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	165274	A. BUILDING _____ B. WING _____	06/12/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
NORTHERN MAHASKA SPECIALTY CARE	2401 CRESTVIEW DRIVE OSKALOOSA, IA 52577

(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 Amended 8/20/2019 following an IDR. Correction Date July 1, 2019 The following deficiencies relate to the annual health survey and investigations of complaints #82873, #82943, and #83190, and facility reported incident #83722. Complaints #83190, #82873 and 82943 were not substantiated. The facility reported incident #83722 was substantiated. See code of Federal Regulations (42 CFR) Park 483, Subpart B-C.	F 000		
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 by: Based on record review, observations and interviews the facility failed to provide proper and complete incontinence care for 1 of 2 sampled (Resident #52). The facility reported a census of 67. Findings include: 1. The Minimum Data Set (MDS) assessment dated 5/17/19 documented Resident#52 had diagnoses of pneumonia, stroke and heart disease. Resident #52 had severe cognitive	F 677		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE — TITLE: Administrator — (X6) DATE: 06/25/2019

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

Jill Schulte PC

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F 677	Continued From page 1 impairments. Review of the MDS dated 5/17/19 revealed Resident #52 required extensive assistance of two staff for bed mobility, transfers, personal hygiene, and bathing. Resident #52 had occasional bladder incontinence and frequent bowel incontinence. The Care Plan revised on 2/15/19 identified Resident #52 had the risk for a decline in activities of daily living and directed the staff to provide assistance with transfers, dressing, hygiene, and bathing. During an observation on 6/9/19 10:00 a.m., revealed Staff M (Nurse Aide) and Staff N (Nurse Aide) provided perineal cares for Resident #52. Resident #52 had a moderate amount of bowel incontinence. Staff M had soiled gloves during the observation and continued to provide cares. Staff M failed to retract Resident #52's foreskin and cleanse the tip of the penis. During an interview on 6/10/19 at 8:00 a.m., the Director of Nurses (DON) reported the staff could have done a better job with the perineal cares. During an interview on 6/11/19 at 10:26 a.m., Staff P (Nurse Aide) reported when performing perineal cares and the gloves become soiled with a bowel movement the staff should change their gloves. During an interview on 6/11/19 at 10:37 a.m., Staff R (Nurse Aide) reported when performing perineal cares on a male the staff pull the foreskin down and cleanse the penis to help prevent infection.	F 677		

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F 689 SS=G	Free of Accident Hazards/Supervision/Devices CFR(s): 483.25(d)(1)(2) §483.25(d) Accidents. The facility must ensure that - §483.25(d)(1) The resident environment remains as free of accident hazards as is possible; and §483.25(d)(2)Each resident receives adequate supervision and assistance devices to prevent accidents. This REQUIREMENT is not met as evidenced by: Based on clinical record review, observations and interviews, the facility failed to follow interventions to prevent a fall for 1 of 1 sampled (Resident #31) which resulted in a hip fracture. The facility reported a census of 67. Findings include: According to the Minimum Data Set (MDS) assessment dated 4/17/19 Resident #31 had diagnoses of dementia, depression, age related osteoporosis without current pathological fracture, repeated falls, and muscle weakness. Resident #31 had severe cognitive impairments. The MDS assessment dated 4/17/19 documented Resident #31 required extensive assistance of one staff for bed mobility, transfer, dressing, toileting and personal hygiene. Resident #31 had unsteady balance but able to stabilize without staff assistance. The Care Plan revealed Resident #31 at risk for falls related to fall prior to admit with minor injury, incontinence, dementia, weakness and possible medication side effects. Resident #31 had a falls on 10/25/2018, 11/4/2018, 11/30/2018,	F 689		

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F 689	Continued From page 3	F 689		

12/10/2018, 2/27/2019, 3/5/2019 and 3/14/2019. The Care Plan directed staff to limit background noise, call light reminder sign in room, family education, grip strips by bed, frequently used items in reach, sign on walker to remind to use, monitor activities in room and do not put footrest up on recliner.

The Progress Notes dated 6/8/19 at 4:00 p.m. revealed the staff found Resident #31 on the floor on her right side with her head on the bed frame. Staff B (Agency Aide) reported a visitor notified her of Resident #31 on the floor. Resident #31 denied any discomfort and the staff assisted her off the floor. The staff notified the Nurse Practitioner of the fall and no new orders received. At 4:45 p.m., Resident #31 complained of pain in the right hip and unable to bear weight on the right leg. The staff notified the Nurse Practitioner who ordered to transfer Resident #31 to the hospital for evaluation.

Review of the #1025 Un-witnessed form dated 6/8/19 at 9:15 p.m., revealed the nurse aide reported that she had just taken the Resident #31to the bathroom and assisted her back to recliner chair and elevated her lower extremities.

Review of Fall Investigation for CNA's sheet dated 6/8/19 revealed Staff B (Agency Aide) notified by a visitor that Resident #31 on the floor. Factors that contributed to the fall included feet tangled in the footrest of the recliner. Staff observed Resident #31 5 minutes earlier when they assisted her to the toilet and then back to the recliner.

The undated Details of Reporting Event sheet revealed Resident #31 returned to the recliner

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F 689	Continued From page 4 after using the toilet and the staff elevated her feet in the recliner. The sheet revealed the agency staff failed to follow the plan of care as the root cause for the fall. Observation on 6/11/19 at 12:00 p.m., revealed a sign on Resident #31's wall that read "Please Do not Put my feet up When in recliner" and had a picture of a recliner. The Radiology - Final report dated 6/8/19 at 5:30 p.m. revealed Resident #31 sustained a intertrochanteric fracture of the right proximal femur and nondisplaced fractures of the left superior and inferior pubic rami. During an interview on 6/11/19 at 2:10 p.m., Staff B (Agency Nurse Aide) reported she worked at the facility part time the last couple of months. Staff B walked by Resident #31 room and saw her up. Staff B assisted Resident #31 to the bathroom and then to the recliner chair. Staff B reported she put Resident #31's feet up in the recliner chair. Staff B reported she did this out of habit. Staff B reported this was the first time she put the footrest up because Resident #31 was usually in bed. Staff B reported at the end of the shift she found out that the care plans were located on the IPod. Staff B stated that she was not aware of this. During an interview on 6/11/19 at 3:31 p.m., Staff C (Nurse Aide) reported she never saw Resident #31 in the recliner with the footrest up. Staff C reported the staff carry an IPod that directed them on the resident care needs. Staff C did not know if the agency staff carried an IPod. During an interview on 6/11/19 at 3:53 p.m., Staff	F 689		

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F 689	Continued From page 5 E (Agency Aide) reported working at the facility three times a week since February. Staff E reported knowing not to put Resident #31's footrest up. Staff E reported Resident #31 had a sign above the recliner to remind the staff not to put the footrest up. Staff F reported he/she carried an IPod and had an IPod and used it to document cares. Staff E reported the IPod had each residents Kardex that directed the staff how to care for the residents. During an interview on 6/11/19 at 4:45 p.m., Staff I (Agency Aide) reported working at the facility for 3 weeks. Staff I reported she was issued an IPod her first day. Staff I reported the IPod directs the staff on the residents care needs. During an interview on 6/12/19 at 5:50 a.m., Staff J (Agency Licensed Practical Nurse) reported working at the facility for 3 months. Staff J reported the aides use the IPod Kardex for directions on how to care for the residents. During an interview on 6/12/19 at 7:10 a.m., Staff K (Registered Nurse) reported Resident #31 had a sign in her room to remind the staff not to put the footrest up. Staff K reported the aides carry an IPod and that is how they know how to take care of the residents. Staff K reported the aides also document on the IPod. During an interview on 6/12/19 at 8:40 a.m., the Director of Nurses reported an expectation of staff to use the Kardex on the IPod to know how to care for the residents. The Director of Nurses reported she enters new interventions in capital letters to get the staff's attention. The Director of Nurses reported the agency staff carry an IPod and received proper orientation.	F 689		

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F 690 SS=E	Bowel/Bladder Incontinence, Catheter, UTI CFR(s): 483.25(e)(1)-(3) §483.25(e) Incontinence. §483.25(e)(1) The facility must ensure that resident who is continent of bladder and bowel on admission receives services and assistance to maintain continence unless his or her clinical condition is or becomes such that continence is not possible to maintain. §483.25(e)(2)For a resident with urinary incontinence, based on the resident's comprehensive assessment, the facility must ensure that- (i) A resident who enters the facility without an indwelling catheter is not catheterized unless the resident's clinical condition demonstrates that catheterization was necessary; (ii) A resident who enters the facility with an indwelling catheter or subsequently receives one is assessed for removal of the catheter as soon as possible unless the resident's clinical condition demonstrates that catheterization is necessary; and (iii) A resident who is incontinent of bladder receives appropriate treatment and services to prevent urinary tract infections and to restore continence to the extent possible. §483.25(e)(3) For a resident with fecal incontinence, based on the resident's comprehensive assessment, the facility must ensure that a resident who is incontinent of bowel receives appropriate treatment and services to restore as much normal bowel function as possible. This REQUIREMENT is not met as evidenced by: Based on record review, observations, and	F 690		

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F 690	Continued From page 7 interview, the facility failed to maintain adequate infection control measures for 1 of 3 sampled (Resident #54) with a catheter. The facility reported a census of 67. Findings included: 1. The Minimum Data Set (MDS) assessment dated 5/15/19 documented Resident #54 had a diagnosis of obstructive uropathy. Resident #54 had severe cognitive impairments. According to the MDS dated 5/15/19 Resident #54 required extensive assistance of two staff for bed mobility, transfers, and toilet use. The MDS documented Resident #54 had a catheter to empty the bladder. The Care Plan revised on 5/14/19 revealed Resident #54 had a urinary catheter and directed the staff to provide catheter care every shift, position the drainage bag and tubing below the level of the bladder and away from the entrance door, monitor tubing for kinks and monitor and document for pain and discomfort. During an observation on 6/10/19 at 8:44 a.m., revealed Resident #54 sitting in his wheelchair in the hallway. The catheter drainage bag had direct contact with the floor. During an observation on 6/10/19 at 8:59 a.m., revealed Resident #54 sitting in his wheelchair in the dining room. The catheter drainage bag had direct contact with the floor. During an observation on 6/10/19 at 9:38 a.m., revealed Resident #54 sitting in his wheelchair in the dining room. The catheter drainage bag had	F 690		

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F 690	Continued From page 8 direct contact with the floor. During an observation on 6/10/19 at 11:30 a.m., revealed Resident #54 sitting in his wheelchair in the dining room. The catheter drainage bag in direct contact with the floor. During an observation on 6/11/19 at 12:25 p.m., revealed Resident #54 sitting in his wheelchair. The catheter drainage bag had direct contact with the floor. During an interview on 6/12/19 at 8:39 a.m., the Director of Nurses reported catheter bags should clear the floor when hanging under the wheelchair. The Catheter Drain Bags-Care Of policy dated January 2015 failed to address the position of catheter drainage bag in relation to the floor.	F 690		
F 812 SS=D	Food Procurement,Store/Prepare/Serve-Sanitary CFR(s): 483.60(i)(1)(2) §483.60(i) Food safety requirements. The facility must - §483.60(i)(1) - Procure food from sources approved or considered satisfactory by federal, state or local authorities. (i) This may include food items obtained directly from local producers, subject to applicable State and local laws or regulations. (ii) This provision does not prohibit or prevent facilities from using produce grown in facility gardens, subject to compliance with applicable safe growing and food-handling practices. (iii) This provision does not preclude residents from consuming foods not procured by the facility.	F 812		

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F 812	Continued From page 9 §483.60(i)(2) - Store, prepare, distribute and serve food in accordance with professional standards for food service safety. This REQUIREMENT is not met as evidenced by: Based on record review, observations, and interviews, the facility failed to serve food in accordance with professional standards for food safety. The facility reported a census of 67 residents. Findings: Observation during the initial kitchen tour on 6/9/19 at 9:04 a.m. revealed the fire suppression system over the stove burners contained a build up of dust and debris. . Observations during food preparation on 6/10/19 at 10:27 a.m. revealed the following: a. Staff S (Cook) had hair hanging out the back of her hairnet. The hairnet failed to fully cover the back of Staff S's head. Staff S prepared and served food. b. The Dietary Manager's hairnet failed to cover the back/bottom portion of her head. The Dietary Manager had hari hanging out the bottom of the hairnet. The Dietary Manager assisted in the kitchen during the meal. c. Staff U (Dietary Aide) had hair hanging out the back of her hairnet. Staff U's hairnet failed to cover the back lower area of her head. Staff U assisted in the kitchen during the meal. d. The fire suppression system continued to	F 812		

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F 812	Continued From page 10 contain a build up of dust and debris. The Personnel Health Standards and Conduct policy dated February 2016, directed the staff to cover their hair properly by a hair restraint. During an interview on 6/10/19 at 2:07 p.m., the Dietary Manager stated hair nets should restrain all hair.	F 812		
F 880 SS=D	Infection Prevention & Control CFR(s): 483.80(a)(1)(2)(4)(e)(f) §483.80 Infection Control The facility must establish and maintain an infection prevention and control program 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:	F 880		

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F 880	Continued From page 11 (i) A system of surveillance designed to identify possible communicable diseases or infections before they can spread to other persons in the facility; (ii) When and to whom possible incidents of communicable disease or infections should be reported; (iii) Standard and transmission-based precautions to be followed to prevent spread of infections; (iv)When and how isolation should be used for a resident; including but not limited to: (A) The type and duration of the isolation, depending upon the infectious agent or organism involved, and (B) A requirement that the isolation should be the 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:	F 880		

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F 880	Continued From page 12 Based on clinical record review, observations, and interviews the facility failed to follow standard precautions when providing cares and administering injections for 1 of 1 sampled (Resident #52). The facility reported a census of 67. Findings include: 1. The Minimum Data Set (MDS) assessment dated 5/17/19 documented Resident#52 had the diagnoses of pneumonia, stroke, and heart disease. Resident #52 had severe cognitive impairments. The MDS dated 5/17/19 documented Resident #52 required extensive assistance of two staff for bed mobility, transfers, personal hygiene, and bathing. Resident #52 had occasional bladder incontinence and frequent bowel incontinence. The Care Plan revised on 2/15/19 revealed Resident #52 at risk for decline in activities of daily living and directed the staff to provide assistance with transfers, dressing, hygiene, and bathing. During an observation on 6/9/19 at 10:00 a.m., Staff M. (Nurse Aide) and Staff N (Nurse Aide) performed perineal care for Resident #52. Resident #52 had bowel incontinence. The loose bowel movement soiled Resident #52's mattress. Staff L (Registered Nurse) placed the soiled linens directly on the floor. Staff L used a disposable wipe to clean the soiled mattress. The staff failed to disinfect the floor and mattress. The Delivery of Soiled Linen to the Laundry policy dated March 2013 failed to direct the staff to	F 880		

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NORTHERN MAHASKA SPECIALTY CARE	2401 CRESTVIEW DRIVE OSKALOOSA, IA 52577

(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 880	Continued From page 13 place soiled linen in a plastic bag. . During an interview on 6/10/19 at 8:00 a.m., the Director of Nurses reported an expectation of staff to place soiled items in a plastic bag and disinfect surfaces contaminated by soiled items. During an interview on 6/11/19 10:26 a.m., Staff P (Nurse Aide) reported the staff place dirty linens in a plastic bag. During an interview on 6/11/19 10:33 a.m., Staff N (Nurse Aide) reported that dirty linen should not go directly on the floor. Staff N reported the staff place dirty linens in a plastic bag.	F 880		

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

Date of Compliance July 4th, 2019
Exception of F689 which is June 25th, 2019

F677
POC Date July 4th, 2019

Northern Mahaska Specialty Care provides proper and complete incontinence care for all residents.

Resident #52 receives proper and complete incontinence care.

All residents with potential to be affected are protected through staff education & auditing.

Staff received education related to peri care on June 13th, 2019.

D.O.N or designee will complete auditing routinely to ensure compliance.

QAPI IDT will review audits to ensure that compliance is permanent.

F689
POC Date June 25th, 2019

Northern Mahaska Specialty Care provides adequate supervision and assistance devices to prevent accidents.

Resident #31 receives adequate supervision and assistance devices.

All residents with potential to be affected are protected through procedural changes to include agency education verification signoff.

Staff education on June 13th, 2019.

D.O.N or designee will complete routine auditing to ensure compliance.

QAPI IDT will review audits to ensure that compliance is permanent.

F690
POC Date July 4th, 2019

Northern Mahaska Specialty Care provides appropriate treatment and services to maintain adequate infection control measures.

Resident #54 is deceased.

All residents with potential to be affected are protected through a change in product selection regarding cath storage devices and staff education

Staff education occurred on June 13th, 2019.

D.O.N or designee will complete auditing routinely to ensure compliance.

QAPI IDT will review audits to ensure solutions are permanent.

F812
POC Date July 4th, 2019

Northern Mahaska Specialty Care serves food in accordance with professional standards for food safety.

Dietary staff received education on hair placement inside hairnets and cleaning schedule changes on 6/12/2019.

Fire Suppression was added to weekly cleaning schedule on 6/12/2019.

DSM or designee will conduct audits routinely to ensure compliance.

QAPI IDT will review audits to ensure solutions are permanent.

F880
POC Date July 4th, 2019

Northern Mahaska Specialty Care provides a safe, sanitary & comfortable environment to help prevent transmission of infections.

Resident #52 & #66 receive care that prevents infections.

All residents with potential to be affected are protected through education and auditing.

D.O.N or designee will complete routine auditing to ensure compliance.

QAPI IDT will review auditing to ensure solutions are permanent.