STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	165466	A. BUILDING _____ B. WING _____	08/22/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
RISEN SON CHRISTIAN VILLAGE	3000 RISEN SON BOULEVARD COUNCIL BLUFFS, IA 51503

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F 000	INITIAL COMMENTS Correction date 10-3-19 The following deficiencies relate to the facility's health survey and investigation of complaints 84606-C, 85108-C and 85149-C. All three complaints were substantiated.	F 000		
F 584 SS=D	See the Code of Federal Regulations Safe/Clean/Comfortable/Homelike Environment CFR(s): 483.10(i)(1)-(7) §483.10(i) Safe Environment. The resident has a right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely. The facility must provide- §483.10(i)(1) A safe, clean, comfortable, and homelike environment, allowing the resident to use his or her personal belongings to the extent possible. (i) This includes ensuring that the resident can receive care and services safely and that the physical layout of the facility maximizes resident independence and does not pose a safety risk. (ii) The facility shall exercise reasonable care for the protection of the resident's property from loss or theft. §483.10(i)(2) Housekeeping and maintenance services necessary to maintain a sanitary, orderly, and comfortable interior; §483.10(i)(3) Clean bed and bath linens that are in good condition;	F 584		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

ADMINISTRATOR 10-03-2019

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

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F 584	Continued From page 1 §483.10(i)(4) Private closet space in each resident room, as specified in §483.90 (e)(2)(iv); §483.10(i)(5) Adequate and comfortable lighting levels in all areas; §483.10(i)(6) Comfortable and safe temperature levels. Facilities initially certified after October 1, 1990 must maintain a temperature range of 71 to 81°F; and §483.10(i)(7) For the maintenance of comfortable sound levels. This REQUIREMENT is not met as evidenced by: Based on observation, resident council interview, family and staff interviews the facility failed to maintain the environment in a clean and sanitary manner. The facility reported a census of 79 residents. Findings include: During a family interview on 8/19/19 at 1:38 PM, the son of a resident stated his wife has had to clean his mother's room because it would get dirty. For example, the family found pillows on the floor and the trash full of dirty adult briefs. During a confidential resident council meeting on 8/20/19 at 10:30 AM residents stated housekeeping (especially on A hall) is not always completed. Random resident room and bathroom observations revealed the following: -08/20/19 at 12:31 PM: In Room B17, a toilet riser	F 584		

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F 584	Continued From page 2 with a brown substance on the front and back of the opening into the toilet. -08/20/19 at 12:34 PM: Room B13, a toilet riser with brown substance on the area of the opening in to the toilet, floor with splashes of brownish/red substance. -08/21/19 at 9:03 AM Room B13 toilet riser and floor remained dirty with brown substance on the area of the opening into the toilet and the brownish/red areas still on the floor. -08/21/19 at 09:04 AM Room B17 toilet riser still dirty -08/22/19 at 10:46 AM Room B13 floor and the front of the toilet riser remained dirty -08/22/19 at 10:48 AM Room B17 toilet riser remained dirty -08/22/19 at 10:50 AM Room B21 bathroom had 3 spots of a brown substance, a clear glove, and toilet paper on the floor During a staff interview on 08/22/19 at 11:26 AM, Staff L Housekeeping Aide stated the toilet risers are cleaned by housekeeping. She stated they have been short staff, so if something is observed it is because they are short of housekeepers. Staff L stated Certified Nursing Assistants can clean the toilet risers if they notice they are dirty. During a staff interview on 08/22/19 at 11:56 AM the Director of Environmental Services and Staff K Lead Housekeeper stated the toilet risers can be wiped down by the nursing staff. The Director of Environmental Services stated that if a toilet	F 584		

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F 584	Continued From page 3 riser is dirty and cleaned by nursing staff they need to let housekeeping know so it can be sanitized. He stated the housekeeping department has been short and they just hired 2 new housekeeping staff. He reported communication was lacking between nursing and housekeeping, but they have now better systems in place to work on these things. In an interview on 08/19/19 at 02:08 PM, Resident #17's daughter reported the bathrooms do not get cleaned regularly. For example, she told the staff 3 days ago about the feces on and around the toilet and they didn't clean it until this morning after the surveyors entered the building. She reported that she doesn't see housekeeping on Hall A at all some days when she is there.	F 584		
F 623 SS=E	Notice Requirements Before Transfer/Discharge CFR(s): 483.15(c)(3)-(6)(8) §483.15(c)(3) Notice before transfer. Before a facility transfers or discharges a resident, the facility must- (i) Notify the resident and the resident's representative(s) of the transfer or discharge and the reasons for the move in writing and in a language and manner they understand. The facility must send a copy of the notice to a representative of the Office of the State Long-Term Care Ombudsman. (ii) Record the reasons for the transfer or discharge in the resident's medical record in accordance with paragraph (c)(2) of this section; and (iii) Include in the notice the items described in paragraph (c)(5) of this section. §483.15(c)(4) Timing of the notice. (i) Except as specified in paragraphs (c)(4)(ii) and	F 623		

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F 623	Continued From page 4 (c)(8) of this section, the notice of transfer or discharge required under this section must be made by the facility at least 30 days before the resident is transferred or discharged. (ii) Notice must be made as soon as practicable before transfer or discharge when- (A) The safety of individuals in the facility would be endangered under paragraph (c)(1)(i)(C) of this section; (B) The health of individuals in the facility would be endangered, under paragraph (c)(1)(i)(D) of this section; (C) The resident's health improves sufficiently to allow a more immediate transfer or discharge, under paragraph (c)(1)(i)(B) of this section; (D) An immediate transfer or discharge is required by the resident's urgent medical needs, under paragraph (c)(1)(i)(A) of this section; or (E) A resident has not resided in the facility for 30 days. §483.15(c)(5) Contents of the notice. The written notice specified in paragraph (c)(3) of this section must include the following: (i) The reason for transfer or discharge; (ii) The effective date of transfer or discharge; (iii) The location to which the resident is transferred or discharged; (iv) A statement of the resident's appeal rights, including the name, address (mailing and email), and telephone number of the entity which receives such requests; and information on how to obtain an appeal form and assistance in completing the form and submitting the appeal hearing request; (v) The name, address (mailing and email) and telephone number of the Office of the State Long-Term Care Ombudsman;	F 623		

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F 623	Continued From page 5 (vi) For nursing facility residents with intellectual and developmental disabilities or related disabilities, the mailing and email address and telephone number of the agency responsible for the protection and advocacy of individuals with developmental disabilities established under Part C of the Developmental Disabilities Assistance and Bill of Rights Act of 2000 (Pub. L. 106-402, codified at 42 U.S.C. 15001 et seq.); and (vii) For nursing facility residents with a mental disorder or related disabilities, the mailing and email address and telephone number of the agency responsible for the protection and advocacy of individuals with a mental disorder established under the Protection and Advocacy for Mentally Ill Individuals Act. §483.15(c)(6) Changes to the notice. If the information in the notice changes prior to effecting the transfer or discharge, the facility must update the recipients of the notice as soon as practicable once the updated information becomes available. §483.15(c)(8) Notice in advance of facility closure In the case of facility closure, the individual who is the administrator of the facility must provide written notification prior to the impending closure to the State Survey Agency, the Office of the State Long-Term Care Ombudsman, residents of the facility, and the resident representatives, as well as the plan for the transfer and adequate relocation of the residents, as required at § 483.70(l). This REQUIREMENT is not met as evidenced by: Based on clinical record review and staff interview the facility failed to notify the ombudsman office of Medicaid transfers to the	F 623		

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F 623	Continued From page 6 hospital for 3 of 3 Residents reviewed (Resident #22, #28 and #40). The facility reported a census of 79 at the time of the survey. Findings include 1. The quarterly Minimum Data Set (MDS) dated 6/14/19 reported Resident #28's Brief Interview for Mental Status (BIMS) score of 14 out of 15 indicated intact cognition for daily decision making. The MDS reported diagnoses of anemia, orthostatic hypotension, manic depressant, schizophrenia, asthma and chronic obstructive pulmonary disease. The clinical record included Resident #28 transferred to the hospital on 7/19/19 and returned to the facility on 7/22/19. During an interview on 8/21/19 at 1:16 PM, the Director of Social Services explained she did not submit the names of the 3 Residents to the ombudsman since they were on Medicaid. She further explained they had a 10 day bed hold so they did not notify the ombudsman for any one on Medicaid. 2. Review of the Census List for Resident #22 revealed he transferred to the hospital on 7/11/19 and returned to the facility on 7/27/19. The clinical record lacked documentation that staff notified the Long Term Care Ombudsman of the transfer of Resident #22 to the hospital on 7/11/19. In Interview with Social Service Director on 8/21/19 and she informed surveyors that the facility did not notify the Ombudsman of Resident #22's transfer to the hospital on 7/11/19. 3. Review of the Census List for Resident #40	F 623		

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F 623	Continued From page 7 revealed he transferred to the hospital on 6/25/19 and returned to the facility on 6/28/19. The clinical record lacked documentation that staff notified the Long Term Care Ombudsman of the transfer of Resident #40 to the hospital on 6/25/19. In an interview with the Social Service Director on 8/21/19, she verified the facility did not notify the Ombudsman of Resident #40's transfer to the hospital on 6/25/19.	F 623		
F 625 SS=E	Notice of Bed Hold Policy Before/Upon Trnsfr CFR(s): 483.15(d)(1)(2) §483.15(d) Notice of bed-hold policy and return- §483.15(d)(1) Notice before transfer. Before a nursing facility transfers a resident to a hospital or the resident goes on therapeutic leave, the nursing facility must provide written information to the resident or resident representative that specifies- (i) The duration of the state bed-hold policy, if any, during which the resident is permitted to return and resume residence in the nursing facility; (ii) The reserve bed payment policy in the state plan, under § 447.40 of this chapter, if any; (iii) The nursing facility's policies regarding bed-hold periods, which must be consistent with paragraph (e)(1) of this section, permitting a resident to return; and (iv) The information specified in paragraph (e)(1) of this section. §483.15(d)(2) Bed-hold notice upon transfer. At the time of transfer of a resident for	F 625		

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F 625	Continued From page 8 hospitalization or therapeutic leave, a nursing facility must provide to the resident and the resident representative written notice which specifies the duration of the bed-hold policy described in paragraph (d)(1) of this section. This REQUIREMENT is not met as evidenced by: Based on clinical record review and staff interview, the facility failed to provide the resident or resident representative with a bed hold when a resident transferred to the hospital for 3 of 3 residents reviewed (Resident #22, #28 and #40). The facility reported a census of 79 at the time of the survey. Findings include: 1. The quarterly Minimum Data Set (MDS) dated 6/14/19 reported Resident #28's Brief Interview for Mental Status (BIMS) score of 14 out of 15 indicated intact cognition for daily decision making. The MDS reported diagnoses of anemia, orthostatic hypotension, manic depressant, schizophrenia, asthma and chronic obstructive pulmonary disease. The clinical record included Resident #28 transferred to the hospital on 7/19/19 and returned to the facility on 7/22/19. During an interview on 8/22/19 at 8:03 AM with the Nurse Consultant she acknowledged, the facility did not do a bed hold for the 3 Residents since the facility did not discharge them out of the system, 2) Review of the Census List for Resident #22 revealed he transferred to the hospital on 7/11/19 and returned to the facility on 7/27/19. The clinical record lacked documentation that	F 625		

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F 625	Continued From page 9 staff notified Resident #22 or the Resident Representative of the transfer to the hospital on 7/11/19. Interview on 08/21/19 with the facility Regional Consultant and she informed surveyors the facility did not do bed hold notification with the resident or resident representative. 3) Review of the Census List for Resident #40 revealed he transferred to the hospital on 6/25/19 and returned to the facility on 6/28/19. The clinical record lacked documentation that staff notified Resident #40 or the Resident Representative of the transfer to the hospital on 6/25/19. Interview on 08/21/19 with the facility Regional Consultant and she informed surveyors the facility did not do bed hold notification with the resident or resident representative.	F 625		
F 644 SS=D	Coordination of PASARR and Assessments CFR(s): 483.20(e)(1)(2) §483.20(e) Coordination. A facility must coordinate assessments with the pre-admission screening and resident review (PASARR) program under Medicaid in subpart C of this part to the maximum extent practicable to avoid duplicative testing and effort. Coordination includes: §483.20(e)(1)Incorporating the recommendations from the PASARR level II determination and the PASARR evaluation report into a resident's assessment, care planning, and transitions of	F 644		

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F 644	Continued From page 10 care. §483.20(e)(2) Referring all level II residents and all residents with newly evident or possible serious mental disorder, intellectual disability, or a related condition for level II resident review upon a significant change in status assessment. This REQUIREMENT is not met as evidenced by: Based on clinical record review and staff interview, the facility failed to refer 1 of 4 residents with a negative Level I result for the Preadmission Screening and Resident Review (PASRR), who were later identified with newly evident or possible serious Mental Disorder, Intellectual Disability, or other related condition, to the appropriate state-designated authority for Level II PASRR evaluation and determination (Resident #52). The facility also failed to care plan the specialized services that were recommended by Ascend for a Level II evaluation for 1 of 2 residents reviewed (Resident #25). The facility reported a census of 79 residents. 1. Review of an annual Minimum Data Set (MDS) assessment tool dated 2/1/19 identified Resident #52 was not considered by the state level II PASRR process to have a serious mental illness and/or intellectual disability or a related condition. The MDS documented diagnoses that included dementia, depression, and psychotic disorder. Review of Resident #52's care plan with a revision date of 7/4/19 revealed she used antidepressant medications related to depression and delusional disorder. Review of Resident #52's Electronic Health Record (EHR) revealed a diagnoses page with	F 644		

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F 644	Continued From page 11 the following diagnoses: major depression with an active date of 9/30/16 and delusional disorder with an active date of 4/9/15. Review of the clinical record revealed a Notice of Negative Level I Screen Outcome dated 4/17/12. The Level I screen documented "no" under question 1, does the individual have any of the following Major Mental Illnesses (MMI) which included depressive disorder and delusional disorder. During a staff interview on 08/21/19 on 1:14 PM the Director of Social Services stated she has only resubmitted to Ascend when there has been a significant change in their mental status such as a mental health hospitalization. 2. The MDS with a completion date of 5/31/19 listed diagnoses of anxiety, depression, and manic depression. A PASRR Notice of Nursing Facility Approval with a determination date of 12/1/17 listed identified specialized services for behavioral health. The care plan with a revision date of 5/28/19 documented focus areas regarding PASRR recommendations but interventions/tasks failed to address specific responsibilities with regard to who provided the service, the type of service, where the service was or would be provided, when the service provision would begin, and the duration of the service. During an interview with the Regional Consultant Registered Nurse (RN) on 8/31/19 at 11:30 A.M., she stated her expectation that staff document recommendations from ASCEND from the Level	F 644		

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F 644	Continued From page 12 II on the careplan with all areas completed with who, what, when, where, and for how long specified. During an interview at 12:05 PM on 8/22/19 with the Regional Consultant Nurse, she stated the resident had received no psychiatric/psychological services since she has been here.	F 644		
F 657 SS=D	Care Plan Timing and Revision CFR(s): 483.21(b)(2)(i)-(iii) §483.21(b) Comprehensive Care Plans §483.21(b)(2) A comprehensive care plan must be- (i) Developed within 7 days after completion of the comprehensive assessment. (ii) Prepared by an interdisciplinary team, that includes but is not limited to-- (A) The attending physician. (B) A registered nurse with responsibility for the resident. (C) A nurse aide with responsibility for the resident. (D) A member of food and nutrition services staff. (E) To the extent practicable, the participation of the resident and the resident's representative(s). An explanation must be included in a resident's medical record if the participation of the resident and their resident representative is determined not practicable for the development of the resident's care plan. (F) Other appropriate staff or professionals in disciplines as determined by the resident's needs or as requested by the resident. (iii)Reviewed and revised by the interdisciplinary team after each assessment, including both the comprehensive and quarterly review	F 657		

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F 657	Continued From page 13 assessments. This REQUIREMENT is not met as evidenced by: Based on record review and staff interview the facility failed to update 1 of 1 resident's care plan reviewed for the use of an anticoagulant after the medication was discontinued (Resident #7). The facility also failed to revise the comprehensive care plan following falls for 1 of 4 (Resident #63) residents reviewed for falls. The facility reported a census of 79 residents. Findings include: Review of a quarterly MDS with a reference date of 5/10/19 revealed Resident #7 had a BIMS score of 3/15, indicated the resident displayed and experienced severe cognitive impairment. The MDS listed the following diagnoses: hypertension, dementia, and atrial fibrillation and documented Resident #7 received an anticoagulant medication for 7 days of the 7 day review period. Review of a quarterly MDS with a reference date of 8/2/19 revealed Resident #7 showed moderately impaired daily decision-making skills. The MDS listed the following diagnoses: hypertension, dementia, and atrial fibrillation and documented she did not receive an anticoagulant during the 7 day review period at that time of the assessment. Review of Resident #7's care plan with a revision date of 11/15/18 revealed she was on anticoagulant therapy related to atrial fibrillation. Chart review of Resident #7's Electronic Health Record (EHR) indicated she received Eliquis	F 657		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	165466	A. BUILDING _____ B. WING _____	08/22/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
RISEN SON CHRISTIAN VILLAGE	3000 RISEN SON BOULEVARD COUNCIL BLUFFS, IA 51503

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F 657	Continued From page 14 (anticoagulant) 4/22/19 through 6/3/19 when it was discontinued. She was then started on Flecainide Acetate (for arrhythmias) on 6/4/19. During a staff interview on 08/22/19 at 2:59 PM, the MDS Coordinator stated the use of an anticoagulant medication should be removed from the care plan if she no longer received the medication. The MDS dated 6/11/19 revealed Resident #63 had a diagnosis of Dementia and a Brief Interview of Mental Status score of 8/15. The MDS for Resident #63 had falls in the last month. The Progress Note dated 7/27/19 at 6:49 PM revealed Resident #63 observed lying on her back on the floor in the dayroom. The Progress Note dated 8/16/19 at 8:40 PM revealed Resident #63 found on the floor on her body pillow and on the floor mat. The Incident Report dated 7/27/19 at 3:45 PM revealed one on one with resident implemented after the fall. This intervention had not been included on the Care Plan. The Incident Report for Resident #63 dated 8/16/19 at 8:25 PM revealed resident found on the floor on top of her body pillow on her floor mat. These interventions had not been included on the Care Plan. The Care Plan for Resident #63 with a focus of falls dated 7/1/19 revealed no revisions or updates after resident fell 7/27/19 and 8/16/19.	F 657		
F 658	Services Provided Meet Professional Standards	F 658		

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	165466	A. BUILDING _____ B. WING _____	08/22/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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F 658 SS=D	Continued From page 15 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: Based on record review, observations, resident and staff interviews the facility failed to provide treatment and care in accordance with professional standards of practice related to implementing Ted hose on admission and providing daily wound care to a skin tear per physician orders for 2 of 18 residents reviewed (Resident #56 and #17). The facility reported a census of 79 residents. Findings include: 1) The Admission Minimum Data Set (MDS) dated 7/29/19 revealed Resident #56 admitted to the facility on 7/23/19 with a diagnosis of pelvic fracture, mitral valve insufficiency and tricuspid valve insufficiency. The MDS documented the resident displayed moderately impaired cognition. The Patient Discharge Instructions from the hospital dated 7/23/19 directed staff to apply Ted hose (anti-embolism stockings) the resident's legs: on daily and off at bedtime. Record review of CHI Admit Screener completed on 7/23/19 revealed no edema present on admission. Observation on 08/20/19 at 03:33 PM revealed both legs swollen with pitting edema and no Ted	F 658		

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	165466	A. BUILDING _____ B. WING _____	08/22/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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F 658	Continued From page 16 hose on either leg. Resident #56 reported this was new for her. Observation on 08/22/19 at 11:10 AM revealed Resident #56 just finished therapy. Legs and feet displayed pitting edema resident and the resident was not wearing Ted hose. During an interview on 08/22/19 at 11:15 AM, Resident #56 reported she hadn't worn Ted hose since she had been here. Interview on 08/22/19 at 11:20 AM with Staff A and she informed surveyor that she was not aware of any edema or Ted hose order for Resident #56 so she had not assessed the edema. The Treatment Administration Record and Medication Administration Record for Resident #56 for the months of July and August 2019 revealed no order for Ted hose. 2) Review of the Treatment Administration Record (TAR) dated April 2019 for Resident #17 revealed she had an order for a daily dressing change to a skin tear to her left foot daily with order date 4/15/19. Record review of Medical Conditions on the TAR dated 4/15/19 revealed Resident #17 had a diagnosis of Peripheral Vascular Disease. Review of the TAR for Resident #17 dated months April 2019, May 2019, June 2019, July 2019 and August 2019 revealed the treatment had not consistently been completed every single day as ordered.	F 658		

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	165466	A. BUILDING _____ B. WING _____	08/22/2019

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F 658	Continued From page 17 Review of the Wound Evaluations for Resident #17 dated 6/5/19, 6/25/19 and 8/14/19 revealed some deterioration of the skin tear. Interview on 08/19/19 at 02:11 PM with Resident #17's daughter and she reported Resident #17 fell in April and she received a skin tear to her left leg and foot. Resident's daughter thought it had taken too long for it to heal and reported the facility hadn't been doing treatments as ordered. Interview with the Director of Nurse on 8/22/19 at 12:55 PM and she informed surveyor that she expected treatments to be done according to physician orders.	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 by: Based on clinical record review and family and staff interviews, the facility failed to provide Resident's with constant baths weekly for 3 of the 3 Residents reviewed (Resident #6, # 19 and #52). The facility reported a census of 79 at the time of the survey. Findings include: 1. The 5-day Medicare Part A Minimum Data Set (MDS) assessment tool dated 3/18/18 for Resident #19 reported a Brief Interview for Mental Status (BIMS) score of 7/15, which indicated severe cognitive impairment for daily decision	F 677		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	165466	A. BUILDING _____ B. WING _____	08/22/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
RISEN SON CHRISTIAN VILLAGE	3000 RISEN SON BOULEVARD COUNCIL BLUFFS, IA 51503

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F 677	Continued From page 18	F 677		

making. The MDS indicated she required total assistance of 3 staff for bathing and had diagnoses that included Alzheimer's disease, depression, and psychotic disorder.

The quarterly MDS assessment tool dated 5/31/19 for Resident #19 reported a BIMS score of 9/15 which indicated severe cognitive impairment for daily decision-making. The MDS indicated Resident #19's bathing did not occur during the 7-day look back period and included diagnoses of Alzheimer's disease, depression, and psychotic disorder.

Resident #19's Care Plan revised on 9/18/18 included a focus area of being at risk of Activities of Daily Living (ADL's) related to dementia. The Care Plan directed staff Resident #19 required assistance of 1 staff for bathing and a female CNA to provide showers.

The Documentation for Resident #19's baths for July indicated she received 4 baths in the 31 days in July and refused a bath 2 of the 31 days. The documentation also contained 4 days that staff had coded NA (not applicable) during July.

The Documentation for Resident #19's baths for August indicated she received 3 baths out of 22 days in August and refused a bath 1 out of the 22 days. The document also contained 1 day that listed NA during the first 22 days of August.

During an interview on 8/22/19 at 7:56 AM, Staff E Certified Nursing Aide (CNA) explained she would list NA if she were assigned to the Resident for the day and it's not their bath day. Staff E further explained she would chart NA so the resident would stay on the bath schedule.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	165466	A. BUILDING _____ B. WING _____	08/22/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
RISEN SON CHRISTIAN VILLAGE	3000 RISEN SON BOULEVARD COUNCIL BLUFFS, IA 51503

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F 677	Continued From page 19 During an interview on 8/22/19 at 1:48 PM, the Director of Nursing (DON) stated staff should chart refused if the resident refused, rather than "NA." The DON reported it had only been brought to her attention earlier that day if a resident refused a bath, staff had been charting "NA" in some instances. 2. According to the annual MDS assessment tool with a reference date of 5/10/19, Resident #6 had a BIMS score of 3, which indicated severe cognitive impairment. The MDS documented Resident #6 required extensive assistance of 2 staff for bed mobility and transfers and was totally dependent on 1 staff for bathing. According to the annual MDS assessment tool dated 8/2/19, Resident #6 had a BIMS score of 6, which meant the resident displayed moderate cognitive impairment. The MDS indicated Resident #6 required extensive assistance of 1 staff for bed mobility and transfers, and also documented bathing did not occur during the 7 day review period. Review of Resident #6's care plan, with a revision date of 2/19/19 revealed she required assistance of 1 staff for bathing. During a family interview on 08/19/19 at 2:43 PM, Resident #6's son stated when he would come to visit, his mom had smelled so bad he and his wife could not sit in the room with her. He stated he has told management and they will get staff down to get her bathed. Chart review revealed staff scheduled to bathe Resident #6 every Thursday and Sunday.	F 677		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	165466	A. BUILDING _____ B. WING _____	08/22/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
RISEN SON CHRISTIAN VILLAGE	3000 RISEN SON BOULEVARD COUNCIL BLUFFS, IA 51503

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F 677	Continued From page 20 Review of the bath sheet revealed the following options available for staff to mark when giving a resident a bath: shower, bed bath, whirlpool bath, partial bath, tub bath, resident not available, resident refused and not applicable. Review of the Documentation Survey Report for July 2019 and August 2019, revealed staff charted not applicable (N/A) under bathing for the following: Sunday July 7th, Thursday July 11th, Sunday July 14th, Thursday July 25th, Sunday July 28th, Thursday August 1st, Sunday August 4th, Thursday August 8th, and Sunday August 11th. Review of the report revealed Resident #6 received a shower 3 times in July and none in August to date. 3. Review of the quarterly MDS with a reference date of 4/26/19, revealed Resident #52 had BIMS score of 13/15 indicating no cognitive impairment. The MDS indicated she required extensive assistance of 2 staff with bed mobility, transfers and extensive assistance of 1 staff for personal hygiene. The MDS indicated Resident #52 required physical help of one staff for bathing, and the following diagnoses: dementia, seizure disorder, depression, psychotic disorder, and failure to thrive. Review of the quarterly MDS dated 7/19/19, revealed Resident #52 had a BIMS score of 12/15 which indicated the resident displayed moderate cognitive impairment, and documented she required extensive assistance of 2 staff with bed mobility and transfers and extensive assistance of 1 staff for personal hygiene. The MDS indicated bathing did not occur during the 7 day look back period. The MDS listed the following diagnoses: dementia, seizure disorder,	F 677		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	165466	A. BUILDING _____ B. WING _____	08/22/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
RISEN SON CHRISTIAN VILLAGE	3000 RISEN SON BOULEVARD COUNCIL BLUFFS, IA 51503

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F 677	Continued From page 21 depression, psychotic disorder, and failure to thrive. Review of Resident #52's care plan with a revision date of 7/13/19 revealed she required assist of 1 staff with bathing and directed staff to monitor skin condition during baths. Chart review revealed staff scheduled to bathe Resident #52 every Monday and Friday. Review of the Documentation Survey Report for July 2019 and August 2019, revealed staff charted N/A under bathing for the following: Monday July 1st, Monday July 8th, Friday July 19th, Monday July 29th, Friday August 2nd, Monday August 5th, Friday August 9th, and Monday August 12th. According to the to this report, Resident #52 received a shower 4 times in July and had not received a shower or bath in August as of August 20th. During a staff interview on 08/21/19 at 3:30 PM, Staff D CNA was asked does it mean on the bath charting when it says not applicable, she stated that means the bath was not given. During a staff interview on 08/21/19 at 4:01 PM Staff F CNA was asked what not applicable means for bath documentation and she reported it meant the resident was not in the facility that day. During a staff interview on 08/22/19 at 8:17 AM, Staff J Unit Manager was asked why staff would document N/A on a bath record, she reported it would be charted if it wasn't their bath day, but if it was their day then the residents didn't get it. Staff J stated CNAs are not good about charting them	F 677		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	165466	A. BUILDING _____ B. WING _____	08/22/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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F 677	Continued From page 22 even when they are done, and staff may offer a bath even if it is not their bath day. She stated staff should chart what was done: bath completed, resident refused, resident not available, etc. She added staff should never chart not applicable.	F 677		
F 686 SS=G	Treatment/Svcs to Prevent/Heal Pressure Ulcer CFR(s): 483.25(b)(1)(i)(ii) §483.25(b) Skin Integrity §483.25(b)(1) Pressure ulcers. Based on the comprehensive assessment of a resident, the facility must ensure that- (i) A resident receives care, consistent with professional standards of practice, to prevent pressure ulcers and does not develop pressure ulcers unless the individual's clinical condition demonstrates that they were unavoidable; and (ii) A resident with pressure ulcers receives necessary treatment and services, consistent with professional standards of practice, to promote healing, prevent infection and prevent new ulcers from developing. This REQUIREMENT is not met as evidenced by: Based on record review, observations and staff interviews, the facility failed to provide care consistent with professional standards to prevent a deterioration of a Stage III pressure ulcer and also failed to ensure pressure relief interventions were always in place for 1 of 3 residents observed (Resident #63), The facility also failed to complete treatments and dressing changes according to physician's orders for 1 of 1 resident's (Resident #51) dressing change(s) observed. The facility reported a census of 79 residents.	F 686		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	165466	A. BUILDING _____ B. WING _____	08/22/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
RISEN SON CHRISTIAN VILLAGE	3000 RISEN SON BOULEVARD COUNCIL BLUFFS, IA 51503

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F 686	Continued From page 23 Findings include: The Admission Minimum Data Set (MDS) dated 6/11/19 revealed Resident #63 admitted to the facility on 6/5/19 with diagnoses of diabetes, hyperlipidemia, thyroid disorder, arthritis, non-Alzheimer's dementia, abnormalities of gait, muscle weakness and dysphagia. The MDS revealed a Brief Interview for Mental Status (BIMS) score of 8/15, which indicated the resident displayed moderately impaired cognition. The MDS revealed Resident #63 required extensive assist of 1 staff for bed mobility, transfers and ambulation (walking). According to the MDS, Resident #63 was at risk of developing pressure ulcers, but was coded as having no pressure ulcers. Record review revealed no documentation that showed facility staff assessed the resident's skin upon admission. A Significant Change in Status MDS dated 7/28/19 documented Resident #63 had a Stage III pressure ulcer present on admission and a BIMS score of 3/15 indicating severe cognitive deficit. The MDS assessment defined a Stage III Pressure Ulcer as a full thickness tissue loss. Subcutaneous fat may be visible but bone, tendon or muscle is not exposed. Slough may be present but does not obscure the depth of tissue loss. May include undermining and tunneling. The Wound Assessment facility policy revised 7/1/19 revealed the facility's practice to provide ongoing wound assessment at least weekly or more often when indicated by wound complications or changes in wound	F 686		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	165466	A. BUILDING _____ B. WING _____	08/22/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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F 686	Continued From page 25	F 686		

apply Mepilex. Change on Mondays, Wednesdays, and Fridays and as needed (PRN). The order also directed staff to ensure the resident wears Prevalon boots when heel of foot rests on bed or chair, float heels whenever possible, and resident to return to the clinic in 2 weeks.

The Wound Assessment Details form from the Wound Care Clinic dated 6/10/19 documented a right lateral calcaneus area as a Stage III Pressure Ulcer measuring 0.5 cm x 1.2 cm x 0.1cm that contained a medium amount of serosanguineous exudate and a small amount of adherent slough present.

Record review for Resident #63 revealed the facility did not begin to document weekly skin assessments until 7/4/19.
The Skin and Wound Evaluation from the facility dated 7/4/19 revealed a Stage III Pressure Ulcer on the resident's right heel that measured 0.3 cm x 0.5 cm x 0.6 cm with 90 percent epithelial tissue, 10 percent granulation, and no exudate present.

The Wound Assessment Details form from the Wound Care Clinic dated 7/8/19 documented a right lateral calcaneus area as a Stage III Pressure Ulcer that measured 0.9 cm x 0.3 cm x 0.1 cm with a large amount of granulation, small amount of serosanguineous exudate, and a small amount of adherent slough present.

The Patient Information form for Hospice revealed Resident #63 admitted to a hospice service on 7/22/19.

The Skin and Wound Evaluation from the facility

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	165466	A. BUILDING _____ B. WING _____	08/22/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
RISEN SON CHRISTIAN VILLAGE	3000 RISEN SON BOULEVARD COUNCIL BLUFFS, IA 51503

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F 686	Continued From page 24	F 686		

characteristics. The facility procedure directed staff to assess all wounds upon on admission, monitor daily, and assess weekly.

The Care Plan for Resident #63 dated 8/16/19 documented a focus area initiated on 6/14/19, which identified the resident as at risk for impairment to skin integrity related to immobility, incontinence, diabetes, hypothyroidism, dysphagia, weight loss and an albumin level of 3.0. The Care Plan directed staff to complete treatment as ordered, turn or reposition frequently or as resident allows, pressure reduction cushion in wheelchair, and pressure relieving mattress on the bed. Another focus area initiated on 6/14/19 identified Resident #63 as at risk for (Activities of Daily Living (ADL) self-care deficiency related to weakness, falls and cognitive status with decline expected. The Care Plan directed staff to wear a Prevalon boot (to relieve pressure) when heel of foot rested on the bed or chair, and float heels whenever possible.

Physician order dated 6/10/19 at 1:02 PM directed staff to ensure the resident wears a Prevalon boot when the heel of the foot rested on the bed or chair, and float heels whenever possible.

The resident's record did not contain information related to a pressure wound on the resident's right heel until an entry on 6/10/2019 at 1:06 PM in the Nurse's Notes that documented the order staff received when the resident returned from the wound clinic.

An order from a wound clinic appointment dated 6/10/19 directed staff to clean the resident's right heel with normal saline, cover with xeroform, then

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	165466	A. BUILDING _____ B. WING _____	08/22/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
RISEN SON CHRISTIAN VILLAGE	3000 RISEN SON BOULEVARD COUNCIL BLUFFS, IA 51503

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F 686	Continued From page 26 dated 7/24/19 revealed a Stage III Pressure Ulcer on the resident's right heel that measured 0.7 cm x 0.9 cm x 0.7 cm with 90 percent epithelial tissue, no granulation tissue, and a scab present. A fax sent by the facility to the physician on 7/31/19 revealed Resident #63 right heel was stable with the surrounding tissue macerated. Staff requested to change the treatment order to skin prep and foam border dressing. A Hospice Routine Visit note dated 8/7/19 revealed hospice ordered a low air loss mattress for the resident. The Skin and Wound Evaluation from the facility dated 8/13/19 revealed a Stage III Pressure Ulcer to Resident #63's right heel that measured 2.4 cm x 1.5 cm x 2.1 cm with 90 percent epithelial tissue, no granulation tissue, and light serosanguineous exudate present A fax sent by the facility to the physician on 8/13/19 revealed Resident #63's right heel pressure injury deteriorated when compared to last week's measurements: 0.6 cm x 1.2 cm vs. 1.5 cm x 2.1 cm. Facility staff requested to change the dressing to Puracol plus and Optifoam. Observation on 08/20/19 at 11:25 AM revealed Resident #63 in a reclining wheelchair in stocking feet which rested on metal foot pedals. Resident unable to sit still in wheelchair, attempted several times to stand up, and then fidgeted in wheelchair. One Prevalon boot found in the resident's room. Observation on 08/21/19 at 12:20 PM revealed	F 686		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	165466	A. BUILDING _____ B. WING _____	08/22/2019

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F 686	Continued From page 27 Resident #63 sat upright in a wheelchair in the dining room with feet in socks, and rested against the metal wheelchair pedals. Further observation revealed one Prevalon boot lay on the resident's bed in her room. Observation on 08/22/19 at 09:26 AM revealed Resident #63 in her wheelchair at the dining room table wearing socks and no Prevalon boots, heels resting against the metal wheelchair pedals. Observation attempted/requested on 08/20/19 at 11:21 AM. Staff B, RN reported she had already assessed the wound and changed the dressing on the resident's right heel that morning (ordered every 36 hours). In an interview on 08/20/19 at 11:30 AM with Staff C, Hospice Nurse and she reported the reclining wheelchair the facility provided for Resident #63 in last week is causing her discomfort. Hospice nurse reported she will have staff go back to the standard wheelchair and will order a tilt and space wheelchair for her to help off load (remove pressure) her heels. Staff C stated the resident should have her heel protector on but hospice nurse reports she doesn't like to wear it. Hospice nurse also informed surveyor when Resident #63 first admitted she had a mattress brought in by family so there was a delay in ordering a low air loss mattress. During an interview on 08/21/19 at 1:05 PM, the facility Regional Consultant reported she expected the staff to attempt to put the resident's prevalon boots on as directed or ordered on the TAR and Care Plan. If a resident refuses or removes them, staff should document that and add it to the Care Plan. In a subsequent interview	F 686		

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F 686	Continued From page 28 at 2:59 PM with the facility Regional Consultant and she informed the surveyor that she could not find any skin assessments completed by staff at the time the resident admitted to the facility. In an interview on 08/21/19 at 03:15 PM with Staff D, she reported they only apply the Prevalon boots at bedtime. In an interview on 08/21/19 at 03:50 PM, the podiatrist that saw Resident #63 at the Wound Care Center verified he ordered the Prevalon boots and expected staff to keep them on the resident's feet at all times except when the resident ambulated. The podiatrist reported he expected staff to also keep her heels floated and added if the boots were not on she would be at risk for further skin breakdown. Based on record review, observations and staff interviews, the facility failed to provide care consistent with professional standards to prevent a deterioration of a Stage III pressure ulcer and also failed to ensure pressure relief interventions were always in place for 1 of 3 residents observed (Resident #63), The facility also failed to complete treatments and dressing changes according to physician's orders for 1 of 1 resident's (Resident #51) dressing change(s) observed. The facility reported a census of 79 residents. Findings include: The Admission Minimum Data Set (MDS) dated 6/11/19 revealed Resident #63 admitted to the facility on 6/5/19 with diagnoses of diabetes, hyperlipidemia, thyroid disorder, arthritis,	F 686		

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F 686	Continued From page 29 non-Alzheimer's dementia, abnormalities of gait, muscle weakness and dysphagia. The MDS revealed a Brief Interview for Mental Status (BIMS) score of 8/15, which indicated the resident displayed moderately impaired cognition. The MDS revealed Resident #63 required extensive assist of 1 staff for bed mobility, transfers and ambulation (walking). According to the MDS, Resident #63 was at risk of developing pressure ulcers, but was coded as having no pressure ulcers. Record review revealed no documentation that showed facility staff assessed the resident's skin upon admission. A Significant Change in Status MDS dated 7/28/19 documented Resident #26 had a Stage III pressure ulcer present on admission and a BIMS score of 3/15 indicating severe cognitive deficit. The MDS assessment defined a Stage III Pressure Ulcer as a full thickness tissue loss. Subcutaneous fat may be visible but bone, tendon or muscle is not exposed. Slough may be present but does not obscure the depth of tissue loss. May include undermining and tunneling. The Wound Assessment facility policy revised 7/1/19 revealed the facility's practice to provide ongoing wound assessment at least weekly or more often when indicated by wound complications or changes in wound characteristics. The facility procedure directed staff to assess all wounds upon on admission, monitor daily, and assess weekly. The Care Plan for Resident #63 dated 8/16/19 documented a focus area initiated on 6/14/19,	F 686		

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F 686	Continued From page 30 which identified the resident as at risk for impairment to skin integrity related to immobility, incontinence, diabetes, hypothyroidism, dysphagia, weight loss and an albumin level of 3.0. The Care Plan directed staff to complete treatment as ordered, turn or reposition frequently or as resident allows, pressure reduction cushion in wheelchair, and pressure relieving mattress on the bed. Another focus area initiated on 6/14/19 identified Resident #63 as at risk for (Activities of Daily Living (ADL) self-care deficiency related to weakness, falls and cognitive status with decline expected. The Care Plan directed staff to wear a Prevalon boot (to relieve pressure) when heel of foot rested on the bed or chair, and float heels whenever possible. Physician order dated 6/10/19 at 1:02 PM directed staff to ensure the resident wears a Prevalon boot when the heel of the foot rested on the bed or chair, and float heels whenever possible. The resident's record did not contain information related to a pressure wound on the resident's right heel until an entry on 6/10/2019 at 1:06 PM in the Nurse's Notes that documented the order staff received when the resident returned from the wound clinic. An order from a wound clinic appointment dated 6/10/19 directed staff to clean the resident's right heel with normal saline, cover with Xeroform, and then apply Mepilex. Change on Mondays, Wednesdays, and Fridays and as needed (PRN). The order also directed staff to ensure the resident wears Prevalon boots when heel of foot rests on bed or chair, float heels whenever possible, and resident to return to the clinic in 2	F 686		

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F 686	Continued From page 31 weeks. The Wound Assessment Details form from the Wound Care Clinic dated 6/10/19 documented a right lateral calcaneus area as a Stage III Pressure Ulcer measuring 0.5 cm x 1.2 cm x 0.1cm that contained a medium amount of serosanguinous exudate and a small amount of adherent slough present. Record review for Resident #63 revealed the facility did not begin to document weekly skin assessments until 7/4/19. The Skin and Wound Evaluation from the facility dated 7/4/19 revealed a Stage III Pressure Ulcer on the resident's right heel that measured 0.3 cm x 0.5 cm x 0.6 cm with 90 percent epithelial tissue, 10 percent granulation, and no exudate present. The Wound Assessment Details form from the Wound Care Clinic dated 7/8/19 documented a right lateral calcaneus area as a Stage III Pressure Ulcer that measured 0.9 cm x 0.3 cm x 0.1 cm with a large amount of granulation, small amount of serosanguinous exudate, and a small amount of adherent slough present. The Patient Information form for Hospice revealed Resident #63 admitted to a hospice service on 7/22/19. The Skin and Wound Evaluation from the facility dated 7/24/19 revealed a Stage III Pressure Ulcer on the resident's right heel that measured 0.7 cm x 0.9 cm x 0.7 cm with 90 percent epithelial tissue, no granulation tissue, and a scab present. A fax sent by the facility to the physician on	F 686		

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F 686	Continued From page 32 7/31/19 revealed Resident #63 right heel was stable with the surrounding tissue macerated. Staff requested to change the treatment order to skin prep and foam border dressing. A Hospice Routine Visit note dated 8/7/19 revealed hospice ordered a low air loss mattress for the resident. The Skin and Wound Evaluation from the facility dated 8/13/19 revealed a Stage III Pressure Ulcer to Resident #63's right heel that measured 2.4 cm x 1.5 cm x 2.1 cm with 90 percent epithelial tissue, no granulation tissue, and light serosanguinous exudate present A fax sent by the facility to the physician on 8/13/19 revealed Resident #63's right heel pressure injury deteriorated when compared to last week's measurements: 0.6 cm x 1.2 cm vs. 1.5 cm x 2.1 cm. Facility staff requested to change the dressing to Puracol plus and Optifoam. Observation on 08/20/19 at 11:25 AM revealed Resident #63 in a reclining wheelchair in stocking feet which rested on metal foot pedals. Resident unable to sit still in wheelchair, attempted several times to stand up, and then fidgeted in wheelchair. One Prevalon boot found in the resident's room. Observation on 08/21/19 at 12:20 PM revealed Resident #63 sat upright in a wheelchair in the dining room with feet in socks, and rested against the metal wheelchair pedals. Further observation revealed one Prevalon boot lay on the resident's bed in her room.	F 686		

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F 686	Continued From page 33 Observation on 08/22/19 at 09:26 AM revealed Resident #63 in her wheelchair at the dining room table wearing socks and no Prevalon boots, heels resting against the metal wheelchair pedals. Observation attempted/requested on 08/20/19 at 11:21 AM. Staff B, RN reported she had already assessed the wound and changed the dressing on the resident's right heel that morning (ordered every 36 hours). In an interview on 08/20/19 at 11:30 AM with Staff C, Hospice Nurse and she reported the reclining wheelchair the facility provided for Resident #63 in last week is causing her discomfort. Hospice nurse reported she will have staff go back to the standard wheelchair and will order a tilt and space wheelchair for her to help off load (remove pressure) her heels. Staff C stated the resident should have her heel protector on but hospice nurse reports she doesn't like to wear it. Hospice nurse also informed surveyor when Resident #63 first admitted she had a mattress brought in by family so there was a delay in ordering a low air loss mattress. During an interview on 08/21/19 at 1:05 PM, the facility Regional Consultant reported she expected the staff to attempt to put the resident's Prevalon boots on as directed or ordered on the TAR and Care Plan. If a resident refuses or removes them, staff should document that and add it to the Care Plan. In a subsequent interview at 2:59 PM with the facility Regional Consultant and she informed the surveyor that she could not find any skin assessments completed by staff at the time the resident admitted to the facility. In an interview on 08/21/19 at 03:15 PM with Staff	F 686		

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F 686	Continued From page 34 D, she reported they only apply the Prevalon boots at bedtime. In an interview on 08/21/19 at 03:50 PM, the podiatrist that saw Resident #63 at the Wound Care Center verified he ordered the Prevalon boots and expected staff to keep them on the resident's feet at all times except when the resident ambulated. The podiatrist reported he expected staff to also keep her heels floated and added if the boots were not on she would be at risk for further skin breakdown. 2. Review of the quarterly MDS dated 7/19/19 revealed Resident #51 had a BIMS score of 15/15, indicating no cognitive impairment demonstrated. The MDS indicated Resident #51 required extensive assistance of 1 staff for transfers and bed mobility. The MDS listed a diagnosis of spinal stenosis. The MDS documented the resident used a urinary catheter for elimination and had unhealed pressure ulcers: two Stage II and one that could not be staged (unstageable). Review of Resident #51's care plan revised 5/2/19 revealed she was at risk for pressure injury development and/or venous stasis ulcers, and directed staff to administer treatments as ordered and monitor for effectiveness of the treatment(s). Observation on 08/20/19 at 9:10 AM revealed Staff B Registered Nurse (RN) had completed Resident #51's treatment and dressing change while Staff J Unit Manager observed. Staff B removed the top dressing on Resident #51's back and it was dated 8/14/19 and bottom dressing was dated 8/20/19.	F 686		

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	165466	A. BUILDING _____ B. WING _____	08/22/2019

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F 686	Continued From page 35 Observation on 08/20/19 at 9:20 AM revealed Staff O CNA and Staff N CNA provided cares for Resident #51. Resident #51 was rolled on to her left side and it was noted she had a coccyx dressing with a date of 8/14/19. Resident #51 was noted to have a colostomy and urinary catheter. Review of Resident #51's Electronic Health Record (EHR) revealed the following orders: -Foam Dressing: Cleanse coccyx with normal saline/wound cleanser, then apply and cover foam sacral dressing every evening shift every 3 day(s) for skin integrity and as needed (PRN) for skin integrity, with a start date of 7/23/19. -foam border dressing to spinal prominence every 72 hours for wound care with a start date of 4/26/2019. Record review of the August 2019 Treatment Administration Record (TAR) revealed the coccyx dressing was last signed as completed on 8/19/19. The spinal prominence dressing was last signed as completed on 8/18/19. Review of Resident #51's August 2019 TAR and progress notes revealed there was no documentation related to the PRN dressing change and it was scheduled to be changed on 8/22/19. During a staff interview on 08/22/19 at 2:17 PM Staff J Unit Manager stated the dressing should be changed every three days. When asked about the dates on the dressings, she reported she did	F 686		

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F 686	Continued From page 36 not look at the dates on the back and coccyx wound dressing because she did not want to make the staff nervous by standing right by them during the observation. She stated staff should be following the orders and changes the dressing as ordered.	F 686		
F 692 SS=D	Nutrition/Hydration Status Maintenance CFR(s): 483.25(g)(1)-(3) §483.25(g) Assisted nutrition and hydration. (Includes naso-gastric and gastrostomy tubes, both percutaneous endoscopic gastrostomy and percutaneous endoscopic jejunostomy, and enteral fluids). Based on a resident's comprehensive assessment, the facility must ensure that a resident- §483.25(g)(1) Maintains acceptable parameters of nutritional status, such as usual body weight or desirable body weight range and electrolyte balance, unless the resident's clinical condition demonstrates that this is not possible or resident preferences indicate otherwise; §483.25(g)(2) Is offered sufficient fluid intake to maintain proper hydration and health; §483.25(g)(3) Is offered a therapeutic diet when there is a nutritional problem and the health care provider orders a therapeutic diet. This REQUIREMENT is not met as evidenced by: Based on observations, clinical record review and interviews the facility failed to provide the needed assistance for eating to prevent a weight loss for 1 of 1 Residents reviewed (Resident # 68) for weight loss. The facility reported a census of 79 during the survey.	F 692		

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F 692	Continued From page 37 Findings include: The admission Minimum Data Set assessment tool dated 7/31/19 for Resident #68 reported a Brief Interview for Mental Status (BIMS) score of 7/15, which indicated the resident demonstrated severe cognitive impairment. The MDS documented the resident needed limited assist 1 staff for eating assistance, and also documented diagnoses of paroxysmal atrial fibrillation, non-traumatic subarachnoid hemorrhage, dysphagia oropharyngeal phase and cognitive communication deficit. Resident #68's Care Plan updated 8/9/19 included a focus area of self-care deficit related to non-traumatic subarachnoid hemorrhage and atrial fibrillation and documented the resident required limited assist of 1 staff for eating. The Care Plan also included a focus area of nutritional problem related to swallowing difficulty documented the resident ate a regular diet, had weight loss, and required cues at meals with difficulty feeding self. The Care Plan directed staff to follow speech therapy's recommendations, monitor resident's weights, and supplement nutrition per doctor and to monitor meal intakes. The Care Plan further directed staff that Resident 68 required cueing at meals and needed special equipment for self-feeding. The focus area of impaired cognitive function or impaired thought processes related to cognitive communication deficit directed staff to monitor, document and report any changes in cognitive function specifically changes in decision-making ability, memory, and recall and general awareness, difficulty expressing self-difficulty understanding other, level of consciousness or mental status	F 692		

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F 692	Continued From page 38 change. The Resident had the following weights: 7/31/19 at 4:10 PM 207.0 Lbs 8/1/19 at 1:39 PM 203.0 Lbs 8/2/19 at 10:16 AM 203.5 Lbs 8/4/19 at 9:29 AM 204.5 Lbs 8/11/19 at 12:12 PM 192.6 Lbs 8/17/19 at 10:50 AM 193.6 Lbs 8/18/18 at 11:17 AM 196.0 Lbs New Order dated 8/16/19 ordered 2.0 cal supplement three times a day for to increase nutrition. Progress Note dated 8/20/19 at 1:05 PM documented Resident #68 unable to stay awake for lunch meal and unable for teach back due to resident's cognition. Task Documentation for Resident #68 Nutritional Intake for 8/20/19 documented Resident #68 ate 75% of her meal at lunch and 200 ml of fluid intake at lunch. Progress Note dated 8/21/19 at 3:42 PM documented Medication given whole in applesauce, resident tolerated well, no difficulty swallowing noted at this time. An Medication Administration Note dated 8/22/19 at 9:19 AM: 2.0 cal supplement three times a day for supplement not given due to resident sleeping. Observations of Resident #68 at the dining room table revealed the following:	F 692		

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F 692	Continued From page 39 8/20/19 at 12:17 PM staff delivered the resident's tray still covered with the resident in the chair, eyes closed. 8/20/19 at 12:18 PM staff just uncovered Resident's plate, but the resident did not eat. 8/20/19 at 12:21 PM staff rubbed the resident's back, walked away, and resident lowered her head and closed her eyes. 8/20/19 at 12:25 PM Staff H Registered Nurse (RN) stopped by and rubbed the resident's arm in an attempt to awaken the resident who sat with her head lowered. Staff H then walked wayfarer the resident kept her head down. 8/20/19 at 12:30 PM Staff J Unit Manager walked into room; Resident # 68 had moved away from the table. 8/20/19 at 12:31 PM Staff approached her and asked Resident #68 what was wrong? 8/20/19 at 12:33 PM Staff lifted the resident's right foot, placed it on the foot pedal, and moved her to the table. 8/20/19 at 12:35 PM Staff F CNA moved her away from the table and wheeled her to the TV room. 8/20/19 at 12:38 PM Staff F CNA took the resident took the dining area to get help, then to her room to lay down. 8/21/19 at 12:22 PM Resident #68 sat with food in front of her but ate nothing. 8/21/19 at 12:23 PM Staff sat down, but the resident did not wake up. 8/21/19 at 12:26 PM Staff left when Staff H, RN told them to try later. 8/21/19 at 12:34 PM Staff H RN tried to awaken the resident, but she kept sleeping and would not wake up. 8/21/19 at 12:39 PM Staff again approached the	F 692		

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F 692	Continued From page 40 resident in an attempt to awaken her. 8/21/19 at 12:44 PM Staff H RN asked Resident # 68 if she wanted lunch and the resident declined. 8/21/19 at 12:45 PM Staff G entered the dining room and asked Staff H RN how Resident #68 was doing? Staff H RN explained they had tried and the resident #68) did not want to eat, not even the pie. 8/21/19 at 12:53 PM Staff J Nurse Manager tried to awaken Resident # 68. 8/21/19 at 12:4 PM Staff I CMA sat down and attempted to awaken the resident. 8/21/19 at 1:01 PM Staff I CMA got up to leave to talk to Staff H RN 8/21/19 at 1:05 PM Staff J Nurse Manager told Staff H RN to let the kitchen to know to keep a tray back for her. 8/22/19 at 8:27 AM Resident # 68 still in bed, although breakfast began at 8 am. 8/22/19 at 8:52 AM and at 9:23 AM Resident # 68 lay in bed with eyes open. The resident's drinks were in the dining room at her place setting and not touched. During an interview on 8/22/19 at 9:26 AM, Staff H RN explained Resident # 68 had a rough night and wanted to stay in bed. During an interview on 8/22/19 at 1:44 PM , the Director of Nursing (DON) stated staff should not have charted the resident ate 50 to 75 % if she did not. The DON explained she also thought they should have had some one with her to help her and keep her awake to eat. The DON stated maybe the facility should be looking at an additional supplement due to Resident #68's overall weight loss,but added she did have a sight weight increase this week.	F 692		

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F 725 SS=E	Sufficient Nursing Staff CFR(s): 483.35(a)(1)(2) §483.35(a) Sufficient Staff. The facility must have sufficient nursing staff with the appropriate competencies and skills sets to provide nursing and related services to assure resident safety and attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident, as determined by resident assessments and individual plans of care and considering the number, acuity and diagnoses of the facility's resident population in accordance with the facility assessment required at §483.70(e). §483.35(a)(1) The facility must provide services by sufficient numbers of each of the following types of personnel on a 24-hour basis to provide nursing care to all residents in accordance with resident care plans: (i) Except when waived under paragraph (e) of this section, licensed nurses; and (ii) Other nursing personnel, including but not limited to nurse aides. §483.35(a)(2) Except when waived under paragraph (e) of this section, the facility must designate a licensed nurse to serve as a charge nurse on each tour of duty. This REQUIREMENT is not met as evidenced by: Based on observation resident, staff and family interviews the facility failed to have adequate staff to care for resident's needs, as identified through resident assessments and the plan of care. The facility reported a census of 79 residents. Findings include:	F 725		

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F 725	Continued From page 42 During a resident interview on 08/19/19 at 10:48 AM Resident #51 stated she has had have to wait 45 minutes to an hour for call light to be answered. She has a tablet and cell phone with a clock on it that she uses. During a family interview on 08/19/19 at 2:38 PM the family stated they don't think they have enough staff working at the facility because his wife has to clean the resident's room, make her bed, and have noticed she does not get a bath like she is supposed to. They stated her call light has taken up to 30 minutes to answer and mentioned they will see staff just walk by as the call light is on. During a resident interview on 08/20/19 at 11:05 AM Resident #58 stated call lights take up to an hour and she wears a watch and times it that way. She stated she has had no accidents waiting as she usually just needed stuff for her room. During a resident interview on 08/20/19 at 3:45 PM Resident #39 stated her call light had been on for 10 minutes entering her room room at 3:45 PM, she was wearing a watch. The interview ended at 4pm and her call light was still on. During a staff interview on 08/21/19 at 2:37 PM Staff Q Certified Nursing Assistant (CNA) was on the A hall. She was asked if she felt they had enough staff to complete their daily tasks such as bathing, answering call lights, taking residents to meals, activities, etc and she stated she can't answer that. During a staff interview on 08/21/19 at 3:30 PM Staff D CNA some days are iffy when it comes to staffing. She stated 2-6pm they usually have 2	F 725		

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F 725	Continued From page 43 staff then 2 more come in at 6pm to help assist bedtime tasks. During a staff interview on 08/21/19 at 4:01 PM Staff F CNA stated there are times when there is not enough staff, particularly on the AM shift when it is time to get residents up. She stated they try to have 3 staff but usually 2 on hall C and will take the bath aide off of baths so they can help on the floor. During a staff interview on 08/22/19 at 11:26 AM Staff L Housekeeping Aide stated they have been short staff, so if something is observed not clean it is because they are short of housekeepers. During a staff interview on 08/22/19 at 11:56 AM the Director of Environmental Services and Staff K Lead Housekeeper stated the housekeeping department has been short and they just hired 2 new housekeeping staff and knows nursing staff has been short as well. During findings meeting with the facility on 8/22/19 at 3:30 PM the Executive Director stated they are getting a new call light system. The new system will notify the nursing staff, no matter where they are in the facility, when a resident has activated their call light. Their current system does not notify nursing staff unless they are walking the halls or at the nurse's station where the call light board is located. 2. During and observation on 8/20/19 at 11:13 AM overheard Staff E Cirtified Nursing Aide (CNA) and Staff F CNA explained that all they have been doning is answering call lights since state is here.	F 725		
F 758 SS=D	Free from Unnec Psychotropic Meds/PRN Use CFR(s): 483.45(c)(3)(e)(1)-(5)	F 758		

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F 758	Continued From page 44 §483.45(e) Psychotropic Drugs. §483.45(c)(3) A psychotropic drug is any drug that affects brain activities associated with mental processes and behavior. These drugs include, but are not limited to, drugs in the following categories: (i) Anti-psychotic; (ii) Anti-depressant; (iii) Anti-anxiety; and (iv) Hypnotic Based on a comprehensive assessment of a resident, the facility must ensure that--- §483.45(e)(1) Residents who have not used psychotropic drugs are not given these drugs unless the medication is necessary to treat a specific condition as diagnosed and documented in the clinical record; §483.45(e)(2) Residents who use psychotropic drugs receive gradual dose reductions, and behavioral interventions, unless clinically contraindicated, in an effort to discontinue these drugs; §483.45(e)(3) Residents do not receive psychotropic drugs pursuant to a PRN order unless that medication is necessary to treat a diagnosed specific condition that is documented in the clinical record; and §483.45(e)(4) PRN orders for psychotropic drugs are limited to 14 days. Except as provided in §483.45(e)(5), if the attending physician or prescribing practitioner believes that it is appropriate for the PRN order to be extended	F 758		

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F 758	Continued From page 45 beyond 14 days, he or she should document their rationale in the resident's medical record and indicate the duration for the PRN order. §483.45(e)(5) PRN orders for anti-psychotic drugs are limited to 14 days and cannot be renewed unless the attending physician or prescribing practitioner evaluates the resident for the appropriateness of that medication. This REQUIREMENT is not met as evidenced by: Based on clinical record review and interview, the facility failed to assure staff attempted non-pharmacological approaches prior to the administration of a psychotropic medication and failed to document the rationale for PRN (as needed) psychotropic usage beyond 14 days for 2 of 21 residents reviewed (Residents #8 and #63). The facility reported a census of 79 residents. Findings include: 1. The Minimum Data Set (MDS) completed 8/2/19 for Resident #8 listed a diagnosis of non-Alzheimer's dementia and depression. The MDS identified the resident had both long term and short term memory problems. A facsimile (fax) sent to the resident's primary care provider dated 7/30/19 requested a medical diagnosis for the use of Risperdal. The provider responded with a diagnosis of agitation/anxiety on 7/31/19. The resident was on Risperdal 0.50 milligrams (mg.) every morning and 0.25 mg. every night at bedtime. Review of the Physician's Order Review Report for August 2019 documented an order with a start	F 758		

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F 758	Continued From page 46 date of 2/12/19 for a compounded gel to be applied to the resident topically (on the skin). The gel contained Lorazepam 1 mg/ml. (antianxiety med), diphenhydramine 25 mg./ml (antihistamine with sedating effect), and Haloperidol 1 mg/ml. (antipsychotic) every 6 hours PRN (as needed) for agitation/anxiety. Review of the February 2019 Medication Administration Record (MAR) indicated the resident received the PRN compounded gel 6 times without documentation of non-pharmacological alternatives attempted. A March 2019 MAR documented the resident received the gel 4 times without documentation of alternatives tried. An April MAR documented the resident received the gel once without alternatives tried. (Risperdal dosage was increased 4/2/19 to the current dose.) A review of the clinical record also revealed lack of documentation regarding the intended length of time for the compounded gel order, the rationale for continued use beyond 14 days or Physician's Progress Notes to indicate further evaluation for the use of the topical medication. 2. Review of Resident #63's diagnosis list in the electronic health record identified a diagnosis of unspecified dementia without behavioral disturbance. The MDS documented Resident #63 was admitted on 6/5/19. A Physician's Order Summary Report for June 2019 documented an order with a start date of 6/5/19 for Haloperidol Lactate Concentrate 2 milligrams (mg.) per milliliter (ml.) by mouth one time a day every HS (hour of sleep/bedtime) related to unspecified dementia without	F 758		

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F 758	Continued From page 47 behavioral disturbance. A Consultant Pharmacist Report dated 6/17/19 requested an indication for use of the Haloperidol. The physician checked "Dementing illnesses with associated behavioral symptoms" as the reason the med was prescribed. was checked as the indication by . A second area of the report requested indication of appropriate criteria for the medication use, and the criteria selected by the Physician for symptoms as follows: the symptoms are significant enough that the resident is experiencing one or more of the following: inconsolable or persistent distress, significant decline in function and/or substantial difficulty receiving needed care. Review of the resident's Nurse's Progress Notes documented the resident as agitated on 6/5/19 when the resident grabbed a nurse's arm, refused to let go, and threatened to break the arm. An order for Haloperidol 2 mg was received at that time. Then, no further documentation of behavior documented until 8/17/19 when staff administered Haloperidol 0.5 ml. every 6 hours PRN at 10:58 A.M. for agitation and irritation according to the Nurse's Progress Notes for that date. No non-pharmacological interventions were documented as being attempted prior to the administration of the medication either time. Review of the Physician's orders for the Haloperidol PRN dosage documented a start date of 8/2/19 and a discontinuation date of 8/20/19; however, continued review of the resident's health record revealed no information or documented rationale for the usage of the PRN dosage greater than 14 days could be found.	F 758		

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F 758	Continued From page 48 A document labeled Non-Chemical Interventions with a review date of 12/8/11 directed: 1.) Prior to requesting any new psychotropic medication, nursing staff will attempt non-chemical interventions for 72 hours. 9.) After the initial 72 hour observation period, a prescribed PRN psychotropic may be used: a. AFTER non-chemical interventions have been attempted unsuccessfully AND b. the interventions and outcome have been documented. During an interview with the Regional Nurse Consultant, at 9:35 AM on 8/22/19, she stated they were unable to locate rationale for continuance of either resident's (#8, #63) PRN medications or further evaluation by the Primary Care Provider. The Nurse Consultant stated she would expect the alternatives tried prior to the use of any PRN medication to be documented on the Medication Administration Record. She stated it showed up as a code on the Documentation Survey Report when interventions are attempted and documented.	F 758		
F 812 SS=E	Food Procurement,Store/Prepare/Serve-Sanitary CFR(s): 483.60(i)(1)(2) §483.60(i) Food safety requirements. The facility must - §483.60(i)(1) - Procure food from sources approved or considered satisfactory by federal, state or local authorities. (i) This may include food items obtained directly from local producers, subject to applicable State and local laws or regulations.	F 812		

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F 812	Continued From page 49 (ii) This provision does not prohibit or prevent facilities from using produce grown in facility gardens, subject to compliance with applicable safe growing and food-handling practices. (iii) This provision does not preclude residents from consuming foods not procured by the facility. §483.60(i)(2) - Store, prepare, distribute and serve food in accordance with professional standards for food service safety. This REQUIREMENT is not met as evidenced by: Based on observation and staff interview, the facility failed to always ensure food was prepared and served under sanitary conditions. The facility identified a census of 79 current residents. Findings include: During an initial kitchen tour on 8/19/18 at 09:50 AM, observation revealed: a. On Blodgrett oven doors, the glass and handle with brown cooked on grease with dust matted to the grease b. Stainless steel back splash behind six burner stove with brown dried material on approximately 50% of the surface c. The top of the stove contained a build up of carbon that surrounded the burners d. The bottom shelf of the Delfrield Fridge contained dried food and drips of liquid e. The Proformance steamer doors, glass, and handles felt sticky with grease and dust particles and the steamer dripped water onto the bottom shelf of the cart leaving a build up of calcium form the hard water f. The NuWave appliance and Black/Decker toaster on the bottom shelf next to stove felt	F 812		

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F 812	Continued From page 50 greasy to touch with dust matted into the grease. During an interview on 8/19/2019 at 10:10 AM, the Director of Culinary Services acknowledged the items noted above needed to be cleaned. He stated at this time he had no cleaning schedule, but had been in the process of creating daily and nightly cleaning schedules.	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: (i) A system of surveillance designed to identify	F 880		

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F 880	Continued From page 51 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: Based on observation, record review and staff	F 880		

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F 880	Continued From page 52	F 880		

interview the facility failed to provide catheter site cares in accordance with infection control standards of practice for 1 of 1 residents (Resident #51) observed. The facility reported a census of 79 residents.

Findings include:

Review of the quarterly MDS dated 7/19/19 revealed Resident #51 had a BIMS score of 15/15, which meant the resident displayed no problems with cognitive impairment. The MDS documented Resident #51 required extensive assistance of 1 staff for transfers and bed mobility, utilized a urinary catheter for elimination, and had a diagnosis of spinal stenosis.

Review of Resident #51's care plan revised 4/26/19 revealed she had an indwelling urinary catheter due to urinary retention.

At 8/20/19 at 9:20 AM, Staff N Certified Nursing Assistant (CNA) and Staff O CNA had provided perineal care while Staff J Unit Manager observed. Staff O obtained adult wipes from the resident's bedside, with had a catheter bag in package with alcohol wipes on it top of the adult wipe package, and put them on the bed. Staff O then pulled out 3 wipes and placed them on top of the adult wipe package. She used those wipes to cleanse Resident #51's perineal area. Staff N came and assisted by giving Staff O new adult wipes. Staff then rolled the resident to her left side and, with same gloved hands, Staff O continued to provide cares and obtained new wipes from Staff N. Staff O dropped one of the wipes on the bed sheet, placed it in her left hand while she wiped with a new wipe in her right hand. Staff O took the wipe from her left hand and used

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	165466	A. BUILDING _____ B. WING _____	08/22/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
RISEN SON CHRISTIAN VILLAGE	3000 RISEN SON BOULEVARD COUNCIL BLUFFS, IA 51503

(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 53 to cleanse resident's back side. Each time she obtained new adult wipes, Staff O folded them in half on the bed sheet, then used them to cleanse the resident's backside; she did this two times. With same gloved hands, Staff O applied barrier cream on Resident #51's buttock. Staff O removed her gloves, donned a new pair of gloves, and assisted with changing the catheter drainage bag. Staff N placed a barrier between the resident and the bed sheet, cleansed the catheter opening, then placed it on the barrier as urine leaked out. A new drainage bag port was cleansed with alcohol wipe and inserted in to the catheter without cleansing the catheter port since it was laying on the barrier as urine leaked out. During a staff interview on 08/22/19 at 2:12 PM, Staff J stated if there are two staff are in the room during cares, they could help by obtaining the adult wipes for the staff that is performing peri-cares. Staff J stated staff should not have put the clean wipes on top of the wipes package but she stated they are the resident's wipes. Staff J also stated staff should not have used the wipes that touched the bed during cares and that staff should have removed her gloves, performed hand hygiene, put on a new pair of gloves then applied the barrier cream.	F 880		

Risen Son Christian Village Plan of Correction

It is the policy of Risen Son Christian Village to follow all federal, state and local guidelines, laws and statutes. This plan of correction is not to be construed as an admission of deficient practice by the facility manager, employee, agents or other individuals. The response to the alleged insufficient practice cited in this statement does not constitute agreement with the insufficiency. The preparation, submission and implementation of this plan of correction will serve as credible allegation of compliance.

F584 Safe, Clean, Homelike Environment

What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice?

Resident #17's room and rooms B13, B17, B21 bathroom/toilet/room were cleaned.

How will you identify other resident having the potential to be affected by the same deficient practice?

The facility completed reviews of cleaning schedule to identify residents having the potential to be affected by the alleged deficient practice. All residents have the potential to be affected.

What measures have/will be put into place or what systemic changes will you make to ensure that the deficient practice does not recur?

Environmental services received education on cleaning procedures on 09/10/19. Nursing leadership also attending the 09/10/19 cleaning procedures training.

How will you monitor the corrective action(s) to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place?

Using the Room Audit, Housekeeping supervisor or designee will monitor 3-5 rooms on each hall 5 times a week x one month, then 3-5 rooms 3 times a week x one month, then 3-5 rooms 1 time a week x one month. Summary of the audits will be reported to the QAA/QAPI committee monthly x 3 months. The QAA/QAPI committee will make recommendations for further corrective actions or continued auditing as deemed necessary to maintain compliance.

Completion Date: 10/03/2019

F623 Notice Requirements for Transfer and Discharge-Notification of ombudsman

What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice?

The social services director completed notifications of transfers for Residents # 22, 28 and 40 to the Ombudsman office on 09/03/19.

How will you identify other resident having the potential to be affected by the same deficient practice?

The facility completed a review of resident transfers to identify other residents having the potential to be affected by the alleged deficient practice. Any resident transferred to the hospital has potential to be affected.

What measures have/will be put into place or what systemic changes will you make to ensure that the deficient practice does not recur?

The Social Services Director or designee will run a monthly report of discharges and hospital transfers. This report will be submitted to the Ombudsman's' office as required by regulation.

How will you monitor the corrective action(s) to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place?

The Administrator or designee will review the SS discharge/transfer report monthly to ensure Ombudsman notifications are completed as required. SS director will confirm monthly report completion at QAA/QAPI meetings x 3 months. The QAA/QAPI committee will make recommendations for further corrective actions or continued auditing as deemed necessary to maintain compliance.

Completion Date: 10/03/19

F625 Failure to Provide Bed Hold Policy

What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice?

Resident # 28 returned to facility without incident on 07/22/2019 and 09/06/2019.

Resident # 22 returned to the facility without incident on 7/27/19.

Resident # 40 returned to the facility without incident on 6/28/19.

How will you identify other resident having the potential to be affected by the same deficient practice?

The facility completed a review of resident transfers to identify other residents having potential to be affected by the alleged deficient practice. All residents transferring to the hospital could be affected.

What measures have/will be put into place or what systemic changes will you make to ensure that the deficient practice does not recur?

Nurses were educated on the bed hold policy. The policy is available at each nurses' station to be sent with the resident or as soon as practical upon transfer to acute care hospital. If resident's representative is not in the facility at time of transfer, transferring nurse to educate the resident's representative regarding bed-hold policy via phone and complete documentation. SSD or designee will call resident representative the day following transfer to confirm they we notified of bed hold.

How will you monitor the corrective action(s) to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place?

The DON or designees will complete an audit of transfers weekly for 8 weeks to ensure compliance with bed hold notice requirements. Summary of the audits will be reported to the QAA/QAPI committee monthly for review x 2 months. The QAA/QAPI committee will make recommendations for further corrective actions or continued auditing as deemed necessary to maintain compliance.

Completion Date: *10/03/19*

F644 Co-ordination with PASARR

What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice?

The facility reviewed the Level 2 PASRR recommendations, discussed them with R #52, implemented the ones the resident agreed to or wanted, and added them to the care plan.

How will you identify other resident having the potential to be affected by the same deficient practice?

The facility completed reviews of residents with level II PASRRs or newly evident diagnoses of serious mental disorders to identify other residents having the potential to be affected by the alleged deficient practice. Any resident with Level II PASRR has potential to be affected.

What measures have/will be put into place or what systemic changes will you make to ensure that the deficient practice does not recur?

The SSD will review any resident referral with level II PASRRs prior to admission to ensure recommendations can be met. The Social Services Director or designee will ensure that requests for updated PASRRs are completed in a timely manner with newly evident diagnoses of serious mental disorders and level II PASRR recommendations are reviewed by the IDT then incorporated into the residents' plan of care.

How will you monitor the corrective action(s) to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place?

The Nurse Managers or designee will audit residents with PASRR Level II recommendations monthly to ensure level II determinations are incorporated into the residents' care planning as well as transitions of care with corrective actions initiated as indicated. Summary of the audits will be reported to the QAA/QAPI committee monthly for review x 3 month. The QAA/QAPI committee will make recommendations for further corrective actions or continued auditing as deemed necessary to maintain compliance.

Completion Date: 10/03/19

F 657 Care-plan Timing and Revision

What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice?

R # 7 's care plan was updated to reflect the discontinuation of the anticoagulant therapy on 8/22/19.

R# 63 no longer resides in facility.

How will you identify other resident having the potential to be affected by the same deficient practice?

The facility completed a review of anticoagulant therapy orders and resident falls to identify other residents having the potential to be affected by the alleged deficient practice. Any resident on anticoagulant therapy or who has had a fall, has the potential to be affected.

What measures have/will be put into place or what systemic changes will you make to ensure that the deficient practice does not recur?

IDT team, including the Resident Assessment Coordinators (RAC), will be responsible for reviewing orders and post-fall interventions. New orders, when appropriate, and post-fall interventions, will be reflected on the care plan. Education for RACs/Nursing administration was completed related to updating care plans.

How will you monitor the corrective action(s) to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place?

The Resident Assessment Coordinators or designee will conduct random audits of 6 care plans a week for one month, then 3 care plans a week for one month and then one care plan weekly for one month, to ensure that status changes are reflected on the care plan. Concerns identified in the auditing process will be reported to the DON or designee for follow up staff re-education or other corrective actions. Summary of the audits will be reported to the QAA/QAPI committee monthly for review x 3 months. The QAA/QAPI committee will make recommendations for further corrective actions or continued auditing as deemed necessary to maintain compliance.

Completion Date: *10/03/19*

F658 Services Provided to Meet Professional Standards

What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice?

Resident # 56 received Ted hose.

Resident # 17's left foot skin tear status was reviewed by the wound nurse on 08/20/19. Treatment was completed BID on 08/20/19.

How will you identify other resident having the potential to be affected by the same deficient practice?

The facility completed reviews of orders to identify other residents having the potential to be affected by the alleged deficient practice. All residents have the potential to be affected.

What measures have/will be put into place or what systemic changes will you make to ensure that the deficient practice does not recur?

Nursing staff were educated on the documentation for MAR/TARs and ensuring compliance with physician orders. Two nurses will check admission orders to ensure all orders are entered into the electronic record orders and avoid transcription errors.

How will you monitor the corrective action(s) to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place?

Nurse managers will conduct audits of five medication/treatment administration records 3x's a week for one month, 2x's a week for one month and then 1x a week for one month to ensure compliance with physician orders. DON or designee will monitor admission orders to ensure two nurses have reviewed orders. Concerns identified in the auditing process will be reported to the DON or designee for investigation of possible omissions and follow up staff re-education or other corrective actions. Summary of the audits will be reported to the QAA/QAPI committee monthly x 3 months for review and recommendations. The QAA/QAPI committee will make recommendations for further corrective actions or continued auditing as deemed necessary to maintain compliance.

Completion Date: 10/03/19

F677 ADL Care Provided for Dependent Residents

What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice?

Resident # 6, Resident # 19 and Resident # 52 received a shower or bath. The residents' bathing schedules were adjusted according to the residents' desired preferences.

How will you protect other resident having the potential to be affected by the same deficient practice?

Nursing administration reviewed the resident bath/shower schedules to identify other residents having the potential to be affected by the alleged deficient practice. All residents have the potential to be affected.

What measures have/will be put into place or what systemic changes will you make to ensure that the deficient practice does not recur?

Bath schedules have been updated to ensure all rooms/residents are included on the list. Individual baths are assigned as C.N.A. tasks in the electronic medical record. The bath protocol was updated and reviewed with all nursing staff,
As part of that protocol, if the resident refuses a bath/shower, the C.N.A. is required to re-offer at additional times. If the resident continues to refuse, the charge nurse will be notified. The charge nurse will be required to speak to the resident, offer the shower/bath again and then document the refusal. Education was provided to nurses and CNAs on the revised procedures.

How will you monitor the corrective action(s) to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place?

The nurse managers will conduct bath/shower audits 5-7 days a week for one month, then 3-5x's a week for one month, then 1-3 x's a week for one month. Summary of the audits will be reported to the QAA/QAPI committee monthly for review and recommendations. The QAA/QAPI committee will make recommendations for further corrective actions or continued auditing as deemed necessary to maintain compliance.

Completion Date: *10/03/19*

F686 Treatment/Services to Prevent or Heal Pressure Ulcers

What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice?

Resident #26: now and at the time of survey, resident #26 had no pressure ulcers and a BIMS of 15/15.

Resident # 63 is no longer a resident of the facility.

Resident # 51's dressing was changed 08/20/19.

How will you identify other resident having the potential to be affected by the same deficient practice?

The facility completed reviews on all residents with wounds or skin integrity impairments to identify other residents having the potential to be affected by the alleged deficient practice. Any resident with wounds or skin integrity impairments have potential to be affected.

What measures have/will be put into place or what systemic changes will you make to ensure that the deficient practice does not recur?

Licensed nursing staff were re-educated on the timely assessment of pressure injuries and wounds including the proper assessment procedures upon resident admission, process for identification of new skin impairments, and implementation of appropriate treatment measures or preventative measures as ordered. The wound nurse or designee will review any new wounds (present on admission or in-house acquired) and verify that the MD has been contacted and treatment orders have been received. The nursing managers will also monitor implementation of new orders during the clinical meeting.

How will you monitor the corrective action(s) to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place?

The wound nurse or designee will complete an audit for timely wound assessments, physician notifications and timely initiation of treatments orders weekly for 3 months. Concerns identified in the auditing process will be reported to the DON for follow up staff re-education or other corrective actions. Summary of the audits will be reported to the QAA/QAPI committee monthly x 3 for review. The QAA/QAPI committee will make recommendations for further corrective actions or continued auditing as deemed necessary to maintain compliance.

Completion Date: 9/23/2019

F692 Nutrition/Hydration Status Maintained

What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice?

Resident # 68 no longer resides in the facility.

How will you identify other resident having the potential to be affected by the same deficient practice?

The facility conducted weight and intake reviews to identify other residents having the potential to be affected by the alleged deficient practice. Any resident with intake deficits or weight loss has potential to be affected.

What measures have/will be put into place or what systemic changes will you make to ensure that the deficient practice does not recur?

The nursing staff received re-education on appropriate documentation of meal intake and aiding in maximizing oral intake. Nursing managers will monitor dining rooms to ensure residents are provided adequate assistance for eating as needed.

How will you monitor the corrective action(s) to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place?

Nursing supervisors will audit 5 residents' meal intakes 5 x/week for one month, then 3 residents 5 x/week for one month, then 3 residents 3x/week for one month. This audit will validate that the amount the resident consumes corresponds with what was documented by the C.N.A. and the resident is provided appropriate levels of assistance to maximize oral intake. Concerns identified in the auditing process will be reported to the DON for follow up staff re-education or other corrective actions. Summary of the audits will be reported to the QAA/QAPI committee x 3 months for review. The QAA/QAPI committee will make recommendations for further corrective actions or continued auditing as deemed necessary to maintain compliance.

Completion Date: 10/03/2019

F725 Sufficient Nursing Staff

What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice?

Staff assisted Residents # 51, #58 and #39 as requested with no negative outcomes noted.

How will you identify other resident having the potential to be affected by the same deficient practice?

The facility completed staffing reviews to identify if other residents have potential to be affected by the alleged deficient practice. All residents have the potential to be affected.

What measures have/will be put into place or what systemic changes will you make to ensure that the deficient practice does not recur?

The licensed and unlicensed nursing staff received re-education on the need to respond to call lights and the residents' requests or needs in a timely manner and to communicate to a nurse if the required assistance is beyond the scope of the person answering the call light.

How will you monitor the corrective action(s) to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place?

The nurse managers and/or departments heads will conduct call light audits 3 – 5 times per week for one month, then 2 - 4 times per week for one month, then 1-2 times a week for one month to ensure compliance with responding to call lights and addressing resident needs in a timely manner. Concerns identified in the auditing process will be reported to the DON for follow up staff re-education or other corrective actions. Summary of the audits will be reported to the QAA/QAPI committee monthly x 2 for review. The QAA/QAPI committee will make recommendations for further corrective actions or continued auditing as deemed necessary to maintain compliance.

Completion Date: 10/03/2019

F758 Free form Unnecessary Psychotropic Medications

What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice?

R# 8's order for the compound medication was discontinued on 9/19/2019.

R# 63 no longer resides in the facility.

How will you identify other resident having the potential to be affected by the same deficient practice?

The facility completed psychotropic medication order reviews on residents that take psychotropics to identify other residents having the potential to be affected by the alleged deficient practice. Any resident that takes psychotropic medications has potential to be affected.

What measures have/will be put into place or what systemic changes will you make to ensure that the deficient practice does not recur?

Orders for PRN psychotropic medications were reviewed and physicians were contacted to discontinue the PRN medication or provide written rationale to support continuation of the order with indication of duration of the order (stop date). Additional instructions for non-pharmacological interventions will be added to the PRN psychotropic medication orders. Nursing managers will monitor new orders for PRN psychotropic medications at clinical meeting to ensure orders do not exceed 14 days without appropriate documentation by the physician.
Nursing staff were educated on providing non-pharmacological interventions prior to administering a PRN.

How will you monitor the corrective action(s) to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place?

The nurse managers will audit PRN psychotropic medication orders and to documentation of non-pharm interventions with use of prn psychotropic medications. The audits will be completed 3x's a week for one month, then 2x's a week for one month and then 1x a week for one month. Concerns identified in the auditing process will be reported to the DON for follow up staff re-education or other corrective actions. Summary of the audits will be reported to the QAA/QAPI committee monthly x3 for review. The QAA/QAPI committee will make recommendations for further corrective actions or continued auditing as deemed necessary to maintain compliance.

Completion Date: 10/03/2019

F812 Food Procurement Store/Prepare/Serve- Sanitary

What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice?

Over doors, stove top and back splash, steamer, bottom steamer shelf and the front of all units was cleaned before completion of the annual survey. Excess equipment was removed from the kitchen area.

How will you identify other resident having the potential to be affected by the same deficient practice?

The facility completed an inspection of the kitchen to identify whether other residents have the potential to be affected by the alleged deficient practice. All residents have potential to be affected.

What measures have/will be put into place or what systemic changes will you make to ensure that the deficient practice does not recur?

A master cleaning list has been created to address these issues and assigned to the staff. The staff was educated on the cleaning list. The cleanliness of the front of all units and the backsplash has been added to the master check list and will be cleaned as needed.

How will you monitor the corrective action(s) to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place?

Audits of the daily cleaning schedule will be conducted by the dining manager or designee 3-5 times a week to ensure compliance x 3 months. The audit will consist of no less than 5 items pulled randomly from the master cleaning list. Summary of the audits will be reported to the QAA/QAPI committee monthly x 3 for review. The QAA/QAPI committee will make recommendations for further corrective actions or continued auditing as deemed necessary to maintain compliance and recommendations for further corrective actions or continued auditing as deemed necessary to maintain compliance.

Completion Date: 10/03/2019

F880 Infection Prevention and Control

What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice?

Resident # 51 was monitored for complications with no adverse effects identified.

How will you identify other resident having the potential to be affected by the same deficient practice?

The facility completed reviews of incontinent/catheter residents to identify other residents having the potential to be affected by the alleged deficient practice. All residents that are dependent on staff for peri-care/catheter care are potentially affected.

What measures have/will be put into place or what systemic changes will you make to ensure that the deficient practice does not recur?

Nursing staff received re-education on proper peri-care/catheter care techniques including infection control principles. The staff development coordinator or designee(s) will conduct peri care and catheter care competency evaluations with the unlicensed nursing staff to ensure compliance with proper infection control techniques and infection control practices. Peri care and catheter care will be reviewed during general orientation for all new nursing staff.

How will you monitor the corrective action(s) to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place?

Staff development nurse or designee will conduct peri-care/catheter care audits 3x's a week for one month, then 2 x's a week for one month and then 1x a week for one month. Concerns identified in the auditing process will be reported to the DON for follow up staff re-education or other corrective actions. Summary of the audits will be reported to the QAA/QAPI committee monthly x 3 for review. The QAA/QAPI committee will make recommendations for further corrective actions or continued auditing as deemed necessary to maintain compliance.

Completion Date: 10/03/2019