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
	165516	A. BUILDING _____ B. WING _____	02/06/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CRESTRIDGE CARE CENTER	1015 WESLEY DRIVE MAQUOKETA, IA 52060

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 000	INITIAL COMMENTS Correction date 2/25/20 F686 3/6/20 The following deficiencies relate to the facility's annual health survey. (See Code of Federal Regulations (42CFR) Part 483, Subpart B-C)	F 000		
F 644 SS=C	Coordination of PASARR and Assessments CFR(s): 483.20(e)(1)(2) §483.20(e) Coordination. A facility must coordinate assessments with the pre-admission screening and resident review (PASARR) program under Medicaid in subpart C of this part to the maximum extent practicable to avoid duplicative testing and effort. Coordination includes: §483.20(e)(1)Incorporating the recommendations from the PASARR level II determination and the PASARR evaluation report into a resident's assessment, care planning, and transitions of care. §483.20(e)(2) Referring all level II residents and all residents with newly evident or possible serious mental disorder, intellectual disability, or a related condition for level II resident review upon a significant change in status assessment. This REQUIREMENT is not met as evidenced by: Based on clinical record review and staff interview, the facility failed to develop a care plan for 7 of 9 residents reviewed following PASRR (Preadmission Screening and Resident Review) level II recommendations for Specialized Services (Resident #2, #5, #22, #35, 41, #49 & #61). The facility census was 64 residents.	F 644		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Amanda Clark — TITLE: Administrator — (X6) DATE: 3/4/2

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 644	Continued From page 1 Findings include: 1. Resident #41's PASRR dated 5/22/19 showed the resident met the criteria for having a diagnosis of mental illness and required Specialized Services. The resident's diagnoses included schizoaffective disorder and obsessive-compulsive personality disorder included ongoing psychiatric services. PASRR identified Specialized Services for ongoing psychiatric services while at the facility to ensure psychiatric needs are met, with routine evaluations to monitor symptoms, the effectiveness of medication on target symptoms, and assess the need for changes in treatment. The Care Plan for the resident dated 1/3/19 and revised on 6/14/19, failed to address the Specialized Services recommended. The Care Plan failed to identify who provided the service, the start of the service, the frequency of the service, and the anticipated duration of the service. During interview on 2/4/20 at 2:10 p.m. the MDS Coordinator, Registered Nurse (RN) and the Assistant Director of Nursing (ADON), Licensed Practical Nurse (LPN), both reported the former Director of Nursing, RN, took care of all the resident's PASRR's and care plans. 2. Resident #35's PASRR dated 7/29/18 showed the resident met the individual criteria for having a mental illness as defined by PASRR. The diagnoses included dementia, schizoaffective disorder, and other psychoses.	F 644		

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F 644	Continued From page 2 PASRR identified Specialized Services for ongoing psychiatric services while at the facility to ensure psychiatric needs are met, with routine evaluations to monitor symptoms, the effectiveness of medication on target symptoms, and assess the need for changes in treatment. The Care Plan for the resident dated 10/1/19 failed to address the Specialized Services recommended. The Care Plan failed to identify who provided the service, the start of the service, the frequency of the service, and the anticipated duration of the service. 3. Resident # 49's PASRR dated 11/20/17 showed the resident met the individual criteria for having a mental illness as defined by PASRR. The diagnoses included dementia and a recurrent, unspecified major depressive disorder. PASRR identified Specialized Services for ongoing evaluation of the effectiveness of current prescribed psychotropic medication to prevent any future behavioral decompensation. The Care Plan for the resident initialed on 11/29/17 failed to address the Specialized Services recommended. The Care Plan failed to identify who provided the service, the start of the service, the frequency of the service, and the anticipated duration of the service. 4. Resident # 61's PASRR dated 10/23/18 showed the resident met the individual criteria for having a mental illness as defined by PASRR. The diagnoses included major depressive disorder single moderate episode. PASRR identified Specialized Services for	F 644		

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F 644	Continued From page 3 ongoing psychiatric services while at the facility to ensure psychiatric needs are met, with routine evaluations to monitor symptoms, the effectiveness of medication on target symptoms, and assess the need for changes in treatment. The PASRR also recommended the resident be followed by the previous provider, and if there is a barrier. the facility should collaborate with the community provider for a continuity of care. The Care Plan for the resident initialed on 11/29/17 failed to address the Specialized Services recommended. The Care Plan failed to identify who provided the service, the start of the service, the frequency of the service, and the anticipated duration of the service. 5. Resident #22's PASRR dated 10/1/19 showed the resident met the individual criteria for having a mental illness as defined by PASRR. The diagnoses included Bipolar II disorder and depression, secondary to health problems. PASRR identified Specialized Services required psychiatric services by a psychiatrist or psychiatric Nurse Practitioner evaluate responses to and effectiveness of medication on target symptoms, modify medication orders, and to evaluate response to and/or need for other services. The PASRR also recommended the resident would benefit from participation in individual therapy to provide a safe and secure environment to process feelings, emotions, and stressors and to develop effective coping mechanisms for better symptom management. The Care Plan for the resident dated 9/3/19 failed to address the Specialized Services recommended. The Care Plan failed to identify	F 644		

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F 644	Continued From page 4 who provided the service, the start of the service, the frequency of the service, and the anticipated duration of the service. Record review of the resident's paper chart failed to identify any individual therapy. 6. Resident #2's PASRR dated 10/14/19 showed the resident met the criteria for having a diagnosis of mental illness and required Specialized Services. The resident's diagnoses included schizoaffective disorder, major depressive disorder, and anxiety disorder. The PASRR identified Specialized Services which required psychiatric services by a psychiatrist or psychiatric Nurse Practitioner to ensure psychiatric needs are met with routine evaluations to monitor symptoms, the effectiveness of medication on target symptoms, and assess the need for changes in treatment. The Care Plan for the resident dated 3/18/19 failed to address the Specialized Services recommended. The Care Plan failed to identify who provided the service, the start of the service, the frequency of the service, and the anticipated duration of the service. 7. Resident #5's PASRR dated 13/6/18 showed the resident met the individual criteria for having a mental illness as defined by PASRR. The diagnoses included generalized anxiety disorder, unspecified single episode major depressive affective disorder, recurrent major depressive disorders, and mild cognitive impairment. PASRR identified Specialized Services for ongoing psychiatric services by a psychiatrist to	F 644		

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F 644	Continued From page 5 evaluate response and effectiveness of psychotropic medications on target symptoms, modify orders, and to evaluate ongoing need for additional behavioral health services. The Care Plan for the resident initialed on 3/18/19 failed to address the Specialized Services recommended. The Care Plan failed to identify who provided the service, the start of the service, the frequency of the service, and the anticipated duration of the service.	F 644		
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 provide as a result of PASARR recommendations. If a facility disagrees with the	F 656		

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F 656	Continued From page 6 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 observation, clinical record review and staff interview, the facility failed to develop a comprehensive person-orientated care plan for two of 20 residents reviewed. (Resident #29, #30 & 212) The facility census was 64 residents. Findings include: 1. The Minimum Data Set (MDS) for Resident # 29 dated 11/20/19, documented diagnoses including Non-Alzheimer's Dementia, depression, and muscle weakness. A Progress note for Resident # 29 stated the resident in receiving a regular diet with a mat and special silverware. The adaptive equipment list showed Resident # 29 needs a mat and special silverware. Review of the care plan for Resident # 29 documented a focus of ADL Self performance deficit. The documented intervention was the	F 656		

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F 656	Continued From page 7 resident requires the use of plastic cups, special silverware and a mat under her plate. Observations include: 2/3/2020 at 11:47 PM Plastic cups and bent silverware used. No mat under plate 2/4/2020 at 12:17 PM Plastic cups and bent silverware used. No mat under plate 2/5/2020 at 12:10 PM Plastic cups and bent silverware used. No mat under plate. During an interview with the interim Director of Nursing on 2/6/2020, she stated she would expect the Adaptive Equipment list to be followed and she would expect the care plan to be followed. 2. Review of the Order Review Report documented Resident #212 was admitted to the facility on 1/8/2020. Review of the Care Plan showed a goal of will not have a fall with injury with in facility. There are no fall prevention interventions on the care plan. 3. The Order Summary Report documented Resident #30 entered the facility and the CCDI unit on 11/14/19. The report documented Resident #30 was on Risperidone 0.5 mg by mouth two times daily for agitation and anxiety. Review of Resident # 30's care plan showed no mention of antipsychotic medication, side effects to monitor for or non-pharmacological interventions.	F 656		
F 657 SS=D	Care Plan Timing and Revision CFR(s): 483.21(b)(2)(i)-(iii)	F 657		

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F 657	Continued From page 8 §483.21(b) Comprehensive Care Plans §483.21(b)(2) A comprehensive care plan must be- (i) Developed within 7 days after completion of the comprehensive assessment. (ii) Prepared by an interdisciplinary team, that includes but is not limited to-- (A) The attending physician. (B) A registered nurse with responsibility for the resident. (C) A nurse aide with responsibility for the resident. (D) A member of food and nutrition services staff. (E) To the extent practicable, the participation of the resident and the resident's representative(s). An explanation must be included in a resident's medical record if the participation of the resident and their resident representative is determined not practicable for the development of the resident's care plan. (F) Other appropriate staff or professionals in disciplines as determined by the resident's needs or as requested by the resident. (iii)Reviewed and revised by the interdisciplinary team after each assessment, including both the comprehensive and quarterly review assessments. This REQUIREMENT is not met as evidenced by: Based on observation, staff interview, and record review the facility failed to update care plans to for 1 of 20 residents reviewed (Resident #7 and 57). The facility identified a census of 64 residents. Findings include: 1. Resident #57's Minimum Data Set (MDS)	F 657		

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F 657	Continued From page 9 assessment dated 12/25/19 showed the resident had moderate memory loss, required extensive staff assistance, did not ambulate, and diagnoses included muscle weakness, dementia, and unsteadiness on the feet. The Care Plan had the latest revision dated 7/22/19 showed the resident had a self-care deficit related to dementia. The interventions for this concern included: - the resident could self propel the wheelchair within the unit for locomotion. - the resident required assistance with 2 staff persons for transfers, dressing, personal hygiene. Observation on 2/03/20 at 2:52 p.m. revealed the resident sat in a broda chair. A broda chair looks like a lounge chair with padding on the lateral sides, high backside, and a continuation extension to the feet. The broda chair can sit upright or be laid back as in a lounge type chair with the feet up. The resident did not wheel the broda chair in the unit. Observation on 2/04/20 at 6:48 a.m. revealed the resident up in the broda chair in main area. The resident did not wheel the broda chair in the unit. Observation on 2/04/20 at 10:44 a.m. revealed the resident back from attending an activity, laying in a broda chair, with the feet up. The resident did not wheel the broda chair in the unit. An interview on 2/04/20 at 11:33 a.m. Staff B and C, both Certified Nursing Aides (CNA's) toileted the resident, who stood to pivot from the broda chair, holding onto the grab bar in shower/bathroom. They reported the resident had been in the broda chair for almost 2 months, or	F 657		

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F 657	Continued From page 10 so, and not in a wheelchair. Both Aides reported the resident did not ambulate. An interview on 2/4/20 at 11:45 a.m. the MDS Coordinator, Registered Nurse (RN), and acting Director of Nursing (DON) reported the resident had not been in a wheelchair for some time now and did not ambulate. She reported care plans were a mess when she became the MDS Coordinator and has been working on getting them updated and revised, She also remarked she knew they were a problem, and the resident's care plan should have been updated to give the true picture and care of the resident.	F 657		
F 658 SS=D	Services Provided Meet Professional Standards CFR(s): 483.21(b)(3)(i) §483.21(b)(3) Comprehensive Care Plans The services provided or arranged by the facility, as outlined by the comprehensive care plan, must- (i) Meet professional standards of quality. This REQUIREMENT is not met as evidenced by: Based on observation, clinical record review and staff interview, the facility failed to follow physician orders as prescribed for one resident reviewed. (Resident #43) The facility census was 64 residents. Findings include: 1. The Minimum Data Set (MDS) assessment dated 12/11/19, documented Resident #43 had diagnoses of coronary artery disease, diabetes and history of pulmonary embolism. The careplan with date initiated 4/28/18 revealed	F 658		

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F 658	Continued From page 11 the resident is on anticoagulation therapy related to Atrial Fibrillation. The interventions directed staff to provide labs as ordered. Report abnormal lab results to the medical doctor. The physician order review report dated 11/1/19 revealed an order for Protime (PT) with International Normalized Ratio (INR) monthly (a test used to monitor how well blood-thinning medication is working to prevent blood clots). Clinical record review revealed the last PT/INR was drawn 12/24/19. During interview on 2/5/20 at 10:40 a.m., Staff A, Registered Nurse (RN) could find no other PT/INR draws since 12/24/19. Staff A telephoned the lab and verified no Protime with INR was done since 12/24/19. On 2/5/20 at 11:11 a.m., Staff A contacted the physician and received orders to draw PT/INR today. During interview on 2/6/20 at 1:56 p.m., the Interim Director of Nursing (DON) states she would expect for labs to be drawn per physician order. The Assistant Director of Nursing (ADON) was responsible for weekly audits on the Coumadin (blood-thinning medication) orders. During interview on 2/6/20 at 2:02 p.m. , the Assistant Director of Nursing (ADON) states she was responsible for doing audits on the labs for the anticoagulant medication. Normally she verify the orders with lab to make sure they have been drawn but was busy and missed the lab drawn.	F 658		
F 686	Treatment/Svcs to Prevent/Heal Pressure Ulcer	F 686		

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F 686 SS=G	Continued From page 12 CFR(s): 483.25(b)(1)(i)(ii) §483.25(b) Skin Integrity §483.25(b)(1) Pressure ulcers. Based on the comprehensive assessment of a resident, the facility must ensure that- (i) A resident receives care, consistent with professional standards of practice, to prevent pressure ulcers and does not develop pressure ulcers unless the individual's clinical condition demonstrates that they were unavoidable; and (ii) A resident with pressure ulcers receives necessary treatment and services, consistent with professional standards of practice, to promote healing, prevent infection and prevent new ulcers from developing. This REQUIREMENT is not met as evidenced by: Based on observation, record review, resident and staff interviews, the facility failed to implement interventions to promote the healing of pressure ulcers for 2 out of 3 residents reviewed (Resident # 50 & #22). The facility reported a census of 64 residents. Findings include: 1. The Minimum Data Set (MDS) Assessment for Resident #22 dated 11/13/19 showed a Brief Interview for Mental Status Score (BIMS) of 14 indicating no memory impairment. The resident required extensive assistance of two staff with bed mobility, transfers, toileting, personal hygiene and documented as non-ambulatory with a risk of pressure ulcers. The resident's diagnoses included cerebrovascular accident (stroke), hemiplegia and aphasia (loss of ability to understand or express speech).	F 686		

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F 686	Continued From page 13 The MDS identified the following descriptions of pressure ulcers Stage I is an intact skin with non-blanchable redness of a localized area usually over a bony prominence. Darkly pigmented skin may not have a visible blanching; in dark skin tones, only it may appear with persistent blue or purple hues. Stage II is partial thickness loss of dermis presenting as a shallow open ulcer with a red or pink wound bed, without slough. May also present as an intact or open/ruptured blister. Stage III Full thickness tissue loss. Subcutaneous fat may be visible but bone, tendon or muscle is not exposed. Slough may be present but does not obscure the depth of tissue loss. May include undermining and tunneling. Stage IV is full thickness tissue loss with exposed bone, tendon or muscle. Slough or eschar may be present on some parts of the wound bed. Often includes undermining and tunneling. Observation of Resident #22 on 2/3/20 at 1:37 p.m. , noted the resident sitting in a wheelchair in her room with a cushion in the seat and also has a low loss air mattress on bed. The resident denies any pain or discomfort from buttocks, but does remark she has painful gallstones that will remain until the sore on her bottom healed. Observation on 2/4/20 at 11:49 a.m., Resident #22 propelling self in hallway towards dining room and has a cushion in place in the wheelchair. During an observation on 2/4/20 at 2:16 p.m., Staff H, Licensed Practical Nurse (LPN) provided a dressing change with the assist from the interim	F 686		

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F 686	Continued From page 14 Director of Nursing (DON). Noted the gluteal crease with a large open area covered with yellow slough directly over the ischium with a black center. The wound packed with calcium alginate, covered with waterproof foam dressing, and then covered with Duoderm. The Braden Scale for Predicting Pressure Sore Risk, completed 11/12/19, identified a score of 14, indicated the resident at a moderate risk of developing a pressure ulcer. The Non-Pressure Skin Condition Report dated 12/14/19 revealed an open area to the left gluteal crease. The area measured 2.3 centimeters (cm) x 1.3 cm open with no depth and no signs and symptoms of infection. Condition Report to medical doctor dated 12/14/19 revealed the following concern of an open area 2.3 cm x 1.3 cm to the left of the gluteal crease, area caused by friction from the depends, will monitor until healed and start Calmoseptine twice a day until healed. The physician signed the report and returned order 12-16-19. The Calmoseptine treatment order fails to appear on the Treatment Administration Record (TAR) until 12-22-19. The Physician Order given to the MDS Coordinator on 12/16/19 and the Director of Nursing signed the order on 12/18/19. Review of the resident's medical record failed to reveal any further documentation on the open wound until 12/31/19 the Nurse's Progress Notes stated the left buttock near the gluteal crease with an open area measuring 3.2 cm by 3 cm with 1 cm rolled edges. The area with 25 percent slough, scant drainage, and darkened tissue	F 686		

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noted to the middle of wound with surrounding skin pale red in color. The resident denies pain with this area.

A Condition Report sent to medical doctor on 12/31/19 and the facility requested a new treatment to apply moistened/activated collagen particles into the wound and then apply a border dressing every bedtime and as needed. The order signed by the physician on 1/2/20, noted and implemented by the facility on 1/2/20 according to Resident #22's Treatment Administration Record (TAR).

The facility started a Wound Evaluation Flow Sheet on 1/6/20 indicating the wound now a Stage 3 pressure area with measurements of 3.7 cm by 3.6 cm with a 2 cm depth, also a 2 cm tunneling at 6 o'clock. The wound with a heavy amount of gray thick purulent drainage. The wound margins rolled with maceration and the surrounding tissue red and hard. The resident reported pain as 4 out of 10. The documentation stated the wound deteriorating. The Flow Sheet documented a modified Roho Cushion put in place on the wheelchair 12/31/19.

The Nurse Progress Notes from 1/10/20 documented the Wound Specialist consulted, who suggested the Wound Clinic to provide debridement and to change the current treatment of the wound. The Nurse's Notes reveal the facility waited until 1/14/20 to schedule the appointment at the Wound Clinic.

A Condition Report facsimile to the attending physician on 1/10/20 noted the wound continues to deteriorate. Measurements currently 4 cm by 4.2 cm with a 1.2 cm depth. The previous tunnel

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F 686	Continued From page 16 now has turned to 2 cm undermining from 2 o'clock to 9 o'clock with edges rolled, macerated and surrounding tissue red, gray/black and hard. The area covered with 100 percent thick slough with a gangrenous odor. Requested and received order for a multivitamin with mineral and very high calorie supplement with meals. The Physician ordered a wound culture and then to start an antibiotic. A Physician Order dated 1/15/20 started a Foley catheter related to pressure ulcer. The Wound Clinic Notes dated 1/21/20 reveal the patient developed a left ischium pressure ulcer approximately 2 months ago which is gradually become worse and now she presents with a necrotic full thickness stage IV pressure ulcer that is essentially down to bone. Primary Diagnosis: Stage IV pressure ulcer to left ischium with localized cellulitis, necrosis and exposed support structures. The Physician Orders from a local hospital dated 1/21/20 documented the following: 1. Physiotherapy for Pressure Mapping and Roho cushion. 2. Apply a low air-loss bed mattress. 3. Dietary consult recommend Elemental Protein Supplement. 4. Plan for wound VAC after surgical debridement of Stage IV left ischium pressure ulcer. The Wound Evaluation Flow Sheet revealed the low air loss mattress not started until 1/24/20. The facility failed to have the Registered Dietician consult until 1/30/20 and no recommendations in the Progress Note for increased protein supplementation noted. A Surgical Consult dated 1/27/20, noted	F 686		

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F 686	Continued From page 17 treatment of this ulcer will require combination of orthopedic and plastic surgery. Discussed the patient briefly with an orthopedic surgeon who suggested referral for further evaluation and management to Iowa City. The Nurse's Progress Note dated 1/30/20, documented a Wound Nurse Specialist recommendation to add Zinc 50 mg daily (mineral used to aid in the production of proteins required for healing) and ProStat (medical supplement used to aid in healing wounds) 30 milliliter (ml) twice a day. The Licensed Dietician notes dated 1/30/20 revealed the Dietitian noted a Stage 4 wound on the resident's left buttocks. The Dietitian requested Remeron or Megace for resident (medication used to stimulate appetite). No recommendations to increase resident's protein or add supplements charted. A Condition Report dated 1/30/20 to the attending physician charted the referring hospital cannot see the resident for pressure ulcer until labs obtained and at following levels: a. Albumin >3 b. Prealbumin >16 c. Protein >7 d. HgbA1c < 7 A Condition Report to the attending physician on 2/5/20 revealed the residents Albumin level is low for the referring hospital requirements can we recheck Albumin in one week. The Care Plan with a date initiated on 11/14/16 identified the resident with the potential for skin breakdown related to incontinence and	F 686		

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decreased physical mobility. The interventions directed staff to assess and document skin integrity weekly, encourage resident to have adequate nutrition and hydration to promote skin integrity, report any skin breakdown to the physician, and to treat skin breakdown per facility protocol. The facility failed to address the pressure ulcer on the Care Plan until 1/30/20.

During an interview on 2/4/20 at 2:16 p.m., the Interim DON reported we have a Dietitian but not sure, if she saw the resident yet, we have asked for recommendations due to the referring hospital will not see the resident for consult until her protein levels are higher.

During an interview on 2/4/20 at 2:31 p.m., the Interim DON reported not sure, when the wound started, and reported the first time seeing the wound on 12/31/19. The Interim DON stated the prior DON responsible for skin measurements; the Interim DON updated the Care Plans, and she must have missed the wound on the Care Plan. The Interim DON explained staff follow the Kardex for providing cares and this comes from the Care Plan and I am the one responsible for updating and not sure why not updated. The Interim DON stated expected staff to start a treatment immediately when they receive an order.

During an interview on 2/6/20 at 10:21 a.m., the Licensed Dietician (LD) stated not aware of the open area for Resident #22 until a couple of weeks ago. Normally she would increase their protein by about 20 grams when there is a pressure sore. Typically, she would recommend a protein supplement for a pressure ulcer and stated had no knowledge about the Wound Clinic

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F 686	Continued From page 19 referral for a Dietary Consult. She stated on 1/31/20, she met with the Assistant Director of Nursing (ADON) and the interim DON, and discussed the resident's nutritional needs and recommendations for the pressure sore. 2. The Minimum Data Set (MDS) Assessment for Resident #50 dated 12/12/19 showed a Brief Interview for Mental Status Score (BIMS) of 15 indicating no memory impairment. The resident required limited to extensive assistance of one to two staff with bed mobility, transfers, toileting and personal hygiene. The MDS identified the resident at risk of pressure ulcers. The resident's diagnoses included coronary artery disease, hypertension (high blood pressure) and diabetes. During an observation of wound care with Resident #50 on 2/6/20 at 11:33 a.m., Staff A, Registered Nurse (RN) provided cares to an area to the right side of the coccyx, over the tail bone which measuring 3.5 centimeter (cm) x 0.5 cm with a 0.1 cm depth, and a yellow slough covering. Staff A, RN states the area is now an unstageable pressure sore due to the wound covered with yellow slough. During this time, the surveyor noted the residents Roho (air cushion) in wheelchair completely flat. The resident states the Nurse Aide just put air in it the other day. The Braden Scale for Predicting Pressure Sore Risk, completed 12/9/19, identified a score of 18, indicating the resident at risk of developing a pressure ulcer. The Nurse's Progress Note dated 1/14/20, revealed a 3.5 cm by 0.7 cm area to right of the coccyx area and appears to be a broken blister,	F 686		

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F 686	Continued From page 20 red edges with pink/yellow wound bed. Report sent to the physician. The Non-Pressure Skin Condition Report sheet on 1/21/20 documented noted area to be 4 cm by 0.8 cm with no depth noted. The medical record revealed no further documentation or measurements of the wound until 2/4/20. The Condition Report to attending physician dated 2/4/20 reveals a pressure ulcer to right side of coccyx is worsening in length and depth. Area with moderate amount of serous drainage and measuring 4.8 cm by 0.8 cm with a depth of 0.7 cm. The wound is painful for the resident. Review of the medical record revealed no documentation concerning a treatment to the area after initially found until 2/4/20 when attending physician sent a condition report. The Care Plan for Resident #50 failed to address the pressure ulcer on the right side of the coccyx. During an interview on 2/5/20 at 3:12 p.m., Staff G, Certified Nursing Assistant (CNA) states Resident #50 with an open area on her coccyx for at least a month and recently is more open the Nurse does the treatment using a cream on it. During an interview on 2/5/20 at 3:16 p.m., the Interim Director of Nursing (DON) states just made aware of Resident #50's pressure ulcer this morning. The Interim DON stated expected staff to let the nurse know when the area found and then the nurse should let the Management Team know so they can get interventions in place. The first interventions is to look at placing cushions in chairs and on the bed, and then look at nutrition. The Interim DON stated she expected family and	F 686		

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F 686	Continued From page 21 physician notified immediately, and the staff get a treatment order immediately. Wound assessments need completed daily with dressing changes and measurements done at the time the wound found and then completed weekly and as needed depending on the condition of the wound. If no improvement in the wound, staff contact the physician or the Wound Nurse to change treatment or try some different interventions. During an interview on 2/5/20 at 4:12 p.m., Staff A, Registered Nurse (RN) states using Calmoseptine cream on Resident #50's buttocks area which has been open for quite a while but not sure how long. During a phone interview on 2/5/20 at 4:45 p.m., Staff E, Licensed Practical Nurse (LPN) states Resident # 50's pressure ulcer on the right side of the coccyx started on the date on the skin sheet she started. Prior to the date, no open areas noted. The area noted with no depth, just a superficial open area. The night Staff E found the area she sent a fax to the medical doctor stating would utilize the Calmoseptine order we already had for her skin. During an interview on 2/6/20 at 10:05 a.m., the Interim DON stated unable to find a fax to the medical doctor or an order for a treatment for when the pressure sore first found. During an interview on 2/6/20 at 10:36 a.m., the Licensed Dietitian (LD) stated not aware of a pressure sore for Resident #50. No Dietary recommendations made for Resident #50 since not aware of the pressure sore. During an interview on 2/6/20 at 11:20 a.m. Staff	F 686		

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F 686	Continued From page 22 B, CNA reported the resident's sore is right on her bottom and not sure how long it has been there but believes the nurses applying Calmoseptine on it. Staff B confirmed the Roho cushion in wheelchair flat when transferred resident out of wheelchair. During an interview with Resident #50 on 2/6/20 at 11:32 a.m., she states the sore does not hurt when sitting on it, but when laying down it is painful and rates the pain at 6 out of 10 on the pain scale. During an interview/observation on 2/6/20 at 11:47 a.m., the interim DON attempting to blow up the Roho cushion and states it does not look right and the cushion appears to be too small for this resident. During an interview on 2/6/20 at 1:16 p.m., the Interim DON stated she contacted the resident's physician office about the pressure sore on resident's coccyx and the office does not have record of the area or a treatment order. The Interim DON reported the physician's office does not keep faxes sent about the resident. During an interview on 2/6/20 at 1:35 p.m., the Occupational Therapist (OT) stated Resident #50 currently with Mosaic Roho cushion in her wheelchair and if she has an open area needs to switch to 2-inch Roho cushion. The OT explained that refers to the size of the fingers in the cushion and the amount of air in the fingers. The Mosaic is a standard cushion for skin prevention, once there is an open area; the resident should be using a different cushion with more fingers and is a higher level.	F 686		

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F 686	Continued From page 23 During an interview on 2/6/20 at 1:51 p.m., the Interim DON confirmed a slow leak noted in the ROJO cushion currently on the resident's wheel chair and this could have contributed to the pressure ulcer worsening. During a telephone interview on 2/6/20 at 3:00 p.m., the Physician's Office Nurse stated they do not keep faxes after answered and signed from the facility; we send them back to the facility and feel they have the documentation. During an interview on 2/6/20 at 3:02 p.m., the Administrator stated unaware of Resident #50 having a pressure ulcer.	F 686		
F 693 SS=D	Tube Feeding Mgmt/Restore Eating Skills CFR(s): 483.25(g)(4)(5) §483.25(g)(4)-(5) Enteral Nutrition (Includes naso-gastric and gastrostomy tubes, both percutaneous endoscopic gastrostomy and percutaneous endoscopic jejunostomy, and enteral fluids). Based on a resident's comprehensive assessment, the facility must ensure that a resident- §483.25(g)(4) A resident who has been able to eat enough alone or with assistance is not fed by enteral methods unless the resident's clinical condition demonstrates that enteral feeding was clinically indicated and consented to by the resident; and §483.25(g)(5) A resident who is fed by enteral means receives the appropriate treatment and services to restore, if possible, oral eating skills and to prevent complications of enteral feeding including but not limited to aspiration pneumonia,	F 693		

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F 693	Continued From page 24 diarrhea, vomiting, dehydration, metabolic abnormalities, and nasal-pharyngeal ulcers. This REQUIREMENT is not met as evidenced by: Based on observation, clinical record review and staff interview, the facility failed to ensure proper technique was utilized when verifying placement of a feeding tube for one resident reviewed. (Resident #33) The facility census was 64 residents. Findings include: 1. The Minimum Data Set (MDS) assessment dated 12/4/19, documented Resident #33 had diagnoses of dysphasia (difficulty producing speech), Gastro-Esophageal Reflux Disease and Non-Alzheimer's Dementia and utilized a feeding tube for nutrition. The Order Summary Report dated 2/5/20 showed the resident was NPO (nothing by mouth) and received Jevity (formula) through her feeding tube 4 times a day. The report documented to ensure proper placement of G-Tube prior to administering any medications or feedings. Review of the facility's Enteral Nutritional Feeding Policy and Procedure, documented to check for residual by placing barrel of syringe into tube and pulling back on syringe. During observation on 2/4/20 at 12:47 p.m., the ADON attached a syringe without the plunger into the resident's G-Tube. She then administered a water flush via gravity, placed a medication that was dissolved in water into the syringe to administer via gravity. A second water flush was administered via gravity. The ADON did not	F 693		

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F 693	Continued From page 25 withdraw any feeding to check residual or verify correct placement of the G-Tube. During interview on 2/4/20 at 1:14 p.m., the ADON stated tube placement should be checked every time before anything was administered through the G-Tube. The ADON stated they should have checked placement but did not.	F 693		
F 803 SS=D	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	F 803		

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F 803	Continued From page 26 by: Based on observation, dietary menu review, facility policy review and staff interview, the facility failed to ensure three resident on a pureed diet received the appropriate serving size during one meal service. The facility census was 64 residents. Findings include: During observation on 2/4/20 at 11:06 a.m., the dietary manager pureed macaroni and cheese and brats for three residents on a pureed diet. The dietary manager put three servings of macaroni and cheese in the food processor and added cheese for additional moisture and appropriate texture. The macaroni and cheese was not measured. The dietary manager put three servings of brats and three buns into the food processor and added milk for moisture. The pureed food items was not measured. After the lunch service at 1:31 p.m., the surveyor noted left over pureed macaroni and cheese and pureed brats in the pans. During interview on 2/4/20 at 2:38 p.m., the dietary manager was asked how he chose scoop size and stated he used the green scoop per the portion chart that was hanging on the side of the refrigerator. When asked about the expanded volume from the liquids added to the food processor, he stated he thought the scoop size accounted for that. When asked about the Puree Process hanging on the front of the refrigerator, he stated "I didn't even see that." A review of the Puree Process, Step 4 stated measure total volume after pureed. Step 5 stated	F 803		

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	165516	A. BUILDING _____ B. WING _____	02/06/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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F 803	Continued From page 27 divide total volume by the original number of portions. See Puree Scoop Chart. A review of the facility's Guidelines for Pureed Consistency policy showed the food is to be scraped from the food processor and transferred into a measuring cup. It also stated to obtain the volume of the pureed mixture and use the altered texture portion chart to determine portion sized based on the yield and number of servings. The Puree Process used by the facility documents at step 4 to measure the volume of the food after it is pureed. Step 5 documents to divide the total volume by the original number of portions (See Puree Scoop Chart).	F 803		
F 804 SS=D	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 observation and staff interview, the facility failed to provide food that was served at a safe, palatable and appetizing temperature for one of three dining rooms served. The facility census was 64 residents, Findings include:	F 804		

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F 804	Continued From page 28 Observation on 2/4/20 at 12:05 p.m., revealed the lunch tray cart was delivered to the dining area on the CCDI unit. There was a test tray on the cart. The last glass of milk was poured for a resident at 12:18 p.m. A test glass of milk was poured at that time and placed on the counter. The last resident tray was removed from the cart at 12:25 p.m. The test tray was removed and the macaroni and cheese measured 89.5 degrees Fahrenheit (F), the brat on a bun measured 107.1 degrees F and the milk measured 44.7 degrees F Surveyor tested a bite of the macaroni and cheese and it was cold to taste. Surveyor tested a bite of the brat and it was cold to taste. During interview on 2/4/20 at 1:28 p.m., the dietary manager stated it was quite a temperature drop.	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 a minimum, the following elements: §483.80(a)(1) A system for preventing, identifying,	F 880		

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F 880	Continued From page 29 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. §483.80(a)(4) A system for recording incidents identified under the facility's IPCP and the	F 880		

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F 880	Continued From page 30 corrective actions taken by the facility. §483.80(e) Linens. Personnel must handle, store, process, and transport linens so as to prevent the spread of infection. §483.80(f) Annual review. The facility will conduct an annual review of its IPCP and update their program, as necessary. This REQUIREMENT is not met as evidenced by: Based on observation, clinical record review, facility policy review and staff interview, the facility failed to use appropriate hand hygiene practices when providing care for two of three residents. (Residents #7 & #45) The facility census was 64 residents. Findings include: 1. The Minimum Data Set (MDS) dated 1/8/20, documented Resident #7 had diagnosis of anxiety disorder, respiratory failure and tracheotomy (breathing tube in the neck) status. The MDS documented a Brief Interview for Mental Status (BIMS) of 15, indicating cognitively intact and received tracheostomy care. The Care Plan revealed a focus areas of tracheostomy related to impaired breathing mechanics dated 2/16/19. The care plan documented an intervention of clean tracheostomy inner cannula every 4 hours and as necessary. During observation on 2/6/20 at 8:52 a.m., Staff A, Registered Nurse (RN) washed her hands and	F 880		

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F 880	Continued From page 31 applied gloves. The resident removed his inner cannula and placed it in a basin. Staff A poured cleaning solution in the basin and allowed the cannula to soak for a few minutes. Staff A used a small brush to clean the inside of the cannula and placed the cannula in the clean basin with the cleaning solution. Staff A swished the cannula around in the clean solution and placed the inner cannula back in the tracheostomy. Staff A removed her gloves and rinsed the basins in the sink and set on a towel on a tray table to dry. The brush was disposed of. Staff A did not change her gloves between the soiled and clean parts of the procedure. During interview on 2/6/20 at 12:29 p.m., the interim DON, she stated her expectation would be for the nurse to change her gloves between the soiled and clean parts of the procedure. 2. The Minimum Data Set (MDS) assessment dated 12/11/19, showed Resident #45 had diagnoses of renal insufficiency, arthritis and osteoporosis. and schizophrenia. During observation on 2/4/20 at 7:45 a.m., Staff F, Certified Nurse Aide, CNA assisted the resident with a transfer from the recliner chair to a wheelchair. Staff F pushed the wheelchair to the main dining room but failed to wash their hands before or after leaving the residents room. During interview on 2/6/20 at 11:40 a.m., Staff C, CNA stated the resident was in isolation for MRSA on her leg. Staff should wash hands after completing cares for residents in isolation and before leaving the room.	F 880		

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F 880	Continued From page 32 During interview on 2/6/20 at 11:45 a.m., Staff A, Registered Nurse, RN stated staff should wash hands before leaving the residents room. The facility provided an undated policy titled Initiating Isolation Precautions which directed staff for prevention strategies for multiple drug resistant organisms to use consistent performance of hand hygiene.	F 880		

Crestridge Nursing Center Plan of Correction

Complaint Survey 2.3.20-2.7.20

This plan of correction constitutes our credible allegation of compliance. Preparation and/or execution of this plan of correction does not constitute admission or agreement by the provider of the conclusion set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because it is required by the provision of the federal and state laws.

F644 Crestridge Care Center reasonably ensures that Pre-admission screen and resident review (PASRR) care plan will incorporate the recommendations from PASRR level II including specialized services.

- R #2 PASRR care plan was reviewed and revised to include any specialized services.
  R #5 PASRR care plan was reviewed and revised to include any specialized services
  R #22 PASRR care plan was reviewed and revised to include any specialized services
  R #35 PASRR care plan was reviewed and revised to include any specialized services
  R #41 PASRR care plan was reviewed and revised to include any specialized services
  R #49 PASRR care plan was reviewed and revised to include any specialized services
  R #61 PASRR care plan was reviewed and revised to include any specialized services

- All residents who are deemed a level II by PASRR and are given recommendations for specialized services may be affected.

  A facility wide audit was completed of all persons deemed level II by PASRR and are given recommendations for specialized services.

  Developed a Care plan checklist tool that will now include identifying in the plan of care Level II services, who is providing services, start of services, and frequency of services and anticipated duration of services.

- On 3.6.20 an ongoing PASRR training for nursing staff involved with writing care plans, MDS/Care plan Coordinator, DON which includes care plan review to include recommendations for specialized services.

- The DON or designee will complete weekly audits with new admissions, quarterly and annual care plan reviews which will include recommendations for specialized services. An audit will be conducted for 12 weeks and then at that time will be reviewed by QA committee for compliance.

- 3.6.2020

F656 Crestridge Care Center reasonably ensures that a person-centered care plan will be developed which includes adaptive equipment, fall preventions interventions and antipsychotic medications, side effects and to monitor for non-pharmacological interventions.

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A. R # 29 resident was reassessed. Care plan reviewed and revised which includes adaptive equipment. Resident currently receiving appropriate adaptive equipment during meals.
B. R #30 Reviewed and revised residents care plan which includes antipsychotic medications, side effects, and to monitor for non-pharmacological interventions.
C. R #212 Reviewed and revised residents care plan which includes fall prevention intervention.

- All residents who utilize adaptive equipment for meals, require fall preventions and are prescribed antipsychotic medications.

  A facility wide care plan audit was completed of all persons who utilize adaptive equipment for meals, that require fall prevention interventions and who are prescribed antipsychotic medication.

  Creating a Care plan checklist tool that will now include adaptive equipment during meals, fall preventions interventions and antipsychotic medications, side effects and to monitor for non-pharmacological interventions.

- On 3.6.20 and ongoing, an training was completed on comprehensive care plan and a comprehensive care plan check list tool for nursing staff involved with writing care plans, MDS/Care plan Coordinator, DON which includes adaptive equipment during meals, fall preventions interventions and antipsychotic medications, side effects and to monitor for non-pharmacological interventions.

- The DON or designee will complete weekly comprehensive care plan audits with new admissions, quarterly, annual care plan and or with significant change in condition reviews which will include adaptive equipment during meal times, fall preventions interventions and antipsychotic medications, side effects and to monitor for non-pharmacological interventions.

  An audit will be conducted for 12 weeks and then at that time will be reviewed by QA committee for compliance.

- 3.6.2020

F657 Crestridge Care Center reasonably ensures that each resident has a person-centered comprehensive care plan that is reviewed and revised timely which includes updating the comprehensive care plan quarterly, annually or with significant change in condition.

- R #7 care plan was reviewed and revised as needed.
  R #57 care plan was reviewed and revised to include the use of a broda chair.

- All residents have the potential to be affected, which includes residents that currently utilize a broda chair.

  A facility wide comprehensive care plan audit was completed which includes all persons who utilize a broda chair.

  Comprehensive care plan audit tool was developed to ensure that adaptive equipment is included

  Developed a Stop and Watch tool for all staff which identifies a resident's change in condition which may require updates to the plan of care.

  Developed a Risk Management Tool which includes a daily review of the Resident Care Programs which includes daily updates to resident's plan of care.

- On 3.6.20 and ongoing a training was completed on updating comprehensive care plan and a comprehensive care plan check list tool for nursing staff involved with writing care plans, MDS/Care plan Coordinator, DON which includes updating comprehensive care plans during quarterly, annual and significant changes in conditions.

  On 3.6.20 and ongoing a training was completed for nursing staff, cna's and nurses on the stop and watch tool.

  On 3.6.20 and ongoing, a training for nurse management team was completed on the Risk management tool which includes resident care systems.

- The DON or designee will complete weekly comprehensive care plan audits for updates.

  An audit will be conducted for 12 weeks and then at that time will be reviewed by QA committee for compliance

- Correction Date: 3.6.2020

F658 Crestridge Care Center reasonably ensures that we meet professional standards of quality by following physician's orders which will include PT/INR.

- R #43 PT/INR completed per physician's orders
- All residents who are currently taking blood thinner/ Coumadin may be affected.

  A facility wide audit was completed of all persons on blood thinner/ Coumadin to ensure that PT/INR is drawn.

  Developed Tracking tools for physician orders.

  Developed Tracking tools for labs.

  Developed INR Flow Sheet.

- On 3.6.20 and ongoing a training was completed for DON and ADON on tracking tools to following physician orders which includes drawing PT/INR.

  On 3.6.20 and ongoing a training was completed for DON and ADON on tracking tools for labs.

  On 3.6.20 and ongoing a training was completed for DON and ADON on use of INR flow sheet.

- The DON or designee will complete weekly physician order audits which includes PT/INR

  An audit will be conducted for 12 weeks and then at that time will be reviewed by QA committee for compliance

- Correction Date: 3.6.2020

F686 Crestridge Care Center reasonably ensures that treatments/ interventions are in place to prevent and heal pressure ulcers which includes the completion of weekly skin sheets timely follow up to wounds specialist recommendations R.D. Notification of new skin conditions revision to residents plan of care and physician notification

- R #50 resident reassessed, completed new Braden score and updated care plan. R #22 resident reassessed, completed new Braden score and updated care plan.

- At risk residents with high Braden scores or currently have pressures may be affected.

  Developed stop and watch sheets.

  Developed bath sheets.

  Developed Skin sheets.

  Developed a skin integrity process.

  Developed a Skin Integrity action team meeting which will be held weekly and include the Registered Dietician.

  DON designated as Skin/Wound nurse and will complete weekly rounds on all skin conditions.

- On 2.25.20 and ongoing a training for CNA's, nurses, DON, ADON MDS Coordinator on the following; Stop and Watch sheets, Bath Sheets, Skin Sheets, Skin Integrity Processes.

  On 2.25.20 and ongoing a training with the DON, ADON, Social Worker and the Registered Dietician with the action team meetings.

- The DON or designee will complete weekly skin audits.

  An audit will be conducted for 12 weeks and then at that time will be reviewed by QA committee for compliance

- Correction Date: 2.25.2020

F693 Crestridge Care Center reasonably ensures that enteral nutrition feeding tubes management to ensure proper placement of G-Tube prior to administering any medications or feedings.

- R #33 placed on MAR to check tub placement prior to administering any medications or feedings.

- Residents with enteral nutrition tube may be at risk.

  A facility audit was completed by DON for all residents with enteral nutrition feeding tubes (G-Tubes).

  Addressed on MAR to check placement prior to administering any medications or feedings.

- On 3.6.20 and ongoing a training for nurses on how to check proper placement of G-Tube.

  On 3.6.20 and ongoing a training for nurses on when to check proper placement of G-Tube.

- The DON or designee will complete weekly audits with nurses to ensure checking of tube placement prior to any medication or feeding.

  An audit will be conducted for 12 weeks and then at that time will be reviewed by QA committee for compliance

- Correction Date: 3.6.20

F803 Crestridge Care Center reasonably ensures that resident receive the appropriate serving size during meals and that residents meals will meet resident's needs, be prepared in advance.

- Three residents on pureed diets are receiving the appropriate serving size during meals.

- Residents with pureed altered diets may be affected.

  A facility wide audit was completed by Dietary Supervisor of all residents on a pureed diet.

  Developed new service sheets to show which residents require pureed diets

  Developed a skills checklist on facility guideline for pureed processes.

  Developed check list and audit tool to ensure review by the R.D.

  Registered Dietician will complete weekly observations of the pureed process with cooks.

- On 3.6.20 and ongoing training was completed with the cooks and Dietary Manager on the facility guidelines for pureed processes, menus and nutritional so that resident receive the appropriate serving size during meals

  On 3.6.20 and ongoing a training with cooks on how to meet the nutritional needs of residents in accordance with established national guidelines.

- The Administrator or designee will complete weekly audits to ensure that resident meals will meet resident's needs, and be prepared in advance.

  An audit will be conducted for 12 weeks and then at that time will be reviewed by QA committee for compliance

- Correction Date: 3.6.20

F804 Crestridge Care Center reasonably ensures that the resident's food is served safe, palatable and appetizing temperatures.

- The residents in the CCDI units are receiving food that is safe, palatable and appetizing temperatures.
- Any resident who is served in a dining area may be affected, which includes the residents in the CCDI unit.

  A facility wide audit was completed of all persons dining in a dining room.

  Developed Tracking tools to check for safe, palatable and appetizing temperatures.

- On 3.6.20 and ongoing a training with the cooks on how to check temperatures

  On 3.6.20 and ongoing a training for cooks on where to document temperatures.

  On 3.6.20 and ongoing a training for cooks for appropriate temperatures of food and drink.

- The Dietary Supervisor or designee will complete weekly audits which includes food and drinks which include safe, palatable and appetizing temperatures.

  An audit will be conducted for 12 weeks and then at that time will be reviewed by QA committee for compliance

- Correction Date: 3.6.2020

F880 Crestridge Care Center reasonably ensures that we 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.

- R #7, staff A was educated regarding the facilities infection control policies and procedures on 3.6.20
  R #45, staff F was educated regarding the facilities infection control policies and procedures on 3.6.20
- All residents may be affected.

  Checklist was created for handwashing and glove usage

  Conducted a skills fair on handwashing and glove usage during cares.

- On 3.6.20 and ongoing a training for cna's and nurses on infections, which includes 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.

  On 3.6.20 and ongoing a training for cna's and nurses was completed on hand washing and glove usage during skills fair.

- The DON or designee will complete weekly infection precaution audits which includes handwashing and glove usage during cares.

  An audit will be conducted for 12 weeks and then at that time will be reviewed by QA committee for compliance

- Correction Date: 3.6.2020