

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 02/05/2020
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 165253	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 01/23/2020
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NAME OF PROVIDER OR SUPPLIER PANORA SPECIALTY CARE	STREET ADDRESS, CITY, STATE, ZIP CODE 805 EAST MAIN PANORA, IA 50216
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(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)	(X6) COMPLETION DATE
F 000	INITIAL COMMENTS Correction date <u>2/14/2020</u> <u>F689-2/5/2020</u> The following deficiencies relate to the facility's recertification survey and investigation of Complaint #87907-C ending on 1/23/2020. (See Code of Federal Regulations (42CFR) Part 483, Subpart B-C)	F 000		
F 578 SS=D	Request/Refuse/Discontinue Trmt; Formile Adv Dir CFR(s): 483.10(c)(6)(8)(g)(12)(i)-(v) §483.10(c)(6) The right to request, refuse, and/or discontinue treatment, to participate in or refuse to participate in experimental research, and to formulate an advance directive. §483.10(c)(8) Nothing in this paragraph should be construed as the right of the resident to receive the provision of medical treatment or medical services deemed medically unnecessary or inappropriate. §483.10(g)(12) The facility must comply with the requirements specified in 42 CFR part 489, subpart I (Advance Directives). (i) These requirements include provisions to inform and provide written information to all adult residents concerning the right to accept or refuse medical or surgical treatment and, at the resident's option, formulate an advance directive. (ii) This includes a written description of the facility's policies to implement advance directives and applicable State law. (iii) Facilities are permitted to contract with other entities to furnish this information but are still legally responsible for ensuring that the	F 578		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

[Signature]

Administrator

DATE
2/10/2020
02/05/2020

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 578	Continued From page 1 requirements of this section are met. (iv) If an adult individual is incapacitated at the time of admission and is unable to receive information or articulate whether or not he or she has executed an advance directive, the facility may give advance directive information to the individual's resident representative in accordance with State Law. (v) The facility is not relieved of its obligation to provide this information to the individual once he or she is able to receive such information. Follow-up procedures must be in place to provide the information to the individual directly at the appropriate time. This REQUIREMENT is not met as evidenced by: Based on clinical record review and staff interview, the facility failed to accurately document resident health decisions regarding advanced directives (to be resuscitated or not) and failed to document an accurate code status for 3 of 16 residents reviewed (Resident #89, #189 and #28). The facility reported a census of 38 residents. Findings include: 1. The Minimum Data Set (MDS) assessment dated 1/20/2020 for Resident #89 indicated the resident admitted to the facility on 1/14/2020 to recover from a fracture of the left femur. The MDS revealed diagnoses that included: heart disease and peripheral artery disease. The MDS documented the resident required extensive assistance with the help of two staff for bed mobility, transfers and the help of one for dressing. A review of the resident's care plan, initiated on	F 578			

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F 578	Continued From page 2 1/14/2020, revealed Resident #89 required the use of the EZ stand lift with the assistance of two staff for transfers. The care plan included directed staff to follow the resident's wishes regarding advanced directives but lacked details regarding the status of his wishes should he stop breathing/heart stops. The paper chart lacked the Iowa Physician Orders for Scope of Treatment (IPOST) for Cardiopulmonary Resuscitation (CPR)/ Do not Resuscitate (DNR) order form that indicates the residents wishes if breathing stops or heart stops beating. On 1/22/2020 at 7:01 AM when asked where she would find directives regarding the residents resuscitation wishes, Staff C LPN stated that she would first go to the electronic chart to find code status if the resident became unresponsive. She pulled up the face page for Resident #89, not seeing a documented status on the face page she then went to the miscellaneous tab for a scanned copy of the document. Not finding it there, she went on to the care plan and scrolled down to find documentation that directed staff to follow resident wishes. At 7:04 she went to the nurse's station to look in the binder chart. Resident #89 did not have a binder chart so she looked in the file cabinet and found a manila folder with his name on it, but there was no documentation of his wishes regarding the use of CPR. On 1/22/2020 at 7:05 AM Staff A stated she was not the nurse for Resident #89 that day and she expected the nurse caring for the resident to know of his or her status. When asked if she would assist if a resident went unresponsive she	F 578			

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F 578	Continued From page 3 indicated that she would be involved and then stated that she would go to the hard chart to find code status. When she could not find a chart for resident #89 she looked in the file cabinet and acknowledged that the residents wishes were not in the manila folder. When asked what she would do if they could not find the resident's wishes, she said that she would begin CPR. On 1/22/2020 at 7:13 AM the Minimum Data Set (MDS) coordinating nurse was asked about code status for resident #89. When she could not find a chart or a copy of the residents wishes she searched in the business office where she found a request for this resident to begin CPR if he were to become unresponsive. On 1/22/2020 at 7:30 AM the Administrator and Director of Nursing were alerted to the fact that resident code status was not readily accessible to the front line staff. 2. Review of the electronic health records (EHR) and filed papers at the nurses' station for Resident #189 with an admission date of 12/19/19 revealed no documentation of the resident's decision regarding code status (to have CPR performed or not). 3. Review of the EHR and filed papers at the nurses' station for Resident #28 with an admission date of 7/1/19 revealed no documentation of the resident's decision regarding code status (to have CPR performed or not). On 1/21/20 at 03:15pm, Staff E, LPN, verified no documentation for Resident #189 and Resident #28 of their decisions regarding code status in the EHR or any paperwork filed in a cabinet by the	F 578			

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F 578	Continued From page 4 desk. Staff E states the staff should know each resident's code status but is unsure where to look if the resident has no hard chart, which Resident #189 and Resident #28 do not, and if the code status requests are not in the scanned documents. On 1/21/20 at 3:25pm, the Administrator reported finding Resident #189's signed code status request in the business office but not being able to locate Resident #28's. The administrator reported being instructed not to scan advanced directives until residents have been discharged and states that the code status should be in front of the hard chart. 01/22/20 at 8:36am, the MDS Coordinator reported locating Resident # 28's request for Full Code Status, dated 7/1/19 in the front office. She stated the resident did not appear to have a hard chart. On 1/22/20 at 3:31pm, the Administrator reports the facility does not have a policy/procedure on where to put CPR requests or physician signed Do Not Resuscitate (DNR) orders. She stated she always keeps a copy in the business office in case they became lost at the stations.	F 578			
F 580 SS=D	Notify of Changes (Injury/Decline/Room, etc.) CFR(s): 483.10(g)(14)(i)-(iv)(15) §483.10(g)(14) Notification of Changes. (i) A facility must immediately inform the resident; consult with the resident's physician; and notify, consistent with his or her authority, the resident representative(s) when there is- (A) An accident involving the resident which results in injury and has the potential for requiring physician intervention; (B) A significant change in the resident's physical,	F 580			

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F 580	Continued From page 5 mental, or psychosocial status (that is, a deterioration in health, mental, or psychosocial status in either life-threatening conditions or clinical complications); (C) A need to alter treatment significantly (that is, a need to discontinue an existing form of treatment due to adverse consequences, or to commence a new form of treatment); or (D) A decision to transfer or discharge the resident from the facility as specified in §483.15(c)(1)(ii). (ii) When making notification under paragraph (g) (14)(i) of this section, the facility must ensure that all pertinent information specified in §483.15(c)(2) is available and provided upon request to the physician. (iii) The facility must also promptly notify the resident and the resident representative, if any, when there is- (A) A change in room or roommate assignment as specified in §483.10(e)(6); or (B) A change in resident rights under Federal or State law or regulations as specified in paragraph (e)(10) of this section. (iv) The facility must record and periodically update the address (mailing and email) and phone number of the resident representative(s). §483.10(g)(15) Admission to a composite distinct part. A facility that is a composite distinct part (as defined in §483.5) must disclose in its admission agreement its physical configuration, including the various locations that comprise the composite distinct part, and must specify the policies that apply to room changes between its different locations under §483.15(c)(9).	F 580			

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F 580	Continued From page 6 This REQUIREMENT is not met as evidenced by: Based on policy review, record review, and staff interviews, the facility failed to notify family and physician of the potential for injury immediately following an incident with a resident's foot and an EZ stand transfer, resulting in diagnoses of fibula, tibia, and fifth metatarsal fractures 8 days later for 1 of 3 residents reviewed for falls (Resident #26). The incident occurred on 11/28/19 and the facility did not notify physician or responsible party until 12/6/19 (8 days later). The facility reported a census of 38 residents. Findings include: The Minimum Data Set (MDS) assessment dated 12/5/19 revealed Resident #26 with diagnoses that included: urinary tract infection, dementia, psychotic disorder, delirium, hypertension, Gastro-esophageal reflux disease without esophagitis, and osteoarthritis. A Brief Interview for Mental Status (BIMS) test identified the resident with a score of "9" indicating moderately impaired cognition. The MDS identified the resident transferred with extensive assist of 2 and did not walk. A care plan focus date 3/5/19 and revised on 12/11/19, identified the resident with a problem of risk for injury related to weakness and immobility. The care plan revealed the resident did not walk and transferred with the EZ stand and assistance of 2. The care plan contained an intervention dated 12/6/19 (after discovery of fracture) that directed staff to ensure the resident's feet stay on the platform during the entire transfer when using the EZ stand.	F 580			

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F 580	Continued From page 7 The Admission Agreement for the facility with revision dates of 3/1/13, 2/15/17, and 6/4/18 stated the facility would notify the resident's legal representative or family member whenever an incident out of the ordinary occurred. The Admission Record for Resident #26 listed the resident's son as emergency contact #1 and responsible party and the daughter as emergency contact #2. On 12/17/19, Staff F, LPN, (licensed practical nurse) typed a late entry progress note with an effective date of 11/28/19 at 12:31pm which revealed Staff F assessed Resident #26 following a CNA (certified nurse aide) report that the resident stepped off the EZ Stand lift foot plate and then reported discomfort to the foot. Staff F, LPN, documented the resident's feet appeared without discoloration, had 1+ edema to both lower extremities, and following a massage, the resident denied pain. The record contained no other documentation of any assessment of the feet in the nursing progress notes until 12/6/19. On 1/21/20 at 4:25pm, Staff F, LPN, verified that a CNA, uncertain of which CNA, notified him on 11/28/19 of the resident stepping off the footplate of the EZ Lift with the right foot. Staff F reported he went directly to the resident's room to assess her and found the resident seated in her recliner with feet elevated on the foot rest. Staff F said he assessed range of motion (ROM) to the right foot as well as signs of visible injury and noted no problems with ROM and no abrasions or bruising. Staff F stated the edema observed would not be unusual for the resident. The resident reported pain which subsided with massage to the right foot. The resident also received a scheduled pain	F 580			

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F 580	Continued From page 8 medication around this time. Resident #26 informed Staff F her foot caught under the lift during the transfer. Staff F stated he did not feel the resident sustained injury so he did not complete an incident report or notify the resident's responsible party. He also did not document anything in the progress notes. On 1/23/20 at 8:27am during a phone interview, Staff F reported the daughter of Resident #26 visited on 11/28/19. He did not recall informing the daughter of the incident. He stated he verbally informed the oncoming nurse in report of the resident's incident with the lift. On 1/22/20 at 11:00 AM, Staff D, CNA, reported she operated the EZ lift on 11/28/19 when the resident's foot came off of the platform. An agency CNA assisted but did not witness the resident's foot come off the lift. As Staff D pushed the resident in the lift to the resident's recliner, the resident yelled. Staff D stopped and noticed the resident's right foot came off the back of the footrest platform. She observed the top of foot wedged against the back of the platform and bottom of the foot against the recliner with the toes pointed towards the floor. Staff D reported noting no signs of injury, specifically no marks or bruising on the foot. Staff D placed the resident's foot back on the platform and completed the transfer. The resident bore weight without difficulty or report of pain. She positioned the resident in the recliner and then immediately notified Staff F, LPN, of the incident. Staff D reported she did not have the leg/calf straps in place to secure the resident's feet/legs while on the lift. On 1/23/20 at 8:17am, Staff D reported the resident's daughter visited an hour or an hour and a half after the resident stepped off the EZ Stand and came to Staff D to clarify what	F 580			

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F 580	Continued From page 9 occurred because the resident informed the daughter she fell. Staff D stated she informed the daughter no fall occurred and then informed her that the resident's foot came off the lift. On 1/22/20 at 6:20 pm, Staff G, LPN, reported working the 6pm to 6am shift from 11/28/19 to 11/29/19 and received report from Staff F, LPN, hours after the EZ Stand incident occurred on Staff F's shift. Staff G stated she could not recall that Staff F informed her the resident stepped off the lift earlier in the day. Staff G felt if he received the information in report that he would have assessed the foot/leg if he had known about the resident stepping off the lift. On 1/22/20 at 9:15am, Staff C, LPN, who worked the 6am to 6pm shift on 11/29/19, the day following the lift incident, stated she received nothing through report about the lift incident and nothing was documented about the lift incident until weeks later. On 1/22/20 at 5:50pm, Staff C stated she would have assessed the resident's foot on 11/29/19 if she had known of the resident's foot coming off the lift. The Director of Nursing (DON) and the Administrator stated on 1/23/20 at 8:10 am, they did not have knowledge of the resident stepping off of the lift from 11/28/19 until 12/6/19. Progress notes revealed Staff C, LPN, documented on 12/6/19, in the progress notes that Resident #26's right ankle contained an 11 centimeter (cm) by 7cm bruise along the anterior aspect of the ankle that appeared to have been there for a few days. The resident voiced increased pain in the right foot and not able to bear weight on the ankle. The facility notified the	F 580			

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F 580	Continued From page 10 PCP who ordered an x-ray of the right foot and ankle. The findings of the x-rays, dated 12/6/19, included: non-displaced fractures of the distal fibula, tibia, and the fifth metatarsal. The on-call physician, updated 12/6/19 on the x-ray results, ordered an ace wrap and non-weight bearing status to the right lower extremity and set up an appointment with the orthopedic doctor. Staff C also updated the resident's son. On 1/22/20 at 9:15am, Staff C, LPN, stated she assessed the resident on 12/6/19 following CNAs reporting that the resident complained of pain and did not bear weight. She reported the bruise looked as if it was there a few days but no staff reported any bruising prior to 12/6/19. Staff C completed an incident report and notified the DON after she received the x-ray reports. She also notified the resident's son. Staff C stated when she updated the son, he said he visited earlier in the day and the resident did not make mention of pain or foot concerns. Record review showed that Staff C, LPN, completed an incident report on 12/6/19 with nothing documented as to cause of the fractures. The major injury determination form, completed on 12/7/19 listed the fractures to the distal fibula, tibia, and fifth metatarsal as the injuries with circumstances of the incident causing the injury as: transfer with EZ Stand. The Administrator wrote in unknown for the date and time of the injury. On 1/22/20 at 4:50pm, the Administrator stated she began the investigation on 12/6/19 as to the cause of the fractures. The electronic health record contained no documentation for the	F 580			

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F 580	Continued From page 11 resident as to any incident which may have caused the injuries. She discovered the resident stepped off of the platform of the lift but did not know the definite day/time when she completed the form. She stated she wrote the EZ lift as the cause of the injury because the resident stepping off the lift was the only possible cause she could find; the resident did not move much on her own to cause a fracture. Clinical record review revealed Resident #26 with an appointment with the orthopedic physician on 12/11/19. The dictated physician report revealed the resident's daughter accompanied the resident to the appointment. The physician documented moderate swelling and bruising consistent with the injuries. The physician chose conservative treatment and placed the resident in a low tide boot walker since the resident did not walk. On 1/23/20 at 10:40am, the orthopedic physician reported vaguely remembering Resident #26 coming into his office. He was at a different clinic without access to the resident's records. He stated that generally speaking, if an injury occurred causing the fractures that the resident has, he would expect pain initially but bruising can be delayed. It is conceivable that scheduled pain medication and the resident being non-ambulatory could delay pain.	F 580			
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	F 656			

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CENTERS FOR MEDICARE & MEDICAID SERVICES

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 165253	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 01/23/2020
NAME OF PROVIDER OR SUPPLIER PANORA SPECIALTY CARE			STREET ADDRESS, CITY, STATE, ZIP CODE 805 EAST MAIN PANORA, IA 50216		
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F 656	Continued From page 12 §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 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 clinical record review, observations and interviews the facility failed to develop or	F 656			

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CENTERS FOR MEDICARE & MEDICAID SERVICES

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F 656	Continued From page 13 implement care plan interventions for 2 of 17 residents reviewed (Resident #29 and Resident #31). The facility reported a census of 38 residents. Findings include: 1. The Minimum Data Set (MDS) dated 12/5/19 for Resident #29 indicated she admitted to the facility on 6/19/15. The MDS documented the resident with a Brief Interview Mental Status (BIMS) score of 11 out of 15, moderate cognitive impairment. The MDS revealed the resident with diagnosis that included: heart disease, schizophrenia, schizoaffective disorder, Down Syndrome, Type 2 Diabetes mellitus and Alzheimer's disease and the resident used supplemental oxygen. Observation showed on 1/22/2020 at 4:30 PM Resident #29 in a chair in the sitting area by the nurse's station with oxygen per nasal cannula at 2 liters. The care plan for Resident #29, last updated on 12/18/19, indicated she had difficulty chewing and swallowing and required staff assistance for all activities of daily living. The care plan lacked any information or interventions related to oxygen use. The electronic record for the resident showed a physician's order, initiated on 7/16/18, for supplemental oxygen in order to keep the oxygen saturation greater than 90%. The chart lacked information on the number of liters to be administered. On 1/23/20 at 9:30 AM, the Director of Nursing	F 656			

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

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F 656	Continued From page 14 (DON) acknowledged the care plan did not address and she agreed the care plan should contain the oxygen care area treatment plan for the resident. She also acknowledged the physician order in the electronic chart lacked specific instructions on how many liters to use and she would follow up to find specific doctor orders. 2. Review of the facility provided list of residents that smoke revealed Resident #31 smokes. The facility's Smoking Policy for Residents dated 11/27/18 revealed the care plan would contain any smoking related privileges, restrictions, and concerns. The care plan for Resident #31 mentioned smoking once, under the focus area of skin breakdown, directing staff to light the resident's cigarettes. On 1/22/20 at 4:00pm, the DON identified herself as the primary person for creating and updating care plans at this time. The DON reported the three residents who smoke all received the same care regarding their smoking and so she felt the staff knew how to care for those residents and the care plan was sufficient. On 1/23/20 at 11:40am, the Administrator stated she expected Resident #31 to have a more extensive care plan regarding smoking, especially considering the resident sometimes falls asleep in the middle of a sentence and has made unsafe choices.	F 656			
F 677 SS=D	ADL Care Provided for Dependent Residents CFR(s): 483.24(a)(2) §483.24(a)(2) A resident who is unable to carry out activities of daily living receives the necessary services to maintain good nutrition, grooming, and	F 677			

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

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F 677	Continued From page 15 personal and oral hygiene; This REQUIREMENT is not met as evidenced by: Based on observation, clinical record review and interview, the facility failed to ensure that a resident who was unable to carry out activities of daily living received the necessary services to maintain good nutrition, grooming, and personal hygiene for 1 of 17 residents reviewed. Resident #2 did not receive lunch until the surveyor intervened. Staff did not implement a positioning device or toilet the resident. The facility reported a census of 38 residents. Findings include: The Minimum Data Set (MDS) dated 1/2/2020 for Resident #2 identified him with diagnoses that included: cerebral palsy, epilepsy, communication deficit, muscle wasting, and abnormalities of gait and mobility. The MDS documented an admission date of 4/3/19 and identified the resident with a Brief Interview for Mental Status score of 14, no cognitive impairment. The MDS documented the resident required extensive assistance of one staff for bed mobility, toileting and dressing, and extensive assistance of two staff for transferring The care plan for Resident #2, last updated on 12/6/19, identified the resident with a swallowing problem related to cerebral palsy and at risk for pressure ulcers to his left ear due to the positioning of his neck as his head often rested on his left shoulder. The care plan revealed he developed a pressure area to his ear in the past and: "I need to use a neck pillow to keep pressure off of my left ear as I tilt my head to the side and rest it on chairs or my shoulder".	F 677			

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CENTERS FOR MEDICARE & MEDICAID SERVICES

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F 677	Continued From page 16 In a continuous observation on 1/21/2020 from 11:15 AM to 11:45 AM, the resident sat at the table in the dining room waiting for lunch. The resident's head rested on his left shoulder while he appeared to sleep. On 1/22/2020 at 10:00 AM the resident sat by the nurses station in a recliner with his head resting on his left shoulder. At 11:30 AM and 11:40 AM he was in the same position. At 11:50 AM the resident still slept with his head resting on his shoulder and foot rest raised on the recliner to elevate his legs. At 12:00 PM the dietary manager identified the Resident #2 as asleep and that staff would save his lunch tray to give to him after he awoke. Observations showed on 1/22/2020 at 12:45 PM, 1:00 PM, 1:30 PM, 2:11 PM, and 2:55 PM the resident in the same position. At 3:25 PM on 1/22/2020 the resident was awake, and the left shoulder area of his shirt appeared wet with saliva. The surveyor approached Staff A RN (registered nurse) at that time and asked if she was the nurse for the resident that day. She indicated that she was. The surveyor asked her if the resident ate lunch or if staff offered toileting. She stated she thought yes and we approached the resident together. Staff A asked the resident if he ate lunch, after some time he recalled he did not eat lunch and indicated that he felt hungry. The surveyor asked Staff A to lift the residents head so we could see his ear. The ear was slightly red but observation revealed no open sores.	F 677			

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

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F 677	Continued From page 17	F 677			
F 689 SS=G	On 1/22/2020 at 3:51 PM the Director of Nursing (DON) identified it as not unusual for the resident to sleep for long periods of time during the day. She stated she thought that a couple of staff offered him lunch but he refused. When asked about support for his neck, the DON stated that he has a neck pillow that the resident used in the past but she did not know where that pillow was or staff did not use it to position the resident's head/neck. 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 observation, policy review, record review, and staff interviews, the facility failed to use shin straps on an EZ Stand lift during a transfer, resulting in the resident's right foot coming off the foot plate and being wedged between the foot plate and recliner chair, causing fractures of the distal fibula, tibia, and fifth metatarsal in 1 of 3 residents reviewed for falls (Resident #26). The facility reported a census of 38 residents. Findings include: The Minimum Data Set (MDS) assessment dated	F 689			

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F 689	Continued From page 18 12/5/19 revealed Resident #26 with diagnoses that included: urinary tract infection, dementia, psychotic disorder, delirium, hypertension, Gastro-esophageal reflux disease without esophagitis, and osteoarthritis. A Brief Interview for Mental Status (BIMS), test identified the resident with a score of "9" indicating moderately impaired cognition. The MDS identified the resident transferred with extensive assist of 2 and did not walk. A care plan focus dated 3/5/19 and revised on 12/11/19, identified the resident with a problem of risk for injury related to weakness and immobility. The care plan revealed the resident did not walk and transferred with the EZ stand and assistance of 2. The care plan contained an intervention dated 12/6/19 (after discovery of fracture) that directed staff to ensure the resident's feet stay on the platform during the entire transfer when using the EZ stand. The EZ Way Smart Stand operator's instructions dated 7/30/18 directed the operator to apply shin straps prior to a transfer if deemed necessary. The facility did not have an EZ Stand policy. On 12/17/19, Staff F, LPN, (licensed practical nurse) typed a late entry progress note with an effective date of 11/28/19 at 12:31 pm which revealed Staff F assessed Resident #26 following a CNA (certified nurse aide) report that the resident stepped off the EZ Stand lift foot plate and then reported discomfort to the foot. Staff F, LPN, documented the resident's feet appeared without discoloration, had 1+ edema to both lower extremities, and following a massage, the resident denied pain. The record contained no other documentation of any assessment of the	F 689			

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F 689	Continued From page 19 feet in the nursing progress notes until 12/6/19. On 1/21/20 at 4:25 pm, Staff F, LPN, verified that a CNA, uncertain of which CNA, notified him on 11/28/19 of the resident stepping off the footplate of the EZ Lift with the right foot. Staff F reported he went directly to the resident's room to assess her and found the resident seated in her recliner with feet elevated on the foot rest. Staff F said he assessed range of motion (ROM) to the right foot as well as signs of visible injury and noted no problems with ROM and no abrasions or bruising. Staff F stated the edema observed would not be unusual for the resident. The resident reported pain which subsided with massage to the right foot. The resident also received a scheduled pain medication around this time. Resident #26 informed Staff F her foot caught under the lift during the transfer. Staff F stated he did not feel the resident sustained injury so he did not complete an incident report nor notify the resident's responsible party. He also did not document anything in the progress notes. On 1/23/20 at 8:27 am during a phone interview, Staff F reported the daughter of Resident #26 visited on 11/28/19. He did not recall informing the daughter of the incident. He stated he verbally informed the oncoming nurse in report of the resident's incident with the lift. On 1/22/20 at 11:00 AM, Staff D, CNA, reported she operated the EZ lift on 11/28/19 when the resident's foot came off of the platform. An agency CNA assisted but did not witness the resident's foot come off the lift. As Staff D pushed the resident in the lift to the resident's recliner, the resident yelled. Staff D stopped and noticed the resident's right foot came off the back of the footrest platform. She observed the top of foot	F 689			

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CENTERS FOR MEDICARE & MEDICAID SERVICES

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F 689	Continued From page 20 wedged against the back of the platform and bottom of the foot against the recliner with the toes pointed towards the floor. Staff D reported noting no signs of injury, specifically no marks or bruising on the foot. Staff D placed the resident's foot back on the platform and completed the transfer. The resident bore weight without difficulty or report of pain. She positioned the resident in the recliner and then immediately notified Staff F, LPN, of the incident. Staff D reported she did not have the leg/calf straps in place to secure the resident's feet/legs while on the lift. On 1/23/20 at 8:17 am, Staff D reported the resident's daughter visited an hour or an hour and a half after the resident stepped off the EZ Stand and came to Staff D to clarify what occurred because the resident informed the daughter she fell. Staff D stated she informed the daughter no fall occurred and then informed her of the incident. A verbal employee coaching document for Staff D, Certified Nursing Assistant (CNA), completed by the Director of Nursing (DON) and dated 12/6/19 recorded that that the expectation is that the leg strap is to be used with all EZ Stand transfers. The coaching document also indicated that Staff F, Licensed Practical Nurse (LPN), addressed the expectation of the leg strap being used with Staff D on 11/28/19. In addition, a Five Minute Meeting for Employees sheet dated 12/18/19 stated that the leg strap is to be used with all EZ Stand transfers. On 1/23/19 at 8:10 am the DON and administrator stated the DON completed the Five Minute Meeting and the verbal employee coaching documents because the expectation is, and had been at the time of the incident, for staff	F 689			

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F 689	Continued From page 21 to secure the leg straps on the EZ Stand. On 1/22/20 at 6:20 pm, Staff G, LPN, reported working the 6 pm to 6 am shift from 11/28/19 to 11/29/19 and received report from Staff F, LPN, hours after the EZ Stand incident occurred on Staff F's shift. Staff G stated she could not recall that Staff F informed her the resident stepped off the lift earlier in the day. Staff G felt if he received the information in report that he would have assessed the foot/leg if he had known about the resident stepping off the lift. On 1/22/20 at 9:15 am, Staff C, LPN, who worked the 6 am to 6 pm shift on 11/29/19, the day following the lift incident, stated she received nothing through report about the lift incident and nothing was documented about the lift incident until weeks later. On 1/22/20 at 5:50 pm, Staff C stated she would have assessed the resident's foot on 11/29/19 if she had known of the resident's foot coming off the lift. The Director of Nursing (DON) and the Administrator stated on 1/23/20 at 8:10 am, they did not have knowledge of the resident stepping off of the lift from 11/28/19 until 12/6/19. Clinical record review revealed no right foot/leg assessments documented following the late entry note on 11/28/19 through 12/5/19. Staff F, LPN, documented the late entry on 12/17/19. The Treatment Administration Record (TAR) contained pain assessments from 11/28/19 through 12/5/19. Staff documented the resident without pain. The MDS pain interview, completed on 12/3/19 on a pain evaluation form and signed on the MDS on 12/4/19, revealed that the resident answered	F 689			

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F 689	Continued From page 22 that over the preceding 5 days she had occasional pain, rated a 4 on a 0-10 scale at its worst, and that the pain did not affect sleep or day-to-day activities. The pain evaluation form did not indicate where on the body the resident felt pain. Resident #26 received showers on 11/30/19 and 12/4/19, and the skin assessments completed by CNAs with the showers noted no skin concerns, such as discoloration. Review of the Medication Administration Record (MAR) for November and December 2019, showed that the resident received ultracet (narcotic) 37.5-235 mg four times a day, with an order start date of 7/10/18. The MAR also revealed that the resident did not receive any as needed (prn) Tylenol 11/28/19-12/6/19. Following the fracture diagnosis the resident received Tylenol on 12/13/19 and twice on 12/31/19. The MAR did not identify anything else for pain. On 1/23/20 at 8:10 am, the DON reported doing rounds with the resident's PCP (primary care physician) on 12/4/19. The physician moved the resident's feet around, while assessing edema, without the resident verbalizing any discomfort. The DON reported she was not aware of the incident on 12/4/9 so she did not notify the physician of the resident stepping off the lift. A nursing home visit progress note signed by the physician on 12/4/19 identified the resident's extremities as weak with no standing or walking. The physician did not change any orders after the visit. Progress notes revealed Staff C, LPN,	F 689			

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F 689	Continued From page 23 documented on 12/6/19, in the progress notes that Resident #26's right ankle contained an 11 centimeter (cm) by 7 cm bruise along the anterior aspect of the ankle that appeared to have been there for a few days. The resident voiced increased pain in the right foot and not able to bear weight on the ankle. The facility notified the PCP who ordered an x-ray of the right foot and ankle. The findings of the x-rays, dated 12/6/19, included: non-displaced fractures of the distal fibula, tibia, and the fifth metatarsal. The on-call physician, updated 12/6/19 on the x-ray results, ordered an ace wrap and non-weight bearing status to the right lower extremity and set up an appointment with the orthopedic doctor. Staff C also updated the resident's son. The 12/6/19 x-ray report revealed a history of bruising, pain and unable to bear weight. The findings included: 2 views of the right ankle demonstrated vertically oriented fracture through the medial malleolus. There was also a transverse fracture of the distal fibula. Considerable tissue swelling noted. 2 views of the right foot demonstrated soft tissue swelling over the dorsum of the foot on lateral view. The previously described tibia and fibular fractures were not well visualized. however there appeared to be an acute transverse fracture at the base of the fifth metatarsal. Old second and third metatarsal fractures noted. Following the x-ray, the physician ordered an ace wrap for support and nonweight bearing to the lower right extremity. An appointment was arranged with an orthopedic physician. On 12/11/19 the orthopedic physician saw the resident for the right foot and ankle injury. the physician documented the resident injured the	F 689			

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CENTERS FOR MEDICARE & MEDICAID SERVICES

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(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 689	Continued From page 24 right foot and ankle a few weeks ago. The nursing home staff attempted to transfer the resident from wheelchair to recliner and somehow the resident fell and got the foot and ankle drawn up underneath her and when she landed, it further complicated things. The resident thought the nurse fell on the ankle. Due to increasing pain and swelling of the ankle over the ensuing few days, a mobile x-ray was performed which showed a bimalleolar fracture of the ankle as well as a proximal fifth metatarsal fracture. The physician stated he would treat the fractures conservatively and continued the ace wrap and also initiated a boot. The resident could bear weight for transfers. Staff should use ice and elevate the right foot and ankle as needed. The resident should return in 6 weeks. On 1/22/20 at 9:15 am, Staff C, LPN, stated she assessed the resident on 12/6/19 following CNAs reporting that the resident complained of pain and did not bear weight. She reported the bruise looked as if it was there a few days but no staff reported any bruising prior to 12/6/19. Staff C completed an incident report and notified the DON after she received the x-ray reports. She also notified the resident's son. Staff C stated when she updated the son, he said he visited earlier in the day and the resident did not make mention of pain or foot concerns. On 1/22/20 at 11:00 am, Staff D, CNA, reported the resident had a slight bruise to her right foot on 12/5/19 but she did not notify anyone. Staff D reported the resident voiced no complaints of foot or leg pain to her from the initial 11/28/19 incident with the lift through 12/5/19. On 1/22/20 at 12:00 pm the DON reported the	F 689			

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CENTERS FOR MEDICARE & MEDICAID SERVICES

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F 689	Continued From page 25 physician completed the major injury determination form as not a major injury (the resident should return to prior functional status) so the facility did not self-report it. Record review showed that Staff C, LPN, completed an incident report on 12/6/19 with nothing documented as to cause of the fractures. The major injury determination form, completed on 12/7/19 listed the fractures to the distal fibula, tibia, and fifth metatarsal as the injuries with circumstances of the incident causing the injury as: transfer with EZ Stand. The Administrator wrote in unknown for the date and time of the injury. On 1/22/20 at 4:50 pm, the Administrator stated she began the investigation on 12/6/19 as to the cause of the fractures. The electronic health record contained no documentation for the resident as to any incident which may have caused the injuries. She discovered the resident stepped off of the platform of the lift but did not know the definite day/time when she completed the form. She stated she wrote the EZ lift as the cause of the injury because the resident stepping off the lift was the only possible cause she could find; the resident did not move much on her own to cause a fracture. Clinical record review revealed Resident #26 with an appointment with the orthopedic physician on 12/11/19. The dictated physician report revealed the resident's daughter accompanied the resident to the appointment. The physician documented moderate swelling and bruising consistent with the injuries. The physician chose conservative treatment and placed the resident in a low tide	F 689			

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F 689	Continued From page 26 boot walker since the resident did not walk. On 1/23/20 at 10:40 am, the orthopedic physician reported vaguely remembering Resident #26 coming into his office. He was at a different clinic without access to the resident's records. He stated that generally speaking, if an injury occurred causing the fractures that the resident has, he would expect pain initially but bruising can be delayed. It is conceivable that scheduled pain medication and the resident being non-ambulatory could delay pain. Observation: On 1/21/20 at 1:32 p.m. the resident stated her "right leg broke". She stated a lady tried to get her from one the chair to another and the lady slipped and landed on the resident's leg. The resident denied falling. On the same date at 1:35 p.m. observation showed 2 staff use the stand lift to stand the resident for incontinence cares. The resident hung onto the lift with her upper extremities and did not bear full weight on the lower extremities. Staff used the shin/leg strap and all other straps required for the transfer.	F 689			
F 730 SS=D	Nurse Aide Peform Review-12 hr/yr In-Service CFR(s): 483.35(d)(7) §483.35(d)(7) Regular in-service education. The facility must complete a performance review of every nurse aide at least once every 12 months, and must provide regular in-service education based on the outcome of these reviews. In-service training must comply with the requirements of §483.95(g). This REQUIREMENT is not met as evidenced by:	F 730			

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F 730	Continued From page 27 Based on personnel file reviews and staff interview, the facility failed to assure all certified nursing assistants (CNA's) completed the required 12 hours of annual education. The facility reported a census of 38 residents. Findings include: In a review of three CNA employee files it was revealed that Staff D was hired on 10/11/2018 and the chart lacked documentation of the required 12 hours of education over the last fiscal year. In an interview with the Director of Nursing on 1/23/20 at 9:30 AM she acknowledged that Staff D did not have the required number of education hours completed and that the facility has a plan to ensure better monitoring of education hours through the Relias on-line training site. She stated that they also plan to offer more monthly face to face education opportunities. On 1/22/20 at 5:38PM the facility administrator provided a copy of the In-Service Education policy dated June 2019. The document indicated that in-service training must be sufficient to ensure the continuing competence of nurse aides and must be no less than 12 hours per year.	F 730			

Panora Specialty Care

805 E. Main Street

Panora, IA 50216

Survey dates: 1/21/2020-1/23/2020

Correction date: 2/14/2020

Panora POC:

F 578

Preparation and/or execution of this plan of correction does not constitute admission or agreement by this provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because it is required by the provisions of federal and/or state law.

This is my credible allegation of compliance to F 578. This allegation does not constitute guilt but that the facility is in compliance to F 578.

Residents #89, #189 and #2 all have appropriate documentation of their Advanced Directives available for staff reference

All resident have appropriate documentation of their Advanced Directives available for staff reference.

Facility reviewed all resident's Advanced Directives on 1/22/2020 to ensure residents had a current signed Advanced Directives sheet to ensure staff know residents current wishes for CPR choices. Facility will scan Advanced Directives into PCC upon obtaining them for staff referral. Copies of Advanced Directives sheet will also be placed in residents files per facility policy. Facility will develop a DNR list for nurses stations which will be reviewed at QA meetings to ensure are kept current at all times. Lists will be kept at nurses stations for quick references.

The facility's QA process will monitor that Advanced Directives are scanned into PCC as sheets are signed. QA team will audit following admission to ensure Advanced Directives were scanned in. QA process will also ensure Advanced Directives are placed in resident files per facility files and that DNR list is reviewed and kept up to date daily as new and or changed Advanced Directives are obtained. Problems will be corrected as they are observed.

F 580

Preparation and/or execution of this plan of correction does not constitute admission or agreement by this provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because it is required by the provisions of federal and/or state law.

This is my credible allegation of compliance to F 580. This allegation does not constitute guilt but that the facility is in compliance to F 580.

Resident #26 continues to have family and Dr. notified of changes in condition and or changes in treatment/medication changes.

All residents continue to have family and Dr. notified of changes in condition and or changes in treatment/medication changes.

Staff was educated on the importance of notifying resident's appropriate family members of any changes in condition, treatment/med changes on 2/14/2020. Staff will document this notification on any Incident Reports and also in Nurse's Notes per facility protocols. Nurse management will review Incident Reports daily for appropriate Dr/family notification for noted changes in condition, with problems being corrected at that time. Nurse Management will continue to review Hot Charts for changes in condition as well as for Dr/family notification for noted changes in condition, with problems being corrected at that time.

Facility's QA process will monitor that Dr/family notification takes place on all Incident Reports and Nurses notes for changes in condition as part of daily QA. Problems will be corrected as they are observed with more staff education as needed.

F 656

Preparation and/or execution of this plan of correction does not constitute admission or agreement by this provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because it is required by the provisions of federal and/or state law.

This is my credible allegation of compliance to F 656. This allegation does not constitute guilt but that the facility is in compliance to F 656.

Resident #29 and Resident #31 Care Plans reveal the fact that they are smokers and contain appropriate smoking interventions

All residents who choose to smoke Care Plans reveal the fact that they are smokers and contain appropriate smoking interventions.

All resident who smoke had their Care Plans reviewed on 1/23/2020 to ensure that their care plans reflected their choice to smoke and that appropriate interventions were also reflected on their care plans. Facility will review Care Plans per the RAI process (Quarterly) and with any changes in condition to

ensure Care Plans are up to date and reflects the resident's choices and needs to allow staff to better care for the residents. Problems will be corrected as they are observed.

Facility's QA process will ensure Care Plans are up to date as part of daily QA and reflect resident choices and needs to better care for the residents. Problems will be corrected as they are observed.

F 677

Preparation and/or execution of this plan of correction does not constitute admission or agreement by this provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because it is required by the provisions of federal and/or state law.

This is my credible allegation of compliance to F 677. This allegation does not constitute guilt but that the facility is in compliance to F 677.

Resident #2 is receiving all ADL support needed to ensure that his needs are being met on a routine basis.

All residents are receiving all ADL support needed to ensure that their needs are being met on a routine basis.

Staff was educated on 2/14/2020 on the importance of providing ADL support to residents per their Care Plans and needs on a timely and routine basis to assist in ensuring that their needs are being met. Staff will be audited Quarterly by nurse management for completion of ADL support to assist in ensuring staff knowledge of resident ADL support needed and proper performance of that ADL support. Problems will be corrected as they are observed, with further staff education as needed.

Facility's QA process will ensure Quarterly audits occur and that proper corrective actions take place to assist in ensuring resident receive ADL support needed to meet their needs.

F 689

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This is my credible allegation of compliance to F 689. This allegation does not constitute guilt but that the facility is in compliance to F 689.

Resident #26 is being transferred properly and safely with mechanical lift to ensure resident remains safe during the transfer process.

All residents who require the use of a mechanical lift are being transferred properly and safely to ensure residents remain safe during the transfer process.

Staff was educated on 2/14/2020 on the proper use of the mechanical lift to assist in ensuring safe transfers for the residents who require the use of mechanical lifts for transfers. Staff was educated on the use of the calf strap for the EZ stand if the resident requires that for safe transfers 12/18/2019. Staff will be audited for proper use of mechanical lifts upon hire and then quarterly with problems and additional education provided as needed. Correction date 2/5/2020.

Facility's QA process will ensure audits occur per daily QA meetings, with proper corrective action taken as needed for observed problems.

F 730

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This is my credible allegation of compliance to F 730 . This allegation does not constitute guilt but that the facility is in compliance to F 730.

All current facility certified nursing assistants are current with their 12 hour inservice requirements.

Facility implemented that a report be ran at the end of every month for all CNA's on 1/23/2020 to assist in monitoring CNA attendance and completion of required assigned inservice training. Staff was educated on the requirement of the 12 hours per year for their position of certified nursing assistant on 2/14/2020. Facility will continue to notify staff on a monthly basis of needed inservice attendance as well as consequences for not attended and falling behind on required inservice completion.

Facility's QA process will monitor monthly that inservice audits are completed timely as well as staff notification of inservice needs. Problems will be corrected as they are observed.

58.28(3)e

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This is my credible allegation of compliance to 481—58.28(135C) Safety and 58.28(3). This allegation d All residents who require the use of a mechanical lift are being transferred properly and safely to ensure residents remain safe during the transfer process.

Resident #26 is being transferred properly and safely with mechanical lift to ensure resident remains safe during the transfer process.

All residents who require the use of a mechanical lift are being transferred properly and safely to ensure residents remain safe during the transfer process.

Staff was educated on insert correct date on the proper use of the mechanical lift to assist in ensuring safe transfers for the residents who require the use of mechanical lifts for transfers. Staff was educated on the use of the calf strap for the EZ stand if the resident requires that for safe transfers on insert correct date. Staff will be audited for proper use of mechanical lifts upon hire and then quarterly with problems and additional education provided as needed.

Facility's QA process will ensure audits occur per daily QA meetings, with proper corrective action taken as needed for observed problems.