483.24(a)(3) Personnel provide basic life support, including CPR, to a resident requiring such emergency care prior to the arrival of emergency medical personnel and subject to related physician orders and the resident's advance directives. This REQUIREMENT is not met as evidenced by:	F 678		

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F 678	Continued From page 9 Based on clinical record review, staff and resident interviews and observations the facility failed to initiate Cardiopulmonary Resuscitation (CPR) for 1 of 16 sampled residents who requested CPR (Resident #1). The facility reported a census of 85 residents. Findings include: According to the Minimum Data Set (MDS) dated 11/27/18, Resident #1 had diagnoses which included peripheral vascular disease, chronic lung disease, abnormal posture, non-pressure chronic ulcer of left thigh, opioid dependence and chronic pain. The MDS dated 11/27/18 revealed Resident #1 required extensive assistance of 1 staff for transfers, dressing, toilet use and utilized a wheelchair for mobility. Resident #1 had no cognitive impairments. Review of Resident #1's Care Plan revealed Resident #1 admitted to the facility on 5/15/18. The Care Plan failed to identify Resident #1's CPR wishes. Review of the clinical record on 3/5/19 at 2:00 p.m. revealed Resident #1's record failed to contain an IPOST (Iowa Physician Orders for Scope of Treatment) form. The IPOST form directed the health professionals of the resident's CPR wishes. Review of the physician's order sheet dated 1/31/19 revealed Resident #1 had a full code status (requested CPR) since 5/16/18. Review of a Progress Note dated 3/2/19 at 1:00	F 678		

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F 678	Continued From page 10 p.m. Staff J (Licensed Practical Nurse) documented she found Resident #1 in bed, breathless and without a pulse. She called the ambulance and attempted 3 times to contact the emergency person listed. The notes failed to include an assessment of the resident. During an interview on 3/5/19 at 9:00 a.m. Staff K (Provisional Administrator) stated this past weekend they found Resident #1 dead in his bed, he was cold and the staff didn't start CPR as they should have. The staff called the ambulance but they should have started CPR while they were waiting for the ambulance and the staff failed to document the incident in the nurses notes. Staff J called Staff K to tell her about Resident #1's death and she told the staff they should have started CPR. During an interview on 3/5/19 at 11:31 a.m. Staff J stated Resident #1 ate breakfast, took his pills around 9:00 a.m. then laid down in bed. At 1:00 p.m., Staff J took the resident's noon pills and lunch tray into the resident's room, when she walked in she loudly said the resident's name, the resident didn't respond. Staff J indicated the resident's face appeared to be yellowish-gray in color. Staff J left the resident's room to check the code status but couldn't find the IPOST, stated she looked on the face sheet which indicated the resident requested CPR. Staff J did not start CPR but called Staff L (Licensed Practical Nurse). Staff J said to Staff L "don't you think we should start CPR?". Staff L responded he was already gone, he was pulseless and cold then directed Staff J to call the doctor. Staff J stated she placed a call to the physician, then called the area ambulance. Staff J informed the ambulance dispatch the resident was a full code. The	F 678		

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F 678	Continued From page 11	F 678		

ambulance arrived quickly to the scene. Staff J stated she never initiated CPR but she just knew she should have.

During a second interview with Staff J (Licensed Practical Nurse) on 3/7/19 at 9:10 a.m. , Staff J stated she had a lapse in judgement and knew she should have started CPR on Resident #1. She indicted she didn't know his code status and couldn't find the IPOST. Staff J stated the only place to find a resident's code status was on the IPOST. Staff J indicated the time lapse from when she first discovered the resident deceased and when she called the ambulance was approximately 15-20 minutes.

During an interview on 3/5/19 at 9:45 a.m. Staff L (Licensed Practical Nurse) reported he received a call from Staff J at approximately 1-1:15 p.m. telling Staff L she just found Resident #1 dead. Staff L entered the resident's room and noted the resident yellow and pale in color, without pulse and respirations and cool to touch. Staff L indicated about 15 minutes after arriving to the 400 Hall Staff J informed him the resident is a full code and asked what they should do. At that point Staff L indicated he didn't know what to do but knew the resident is already is gone, Staff L indicated neither of them knew what to do at that point. Staff L did not chart anything about the incident and assumed Staff J would document. Staff L stated Staff J did not know Resident #1's code status at time of incident.

During an interview on 3/5/19 at 1:40 p.m. Staff Q (Nurse Aide) reported she worked with Resident #1 on 3/2/19 on day shift. She stated in the morning the resident was sleepy. She peeked on him through the morning but the resident took

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F 678	Continued From page 12 care of own needs and would rarely use call light. Staff J entered the residents room and returned to nurses station calling staff to assist her. Staff J informed Staff Q that the resident passed away. She entered the resident's room and found his eyes partially open, his hand on wheelchair, he was laying flat in bed. Staff Q touched the resident and noted he did not feel cool to the touch but didn't have respirations. Staff Q indicated the ambulance arrived but does not know the time. During an interview on 3/5/19 at 1:51 p.m. Staff R (Nurse Aide) stated she last saw Resident #1 at 10:00 a.m. Staff J paged Staff Q and Staff R and told them Resident #1 died and that she had EMS on the way. Review of the pre-hospital care report summary (ambulance report) revealed the medics received the initial call to the facility at 1:16 p.m. on 3/2/19 for a patient who is not breathing and not conscious. The medics arrived to the scene at 1:22 p.m. Dispatch called the medics and cancel the call as the patient was "too far gone". The medics found Resident #1 without a pulse, unresponsive, cool to the touch. The staff were not performing CPR at the time the medics arrived. The medics noted Resident #1 had a full code status. During an interview on 3/5/19 at 11:15 a.m. Staff P (Director of Nurses) stated she cannot locate the IPOST for Resident #1, stating it should have been in the clinical record. She indicated the resident experienced a hospitalization the week prior and wondered if maybe the hospital had the IPOST. Staff P reported when the staff transfer the resident to the hospital they send the IPOST.	F 678		

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F 678	Continued From page 13 On 3/20/19, 15 days past the first request for a copy of the resident's IPOST, the facility continues to be unable to locate the IPOST. During an interview on 3/5/19 at 1:30 p.m. Staff K (Registered Nurse) stated if she found a resident without a pulse and breathless she would check the IPOST for their wishes and if resident requested CPR she would start CPR. During an interview on 3/5/19 at 1:00 p.m. Staff N (Licensed Practical Nurse) stated if she found a resident without a pulse and breathless, she would check the IPOST for their wishes and if resident requested CPR she would start CPR. During an interview on 3/5/19 at 11:18 a.m. Resident #1's Primary Care Physician (PCP) stated he would have expected the staff to initiate CPR in accordance to the resident's wishes. The PCP stated he was called on 3/2/19 at 2:29 p.m. and informed of the resident's death but didn't know the staff failed to initiate CPR in accordance to the resident's wishes. During an interview on 3/5/19 at 1:36 p.m. Staff O (Social Worker Designee) stated she completed an IPOST audit on 3/1/19 and noted that 5 current residents did not have an IPOST in their clinical record and could not locate them, the list did not include Resident #1. Observation/audit on 3/5/19 at 1:36 p.m. of all resident clinical records revealed 27 residents had an IPOST that indicated they requested CPR, 5 resident had conflicting information on their IPOST, 4 records had conflicting stickers in their charts which did not reflect their wishes, either full code or do not resuscitate and 3 resident's did	F 678		

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F 678	Continued From page 14 not have an IPOST in their clinical record. Review of the facilities undated CPR policy it directed staff to initiate CPR on all patients, employees or visitors for who the intervention is indicated. CPR will be initiated by any member of the nursing department who has been trained in this procedure. On 3/6/18, the facility abated the immediate jeopardy. The facility provided CPR education to all staff, ensured all clinical records had a current IPOST and provided staff education to ensure the Social Worker completes an IPOST when each resident admits to the to the facility.	F 678		
F 684 SS=G	Quality of Care CFR(s): 483.25 § 483.25 Quality of care Quality of care is a fundamental principle that applies to all treatment and care provided to facility residents. Based on the comprehensive assessment of a resident, the facility must ensure that residents receive treatment and care in accordance with professional standards of practice, the comprehensive person-centered care plan, and the residents' choices. This REQUIREMENT is not met as evidenced by: Based on record review, observations and interviews the facility failed to identify, assess and treat skin conditions for 1 of 5 sampled (Resident #4). The facility reported a census of 85 residents. Findings include: 1. According to the Minimum Data Set (MDS)	F 684		

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F 684	Continued From page 15 dated 2/4/19 Resident #4 had diagnoses of heart failure, diabetes mellitus, psychotic disorder, anxiety and severe morbid obesity. The MDS revealed Resident #4 had no cognitive impairments. The MDS dated 2/4/19 revealed Resident #4 required total staff assistance with bed mobility and toilet use. The MDS revealed Resident #4 bedfast and had no skin conditions. The MDS documented a weight of 550 pounds. The Care Plan dated 8/3/18 revealed Resident #4 had potential/actual impaired skin integrity and stated the resident would not have any skin breakdown. The care plan informed the staff the resident does not want to be repositioned every 2 hours and to educate the resident on the risk of skin breakdown, assess for risk factors related to skin breakdown, keep skin clean and dry and to apply topical treatments as ordered. Review of the Braden Scale for Predicating Pressure Sore form revealed Resident #4 had an assessment completed on 9/25/18 and no further assessments completed after that. Observation on 3/7/19 at 11:40 a.m. revealed Resident #4 laying in bed on his right side, his legs were extended to the left of his body. Staff Z (Nurse Aide) and Staff AA (Agency Nurse Aide) prepared to do cares, Staff Z stated she still had not been in to provide any cares for the resident yet today because he does not like cares done. Observation revealed the resident laying on a wet sheet that exceeds his body size, a foul odor was noted. Staff Z states he has a "discharge" from somewhere on his body. Staff Z states the resident always lays on his right side and yells out	F 684		

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F 684	Continued From page 16 in pain when they attempt to do cares. The staff noticed Resident #4 had his right heel pressing against his left shin while laying in bed, both lower legs had edema. Observation on 3/7/19 at 12:20 p.m. revealed Staff Y (Registered Nurse/Skin Nurse) completed a head to toe skin assessment on Resident #4 at the request of the surveyor. Staff Y rolled Resident #4 to his right side. Resident #4 had feces dried to his buttocks. The bed sheet had a soiled area surrounding the residents entire body. Staff Y stated the resident has serous drainage from his skin, mixed with fungal skin infections which she felt was the source of the odor. Staff Y identified the following new skin conditions: a. Wound #1, a pressure ulcer to the left shin measuring 6 centimeters (cm) by 4.2 cm. Resident #4 complained of pain when repositioned. b. Wound #2, a red bruise area to the right lower calf measuring 6.0 cm by 5.5 cm. c. Wound #4, an excoriation to the right lateral abdomen measuring 16 cm by 4.3 cm with copious amounts of serous drainage and a foul odor. Resident #4 complained of pain. Review of Resident #4's Non-Pressure Skin Condition Report sheets revealed the following: a. Wound #3, a left groin excoriation that measured 3.0 cm by 0.25 cm on 9/25/18. The sheets revealed no weekly skin assessments for 10 weeks from 10/10/18 to 12/14/18, no assessments for 7 weeks from 12/14/18 to	F 684		

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F 684	Continued From page 17 1/29/19 and lastly no assessment on 2/3/19. b. Wound #5, a right groin excoriation that measured 2.0 cm by 0.25 cm on 9/25/18. The sheets revealed no weekly assessments for 10 weeks from 10/10/18 to 12/14/18, no assessments for 7 weeks from 12/14/18 to 12/29/18 and lastly no assessment on 2/17/19. On 3/7/19, the area measured 3.0 cm by 1.2 cm and had copious amounts of foul smelling drainage. The area bled when cleansed. c. d. Wound #6, under right breast that measured 7.0 cm by 4.5 cm on 11/8/18. The sheets revealed no weekly skin assessments for 5 weeks from 11/8/18 to 12/14/18, no weekly assessments for 7 weeks from 12/14/18 to 1/29/19 and no assessment for 1 week from 1/29/19 to 2/12/19. d. Wound #8, a right axilla excoriation that measured 1.0 cm by 0.25 cm on 9/25/18. The sheets revealed no weekly skin assessments for 10 weeks from 10/10/18 to 12/14/18, no assessments for 7 weeks from 12/14/18 to 1/29/19 and lastly no assessment on 2/3/19. On 3/7/19, the area measured 1.0 cm by 0.3 cm with a moderate amount of foul smelling serous drainage. During an interview on 3/7/19 at 1:00 p.m., Staff Y stated she began her employment in August of 2018 and became the facility skin nurse in Dec. 2018. In January 2019 she was unable to complete any of her skin duties because she was pulled to work the floor and didn't have time to assess the resident's skin.	F 684		

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F 684	Continued From page 18 During an interview on 3/8/19 at 10:00 a.m., the Director of Nurses (DON) stated Staff Y came to her and was upset and crying regarding the skin condition of Resident #4, she told the DON she didn't know she needed to complete a skin sheet for new skin issues. During an interview on 3/8/19 at 1:48 p.m., Resident #4 stated he does refuse cares sometimes but not all the time. Resident #4 complained of pain to his left shin when the staff checked his skin over yesterday and reports he has neuropathy. During an interview on 3/8/19 at 1:20 p.m., Resident #4's Primary Care Physician (PCP) stated he advised the staff to turn the resident at least daily and recommended to place absorbent padding between the resident's skin layers to prevent skin on skin issues. The PCP does not agree that the resident will not allow cares and feels it is an excuse. He believed Resident #4 had non-compliance. The PCP believed the staff could change their approach and were not protecting his dignity. The PCP would expect the staff to assess each resident's skin weekly, especially if their skin is compromised. During an interview on 3/12/19 at 8:50 a.m., Resident #4's Hospice Nurse stated she informed the staff to keep trying to reposition Resident #4 every time she comes to the facility. He now had contractures of his lower extremities and this will cause him pain when they roll him from side to side. She stated the odor from his wounds/skin had worsened. Review of a undated Wound Care Process directs the nursing staff to complete a stop and	F 684		

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F 684	Continued From page 19 watch form if they observe any new skin conditions and provide a copy to the charge nurse, Administrator, Director of Nurses, and Unit Manager. The nurse will complete an assessment and document on the skin sheet. The Nurse Manager will complete skin rounds on any new and existing skin condition a resident may 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: Based on clinical record review, staff and resident interviews, and observations the facility failed to prevent the development of pressure sores for 2 of 5 residents reviewed (Resident #4 and #14). The facility reported a census of 85 residents. Findings include: 1. According to the Minimum Data Set (MDS) dated 2/4/19 Resident #4 had diagnoses of heart failure, diabetes mellitus, psychotic disorder,	F 686		

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F 686	Continued From page 20	F 686		

anxiety and severe morbid obesity. The MDS revealed Resident #4 had no cognitive impairments.

The MDS dated 2/4/19 revealed Resident #4 required total staff assistance with bed mobility and toilet use. The MDS revealed Resident #4 bedfast and had no skin conditions. The MDS documented a weight of 550 pounds.

The Care Plan dated 8/3/18 revealed Resident #4 had potential/actual impaired skin integrity and stated the resident would not have any skin breakdown. The care plan informed the staff the resident does not want to be repositioned every 2 hours and to educate the resident on the risk of skin breakdown, assess for risk factors related to skin breakdown, keep skin clean and dry and to apply topical treatments as ordered.

Review of the Braden Scale for Predicating Pressure Sore form revealed Resident #4 had an assessment completed on 9/25/18 and no further assessments completed after that.

Observation on 3/7/19 at 11:40 a.m. revealed Resident #4 laying in bed on his right side, his legs were extended to the left of his body. Staff Z (Nurse Aide) and Staff AA (Agency Nurse Aide) prepared to do cares, Staff Z stated she still had not been in to provide any cares for the resident yet today because he does not like cares done. Observation revealed the resident laying on a wet sheet that exceeds his body size, a foul odor is noted. Staff Z states he has a "discharge" from somewhere on his body. Staff Z states the resident always lays on his right side and yells out in pain when they attempt to do cares. Resident is noted to have his right heel pressing against his

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F 686	Continued From page 21 left shin while laying in bed, both lower legs edematous. Observation on 3/7/19 at 12:20 p.m. revealed Staff Y (Registered Nurse/Skin Nurse) completed a head to toe skin assessment on Resident #4 at the request of the surveyor. Staff Y rolled Resident #4 to his right side. Resident #4 had feces dried to his buttocks. The bed sheet had a soiled area surrounding the residents entire body. Staff Y stated the resident has serous drainage from his skin, mixed with fungal skin infections which she felt was the source of the odor. Staff Y identified a pressure sore (Wound #1) to the left shin measuring 6 centimeters (cm) by 4.2 cm. Resident #4 complained of pain when repositioned. Staff Y acknowledged the left shin pressure area was a result of pressure from Resident #4's right heel. During an interview on 3/7/19 at 1:00 p.m., Staff Y stated she began her employment in August of 2018 and became the facility skin nurse in Dec. 2018. In January 2019 she was unable to complete any of her skin duties because she was pulled to work the floor and didn't have time to assess the resident's skin conditions. During an interview on 3/8/19 at 10:00 a.m., the Director of Nurses (DON) stated Staff Y came to her and was upset and crying regarding the skin condition of Resident #4, she told the DON she didn't know she needed to complete a skin sheet for new skin issues. During an interview on 3/8/19 at 1:48 p.m., Resident #4 stated he does refuse cares sometimes but not all the time. Resident #4 complained of pain to his left shin when the staff	F 686		

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F 686	Continued From page 22 checked his skin over yesterday and reports he had neuropathy. During an interview on 3/8/19 at 1:20 p.m., Resident #4's Primary Care Physician (PCP) stated he advised the staff to turn the resident at least daily and recommended to place absorbent padding between the resident's skin layers to prevent skin on skin issues. The PCP does not agree that the resident will not allow cares and feels it is an excuse the facility is using. He believes the resident has elements of non-compliance but believes it is in the approach and believes they are not protecting his dignity. The PCP would expect the staff to assess each resident's skin weekly, especially if their skin is compromised. During an interview on 3/12/19 at 8:50 a.m., Resident #4's Hospice Nurse stated she informed the staff to keep trying to reposition Resident #4 every time she comes to the facility. He now has contractures of his lower extremities and this will cause him pain when they roll him from side to side. She stated the odor from his wounds/skin had worsened. Review of a undated Wound Care Process directs the nursing staff will complete a stop and watch form if they observe any new skin conditions and provide a copy to the charge nurse, the Administrator, the Director of Nurses, and the Unit Manager. The nurse will complete an assessment and document the assessment on the skin sheet. The Nurse Manager will complete skin rounds on any new and existing skin condition a resident may have. 2. The MDS dated 11/27/18 revealed Resident	F 686		

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F 686	Continued From page 23 #14 had diagnoses of heart failure, peripheral vascular disease, diabetes mellitus, acute kidney failure. Resident #14 had no cognitive impairments. The MDS dated 11/27/19 revealed Resident #14 required extensive assistance of two staff with bed mobility, toilet use and personal hygiene. The MDS revealed Resident #14 at risk for pressure ulcer development and no current pressure ulcers. The Care Plan revised on 3/5/18 revealed Resident #14 had a potential for impaired skin integrity due to current health status and directed the staff to assist with repositioning, keep skin clean and dry, monitor skin for signs and symptoms of impairment and provide treatments as ordered. The Braden Scale for Predicting Pressure Sore Risk dated 12/5/18 revealed Resident #14 scored a "13". A score of 13 - 14 revealed a moderate risk. The Wound/Skin Healing Record sheets dated 10/20/18 revealed Resident #14 had a Stage II pressure sore to the left heel that measured 3.0 centimeters (cm) by 2.0 cm. with black/brown eschar, no drainage and mushy. The sheets revealed a lack of weekly assessments for 10 weeks from 10/20/18 to 1/3/19 , a lack of weekly assessments for 2 weeks from 1/3/19 to 1/22/19 and a lack of weekly assessments for 1 week from 1/22/19 to 2/6/19. The assessment dated 3/8/19 revealed the wound measured 1.8 cm by 1.0 cm with a moderate amount of serous drainage.	F 686		

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F 686	Continued From page 24 Review of the Progress Notes dated 3/8/19 the staff failed to document the resident had a new open area to the coccyx area but stated the staff found a new right heel wound during cares today. On 3/8/19 at 2:00 p.m. Staff Y (Registered Nurse/Skin Nurse) completed a head to toe skin assessment at the request of the surveyor. Staff Y discovered an open area to Resident #14's coccyx that measured 0.3 cm by 0.4 cm. Staff Y stated the area was new, she had no previous knowledge of the area and planned to notify the physician. The fax dated 3/8/19 revealed the staff notified the physician of the open area on Resident #14's coccyx which measured 0.3 cm x 0.4 cm x 0.1 cm depth. The staff requested a treatment order. The physician requested the resident be seen in the local wound clinic. During an interview on 3/11/19 at 4:45 p.m., Staff Y reported she completed the skin assessment on 3/8/19. Staff Y reported she measured the wound but did not know the stage of the wound as she did not know how to stage wounds. The Pressure Sore list dated 3/13/19 revealed the facility identified 7 residents with pressure sores. 2 of the 7 identified were not identified prior to the surveyor requested assessment. The facility identified 31 residents with other skin issues which included bruise, scratches, skin tears or rashes. During an interview on 3/18/19 at 1:00 p.m. Staff Y stated the pressure sore to Resident #14's coccyx is facility acquired.	F 686		

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F 686	Continued From page 25 During an interview on 3/12/19 at 11:00 am. the Primary Care Physician (PCP) stated an expections of the staff to follow the skin assessment protocol and do at least a weekly skin assessment. The assessment should be completed by a trained professional. The PCP stated he was not aware of a pressure sore to the resident's coccyx. Review of a undated Wound Care Process directs the nursing staff will complete a stop and watch form if they observe any new skin conditions and provide a copy to the charge nurse, the Administrator, the Director of Nurses, and the Unit Manager. The nurse will complete an assessment and document the assessment on the skin sheet. The Nurse Manager will complete skin rounds on any new and existing skin condition a resident may have.	F 686		
F 688 SS=G	Increase/Prevent Decrease in ROM/Mobility CFR(s): 483.25(c)(1)-(3) §483.25(c) Mobility. §483.25(c)(1) The facility must ensure that a resident who enters the facility without limited range of motion does not experience reduction in range of motion unless the resident's clinical condition demonstrates that a reduction in range of motion is unavoidable; and §483.25(c)(2) A resident with limited range of motion receives appropriate treatment and services to increase range of motion and/or to prevent further decrease in range of motion. §483.25(c)(3) A resident with limited mobility receives appropriate services, equipment, and assistance to maintain or improve mobility with	F 688		

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F 688	Continued From page 26 the maximum practicable independence unless a reduction in mobility is demonstrably unavoidable. This REQUIREMENT is not met as evidenced by: Based on clinical record review, staff and resident interviews and observations the facility failed to complete restorative programs for 3 of 7 residents sampled (Resident #6, 9,18). The facility reported a census of 85 residents. Findings include: 1. According to the Minimum Data Set (MDS) assessment dated 1/1/19, Resident #6 had diagnoses which included heart failure, stroke, quadriplegia, dysphasia, muscle weakness, chronic kidney disease and muscle spasms. The resident required extensive assistance of 2 staff for bed mobility, transfers, dressing, toilet use, personal hygiene and used a wheelchair for mobility. The resident had a BIMS score of 15 which indicated they were alert and oriented. Review of a list of residents on a restorative program dated 3/19/19 revealed Resident #6 had a passive range of motion program. The Care Plan dated 3/30/18 failed to reflect Resident #6 had a restorative program. During an interview 3/8/19 at 11:03 a.m., Resident #6 stated he was not getting restorative exercises any longer and reported he really needs it. He shared he was becoming stiff and now his leg won't stay on his wheelchair pedals and reported he hasn't had restorative exercises for several months. Observations on 3/10/19 at 12:12 p.m. revealed	F 688		

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F 688	Continued From page 27 the resident sitting in a wheelchair, the staff assisted him to bend his legs, placed them on the wheelchair pedals, the resident's feet are placed on the pedals but they slip off, his feet came off the pedals extending out in front of the wheelchair pedals. Observation on 3/12/19 at 2:06 p.m. revealed two Certified Nurse Aides placed a pivot disc in front of the wheelchair, staff stood Resident #6, turned him and sat him on the bed. The resident did not take any steps and required extensive assistance of 2 staff to stand, pivot and sit on his bed. Observation on 3/13/19 at 12:00 p.m. revealed Staff U-Restorative Aide assisting the resident with restorative exercises, the resident stated "Oh, that feels so good" as the aide performs stretching exercises. Review of Resident #6's Restorative Nursing Care Program dated May 2018 directed the staff to complete assisted active range of motion 1-3 times a week. Review of the restorative sign off sheets the resident received the following exercise: a. January 2019 the resident received restorative 1 time. b. February 2019 the resident received restorative 2 times. c. March 2019 the resident received restorative 1 time up to March 13. During an interview on 3/8/19 at 12:08 p.m. Staff DD (Contracted Restorative Staff) reported the facility does not have anyone overseeing the restorative program but does have Staff U (Nurse Aide/Restorative Aide) who heads up the	F 688		

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F 688	Continued From page 28 program. Staff DD stated she has noted a decline in the ambulation and functional ability for Resident #6 these past several months. Staff DD stated Staff U-Restorative Aide reported the owners directed her to put the restorative program on hold so the restorative aides could work on the floor to decrease the use of agency staff. Review of the Occupational Therapy Functional Maintenance Program dated 2/12/19 directed the staff to complete passive range of motion exercises with the right upper extremities and left lower extremities exercises using a 2 pound weight 1-3 times weekly. Review of the Physical Therapy Functional Maintenance Program dated 12/7/18 directed staff to complete seated truck flexion, hamstring stretch and glut stretches with the resident 1-3 times weekly. During a Physical Therapy progress note dated 12/5/18 revealed the Physical Therapist discussed the flexion program with the RA staff, the resident was upset he was only working with restorative once a week. During an interview on 3/12/19 at 2:30 p.m. Staff EE (Physical Therapy Assistant) reported Resident #6 had a decline in his flexion from a lack of stretching exercises. During an interview on 3/10/19 at 10:40 a.m., the Provisional Administrator stated the contracted therapy company puts the restorative programs together and the facility restorative aides were not completing the programs. The MDS coordinator provided copies of the changes. The facility	F 688		

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F 688	Continued From page 29 failed to designate a nurse to oversee the restorative program. The Administrator acknowledged the restorative aides have been pulled to cover the staffing on the floor and could not complete restorative exercises as directed. During an interview on 3/8/19 at 11:08 a.m., Staff L (Licensed Practical Nurse) stated a couple of months ago Resident #6's legs would bend and stay on his wheelchair pedals but now they cannot. Staff L feels the resident has had a decline in his ability to transfer, when he transferred he used to be able to take several steps. Staff L stated the nursing staff pull the restorative staff to work on the floor. During an interview with Staff P-DON on 3/8/19 at 10:45 a.m., Staff P stated the owners informed her that the restorative program will be put on the "back burner" to keep the use of agency staff down, she was directed to pull the restorative aides to work on the floor. Staff P stated today they had a staff call in which resulted in pulling the restorative aide to work on the floor. During an interview on 3/12/19 at 11:00 a.m. the Primary Care Physician (PCP) reported he was not aware his patients were not receiving restorative programs. The PCP had an expectation of the staff to complete the programs as prescribed. The PCP felt it was important to maintain the residents best capabilities. 2. According to the Minimum Data Set (MDS) dated 1/15/19 Resident #9 had diagnoses which included stroke, dementia, hemiplegia, repeated falls and muscle weakness. The resident required limited assistance of 1 staff for bed mobility, independent in his room but didn't walk in the	F 688		

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F 688	Continued From page 30 corridor, the resident utilizes a cane and wheelchair for mobility. The MDS indicated the resident experienced 2 falls with injuries. The resident had a BIMS score of 4, which indicated he had severe cognitive ability. Review of the resident's care plan dated 10/27/17 indicated the resident had a restorative program to address the need for assistance with ambulation and wheelchair use. The plan stated the resident will participate in a restorative program 3 times a week. Review of Resident's #9 Restorative Nursing Care Program, last updated on 10/11/17, directed the staff to assist the resident with active range of motion 1-3 times a week and to ambulate 1-3 times a week as tolerated. Review of the restorative sign off sheets the resident received the following exercises: a. January 2019 the resident received restorative 1 time. b. February 2019 the resident received restorative 0 times. c. March 2019 the resident received restorative 1 time up to March 13. Observation on 3/10/19 at 9:36 a.m. two staff assisted Resident #9 to transfer from his bed into the wheelchair, when the resident stood a personal alarm sounded. The staff stated usually the resident could wheel self to the dining room but not able to complete this task today due to weakness. The staff had to assist the resident to the dining room. During an on 3/12/19 at 2:30 p.m., Staff EE (Physical Therapy Assistant) stated Resident #9	F 688		

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F 688	Continued From page 31 used to walk better but has noticed a decline in his ability. During an interview with Staff U-RA on 3/13/19 at 2:00 p.m. the staff stated the resident has had a decline with ambulation and transfers and continues to have falls. Staff U stated she made another referral to Physical Therapy due to a decline in ambulation , mobility and an increase in falls. Review of the the resident's Progress Notes from 1/1/19-3/13/19 the resident experienced 5 falls attempting to ambulate independently. 3. According to the Minimum Data Set (MDS) dated 1/15/19 Resident #18 had diagnoses which included Dementia, contractures of the right and left knee and difficulty walking. The resident required extensive assistance of 2 staff for bed mobility and total dependence on 2 staff for transfers, movement about the facility, toilet use and utilized a wheelchair for mobility about the facility. The resident has severe cognitive ability. Review of a care plan dated 8/7/17 informed the staff the resident participated in a restorative program to maintain her current abilities. The staff will complete the restorative program for strengthening and transfers, the restorative aides will place the residents bilateral lower leg braces on and complete passive range of motion 1-3 times a week. During an interview with Staff EE-PTA on 3/12/19 at 2:30 p.m., the staff stated Resident #18 has bilateral knee braces that only the restorative aides have been trained to apply, they haven't been on for quite some time.	F 688		

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F 688	Continued From page 32 Observations on 3/12/19 at 3:05 p.m. revealed the resident sitting in her wheelchair in the dining room, the resident does not have her leg braces on, her legs are drawn up to her chest. Observations on 3/13/19 at 8:30 a.m. revealed the resident laying in bed in a fetal position. Staff U and Staff P worked to place Resident #18's leg braces on her knees. The staff placed the resident's braces on with difficulty, the Velcro had to be loosed to allow the braces to go onto the residents legs. The resident grimacing and appeared to be uncomfortable. Review of a Physical Therapy established program dated 9/28/17 the program directs the restorative staff to apply braces to both knees 4 hours a day 5 times a week. Review of a restorative nursing care program dated 10/11/17, the program directed the restorative staff to complete the physical therapy program and to do passive range of motion 1-3 times per week. Review of the restorative sign off sheets the resident received the following exercise: a. January 2019 the resident received restorative 1 time. b. February 2019 the resident received restorative 1 time. c. March 2019 the resident received restorative 1 time up to March 13. During an interview on 3/8/19 at 10:45 a.m. the Director of Nurses stated the facility does not have a policy for the restorative care program for the residents.	F 688		
F 689	Free of Accident Hazards/Supervision/Devices	F 689		

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F 689 SS=J	Continued From page 33 CFR(s): 483.25(d)(1)(2) §483.25(d) Accidents. The facility must ensure that - §483.25(d)(1) The resident environment remains as free of accident hazards as is possible; and §483.25(d)(2)Each resident receives adequate supervision and assistance devices to prevent accidents. This REQUIREMENT is not met as evidenced by: Based on clinical record reviews, staff and resident interviews and observations the facility failed to provide supervision for 1 of 9 residents who utilized an electric wheelchair for 1 of 23 sampled (Resident #1). The facility reported a census of 85. 1. According to the Minimum Data Set (MDS) dated 11/27/18, Resident #1 had diagnoses which included peripheral vascular disease, chronic lung disease, abnormal posture, non-pressure chronic ulcer of left thigh, opioid dependence, chronic pain and left above knee amputation. The resident required extensive assistance of 1 staff for transfers, dressing, toilet use and utilizes a wheelchair for mobility. The resident had a brief interview for mental status (BIMS) score of 15 which indicted the resident had intact cognitive ability. The assessment revealed the resident experienced a recent fall. Review of Resident #1's care plan revealed the staff failed to document the resident utilized an electric wheelchair and failed to inform staff the resident could go out into the community in his electric wheelchair, unaccompanied by staff. The care plan failed to identify safety concerns with	F 689		

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F 689	Continued From page 34 the use of the electric wheelchair. The care plan identified the resident had a moderate risk of falls related to balance/gait problems. Review of the progress notes from admission on 5/15/18-3/2/19 contained the following notes: a. On 7/16/18, staff had to remind the resident to slow down in his electric wheelchair, he does not comply with request. b. On 7/18/18, Staff O-SSD contacted an outside agency to come to facility and turn down the resident's wheelchair speed. The resident has been educated, asked to slow down but does not comply. The resident runs his wheelchair into things and people. c. On 8/7/18, the resident is noted to smell of alcohol while using his electric wheelchair and experienced a fall from the electric wheelchair. The resident complained of rib pain and requested to go to a local emergency room. The notes revealed the resident went around a female peer, flipped over sideways out of the chair. d. On 8/11/18, the resident went out the smoking door without waiting for someone to hold the door open, the door closed, hitting his wheelchair and knocked him over the edge of the sidewalk, causing the resident to fall from his wheelchair onto landscaping rocks. The resident sustained scratches. e. On 8/28/18, the former Administrator and Therapy Director spoke to the resident about use of his electric wheelchair as it is unsafe due to falls, non-compliance with safety education, running into and breaking equipment like other	F 689		

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F 689	Continued From page 35	F 689		

resident's walkers. The staff took the electric wheelchair from the resident and gave him a manual wheelchair. The staff told the resident they would reach out to the wheelchair clinic for support in obtaining his own personal electric wheelchair as the current electric wheelchair did not fit him right and was broken. They explained to the resident that is was unsafe to drive the electric wheelchair in the manner he did that he could injure himself or others.

f. On 10/27/18, the electric wheelchair returned to the resident as he signed himself out against medical advice.

g. On 11/9/18, the nurse responded to exit door 3, the staff found Resident #1 on the ground and the electric wheelchair on its side. The resident explained he ran off the sidewalk in his electric wheelchair while outside smoking, The resident refused an assessment for injuries.

h. On 1/20/19, the resident was on his way in his electric wheelchair to the gas station 2 blocks from the facility, he tipped over sideways into the snow in his wheelchair on the way to the local gas station. Two bystanders picked up the resident and put him back into the wheelchair, they purchased his cigarettes he wanted and he returned to facility. Upon return the resident went outside to smoke and refused to allow the staff to assess him for injuries.

i. On 1/29/19, the staff reports the resident signs himself self out to go to the local gas station 2 blocks away. The Director of Nurses informed the resident after his last fall outside that he is not making safe choices. The D.O.N. notes the resident gets stuck outside on the ice and snow

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F 689	Continued From page 36 and going uphill but still chooses to smoke and make poor safety choices. The D.O.N. informed the resident she will be asking the physician for an order in the event of inclement weather the resident will be required to stay in the facility and only be out in the daylight hours. j. On 2/8/19, Staff L-LPN gets called to resident's room, he had fallen out of his wheelchair and onto floor. The staff noted the resident did not sustain any injuries. Review of the Accuweather website revealed the weather on 1/20/19 in Marion, Iowa had a high of 11 degrees and low of -4 degrees. The weather on 1/29/19 in Marion, Iowa had a high temperature of 2 degrees and low of -19 degrees, both of these temperatures were the actual temperatures, wind chill not factored in. Review of the Visitor sign-in sheet form revealed on 1/20/19 Resident #1 went by self to the gas station at 1:42 p.m. and returned at 2:06 p.m. Review of the sign-in sheet revealed the resident failed to sign self out on 1/29/19. During an interview on 3/5/19 at 11:18 a.m. Primary Care Physician stated he does not remember the staff asking him for an order to not allow Resident #1 to go outside to smoke in inclement weather or be outside in his electric wheelchair. During an interview with Staff EE-PTA on 3/12/19 at 2:30 p.m., the staff stated cognitively the resident could probably go out by himself but physically he was not able, he did not have the upper body strength to right himself in his wheelchair due to a leg amputation and couldn't	F 689		

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F 689	Continued From page 37 stop the wheelchair from tipping over. During an interview on 3/5/19 at 11:31 a.m. Staff J (Licensed Practical Nurse) stated she was aware the resident had falls out of his electric wheelchair and the last incident she was aware of happened in February 2019, when we had a snow storm. The staff stated the resident was okay to go on the public bus by himself but the problems happened when he took the electric wheelchair to the gas station, he was not very safe in his wheelchair. During an interview on 3/5/19 at 9:45 a.m. Staff L (Licensed Practical Nurse) stated the resident would leave the facility in his electric wheelchair to smoke. The resident would sign self out of the facility and would come back 3-4 hours later, he would go to Walmart or to restaurants. Staff L stated the resident would go outside the facility and get stuck in the snow, this would happen several times a day. The resident had a left above knee amputation, he wouldn't wear a seat belt and would easily topple out of the wheelchair. During an interview on 3/19/19 at 9:00 a.m. Staff O(Social Service) stated the resident would frequently run into facility walls and they would have to be repaired by maintenance. The former Administrator handled the wheelchair safety issues and reported she actually took the electric wheelchair from the resident due to safety concerns but gave it back to him sometime in November 2018. Review of the Occupational Therapy Treatment Notes dated 10/2/18 indicated they reminded the resident that he would need to pass the electric wheelchair safety assessment with Occupational	F 689		

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F 689	Continued From page 38 Therapy when/if he gets the electric wheelchair. During an interview on 3/5/19 at 11:00 a.m. the Provisional Administrator verified Resident #1 never had a wheelchair safety assessment completed. The Inclement Weather Policy dated 3/5/19 revealed a plan to maintain the safety and well being of residents during times of inclement weather. The policy stated smoking will not be allowed during inclement weather conditions as well. The policy stated a resident with a BIMS score of 11 or less will not be allowed to leave the facility unsupervised. The facility abated the Immediate Jeopardy on 3/6/19. The facility provided all staff education on inclement weather protocols, updated care plans to address smoking during inclement weather, and leaving the facility independently.	F 689		
F 695 SS=D	Respiratory/Tracheostomy Care and Suctioning CFR(s): 483.25(i) § 483.25(i) Respiratory care, including tracheostomy care and tracheal suctioning. The facility must ensure that a resident who needs respiratory care, including tracheostomy care and tracheal suctioning, is provided such care, consistent with professional standards of practice, the comprehensive person-centered care plan, the residents' goals and preferences, and 483.65 of this subpart. This REQUIREMENT is not met as evidenced by: Based on clinical record review, staff and resident interviews and observations the facility failed to perform tracheostomy care for 1 of 2	F 695		

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F 695	Continued From page 39 sampled (Resident #7). The facility reported a census of 85. Findings include: Review of Resident #7's Minimum Data Set assessment revealed the resident had an admission date to the facility of 2/25/19. The Care Plan dated 3/5/19 revealed Resident #7 had a tracheostomy due to impaired breathing and directed the staff to ensure the trach ties are secured at all times, monitor the resident for restlessness, agitation and confusion, reassure the resident to decrease anxiety and to suction as ordered. The Clinical Physician's Orders sheet dated 3/18/19 revealed the resident had an order to suction the resident's tracheostomy every shift (initiated on 3/6/19). During an interview on 3/7/19 at 10:40 a.m. Resident #7 reported the staff suctioned her tracheostomy last at 2:00 p.m. on 3/6/19 and failed to suction her again until the day nurse suctioned her tracheostomy at 7:00 a.m. on 3/7/19. The resident stated she is suppose to get suctioned every shift and 17 hours is too long between suctioning. She stated she is frightened that she won't get suctioned when she needs it and will have a respiratory emergency. During an interview on 3/7/19 at 7:30 a.m. Staff BB (Registered Nurse) reported she arrived to work at 6:57 a.m. and Resident #7 was waving her down. Resident #7 needed to be suctioned and could barely speak. Resident #7 told Staff BB she hadn't been suctioned since yesterday and	F 695		

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F 695	Continued From page 40 was in extreme need. Staff BB suctioned the resident and removed a large mucus plug. Review of the Treatment Administration Record revealed the 10:00 p.m. to 6:00 a.m. nurse documented he suctioned the resident on the over night shift from 3/6/19 to 3/7/19. During an interview on 3/7/19 at 10:52 a.m. Staff CC (Registered Nurse) reported he didn't suction Resident #7 during his shift because she was sleeping so peacefully and he didn't want to wake her. Staff CC reported he signs off tasks before he does them and stated "I probably shouldn't do that". He stated he will make a note that the suctioning was not done. The undated Tracheotomy Care policy indicated tracheostomy care is provided to maintain the resident's airway, evacuate secretions and to prevent and/or reduce infections. The policy provides step by step detailed directions on how to provide tracheal suctioning.	F 695		
F 730 SS=D	Nurse Aide Peform Review-12 hr/yr In-Service CFR(s): 483.35(d)(7) §483.35(d)(7) Regular in-service education. The facility must complete a performance review of every nurse aide at least once every 12 months, and must provide regular in-service education based on the outcome of these reviews. In-service training must comply with the requirements of §483.95(g). This REQUIREMENT is not met as evidenced by: Based on clinical record review and staff interviews the facility failed to complete performance reviews for 4 of 4 aides sampled.	F 730		

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F 730	Continued From page 41 The facility reported a census of 85. Findings include: Review of 4 sampled Certified Nurses Aides employee files revealed: a. Staff G had a hire date of 1996 and received her last evaluation in 2008. b. Staff U had a hire date of 1995 and received her last evaluation in 2013. c. Staff R had a hire date of 2008 and received her last evaluation in 2013. d. Staff V had a hire date of 2002 and received her last evaluation in 2010. During an interview on 3/20/19 at 10:00 a.m. the Business Officer Manager reported she was told that performance evaluations are not done yearly because the corporation hasn't given the staff a raise for quite some time and it's a waste of time to do them.	F 730		
F 732 SS=D	Posted Nurse Staffing Information CFR(s): 483.35(g)(1)-(4) §483.35(g) Nurse Staffing Information. §483.35(g)(1) Data requirements. The facility must post the following information on a daily basis: (i) Facility name. (ii) The current date. (iii) The total number and the actual hours worked by the following categories of licensed and unlicensed nursing staff directly responsible for resident care per shift: (A) Registered nurses. (B) Licensed practical nurses or licensed vocational nurses (as defined under State law). (C) Certified nurse aides.	F 732		

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F 732	Continued From page 42 (iv) Resident census. §483.35(g)(2) Posting requirements. (i) The facility must post the nurse staffing data specified in paragraph (g)(1) of this section on a daily basis at the beginning of each shift. (ii) Data must be posted as follows: (A) Clear and readable format. (B) In a prominent place readily accessible to residents and visitors. §483.35(g)(3) Public access to posted nurse staffing data. The facility must, upon oral or written request, make nurse staffing data available to the public for review at a cost not to exceed the community standard. §483.35(g)(4) Facility data retention requirements. The facility must maintain the posted daily nurse staffing data for a minimum of 18 months, or as required by State law, whichever is greater. This REQUIREMENT is not met as evidenced by: Based on observations and interviews the facility failed to post nurse staffing data at the beginning of each shift in a prominent place readily accessible to residents and visitors. The facility reported a census of 85 residents. Findings include: Observation on 3/8/19 at 9:00 a.m. of the Daily Nurse Staffing Form posted at the nurses station, adjacent to the resident dining room revealed a dated of 3/7/19. Observation on 3/10/19 at 10:50 a.m. of the Daily Nurse Staffing Form posted at the nurses station	F 732		

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F 732	Continued From page 43 revealed a date of 3/7/19. Observation on 3/18/19 at 5:30 a.m. of the Daily Nurse Staffing Form posted at the nurses station revealed a date of 3/15/19. Observation on 3/19/19 at 8:00 a.m. of the Daily Nurse Staffing From posted at the nurses station revealed a date of 3/18/19. During an interview on 3/10/19 at 10:53 a.m., the Administrator stated she didn't know who was responsible for the daily staffing data postings. The Administrator asked Staff T who posts the staffing data. Staff T stated stated the Business Office Manager is responsible for the daily nurse hours postings and no one does it on the weekend. The Administrator asked Staff T who updates the form with changes, Staff T responded she didn't know it needed to be updated with staffing changes.	F 732		
F 801 SS=E	Qualified Dietary Staff CFR(s): 483.60(a)(1)(2) §483.60(a) Staffing The facility must employ sufficient staff with the appropriate competencies and skills sets to carry out the functions of the food and nutrition service, taking into consideration resident assessments, individual plans of care and the number, acuity and diagnoses of the facility's resident population in accordance with the facility assessment required at §483.70(e) This includes: §483.60(a)(1) A qualified dietitian or other clinically qualified nutrition professional either full-time, part-time, or on a consultant basis. A	F 801		

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F 801	Continued From page 44 qualified dietitian or other clinically qualified nutrition professional is one who- (i) Holds a bachelor's or higher degree granted by a regionally accredited college or university in the United States (or an equivalent foreign degree) with completion of the academic requirements of a program in nutrition or dietetics accredited by an appropriate national accreditation organization recognized for this purpose. (ii) Has completed at least 900 hours of supervised dietetics practice under the supervision of a registered dietitian or nutrition professional. (iii) Is licensed or certified as a dietitian or nutrition professional by the State in which the services are performed. In a State that does not provide for licensure or certification, the individual will be deemed to have met this requirement if he or she is recognized as a "registered dietitian" by the Commission on Dietetic Registration or its successor organization, or meets the requirements of paragraphs (a)(1)(i) and (ii) of this section. (iv) For dietitians hired or contracted with prior to November 28, 2016, meets these requirements no later than 5 years after November 28, 2016 or as required by state law. §483.60(a)(2) If a qualified dietitian or other clinically qualified nutrition professional is not employed full-time, the facility must designate a person to serve as the director of food and nutrition services who- (i) For designations prior to November 28, 2016, meets the following requirements no later than 5 years after November 28, 2016, or no later than 1 year after November 28, 2016 for designations after November 28, 2016, is:	F 801		

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F 801	Continued From page 45 (A) A certified dietary manager; or (B) A certified food service manager; or (C) Has similar national certification for food service management and safety from a national certifying body; or D) Has an associate's or higher degree in food service management or in hospitality, if the course study includes food service or restaurant management, from an accredited institution of higher learning; and (ii) In States that have established standards for food service managers or dietary managers, meets State requirements for food service managers or dietary managers, and (iii) Receives frequently scheduled consultations from a qualified dietitian or other clinically qualified nutrition professional. This REQUIREMENT is not met as evidenced by: Based on record review and staff interview, the facility failed to employ sufficient staff with the appropriate competencies to carry out the functions of the food and nutrition service. The facility employed a dietician on a part time consultant basis and designated a person to serve as the director of food and nutrition that lacked the required certification. The facility reported a census of 85. Findings include: Review of a document submitted by the consultant Registered Dietitian for hours worked at the facility revealed 5 visits (32.25 hours) for December 2018, 8 visits (47.5 hours) for January 2019 and 6 visits (33 hours) for February 2019. During an interview on 3/5/19 at 9:07 a.m. the Dietary Manager reported she was promoted in	F 801		

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F 801	Continued From page 46 November 2018, but is not certified. The Dietary Manager stated the facility planned to put her through school but is not enrolled. The Dietary Manager reported the facility employed a Dietitian two days a week who answers questions. During an interview on 3/6/19 at 2:37 p.m. the Administrator confirmed the Dietary Manager is not certified and the Dietitian is employed on a part time consultant basis.	F 801		
F 812 SS=E	Food Procurement,Store/Prepare/Serve-Sanitary CFR(s): 483.60(i)(1)(2) §483.60(i) Food safety requirements. The facility must - §483.60(i)(1) - Procure food from sources approved or considered satisfactory by federal, state or local authorities. (i) This may include food items obtained directly from local producers, subject to applicable State and local laws or regulations. (ii) This provision does not prohibit or prevent facilities from using produce grown in facility gardens, subject to compliance with applicable safe growing and food-handling practices. (iii) This provision does not preclude residents from consuming foods not procured by the facility. §483.60(i)(2) - Store, prepare, distribute and serve food in accordance with professional standards for food service safety. This REQUIREMENT is not met as evidenced by: Based on observation and staff interview, the facility failed to ensure surfaces in the kitchen were maintained in a sanitary manner and failed to protect food from contamination during meal	F 812		

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F 812	Continued From page 47 service. The facility reported a census of 85. Findings include: 1. During the initial dietary tour on 3/5/19 at 9:07 a.m., observation of the kitchen revealed a red bucket that contained a liquid on the food prep counter with a dish rag next to it. Staff A (Dietary Aide) reported the red bucket contained water and dish soap, and reported the facility had been out of chemicals for three weeks. Staff A confirmed had used the soapy water to clean all the food prep counters in the kitchen. At that same time the Dietary Manger provided a spray bottle labeled quat (RTU) quaternary FCS sanitizer. Staff A, dietary aide stated had not been instructed to use the spray sanitizer, and confirmed had not used to clean the kitchen. 2. Observation on 3/5/19 at 9:10 a.m. revealed Staff B (Dietary Aide) with his beard uncovered in the food prep area of the kitchen and washing dishes. Observation on 3/6/19 at 8:00 a.m. revealed Staff B entering and exiting the kitchen during breakfast with his full beard uncovered. Observation on 3/5/19 at 11:18 a.m. revealed an unknown maintenance employee pushed a cart through the kitchen during meal service and failed to have hair covered. The employee donned a hair net after passing through the kitchen. The undated Dress Code and Grooming policy directed staff hair should be kept clean and well-trimmed and long hair should be tied back. Hair of dietary personnel must be completely covered, including beards of male employees.	F 812		

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F 812	Continued From page 48 During an interview on 3/6/19 at 2:37 p.m., the Provisional Administrator stated educated Staff B on covering his beard while working in the kitchen. The Provisional Administrator reported an expectation of all employees working in the kitchen to have all hair, which included facial hair covered when in the kitchen and food prep areas. 3. Observation of lunch in the Main Dining Room 3/5/19 at 11:18 a.m. revealed the Dietary Manager, donned gloves and began serving. The Dietary Manager touched a variety of surfaces including, but not limited to serving utensil handles, and the outside of a kitchen drawer and then with the same gloved hands touched the entire surface of the ready to eat pizza as pulled the pieces of pizza apart and placed on plates. Continued observation on 3/5/19 at 11:55 revealed Staff C, dietary aide donned a pair of gloves and began to cut whole pizzas for service. Staff C observed to touch a variety of surfaces including, but not limited to her hair net, the surface of the counter and the outside of the pizza pan and then with the same gloved hands repeatedly touched the surface of the pizza as cut the pizza into pieces for service. Under continued observation pizza, touched with contaminated gloves, served to residents and consumed. Review of facility policy, titled Limited Bare Hand Contact for Ready-To-Eat Foods, instructed staff to wash hands and change gloves before beginning a new task, after touching equipment or utensils that have not been sanitized, and any time contamination of a glove might have occurred. The purpose of the policy was identified as preventing foodborne illness due to	F 812		

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F 812	Continued From page 49 hand to food cross- contamination. During an interview on 3/11/19 at 11:20 a.m. the Administrator reported dietary staff are trained to safely handle food to prevent food-borne illness. The Administrator stated staff should use utensils to serve food, and would not expect staff to touch food ready to eat with bare hands or contaminated gloves. Further stated, would expect staff to sanitize food prep areas with a pre-filled spray solution available in the kitchen and would not expect to use dish soap and water. The Food Code requires that food employees may not touch ready-to-eat food with their bare hands and must use suitable utensils such as deli tissue, spatulas, tongs, single-use gloves or dispensing equipment. The Food Code further requires food employees to clean their hands immediately before engaging in food preparation, including before donning gloves for working with food, and as often as necessary to remove soil and contamination in order to prevent cross contamination when changing tasks.	F 812		
F 921 SS=D	Safe/Functional/Sanitary/Comfortable Environ CFR(s): 483.90(i) §483.90(i) Other Environmental Conditions The facility must provide a safe, functional, sanitary, and comfortable environment for residents, staff and the public. This REQUIREMENT is not met as evidenced by: Based on observations and interviews the failed to maintain sanitary shower chairs for 3 of 4 shower rooms and failed to repair wall paper in 1 of 3 residents bedroom (Resident #2). The facility reported a census of 85 residents.	F 921		

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F 921	Continued From page 50 Findings include: 1. Observations of the shower rooms on 3/20/19 at 10:25 a.m. to 10:29 a.m. with Staff D (Housekeeping) and Staff E (Nurse Consultant) revealed the following: a. The 300 Hall Shower room contained two shower chairs. Both shower chairs had a brown substance on the underside of the seats. b. The 400 Hall Shower room contained two shower chairs. Both shower chairs had a brown substance on the underside of the seats. c. The 100 Hall Shower room contained two shower chairs. Both shower chairs had a brown substance on the underside of the seats. During an interview with Staff D, she indicated the nursing staff are responsible for the cleaning of shower chairs. During an interview with Staff E, she stated the shower chairs are to be clean between each resident use. 2. Observation on 3/20/19 at 8:40 a.m. revealed a large area near the ceiling of Resident #2's bedroom with missing wallpaper. The area measured approximately 16 inches long and approximately 10 inches wide. The wall had blackish discolored areas scattered throughout the area missing wall paper. During an interview with Staff F-Maintenance Supervisor on 3/20/19 at 8:47, Staff F stated the area looks like the result of a leak in the roof and will fix it today. At 9:10 a.m. Staff F stated he removed the rest of the wall paper around the missing wall paper and the area of blackish	F 921		

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F 921	Continued From page 51 discoloration is from the wall paper and not mold.	F 921		
F 947 SS=D	Required In-Service Training for Nurse Aides CFR(s): 483.95(g)(1)-(4) §483.95(g) Required in-service training for nurse aides. In-service training must- §483.95(g)(1) Be sufficient to ensure the continuing competence of nurse aides, but must be no less than 12 hours per year. §483.95(g)(2) Include dementia management training and resident abuse prevention training. §483.95(g)(3) Address areas of weakness as determined in nurse aides' performance reviews and facility assessment at § 483.70(e) and may address the special needs of residents as determined by the facility staff. §483.95(g)(4) For nurse aides providing services to individuals with cognitive impairments, also address the care of the cognitively impaired. This REQUIREMENT is not met as evidenced by: Based on record review and staff interviews the facility failed to assure nurse aides receive no less than 12 hours of in-service training yearly for 2 of 6 sampled Nurses Aides. The facility reported a census of 85 residents. Findings include: Review of 6 Certified Nurses Aide personnel files revealed the following: a. Staff U had a hire date of 1995 and received a total of 9 in-service hours from March of 2018 to	F 947		

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F 947	Continued From page 52 March 2019. b. Staff W had a hire date of May 2018 and received a total of 1 inservice hour from May 2018 to March 2019. During an interview on 3/201/9 at 10:00 a.m., the Director of Nurses reported she noticed the attendance was low for in-service trainings and began offering in-services twice a month in an attempt to accommodate the night shift. The Director of Nurses was not aware of the hours of in-service requirement for the Certified Nurse Aides.	F 947		

This plan and the individual responses to each F-tag are written solely to maintain certification with Medicare and Medicaid programs and as required are submitted as a credible allegation of compliance. These written responses do not constitute an admission of noncompliance with any requirement. Crestview Acres wishes to preserve our right to dispute these findings in their entirety should any remedies be imposes and In any legal or administrative proceedings.

F 584 Crestview Acres reasonably ensures the residents have a safe, clean comfortable and home like environment including to supply adequate linens to preform resident cares.

- Linen closets 300/400 hall have been reorganized and labeled to ensure there are wash cloths and hand towels available for resident cares

  The 100/300 and 400 Hall linen carts are stocked with hand with wash cloths, hand towels, and bath towels by the CNA's and used only to distribute clean linen for cares

  The lock was removed from all linen closets to ensure easy access for CNA's and Nurses

- All facility residents have the potential to be effected

  An inventory was completed of wash cloths, hand towels, bath towels, on 03/19 and again on 04/24/10

  An order for wash cloths, hand towels and bath towels was completed on 03/08/19, 03/11/19, and 04/17/19

  The House Keeping and Laundry Supervisor will complete ongoing inventory no less the monthly to ensure an adequate supply of linens are available for resident cares

- The House Keeping Supervisor and Laundry staff received training by 05/10/19 on the stocking, ordering of linens, inventory of linens, and appropriate par levels for the linen closets

- The facility Administrator or designee will complete weekly audits of the linens/linen closets to ensure an adequate supply for resident cares for 3 months to be reviewed by the QA team quarterly for compliance

- Compliance Date: 05/22/19

F 600 The facility reasonably ensures the residents are free from abuse, neglect, and misappropriation of resident property this includes resident to resident incidents.

- Resident R #17 has had no further contact with R #16. R #17 has had no incidents with any other residents and has experienced no negative outcome from the incident

  Resident R #16 was assessed and care plan updated. R # 16 was relocated of the Memory Care Unit and has no further incidents

  Both R # 16 and R # 17 charts we updated to include documentation in the medical record of the incident

- All Residents have the potential to be affected

  Resident interviews will be completed to ensure they are free from abuse neglect, misappropriation of property including resident to resident incidents

  The DON and ADON will review incidents reports to ensure completed timely and accurately

  The facility Abuse policy was reviewed to ensure it included Resident to Resident abuse

- The Licensed Nurses received training 05/10/19 and ongoing on completing Incident reports, assessment, and documentation in the residents medical record

  The CNA's and licensed Nurses received training on 05/10/19 and ongoing on Abuse and Neglect (i.e Resident to Resident abuse)

- The facility Administrator or designee will complete weekly audits of the Abuse and neglect policy to include resident to resident abuse and resident interviews for 3 months to be reviewed by the QA team quarterly for compliance

- Compliance Date: 05/22/19

F 677 The facility reasonably ensures ADL care is provided for dependent Residents to maintain good nutrition, grooming, and personal and oral hygiene which includes providing baths/showers.

- R # 9, R #11, and R # 13 have been assessed and ADL care plans revised to include the bath/shower preferences. There were no negative outcome to the residents

- New Bath sheets were created to obtain better information on ADL's care

  A monthly tracking sheet was developed for each resident and reviewed daily by the Nurse Manager for completion

  The DON reviewed and revised the bath/shower schedule and assignment for all facility residents

  2 CNA's were hired to provide showers/baths for residents based on their plan of care

- The Licensed Nurse and CNA's and Bath Aids have received training on 05/10/19 and ongoing on the facility practice of bath/showers, bath sheets, and revised bath and shower schedule

- The facility DON or designee will complete weekly audits of the shower/bath documentation to ensure completion for 3 months to be reviewed by the QA team quarterly for compliance

- Compliance Date: 05/22/19

F 678 The facility reasonably ensures personnel provide basic life support including CPR to a resident requiring emergency care prior to the arrival of emergency personnel and subject to related physician orders and the residents advanced directives.

- R # 1 no longer resides at the facility

- All facility residents have the potential to be affected

  A 100 % audit was completed of residents IPOST to ensure available and completed accurately. The audit included removing conflict information and updating the residents DNR/CPR status in the residents medical record

  A master list of residents CPR/DNR status was created and kept current is available and posted at each nurse's station

  The DON and ADON will review incidents reports to ensure assessment is completed and incident reports are timely and accurately

  Staff J and K have received additional training on facility practice of CPR/DNR and IPOST

- The facility Licensed Nurses received immediate training and received training again 05/10/19 and ongoing on the facility protocol on DNR/CPR, IPOST along with the master list of CPR/DNR status

- The facility DON or designee will complete weekly audits of the IPOST's and a master list of residents CPR/DNR status, along with Licensed staff interview on facility CPR/DNR practice to ensure completion for 3 months and to be reviewed by the QA team quarterly for compliance

- Compliance Date: 04/25/19

F 684 The Facility reasonably ensures quality of care applies to all treatment and care provided to facility residents which includes identifying, assessing, and treatment of skin conditions.

- R #4 was reassessed by the licensed nurse and MDS and care plan reviewed and modified to reflect current skin conditions and services as ordered by the physician.

  R # 4 was evaluated on 04/26/19 by a VA DR which included a overall physical evaluation and a review of his skin care condition and needs. The Physician felt his overall condition was stable and included no further recommendations on skin and wound care.

- All facility residents have the ability to be affected

  The facility has contracted with a Certified Wound Care Nurse who is rounding weekly with facility staff Nurse Mangers

  A facility audit of Residents Braden Scale assessments completed to ensure updated and accurate. The Braden Scale will be reviewed and updated based on change of condition or quarterly.

  New Skin bath/shower sheets were put in place for all facility residents. CNA's and Licensed Nurses can ensure prompt identification of any potential skin areas and provided to the Nurse Managers for follow up. This includes weekly skin checks by the licensed nurses

- Facility CNA's , Licensed Nurses and Nurse Managers received training on facility skin protocols, New skin/bath sheets, along with weekly skin checks.

- The facility DON or designee will complete weekly audits of the skin sheets, shower/bath sheets to ensure completion for 3 months and to be reviewed by the QA team quarterly for compliance

- Compliance Date: 04/25/19

F 686 The facility reasonably ensures based on comprehensive assessment the resident receives care consistent with professional standards and receives treatment and services consistent with professional standards to prevent pressure sores.

- R #4 was re-assessed by the licensed nurse and MDS and care plan reviewed and modified to reflect current skin conditions and services as ordered by the physician

  R # 4 was evaluated on 04/26/19 by a VA DR which included a overall physical evaluation and a review of his skin care condition and needs. The Physician felt his overall condition was stable and included no further recommendations on skin and wound care

  R#14 was re-assessed by the licensed nurse and MDS and care plan reviewed and modified to reflect current skin conditions and services as ordered by the physician

  R # 14 currently has no open areas

- All facility residents have the ability to be affected

  The facility has contracted with a Certified Wound Care Nurse who is rounding weekly with facility staff Nurse Mangers

  A facility audit of Residents Braden Scale assessments completed to ensure updated and accurate. The Braden Scale will be reviewed and updated based on change of condition or quarterly

  New Skin bath/shower sheets were put in place for all facility residents. CNA's and Licensed Nurses can ensure prompt identification of any potential skin areas and provided to the Nurse Managers for follow up. This includes weekly skin checks by the licensed nurses

- Facility CNA's , Licensed Nurses and Nurse Managers received training on facility skin protocols, New skin/bath sheets, along with weekly skin checks.

- The facility DON or designee will complete weekly audits of the skin sheets, shower/bath sheets to ensure completion for 3 months and to be reviewed by the QA team quarterly for compliance

- Compliance Date: 04/25/19

F 688 The facility reasonably ensures residents who enter the facility without limited range of motion do not experience reduction in range unless the resident's clinical condition demonstrates the reduction in range is unavoidable. The resident's limited range receives appropriate treatment and the appropriate services.

- R #6, R #9, and R #9, and R #18 were re-assessed by a licensed nurse and restorative program reviewed and modified based on current needs. R #6, R #9 and R # 18 are receiving restorative programs based on their individualized plan of Care. R # 18 is being reassessed for the need for her bilateral Knee braces

- All residents have the potential to be effected

  All current residents identified in need of a restorative program we reviewed and care plans updated by licensed nurses to reflect restorative program/intervention needs

  An additional restorative Nursing assistant was added to ensure appropriate coverage in the absence of one of the primary RA's

  Restorative Aid documentation is being reviewed daily by the DON or ADON to ensure programs and documentation are being completed

  Restorative documentation/tracking were reviewed and revised

  The 2 Nurse Managers were identified as the Restorative Nurses for their assigned case load

- The 2 restorative nurses and the Restorative CNA's received Immediate Training and received additional training on 05/10/19 and ongoing on the restorative programs, restorative documentation and the restorative schedule. (Not being pulled to the floor)

- The facility DON or designee will complete weekly audits of the restorative program and documentation to ensure completion for 3 months and to be reviewed by the QA team quarterly for compliance

- Compliance Date: 04/25/19

F 689 The facility reasonably ensures the resident's environment remains free of accidents and hazards as possible and residents receive adequate supervision

- R # 1 no longer resides at the facility

- Residents wanting to go out into the community or go out and smoke during inclement weather can be affected. The facility identified all residents that may be affected and licensed nursing staff reviewed and modified the resident's care plan to ensure appropriate supervision including times of inclement weather

  The Facility developed and inclement weather protocol

  The facility Licensed Nurse reviewed and revised care plans for resident smoking during inclement weather and residents leaving the facility independently to ensure adequate supervision

- The facility provided immediate training on inclement weather protocols, and resident smoking or leaving the facility independently during inclement weather

- The facility DON or designee will complete weekly audits of the inclement weather and resident smoking policy. This will include residents leaving the facility independently. and documentation to ensure completion for 3 months and to be reviewed by the QA team quarterly for compliance

- Compliance Date: 04/25/19

F 695 The facility reasonably ensure residents who need respiratory care including tracheostomy care and tracheal suctioning is provided such care consistent with professional standards of practice

- R # 7 was reviewed and care plan revised as necessary to include tracheostomy care and tracheal suctioning to meet the residents needs

- Residents with a tracheostomy have the potential to be affected

  All Licensed Nurses will perform a return demonstration on tracheostomy care and tracheal suctioning

  Staff BB and CC received additional training and education on tracheostomy care and trachea suctioning and documentation

  Resident Tracheostomy cares and suction was removed from the TAR and placed in the Resident MAR

- Facility Licensed Nurses received additional training and performed return demonstration 05/10/19 on tracheostomy care and trachea suctioning

- The facility DON or designee will complete weekly audits on Tracheostomy care and suctioning and MAR documentation for 3 months and to be reviewed by the QA team quarterly for compliance

- Compliance Date: 05/22/19

F 730 The facility reasonably ensures a completed performance review of every nurse aid is completed once every 12 months and must provide regular in-service training.

- Staff G, U. R, V have all received and completed a performance review
- All certified nurse aides have the potential to be affected

  A 100 % audit was completed of Nurse Aides and a completed performance review was completed and provided to all certified nurse aides

  The Office Manager will create a monthly schedule and distribute assigned Nurse Aid Performance reviews to the DON for all new month Nurse Aides and Licensed Nurse Performance review

- All Department Manages including the DON were received education on 05/10/19 on the facility handbook/completing annual performance reviews and the new schedule and distribution of monthly performance reviews
- The facility Administrator or designee will complete weekly audits on the completion of Nurse Aide performance reviews for 3 months and to be reviewed by the QA team quarterly for compliance
- Compliance Date: 05/22/19

F 732 The facility reasonably ensures it post daily the facility name, current date, total number and the actual hours worked by licensed and unlicensed nursing staff directly responsible for resident care per shift. RN's LPN's CNA's.

- The facility has been posting daily nurse staffing for each shift in a prominent place readily accessible to residents and visitors
- All residents, family members, visitors have the potential to be affected

  The DON or designee has been assigned the responsibility of posting daily nurse staffing for each shift. On Weekends it is the Manager on Duty/Nurse on Call responsible for posting nursing staff.

- The DON and Nurse Mangers received training on 05/10/19 on the requirement for posting daily of nurse staffing data
- The facility DON or designee will complete weekly audits on the completion of Nurse posting nurse staffing data for 3 months and to be reviewed by the QA team quarterly for compliance
- Compliance Date: 05/22/19

F 801 The facility reasonably ensures it employ sufficient staff with appropriate competencies and skills sets to carry out the functions of the food and nutrition service which includes a Certified Dietary Manager.

- The facility currently has contracted with a Certified Dietary Manager

- All Facility residents have the potential to be affected

  A Certified Dietary Manager was contracted and starts effective 05/22/19

- Administrator and DON were educated on the requirements for Certified Dietary Manager

- The facility Administrator or designee will complete weekly audit on the Certified Dietary Manager for 3 months and to be reviewed by the QA team quarterly for compliance

- Compliance Date: 05/22/19

F 812 The facility reasonably ensures it stores prepares, distributes and serves food in accordance to professional standards

- The facility had a sanitizing station installed by martin Brothers in the kitchen with sanitizing solution

  Staff B received additional education on wearing a beard cover in the food prep area of the kitchen and while washing dishes

  Maintenance employee received additional education on wearing a beard cover in the food prep area of the kitchen and while washing dishes

  Dietary Manager no longer employed by facility Dietary Staff C received additional training on glove usage/infection control/sanitation and removing and washing hands re-gloving

- All Residents have the potential to be affected

- Dietary Staff received training on Sanitation practices from martin brothers and additional training 05/10/19 on sanitation practices (i.e hair/beard nets, sanitation solution, bare handed contact with food glove usage/hand hygiene general sanitation practices...)

- The facility Administrator or designee will complete weekly sanitation audits in the kitchen for 3 months and to be reviewed by the QA team quarterly for compliance

- Compliance Date: 05/22/19

F 921 The facility reasonably ensures the environmental condition are safe, functional, sanitary, comfortable environment for residents, staff and public, this includes maintaining sanitary shower chairs and repair of wall paper

- The shower chairs on 100, 300, 400 shower chairs have been clean and sanitized removing the brown substance on the underside of seats

  R #2 wall paper has been repaired

- All residents have the potential to be affected

  The DON has created a new protocol, schedule, and assignments for the cleaning of the shower chairs

  The Maintenance Director completed a 100 % sweep of all resident rooms and areas and ensured all wall paper to be in good repair

  The Maintenance Director will complete weekly facility rounds on environmental conditions

- Facility CNA and staff received training on the new schedule and assignments for the cleaning of shower chairs. Maintenance personnel received training on wall paper repair and facility environmental rounds.

- The facility Administrator or designee will complete weekly audits on shower chairs and facility environment to ensure safe, functional, sanitary, and comfortable environment for 3 months and to be reviewed by the QA team quarterly for compliance

- Compliance Date: 05/22/19

F 947 The facility reasonably ensures nurse aides receive no less than 12 hours of in-service training yearly.

- Staff U and Staff W have received all their 12 hours of required
- The facility completed a 100% audit of all Certified Dietary Aides to ensure all Nurse aides have received the 12 hours of required in-servicing
- The DON and Facility CNA's received in-service training 05/10/19 on the 12 hour requirements for CNA in-servicing
- The facility DON or designee will complete weekly audits on CNA in-service training for 3 months and to be reviewed by the QA team quarterly for compliance
- Compliance Date: 05/22/19