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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	165580	A. BUILDING _____ B. WING _____	01/30/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
URBANDALE HEALTH CARE CENTER	4814 NW 84TH STREET URBANDALE, IA 50322

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F 000	INITIAL COMMENTS Correction Date F607, F636, F804 1/31/2020 F761, F880 2/13/2020 The following deficiencies were identified during the facility's recertification survey and investigation of Complaints #87563-C and #88202-C conducted 1/27/2020 thru 1/30/2020. Complaint #87563-C was not substantiated. Complaint #88202-C was not substantiated. See the Code of Federal Regulations (42CFR) Part 483, subpart B-C).	F 000		
F 607 SS=D	Develop/Implement Abuse/Neglect Policies CFR(s): 483.12(b)(1)-(3) §483.12(b) The facility must develop and implement written policies and procedures that: §483.12(b)(1) Prohibit and prevent abuse, neglect, and exploitation of residents and misappropriation of resident property, §483.12(b)(2) Establish policies and procedures to investigate any such allegations, and §483.12(b)(3) Include training as required at paragraph §483.95, This REQUIREMENT is not met as evidenced by: Based on personnel file reviews, facility policy review and staff interview, the facility failed to implement their policy and complete criminal and abuse background check for new hires prior to them working in the facility for one of five current employees sampled (Staff A). The facility identified a census of 95 residents.	F 607		

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

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 607	Continued From page 1 Findings include: The personnel file for Staff A, CNA (certified nurse aide), documented a hire date of 6/11/19. The file failed to contain criminal background and abuse registry checks completed prior to hire. Time card documentation revealed Staff A, CNA worked 36 shifts from 6/11/19 to the time background check were completed on 8/28/19. The facility's Abuse Prevention, Identification, Investigation, and Reporting Policy Procedure effective 6/21/17 directed the following: Employee Screening: The facility shall screen all potential employees for a history of abuse, neglect, exploitation, misappropriation of property, or mistreatment of Residents. The facility will accomplish screening by completing the following and maintain documentation of the results: The facility will conduct an Iowa criminal record check and dependent adult/child abuse registry check on all prospective employees and other individuals engaged to provide services to residents, prior to hire, in the manner prescribed under 481 Iowa Administrative Code 58.11(3). On 01/29/20 12:31 PM the Business Office Manager (BOM) stated she began employment 11/4/2019 and had 2 days training with the former BOM. She stated understands the timeliness of checking criminal background checks but was not employed here at that time.	F 607		

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F 607	Continued From page 2 On 01/29/20 01:04 PM the facility Administrator acknowledged the facility did not complete Staff A's background check timely. The Administrator acknowledged Staff A began employment on 6/11/2019. and the BOM at that time failed to do the background check prior to employment.	F 607		
F 636 SS=B	Comprehensive Assessments & Timing CFR(s): 483.20(b)(1)(2)(i)(iii) §483.20 Resident Assessment The facility must conduct initially and periodically a comprehensive, accurate, standardized reproducible assessment of each resident's functional capacity. §483.20(b) Comprehensive Assessments §483.20(b)(1) Resident Assessment Instrument. A facility must make a comprehensive assessment of a resident's needs, strengths, goals, life history and preferences, using the resident assessment instrument (RAI) specified by CMS. The assessment must include at least the following: (i) Identification and demographic information (ii) Customary routine. (iii) Cognitive patterns. (iv) Communication. (v) Vision. (vi) Mood and behavior patterns. (vii) Psychological well-being. (viii) Physical functioning and structural problems. (ix) Continence. (x) Disease diagnosis and health conditions. (xi) Dental and nutritional status. (xii) Skin Conditions. (xiii) Activity pursuit. (xiv) Medications.	F 636		

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F 636	Continued From page 3 (xv) Special treatments and procedures. (xvi) Discharge planning. (xvii) Documentation of summary information regarding the additional assessment performed on the care areas triggered by the completion of the Minimum Data Set (MDS). (xviii) Documentation of participation in assessment. The assessment process must include direct observation and communication with the resident, as well as communication with licensed and nonlicensed direct care staff members on all shifts. §483.20(b)(2) When required. Subject to the timeframes prescribed in §413.343(b) of this chapter, a facility must conduct a comprehensive assessment of a resident in accordance with the timeframes specified in paragraphs (b)(2)(i) through (iii) of this section. The timeframes prescribed in §413.343(b) of this chapter do not apply to CAHs. (i) Within 14 calendar days after admission, excluding readmissions in which there is no significant change in the resident's physical or mental condition. (For purposes of this section, "readmission" means a return to the facility following a temporary absence for hospitalization or therapeutic leave.) (iii)Not less than once every 12 months. This REQUIREMENT is not met as evidenced by: Based on clinical record review, observations, resident and staff interviews, the facility failed to complete a comprehensive and accurate assessment using the Resident Assessment Instrument (RAI) specified by CMS for 1 of 3 residents reviewed (Residents # 77). The MDS (Minimum Data Set) incorrectly stated "no" when asked if the resident was considered by the state	F 636		

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F 636	Continued From page 4	F 636		

level II PASRR (Preadmission Screening and Resident Review) to have a serious mental illness. The facility reported a census of 95 residents at the time of the survey

Findings Include;

1. The annual Minimum Data Set (MDS) dated 4/2/19 for Resident #77 identified a Brief Interview for Mental Status (BIMS) score of 15 out of 15 (no cognitive impairment). The MDS included diagnoses of anxiety, depression, and manic depression. The MDS lacked information that identified a level II PASRR documented a serious mental illness and/or intellectual disability.

Resident #77's Care Plan updated 1/2019 included a focus areas for PASRR identified services and included interventions listed in the PASRR for Resident #77.

The PASRR for Resident #77 dated 5/25/18 included Rehabilitative Services for ongoing evaluation of the effectiveness of psychotropic medications on targeted symptoms and the resident met criteria for having a diagnosis of mental illness as defined by PASRR.

During an interview on 1/29/20 at with the Director of Nursing (DON) acknowledged she would expect the MDS to be done accurately.

On 1/29/20 at 3:06 PM with Staff D Social Worker acknowledged she did not understand the level II PASRR and did them wrong. Staff D explained she received no education on them and corrected some level II PASRRs but Resident #77's did not get corrected. .

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F 761	Continued From page 5	F 761		
F 761 SS=D	Label/Store Drugs and Biologicals CFR(s): 483.45(g)(h)(1)(2) §483.45(g) Labeling of Drugs and Biologicals Drugs and biologicals used in the facility must be labeled in accordance with currently accepted professional principles, and include the appropriate accessory and cautionary instructions, and the expiration date when applicable. §483.45(h) Storage of Drugs and Biologicals §483.45(h)(1) In accordance with State and Federal laws, the facility must store all drugs and biologicals in locked compartments under proper temperature controls, and permit only authorized personnel to have access to the keys. §483.45(h)(2) The facility must provide separately locked, permanently affixed compartments for storage of controlled drugs listed in Schedule II of the Comprehensive Drug Abuse Prevention and Control Act of 1976 and other drugs subject to abuse, except when the facility uses single unit package drug distribution systems in which the quantity stored is minimal and a missing dose can be readily detected. This REQUIREMENT is not met as evidenced by: Based on observation, policy review and staff interviews the facility failed to store medications according to professional standards. The facility reported a census of 95 residents. Findings include: The facility policy Medication Receipt, Storage and Destruction included the following	F 761		

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F 761	Continued From page 6 information: expired medications will be disposed of properly in accordance with regulations. Items will be dated when opened. During and observation of a Medication Storage Room on 1/29/20 at 9:36 AM with Staff B Registered Nurse (RN) observed the following; 1. Tuberculin 5 TU /0.1 ml, 5 ml vial with and open date of 11/29/19. 2. Tuberculin 5 TU /0.1 ml, 5 ml vial open no date. During an interview on 1/29/20 at 9:36 AM with Staff B RN stated an open vial should be discarded after 30 days. During an interview on 1/29/20 at 10:38 AM with the Director of Nursing (DON) explained she would expect staff to date vials when opened.	F 761		
F 804 SS=E	Nutritive Value/Appear, Palatable/Prefer Temp CFR(s): 483.60(d)(1)(2) §483.60(d) Food and drink Each resident receives and the facility provides- §483.60(d)(1) Food prepared by methods that conserve nutritive value, flavor, and appearance; §483.60(d)(2) Food and drink that is palatable, attractive, and at a safe and appetizing temperature. This REQUIREMENT is not met as evidenced by: Based on observations, interviews and review of facility policy, the facility failed to serve and maintain food at safe and appetizing temperatures during the lunch meal service on	F 804		

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F 804	Continued From page 7 1/28/20, served at 11:26 AM. The facility reported a census of 95 residents. Findings include: The menu for Week 2, Tuesday, included: meatloaf, mashed potatoes, beef gravy, bread/margarine, frosted cake and milk. The main kitchenette also served: macaroni salad, pasta salad, and egg salad sandwiches for residents that did not want to eat the items off the menu. Observation revealed on 1/28/2019 at at 11:26 AM, the egg salad sandwiches on a large sheet pan, uncovered and not on an ice bed. Meal service at 11:26 am. Observation revealed serving ended at 1 p.m. At that time, the temperature of the Macaroni Salad was 53 degrees Fahrenheit and the temperature of the egg salad sandwiches measured 64 degrees Fahrenheit. The facility did not have alcohol swabs available to sanitize the thermometer for food temperature checks. Observation revealed on 1/30/20 at 11:02 AM, the temperature log book only contained food temperatures obtained at the start of meal service and no food temperatures recorded at the end of serving for two out of two meals reviewed. On 1/28/2019 at 11:26 AM, the dietary manager (DM) stated staff checked food temperatures prior to serving in the kitchen. On 1/30/2019 at 11:00 AM, Staff F (cook) identified no thermometer kept in the main kitchenette. Staff F stated they rarely check temperatures at the end of serving time unless	F 804		

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F 804	Continued From page 8 food goes out for a resident but then comes back to hold and keep warm for the resident. An undated policy titled "Food Temperatures" revealed hot food temperatures must read no less than 140 degrees Fahrenheit when residents are served and cold food temperatures should be below 41 degrees Fahrenheit when served. The food service manager or designee must be informed of any temperature not within acceptable range and the appropriate action must be taken to ensure food safety. Hot food should be immediately reheated to an internal temperature of 165 degrees or above Fahrenheit for at least 15 seconds before serving to residents. Cold foods should be placed in the freezer in order to chill them quickly to below 41 degrees Fahrenheit. A thermometer and alcohol swabs will be available and staff will properly. Staff will properly sanitize the thermometer between each food item tested. Staff will obtain food temperatures at the completion of cooking and prior to the start of meal service.	F 804		
F 880 SS=D	Infection Prevention & Control CFR(s): 483.80(a)(1)(2)(4)(e)(f) §483.80 Infection Control The facility must establish and maintain an infection prevention and control program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of communicable diseases and infections. §483.80(a) Infection prevention and control program. The facility must establish an infection prevention and control program (IPCP) that must include, at	F 880		

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F 880	Continued From page 9 a minimum, the following elements: §483.80(a)(1) A system for preventing, identifying, reporting, investigating, and controlling infections and communicable diseases for all residents, staff, volunteers, visitors, and other individuals providing services under a contractual arrangement based upon the facility assessment conducted according to §483.70(e) and following accepted national standards; §483.80(a)(2) Written standards, policies, and procedures for the program, which must include, but are not limited to: (i) A system of surveillance designed to identify possible communicable diseases or infections before they can spread to other persons in the facility; (ii) When and to whom possible incidents of communicable disease or infections should be reported; (iii) Standard and transmission-based precautions to be followed to prevent spread of infections; (iv)When and how isolation should be used for a resident; including but not limited to: (A) The type and duration of the isolation, depending upon the infectious agent or organism involved, and (B) A requirement that the isolation should be the least restrictive possible for the resident under the circumstances. (v) The circumstances under which the facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease; and (vi)The hand hygiene procedures to be followed by staff involved in direct resident contact.	F 880		

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F 880	Continued From page 10 §483.80(a)(4) A system for recording incidents identified under the facility's IPCP and the corrective actions taken by the facility. §483.80(e) Linens. Personnel must handle, store, process, and transport linens so as to prevent the spread of infection. §483.80(f) Annual review. The facility will conduct an annual review of its IPCP and update their program, as necessary. This REQUIREMENT is not met as evidenced by: Based on clinical record review, facility policy, observations and staff interviews the facility failed to follow proper infection control practices for 2 of 4 Residents (Resident #64 and #66). The facility also failed to properly handle medication during administration. The facility reported a census of 95 residents. Findings include; 1. The admission Minimum Data Set (MDS) dated 1/7/20 for Resident #64 assessed the resident with a Brief Interview for Mental Status (BIMS) score of 15 (no cognitive impairment. The resident required limited assistance of one staff for bed mobility, transfers dressing and personal hygiene. The resident had diagnoses that included: heart failure, peripheral disease and had open lesions other then ulcers, rashes or cuts and required applications of nonsurgical dressings and ointments/medications. Resident #64's Care Plan included a risk for alteration in skin integrity and directed staff to	F 880		

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F 880	Continued From page 11 complete skin treatments as ordered and weekly skin assessments. Resident #64's After Visit Summary dated 1/7/2020 revealed the resident with a diagnosis of Calciphylasis (a serious, uncommon disease in which calcium accumulates in small blood vessels of the fat and skin tissues) ulcers of the left and right lower extremity with fat layer exposed. A policy and procedure titled Handwashing included the following under procedure: Indications: Wash hands with antibacterial soap and water or an alcohol-based hand gel; a. At the beginning and end of your shift. b. Before and after each resident contact. c. After moving from a contaminated to a clean area during the care of an individual resident. d. Before putting on and taking of gloves. e. After handling soiled equipment and materials. Including linens. f. Before performing any procedures ie. Wound care. A form provided by the Director of Nursing (DON) on 1/30/20 at 12:31 titled "Clean Dressing Change Audit" listed the following step: a. Check physician's order. b. Gather equipment towel for clean field. c. Inform resident what you are going to doing. d. Place plastic bag near foot of bed for discarding soiled materials. e. Create a clean field with paper towels/towel. f. Open dressings. g. Put first pair of disposable gloves. h. Remove soiled dressing (observe for drainage, color, odor discard in plastic bag). i. Dispose of gloves in plastic bag.	F 880		

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F 880	Continued From page 12 j. Wash hands and put on second pair of gloves. k. Cleanse wound with prescribed solution, working from the inside out, using a separate piece of gauze for cleansing each area discard into plastic bag. l. Measure wounds. m. Apply prescribed medication n. Apply prescribed dressing. o. Remove gloves and discard into plastic bag. p. Wash hands. q. Assist resident to comfortable position. r. Dispose of plastic bag in utility room, wash hands. s. Document procedure. Observation revealed on 01/28/20 at 8:56 AM Resident #64 with wounds on bilateral legs with drainage showing on the outer dressings. Observation revealed on 1/28/20 at 9:50 AM Staff B Registered Nurse (RN) laid the following items out on the towel over the tray table: silver antimicrobial ointment, kerlix and gauze. Staff B washed her hands and donned gloves, cut off old soiled dressings and placed the soiled scissors on top the towel barrier. Staff B placed Resident #64's legs on top of the sheet with old drainage on it. Staff B removed gloves and donned new gloves without using hand sanitizer. She wet some gauze with soap and water and cleansed the left leg. She wet new gauze and wiped the right leg with soap and water. Staff B removed her gloves and donned new gloves without using hand sanitizer and wet gauze and rinsed the bilateral legs by placing the legs back down on the soiled sheets. Staff B removed gloves, donned one glove and stated she should have used hand sanitizer but still proceeded. Staff B	F 880		

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F 880	Continued From page 13	F 880		

donned the other glove and placed silver dressing on right leg wound and wrapped in kerlix. Staff B removed gloves and left the room at 10:01 AM. Staff B returned at 10:09 AM with larger dressings and washed her hands and donned gloves. Staff B covered area with a dressing and wrapped with it kerlix and taped it in place. Staff B removed gloves and used hand sanitizer and then cut tubi grips with the soiled scissors that she did not clean after she cut the soiled dressing off earlier. Staff b applied tubi grips on the resident's legs. Observation showed the resident with an open area on the back of the leg not covered with a dressing and a black area to his left heel. Staff B removed gloves, donned new gloves, cleaned the scissors and removed gloves. Staff B picked up the garbage and placed a new bag into the garbage. She placed items into his drawer and picked up the towel, scissors and disinfection wipes. Staff B walked down the hallway to the soiled utility room, opened door and placed the items into the garbage and the linen receptacles. She then opened soiled utility room door and went to the treatment cart and placed the scissors in the cart. Staff B then took keys out of her pocket and unlocked the cart and opened the medication cart and placed Sani wipes into the drawer, logged on to her computer and opened drawer to pull out medications and then used hand sanitizer.

On 1/29/20 at 10:39 AM the Director of Nursing (DON) acknowledged she expected staff to wash hands or use hand sanitizer between each glove change. The DON explained she also expected staff to place a barrier under the legs after cleansing and not put the legs on a soiled sheet.

2. The recent MDS for Resident #66 revealed the

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	165580	A. BUILDING _____ B. WING _____	01/30/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
URBANDALE HEALTH CARE CENTER	4614 NW 84TH STREET URBANDALE, IA 50322

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 880	Continued From page 14 resident used a Gastrostomy (g)-tube. The MDS also revealed the resident received an ointment/medication other than for feet. The MDS identified the resident at risk for malnutrition. The MDS also revealed the resident at risk for skin/pressure injuries. The recent care plan revealed a goal for the resident initated 7/15/19 that stated, " I will be free of complications related to the feeding tube through the next review date." The intervention directed staff to provide local care to g-tube site as ordered and observe for signs and symptoms of infection. Observation showed on 01/29/20 at 08:00 AM, Staff C perform g-tube cares on Resident #66. Resident #66's medical ointment for his g-tube was in a ziplock treatment bag with gauzes. Staff C placed the bag on the resident's bedside table during care. Staff C did not disinfect the bedside table, nor did they place a barrier on the bedside table. On 1/30/20 at 12:12 PM the Director of Nursing acknowledged the failure to disinfect the bedside table. She stated she expected staff to disinfect the equipment and place a barrier down. Policy: An infection control policy dated September 2009, revealed the facility would take action to prevent resident equipment and supplies from becoming sources of infection. All used equipment and supplies are considered contaminated with potential infections material and staff should clean and disinfect or sterilize as applicable before use with another resident. Resident care equipment will be classified, as recommended by	F 880		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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F 880	Continued From page 15 the Centers for Disease Control (CDC), into three general categories: Critical Items, Semicritical Items and Noncritical Items. The bedside table is considered a noncritical item. For noncritical items, "utilize a low-level disinfectant per EPA guidelines with MRSA and TB kill rates for 10 minutes." Review of an undated audit used for clean wound care revealed a towel should be placed on a clean table when performing cares.	F 880		

Plan of Correction for Urbandale Health Care Center-Provider #165580

Date of Investigation: January 27, 2020 – January 30,2020

Plan and/or execution of this plan of correction does not constitute admission or agreement by this provider of the truth of deficiencies. The plan of correction is prepared and executed solely because it is required in accordance with State and Federal Law.

F-607 Develop/Implement Abuse/Neglect Policies

- The facility does develop and implement policies that prohibit and prevent abuse and investigates any such allegations including training as required.
- A complete audit of all employee records was conducted on 1/31/2020 and all employee background checks are complete.
- BOM was re-educated on 1/31/2020 regarding the following:
    - Procedure when new employees are hired at UHCC, checklist is complete and signed off by administrator prior to starting employment. (BOM/Administrator/Designee)
    - Results discussed at weekly QA meeting for continued compliance. (BOM/Administrator/Designee)

Responsible Party: BOM/Administrator/Designee

Compliance Date: 1/31/2020

F-636 Comprehensive Assessments & Timing

- The facility does complete a comprehensive and accurate assessment using the RAI.
- The incorrect MDS was corrected where it was incomplete.
- A complete audit was done to ensure all coding was accurate.
- Social Services was educated regarding checking the accuracy of the MDS while coding. (Social Services/ MDS/DON/Administrator/Designee)
- MDS coordinator will audit section A of the MDS prior to future transmissions to assure accuracy. (Social Services/ MDS/DON/Administrator/Designee)

Responsible Party: Social Services/ MDS/DON/Administrator/Designee

Compliance Date: 1/31/2020

F-761 Label/Store Drugs and Biologicals

- The facility does store medications according to professional standards.
- A complete audit was done and all medications currently in use are labeled and dated according to federal and state regulations and professional standards.
- The undated TB solution was destroyed.
- Nursing staff were educated on 2/13/2020 regarding the following:

- TB solution must be dated when opened and destroyed then expired. (DON/Administrator/Designee)
- Weekly audits times 4 weeks, monthly audits times 4 months and PRN will be completed on all medication rooms with results discussed at weekly QA meeting for continued compliance. (DON/Administrator/Designee)

Responsible Party: DON/Administrator/Designee

Compliance Date: 2/13/2020

F-804 Nutritive Value/Appear, Plateable/Prefer Temp

- The facility does serve and maintain food at safe and appetizing temperatures during the lunch meal service.
- The refrigerator in the kitchenette was repaired on 1.31.2020 and holds appropriate temperatures. This is being temped 2 times daily going forward. (CDM, Administrator, Designee)
- The salad cooler in the kitchenette was repaired on 1.31.2020 and holds appropriate temperatures. This is being temped 2 times daily going forward. (CDM, Administrator, Designee)
- Dietary staff were educated on 1.31.2020 regarding holding cold foods in the 2 coolers while serving to maintain the temperature of cold foods. (CDM, Administrator, Designee)
- If either the refrigerator or the kitchenette fails to work, staff will use cambro cold bins and smaller quantities out at the time of service. (CDM, Administrator, Designee)

Responsible Party: CDM/Administrator/Designee

Compliance Date: 1/31/2020

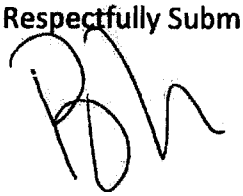
F-880 Infection Prevention & Control

- The facility does provide proper infection control techniques while providing cares to residents.
- Nursing staff were educated on 2/13/2020 regarding the following:
    - Procedure and importance of providing a barrier when setting clean supplies on a bedside table. (DON/Administrator/Designee)
    - Procedure and importance of proper infection control practices during wound dressing changes. (DON/Administrator/Designee)
    - Procedure when a medication is dropped on the med cart, a new medication is obtained and the dirty is destroyed. (DON/Administrator/Designee)
    - Continued audits will be completed with nurses and medication aides on various shifts to ensure compliance with infection control practices with results discussed at weekly QA meeting for continued compliance. (DON/Administrator/Designee)

Responsible Party: DON/Administrator/Designee

Compliance Date: 2/13/2020

Respectfully Submitted



Bethany Lee- Administrator LNHA

515-270-6838