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F 000	INITIAL COMMENTS Correction Date_____ The following deficiencies resulted from the recertification survey and investigation of Complaint #86543-C and Complaint #87095-C completed. Complaint #86543-C was substantiated. Complaint #87095-C was not substantiated. See the Code of Federal Regulations (42CFR) Part 483, Subpart B-C.	F 000		
F 584 SS=D	Safe/Clean/Comfortable/Homelike Environment CFR(s): 483.10(i)(1)-(7) §483.10(i) Safe Environment. The resident has a right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely. The facility must provide- §483.10(i)(1) A safe, clean, comfortable, and homelike environment, allowing the resident to use his or her personal belongings to the extent possible. (i) This includes ensuring that the resident can receive care and services safely and that the physical layout of the facility maximizes resident independence and does not pose a safety risk. (ii) The facility shall exercise reasonable care for 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,	F 584		

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

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and comfortable interior;

§483.10(i)(3) Clean bed and bath linens that are in good condition;

§483.10(i)(4) Private closet space in each resident room, as specified in §483.90 (e)(2)(iv);

§483.10(i)(5) Adequate and comfortable lighting levels in all areas;

§483.10(i)(6) Comfortable and safe temperature levels. Facilities initially certified after October 1, 1990 must maintain a temperature range of 71 to 81°F; and

§483.10(i)(7) For the maintenance of comfortable sound levels.
This REQUIREMENT is not met as evidenced by:
Based on observation, resident and staff interview, the facility failed to provide a clean, comfortable and homelike environment for resident bathrooms and common areas. The facility identified a census of 45 residents at the time of the survey.

Findings include:

1.During an observation on 11/18/19 at 1:51 PM Resident #9's bathroom light above the sink appeared dim. The inside of the bathroom door appeared marred with deep scratches all the way across the door and the lower walls appeared scraped with missing paint. The floor and ceiling looked stained.

2.Observation on 11/20/19 at12:47 PM of the floor at the beginning of the 400 hallway was

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missing an area of flooring approximately 3 inches wide x 3 feet long with the floor patch underneath showing. The alcove in the 500 hallway had 2 areas with partial missing floor tile with adhesive showing . The areas were unsanitizable.

3. On 11/21/19 at 9:32 AM the Maintenance Supervisor identified knowing what needed to be done for Resident #9's room. He did not get to it yet. He explained as he walks through the building, he always gets pulled to fix something.
4. The Minimum Data Set (MDS) assessment dated 8/9/19 for Resident #16 indicated he had a BIMS (Brief Interview for Mental Status) score of 15 indicating no cognitive impairment. The MDS indicated diagnosis including neurogenic bladder, requiring a catheter and diabetes. The MDS indicated the resident was independent with transferring and mobility.

In an observation on 11/19/19 at 1:00 PM, the resident's room had a heavy odor of urine as he laid in bed with his coat on. Trash laid on the floor around his bed. Observation showed scuff marks on the wall behind his bed. The closet door appeared stained with what appeared to be dirty hand marks. The bathroom was shared with another resident and contained a handlebar fastened to the wall in front of the toilet. Above the handlebar was the light switch which had a broken plate with sharp edges. The painted wall behind the handlebar showed heavy staining with dark smears. The paint was worn down to the point of revealing drywall board.

5. The MDS assessment for Resident #249 indicated that the resident had diagnosis including respiratory failure, malignant neoplasm of the

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F 584	Continued From page 3 brain, nutritional deficiency and chronic obstructive pulmonary disease. In an observation on 11/19/19 at 1:37 PM the residents' bed was pulled away from the wall as the Certified Nursing Assistants (CNA) moved between the bed and wall to provide hygiene cares to the resident. Upon moving the bed, it was revealed paint was peeling off the wall and off the heating element. Paint chips were scattered all along the floor below. In an interview on 11/20/19 at 7:40 AM with the Administrator, we went to the room of resident #16. He was shown the dirty floors and the stains on the walls and broken light switch plate. The Administrated stated he expected the switch to be replaced and the wall to be painted. He also said the floor in the bathroom needed deep cleaning. We went into the room of Resident #249 but she was still in bed and we couldn't see the chipped paint without disturbing her at that time. During interview with the maintenance manager on 11/21/19 at 9:20 AM, the surveyor showed him the concerns in the rooms of Resident #16 and Resident #249. He stated that he was unaware of the broken light plate and the chipped paint. He stated the facility utilized a maintenance log where staff are asked to communicate such concerns. The maintenance manager said he checked the log daily.	F 584		
F 585 SS=D	Grievances CFR(s): 483.10(j)(1)-(4) §483.10(j) Grievances. §483.10(j)(1) The resident has the right to voice grievances to the facility or other agency or entity	F 585		

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that hears grievances without discrimination or reprisal and without fear of discrimination or reprisal. Such grievances include those with respect to care and treatment which has been furnished as well as that which has not been furnished, the behavior of staff and of other residents, and other concerns regarding their LTC facility stay.

§483.10(j)(2) The resident has the right to and the facility must make prompt efforts by the facility to resolve grievances the resident may have, in accordance with this paragraph.

§483.10(j)(3) The facility must make information on how to file a grievance or complaint available to the resident.

§483.10(j)(4) The facility must establish a grievance policy to ensure the prompt resolution of all grievances regarding the residents' rights contained in this paragraph. Upon request, the provider must give a copy of the grievance policy to the resident. The grievance policy must include:
(i) Notifying resident individually or through postings in prominent locations throughout the facility of the right to file grievances orally (meaning spoken) or in writing; the right to file grievances anonymously; the contact information of the grievance official with whom a grievance can be filed, that is, his or her name, business address (mailing and email) and business phone number; a reasonable expected time frame for completing the review of the grievance; the right to obtain a written decision regarding his or her grievance; and the contact information of independent entities with whom grievances may

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be filed, that is, the pertinent State agency, Quality Improvement Organization, State Survey Agency and State Long-Term Care Ombudsman program or protection and advocacy system;
(ii) Identifying a Grievance Official who is responsible for overseeing the grievance process, receiving and tracking grievances through to their conclusions; leading any necessary investigations by the facility; maintaining the confidentiality of all information associated with grievances, for example, the identity of the resident for those grievances submitted anonymously, issuing written grievance decisions to the resident; and coordinating with state and federal agencies as necessary in light of specific allegations;
(iii) As necessary, taking immediate action to prevent further potential violations of any resident right while the alleged violation is being investigated;
(iv) Consistent with §483.12(c)(1), immediately reporting all alleged violations involving neglect, abuse, including injuries of unknown source, and/or misappropriation of resident property, by anyone furnishing services on behalf of the provider, to the administrator of the provider; and as required by State law;
(v) Ensuring that all written grievance decisions include the date the grievance was received, a summary statement of the resident's grievance, the steps taken to investigate the grievance, a summary of the pertinent findings or conclusions regarding the resident's concerns(s), a statement as to whether the grievance was confirmed or not confirmed, any corrective action taken or to be taken by the facility as a result of the grievance, and the date the written decision was issued;
(vi) Taking appropriate corrective action in accordance with State law if the alleged violation

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of the residents' rights is confirmed by the facility or if an outside entity having jurisdiction, such as the State Survey Agency, Quality Improvement Organization, or local law enforcement agency confirms a violation for any of these residents' rights within its area of responsibility; and
(vii) Maintaining evidence demonstrating the result of all grievances for a period of no less than 3 years from the issuance of the grievance decision.
This REQUIREMENT is not met as evidenced by:
Based on clinical record review, observations, resident and staff interviews, the facility failed to follow through with the plan outlined in the grievance file for 1 of 1 residents reviewed (Resident #9) that filed a grievance. The facility reported a census of 45 Residents at the time of the survey.

Findings Include;

1. The annual Minimum Data Set (MDS) dated 7/30/19 identified Resident #9 with a Brief Interview for Mental Status (BIMS) score of 15. A score of 15 identified the resident with intact cognition for daily decision making. The MDS included diagnoses of: coronary artery disease, myocardial infarction and macular degeneration. The MDS further identified Resident # 9 as independent with toilet use and personal hygiene.

The QAPI (quality assurance performance improvment) Grievance Form revised 5/2017 identified the form's purpose as the following:
" To document receipt of a grievance/concern or complaint, facility actions and resolution.
" Greivance/concern/complaint is defined as a concern or complaint this is unable to be

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immediately resolved and requires further investigation and action by facility leadership to achieve resolution.

A grievance form filed 6/17/19 by Resident #9 revealed concerns that her room wall and bathroom door frame needed painting and the resident identified a need for a new panel on the bathroom door. The floor and the ceiling were dirty and need cleaned.

The investigation report identified the housekeeping supervisor would fix everything in the room once he finished the room he currently worked on. The facility would move Resident #9 out of her room and fix the room and move the resident back into the room when the room repairs were completed.

Review of the maintenance book listed all the maintenance request logs going back to 3/1/19. The log did not contain the repairs and cleaning that Resident #9 requested on the grievance form.

During an interview on 11/18/19 at 1:45 PM Resident #9 explained the Administrator and the Maintenance Supervisor came in her room a few months ago to find out what she needed done in the bathroom and it still has not been done.

During an interview on 11/19/19 at 2:53 PM the Activities Supervisor explained how the grievances worked. The Activities Supervisor acknowledged Resident #9 filed a grievance about her bathroom. Activities took the grievance to the Administrator and he went down, talked to Resident #9, and let her know what they were going to do in the bathroom. Resident #9 agreed

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F 585	Continued From page 8 to sign the grievance form since it was verbally resolved. The Administrator told her he was going to have maintenance fix the bathroom. Activities explained she went "round and round" with the Administrator about the bathroom not getting fixed. During an interview on 11/21/19 at 9:32 AM with the Maintenance Supervisor, he acknowledged he knew what needed to be done in Residents #9's room. He just did not get to it.	F 585		
F 638 SS=E	Qrtly Assessment at Least Every 3 Months CFR(s): 483.20(c) §483.20(c) Quarterly Review Assessment A facility must assess a resident using the quarterly review instrument specified by the State and approved by CMS not less frequently than once every 3 months. This REQUIREMENT is not met as evidenced by: Based on chart review and interview the facility failed to assess residents using the quarterly review instrument every 3 months for 7 of 16 residents (Resident #5, Resident #6, Resident #1, Resident #9, Resident #250, Resident #40, Resident #14). The facility reported a census of 45 residents. Findings include: 1. The quarterly Minimum Data Set (MDS) for Resident #5 dated 7/13/19 indicated a Brief Interview for Mental Status (BIMS) score of 15 indicating intact cognitive ability. The MDS documented diagnoses included: dysthymic disorder, hypertension, chronic pain, muscle weakness and adult failure to thrive. A care plan	F 638		

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for Resident #5 dated 7/27/19 identified the resident with impaired cognitive function, potential for significant weight change and dehydration related to failure to thrive.

A review of the charts revealed that the MDS for Resident #5 was due for an update on 10/11/19. The assessment was completed and signed on 11/18/19.

2. The MDS dated 10/13/19 for Resident #6 had no BIMS score, indicating severe cognitive impairment. The MDS documented diagnoses that included: fracture of right clavicle, dementia, muscle weakness and difficulty walking. The resident required extensive assistance of 2 staff for bed mobility, transfers, dressing and toileting. The care plan for Resident #6, last updated on 4/22/19, indicated a self-care performance deficit, limited range of motion and impaired visual functioning.

A review of the chart for Resident #6 revealed that the MDS was due on 10/13/19. It was completed and signed on 11/10/19.

3. The MDS for Resident #1 dated 7/11/19 identified the resident with diagnoses that included: hyperlipidemia, schizophrenia, insomnia, muscle weakness, and dementia with behavioral disturbance. A care plan last updated on 11/19/19, identified the resident with behaviors related to diagnoses of schizophrenia and dementia.

A review of Resident #1's chart revealed that the MDS was due on 10/11/19. It was completed and signed on 11/19/19.

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F 638	Continued From page 10 4. The clinical record for Resident #9 revealed the quarterly MDS with a reference date of 10/18/19 contained a completion date of 11/15/19 14 days after the 14 day look back period. 5. The quarterly Minimum Data Set dated 11/2/19 for Resident #40 was not signed as completed until 11/20/19. On 11/20/19 at 8:45 AM the Director of Nursing and Nurse Consultant reported that they are aware that Care Plans and Minimum Data Set Assessments may be late or not done due to they haven't had a nurse for that position.	F 638		
F 641 SS=D	Accuracy of Assessments CFR(s): 483.20(g) §483.20(g) Accuracy of Assessments. The assessment must accurately reflect the resident's status. This REQUIREMENT is not met as evidenced by: Based on record review and staff interviews the facility failed to complete the resident assessment for 2 of 20 residents (Resident #41 and Resident #250) reviewed. The facility reported a census of 45 residents. Findings include: 1. The Census List for Resident #41 documented an admission date of 10/11/19. Review of the admission Minimum Data Set assessment dated 10/17/19 revealed the MDS not completed and "still in progress". On 11/20/19 at 08:45 AM the Director of Nursing	F 641		

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F 641	Continued From page 11 and Nurse Consultant reported they had knowledge of late or uncompleted Care Plans and Minimum Data Set Assessments. They haven't had a nurse for that position. 2. The clinical record for Resident #250 identified the 5 day MDS due 10/12/19 and completed on 10/29/19. During an 11/20/19 at 3:38 PM the Director of Nursing (DON) acknowledged she did the 5 day MDS and finished it late and the Care Plan did not get done.	F 641		
F 656 SS=D	Develop/Implement Comprehensive Care Plan CFR(s): 483.21(b)(1) §483.21(b) Comprehensive Care Plans §483.21(b)(1) The facility must develop and implement a comprehensive person-centered care plan for each resident, consistent with the resident rights set forth at §483.10(c)(2) and §483.10(c)(3), that includes measurable objectives and timeframes to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment. The comprehensive care plan must describe the following - (i) The services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §483.24, §483.25 or §483.40; and (ii) Any services that would otherwise be required under §483.24, §483.25 or §483.40 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(c)(6). (iii) Any specialized services or specialized rehabilitative services the nursing facility will	F 656		

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provide as a result of PASARR recommendations. If a facility disagrees with the findings of the PASARR, it must indicate its rationale in the resident's medical record.
(iv)In consultation with the resident and the resident's representative(s)-
(A) The resident's goals for admission and desired outcomes.
(B) The resident's preference and potential for future discharge. Facilities must document whether the resident's desire to return to the community was assessed and any referrals to local contact agencies and/or other appropriate entities, for this purpose.
(C) Discharge plans in the comprehensive care plan, as appropriate, in accordance with the requirements set forth in paragraph (c) of this section.
This REQUIREMENT is not met as evidenced by:
Based on record review, resident and staff interviews the facility failed to develop and implement a comprehensive person centered care plan for 3 of 20 residents (Resident #41, Resident #39, Resident #250) reviewed. The facility reported a census of 45 residents.

Findings include:

1. The Admission Record face sheet for Resident #41 documented the resident admitted to the facility on 10/11/19.

On 11/19/19 at 08:37 AM Resident #41 informed the surveyor that no one talked to her about her care plan and she didn't know what it was.

Review of Resident #41's care plan dated 10/16/19 revealed staff did not complete the care

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plan. Review of the resident's record failed to identify the facility completed a baseline care plan. The record lacked evidence the facility discussed the care plan with the resident.

On 11/20/19 at 08:45 AM the Director of Nursing and Nurse Consultant reported knowledge of Care Plans and Minimum Data Set Assessments late or not completed. The facility did not have a nurse for the MDS/care plan position.

2. The Smoking Data Collection Tool dated 9/27/2019 for Resident #39 documented the resident as independent with smoking without any safety devices and that the facility reviewed the smoking policy with the resident and/or resident representative and they verbalized understanding.

The Director of Nursing reported Resident #39 as a smoker during the entrance conference on 11/18/19.

The Care Plan dated 7/3/19 for Resident #39 did not address smoking or any smoking interventions.

3. According to the clinical record Resident #250 entered the facility 10/1/19 transported back to the hospital that same day and readmitted to the facility on 10/9/19. The clinical record revealed she had skin issues and required foot soaks daily.

Resident #250's Care Plan only addressed nutritional status and lacked any direction for her required cares.

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F 656	Continued From page 14 The Treatment Administration Record for Resident #250 revealed Foot Soak daily. During an 11/20/19 at 3:38 PM the Director of Nursing (DON) acknowledged she did the 5 day MDS and finished it late and the Care Plan did not get done. 4) A review of the clinical chart revealed that Resident # 248 was admitted to the facility on 10/22/19. She was admitted for physical therapy, occupational therapy and speech therapy services after surgery for diverticulum. As of 11/21/19 the resident did not have a care plan in the electronic record.	F 656		
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	F 657		

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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 assessments.
This REQUIREMENT is not met as evidenced by:
Based on clinical record review, observations, resident and staff interviews, the facility failed to update the Care Plan for 3 of 20 Residents reviewed (Resident #11, Resident #19 and Resident #40). The facility reported a census of 45 residents.

Findings Include;

1.The annual Minimum Data Set (MDS) dated 8/20/19 for Resident #11 reported her Brief Interview for Mental Status score 14 out 15 indicating intact cognition. The MDS included diagnoses of: atrial fibrillation, renal insufficiency, diabetes mellitus and arthritis. The MDS further reported Resident #11 at risk for pressure injuries. The resident had application of ointment or medication to areas other than feet.

Resident #11's Care Plan updated 8/312/19 lacked a focus area of skin issues or any intervention to address the open skin area on the left lower leg

The clinical record lacked documentation of Resident #11's input in the development and discussion of her care plan.

Observation on 11/20/19 at 10:27 AM showed Staff C License Practical Nurse (LPN) entered Resident #11's room with dressing change

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supplies after Resident #11's shower. Staff C placed triple antibiotic ointment on an approximate 6 centimeter round open area to Resident #11's left leg above the ankle.

During an interview on 11/18/19 at 1:55 PM Resident # 11 acknowledged she living at the facility since July. She explained a few days after her arrival they had a conference call about her care. Resident #11 further acknowledged they did not discuss her care since. Resident # 11 reported she her left leg contained a blister and staff changed the dressing daily.

On 11/20/19 at 4:13 PM the Director of Nursing (DON) acknowledged Resident #11's care plan did not contain a focus area for skin issues and it needed to be added. During a subsequent interview, the DON explained they did have a Care Plan Coordinator since 7/15/19 and the facility did not conduct care plan meetings with residents.

3. The Census List for Resident #40 documented she transferred to the hospital on 10/2/19 and readmitted to the facility on 10/15/19.

The Progress Note dated 10/2/19 documented Resident #40 admitted to the hospital for a urinary tract infection.

The Order Review Report dated 10/24/19 documented new orders for skilled care, urinalysis order and catheter change, physical therapy and new wound vac orders.

The care plan last revised 7/12/19 addressed the catheter and potential for urinary tract infection but lacked updates or revisions of the new orders after the hospitalization 10/2/19 to 10/15/19.

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F 657	Continued From page 17 On 11/20/19 at 08:45 AM DON and Nurse Consultant reported knowledge of care plans and MDSs late or not done due to they no nurse for that position. 4. The MDS dated 5/25/19 for Resident #19 indicated a Brief Interview for Mental Status (BIMS) score of 5, indicating severe cognitive deficit. The MDS documented diagnosis of dementia, heart failure, muscle wasting and diabetes mellitus The MDS documented that the resident required assistance of one staff for bed mobility, dressing, eating and personal hygiene, and extensive assistance for transferring to the toilet. The MDS dated 8/14/19 identified a declined in the resident's functional status. The resident required total dependence for transfers, toileting and personal hygiene. A review of the clinical record identified the last care plan meeting offered to the resident and her family as on 6/13/19, noting that the resident was in activities and "did not want to attend". The care plan did not have updates regarding the decline in activities of daily living.	F 657		
F 661 SS=D	Discharge Summary CFR(s): 483.21(c)(2)(i)-(iv) §483.21(c)(2) Discharge Summary When the facility anticipates discharge, a resident must have a discharge summary that includes, but is not limited to, the following: (i) A recapitulation of the resident's stay that includes, but is not limited to, diagnoses, course of illness/treatment or therapy, and pertinent lab, radiology, and consultation results.	F 661		

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(ii) A final summary of the resident's status to include items in paragraph (b)(1) of §483.20, at the time of the discharge that is available for release to authorized persons and agencies, with the consent of the resident or resident's representative.
(iii) Reconciliation of all pre-discharge medications with the resident's post-discharge medications (both prescribed and over-the-counter).
(iv) A post-discharge plan of care that is developed with the participation of the resident and, with the resident's consent, the resident representative(s), which will assist the resident to adjust to his or her new living environment. The post-discharge plan of care must indicate where the individual plans to reside, any arrangements that have been made for the resident's follow up care and any post-discharge medical and non-medical services.
This REQUIREMENT is not met as evidenced by:
Based on interview and chart review the facility failed to provide a discharge summary and recapitulation of stay upon discharge for 1 of 1 residents (Resident #195). The facility reported a census of 45 residents.

Findings include:

A clinical chart review revealed Resident #195 admitted to the facility on 9/22/18 and discharged to another facility on 9/27/19. According to the admission orders, the resident had a diagnosis that included: hypertension, muscle weakness, atrial fibrillation, chronic pain, kidney failure and chronic obstructive pulmonary disease.

A review of the clinical chart for Resident #195

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F 661	Continued From page 19 revealed the chart lacked documentation of a recapitulation of the stay to provide continuing care information, or documentation of disposition of the resident's medications upon discharge. In an interview with the Director of Nursing (DON) on 11/21/19 at 10:30 AM she acknowledged that the discharge summary, a recapitulation of the stay, and documentation of dispensing of the medications were all missing.	F 661		
F 688 SS=G	Increase/Prevent Decrease in ROM/Mobility CFR(s): 483.25(c)(1)-(3) §483.25(c) Mobility. §483.25(c)(1) The facility must ensure that a resident who enters the facility without limited range of motion does not experience reduction in range of motion unless the resident's clinical condition demonstrates that a reduction in range of motion is unavoidable; and §483.25(c)(2) A resident with limited range of motion receives appropriate treatment and services to increase range of motion and/or to prevent further decrease in range of motion. §483.25(c)(3) A resident with limited mobility receives appropriate services, equipment, and assistance to maintain or improve mobility with the maximum practicable independence unless a reduction in mobility is demonstrably unavoidable. This REQUIREMENT is not met as evidenced by: Based on observation, record review and interviews the facility failed to assure planned restorative programs for 1 of 16 residents (Resident #19). The facility reported a census of 45 residents.	F 688		

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Findings included:

The Minimum Data Set (MDS) dated 5/25/19 for Resident #19 indicated a Brief Interview for Mental Status (BIMS) score of 5, indicating severe cognitive deficit. The MDS documented the resident required limited assistance of one staff for bed mobility, dressing, and personal hygiene, and extensive assistance of two staff transfers and toilet. The resident walked with one staff in room once or twice .

The MDS dated 8/14/19 indicated the residents' functional status declined and the resident now required total dependence with transfers, toileting and personal hygiene. The resident did not ambulate in room.

A physical therapy (PT) evaluation dated 2/22/19 to 3/24/19 identified the resident with good rehab potential. The functional mobility assessment area of the evaluation identified the resident could ambulate 25 feet on level surfaces with minimum assistance and a two wheeled walker. The resident required maximum assistance with transfers, bed mobility and sit to stand. At the conclusion of therapy on 3/22/19, PT recommended a restorative nursing program (RNP). The RNP program directed staff to ensure the resident performed Nu Step 3 to 4 times a week for 10 to 15 minutes, Stand frame, seated therapy exercise with 3 pound ankle weights and sit to stands 5 reps.

The care plan updated on 6/1/18 identified the resident with potential for pain and directed staff to monitor changes in self-care deficit and report changes to the medical director. The care plan

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also indicated communication difficulties and impaired cognitive functioning.

The clinical record contained no documentation of RNP services provided to the resident.

Another referral had been made to PT and OT services which was approved from 7/25/19 through 8/23/19.
OT initial assessment from 7/25/19 identified the resident with weakness and decline in ADLs (activities of daily living) from last evaluation completed 4/19. At the conclusion of OT therapy on 8/23/19, OT did not recommend an RNP program.
During interview on 11/20/19 at 9:57 AM, LPN staff D stated that the facility hasn't had restorative services for a couple years. She stated she understood it was one of the deficiencies from last year's survey but there were no changes made.

Observation:

During an observation on 11/18/19 at 11:28 AM in the dining room, the resident sat in her wheel chair in a slouched position with her head hanging close to her lap. On 11/18/19 at 12:11 PM she was at the lunch table attempting to drink from a cup but had difficulty due to her slouched position with her chin at the level of the table.

On 11/19/19 at 10:30 AM observation showed the resident sleeping in her wheel chair with her head in her chest, almost in her lap.

Director of Nursing (DON) Interview:

On 11/21/19 at 7:50 AM the DON stated that

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F 688	Continued From page 22 there had not been a restorative program at the facility for over 4 years. When asked what happens when there is a recommendation from PT for a resident after they've been discharged, she said the referral comes to her but because the corporation doesn't support a restorative program so they are unable to follow through. She stated she had a couple of Certified Nursing Assistants (CNA's) trained to do restorative and they would like to but are forced to work on the floor. The DON stated she recently referred the resident back to PT and is looking into getting her a better wheel chair so she can reach the table better. She understands that there has been a decline in the residents Activities of Daily Living (ADL) due to the gaps in services.	F 688		
F 689 SS=D	Free of Accident Hazards/Supervision/Devices CFR(s): 483.25(d)(1)(2) §483.25(d) Accidents. The facility must ensure that - §483.25(d)(1) The resident environment remains as free of accident hazards as is possible; and §483.25(d)(2)Each resident receives adequate supervision and assistance devices to prevent accidents. This REQUIREMENT is not met as evidenced by: Based on observations, record review and interviews the facility failed to ensure the environment is free from hazards for 3 of 3 residents (Resident #41, Resident #13 and Resident #39) reviewed. The facility reported a census of 45 residents. Findings include:	F 689		

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F 689	Continued From page 23	F 689		

1. The Director of Nursing (DON) reported Resident #41 as "a smoker" during the entrance conference on 11/18/19.

The Smoking Data Collection Tool dated 10/17/19 documented Resident #41 required a smokers apron and the facility reviewed the smoking policy with the resident and/or resident representative and they verbalized understanding.

On 11/18/19 at 02:31 PM a surveyor observed Resident #41 outside smoking in the gazebo and not wearing a smokers apron.

The Care Plan for Resident #41 dated 10/16/19 did not address smoking or any smoking interventions.

On 11/20/19 at 08:43 AM the DON reported that she expected Resident #41 to wear an apron if she is assessed to wear one.

2. The DON identified Resident #13 as "a smoker" during the entrance conference on 11/18/19.

The Smoking Data Collection Tool dated 10/7/19 documented Resident #13 as independent with smoking without any safety devices and that the facility reviewed the smoking policy the resident and/or resident representative and they verbalized understanding.

The Care Plan for Resident #13 last revised 6/7/19 documented resident is able to smoke independently in a designated smoking area.

On 11/19/19 at 4:11 PM observed Resident #13

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smoking right outside the main front entrance of the building within 5 feet of the front door.

3. The Director of Nursing reported Resident #39 as "a smoker" during the entrance conference on 11/18/19.

The Smoking Data Collection Tool dated 9/27/2019 documented Resident #39 as independent with smoking without any safety devices and that the facility reviewed the smoking policy with the resident and/or resident representative and they verbalized understanding.

The Care Plan dated 7/3/19 for Resident #39 did not address smoking or any smoking interventions.

On 11/19/19 at 4:11 PM observation showed Resident #39 smoking right outside the main front entrance of the building within 5 feet of the front door.

The facility individual smoking policy documented the designated smoking area as the gazebo located outside the employee entrance.

The Smoking Policy from the Administrative Manual documented smoking is prohibited outside the designated smoking area and that smoking may not occur within 50 feet of an exit or entrance to the facility.

On 11/20/19 at 08:43 AM the DON reported the designated smoking area is the gazebo and the residents were instructed not to smoke by the front door.

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F 803	Continued From page 25	F 803		
F 803 SS=E	Menus Meet Resident Nds/Prep in Adv/Followed CFR(s): 483.60(c)(1)-(7) §483.60(c) Menus and nutritional adequacy. Menus must- §483.60(c)(1) Meet the nutritional needs of residents in accordance with established national guidelines.; §483.60(c)(2) Be prepared in advance; §483.60(c)(3) Be followed; §483.60(c)(4) Reflect, based on a facility's reasonable efforts, the religious, cultural and ethnic needs of the resident population, as well as input received from residents and resident groups; §483.60(c)(5) Be updated periodically; §483.60(c)(6) Be reviewed by the facility's dietitian or other clinically qualified nutrition professional for nutritional adequacy; and §483.60(c)(7) Nothing in this paragraph should be construed to limit the resident's right to make personal dietary choices. This REQUIREMENT is not met as evidenced by: Based on observations, staff interviews and resident interviews the facility failed to follow the menu to meet the nutritional requirements of the residents. The facility reported a census of 45 residents. Findings include:	F 803		

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F 803	Continued From page 26 Observation of meal service on 11/19/19 at 11:53 AM by Staff A revealed the meal served as ham, carrots, hash brown casserole, brownie with hamburger patty as the alternate. Observation showed no bread and butter served to any of the residents. The Weekly Menu approved by the Registered Dietician for the week of 11/18/19 documented bread and margarine would be served with the noon meal. During the confidential interview at resident council on 11/19/19 at 01:40 PM two residents reported they asked for a peanut butter and jelly sandwich last night for supper and were told no because they didn't have enough bread. Five of the residents present reported they were told the facility has one loaf of bread to use per day. Interview with the Certified Dietary Manager on 11/20/19 at 01:00 PM and she reported that if bread and butter was on the menu yesterday then it should have been served.	F 803		
F 812 SS=E	Food Procurement,Store/Prepare/Serve-Sanitary CFR(s): 483.60(i)(1)(2) §483.60(i) Food safety requirements. The facility must - §483.60(i)(1) - Procure food from sources approved or considered satisfactory by federal, state or local authorities. (i) This may include food items obtained directly from local producers, subject to applicable State and local laws or regulations. (ii) This provision does not prohibit or prevent	F 812		

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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 interviews the facility did not store dishes under sanitary conditions and did not prepare food under sanitary conditions. The facility reported a census of 45 residents.

Findings include:

Initial walk thru of the kitchen on 11/18/19 at 10:15 AM with the Administrator and Kitchen Supervisor present revealed food crumbs in several clean steam table pans. The kitchen supervisor stated she hadn't noticed that before and would clean that out by the end of the day.

On 11/19/19 at 11:21 AM observation showed Staff B did not wear a heait net when she came in to the kitchen to get the food for the attached assisted living building. She was in the walk in cooler and in the kitchen where food is stored and prepared.

On 11/19/19 at 11:40 AM observation showed the ceiling exhaust fan and vent directly above the food prep area covered with a thick layer of dust. The fan was running.

On 11/19/19 at 02:27 PM the certified Dietary

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	165256	A. BUILDING _____ B. WING _____	11/21/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ELMWOOD CARE CENTRE	222 NORTH 15TH STREET ONAWA, IA 51040

(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 812	Continued From page 28 Manage reported she expected everyone that entered the kitchen to wear a hair net. On 11/19/19 at 02:30 PM the Administrator identified the Maintenance Supervisor as responsible for the cleaning schedule of the kitchen exhaust fans and he would get the cleaning schedule from him. On 11/20/19 at 08:40 AM the Administrator requested the copy of the cleaning schedule of the ceiling exhaust fan and he reported that there is not one. On 11/21/19 at 11:30 AM the Administrator informed the surveyor that the Maintenance Supervisor cleaned the exhaust fan and presented a copy of the Work History Report.	F 812		