STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	165162	A. BUILDING _____ B. WING _____	C 04/03/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ALTOONA NURSING AND REHABILITATION CENTER	200 SEVENTH AVENUE SW ALTOONA, IA 50009

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 000	INITIAL COMMENTS Correction Date 5/17/19 The following relates to the investigation of facility reported incidents #81124, 81681 and 81997 and complaints #80516, #81318, #81657, #81781, #81806, #81908, #81938, #81942 and #82040 and abuse allegation #81645. See Code of Federal Regulations (42CFR) Part 483, Subpart B-C.	F 000	E 000 This plan of correction constitutes our credible Allegation of Compliance. Preparation and or execution of this plan of correction does not constitute admission or agreement by the provider of the conclusion set forth in the statement of deficiencies. The plan of correction is prepared and / or executed solely because it is required by the provision of the federal and state laws.	
F 580 SS=E	Notify of Changes (Injury/Decline/Room, etc.) CFR(s): 483.10(g)(14)(i)-(iv)(15) §483.10(g)(14) Notification of Changes. (i) A facility must immediately inform the resident; consult with the resident's physician; and notify, consistent with his or her authority, the resident representative(s) when there is- (A) An accident involving the resident which results in injury and has the potential for requiring physician intervention; (B) A significant change in the resident's physical, mental, or psychosocial status (that is, a deterioration in health, mental, or psychosocial status in either life-threatening conditions or clinical complications); (C) A need to alter treatment significantly (that is, a need to discontinue an existing form of treatment due to adverse consequences, or to commence a new form of treatment); or (D) A decision to transfer or discharge the resident from the facility as specified in §483.15(c)(1)(ii). (ii) When making notification under paragraph (g)(14)(i) of this section, the facility must ensure that all pertinent information specified in §483.15(c)(2) is available and provided upon request to the	F 580	F 580 NOTIFICATIONS OF CHANGES The facility does and will continue to ensure to immediately inform the resident; consult with the resident's physician; and if known, notify the resident's legal representative or an interested family member when there is an accident involving the resident which results in injury and has the potential for requiring physician intervention; a significant change in the resident's physical, mental, or psychosocial status; a need to alter treatment significantly; or a decision to transfer or discharge the resident from the facility. A) Residents residing in the facility with changes in condition requiring notification of responsible party have the potential to be affected in the same manner; each resident will have their physician and legal representative notified as required. Residents 5, 8, 9, no longer reside in the facility.	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
[signature]	Administrator	5-17-19

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F 580	Continued From page 1 physician. (iii) The facility must also promptly notify the resident and the resident representative, if any, when there is- (A) A change in room or roommate assignment as specified in §483.10(e)(6); or (B) A change in resident rights under Federal or State law or regulations as specified in paragraph (e)(10) of this section. (iv) The facility must record and periodically update the address (mailing and email) and phone number of the resident representative(s). §483.10(g)(15) Admission to a composite distinct part. A facility that is a composite distinct part (as defined in §483.5) must disclose in its admission agreement its physical configuration, including the various locations that comprise the composite distinct part, and must specify the policies that apply to room changes between its different locations under §483.15(c)(9). This REQUIREMENT is not met as evidenced by: The following deficiency relates to intakes 81806-C, 81781-C, 81908-I and 81942-C. Based on record review and staff interview the facility failed to consult with a resident's physician following an accident, event or change of condition which may have potential for requiring physician intervention and failed to notify family of an accident, event, change of condition or transfer from the facility for 4 of 5 sampled. (Resident #5, #6, #8 and #9) The facility reported a census of 97. Findings include:	F 580	B) An audit tool was developed as a guide for Department Nursing Staff to use during morning QA to ensure, at a minimum all documentation of assessments, change of conditions, incidents and interventions, care plans updates, lab review, wound care, review of MARS and TARS are reviewed during the QA daily process with proper notification to physicians and family/representative. C) All nursing staff was re-educated on the following: • Proper procedures for notifying physicians when there is a significant change and family/ representative. • Documentation of notification to physician, families have entries in the medical records. D) The Quality Assurance Nurse or designee will perform audits to maintain the integrity of system with results forwarded to the Quality Assessment and Assurance Committee for further review and recommendation. E) Responsible Party: Director of Nursing Alleged Date of Compliance: 5/17/2019	

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F 580	Continued From page 2	F 580		

1. According to the Minimum Data Set (MDS) assessment dated 2/20/19 Resident #5 had a brief interview for mental status (BIMS) score of 5 indicating a severely impaired cognitive status. Resident #5 required total dependence on others with mobility, transfers, dressing, toilet use and personal hygiene needs. Resident #5's diagnosis included Non-Alzheimer's dementia, seizure disorder, Parkinson's and dysphasia.

During an interview on 3/5/19 at 3:30 p.m., Staff J (Nurse Aide) stated some time ago while assisting Resident #5 to eat she choked on green beans and and turned colors. Staff J hollered for Staff K (Licensed Practical Nurse) who performed the Heimlich maneuver. Resident #5 started breathing again. The staff assisted Resident #5 to her room and cleaned her up. Staff K stated Resident #5 was fine, but never listened to her lungs or assessed her. Staff J stated the next day Staff C (Assistant Director of Nurses) talked to Resident #5's daughter. Staff J pulled Staff C to the side and informed her Resident #5 aspirated last night. Staff C was unaware and stated the event was not charted.

During an interview on 3/5/19 at 5:20 p.m., Staff C (Assistant Director of Nursing) stated Resident #5 had a choking incident in the fall of 2018. Staff C stated she was not present but reportedly Staff K stood behind Resident #5. Staff C did not know if Staff K performed the Heimlich maneuver. Staff C stated the family found out and was upset. Staff K no longer cared for Resident #5.

During an interview on 3/5/19 at 5:47 p.m., the Director of Nursing (DON), provided Departmental Notes dated 10/10/18 at 4:36 p.m.

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F 580	Continued From page 3 that documented Resident #5 had a choking event and the Heimlich maneuver performed. The DON confirmed Staff C completed the entry three days after the event and Staff C was not the involved in the event. The DON reported the record lacked an assessment and physician notification of the event. The DON stated she would expect staff to fill out an incident report with an assessment and all pertinent notifications and for the nurse to document the event in the nurse's notes. The DON provided an incident report related to the event completed by Staff C, not the nurse involved. and there was no recorded assessment or family or physician notification. 2. According to the Minimum Data Set (MDS) assessment dated 2/8/19 Resident #6 had a brief interview for mental status (BIMS) score of 9 indicating an impaired cognitive status. Resident #6 required extensive assistance with mobility, transfers, dressing, toilet use and personal hygiene needs. Resident #6's diagnosis included Alzheimer's disease, Non-Alzheimer's dementia, diabetes mellitus, hypertension and urinary tract infection. During an interview on 4/2/19 at 2:00 p.m., Staff Z (Licensed Practical Nurse) stated on 2/3/19 Resident #6 complained of his bottom hurting. Staff Z observed Resident #6's buttocks and noted (3) Stage II pressure ulcers. Staff Z documented an assessment on a wound assessment report and completed a fax notification form requesting an order for cleansing the wounds and applying Calmoseptine three times a day until healed. Staff Z reported she did not personally contact the physician and did not fax the order request, but instead placed it in the physician's folder. Consequently the physician	F 580		

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F 580	Continued From page 4 did not see the order request until 2/5/19 and wound treatment was not initiated until 2/6/19. According to the Treatment Administration Record (TAR) for February 2019 revealed Resident #6 received the initial treatment of Calmoseptine ointment to the buttocks on 2/6/19. 3. According to the Minimum Data Set (MDS) assessment dated of 1/31/19 Resident #9 had a brief interview for mental status (BIMS) score of 9 indicating a moderately impaired cognitive status. Resident #9 required extensive assistance with mobility, transfers, dressing, toilet use and personal hygiene needs. Resident #9's diagnosis included hypertension, diabetes mellitus, arthritis and chronic obstructive pulmonary disease. During an interview on 3/13/19 at 2:30 p.m., Staff H (Registered Nurse) stated on the evening of 2/28/19 she received lab results for Resident #9. The lab results showed renal failure. Staff H contacted the on-call physician and reported the findings. Staff H asked if Resident #9 should be sent out for evaluation. Staff H stated the on-call physician (not Resident #9's primary care physician) stated no and hung up abruptly. Staff H stated she was concerned and instructed the overnight staff to report to the day shift nurse that the primary care physician needed notified of the lab results first thing in the morning. Staff H stated the following day she came into work early (12:00 p.m.) to ensure someone had followed up on the lab results. Nothing had been followed up on and she instructed Staff P (day shift nurse) to contact the physician. Staff P stated she thought Resident #9's condition was chronic renal failure. Staff H stated the physician was eventually contacted, but she was upset with the delay in	F 580		

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F 580	Continued From page 5 seeking medical attention. During an interview on 3/13/19 at 12:08 p.m., Staff S (Registered Nurse) stated she came into work at 2:00 p.m. on 3/1/19 and in report given by Staff P, Resident #9 had abnormal lab results last night and the on-call physician instructed staff to follow up with the primary care physician the next morning. Staff S stated nothing had been done, so she told Staff P and Staff T they needed to take care of it. Staff S stated she didn't do much, but when she checked the nurse's notes later, there was nothing documented, so she wrote a note. Staff S stated did not notify the family. During an interview on 3/13/19 at 9:30 a.m. Staff P (Registered Nurse) stated she was working the morning of 3/1/19 and assigned north hall, which includes Resident #9. Staff P stated she recalled Resident #9 complaining of nausea that day, but did not recall being informed of abnormal lab results. Staff P stated at shift change (2:00 p.m.) Staff S, asked her to contact the physician and make arrangements to send Resident #9 out for evaluation. Staff P stated she contacted the physician assistant and received an order to send Resident #9 out for an evaluation. Staff P stated she was not involved with anything else. Staff P stated it was facility practice to notify family of transfers out of the facility. Staff P reported she did not contact the family. During an interview on 3/13/19 at 1:15 p.m., Staff T (Licensed Practical Nurse) stated she worked Resident #9's unit on 3/1/19. Staff P stated Resident #9 had abnormal lab results related to renal failure, but noted there was nothing to do. Staff T stated she was familiar with Resident #9 and contacted the Physician's Assistant and	F 580		

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F 580	Continued From page 6 obtained an order to transfer Resident #9 to the hospital. Staff T stated she did not notify the family of the transfer. During an interview on 3/13/19 at 12:01 p.m., the Physician's Assistant (PA) stated she did not recall the specifics regarding Resident #9 being sent to the emergency room to be evaluated. The PA stated the necessity of immediate notification of the lab results would depend on the resident's baseline and if his condition was worsening. During an interview on 3/13/19 at 12:25 p.m., Resident #9's son stated he arrived at the facility on 3/1/19 at 6:00 p.m. and discovered his father had been sent to the emergency room a couple hours earlier. Resident #9's son stated he went to the hospital and his father was admitted with acute renal failure and dehydration. Resident #9's son stated he was not informed of his fathers abnormal lab results or of him being sent out to the hospital. 4. According to the Minimum Data Set (MDS) assessment dated of 2/14/19, Resident #8 had a brief interview for mental status (BIMS) score of 6 indicating a severely impaired cognitive status. Resident #8 required extensive assistance with mobility, transfers, dressing, toilet use and personal hygiene needs. Resident #8 had frequent incontinence of bowel and a catheter. Resident #8's diagnosis included atrial fibrillation, hypertension, cerebral infarction and failure to thrive. During an interview on 3/13/19 at 2:00 p.m. Staff W (Physical Therapy Assistant) stated back in February she discovered a blister on Resident	F 580		

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F 580	Continued From page 7 #8's right heel. Staff W stated she reported her findings to an unknown nurse and documented the observation. The Physical Therapy Treatment Encounter notes dated 2/19/19 revealed a blister observed on Resident #8's right heel. The nursing department notified and unaware of the blister and stated they would provide heel float/booties for Resident #9. The Departmental Notes lacked of documentation of the blister on Resident #9's right heel, lacked a wound assessment report, lacked physician notification, lacked family notification and lacked care plan interventions related to wound care. During an interview on 3/13/19 at 4:40 p.m., Staff H (Registered Nurse) stated Staff T informed her of the blister. Staff H stated at the time they were going to float the heel with pillows. Staff H stated she did not notify a physician as she thought Staff T probably had. Staff H stated she remembered telling the overnight staff about the blister. Staff H stated she does not remember if interventions were added to the care plan. During an interview on 3/14/19 at 10:30 a.m., Staff X (Nurse Aide) stated on 2/24/19 she discovered a sore on Resident #8's bottom and reported it to Staff T (Licensed Practical Nurse) but noted nothing was done. On 2/26/19, Staff X stated the sore worsened and she reported this to Staff Y (Licensed Practical Nurse) as well as the discovery of a huge blister on her right heel. Review of Departmental Notes lacked documentation of the reported pressure ulcer on Resident #8's left buttock, lacked a wound assessment, lacked physician notification, lacked	F 580		

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F 580	Continued From page 8 family notification and lacked care plan interventions for wound care. During an interview on 3/14/19 at 10:19 a.m., Staff Y (Licensed Practical Nurse) stated Staff X (Nurse Aide) informed her on 2/26/19 of the right heel blister and the sore on Resident #9's bottom. Staff Y stated Staff X stated she reported the sore a couple days earlier to Staff T and nothing had been done. Staff Y stated she informed the Director of Nurses an competed a wound assessment report for both areas, contacted the physician and obtained treatment orders. Staff Y stated she asked Staff T about the skin wounds. Staff T denied knowing anything about them. Staff Y stated she had recently resigned because nurses were not properly taking care of issues professionally, ignored wound care and neglected residents.	F 580		
F 609 SS=D	Reporting of Alleged Violations CFR(s): 483.12(c)(1)(4) §483.12(c) In response to allegations of abuse, neglect, exploitation, or mistreatment, the facility must: §483.12(c)(1) Ensure that all alleged violations involving abuse, neglect, exploitation or mistreatment, including injuries of unknown source and misappropriation of resident property, are reported immediately, but not later than 2 hours after the allegation is made, if the events that cause the allegation involve abuse or result in serious bodily injury, or not later than 24 hours if the events that cause the allegation do not involve abuse and do not result in serious bodily injury, to the administrator of the facility and to other officials (including to the State Survey Agency and	F 609	**F 609 483.12(1) (c) Investigate/Report Allegations/Individuals.** The facility does and will continue to ensure that All alleged violations involving mistreatment, neglect or abuse including unknown injuries, misappropriation of resident property is reported immediately to the administrator, and proper State agency including the investigation and outcome with appropriate corrective action taken. A) DON and Administrator reviewed the requirements for reporting alleged allegations of abuse / and injuries of unknown origin. Administrator and / or DON will hold the responsibility to ensure all allegations are reported to the DIA immediately. DON: Who failed to investigate and report is no longer with the facility.	

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F 609	Continued From page 9 adult protective services where state law provides for jurisdiction in long-term care facilities) in accordance with State law through established procedures. §483.12(c)(4) Report the results of all investigations to the administrator or his or her designated representative and to other officials in accordance with State law, including to the State Survey Agency, within 5 working days of the incident, and if the alleged violation is verified appropriate corrective action must be taken. This REQUIREMENT is not met as evidenced by: This deficiency relates to self reported incident 81645-A. Based on record review and staff interviews, the facility failed to report and investigate an incident involving neglect with injury for 1 of 5 sampled (Residents #3). The facility reported a census of 97. Findings include: According to the Minimum Data Set (MDS) assessment dated 2/12/19 Resident #3 had a brief interview for mental status (BIMS) score of 12 indicating a minimally impaired cognitive status. Resident #3 required extensive assistance with mobility, transfers, dressing, toilet use and personal hygiene needs. Resident #3's diagnosis included Bipolar disorder, diabetes mellitus and hypertension. The Care Plan directed the staff to provide Resident #3 assistance of one staff with transfers, walking and toilet use.	F 609	B) Facility Ambassador Team will continue to monitor the resident cares and safety to ensure free from abuse through daily monitoring of care plans, progress notes and social interviews and interaction with residents. C) Communication was presented to all facility departments on the following guidelines: • *Documentation of alleged reported abuse to residents and reporting promptly with full documentation of such findings.* • *To ensure assessments are complete, notification to physician, families and entries in the medical records.* • *Notification to administrator / DON immediately of any alleged abuse.* • *Staff Education and training for proper transfer procedures and gait belt usage was conducted with ongoing education and oversight* D) Human Resource Manager and Administrator will monitor employee records for training / education with results given to the QA committee for further review. E) Responsible Persons: HR Manager/ Administrator and Director of Nursing. Alleged Date of Compliance: 5/17/2019	

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F 609	Continued From page 10 The Radiology Report sheet dated 2/26/19 revalued right ankle pain for one week and soft tissue swelling about the ankle. The sheet revealed Resident #3 had diffuse osteopenia that limited a detailed evaluation of the bone and nondisplaced fractures. Resident #3 had no discrete fractures or dislocations. During an interview on 2/28/19 at 11:30 a.m., Resident #3 stated a girl moved her from the wheel chair to the bed and failed to use a gait belt. Resident #3 reported she stood up, lost her balance and fell along the side of the bed into the side rails. Resident #3 stated she did not fall to the floor. The aide pulled her up in bed and Resident #3 then realized her right ankle was hurting. Resident #3 stated she told the nurse about it the next day. During an interview on 2/28/19 at 9:08 a.m., Staff E (Therapy Director) stated on 2/21/19 he worked with Resident #3. Resident #3 reported pain in her right ankle which was related to an incident the evening before. Resident #3 stated the staff transferred her from the recliner to the bed and did not use a gait belt. Resident #3 stated she fell and struck her right ankle on the bed frame. Staff E reported the incident to the Director of Nursing. The Physical Therapy Treatment Encounter note dated 2/21/19 revealed Resident #3 stated during a transfer without a gait belt she hit her ankle on the bed rail. Resident #3 reported increased pain with walking. During an interview on 2/28/19 at 10:45 a.m., the Director of Nursing (DON) stated the therapy staff reported Resident #3 bumped her right ankle	F 609		

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F 609	Continued From page 11 during a transfer and had pain and tenderness. The DON reported she did not talk to the aide that transferred Resident #3. The DON did not initially disclose that the aide was allegedly not using a gait belt. The DON reported she did talk to Resident #3 and her son. When informed by this surveyor that Resident #3 had reportedly stumbled during a transfer and staff was not using a gait belt, the DON then admitted therapy staff had informed her the aide was allegedly not using a gait belt. In response to staff not using a gait belt the DON put out a staff education memo reminding staff to use a gait belt during transfers. The DON was not aware of who the aide was that had not used a gait belt and consequently had not spoken too or disciplined the aide for her failure to use a gait belt. The DON stated it is an expected standard of practice that a gait belt be use anytime transferring or walking with a resident who requires physical assistance, that the incident is reported and that an incident report be filled out. The DON stated there is no incident report related to this event and admitted the incident was not reported or investigated as a potential abuse.	F 609		
F 610 SS=D	Investigate/Prevent/Correct Alleged Violation CFR(s): 483.12(c)(2)-(4) §483.12(c) In response to allegations of abuse, neglect, exploitation, or mistreatment, the facility must: §483.12(c)(2) Have evidence that all alleged violations are thoroughly investigated. §483.12(c)(3) Prevent further potential abuse, neglect, exploitation, or mistreatment while the investigation is in progress.	F 610	**F 610 483.12(1) (c) Investigate/Prevent/ Correct Alleged Violation.** The facility does and will continue to ensure that all alleged violations involving, neglect, abuse, exploitation, mistreatment are investigated thoroughly and that all residents remain free from further potential abuse, neglect, exploitation, or mistreatment while the investigation is in process. The facility will continue to ensure proper reporting to the State agency including the investigation and outcome with appropriate corrective action taken.	

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ALTOONA NURSING AND REHABILITATION CENTER	200 SEVENTH AVENUE SW ALTOONA, IA 50009

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F 610	Continued From page 12 §483.12(c)(4) Report the results of all investigations to the administrator or his or her designated representative and to other officials in accordance with State law, including to the State Survey Agency, within 5 working days of the incident, and if the alleged violation is verified appropriate corrective action must be taken. This REQUIREMENT is not met as evidenced by: This deficiency relates to self reported incident 81645-A. Based on record review and staff interviews, the facility failed to investigate, separate and report an incident involving neglect with injury for 1 of 5 sample (Residents #3). The facility reported a census of 97. Findings include: According to the Minimum Data Set (MDS) assessment dated 2/12/19, Resident #3 had a brief interview for mental status (BIMS) score of 12 indicating a minimally impaired cognitive status. Resident #3 required extensive assistance with mobility, transfers, dressing, toilet use and personal hygiene needs. Resident #3's diagnosis included Bipolar disorder, diabetes mellitus and hypertension. The Care Plan directed the staff to provide Resident #3 assistance of one with transfers, walking and toilet use. The Radiology Report sheet dated 2/26/19 revalued right ankle pain for one week and soft tissue swelling about the ankle. The sheet revealed Resident #3 had diffuse osteopenia that	F 610	A) DON and Administrator reviewed the requirements for reporting alleged allegations of abuse / and injuries of unknown origin. Administrator and / or DON will hold the responsibility to ensure all allegations are reported to the DIA immediately. DON: Who failed to investigate and report is no longer with the facility. Resident #3 no longer resides in facility. Associate, determined to have been involved was placed on leave pending review and further education to associate. B) Facility Ambassador Team will continue to monitor the resident cares and safety to ensure free from abuse through daily monitoring of care plans, progress notes and social interviews and interaction with residents. C) Education of Investigating and Reporting guidelines were reviewed with the DON and QA Department team to ensure proper understanding of the regulations and steps to follow for alleged abuse; including: • *Documentation of alleged reported abuse to residents and reporting promptly with full documentation of such findings through investigation and interventions implemented.* • *To ensure assessments are complete, notification to physician, families / representatives and entries in the medical records.* D) Nursing Department team will continue to monitor through the daily QA process with all results present to the QA committee for further review. E) Responsible Persons: Administrator and Director of Nursing. Alleged Date of Compliance: 5/17/2019	

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F 610	Continued From page 13 limited a detailed evaluation of the bone and nondisplaced fractures. Resident #3 had no discrete fractures or dislocations. During an interview on 2/28/19 at 11:30 a.m., Resident #3 stated a girl moved her from the wheel chair to the bed and failed to use a gait belt. Resident #3 reported she stood up, lost her balance and fell along the side of the bed into the side rails. Resident #3 stated she did not fall to the floor. The aide pulled her up in bed and Resident #3 then realized her right ankle was hurting. Resident #3 stated she told the nurse about it the next day. In an interview on 2/28/19 at 9:08 a.m. Staff E, therapy director, stated on Thursday, 2/21/19 he was working with Resident #3, when she reported having pain in her right ankle which was related to an incident the evening before. Resident #3 stated the nurse was transferring her from her recliner into bed and not using a gait belt. Resident #3 stated she fell, striking her right ankle on the bed frame. Staff E stated he reported the incident to the Director of Nursing. Physical Therapy Treatment Encounter note dated 2/21/19 and written by Staff E stated Resident #3 states she was being transferred by an aide last night without a gait belt and that she hit her ankle on the bed rails while transferring from her wheel chair to bed. Resident #3 states she has increased pain with walking. During an interview on 2/28/19 at 9:08 a.m., Staff E (Therapy Director) stated on 2/21/19 he worked with Resident #3. Resident #3 reported pain in her right ankle which was related to an incident the evening before. Resident #3 stated the staff	F 610		

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F 610	Continued From page 14	F 610		

transferred her from the recliner to the bed and did not use a gait belt. Resident #3 stated she fell and struck her right ankle on the bed frame. Staff E reported the incident to the Director of Nursing.

The Physical Therapy Treatment Encounter note dated 2/21/19 revealed Resident #3 stated during a transfer without a gait belt she hit her ankle on the bed rail. Resident #3 reported increased pain with walking.

During an interview on 2/28/19 at 10:45 a.m., the Director of Nursing (DON) stated the therapy staff reported Resident #3 bumped her right ankle during a transfer and had pain and tenderness. The DON reported she did not talk to the aide that transferred Resident #3. The DON did not initially disclose that the aide was allegedly not using a gait belt. The DON reported she did talk to Resident #3 and her son. When informed by this surveyor that Resident #3 had reportedly stumbled during a transfer and staff was not using a gait belt, the DON then admitted therapy staff had informed her the aide was allegedly not using a gait belt. In response to staff not using a gait belt the DON put out a staff education memo reminding staff to use a gait belt during transfers. The DON was not aware of who the aide was that had not used a gait belt and consequently had not spoken too or disciplined the aide for her failure to use a gait belt. The DON stated it is an expected standard of practice that a gait belt be use anytime transferring or walking with a resident who requires physical assistance, that the incident is reported and that an incident report be filled out. The DON stated there is no incident report related to this event and admitted the incident was not reported or investigated as a potential abuse.

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F 658 SS=D	Services Provided Meet Professional Standards CFR(s): 483.21(b)(3)(i) §483.21(b)(3) Comprehensive Care Plans The services provided or arranged by the facility, as outlined by the comprehensive care plan, must- (i) Meet professional standards of quality. This REQUIREMENT is not met as evidenced by: This deficiency relates to complaint 81318-C, 81781-C, 81938-C and 82040-C. Based on observation, record review and staff interviews, the facility failed to meet professional standards of care when they failed to follow physician orders for 4 of 4 sampled (Resident #2, #6, #12 and #13). The facility reported a census of 97. Findings include: 1. According to the Minimum Data Set (MDS) assessment dated of 1/6/19, Resident #2 had a brief interview for mental status (BIMS) score of 6 indicating a severely impaired cognitive status. Resident #2 required extensive assistance with mobility, transfers, dressing, toilet use and personal hygiene needs. Resident #2's diagnoses included hypertension, hip fracture and glaucoma. The Wound Assessment Report sheet dated 1/2/19 revealed Resident #2 admitted on 12/31/18 with a Stage II pressure ulcer on her sacrum. The sheet had an order to treat with a zinc oxide ointment topically twice per day until healed. The Physician Order dated 1/9/19 revealed the	F 658	F 658 Services Provided Meet Professional Standards The Facility does and will continue to ensure that services provided or arranged by the comprehensive Care Plans meet professional standards of quality which is evidenced by the following: A) Resident #6 had his physician orders reviewed. Residents 2, 12, 13, no longer reside in the facility. Residents residing in the facility with physician orders have the potential to be affected in a similar manner. B) The facility has implemented a Daily QA audit tool to aide DON and QA team in reviewing all labs and physician orders during the morning QA process to ensure labs and physician orders are reviewed. The facility has hired a certified Wound Nurse on April 22, 2019. Wound nurse to perform weekly skin assessments, verify treatments and treatment orders, documentation and education to floor nursing staff.	

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F 658	Continued From page 16 physician changed Resident #2's wound treatment to medihoney to wound base on buttocks and cover with optifoam every other day and as needed until healed. The staff noted the order on 1/11/19. The Treatment Record dated January 2019 revealed the the zinc oxide treatment discontinued at 7:00 a.m. on 1/9/19 and the medihoney treatment initiated at 6:00 a.m. on 1/11/19. The staff failed to provide treatment to Resident #2's wound for two days. 2. According to the Minimum Data Set (MDS) assessment dated 2/8/19, Resident #6 had a brief interview for mental status (BIMS) score of 9 indicating an impaired cognitive status. Resident #6 required extensive assistance with mobility, transfers, dressing, toilet use and personal hygiene needs. Resident #6's diagnoses included Alzheimer's disease, Non-Alzheimer's dementia, diabetes mellitus, hypertension and urinary tract infection. During an interview on 4/2/19 at 2:00 p.m., Staff Z (Licensed Practical Nurse) stated on 2/3/19 Resident #6 complained of his bottom hurting. Staff Z observed (3) Stage II pressure ulcers on Resident #6's buttocks. Staff Z documented an assessment on a wound assessment report and completed a fax notification to the physician requesting an order for cleansing the wounds and applying Calmoseptine three times a day until healed. Staff Z reported she placed the fax in the physician's folder and did not fax the request. Resident #6 failed to receive treatment to the wound until 2/6/19. According to the treatment administration record	F 658	C) All licensed nursing personal was reeducated for proper protocols of: • Following physician orders, follow through, communication and documentation. • Nursing staff educated on proper documentation in the MAR and TAR records D.) Wound Nurse or designee to complete weekly audits/ inspections to ensure that physician orders are followed timely with skin interventions, and communicated to appropriate departments, with the results forwarded to the Quality Assessment and Assurance Committee for further review and recommendation. E.) Responsible Party: Wound Nurse and Director of Nursing Alleged date of Compliance: 5/17/2017	

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F 658	Continued From page 17	F 658		

(TAR) for February 2019, Resident #6 received Calmoseptine ointment treatments three times a day from 2/6/19 through the morning of 2/12/19. On 2/12/19 the treatment order was changed to cleansing the wound, pat dry and applying zinc oxide twice per day. Resident #6 failed to receive a treatment to the wound on the evenings of 2/16, 2/19, 2/20 and 2/21 and the morning of 2/20.

According to the treatment administration record (TAR) for February 2019, Resident #6 was to have weekly skin assessments and to document these assessments in the wound assessment manager every Friday. Despite documenting the weekly skin assessments as being completed on 2/8 and 2/15, there were no wound assessment reports or documentation indicating the wounds, identified on 2/3/19, were assessed and measured per protocol.

3. According to the Minimum Data Set (MDS) assessment dated of 1/23/19, Resident #12 had a brief interview for mental status (BIMS) score of 12 indicating a minimally impaired cognitive status. Resident #12 required extensive to total dependence on others with mobility, transfers, dressing, toilet use and personal hygiene needs. Resident #12's diagnoses included cerebrovascular accident, hemiplegia, pressure ulcer sacral and right heel.

The Treatment Records dated March 2019 revealed Resident #12 had the following treatment orders:

a. Soak gauze in Betadine and apply to right foot wounds on heel, ankle, toes and side of foot, hold in place with bordered gauze and kerlix every day. Wound treatment not completed on 3/5,

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F 658	Continued From page 18 3/10 and 3/18. b. Cleanse wound to right heel with wound cleanser, allow to air dry, apply calcium alginate, cut size to wound, cover with foam and secure with rolled gauze. Wound treatment not completed on 3/5, 3/10 and 3/18. c. Apply zinc oxide to buttocks twice daily until healed. Wound treatment not completed on the morning of 3/5 and 3/10 or on the evening of 3/5, 3/14 and 3/15. d. Assess skin every Wednesday. Staff documented skin assessment done on 3/6, but not on 3/13. Wound assessment report completed for 3/6. During an observation on 3/19/19 at 10:15 a.m. Staff AA (Licensed Practical Nurse) and Staff Z (MDS Coordinator) entered Resident #12's room to complete a dressing change. Staff AA removed a dressing dated 3/17/19 with initials "JG" from Resident #12's right foot. Staff AA stated she changed the dressing on 3/17/19 and apparently it hadn't been changed since. Staff AA exchanged gloves without sanitizing and proceeded to dab the wound on ankle and heel with Betadine, then placed an antibacterial foam dressing (Hydrofera Blue) over the ankle and heel wound, wrapped with kerlix and when finished labeled the dressing with 3/19/19 and her initials. Staff AA placed the blue boots on Resident #12's foot, washed her hands and left the room. In an interview on 3/19/19 at 10:30 a.m. Staff AA (Licensed Practical Nurse) stated it was not unusual for her to come across dressings that have not been changed as ordered, noting it	F 658		

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F 658	Continued From page 20 being noted by Staff H on 2/27/19, the labs were not recorded in the facilities lab schedule and was not completed as ordered. During an interview on 3/27/19 at 4:55 p.m., Staff H Registered Nurse) stated she noted the physician's order on 2/27/19 for the weekly labs on Mondays. Staff H reported when noting an order the nurse transcribes the order on Treatment Record, Medication record or in this case the facility lab book. Staff H reported she failed to record the lab order in the Facility Lab Book. According to the Facility Lab Book Resident #13 had labs scheduled on Thursday 3/7/19. However, the facility failed to complete the lab work as ordered. During an interview on 3/27/19 at 4:30 p.m., Staff Z (Licensed Practical Nurse) stated she reviewed the charts and noticed the order for Resident #13 dated 2/271/9 for scheduled labs on Mondays. Staff Z looked at the Facility Lab Book and noticed the staff failed to log the order on 3/4/19. Staff Z immediately recorded it to be done on Thursday 3/7/19. Staff Z stated she contacted the lab (3/27/19) and the lab informed her the lab work originally ordered on 2/27/19 had not been completed.	F 658		
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 personal and oral hygiene; This REQUIREMENT is not met as evidenced	F 677		

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F 658	Continued From page 19 happens frequently. Staff AA questioned about treatment of Resident #12's wounds and why treatment orders were not followed. Staff AA used an antibacterial dressing instead of calcium alginate on Resident #12's right heel and failed to cleanse the wound with wound cleanser. Staff AA also used the antibacterial foam over the ankle wound when the orders are to use bordered gauze. Staff AA stated the hospice nurse had suggested using the foam pad over the ankle wound to provide more cushion and comfort, but noted the physician had not been consulted to change the order. 4. According to the Minimum Data Set (MDS) assessment dated of 2/26/19, Resident #13 had a brief interview for mental status (BIMS) score of 15 indicating an intact cognitive status. Resident #13 required limited assistance on others with mobility, transfers, dressing, toilet use and personal hygiene needs. Resident #13's diagnoses included atrial fibrillation, anxiety and chronic obstructive pulmonary disease. Resident #13 was admitted 2/19/19 with a peripherally inserted central catheter (PICC) line. The Treatment Record dated February 2019 revealed Resident #13 had an order to change the Peripheral Inserted Central Catheter (PICC) line dressing and cap weekly. The staff failed to complete the dressing change on 2/23 as ordered. On 2/27/19 Resident #13 had an appointment with her infectious diseases physician. Resident #13 was given an order to have weekly labs completed on Mondays and to fax to the physician for review. Resident #13 was due for these labs on Monday 3/4/19. Despite the orders	F 658		

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F 677	Continued From page 21 by: The following deficiency relates to complaints 81645-A, 81681-C, 81806-C and 81942-C. Based on observation, record review, staff interviews and resident group interview, the facility failed to provide care and services to maintain a residents optimal health and well being for residents unable to carry out the activity independently for 4 of 7 sampled (Residents #3, #4, #5, #8). The facility reported a census of 97. Findings include: 1. According to the Minimum Data Set (MDS) assessment dated of 2/12/19, Resident #3 had a brief interview for mental status (BIMS) score of 12 indicating a minimally impaired cognitive status. Resident #3 required extensive assistance with mobility, transfers, dressing, toilet use and personal hygiene needs. Resident #3's diagnoses included Bipolar disorder, diabetes mellitus and hypertension. Record review revealed Resident #3 had scheduled baths on Monday and Thursday. Review of the facility bath logs from from 2/1/19 to 3/5/19 revealed Resident #3 failed to receive a bath/shower on 2/4/19 and 2/18/19. 2. According to the Minimum Data Set (MDS) assessment dated of 1/2/19, Resident #4 had a brief interview for mental status (BIMS) score of 15 indicating an intact cognitive status. Resident #4 is totally dependent on others with mobility, transfers, dressing, toilet use and personal hygiene needs. Resident #4's had a diagnosis of multiple sclerosis.	F 677	**F 677 ADL CARE PROVIDED FOR DEPENDENT RESIDENTS** A) The facilities bath schedule was reviewed to ensure all residents residing in the facility have a proper schedule of bath days. B) The facility does and will continue to ensure that all residents who are unable to carry out activities of daily living receives the necessary services to maintain good nutrition, grooming, and personal and oral hygiene. 5-1-2019 Facility has hired and designation a Staff Development Nurse and CMA Preceptor to conduct training with weekly and monthly audits on all nursing staff for ADLS including peri-care, incontinent care, grooming, oral care. C) Through ongoing documented audits Nursing staff continues to receive education on a. Procedures for providing ADLS on grooming, oral care, personal hygiene b. Peri-Care c. Review of the shower schedule, documentation of to provide insurance of completion of weekly showers for each resident.	

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F 677	Continued From page 22 Record review revealed Resident #4 had scheduled baths on Monday, Tuesday and Thursday. Review of the facility bath logs from 2/1/19 to 3/5/19 revealed Resident #4 failed to receive a bath/shower on 2/4/19 and 2/26/19. 3. According to the Minimum Data Set (MDS) assessment dated of 2/20/19, Resident #5 had a brief interview for mental status (BIMS) score of 5 indicating a severely impaired cognitive status. Resident #5 required total dependence on others with mobility, transfers, dressing, toilet use and personal hygiene needs. Resident #5 had diagnoses of dementia, seizure disorder, Parkinson's and dysphasia. Record review revealed Resident #5 had scheduled baths on Tuesday and Friday. Review of the facility bath logs from 2/1/19 to 3/5/19 revealed Resident #5 failed to receive a bath/showed on 2/26/19 and 3/1/19. 4. According to the Minimum Data Set (MDS) assessment dated of 1/2/19, Resident #4 had a brief interview for mental status (BIMS) score of 15 indicating an intact cognitive status. Resident #4 is totally dependent on others with mobility, transfers, dressing, toilet use and personal hygiene needs. Resident #4 had a diagnosis of multiple sclerosis. Observation on 3/4/19 at 11:13 a.m. Resident #4 lying in bed watching television. Resident #4 remained in bed throughout the day with no observations of staff providing incontinence	F 677	D) The Staff Development Nurse and CMA Preceptor with DON will complete periodic weekly audits to monitor for peri-care, incontinent care, grooming and hygiene, and shower schedule review, with the results forwarded to the Quality Assessment and Assurance Committee for further review and recommendation. E) Responsible Party: Director of Nursing and Administrator. Alleged Date of Compliance: 5/17/2019	

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ALTOONA NURSING AND REHABILITATION CENTER	200 SEVENTH AVENUE SW ALTOONA, IA 50009

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F 677	Continued From page 23	F 677		

cares. At 6:30 p.m., Resident #4 reported the staff had not been in today to check or change her brief. At 6:35 p.m., Staff B and Staff I entered Resident #4's room and provided incontinence cares and a clean brief.

During an interview on 3/4/19 at 7:34 p.m., Staff B (Nurse Aide) stated she checked on Resident #4 at 2:00 p.m., but never checked her for incontinence, noting Resident #4 knows when she needs changed. Staff B stated she and Staff I provided incontinence cares at around 6:30 p.m.

During an interview on 3/4/19 at 7:30 p.m., Staff I (Nurse Aide) stated he and Staff B provided incontinence cares for Resident #4 at around 6:30 p.m. Staff I stated prior to that, since coming in at 2:00 p.m. he checked in on Resident #4, but never checked her for incontinence, noting she had several visitors.

Observations on 3/5/19 at 8:45 a.m. revealed Resident #4 lying in bed watching television. Resident #4 had a black top on she had on the day before. Resident #4's brief had a pen mark. At 10:20 a.m., the brief still had the pen mark. At 10:40 a.m., staff entered the room, provided incontinence cares and changed Resident #4's brief. Staff again provided incontinence cares at 1:40 p.m.

During an interview on 3/5/19 at 2:15 p.m. Staff L (Nurse Aide) stated Resident #4 frequently uses her call light. Staff L stated she was assigned south hall today. Resident #4 was checked and dry at 6:00 a.m. Staff L stated she was in and out of the room as the call light was activated. Staff L stated she and Staff M checked and changed Resident #4 at 9:00 a.m., 10:30 a.m. and 1:30

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F 677	Continued From page 24	F 677		

p.m. Staff L asked whether she provided grooming and oral hygiene cares this morning. Staff L stated they did not provide any grooming, change of clothes or oral cares this morning.

During an interview on 3/5/19 at 2:05 p.m. Staff M (Nurse Aide) stated she arrived to work at 6:00 a.m. and had Resident #4's hall. Staff M stated the overnight shift had just changed Resident #4, but she checked her for incontinence anyway and she was dry. Staff M stated they turned on the lights and television and positioned Resident #4 up in bed, but noted neither she or Staff L provided any grooming, dressing or oral hygiene cares. Staff M stated Resident #4's husband prefers to groom and brush her teeth and gets upset when staff does this. This is not addressed in Resident #4's plan of care. Staff M stated Resident #4 utilizes her call light several times a day for a variety of reasons. Staff M stated after breakfast Resident #4 usually gets her shower, but since her fall, she prefers bed baths. Staff M stated sometime around 10:30 a.m. and 1:30 p.m. she and Staff L provided incontinence cares. Staff M admits Resident #4 was not dressed or provided a new shirt to wear that day.

5. According to the Minimum Data Set (MDS) assessment dated of 2/20/19, Resident #5 had a brief interview for mental status (BIMS) score of 5 indicating a severely impaired cognitive status. Resident #5 required total dependence on others with mobility, transfers, dressing, toilet use and personal hygiene needs. Resident #5's diagnoses included Non-Alzheimer's dementia, seizure disorder, Parkinson's and dysphasia.

During an observation on 3/13/19 at 5:40 p.m. revealed a trash can next to Resident #5's bed

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F 677	Continued From page 25 contained a brief. Upon closer examination of the trash, the surveyor noticed a brief and gloves, but no disposed wipes. Following supper, Resident #5 propelled back to her room. At 7:00 p.m. this surveyor stepped into the room. Resident #5 had been transferred into her bed and Staff R was observed standing over Resident #5 putting on a new brief. A soiled brief was lying on the floor. Staff R was not wearing gloves and there were no wipes visible either on the floor or in the trash. When finished attaching the brief, Staff R placed Resident #5's nasal cannula on her nose and pulled the sheet over her lower legs and body. Staff R was never observed washing or sanitizing her hands in between tasks. Staff R then disposed of the soiled brief in the trash can. During an interview on 3/13/19 at 7:00 p.m. Staff R (Nurse Aide) was asked if she had provided perineal care for Resident #5 and she responded yes. Staff R was then asked where she had disposed of her wipes. Staff R stated in the trash. In the presence of Staff R, this surveyor gloved and then removed two soiled briefs from the trash can and showed Staff R the remaining contents which included a few gloves, but no wipes. Staff R again asked if she had used wipes and provided peri care and this time she responded no. Staff R denied being the one that had changed Resident #5's brief prior to supper, but all other aides asked also denied changing the brief and Staff R was assigned 1:1 for Resident #5. 6. According to the Minimum Data Set (MDS) assessment with assessment reference date of 2/14/19, Resident #8 had a brief interview for mental status (BIMS) score of 6 indicating a severely impaired cognitive status. Resident #8	F 677		

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F 677	Continued From page 26 required extensive assistance with mobility, transfers, dressing, toilet use and personal hygiene needs. Resident #8 had frequent incontinence of bowel and a catheter. Resident #8's diagnoses included atrial fibrillation, hypertension, cerebral infarction and failure to thrive. During an observation on 3/12/19 at 6:00 p.m. Staff U (Nurse Aide) and Staff V (Nurse Aide) provided incontinence cares for Resident #8. Both staff had donned gloves, but failed to maintain aseptic technique during cares. Staff failed to remove contaminated gloves and wash or sanitize their hands in between going from a contaminated task to a clean one. Staff failed to apply barrier cream following peri care.	F 677		
F 684 SS=E	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: This deficiency relates to complaints 81645-A, 81806-C, 81781-C, 81908-C, 81938-C, 81942-C and 82040-C. Based on observations, record review, staff interviews and resident interview, the facility failed to meet professional standards of practice	F 684	**F 684 483.25 Quality of Care** The facility does and will continue to reasonably ensure each resident receives treatment and care in accordance with professional standards of practice, the comprehensive person-centered care plan and resident choice. A) Residents # 6 ,9,10,11 have had their care plans reviewed on 5/9/2019 Residents 3,5,8,12,13, no longer reside in the facility All residents of the facility will continue to have their care plans reviewed at a minimum quarterly and as needed with pocket-care-plans for c.n.a staff to be reviewed and updated as needed by staff CMA preceptor.	

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F 684	Continued From page 27 involving medication administration and assessment of residents with wounds, falls, events or changes in condition which warrant assessment and intervention for 9 of 20 open sampled (Residents #3, #5, #6, #8, #9, #10, #11, #12, #13). The facility reported a census of 97. Findings include: 1. According to the Minimum Data Set (MDS) assessment dated 2/20/19, Resident #5 had a brief interview for mental status (BIMS) score of 5 indicating a severely impaired cognitive status. Resident #5 required total dependence on others with mobility, transfers, dressing, toilet use and personal hygiene needs. Resident #5's diagnoses included Non-Alzheimer's dementia, seizure disorder, Parkinson's and dysphasia. During an an interview on 3/5/19 at 3:30 p.m. Staff J (Nurse Aide) stated some time ago (10/7/18) there was an incident in which while feeding Resident #5 she choked on some green beans and was turning colors. Staff J hollered for the nurse (Staff K), who responded and performed a Heimlich thrust twice. Resident #5 started breathing again. Staff J stated Resident #5 was taken to her room and cleaned up. Staff K stated Resident #5 was fine, but never listened to her lungs or assessed her. Staff J stated the next day (actually 10/10/18), Staff C was talking to Resident #5's daughter. Staff J stated she pulled Staff C aside and informed her Resident #5 had aspirated the evening before. Staff C was unaware, noting the event was not charted. During an interview on 3/5/19 at 5:20 p.m. Staff C (Assistant Director of Nurses) stated there was an incident in the fall of 2018 in which Resident	F 684	B) An audit tool was developed as a guide for Department Nursing Staff to use during morning QA to ensure, at a minimum all documentation of assessments, change of conditions, incidents and interventions with care plans updates, wound care, review of MARS and TARS are reviewed during the QA daily process with proper notification to physicians and family/representative. Certified Wound Nurse was hired on 4/20/2019 to aide in education, assessment, treatment and documentation. C) Nursing staff inserviced on: Assessment protocol Incidents Reporting and Documentation Progress Note Entries Hot Charting /Communication Wound Documentation Care Plan Updating Notification to Physician Notification to Legal Representative Stop and Watch Protocols C.N.A. staff communication binder updated to remind c.n.a to use the STOP and Watch, to inform the DON and Administrator immediately of any change of condition or concern if they feel it has not been addressed. D) The Administrator or designee will perform random reviews of the QA processes to maintain the integrity of system with results forwarded to the Quality Assessment and Assurance Committee for further review and recommendation. E) Responsible Party: Director of Nursing and Administrator Alleged Date of Compliance: 5/17/2019	

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F 684	Continued From page 28 #5 had a choking incident and Staff K was the nurse. Staff C stated she was not there, but reportedly Staff K stood behind Resident #5 and Staff C stated she was not certain whether Staff K performed a Heimlich. Staff C stated the family found out and was upset and Staff K was no longer allowed to take care of Resident #5. During an interview on 3/5/19 at 5:47 p.m., the Director of Nursing (DON), provided Departmental Notes dated 10/10/18 at 4:36 p.m. for Resident #5 noting Resident #5 had a choking event and Heimlich thrust done one time. The note was written by Staff C three days after the event and not written by the nurse involved, Staff K. There was no assessment recorded or notification of a physician. The DON stated she would expect staff to fill out an incident report with an assessment and all pertinent notifications and for the nurse to document the event in the nurse's notes. The DON provided an incident report related to the event that was filled out by Staff C, not the nurse involved and there was no recorded assessment or family or physician notification. 2. According to the Minimum Data Set (MDS) assessment dated of 2/12/19, Resident #3 had a brief interview for mental status (BIMS) score of 12 indicating a minimally impaired cognitive status. Resident #3 required extensive assistance with mobility, transfers, dressing, toilet use and personal hygiene needs. Resident #3's diagnoses included Bipolar disorder, diabetes mellitus and hypertension. Resident #3's plan of care indicates she requires assistance of one with transfers, walking and toilet use.	F 684		

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F 684	Continued From page 29 Radiology Report dated 2/26/19 related to right ankle pain for one week. Impression: diffuse osteopenia mildly limits the detailed evaluation of the bone and nondisplaced fractures. No discrete fractures or dislocations. There is soft tissue swelling about the ankle. There is a small plantar calcaneal spur. During an interview on 2/28/19 at 11:30 a.m., Resident #3 stated a girl was moving her from her wheel chair into bed and not using a gait belt. They stood up and she lost her balance and fell along the side of the bed into the side rails. Resident #3 stated she did not fall to the floor. The aide then pulled her up in bed and Resident #3 then realized her right ankle was hurting. Resident #3 stated she told the nurse about it the next day (2/20/19). During an interview on 3/4/19 at 2:05 p.m., Staff G (Nurse Aide) stated she was working the evening of Wednesday, 2/20/19 and assigned north hall. Staff G stated she was involved with Resident #3's care with two other aides, but did not put her to bed that evening. Staff G stated on Thursday, 2/21/19 when she got to work Resident #3's call light was on. Resident #3 asked Staff G if she could get her an ice pack for her ankle. Resident #3's son was present and stated Resident #3 had fallen and was supposed to have an ice pack. Staff G stated she went to the nurse, Staff H and asked if she could get an ice pack and Staff H stated yes. Staff G returned with the ice pack. Later that same evening Staff G was assisting with transferring Resident #3 onto the toilet and put her gait belt around Resident #3's waist. Resident #3 stated the person transferring her last night did not use a gait belt. Staff G stated Resident #3 requires	F 684		

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F 684	Continued From page 30 extensive assistance of one staff with transfers and needs a gait belt. Staff G stated she thought she informed Staff H about the aide not using a gait belt. During an interview on 3/4/19 at 2:38 p.m., Staff H (Registered Nurse) stated she remembered Staff G making a comment about Resident #3 wanting an ice pack for her right ankle and her giving Staff G a key to the medication room to get the ice pack. Staff H stated she did not do an assessment of Resident #3's right ankle at that time, but later on had asked her how her ankle was doing and looked at it. According to Staff H the ankle was edematous, but no more or less than usual. There was no record of an assessment or rationalization for an ice pack. 3. According to the Minimum Data Set (MDS) assessment dated 2/8/19, Resident #6 had a brief interview for mental status (BIMS) score of 9 indicating an impaired cognitive status. Resident #6 required extensive assistance with mobility, transfers, dressing, toilet use and personal hygiene needs. Resident #6's diagnosis included Alzheimer's disease, Non-Alzheimer's dementia, diabetes mellitus, hypertension and urinary tract infection. During an interview on 4/2/19 at 2:00 p.m., Staff Z (Licensed Practical Nurse) stated on Sunday 2/3/19, Resident #6 was complaining of his bottom hurting. Staff Z observed Resident #6's buttocks and noted (3) stage 2 pressure ulcers. Staff Z recorded her assessment on a wound assessment report and filled out a fax notification form requesting an order for cleansing the wounds and applying Calmoseptine three times a day until healed. Staff Z admits she did not	F 684		

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personally contact the physician and did not fax the order request, but instead placed it in the physician's folder. Consequently the physician did not see the order request until Tuesday, 2/5/19 and wound treatment was not initiated until 2/6/19.

According to the Treatment Record dated February 2019, Resident #6 received Calmoseptine ointment treatments three times a day from 2/6/19 through the morning of 2/12/19. On 2/12/19 the treatment order was changed to cleansing the wound, pat dry and applying zinc oxide twice per day. According to the TAR, Resident #6 did not receive wound treatment on the evenings of 2/16, 2/19, 2/20 and 2/21 and did not receive wound treatment on the morning of 2/20.

According to the Treatment Record dated February 2019, Resident #6 was to have weekly skin assessments and to document these assessments in the wound assessment manager every Friday. Despite documenting the weekly skin assessments as being completed on 2/8 and 2/15, there were no wound assessment reports or documentation indicating the wounds, identified on 2/3/19, were assessed and measured per protocol.

4. According to the Minimum Data Set (MDS) assessment dated 1/31/19, Resident #9 had a brief interview for mental status (BIMS) score of 9 indicating a moderately impaired cognitive status. Resident #9 required extensive assistance with mobility, transfers, dressing, toilet use and personal hygiene needs. Resident #9's diagnoses included hypertension, diabetes mellitus, arthritis and chronic obstructive pulmonary disease.

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F 684	Continued From page 32 During an interview on 3/13/19 at 2:30 p.m. Staff H (Registered Nurse) stated on the evening of 2/28/19 she received lab results for Resident #9 noting high results indicative of renal failure. Staff H contacted the on call physician and reported the findings and questioned whether Resident #9 should be sent out for evaluation. Staff H stated the physician, who was not Resident #9's primary care physician, stated no and hung up abruptly. Staff H stated she was concerned and instructed the overnight staff at shift change report to have the day nurse contact the primary care physician first thing in the morning to report the lab results. Staff H stated the following day she came into work early (12:00 p.m.) to ensure someone had followed up on the lab results. Nothing had been followed up on and she instructed the day nurse, Staff P to contact the physician. Staff P stated she thought Resident #9's condition was chronic renal failure. Staff H stated the physician was eventually contacted, but she was upset with the delay in seeking medical attention. During an interview on 3/13/19 at 12:08 p.m., Staff S (Registered Nurse) stated she arrived to work at 2:00 p.m. on 3/1/19 and received report from Staff P (Registered Nurse) who reported Resident #9 had an abnormal lab results last night and the on-call physician instructed staff to follow up with the primary care physician the next morning. Staff S stated nothing had been done, so she told Staff P and Staff T they needed to take care of it. Staff S stated she didn't do much, but when she checked the nurse's notes later, there was nothing documented, so she wrote a note. Staff S stated she was not involved in notifying the family.	F 684		

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F 684	Continued From page 33 During an interview on 3/13/19 at 9:30 a.m.. Staff P, (Registered Nurse) stated she was working the morning of 3/1/19 and assigned north hall, which includes Resident #9. Staff P stated she recalled Resident #9 complaining of nausea that day, but did not recall being informed of abnormal lab results. Staff P stated at shift change (2:00 p.m.) Staff S, must have came across the lab results and asked her to help contact the physician and make arrangements to send out for evaluation. Staff P stated she contacted the physician assistant and got an order to send Resident #9 out for an evaluation. Staff P stated she was not involved with anything else. Staff P stated it was facility practice to notify family of transfers to the emergency room and noted she was not involved with contacting the family. During an interview on 3/13/19 at 1:15 p.m., Staff T (Licensed Practical Nurse) stated she was working west hall on 3/1/19. The day nurse on North hall, Staff P, stated Resident #9 had abnormal lab results related to renal failure, but noted there was nothing to do. Staff T stated she was familiar with Resident #9 and contacted the physician assistant and obtained orders to have Resident #9 transferred. Staff T stated she was not involved with anything else. Staff T stated she was not involved with notifying family of the transfer. During an interview on 3/13/19 at 12:01 p.m., the Physician Assistant (PA) stated she did not recall the specifics regarding Resident #9 being sent to the emergency room to be evaluated. PA informed of lab results indicating renal failure and whether the lab values would have necessitated immediate notification and intervention. PA stated it would depend on a resident's baseline	F 684		

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F 684	Continued From page 34 and if his condition was worsening. During an interview on 3/13/19 at 12:25 p.m., Resident #9's son stated he arrived at the facility on 3/1/19 at around 6:00 p.m. and discovered his father had been sent to the emergency room a couple hours earlier. Resident #9's son stated he went to the hospital and his father was admitted with acute renal failure and dehydration. Resident #9's son stated he was not informed of his fathers abnormal lab results or of him being sent out to the hospital. 5. According to the Minimum Data Set (MDS) assessment dated 2/14/19, Resident #8 had a brief interview for mental status (BIMS) score of 6 indicating a severely impaired cognitive status. Resident #8 required extensive assistance with mobility, transfers, dressing, toilet use and personal hygiene needs. Resident #8 had frequent incontinence of bowel and a catheter. Resident #8's diagnoses included atrial fibrillation, hypertension, cerebral infarction and failure to thrive. During an interview on 3/13/19 at 2:00 p.m., Staff W (Physical Therapy Assistant) stated back in mid-February (2/19/19) she discovered a blister on the right heel of Resident #8. Staff W stated she reported her findings to the nurse (unknown) and documented in her notes. Physical Therapy Treatment Encounter notes dated 2/19/19 and written by Staff W states physical therapy assistant observed blister on patient's (Resident #8) right heel and informed nursing this date. Nursing was not aware of blister and stated they would provide heel float/booties for patient.	F 684		

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F 684	Continued From page 35 Facilities daily assignment sheet for 2/19/19 indicates Staff T is assigned nurse 6:00 a.m. to 2:00 p.m. for north hall and Staff H is assigned north hall 2:00 p.m. to 10:00 p.m. Review of Departmental Notes finds no documentation of reported blister on right heel, no wound assessment report, no physician notification, no family notification and no care planned interventions related to wound care. During an interview on 3/13/19 at 4:40 p.m. Staff H (Registered Nurse) stated she had first heard about Resident #8 having a blister on her right heel by Staff T. Staff H stated at the time they were going to float the heel with pillows. Staff H stated she did not notify a physician, noting she thought Staff T probably had. Staff H stated she remembers telling the overnight staff about the blister. Staff H stated she does not remember whether any interventions were added to the care plan. During an interview on 3/14/19 at 10:30 a.m. Staff X (Nurse Aide) stated on 2/24/19 she discovered a sore on Resident #8's bottom and reported it to the nurse, Staff T, but noted nothing was done. Then on 2/26/19 Staff X stated the sore on Resident #8's bottom was getting worse and she reported this to Staff Y as well as the discovery of a huge blister on her right heel. Facility daily assignment sheet for 2/24/19 indicates Staff X worked 6:00 a.m. to 2:00 p.m. shift and was assigned Resident #8's room. Staff T was the day nurse and assigned Resident #8's hall (north).	F 684		

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F 684	Continued From page 36 Review of Departmental Notes finds no documentation of reported pressure ulcer on left buttocks, no wound assessment report, no physician notification, no family notification and no care planned interventions related to wound care. During an interview on 3/14/19 at 10:19 a.m. Staff Y (Licensed Practical Nurse) stated on 2/26/19 she was informed by Staff X that Resident #8 had a sore on her bottom and a blister on her right heel. Staff Y stated Staff X stated she had reported the sore on Resident #8's bottom a couple days earlier to Staff T and nothing had been done. Staff Y stated she informed the DON and filled out wound assessment reports for both areas, contacted the physician and obtained treatment orders. Staff Y stated she asked Staff T about the skin wounds and Staff T denied knowing anything about them. Staff Y stated she had recently resigned because nurses were not properly taking care of issues professionally, ignored wound care and neglected residents. Wound Assessment Report dated 2/26/19 written by Staff Y indicates Resident #8 with a pressure ulcer blister on her right heel 4 centimeters by 5.5 centimeters and a stage II pressure ulcer on her left buttocks 6 centimeters by 4.7 centimeters and 0.1 centimeter in depth. The Treatment Orders dated 2/26/19 indicate left buttock to be cleansed with wound cleanser, apply triad wound gel, cover with optifoam, gentle dressing change every 3 days and as needed. Check placement of dressing daily to buttock. Left heel, paint blister like area with Betadine twice daily until healed.	F 684		

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F 684	Continued From page 37	F 684		

Review of care plan and pocket care plan finds no interventions to address floating of heels, repositioning, use of barrier cream, etc.

Wound Assessment Report dated 3/4/19 written by the Director of Nursing, indicates Resident #8 with irritation and excoriation of coccyx area 5 centimeters by 5 centimeters related to moisture. Physician notified. No orders.

Review of care plan and pocket care plan finds no interventions to address excoriation of coccyx due to moisture such as use of barrier cream, frequent incontinent cares, etc.

The Wound Assessment Report dated 3/7/19 written by Staff T notes blister on left lateral shin, 11 centimeters by 12 centimeters related to moisture. Physician notified.

Review of Departmental Notes for 3/7/19 revealed a lack of documentation related to left shin blister, no family notification and no care planned interventions related to wound care.

During an interview on 3/14/19 at 9:50 a.m., Staff Z (MDS Coordinator) stated on Monday 3/11/19 the blistering on Resident #8 was progressing onto her toes. Staff Z stated she filled out wound assessment reports, notified the physician and obtained treatment orders. Staff Z stated she was not certain who within the facility was currently providing weekly skin assessments.

The Wound Assessment Report dated 3/11/19 written by Staff Z indicates blister on left lateral shin has now expanded into Resident #8's foot and toes. Physician notified and treatment orders obtained. New treatment now to cleanse left

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F 684	Continued From page 38 lower leg with wound cleanser, apply Vaseline gauze and wrap with kling, apply triple antibiotic to top of left foot blister, cover with 4 x 4's and wrap with kling twice daily and apply Betadine to left 3rd, 4th and 5th toes twice daily. Observations on 3/12/19 at 4:35 p.m. and 3/13/19 at 7:50 a.m. revealed Resident #8 wearing foam boots and staff floating heels while in bed. However, the care plan and pocket care plans do not have use of foam boots or floating of heels as a formal intervention. 6. According to the Minimum Data Set (MDS) assessment dated 1/9/19, Resident #10 had a brief interview for mental status (BIMS) score of 15 indicating an intact cognitive status. Resident #10 required limited assistance with mobility, transfers, dressing, toilet use and personal hygiene needs. Resident #10 had a diagnosis of fractured tibia. The Treatment Record for February and March 2019 revealed an order to clean Resident #10's 5 pin sites with normal saline every two days and wrap with kerlix and complete a weekly skin assessments every Sunday. During an interview on 3/18/19 at 5:55 p.m., Resident #10 stated there was a time in which staff were not providing routine wound treatments, but noted they are much better now. Resident #10 pointed to a clip board in the room and stated staff are now required to sign the completion of treatments. The clip board was initiated 3/8/19. During an interview on 3/18/19 at 3:40 p.m., Staff E, (Physical Therapy Assistant) stated Resident	F 684		

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F 684	Continued From page 39 #10 received physical therapy daily and during one session (3/6/19) mentioned that staff were not cleaning around his pins every other day as ordered. Staff E stated he filled out a Therapy Communication Alert and provided it to nursing staff. During an interview on 3/19/19 at 2:00 p.m., Staff P (Interim Director of Nursing) stated she was alerted to a concern in which Resident #10 was not getting pin site wound care every other day as ordered. Resident #10 had reported there had been upwards to one week in which care had not been provided. Staff P stated upon reviewing the treatment administration record (TAR), staff had been documenting treatment as completed. Staff P stated she implemented a clip board in which staff are now required to sign the clip board after providing treatments and Resident #10 signs next to the nurses signature to verify. According to the February and March 2019 Treatment Record Resident #10 had omissions in the pin treatment on 2/4, 2/10 and 2/26. The staff documented the weekly skin assessments as completed every week with exception to 2/8. However, the record lacked wound assessment reports related to the pin sites during February and March. During an interview on 3/20/19 at 1:30 p.m., the Assistant Director of Nursing (ADON) stated when residents are admitted a skin assessment is done to identify any on-going skin issues and a weekly skin assessment prompt is added to the computer to alert staff of needed skin assessments. Staff are to assess and document wound conditions weekly and fill out a wound assessment report for each active wound. The	F 684		

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F 684	Continued From page 40 ADON stated the facility has had difficulty in keeping a wound nurse and assessments have been inconsistent. During an interview on 3/20/19 at 1:05 p.m., Staff CC (Registered Nurse) stated the computer prompts the nurses to complete the weekly skin assessments. Nurses would click on the prompt which takes them to a wound assessment report which can then be filled out measuring the wound and assessing the condition. During an interview on 3/20/19 at 12:55 p.m., Staff AA (Licensed Practical Nurse) stated she was not certain how the weekly skin assessments were to be done and whether wound assessment reports were to be done on all on-going skin issues. During an interview on 3/20/19 at 12:50 p.m. Staff Z (Licensed Practical Nurse) stated weekly skin assessments are to be done and recorded on the TAR and wound assessment report. 7. According to the Minimum Data Set (MDS) assessment dated of 2/22/19, Resident #11 had a brief interview for mental status (BIMS) score of 12 indicating a minimally impaired cognitive status. Resident #11 required extensive assistance with mobility, transfers, dressing, toilet use and personal hygiene needs. Resident #11's diagnoses included post traumatic stress disorder, renal insufficiency, hypertension and chronic obstructive pulmonary disease. The Treatment record dated February 2019 revealed an order to to re-wrap Resident #11's bilateral lower legs per instructions in communication book daily and complete a weekly	F 684		

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F 684	Continued From page 41 skin assessment. The staff documented all treatments as completed with exception to 2/26. The Treatment Records dated March 2019 revealed Resident #11's treatment changed on 3/5/19 to apply Eucerin cream over entire body including both lower extremities (BLE) and to wrap BLE with kerlix, then ace wrap. All treatments are recorded as completed with exception to 3/7. Weekly skin assessments were documented as completed on 3/4, 3/11 and 3/18, however no wound assessment reports completed for 3/4 or 3/18. During an interview on 3/19/19 at 3:15 p.m., Resident #11 stated stated no one has changed his dressing today, noting they never do. At 9:35 p.m. Resident stated no one put cream on his legs this evening or re-wrapped his legs. 8. According to the Minimum Data Set (MDS) assessment dated of 1/23/19, Resident #12 had a brief interview for mental status (BIMS) score of 12 indicating a minimally impaired cognitive status. Resident #12 required extensive to total dependence on others with mobility, transfers, dressing, toilet use and personal hygiene needs. Resident #12's diagnoses included cerebrovascular accident, hemiplegia, pressure ulcer sacral and right heel. The Treatment Record dated February 2019 revealed the following orders for Resident #12: a. Soak gauze in Betadine and apply to right foot wounds on heel, ankle, toes and side of foot, hold in place with bordered gauze and kerlix every day. Wound treatment not completed on 2/5, 2/7, 2/11, 2/18, 2/19 and 2/26.	F 684		

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F 684	Continued From page 42 b. Cleanse wound to right heel with wound cleanser, pat dry, apply collagen pad moistened with normal saline, cover with foam and secure kerlix every three days. Then changed on 2/12/19 to cleanse wound to right heel with wound cleanser, allow to air dry, apply calcium alginate, cut size to wound, cover with foam and secure with rolled gauze. Wound treatment not completed on 2/18, 2/19, 2/21 and 2/26. c. Apply zinc oxide to buttocks twice daily until healed. Wound treatment not completed on the morning of 2/5, 2/7 and 2/18 or on the evening of 2/5, 2/7, 2/8, 2/11 and 2/18. d. Assess skin every Wednesday. Staff documented skin assessments done weekly on 2/6, 2/13, 2/20 and 2/27, however no wound assessment reports on record for those dates. The Treatment Record dated March 2019 revealed the following orders for Resident #12: a. Soak gauze in Betadine and apply to right foot wounds on heel, ankle, toes and side of foot, hold in place with bordered gauze and kerlix every day. Wound treatment not completed on 3/5, 3/10 and 3/18. b. Cleanse wound to right heel with wound cleanser, allow to air dry, apply calcium alginate, cut size to wound, cover with foam and secure with rolled gauze. Wound treatment not completed on 3/5, 3/10 and 3/18. c. Apply zinc oxide to buttocks twice daily until healed. Wound treatment not completed on the morning of 3/5 and 3/10 or on the evening of 3/5,	F 684		

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F 684	Continued From page 43 3/14 and 3/15. d. Assess skin every Wednesday. Staff documented skin assessment done on 3/6, but not on 3/13. Wound assessment report completed for 3/6. During an observation on 3/19/19 at 10:15 a.m., Staff AA (Licensed Practical Nurse) and Staff Z (MDS Coordinator) completed dressing changes to Resident #12's wounds. Both staff washed hands and donned gloves. Staff AA removed old dressing while Staff Z lifted right foot. Old dressing labeled 3/17/19 with initials JG. Staff AA stated she had last changed the dressing on Sunday, 3/17/19 and apparently it hadn't been changed since. Staff AA exchanged gloves without sanitizing and proceeded to dab the wound on ankle and heel with Betadine, then placed an antibacterial foam dressing (Hydrofera Blue) over the ankle and heel wound, wrapped with kerlix and when finished labeled the dressing with 3/19/19 and her initials. Staff AA placed the blue boots on Resident #12's foot, washed her hands and left the room. During an interview on 3/19/19 at 10:30 a.m. Staff AA (Licensed Practical Nurse) stated it was not unusual for her to come across dressings that have not been changed as ordered, noting it happens frequently. Staff AA questioned about treatment of Resident #12's wounds and why treatment orders were not followed. Staff AA used an antibacterial dressing instead of calcium alginate on Resident #12's right heel and failed to cleanse the wound with wound cleanser. Staff AA also used the antibacterial foam over the ankle wound when the orders are to use bordered gauze. Staff AA stated the hospice nurse had	F 684		

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F 684	Continued From page 44 suggested using the foam pad over the ankle wound to provide more cushion and comfort. During an interview on 3/19/19 at 12:00 p.m., Staff BB (Registered Nurse) stated she completed the treatment on Resident #12's bottom on 3/18/19, but did not change the dressings or provide treatment on Resident #12's right foot and heel. Staff BB admitted she recorded the treatment and dressing change as completed on the TAR in error. 9. According to the Minimum Data Set (MDS) assessment dated 2/26/19, Resident #13 had a brief interview for mental status (BIMS) score of 15 indicating an intact cognitive status. Resident #13 required limited assistance on others with mobility, transfers, dressing, toilet use and personal hygiene needs. Resident #13's diagnosis included congestive heart failure, atrial fibrillation, anxiety and chronic obstructive pulmonary disease. Resident #13 admitted on 2/19/19 with a Peripherally Inserted Central Catheter (PICC) line. The February 2019 Treatment record revealed the following orders for Resident #13: a. Change the PICC line dressing and cap weekly. Wound treatment not completed on 2/23. b. Assess skin and document in wound module weekly. Staff documented skin assessment done weekly on 2/22 however no wound assessment report on record for that date. The February 2019 Treatment record revealed the following orders for Resident #13:	F 684		

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F 684	Continued From page 45 a. Change the PICC line dressing and cap weekly. Wound treatment documented as completed on 3/2. b. Assess skin and document in wound module weekly. Staff documented skin assessment done weekly on 3/1, however no wound assessment report on record for that date. During an interview on 3/27/19 at 8:15 a.m., Staff EE (Nurse Aide) stated when she arrived to work on 3/8/19 at around 6:00 a.m. she was informed in report that Resident #13 had had a rough night and was up at the nurse's station most of the night. Staff EE stated she checked on Resident #13 first thing and was accompanied by Staff V. When entering the room, Resident #13 was leaning over the bedside table, stating she was not feeling well and and asking to go to the hospital. Staff EE stated she immediately went to the nurse's station and informed Staff Y and Staff FF, Resident #13 was not doing well and requesting to go to the hospital. Staff EE reported Resident #13's lips were blue and color was not good. Staff EE stated Staff FF came to the room a little later and hung an antibiotic and opened her window, but did not check her vital signs. Staff EE stated she checked on Resident #13 frequently that morning and she was very restless. Around 6:30 a.m. Staff Y came to the room and checked Resident #13's vital signs. Staff EE stated she went to retrieve an oximeter and stated when checked the oxygen saturation level was 67%. Staff EE stated out load the oxygen level to (Staff Y) who was present in the room. Staff Y stated something about the wheelchair being on the tubing. Staff EE stated she also saw the blood pressure reading which was in excess of 100 diastolic. Staff EE stated	F 684		

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F 684	Continued From page 46	F 684		

Staff Y never rechecked the oxygen level and was very upset that Staff Y didn't do anything. Staff EE stated Staff Y kept mentioning Resident #13 had behaviors. At around 8:30 a.m. Staff EE noted Resident #13's respirations were labored and 13 per minute. Staff EE stated she reported this to Staff Y and still nothing was done. At around 9:00 a.m. Staff Y and Staff GG were standing at Resident #13's doorway as she was walking down the hall. Staff Y stated Resident #13 was in a brief and exposed from her waist down and asked Staff EE to get a blanket to cover her. Staff EE stated she walked directly to the linen closet, got a blanket and returned to the room. Staff EE stated as she entered the room, it was clear Resident #13 had passed away. Staff EE ran to the Administrators office where they were having a meeting and informed everyone Resident #13 was dead. Staff responded to the room. Staff EE stated she repeatedly told Staff Y, I told you so. Staff EE was sent to the break room while staff proceeded with cardiopulmonary resuscitation (CPR).

During an interview on 3/28/19 at 8:08 a.m., Staff V (Nurse Aide) stated she worked the day shift on 3/8/19 and had Resident #13's hall. As she walked onto the hall, Resident #13's call light was on. Staff V responded and noted Resident #13 was not looking good and she was having difficulty breathing. Resident #13 was requesting to see a nurse. Staff V stated she got Staff EE to stay with Resident #13 while she went to the nurse's station where both nurses, Staff FF and Staff Y were talking to one another. Staff V reported Resident #13 was not looking good and needs a nurse. Neither nurse looked up towards Staff V or responded to her comment. Staff V remained standing at the nurse's station and after

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F 684	Continued From page 47 about 3 minutes, Staff EE came up and asked why they were ignoring Staff V and that Resident #13 doesn't look good and needs help. Overnight nurse Staff FF stated she took Resident #13's vital signs and gave her her medications and she is fine. Staff V stated she and Staff EE left to help other residents. About 15-20 minutes later, Resident #13's call light was on again. Staff V and Staff EE responded to the room. Resident #13 was again requesting a nurse and day nurse, Staff Y was informed and again ignored Staff V. Finally about the third time Resident #13 had turned on her call light, Resident #13 was now requesting to go to the hospital. Staff EE informed Staff Y what Resident #13 had said and Staff Y still didn't do anything. Staff EE then went back and checked Resident #13's respirations and they were around 12 per minute and Resident #13 was not breathing well. Staff V stated she and Staff EE informed Staff Y of Resident #13's condition and that she needed to go to the hospital. Staff Y stated she would see Resident #13 soon. A while later Resident #13's call light was on again and Staff V and Staff EE responded. Resident #13 stated please Staff EE I need to go to the hospital and Staff EE responded I'm sorry, but I don't have the power to do so, I wish I did. Staff V stated she and Staff EE went to the dining room to feed residents. A while later Staff EE was running down the hallway and said Resident #13 was dead. During an interview on 4/2/19 at 8:10 a.m., Staff JJ (Assistant Business Office Manager stated the morning of 3/8/19 at around 7:55 a.m. she walked past Resident #13's room. Resident #13 was lying down on her bed and didn't seem herself. When asked if she was okay, Resident #3 stated no. Staff JJ stated she informed Staff Y that she	F 684		

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F 684	Continued From page 48 might want to check on Resident #13. Staff JJ stated she did not notice Resident #13 to be in any respiratory distress, but noted Resident #13 was not herself that morning. During an interview on 3/27/19 at 12:42 p.m., Staff Y (Licensed Practical Nurse stated during report on 3/8/19 at 6:00 a.m. she was informed Resident #13 was up most of the night complaining of a stomach ache. At around 6:30 a.m. Staff EE claimed Resident #13 was sitting on the edge of her bed and not breathing well. Staff Y stated she went to the room and stated Resident #13 was talking fine and nothing seemed unusual. Staff Y stated she was having difficulty with her blood pressure cuff and oximeter but eventually got vital signs which were normal for Resident #13. Staff Y stated she recalled the comment regarding the wheelchair pinching the oxygen tubing, but doesn't recall there being an oxygen saturation level of 67%. Staff Y stated later on she gave Resident #13 her medications and a breathing treatment. Vital signs were again taken at 8:30 a.m. Resident #13 seemed fine, but her breakfast tray had been untouched and Staff Y stated she helped with setting up the meal. Staff Y stated Staff HH had mentioned getting Resident #13 a medication review related to her yelling and acting out behavior and Staff P stated Resident #13 needed some labs drawn that hadn't been completed. Staff Y stated at around 9:00 a.m. Resident #13 was observed in bed with the bottom half of her body exposed. Staff Y instructed Staff EE to get a blanket and cover her. Staff EE got the blanket and reported Resident #13 was dead. Resident #13 was immediately attended to. Staff Y stated there were no indications Resident #13 was in distress that morning and much of Resident #13's	F 684		

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F 684	Continued From page 49 behavior is manipulative. Staff Y denies any aide or Resident #13 stating she wanted to go to the hospital that morning. Staff Y stated Resident #13 is alert and can make her own decisions and had she requested to go to the hospital she would have called a physician and made the arrangements. In a follow up interview on 4/1/19 at 11:01 a.m. Staff Y reiterated that in her opinion there were no red flags that would have warranted physician involvement or hospitalization. Staff Y stated the oxygen was set at 3 liters per minute and she was not involved in increasing the rate above the physician ordered rate of 1 liter per minute and was unaware of the rationale for the increase. Staff Y express frustration with the work load noting the facility expects nurses to do everything and there is not enough time or help. Staff Y stated this is why she quit. Staff Y stated she was instructed by Staff Z to write up her nurse's note regarding the incident involving Resident #13 and submit it to her and the corporate nurse for approval before it was formally typed into the record. Staff Y stated nothing was altered from her original note. During an interview on 3/27/19 at 10:20 p.m., Staff II (Certified Nurse Aide) stated she worked the overnight shift (10:00 p.m. to 6:00 a.m.) on 3/7/19. Early on in her shift Resident #13 was not herself. Resident #13 was anxious and restless. Her breathing was bad and she was pale and had purple lips. Resident #13 wanted to stay up and likes the overnight nurse (Staff FF). Staff FF stated she thought it was Resident #13's anxiety, but Staff II stated it was much different. Staff II stated Resident #13 had been able to ambulate with assistance, but now needed to use a wheelchair and was short of breath. Staff II stated she recalled at one point Staff FF was	F 684		

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F 684	Continued From page 50	F 684		

unable to get a blood pressure or oxygen level. Staff II stated Resident #13 had stated she wanted to go to the hospital in the presence of Staff FF, but nothing was done. Staff II stated she last saw Resident #13 at 5:45 a.m. 3/8/19 when she assisted her to bed. Staff II was tearful, noting much more should have been done to help Resident #13.

During an interview on 3/28/19 at 1:22 p.m., Staff FF (Registered Nurse) stated she knew Resident #13 very well and they often sat up at night talking. Resident #13 was normally anxious. Staff FF stated Resident #13 was having a rougher than normal evening on 3/7/19, noting Resident #13 was not feeling well and her stomach was bothering her. Staff FF stated she gave her some milk of magnesia and had staff sit with her when she had to be away from the nurse's station. Staff FF stated Resident #13's vital signs were normal, but she had a gut feeling something was wrong. Staff FF stated she didn't think there was justification to notify a physician on a gut feeling. Staff FF stated she remembered talking about hospitalization with her aides, but also noted Resident #13 was adamant about not wanting to go to the hospital. Staff FF stated at shift change (6:00 a.m.) she gave report to on coming nurse Staff Y and told her to keep an eye on Resident #13. Staff FF stated she remembered some aides reporting Resident #13 was not feeling well, but noted report was over and she thought Staff Y would be taking care of her. Staff FF stated Staff EE approached her prior to her leaving and reported Resident #13's oxygen saturation level was 67% and diastolic blood pressure over 100. Staff FF stated she assumed Staff Y would be sending Resident #13 out to be evaluated. Staff FF stated she had not

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F 684	Continued From page 51 noticed any breathing difficulties, weakness or shortness of breath on her shift. Staff FF did not see any color changes or purple lips as others had described. Staff FF stated Resident #13 will breath rapidly and forcefully when anxious, but slows down when spoken too. Staff FF stated Resident #13 never mentioned wanting to go to the hospital and if she had it would have been out of character and something would have been significantly wrong. Staff FF stated had Resident #13 requested to go to the hospital or if there was tangible evidence something was wrong, she would have not hesitated to call a physician and get her sent out. Staff FF stated before she left that morning she had spoken with the Director of Nurses and voiced her concerns for Resident #13. The Nursing Note dated 3/8/19 at 4:16 a.m. revealed Resident #13 had a Blood Pressure (BP) reading of 105/58, Temperature (T) 97.1, Pulse (P) 61, Respirations (R) 20, Oxygen saturation level (SpO2) 95%. Resident #13 complaining of nausea, stomach ache and feels like needing to have a bowel movement. Resident #13 states I feel miserable and don't know why. My stomach feel bad. Resident #13 has no slept except for short 10-15 minute spurts and has been at the nurse's station most of the night. Resident #13 stated to Staff FF, I want you to stay near me, don't leave me, don't send me to the hospital. The Nursing Note dated 3/8/19 at 7:24 p.m., revealed a Late Entry for 3/8/19 at 6:30 a.m. The staff summoned the nurse to Resident #13's room. The nurse entered room and observed Resident #13 sitting on edge of bed leaning over bedside table. Resident #13 alert and talking.	F 684		

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F 684	Continued From page 52 BP 153/94, P 87, R 16 and SpO2 92% at 3 liters per minute. At 8:30 a.m., Resident #13 had morning medications without problem. Resident #13 removed breathing treatment mask several times. BP 153/93, T 97.4, P 90, R 20 and SpO2 91% at 3 liters per minute. Lung sounds with expiratory wheezing. Resident #13 answering questions appropriately. Denies pain, breakfast tray served. At 9:15 a.m. summoned to Resident #13's room by nurse aide reporting she's dead, not breathing. 10. According to the Minimum Data Set (MDS) assessment dated 3/26/19, Resident #16 had a brief interview for mental status (BIMS) score of 14 indicating an intact cognitive status. Resident #14 required extensive assistance on others with mobility, transfers, dressing, toilet use and personal hygiene needs. Resident #16's diagnoses included cerebrovascular accident with hemiplegia, congestive heart failure and diabetes mellitus. Observations on 4/2/19 at 11:35 a.m. revealed Staff KK (Registered Nurse) passing medications to Resident #16 and others. According to the Medication Administration Record dated April 2019 Resident #16 had medications scheduled at 7:00 a.m. During an interview on 4/2/19 at 11:10 a.m., Staff KK (Registered Nurse) stated she just finished passing the morning medications to the final three residents (Resident #16, #17 and #18) on her hall. Staff KK stated on most days she is done by 10:30 a.m. which she admits is still considered late for most 7:00 a.m. medications.	F 684		

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F 684	Continued From page 53 On 4/2/19 at 12:00 p.m. Staff Z accessed computer records of administration times for 7:00 a.m. medications for Resident #16 in March 2019. 20 times in 31 days 7:00 a.m. medications for Resident #16 were administered in excess of 9:00 a.m. According to facility policy on Medication Errors an error includes administering medications at the wrong time and according to Medication Administration General Guidelines #14 Medications are to be administered within 60 minutes of scheduled time except for before and after meal time orders. During an interview on 4/2/19 at 11:50 a.m.., Staff P (Acting Director of Nursing) stated medications are considered in error when administer one hour before or after the scheduled time. A medication error requires the nurse to to contact a physician and to fill out a medication error form. Staff P stated late medications is a pervasive problem and staff are not following policy related to medication errors.	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	F 686	F 686 Treatment/Svcs to Prevent/Heal Pressure Ulcer The facility does and will continue to reasonably ensure residents who enter the facility without pressure sores does not develop pressure sores unless the individual's clinical condition demonstrates that they were unavoidable, and a resident having pressure sores receives necessary treatment and services to promote healing, prevent infection, and prevent new sores from developing.	

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F 686	Continued From page 54 with professional standards of practice, to promote healing, prevent infection and prevent new ulcers from developing. This REQUIREMENT is not met as evidenced by: The following deficiency relates to complaint #81806. Based on record review and staff interviews, the facility failed to provide necessary treatment and services consistent with professional standards of practice, to promote healing and prevent new ulcers from developing for 1 of 18 sampled (Resident #8). The facility reported a census of 97. Findings include: According to the Minimum Data Set (MDS) assessments dated of 2/14/19 Resident #8 had diagnoses that included atrial fibrillation, hypertension, cerebral infarction and failure to thrive. Resident #8 had severe cognitive impairments. The MDS dated 2/14/19 revealed Resident #8 required extensive assistance with mobility, transfers, dressing, toilet use and personal hygiene needs. Resident #8 had frequent incontinence of bowel and had a catheter. The CNA (Nurse Aide) Pocket Care Plan revealed no interventions for Resident #8. The Physical Therapy Treatment Encounter notes dated 2/19/19 revealed the Physical Therapy Assistant observed a blister on Resident #8's right heel and informed the nursing staff. The notes revealed the nursing staff unaware of the	F 686	A) Resident # 8 no longer resides in facility. All residents residing in the facility have had a skin assessment completed. B) The facility policy and procedure on Prevention and Treatment of Wounds has been reviewed with all floor nursing. Wound Nurse completed an audit all residents and highlighted all residents at high risk of skin breakdown for appropriate interventions to prevent skin alterations based on the Braden Scale. PCP updated for the nursing staff to include proper devices/ positioning/ orders for wound care are being implemented. Care plans to be updated during daily morning QA meeting and as needed for proper interventions. A daily QA audit tool was developed as a guide for Department Nursing Staff to use during morning QA to ensure at a minimum all documentation of assessments, change of conditions, incidents and interventions with care plans updates, wound care, review of MARS and TARS are reviewed during the QA daily process with proper notification to physicians and family/representative. A Certified Wound Nurse has been hired by the facility. 4-20-2019. Wound Nurse will monitor all wounds at a minimum of weekly or as needed until their wounds have healed and ensure wound module is updated at a minimum of weekly or as needed.	

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F 686	Continued From page 55 blister and stated they would provide heel float/bootles for Resident #8. During an interview on 3/13/19 at 2:00 p.m., Staff W (Physical Therapy Assistant) stated in mid-February she discovered a blister on Resident #8's right heel. Staff W stated she reported this to an unknown nurse and documented it in her notes. During an interview on 3/14/19 at 10:30 a.m., Staff X (Certified Nurse Aide) stated she discovered a sore on Resident #8's bottom on 2/24/19 and reported it to the nurse. She noticed on 2/26/19 the sore had worsened and informed the nurse. On 2/26/19, Staff X also discovered a huge blister on Resident #8's right heel and informed the nurse of this as well. During an interview on 3/13/19 at 4:40 p.m., Staff H (Registered Nurse) stated she first heard about Resident #8's blister from Staff T. Staff H reported they implemented measures to float Resident #8's heels. Staff H stated she did not notify the physician. Staff H remembered informing the overnight staff of the blister. Staff H did not remember if interventions were added to the care plan. During an interview on 3/14/19 at 10:19 a.m., Staff Y (Licensed Practical Nurse) stated on 2/26/19 she was informed by Staff X that Resident #8 had a sore on her bottom and a blister on her right heel. Staff Y stated Staff X stated she had reported the sore on Resident #8's bottom a couple days earlier to Staff T and nothing had been done. Staff Y stated she informed the Director of Nurses and filled out wound assessment reports for both areas,	F 686	C) All nursing staff was re-educated on the following: • Using STOP and Watch Forms to report concerns to DON and Administrator • Using Pocket Care Plan Sheets for devices and cares • Floor Nurses in-serviced on how to use: • Skin Module Report • Completing a Skin assessment • Interventions • Physician and Family Notification • Positioning and Devices for residents with sores • Hot Charting A communication form was placed in the therapy department, to be filled out and delivered to Administrator on any concerns noted during a therapy session to communicate and alert Administrator of a resident concern. • A Stop and Watch form was added to daily schedule book to prompt reporting of changes. • Communications forms and a mailbox were added to Wound Nurse Office Door for communication.	

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F 686	Continued From page 56 contacted the physician and obtained treatment orders. Staff Y stated she asked Staff T about the skin wounds and Staff T denied knowing anything about them. Staff Y stated she had recently resigned because nurses were not properly taking care of issues professionally, ignored wound care and neglected residents. The Departmental Notes lacked a wound assessment report, physician notification, family notification and care plan interventions for the heel wound and left buttock wound. The Wound Assessment Report dated 2/26/19 revealed Resident #8 had pressure ulcer on the right heel measuring 4 centimeters (cm) (length) by 5.5 cm (width) and a Stage II pressure ulcer on her left buttock that measured 6 cm (length) by 4.7 cm (width) and 0.1 cm (depth). The Telephone Orders dated 2/26/19 revealed the following orders: a. Cleanse the left buttock, apply triad wound gel, cover with optifoam, gentle dressing and change every three days. b. Check the placement of the left buttock dressing every day. c. Paint the left heel blister with Betadine twice a day until healed. Review of the February 2019 Treatment Record sheet revealed an order dated 2/26/19 to complete a weekly skin assessment and document in wound manager. The Wound Assessment Report dated 3/4/19 revealed Resident #8 had an irritation and excoriation from moisture on his coccyx	F 686	D) The Wound Nurse or designee will perform audits to monitor for skin breakdown of all residents at risk and all treatments on residents with skin impairments at a minimum of weekly with the results forwarded to the Quality Assessment and Assurance Committee for further review and recommendation. E) Responsible Party: Wound Nurse /Director of Nursing Alleged Date of Compliance: 5/17/2019	

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F 686	Continued From page 57 measuring 5 cm (length) by 5 cm (width). The staff notified the physician and no new orders received. The Departmental Notes dated 3/4/19 at 5:22 p.m., revealed Resident 8's Family Member had concerns that Resident #8 had been at the facility for 24 days and now had pressure wounds: The Familiity Member reported it appeared Resident #8 was not getting treatments, the aides were not floating her heels and the nurses did not know the treatment for her bottom. The staff explained they would follow up and look at the wounds. The Wound Assessment Report dated 3/7/19 revealed Resident #8 had a blister on left lateral shin measuring 11 cm (length) by 12 cm (width). The staff notified the physician. The Departmental Notes dated 3/7/19 lacked documentation of the left shin blister, family notification and care plan interventions related to wound care During an interview on 3/14/19 at 9:50 a.m. Staff Z (MDS Coordinator) stated on Monday 3/11/19 she noticed the blistering progressed to Resident #8's toes. Staff Z stated she filled out wound assessment reports, notified the physician and obtained treatment orders. Staff Z stated she was not certain who within the facility was currently providing weekly skin assessments. The Wound Assessment Report sheet dated 3/11/19 revealed Resident #8's left lateral shin blister expanded onto Resident #8's foot and toes. The sheet revealed the staff notified the physician and received a new treatment to cleanse left lower leg with wound cleanser, apply	F 686		

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ALTOONA NURSING AND REHABILITATION CENTER	200 SEVENTH AVENUE SW ALTOONA, IA 50009

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F 686	Continued From page 58 Vaseline gauze, wrap with kling; apply triple antibiotic to the left foot blister, cover with 4 x 4's and wrap with kling twice daily and apply Betadine to left 3rd, 4th and 5th toes twice daily. The Departmental Notes dated 3/12/19 at 1:59 p.m., revealed the areas on Resident #8's legs and feet worsening and contacted the Physician. The Physician ordered an arterial Doppler to both lower extremities to rule out arterial insufficiency. Observations on 3/12/19 at 4:35 p.m. and 3/13/19 at 7:50 a.m. found Resident #8 wearing foam boots and staff floating heels while in bed. However the care plan and pocket care plans do not have use of foam boots or floating of heels as a formal intervention.	F 686		
F 689 SS=D	Free of Accident Hazards/Supervision/Devices CFR(s): 483.25(d)(1)(2) §483.25(d) Accidents. The facility must ensure that - §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: This deficiency relates to self reported incident 81124-I, 81645-A and 81938-C. Based on record review, staff interviews and resident interview, the facility failed to provide adequate supervision and assistance devices to mitigate a resident's risk for falls and injury for 3 of 8 sampled (Residents #1, #3 and #12). The	F 689	**F 689 FREE OF ACCIDENTS AND SUPERVISION / DEVICES** The facility does and will continue to ensure that the residents environment remains as free of accidents and hazards as possible; and each resident receives adequate supervision and assistance to prevent accidents and hazards, which is evidenced by the following: A) Resident # 1, 3, 12 no longer reside at the facility. All resident care plans will continue to be reviewed at a minimum of quarterly and as needed.	

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F 689	Continued From page 59 facility reported a census of 97. Findings include: 1. According to the Minimum Data Set (MDS) assessment dated of 10/22/18, Resident #1 had impaired long and short term memory and moderately impaired cognitive skills for daily decision making. Resident #1 required extensive assistance with mobility, transfers, dressing, toilet use and personal hygiene needs. Resident #1's diagnoses included Parkinson's disease, arthritis and coronary artery disease. According to a fall risk assessment dated 10/15/18, Resident #1 scored 8 indicating a high risk for falls. The care plan identified a risk for falls and injury related to a history of falls, weakness, immobility, confusion and poor safety awareness with approaches which included an environment free of clutter, adequate lighting and hazards, ensure appropriate footwear and transfer with assist of one staff short distances and wheelchair for longer distances. The Incident Report dated 12/19/18 indicated at 1:15 p.m. Resident #1 was discovered on the bedroom floor. Resident #1 had been assisted to the toilet 10 minutes earlier and left unattended. Resident #1 was attempting to get back to his wheelchair when he fell to the floor. No injuries were noted. Following the fall, no interventions were added to the care plan. The Incident Report dated 12/21/18 indicated at 2:15 p.m. Resident #1 was discovered on the bedroom floor. Resident #1 was self transferring	F 689	B) An audit tool was developed as a guide for Department Nursing Staff to use during morning QA to ensure, at a minimum all documentation of assessments, change of conditions, incidents and interventions with care plans updates, wound care, review of MARS and TARS are reviewed during the QA daily process with proper notification to physicians and family/representative. MDS staff to bring care plan Binder to daily QA meeting ensuring Care Plans are update at this time with necessary changes including safety interventions. C) Nursing staff was re-educated on the following: • Falls Prevention • Care Plans • TARs • Ensuring Resident Safety, free from accidents and hazards and adequate supervision. • Transfers skills, Gait Belts • Notification to Charge Nurse, DON and Administrator. 5-1-2019 Facility has hired and designation a Staff Development Nurse and CMA Preceptor to conduct training with weekly and monthly audits on all nursing staff for ADLS including peri-care, incontinent care, grooming, oral care. Audits will be present to the QA team weekly. D) The Quality Assurance Committee will review the audits monthly for further review and recommendation. E) Responsible Party: Director of Nursing and Administrator. Alleged Date of Compliance: 5/17/2019	

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F 689	Continued From page 60	F 689		

from the bathroom to his chair when he tripped and fell into his bedside table sustaining multiple lacerations to his head. Resident was sent to the emergency room where his lacerations were sutured. Following this fall an intervention was added to Resident #1's care plan to not leave Resident #1 unattended in the bathroom.

During an interview on 3/6/19 at 3:09 p.m. Staff A (Nurse Aide) stated he was the aide assigned to Resident #1 on 12/21/18 when he fell and hit his head. Staff A stated he assisted Resident #1 onto the toilet and gave him his call light, but noted Resident #1 was confused some and didn't always use his call light. Staff A stated he left Resident unattended and when he returned, Resident #1 was on the floor.

During an interview on 3/6/19 at 3:10 p.m. Staff B (Nurse Aide) stated she was working the day (12/21/18) Resident #1 fell and hit his head and thought Staff A was assigned his hall. Staff B stated she was not familiar with the details, but thought Resident #1 was assisted to the toilet, left unattended and got up unassisted and fell. Staff B it was common for Resident #1 to be assisted to the bathroom and not required of staff to remain with him.

During an interview on 3/5/19 at 10:23 a.m. Staff C (Assistant Director of Nursing) stated the staff summoned her to Resident #1's room following a fall on 12/21/18. Staff C did not know the circumstances prior to the fall, but noted Resident #1 he tripped retiring from the bathroom. Staff C reported Staff D had the responsibility of updating the care plan with interventions.

During an interview on 3/5/19 at 11:01 a.m., Staff

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F 689	Continued From page 61 D (Licensed Practical Nurse) stated she was on leave at around the time Resident #1 had his falls in December 2018 and was not certain of the details surrounding the falls. Staff D noted Resident #1 was a high risk for falls and had had several falls. Staff D claimed facility staff often didn't fill out incident reports or communicate well to get needed interventions on the care plan. Staff D stated the administration was not doing investigations on falls. During an interview on 2/28/19 at 10:00 a.m., the Administrator stated she was unable to find an investigation file on Resident #1's falls in December 2018. 2. According to the Minimum Data Set (MDS) assessment dated of 2/12/19, Resident #3 had a brief interview for mental status (BIMS) score of 12 indicating a minimally impaired cognitive status. Resident #3 required extensive assistance with mobility, transfers, dressing, toilet use and personal hygiene needs. Resident #3's diagnoses included Bipolar disorder, diabetes mellitus and hypertension. Resident #3's plan of care indicates she requires assistance of one with transfers, walking and toilet use. The Radiology Report dated 2/26/19 related to right ankle pain for one week. Impression: diffuse osteopenia mildly limits the detailed evaluation of the bone and nondisplaced fractures. No discrete fractures or dislocations. There is soft tissue swelling about the ankle. There is a small plantar calcaneal spur. During an interview on 2/28/19 at 11:30 a.m.,	F 689		

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F 689	Continued From page 62 Resident #3 was asked about her right ankle. Resident #3 stated a girl was moving her from her wheel chair into bed and not using a gait belt. They stood up and she lost her balance and fell along the side of the bed into the side rails. Resident #3 stated she did not fall to the floor. The aide then pulled her up in bed and Resident #3 then realized her right ankle was hurting. Resident #3 stated she told the nurse about it the next day. During an interview on 2/28/19 at 9:08 a.m., Staff E (Therapy Director) stated on Thursday, 2/21/19 he was working with Resident #3, when she reported having pain in her right ankle which was related to an incident the evening before. Resident #3 stated the nurse was transferring her from her recliner into bed and not using a gait belt. Resident #3 stated she fell, striking her right ankle on the bed frame. Staff E stated he reported the incident to the Director of Nursing. The Physical Therapy Treatment Encounter note dated 2/21/19 revealed Resident #3 stated she was being transferred by an aide last night without a gait belt and that she hit her ankle on the bed rails while transferring from her wheel chair to bed. Resident #3 states she has increased pain with walking. During an interview on 2/28/19 at 10:45 a.m., the Director of Nursing (DON) stated therapy staff had reported that during a transfer with an aide, Resident #3 had bumped her right ankle into the bed frame or wheelchair and she was now complaining of pain and tenderness. The DON did not disclose that the aide was allegedly not using a gait belt. When asked if she had spoken with the aide that had transferred Resident #3,	F 689		

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F 689	Continued From page 63 the DON stated no. The DON stated she had spoken with Resident #3 and her son. When informed by this surveyor that Resident #3 had reportedly stumbled during a transfer and staff was not using a gait belt, the DON then admitted therapy staff had informed her the aide was allegedly not using a gait belt. In response to staff not using a gait belt the DON put out a staff education memo reminding staff to use a gait belt during transfers. The DON was not aware of who the aide was that had not used a gait belt and consequently had not spoken too or disciplined the aide for her failure to use a gait belt. The DON stated it is an expected standard of practice that a gait belt be use anytime transferring or walking with a resident who requires physical assistance, that the incident is reported and that an incident report be filled out. The DON stated there is no incident report related to this event. During an interview on 3/4/19 at 2:28 p.m., Staff F(Nurse Aide) stated on the evening of 2/20/19 she prepared Resident #3 for bed, put on her night gown and transferred her into bed. Staff F stated she used her gait belt and the transfer was uneventful. During an interview on 3/4/19 at 2:05 p.m., Staff G (Nurse Aide) stated she was working the evening of Wednesday, 2/20/19 and assigned north hall. Staff G stated she was involved with Resident #3's care with two other aides, but did not put her to bed that evening. Staff G stated on Thursday, 2/21/19 when she got to work Resident #3's call light was on. Resident #3 asked Staff G if she could get her an ice pack for her ankle. Resident #3's son was present and stated Resident #3 had fallen and was suppose to have an ice pack. Staff G stated she went to the	F 689		

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F 689	Continued From page 64	F 689		

nurse, Staff H and asked if she could get an ice pack and Staff H stated yes. Staff G returned with the ice pack. Later that same evening Staff G was assisting with transferring Resident #3 onto the toilet and put her gait belt around Resident #3's waist. Resident #3 stated the person transferring her last night did not use a gait belt. Staff G stated Resident #3 requires extensive assistance of one staff with transfers and needs a gait belt. Staff G stated she thought she informed Staff H about the aide not using a gait belt.

During an interview on 3/4/19 at 2:38 p.m., Staff H (Registered Nurse) stated she remembered Staff G making a comment about Resident #3 wanting an ice pack for her right ankle and her giving Staff G a key to the medication room to get the ice pack. Staff H stated she did not do an assessment of Resident #3's right ankle at that time, but later on had asked her how her ankle was doing and looked at it. The ankle was edematous, but no more or less than usual. Staff H stated she was not aware of any event which may have caused the pain. A few days later Staff H had heard Resident #3 had twisted or hit her ankle against something. Staff H stated she was not aware of an aide not using a gait belt and Resident #3 falling.

3. According to the Minimum Data Set (MDS) assessment dated 1/23/19 revealed Resident #12 had a brief interview for mental status (BIMS) score of 12 indicating a minimally impaired cognitive status. Resident #12 required extensive to total dependence on others with mobility, transfers, dressing, toilet use and personal hygiene needs. Resident #12's diagnoses included cerebrovascular accident, hemiplegia,

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F 689	Continued From page 65 pressure ulcer sacral and right heel. During an observation on 3/19/19 at 7:34 a.m., Staff X (Nurse Aide) transferred Resident #12 from his bed into his broda chair per a hoyer lift by herself. On the wall there was a sign reminding staff that Resident #12 is to be transferred using two staff. Resident #12's plan of care indicates Resident #12 is at risk for injury related to falls and is to be transferred with two person assistance.	F 689		
F 726 SS=E	Competent Nursing Staff CFR(s): 483.35(a)(3)(4)(c) §483.35 Nursing Services The facility must have sufficient nursing staff with the appropriate competencies and skills sets to provide nursing and related services to assure resident safety and attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident, as determined by resident assessments and individual plans of care and considering the number, acuity and diagnoses of the facility's resident population in accordance with the facility assessment required at §483.70(e). §483.35(a)(3) The facility must ensure that licensed nurses have the specific competencies and skill sets necessary to care for residents' needs, as identified through resident assessments, and described in the plan of care. §483.35(a)(4) Providing care includes but is not limited to assessing, evaluating, planning and implementing resident care plans and responding to resident's needs.	F 726	**F 726 SUFFICIENT 24 NURSING STAFF** A) The facility does and will continue to ensure that it provides sufficient nursing staff to provide nursing related services to attain or maintain the highest practicable physical, mental and psychosocial; well-being of each resident. B) Staff Development Nurse and CMA Preceptor will randomly to conduct audits and monitor call light response times and to record resident feedback from interviews of call light response of staff. C) A communication was presented to all staff of the facility, educating that all associate in any department should respond to a call light and how to respond to a call light. The facility implemented the Ambassador Program to ensure residents feedback is gathered on more frequent basis throughout the week. Ongoing feedback will be monitored during resident council meetings.	

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F 726	Continued From page 66 §483.35(c) Proficiency of nurse aides. The facility must ensure that nurse aides are able to demonstrate competency in skills and techniques necessary to care for residents' needs, as identified through resident assessments, and described in the plan of care. This REQUIREMENT is not met as evidenced by: The following deficiency relates to complaint 77740-C Based on observation, staff interview and resident group interview, the facility failed to provide prompt response for the residents use of the nurse call system. The facility reported census of 97. Findings include: During an observation on 3/5/19 at 7:36 a.m. revealed a call light activated for room S18. The staff responded to the call light at 7:56 a.m. During an observation on 3/19/19 at 8:00 a.m. revealed a call light activated for rooms B48 and C53. The staff responded to both rooms at 8:17 a.m. During a resident group interview in which 6 residents were represented, residents expressed concern with inadequate staffing on ABC halls, noting there are only three aides on their hall and it is a heavy load hall with multiple residents who are two person mechanical lift residents. Residents stated it takes 30-45 minutes for staff to respond to call lights and one resident stated she was incontinent while waiting for help.	F 726	D) The Staff Development Nurse and Assigned Preceptor will continue to audit and monitor timing of call lights, and interviewing residents for call light response with the results forwarded to the Quality Assessment and Assurance Committee for further review and recommendation. E) Responsible Party: Director of Nursing / Administrator Alleged Date of Compliance: 5/17/2019	

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F 726	Continued From page 67 During an interview on 3/5/19 at 2:30 p.m., the Family Member stated one evening her loved one was left on the toilet and no one answered his call light. The resident was pounding on the walls and screaming for help. The resident finally called her and she had to come into the facility to get him help. During an interview on 3/20/19 at 11:10 a.m., the Assistant Director of Nursing (ADON) stated there are 50 residents on ABC hall and 32 of them require two person assistance. The ADON stated the overnight staffing last night was 1 nurse and 1 aide, because an aide had called in. The ADON stated the on-call nurse is required to cover call-ins, however she refused to come in last night to help.	F 726		
F 760 SS=D	Residents are Free of Significant Med Errors CFR(s): 483.45(f)(2) The facility must ensure that its- §483.45(f)(2) Residents are free of any significant medication errors. This REQUIREMENT is not met as evidenced by: Based on record review and staff interview the facility failed to ensure residents are free of any significant medication errors for 1 of 3 sampled (Resident #7). The facility reported a census of 97. Findings include: According to the Minimum Data Set (MDS) assessment dated 2/4/19 revealed Resident #7 had a Brief Interview for Mental Status (BIMS) score of 14 indicating an intact cognitive status. Resident #7 required limited assistance with	F 760	F 760 RESIDENTS ARE FREE OF SIGNIFICANT MED ERRORS The facility does and will continue to reasonably ensure each resident remains free of any significant medication error. A) Resident # 7 Medical Administration Record was reviewed updated with insulin parameters.	

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F 760	Continued From page 68 transfers, ambulation, toilet use and personal hygiene needs and extensive assistance with dressing. Resident #7's diagnoses included atrial fibrillation, hypertension, peripheral vascular disease, diabetes mellitus, chronic obstructive pulmonary disease. During an interview on 3/5/19 at 8:10 p.m., Resident #7 stated on 3/3/19, Staff N wanted to check her blood glucose level after supper and she refused because she just ate supper. Resident #7 told Staff N she wanted it checked later. Resident #7 stated Staff N informed the on-coming nurse, Staff O to check her glucose level later and give her insulin accordingly. Resident #7 stated Staff O told her he would just write down an 88 and she wouldn't have to take any insulin and then winked at her. Resident #7 stated Staff O never rechecked her blood sugars or administered any of her evening insulin. During an interview on 3/6/19 at 10:30 a.m., Staff N (Medication Aide) stated she checked blood glucose levels the evening of 3/3/19. Staff N reported she obtained Resident #7's 5:00 p.m. blood sugar level and wrote it on a piece of paper and gave it to Staff P. After supper, Staff N stated she went to check Resident #7's blood sugar. Resident #7 refused stating it was too early. Staff N stated she wrote a note and personally told Staff O (on-coming nurse) that he would have to check her blood sugar later and give her insulin. Staff O stated he would do it. The following day Staff N asked Resident #7 if she had gotten her blood sugar checked and insulin given and she stated no. Staff N stated she reported the incident to the Director of Nursing.	F 760	B) All residents residing in the facility had their MARs reviewed. C) All nursing staff were re-educated on: How to provide insulin and monitor blood sugar/ MAR. Proper procedures to Medication Administration. D) Staff Development Nurse and ADONs complete random audits to ensure medication errors are less than CMS regulatory guidelines with results forwarded to the Quality Assurance team for review and recommendation. E) Responsibility Party: Director of Nursing. Alleged Date of Compliance:5/17/2019	

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ALTOONA NURSING AND REHABILITATION CENTER	200 SEVENTH AVENUE SW ALTOONA, IA 50009

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F 760	Continued From page 69 During an interview on 3/6/19 at 2:00 p.m. Staff P (Registered Nurse) stated on 3/3/19 she remembered Resident #7 had a blood sugar of 361 at 5:00 p.m. Staff P stated she was running behind and asked Staff O (on-coming nurse) to follow up with Staff Q to ensure Resident #7's insulin was given. Staff O stated he would. Staff P stated she did not give Resident #7 her 5:00 p.m. insulin. During an interview on 3/6/19 at 2:20 p.m., Staff O (Licensed Practical Nurse) stated when he arrived to at 6:00 p.m. on 3/3/19 Staff P provided blood sugar levels for Resident #7. Staff P asked Staff O to follow up and administer insulin. Staff O checked Resident #7's blood sugar and obtained a level of 68. Resident #7 didn't need any sliding scale insulin. According to the March 2019 MAR Resident #7's blood sugars consistently run over 300 at 5:00 p.m. and 8:00 p.m. checks. Staff O stated he gave the routine Novolog and Lantus insulin, but failed to document. According to Resident #7's Medication Administration Record dated March 2019 Resident #7 had an order to receive Lantus 34 units every 12 hours, Novolog 5 units four times a day and Novolog on a sliding scale four times a day, based on blood glucose levels. There was no recorded blood glucose check on 3/3/19 at 5:00 p.m. or 8:00 p.m. and no recorded administration of routine Lantus insulin at 8:00 p.m., no recorded routine Novolog insulin at 5:00 p.m. and 8:00 p.m. and no sliding scale Novolog insulin given at 5:00 p.m. or 8:00 p.m.	F 760		
F 812 SS=E	Food Procurement,Store/Prepare/Serve-Sanitary CFR(s): 483.60(i)(1)(2)	F 812		

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F 812	Continued From page 70 §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: The following deficiency relates to intake 80516-C. Based on observation, record review, and staff interview the facility failed to ensure the kitchen and food storage areas meet professional standards of cleanliness and sanitation. The facility reported a census of 97. Findings include: Observation on 3/19/19 at 9:30 a.m revealed the kitchen and storage areas had clutter and with food debris on the floor. The refrigerator and freezer had clutter due to a recent delivery. The freezer had a build up of frost along the interior ceiling. One freezer had a nonfunctioning fan.	F 812	**F 812 FOOD PROCEDURES, STORE/PREPARE/SERVE-SANITARY** A) On 4/28/2019 maintenance cleaned the air vents and stove vents. The freezer was waiting for a repair and has been repaired. The equipment in the dietary area has been clean of any tacky substance, food waste. B) The facility does and will continue to ensure the kitchen and food storage areas meet professional standards of cleanliness and sanitation. C) Dietary Manager and dietary staff were in-serviced on proper procedures to ensure sanitary conditions are met using: • Food Storage • Sanitation • Cleaning List • TELS work order request for maintenance orders • A new weekly cleaning list was implement on 5/1/2019	

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F 812	Continued From page 71 Observation on 3/19/19 at 2:45 p.m. revealed the cook preparing supper. The sides of the steam table, carts and ovens had a tacky substance and contained food debris and spatter. The floor under the sink contained a tub with soiled towels. The floor had a build up of dirt, grime and food debris. The stove vents contained a build up of dust, dirt and debris. Observation on 3/19/19 at 10:15 p.m. revealed the staff completed the cleaning of the kitchen and storage areas. The kitchen floor contained food debris. The floor under the sink contained a dirty rag and pop can. The food carts contained a build up of food and waste. The freezer contained paper and debris. The dry storage area observed earlier in the day revealed a lack of cleaning. The ovens, stoves and appliances remained dirty with built up lint, splatter and grease along the sides. A rack contained an uncovered cake. During an interview on 3/19/19 at 9:30 a.m. Staff DD (Dietary Supervisor) stated the dietary department had a full staff. Staff DD reported the staff had a daily cleaning assignment, but reported no scheduled time frame to complete the cleaning. Staff DD reported the staff need to clean before the end of their shift. Review of Cleaning Schedule sheet revealed scheduled cleaning on Monday through Friday. The sheet had omissions in many of the cleaning activities. The sheet revealed additional cleaning activities necessary to maintain a clean and sanitary kitchen unassigned.	F 812	D) The CDM, Maintenance Director and Administrator will conduct weekly audits of the dietary department and review weekly cleaning lists for proper food storage and sanitation and cleanliness, the results the results forwarded to the Quality Assessment and Assurance Committee for further review and recommendation. E.) Responsible Party: CDM / Maintenance Director / Administrator Alleged date of Compliance: 5/17/2019	
F 842	Resident Records - Identifiable Information	F 842		

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F 842 SS=D	Continued From page 72 CFR(s): 483.20(f)(5), 483.70(i)(1)-(5) §483.20(f)(5) Resident-identifiable information. (i) A facility may not release information that is resident-identifiable to the public. (ii) The facility may release information that is resident-identifiable to an agent only in accordance with a contract under which the agent agrees not to use or disclose the information except to the extent the facility itself is permitted to do so. §483.70(i) Medical records. §483.70(i)(1) In accordance with accepted professional standards and practices, the facility must maintain medical records on each resident that are- (i) Complete; (ii) Accurately documented; (iii) Readily accessible; and (iv) Systematically organized §483.70(i)(2) The facility must keep confidential all information contained in the resident's records, regardless of the form or storage method of the records, except when release is- (i) To the individual, or their resident representative where permitted by applicable law; (ii) Required by Law; (iii) For treatment, payment, or health care operations, as permitted by and in compliance with 45 CFR 164.506; (iv) For public health activities, reporting of abuse, neglect, or domestic violence, health oversight activities, judicial and administrative proceedings, law enforcement purposes, organ donation purposes, research purposes, or to coroners, medical examiners, funeral directors, and to avert	F 842	F 842 483.70 (i) (1) - (5) Records-Complete / Accurate /Accessible. A) Resident #12 no longer resides in the facility. B) The facility does and will continue to reasonable ensure that medical records are maintained as complete, accurately documented, readily accessible and systematically organized. An audit tool was developed as a guide for Department Nursing Staff to use during morning QA to ensure, at a minimum all documentation of the MARS and TARS are complete and reviewed during the QA daily process. The facility hired a certified Wound Nurse on April 22, 2019. Wound nurse to perform random daily checks of treatments and weekly skin assessments, verify treatments and treatment orders, documentation and education to floor nursing staff.	

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F 842	Continued From page 73 a serious threat to health or safety as permitted by and in compliance with 45 CFR 164.512. §483.70(i)(3) The facility must safeguard medical record information against loss, destruction, or unauthorized use. §483.70(i)(4) Medical records must be retained for- (i) The period of time required by State law; or (ii) Five years from the date of discharge when there is no requirement in State law; or (iii) For a minor, 3 years after a resident reaches legal age under State law. §483.70(i)(5) The medical record must contain- (i) Sufficient information to identify the resident; (ii) A record of the resident's assessments; (iii) The comprehensive plan of care and services provided; (iv) The results of any preadmission screening and resident review evaluations and determinations conducted by the State; (v) Physician's, nurse's, and other licensed professional's progress notes; and (vi) Laboratory, radiology and other diagnostic services reports as required under §483.50. This REQUIREMENT is not met as evidenced by: This deficiency relates to complaint 82040-C. Based on observation, record review and staff interview, the facility failed to maintain accurately documented medication and treatment records for 1 of 20 open sampled (Resident #12). The facility reported a census of 97. Findings include:	F 842	C) The nursing department was In-serviced on the facilities policy and procedure for: Proper documentation of all treatments / medication administration and following physician orders. D) The Director of Nursing and or designee will review daily x (5) the documentation of the MARS and TARS and results of the documented skin inspections by the wound nurse weekly to ensure compliance to the regulation with results forwarded to the Quality Assessment and Assurance Committee for further review and recommendation. E) Responsible Person: Director of Nursing, Administrator Alleged Date of Compliance: 5/17/2019	

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F 842	Continued From page 74 1. According to the Minimum Data Set (MDS) assessment dated 1/23/19, Resident #12 had a brief interview for mental status (BIMS) score of 12 indicating a minimally impaired cognitive status. Resident #12 required extensive to total dependence on others with mobility, transfers, dressing, toilet use and personal hygiene needs. Resident #12's diagnoses included cerebrovascular accident, hemiplegia, pressure ulcer sacral and right heel. The March 2019 Treatment Record revealed Resident #12 had orders for wound care to his right foot and heel. The staff documented the treatment completed on 3/18/19 by Staff BB. During an observation on 3/19/19 at 10:15 a.m., Staff AA (Licensed Practical Nurse) and Staff Z (MDS Coordinator) changed the dressings on Resident #12's wounds. Staff AA removed the old dressing dated 3/17/19 with the initials "JG". Staff AA stated changed the dressing on 3/17/19 and apparently no one changed it on 3/18/19. During an interview on 3/19/19 at 10:30 a.m., Staff AA (Licensed Practical Nurse) stated it's not uncommon for her to find dressings not changed as ordered. During an interview on 3/19/19 at 12:00 p.m., Staff BB (Registered Nurse) stated she completed the treatment on Resident #12's bottom on 3/18/19, but did not change the dressings or provide treatment on Resident #12's right foot and heel. Staff BB admitted she recorded the treatment and dressing change as completed on the TAR in error.	F 842		
F 880	Infection Prevention & Control	F 880		

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F 880 SS=E	Continued From page 75 CFR(s): 483.80(a)(1)(2)(4)(e)(f) §483.80 Infection Control The facility must establish and maintain an infection prevention and control program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of communicable diseases and infections. §483.80(a) Infection prevention and control program. The facility must establish an infection prevention and control program (IPCP) that must include, at a minimum, the following elements: §483.80(a)(1) A system for preventing, identifying, reporting, investigating, and controlling infections and communicable diseases for all residents, staff, volunteers, visitors, and other individuals providing services under a contractual arrangement based upon the facility assessment conducted according to §483.70(e) and following accepted national standards; §483.80(a)(2) Written standards, policies, and procedures for the program, which must include, but are not limited to: (i) A system of surveillance designed to identify possible communicable diseases or infections before they can spread to other persons in the facility; (ii) When and to whom possible incidents of communicable disease or infections should be reported; (iii) Standard and transmission-based precautions to be followed to prevent spread of infections; (iv)When and how isolation should be used for a	F 880	F 880 The facility does and will continue to ensure that there is an infection control program designed to prevent the development and transmission of disease and infection. A) Nursing Staff in-serviced-educated on / for removing / changing gloves and washing hands when providing cares including but not limited to: peri-care, oral care, handling of catheter bagging and tubing, wound care and situations of direct care in which hand washing is indicated. There were no negative outcomes to residents # 5,8,12. B) Audits to be performed by the Wound Nurse / Staff Development Nurse and CMA Preceptor to ensure proper sanitation and to help prevent the development and transmission of disease include: • Hand washing • Peri Care • Catheter care • Wound Care • Accu check	

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F 880	Continued From page 76 resident; including but not limited to: (A) The type and duration of the isolation, depending upon the infectious agent or organism involved, and (B) A requirement that the isolation should be the least restrictive possible for the resident under the circumstances. (v) The circumstances under which the facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease; and (vi)The hand hygiene procedures to be followed by staff involved in direct resident contact. §483.80(a)(4) A system for recording incidents identified under the facility's IPCP and the corrective actions taken by the facility. §483.80(e) Linens. Personnel must handle, store, process, and transport linens so as to prevent the spread of infection. §483.80(f) Annual review. The facility will conduct an annual review of its IPCP and update their program, as necessary. This REQUIREMENT is not met as evidenced by: The following deficiency relates to complaints 81938-C, 81806-C and 81942-C. Based on observation and staff interview, the facility failed ensure staff wash or sanitize their hands prior, during and after cares in which hand washing is indicated by accepted professional practice for 3 of 20 open sampled (Residents #5, #8 and #12). The facility reported a census of 97.	F 880	C) All Nursing staff were re-educated on the following facility guidelines: • *Hand washing* • *Peri-care* • *Catheter Care* • *Wound Care* • *Accu Check* • *Infection control* D) The Wound Nurse and Staff Development Nurse or Designee will conduct ongoing audits with results forwarded to the Quality Assessment and Assurance Committee for further review and recommendation. E) Responsible Party: Director of Nursing / Administrator Alleged date of Compliance: 5/17/2019	

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F 880	Continued From page 77 Findings include: 1. According to the Minimum Data Set (MDS) assessment dated 2/20/19, Resident #5 had a brief interview for mental status (BIMS) score of 5 indicating a severely impaired cognitive status. Resident #5 required total dependence on others with mobility, transfers, dressing, toilet use and personal hygiene needs. Resident #5's diagnosis included Non-Alzheimer's dementia, seizure disorder, Parkinson's and dysphasia. During an observation on 3/13/19 at 5:40 p.m., revealed the trash can next to Resident #5's bed contained a brief and gloves, but no disposed wipes. At 7:00 p.m., the surveyor stepped into Resident #5's room. Staff R stood over Resident #5 in bed with clean brief, the floor beside the bed contained a soiled brief. Staff R had no gloves on and no wipes visible on the floor or in the trash. When finished attaching the brief, Staff R placed Resident #5's nasal cannula on her nose and pulled the sheet over her lower legs and body. Staff R failed to wash or sanitizing her hands in between tasks. Staff R disposed of the soiled brief in the trash can. During an interview on 3/13/19 at 7:00 p.m., Staff R (Certified Nurse Aide) reported she provided perineal care for Resident #5. Staff R reported the wipes she used were in the trash can. In the presence of Staff R, the surveyor gloved and then removed two soiled briefs from the trash can and showed Staff R the remaining contents which included a few gloves, but no wipes. Staff R then reported she did not use wipes and provided perineal cares. Staff R denied she changed Resident #5's brief prior to supper.	F 880		

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F 880	Continued From page 78 2. According to the Minimum Data Set (MDS) assessment dated 2/14/19, Resident #8 had a brief interview for mental status (BIMS) score of 6 indicating a severely impaired cognitive status. Resident #8 required extensive assistance with mobility, transfers, dressing, toilet use and personal hygiene needs. Resident #8 had frequent incontinence of bowel and a catheter. Resident #8's diagnoses included atrial fibrillation, hypertension, cerebral infarction and failure to thrive. During an observation on 3/12/19 at 6:00 p.m., Staff U (Nurse Aide and Staff V (Nurse Aide) provided incontinence cares for Resident #8. Staff U and Staff V failed to remove contaminated gloves and wash or sanitize their hands in between going from a contaminated task to a clean one. 3. According to the Minimum Data Set (MDS) assessment dated 1/23/19, Resident #12 had a brief interview for mental status (BIMS) score of 12 indicating a minimally impaired cognitive status. Resident #12 required extensive to total dependence on others with mobility, transfers, dressing, toilet use and personal hygiene needs. Resident #12's diagnoses included cerebrovascular accident, hemiplegia, pressure ulcer sacral and right heel. During an observation on 3/19/19 at 10:15 a.m. Staff AA (Licensed Practical Nurse) and Staff Z (MDS Coordinator) changed Resident #12's right foot wound dressing. Both staff washed hands and donned gloves. Staff AA removed the old dressing dated 3/17/19 with initials "JG". Staff AA stated she had last changed the dressing on 3/17/19 and apparently it hadn't been changed	F 880		

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F 880	Continued From page 79 since. Staff AA changed gloves without sanitizing and proceeded to dab the wound on ankle and heel with betadine, then placed an antibacterial foam dressing (Hydrofera Blue) over the ankle and heel wound, wrapped with kerlix and when finished labeled the dressing with 3/19/19 and her initials. Staff AA placed the blue boots on Resident #12's foot, washed her hands and left the room.	F 880		