STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	165145	A. BUILDING _____ B. WING _____	C 10/26/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
EMBASSY REHAB AND CARE CENTER	206 PORT NEAL ROAD SERGEANT BLUFF, IA 51054

(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 11/11/20 A Focused COVID-19 Infection Control Survey and investigation of Facility Reported Incident #90775-I and Complaints #87334-C, #90625-C, #93383-C were investigated ending on 10/26/20 and resulted in the following deficiencies. Facility Reported Incident #90775-I was substantiated Complaint #87334-C was substantiated. Complaint #90625-C was substantiated. Complaint #93383-C was substantiated. The facility was found not to be in compliance with CMS and Centers for Disease Control and Prevention (CDC) recommended practices to prepare for COVID-19. Total residents: 42 (See Code of Federal Regulations (42CFR) Part 483, Subpart B -C).	F 000		
F 550 SS=E	Resident Rights/Exercise of Rights CFR(s): 483.10(a)(1)(2)(b)(1)(2) §483.10(a) Resident Rights. The resident has a right to a dignified existence, self-determination, and communication with and access to persons and services inside and outside the facility, including those specified in this section. §483.10(a)(1) A facility must treat each resident with respect and dignity and care for each resident in a manner and in an environment that promotes maintenance or enhancement of his or her quality of life, recognizing each resident's	F 550	Staff retrained on 11/11/20 regarding resident rights. At each resident council meetings residents will be asked regarding experiencing or hearing any yelling, derogatory remarks, rudeness, roughness associated with care towards residents and resident having items thrown at them or their roommates. Resident Council meeting will be held on 11/9/20.	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Patricia Leck | TITLE: Administrator | (X6) DATE: 11-12-2020

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	165145	A. BUILDING _____ B. WING _____	C 10/26/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
EMBASSY REHAB AND CARE CENTER	206 PORT NEAL ROAD SERGEANT BLUFF, IA 51054

(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 550	Continued From page 1 individuality. The facility must protect and promote the rights of the resident. §483.10(a)(2) The facility must provide equal access to quality care regardless of diagnosis, severity of condition, or payment source. A facility must establish and maintain identical policies and practices regarding transfer, discharge, and the provision of services under the State plan for all residents regardless of payment source. §483.10(b) Exercise of Rights. The resident has the right to exercise his or her rights as a resident of the facility and as a citizen or resident of the United States. §483.10(b)(1) The facility must ensure that the resident can exercise his or her rights without interference, coercion, discrimination, or reprisal from the facility. §483.10(b)(2) The resident has the right to be free of interference, coercion, discrimination, and reprisal from the facility in exercising his or her rights and to be supported by the facility in the exercise of his or her rights as required under this subpart. This REQUIREMENT is not met as evidenced by: Based on record review, policy review, personnel file review, and staff interviews the facility failed to ensure the residents were treated with dignity and respect for 5 of 11 residents reviewed (Residents #6, #8, #10, #17, & #26). The facility reported a census of 42 residents. Findings include: 1. A Minimum Data Set (MDS) with a completion	F 550	Staff retrained on abuse on 11/11/20 regarding verbal and physical abuse and on resident rights policy and facility staff will be questioned randomly on abuse this will be completed weekly x 4 weeks then monthly x 4 by social service/ designee. Results will be communicated to the QAPI team.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	165145	A. BUILDING _____ B. WING _____	C 10/26/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
EMBASSY REHAB AND CARE CENTER	206 PORT NEAL ROAD SERGEANT BLUFF, IA 51054

(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 550	Continued From page 2 date of 8/27/20, for Resident #6, listed diagnoses of Alzheimer's disease, Non-Alzheimer's Disease, and Cerebrovascular Accident. The MDS scored the resident with a BIMS of 5, severe cognitive impairment. The MDS documented the resident as requiring assist of one staff for bed mobility, transfers, dressing, toileting, and personal hygiene. Care Plan: Care plan focus area psychosocial well-being and activity level with initiation date of 3/8/17, identified resident at risk due to forgetfulness as evidenced by diagnosis. Interventions included: friendly and enjoy socializing with others in the afternoons and evenings (3/8/17) and enjoy late night socializing in the common areas (12/8/17). 2. A MDS with a completion date of 9/17/20, for Resident #8, listed diagnosis of Alzheimer's Dementia, Diabetes Mellitus, Hypertension, and Legally Blind. The MDS scored the resident with a BIMS of 7, severe cognitive impairment. The MDS coded the resident as requiring extensive assist of 1 staff for bed mobility, transfers, dressing, toileting, and personal hygiene. 3. A MDS with a completion date of 09/24/20, for Resident #10, listed diagnosis of Anxiety, Depression, Other Mental Disorder due to known Physiological condition, and disorientation. The MDS scored the resident with a BIMS of 1, severe cognitive impairment. The MDS coded the resident as requiring extensive assist of 1 for bed mobility, transfers, dressing, toileting, and personal hygiene. Care Plan:	F 550		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	165145	A. BUILDING _____ B. WING _____	C 10/26/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
EMBASSY REHAB AND CARE CENTER	206 PORT NEAL ROAD SERGEANT BLUFF, IA 51054

(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 550	Continued From page 3 Care plan focus area psychosocial well-being and activity level with initiation date of 5/4/17, identified the resident at risk due to forgetfulness as evidenced by diagnosis. Interventions included: enjoy strolling through facility visiting with other residents (5/4/17) and sometimes feels lost in thought, and feel at ease with patience and explanation (12/18/17). 4. A MDS with a completion date of 9/8/20, for Resident #17, listed diagnoses of Cerebrovascular Accident, Renal Insufficiency, Atrial Fibrillation, and Hypertension. The MDS scored the resident with a Brief Interview of Mental Status (BIMS) of 5, severe cognitive impairment. The MDS documented the resident as requiring physical assist of two staff for bed mobility, transfers, dressing, toileting, and personal hygiene. Care Plan: Care plan focus behaviors with initiation date of 2/14/20, identified abusive language. Interventions included: staff will re-direct the resident as needed and staff will show the resident respect at all times (2/14/20). Care plan focus activities of daily living with initiation date of 5/31/19, identified the resident required assistance with dressing, grooming, and bathing. Intervention included: when getting the resident dressed be careful with left arm due to limited mobility in that shoulder (8/27/19). 5. A MDS with a completion date of 8/17/20, for Resident #26, listed diagnosis of Non-Alzheimer's Dementia, Alzheimer's Dementia, Anxiety, and	F 550		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	165145	A. BUILDING _____ B. WING _____	C 10/26/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
EMBASSY REHAB AND CARE CENTER	206 PORT NEAL ROAD SERGEANT BLUFF, IA 51054

(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 550	Continued From page 4 Hypertension. The MDS identified the resident with short term and long term memory impairment. The MDS coded the resident as requiring extensive assist of 2 staff for bed mobility, transfers, dressing, toileting, and personal hygiene. Care Plan: Care plan focus diagnosis of Alzheimer's and anxiety with initiation date of 11/29/17, identified the resident displayed signs of agitation, restlessness, pacing, repetitive questions, raised voice, refusing cares, and becoming combative with staff and other residents. Interventions included: Ativan scheduled every day (10/9/19), went to Hope Harbor to monitor behaviors and medications (10/7/19), room moved to another hallway that was quiet as noise agitated me at times (8/8/19), encouraged to remain in the hallway of current room (11/10/19), encouraged to sit in recliner to look outside and watch television (8/8/19), encouraged to sit at nurses station, away from flow of traffic to maintain personal space (7/3/19), assess, identify, & resolve why agitated (11/29/17), remain calm and speak with low tone and slow rate (11/29/17), and allow adequate personal space (11/29/17). Policies: Abuse Prevention Plan - Iowa Policy with a revision date of March 2019: all residents residing in the facility will be protected from abuse, neglect, misappropriation of funds/property, exploitation, or involuntary seclusion, mistreatment/maltreatment, and that interventions are implemented to provide the vulnerable adult with a safe living environment. Reportable Situations Policy with a revision date	F 550		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	165145	A. BUILDING _____ B. WING _____	C 10/26/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
EMBASSY REHAB AND CARE CENTER	206 PORT NEAL ROAD SERGEANT BLUFF, IA 51054

(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 550	Continued From page 5 of March 2019: staff to report alleged abuse/neglect, or incidents which result in injury that require more than first aide. This could be resident to resident, staff to resident, visitor incident/injury. Resident Incident Report Policy with a revision date of March 2019: to ensure all incidents are reported in a timely manner. To ensure that the appropriate facility staff are informed of all resident incidents. To ensure the resident care plans adequately reflect resident care needs. Job Descriptions for Registered Nurse, Licensed Practical Nurse, and Certified Nursing Assistants dated 7/1/2018 include: " Knowledgeable to resident rights and ensures an atmosphere which allows for the privacy, dignity, and well-being of a all residents in a safe, secure environment " Residents always come first, and their needs will be met " Residents, resident families, co-workers, and visitors will be treated with respect, dignity, and kindness Review of Personnel files: Staff L Certified Medication Aide - one disciplinary action dated 4/30/20, due to inappropriate behavior, verbally and nonverbally. Two complaints from residents that Staff L tone of voice and actions were rude, had lack of respect, and dignity of residents. Staff P Certified Nursing Assistant - no disciplinary action in the last 6 months Staff J Licensed Practical Nurse - no disciplinary action in the last 6 months Interview on 9/24/20 at 11:10 AM, Staff L Certified Medication Aide (CMA) stated she witnessed	F 550		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	165145	A. BUILDING _____ B. WING _____	C 10/26/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
EMBASSY REHAB AND CARE CENTER	206 PORT NEAL ROAD SERGEANT BLUFF, IA 51054

(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 550	Continued From page 6	F 550		

Staff J Licensed Practical Nurse (LPN) rude and yelled at residents. Staff L CMA stated Resident #10, had dementia and did not understand. The CMA stated Staff J LPN does not have patience for Resident #10. The CMA stated the night she witnessed Staff J rude & yelling at Resident #10, she tried to intervene. The CMA stated she refuses to work with Staff J. The CMA identified Administration as aware of the concerns with Staff J. The CMA stated when Staff J was rude & yelling at Resident #10, it made the resident feel awful as the resident is already confused.

Interview on 10/1/20 at 8:00 AM, Staff J LPN stated Resident #8 complained about Staff L CMA, however, unable to provide any specific complaints or concerns. The LPN stated Resident #8 was not easily re-directed when talking about Staff L. The LPN stated she filed complaints in writing to Administration regarding how Staff L treats Resident #17, however, felt the resident was retaliated against and no longer reports concerns.

Interview on 10/5/20 at 11:46 AM, Staff O Certified Nursing Assistant (CNA) stated Staff J LPN talks down to residents and will yell at them. The CNA stated she witnessed Staff P CNA call the dementia residents' names and be rough with them during cares.

Interview on 10/5/20 at 1:52 PM, Staff Q CNA stated she wrote several letters to the Administrator and Nurse Consultant/Interim Director of Nursing (DON) of her concerns with Staff J LPN and Staff P CNA, regarding their treatment of residents during cares. The CNA stated Staff J LPN yelled at residents when residents came out of their rooms. The CNA

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	165145	A. BUILDING _____ B. WING _____	C 10/26/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
EMBASSY REHAB AND CARE CENTER	206 PORT NEAL ROAD SERGEANT BLUFF, IA 51054

(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 550	Continued From page 7 stated she witnessed Staff J yell down the hall at Resident #6, instead of go the resident and this caused Resident #6 frustration and not able to understand. The CNA stated she witnessed Staff P CNA rough with Resident #17, while providing cares. The CNA stated Staff P CNA pulled on Resident #17's left arm and it caused pain. Interview on 10/5/20 at 3:41 PM, Staff R CMA stated she informed the Administrator, over 2 months ago, that she needed to discuss concerns about Staff J & Staff P behaviors towards the residents, however, the CMA stated her schedule was adjusted so she never worked with Staff P after that. The CMA stated the Administrator did not acknowledge her letters and had never spoke with her about her concerns. The CMA stated she witnessed Staff J LPN yell at the residents to return to their rooms. The CMA stated she witnessed Staff P CNA throw a bag of garbage at Resident #26 after they completed cares during the night shift. The CMA stated Staff P threw the bag of garbage at the resident, making contact with the resident, because Staff P stated Resident #26 had behaviors on purpose. The CMA stated Resident #26 did have behaviors that night; had been yelling, wanted up, and was hungry. The CMA stated Staff P stated she was not going to reward bad behavior by getting the resident something to eat. The CMA stated she had left specific notes for the Administration regarding her concerns. Interview on 10/12/20 at 12:31 PM, Staff S LPN stated she witnessed Staff J LPN and Staff P CNA talk rudely and degrading to Resident #10. The LPN stated in the last 2-3 weeks, she witnessed Staff J LPN yell at the residents from the nurse's station. The LPN stated if residents	F 550		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	165145	A. BUILDING _____ B. WING _____	C 10/26/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
EMBASSY REHAB AND CARE CENTER	206 PORT NEAL ROAD SERGEANT BLUFF, IA 51054

(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 550	Continued From page 8 come out of their rooms at 10:00 PM, while staff are in report, Staff J will yell from the nurses station for the residents to return to their room, stating they know they are not supposed to be out of their rooms. Interview on 10/13/20 at 9:06 AM, Staff R CMA stated she witnessed Staff P CNA throw a bag of garbage at Resident #26. The CMA stated she was unable to recall specific day, however, Staff R reported the incident to the Director of Nursing (DON) at the time of the incident. The CMA stated she felt the DON, at the time, attempted to deal with staff issues. The CMA stated Staff P and herself went into Resident #26 room to provide cares and Staff P just pulled back the covers without explaining to the resident what she was doing, which startled Resident #26. The CMA stated once they completed cares, Staff P took the bag of garbage and threw it at Resident #26, and it landing on the resident's chest. The CMA stated Resident #26, grabbed the bag of garbage and called Staff P a derogatory name. The CMA stated she picked up the bag of garbage, calmly talked to Resident #26, and covered her prior to leaving the room. The CMA stated as Staff P left the resident's room, she told the CMA to deal with the resident. The CMA stated she wrote a note to the Administrator and DON, at the time, that she needed to speak with them about Resident #26 and Staff P. Interview on 10/13/20 at 11:35 AM, the Administrator stated she had no idea about the incident between Resident #26 and Staff P CNA. The Administrator continued to state she had never heard of this incident and if she had been aware, she would have investigated.	F 550		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	165145	A. BUILDING _____ B. WING _____	C 10/26/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
EMBASSY REHAB AND CARE CENTER	206 PORT NEAL ROAD SERGEANT BLUFF, IA 51054

(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 550	Continued From page 9 Interview on 10/26/20 at 9:29 AM, the Administrator stated she would expect all residents and staff to be treated with respect. The Administrator stated all staff knew to walk away if they need to. The Administrator stated no one was to be treated rudely.	F 550		
F 552 SS=D	Right to be Informed/Make Treatment Decisions CFR(s): 483.10(c)(1)(4)(5) §483.10(c) Planning and Implementing Care. The resident has the right to be informed of, and participate in, his or her treatment, including: §483.10(c)(1) The right to be fully informed in language that he or she can understand of his or her total health status, including but not limited to, his or her medical condition. §483.10(c)(4) The right to be informed, in advance, of the care to be furnished and the type of care giver or professional that will furnish care. §483.10(c)(5) The right to be informed in advance, by the physician or other practitioner or professional, of the risks and benefits of proposed care, of treatment and treatment alternatives or treatment options and to choose the alternative or option he or she prefers. This REQUIREMENT is not met as evidenced by: Based on record review, staff and family interviews the facility failed to provide the resident &/or the resident representative the right to be informed and make decisions related to the pharmacy provider for 1 of 1 residents reviewed (Resident #17). The facility reported a census of 42 residents.	F 552	Resident #17 payer status changed to Medicaid on 2/1/20. Current residents are veterans will be reviewed and responsible party contacted regarding us of VA meds by 11/9/20. Resident residing currently at Embassy that incur a payer change will be offered choice of pharmacies depending on their payer status. All new admissions to Embassy will be identified upon admission and offered choice of pharmacy dependent on payer status. Audits will be completed weekly for 4 weeks and then 4 months by DON/ Designee. Results will be reported to the QAPI team.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	165145	A. BUILDING _____ B. WING _____	C 10/26/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
EMBASSY REHAB AND CARE CENTER	206 PORT NEAL ROAD SERGEANT BLUFF, IA 51054

(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 552	Continued From page 10 Findings include: A Minimum Data Set (MDS) for Resident #17 with a completion date of 9/8/20, listed diagnoses of Cerebrovascular Accident, Renal Insufficiency, Atrial Fibrillation, and Hypertension. The MDS scored the resident with a Brief Interview of Mental Status (BIMS) of 5, severe cognitive impairment. The MDS documented the resident as requiring physical assist of two staff for bed mobility, transfers, dressing, toileting, and personal hygiene. Review of Census in the resident's Electronic Health Record revealed: " 5/31/2019 - the resident admitted to the facility with primary payer identified as Medicare A Iowa " 6/12/2019 - the resident discharged to the hospital " 7/17/2019 - the resident admitted to the facility with primary payer identified as Medicare A Iowa " 10/11/2019 - the resident primary payer changed to Private Pay Iowa " 2/1/2020 - the resident primary payer changed to Iowa Total Care (Medicaid) On 10/6/20 at 1:06 PM, the Nurse Consultant/Interim Director of Nursing (DON) stated she did not know if the facility offered the resident &/or resident representative medications from the Veterans Administration (VA) Pharmacy when the resident's primary payer changed to Private Pay. On 10/6/20 at 10:55 AM, the Business Office Manager (BOM) confirmed the resident's primary payer from 10/11/20 - 1/31/20 as Private Pay. The	F 552		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	165145	A. BUILDING _____ B. WING _____	C 10/26/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
EMBASSY REHAB AND CARE CENTER	206 PORT NEAL ROAD SERGEANT BLUFF, IA 51054

(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 552	Continued From page 11 BOM stated she did not know if the former DON offered the VA Pharmacy at that time. The BOM confirmed the facility obtained the resident's veteran status on 5/30/19. On 10/13/20 at 1:55 PM, the BOM stated when residents are admitted to the facility with the primary payer as Medicare A, Omnicare Pharmacy is used for all medications. The BOM stated when the resident changes primary payer to Medicaid or Private Pay, the pharmacy provider stays the same unless the family requests a different pharmacy. On 10/14/20 at 2:50 PM, the resident's daughter (the resident's Power Of Attorney at the time the resident's primary payer was Private Pay) stated the facility did not discuss pharmacy options with her and the ability to get the resident's medications from the VA Pharmacy. The resident's daughter stated she would have gotten the resident's medications from the VA Pharmacy due to previously utilizing the VA Benefits. Interview on 10/26/20 at 9:40 AM, the Nurse Consultant/Interim DON stated she was unsure exactly of the facilities procedure, however, typically the facility would use Omnicare pharmacy for all residents unless the resident &/or the resident representative requested a different pharmacy.	F 552		
F 580 SS=D	Notify of Changes (Injury/Decline/Room, etc.) CFR(s): 483.10(g)(14)(i)-(iv)(15) §483.10(g)(14) Notification of Changes. (i) A facility must immediately inform the resident; consult with the resident's physician; and notify, consistent with his or her authority, the resident	F 580		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	165145	A. BUILDING _____ B. WING _____	C 10/26/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
EMBASSY REHAB AND CARE CENTER	206 PORT NEAL ROAD SERGEANT BLUFF, IA 51054

(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 580	Continued From page 12 representative(s) when there is- (A) An accident involving the resident which results in injury and has the potential for requiring physician intervention; (B) A significant change in the resident's physical, mental, or psychosocial status (that is, a deterioration in health, mental, or psychosocial status in either life-threatening conditions or clinical complications); (C) A need to alter treatment significantly (that is, a need to discontinue an existing form of treatment due to adverse consequences, or to commence a new form of treatment); or (D) A decision to transfer or discharge the resident from the facility as specified in §483.15(c)(1)(ii). (ii) When making notification under paragraph (g)(14)(i) of this section, the facility must ensure that all pertinent information specified in §483.15(c)(2) is available and provided upon request to the physician. (iii) The facility must also promptly notify the resident and the resident representative, if any, when there is- (A) A change in room or roommate assignment as specified in §483.10(e)(6); or (B) A change in resident rights under Federal or State law or regulations as specified in paragraph (e)(10) of this section. (iv) The facility must record and periodically update the address (mailing and email) and phone number of the resident representative(s). §483.10(g)(15) Admission to a composite distinct part. A facility that is a composite distinct part (as defined in §483.5) must disclose in its admission agreement	F 580	Resident #8 and Resident #14 expired on 10/15/20. Resident #14 responsible party updated on 11/9/20 regarding falls occurring on 7/14/20, 7/16/20, and 7/25/20. All residents assessed in the building on 11/10/20 regarding possible condition changes. Professional nursing staff retrained on Policy of Change of Condition and Status on 11/9/20. Audits will be completed weekly for 4 weeks and then monthly for 4 months by DON/Designee. Results will be reported to the QAPI team.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	165145	A. BUILDING _____ B. WING _____	C 10/26/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
EMBASSY REHAB AND CARE CENTER	206 PORT NEAL ROAD SERGEANT BLUFF, IA 51054

(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 580	Continued From page 13 its physical configuration, including the various locations that comprise the composite distinct part, and must specify the policies that apply to room changes between its different locations under §483.15(c)(9). This REQUIREMENT is not met as evidenced by: Based on record review, policy review, and staff interview the facility failed to notify the family &/or the residents' representative of a change in condition for 3 of 3 (Residents #8, #14, & #26) residents reviewed. The facility reported a census of 42 residents. Findings Include: 1. A Minimum Data Set (MDS) with a completion date of 9/17/20, for Resident #8, listed diagnosis of Alzheimer's Dementia, Diabetes Mellitus, Hypertension, and Legally Blind. The MDS scored the resident 7, severely cognitive impaired on the Brief Interview for Mental Status (BIMS). The MDS coded the resident as requiring extensive assist of 1 staff for bed mobility, transfers, dressing, toileting, and personal hygiene. Care Plan: Care plan focus altered skin integrity related to bladder incontinence and decreased mobility with initiation date of 6/17/14, identified the resident had an open area on buttocks 6/9/20 and was healed on 6/16/20. Listed interventions included: incontinent products, staff to assist with incontinent cares, staff to monitor skin, and encourage to lay down in bed after meals to allow pressure relief. Progress note entry dated 6/9/20 at 11:15 AM, while the Certified Nursing Assistant (CNA)	F 580		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	165145	A. BUILDING _____ B. WING _____	C 10/26/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
EMBASSY REHAB AND CARE CENTER	206 PORT NEAL ROAD SERGEANT BLUFF, IA 51054

(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 580	Continued From page 14 assisted the resident with toileting staff observed an area to the right gluteal crease near coccyx measuring 0.5 x 0.5 centimeters (cm) pink appearing as a wrinkled spot, blister like without fluid. Staff cleansed the area and applied barrier cream. Discussed with the resident about lying down after breakfast and lunch and discussed with therapy about different chair &/or cushion. Name of family member notified and time of notification was left blank. The residents' primary care provider was notified. An incident report dated 6/9/20 at 11:15 AM, identified the resident with a spot on her bottom. The incident report identified that the residents' primary care provider received notification but there was no documentation that the residents' responsible party was notified. A physician order dated 6/10/20 at 12:21 PM, identified an order for Calmoseptine Ointment (Menthol-Zinc Oxide) to gluteal crease topically every shift for skin integrity and discontinue when healed. Review of the clinical record revealed the facility failed to notify the residents' responsible party of the area on the coccyx on 6/9/20, &/or of the new treatment order received on 6/10/20. 2. A MDS with a completion date of 10/13/20, for Resident #14, listed diagnosis of Non-Alzheimer's Dementia, Diabetes Mellitus, Cerebrovascular Accident, and Schizophrenia. A BIMS test identified the resident with a score of 14 (cognitively intact). The MDS coded the resident as requiring limited assist of 1 staff for bed mobility, transfers, dressing, toileting, and personal hygiene. The MDS identified the	F 580		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	165145	A. BUILDING _____ B. WING _____	C 10/26/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
EMBASSY REHAB AND CARE CENTER	206 PORT NEAL ROAD SERGEANT BLUFF, IA 51054

(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 580	Continued From page 15 resident as occasionally incontinent of urine and always continent of bowel. Care Plan: Care plan focus for transfers, bed mobility, and ambulation with initiation date of 7/2/20, identified the resident needed assistance and had falls identified on 7/14/20, 7/16/20 x 2, and 7/25/20. Goal was: maintain ability to ambulate independently initiated 7/13/20. Interventions included: assist x 1 with mobility (7/13/20), grab bar to outside of bed (7/15/20), sit in recliner by nurses station when awake (7/16/20), sign placed in room reminding to ask for assist with transfers (7/16/20), ensure wheeled walker in good repair and available at all times (7/13/20), therapy determine height of bed and marked on wall and at that height when not sleeping (7/27/20), and use of wheeled walker (7/2/20). Care plan focus for toileting with initiation date of 7/2/20, identified the resident needed assist of 1 with toileting. Progress Notes: " 7/14/20 at 3:42 AM, the resident was found sitting on the bed, the walker laying on its side, urine on the floor in front of the bathroom door, and a small amount of blood noted on the floor near the bed. Noted the resident had a 1 centimeter (cm) skin tear to left elbow and small red area to right knee. Area was cleansed and steri-strips applied. Noted the resident was slightly confused per usual. " 7/16/20 at 8:08 PM, the resident was found on the floor on his back. The resident stated he was going to bathroom, grabbed door frame, got dizzy, and fell. No injuries noted, however, noted	F 580		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	165145	A. BUILDING _____ B. WING _____	C 10/26/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
EMBASSY REHAB AND CARE CENTER	206 PORT NEAL ROAD SERGEANT BLUFF, IA 51054

(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 580	Continued From page 16 high heart rate. Noted resident to be impulsive, re-orientated, asks about wife coming to visit, and incontinent. " 7/25/20 at 2:25 AM, the resident was found sitting on the floor against his bed. The resident stated he was sitting on the edge of the bed and slid down. The resident was incontinent at this time. The residents' primary care provider was notified and family will be notified later in the morning. Incident reports: " 7/14/20 at 3:00 AM, identified the resident had fallen in his room. The resident was found sitting on the bed, with the walker laying on its side, urine on the floor in front of the bathroom door, and a small amount of blood noted on the floor near the bed. Mental status: orientated to person and to situation. Section where Agencies/People Notified was blank. " 7/16/20 at 5:45 PM, identified the resident had fallen in his room. The resident was found lying on back, partly in room and partly in bathroom. Mental status: orientated to person. Predisposing physiological factors: recent change in condition. The residents' primary care provider was notified at 8:16 PM. " 7/25/20 at 2:25 AM, identified the resident had fallen in his room. The resident was found sitting on the floor against his bed. Mental status: orientated to person, situation, and time. The residents' primary care provider was notified at 4:48 AM. Review of the clinical record revealed the facility failed to notify the residents' responsible party of the falls that occurred on 7/14/20, 7/16/20, and 7/25/20. 3. A MDS with a completion date of 8/17/20, for	F 580		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	165145	A. BUILDING _____ B. WING _____	C 10/26/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
EMBASSY REHAB AND CARE CENTER	206 PORT NEAL ROAD SERGEANT BLUFF, IA 51054

(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 580	Continued From page 17 Resident #26, listed diagnosis of Non-Alzheimer's Dementia, Alzheimer's Dementia, Anxiety, and Hypertension. The MDS identified the resident with short term and long term memory impairment. The MDS coded the resident as requiring extensive assist of 2 staff for bed mobility, transfers, dressing, toileting, and personal hygiene. The MDS coded the resident as requiring limited assist of one staff for eating. The MDS identified the resident as receiving on a mechanically altered diet. Care Plan: Care plan focus diagnosis of Alzheimer's and anxiety with initiation date of 11/29/17, identified the resident displayed signs of agitation, restlessness, pacing, repetitive questions, raised voice, refusing cares, and becoming combative with staff and other residents. Interventions included: Ativan scheduled every day (10/9/19), went to Hope Harbor to monitor behaviors and medications (10/7/19), room moved to another hallway that was quiet as noise agitated me at times (8/8/19), encouraged to remain in the hallway of current room (11/10/19), encouraged to sit in recliner to look outside and watch television (8/8/19), encouraged to sit at nurses station, away from flow of traffic to maintain personal space (7/3/19), assess, identify, & resolve why agitated (11/29/17), remain calm and speak with low tone and slow rate (11/29/17), and allow adequate personal space (11/29/17). Care plan focus Activities of daily living with initiation date of 11/30/17, identified the resident required extensive assist due to diagnosis progression. Care plan focus diet/eating with initiation date of	F 580		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	165145	A. BUILDING _____ B. WING _____	C 10/26/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
EMBASSY REHAB AND CARE CENTER	206 PORT NEAL ROAD SERGEANT BLUFF, IA 51054

(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 580	Continued From page 18 11/30/17, identified the resident as independent with eating and on a general dysphagia advanced diet with ground meat and nectar thick liquids. Interventions included: staff to monitor for changes in ability to eat independently or safely (11/30/17). Progress Notes: " 4/17/20 at 5:54 AM, the resident hollered to get out of her room and staff took her to the dining room. The resident asked for a cup of coffee and staff provided her with a cup of thickened coffee. The resident took sips of coffee and missed the table, and dropped the coffee on her lap resulting in a fluid filled blister measuring 4.7 x 2.8, which staff covered with tegaderm (transparent dressing). " 5/22/20 at 12:58 AM, the resident called out for her mom and yelled help me. Staff found the resident lying on the floor next to the bed resulting in a 2.8 centimeter moon shaped skin tear to left arm. Staff cleansed the area, applied steri-strips and covered it with gauze. The residents' primary care provider was notified at 3:04 AM. An incident report dated 4/17/20 at 5:52 AM, revealed the resident was in the dining room and spilled coffee on her lap. Immediate action taken: area assessed and tegaderm applied over fluid filled blister. Injuries observed at time of incident: blister to right thigh. Witness section was left blank. The residents' primary care provider was notified at 5:54 AM. Review of the clinical record revealed the facility failed to notify the residents' responsible party of the coffee spill that resulted in a blister that occurred on 4/17/20, and of the fall that resulted in a skin tear on 5/22/20.	F 580		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	165145	A. BUILDING _____ B. WING _____	C 10/26/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
EMBASSY REHAB AND CARE CENTER	206 PORT NEAL ROAD SERGEANT BLUFF, IA 51054

(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 580	Continued From page 19 Policies: Fall Prevention and Response Policy with a revision date of April 2020, instructed when fall occurs: " The resident's family will be notified of the resident's assessed fall risk. The resident's family will be requested to participate in the planning for interventions to prevent further falls " Post fall documentation includes notifications to physician and family/responsible party, root cause analysis, interventions, response to interventions, effectiveness, of interventions, and injuries noted. Change of Condition or Status Policy with a revision date of March 2019, instructed: " Assure all necessary parties are notified promptly when a resident has had a change in condition which may necessitate orders from the physician and maintain accuracy with the resident's overall plan of care " Families/resident representative will be notified of any change in condition, emergent or not. If incident occurs with no injury or slight injury, during sleeping hours the call should be made the next morning. " Notification of family/significant other: the facility must promptly notify the resident and family or legal representative when the resident is involved any accident or incident that results in an injury, including injuries of unknown origin; and document in the medical record who was contacted and what time Interview 10/14/20 at 11:25 AM, the Nurse Consultant/Interim Director of Nursing (DON) confirmed the facility did not notify Resident #26's	F 580		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	165145	A. BUILDING _____ B. WING _____	C 10/26/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
EMBASSY REHAB AND CARE CENTER	206 PORT NEAL ROAD SERGEANT BLUFF, IA 51054

(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 580	Continued From page 20 family of the coffee being spilled and resulting lister. Interview 10/15/20 at 10:00 AM, the Nurse Consultant/Interim DON confirmed the facility did not nbotify Resident #8's family of change in condition or Resident #14's family of falls. The Nurse Consultant/Interim DON stated she would expect families to be notified of falls and change in resident's condition.	F 580		
F 609 SS=D	Reporting of Alleged Violations CFR(s): 483.12(c)(1)(4) §483.12(c) In response to allegations of abuse, neglect, exploitation, or mistreatment, the facility must: §483.12(c)(1) Ensure that all alleged violations involving abuse, neglect, exploitation or mistreatment, including injuries of unknown source and misappropriation of resident property, are reported immediately, but not later than 2 hours after the allegation is made, if the events that cause the allegation involve abuse or result in serious bodily injury, or not later than 24 hours if the events that cause the allegation do not involve abuse and do not result in serious bodily injury, to the administrator of the facility and to other officials (including to the State Survey Agency and adult protective services where state law provides for jurisdiction in long-term care facilities) in accordance with State law through established procedures. §483.12(c)(4) Report the results of all investigations to the administrator or his or her designated representative and to other officials in accordance with State law, including to the State	F 609	Resident #26 expired on 10/15/20. Facility staff retrained on 11/11/20 on Compliance with Reporting Allegations of Abuse/Neglect/ Exploitation. New signage created regarding notification of allegations of abuse placed at nurse's station, laundry room, therapy room, dietary department on 11/9/20. Audits will be completed weekly for 4 weeks and then monthly for 4 months by DON/ Designee. Results will be reported to the QAPI team.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	165145	A. BUILDING _____ B. WING _____	C 10/26/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
EMBASSY REHAB AND CARE CENTER	206 PORT NEAL ROAD SERGEANT BLUFF, IA 51054

(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 609	Continued From page 21 Survey Agency, within 5 working days of the incident, and if the alleged violation is verified appropriate corrective action must be taken. This REQUIREMENT is not met as evidenced by: Based on record review, policy review, personnel file review, and staff interview, the facility failed to investigate and report mistreatment of a resident for 1 of 1 residents (Resident #26) reviewed. The facility reported a census of 42 residents. Findings include: A Minimum Data Set with a completion date of 8/17/20, for Resident #26, listed diagnosis of Non-Alzheimer's Dementia, Alzheimer's Dementia, Anxiety, and Hypertension. The MDS identified the resident with short term and long term memory impairment. The MDS coded the resident as requiring extensive assist of 2 staff for bed mobility, transfers, dressing, toileting, and personal hygiene. Care Plan: Care plan focus diagnosis of Alzheimer's and anxiety with initiation date of 11/29/17, identified the resident displayed signs of agitation, restlessness, pacing, repetitive questions, raised voice, refusing cares, and becomes combative with staff and other residents. Interventions included: Ativan scheduled every day (10/9/19), went to Hope Harbor to monitor behaviors and medications (10/7/19), room moved to another hallway that was quiet as noise agitated me at times (8/8/19), encouraged to remain in the hallway of current room (11/10/19), encouraged to sit in recliner to look outside and watch television (8/8/19), encouraged to sit at nurses	F 609		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	165145	A. BUILDING _____ B. WING _____	C 10/26/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
EMBASSY REHAB AND CARE CENTER	206 PORT NEAL ROAD SERGEANT BLUFF, IA 51054

(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 609	Continued From page 22 station, away from flow of traffic to maintain personal space (7/3/19), assess, identify, & resolve why agitated (11/29/17), remain calm and speak with low tone and slow rate (11/29/17), and allow adequate personal space (11/29/17). Policies: Abuse Prevention Plan-Iowa Policy revised date of March 2019, all residents residing the facility will be protected from abuse, neglect, misappropriation of funds/property, exploitation or involuntary seclusion, mistreatment/maltreatment and that interventions are implemented to provide the vulnerable adult with a safe living environment. " Any covered individual is required to report any reasonable suspicion of a crime against a resident per the reporting requirements in this policy " Facility will identify events that may constitute maltreatment such as abuse, neglect, exploitation and misappropriation of resident property and determine the direction of the investigation " Facility will investigate all incidences such as falls, bruises, medication errors, resident complaints, etc " Residents, the alleged perpetrator, other staff and the integrity of the investigation will be protected from harm during an investigation " The facility requires that all suspected maltreatment will be reported to the Administrator and the State promptly " All staff are required to report suspected maltreatment of a vulnerable adult to the Administrator " The Administrator will make sure that a report is filed, that the internal investigation begins immediately, and the appropriate reporting takes	F 609		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	165145	A. BUILDING _____ B. WING _____	C 10/26/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
EMBASSY REHAB AND CARE CENTER	206 PORT NEAL ROAD SERGEANT BLUFF, IA 51054

(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 609	Continued From page 23 place " All alleged violations of abuse, neglect, exploitation or mistreatment, including injuries of unknown source and misappropriation of resident property, are reported immediately: but not later than 2 hours after the allegation is made if the events that cause the allegation involve abuse or result in serious bodily injury, or not later than 24 hours if the events that cause the allegation do not involve abuse and do not result in serious bodily injury " The facility will take all necessary corrective actions depending on the results of the investigation and complete and send a final investigation report to the State Agency within 5 business days " Any reasonable suspicion of a crime against a resident that results in serious bodily harm will be reported immediately but no later than 2 hours to the Administrator, State Survey Agency, and one or more law enforcement entities for the political subdivision in which the facility is located or not later than 24 hours if the event that cause suspicion of a crime do not result in seriously bodily injury " The facility will have an internal reporting system in place for all suspected incidents of maltreatment " All incidents that are suspicious in nature will be investigated by the internal process " Upon receipt of the report, investigating the situation by conducting a physical assessment of the resident, speaking to all staff involved in the situation and document such findings " This information will be used to determine the appropriateness of reporting to the State Agency " If the decision is made to not report to the State, based on the situation not meeting the requirements as stated in this policy, the	F 609		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	165145	A. BUILDING _____ B. WING _____	C 10/26/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
EMBASSY REHAB AND CARE CENTER	206 PORT NEAL ROAD SERGEANT BLUFF, IA 51054

(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 609	Continued From page 24 information will still be maintained on file with appropriate documentation (completing the Accident/Incident report or issue and a concern form or internal investigation form) Reportable Situations Policy revised date March 2019: alleged abuse/neglect, or incident which result in injury that require more than first aid. This could be resident to resident, staff to resident, visitor incident/injury. Include any sexual or alleged sexual incidents. Resident Incident Report Policy revised date March 2019: to ensure all incidents are reportedly in a timely manner. To ensure that the appropriate facility staff are informed of all resident incidents. To ensure the resident care plans adequately reflect resident care needs. " A Resident Incident Report is filled out on all incidents (an incident is defined as anything out of the ordinary, unusual happening for example skin tear, falls, family concerns, allegation of abuse or neglect, altercation between residents) Personnel file for Staff P, Certified Nursing Assistant, lacked documentation of any disciplinary action in the last 6 months. Interview on 10/5/20 at 3:41 PM, Staff R CMA (certified medication aide) stated she informed the Administrator, over 2 months ago, that she needed to discuss concerns about Staff J & Staff P behaviors towards the residents, however, the CMA stated her schedule was adjusted so she never worked with Staff P after that. The CMA stated the Administrator did not acknowledge her letters and never spoke with her about her concerns. The CMA stated she witnessed Staff J LPN yell at the residents to return to their rooms.	F 609		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	165145	A. BUILDING _____ B. WING _____	C 10/26/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
EMBASSY REHAB AND CARE CENTER	206 PORT NEAL ROAD SERGEANT BLUFF, IA 51054

(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 609	Continued From page 25 The CMA stated she witnessed Staff P CNA throw a bag of garbage at Resident #26 after the completed cares during the night shift. The CMA stated Staff P threw the bag of garbage because Staff P stated Resident #26 had behaviors on purpose. The CMA stated Resident #26 did have behaviors that night; had been yelling, wanted up, and was hungry. The CMA stated Staff P stated she was not going to reward bad behavior by getting the resident something to eat. The CMA stated she had left specific notes for the Administration regarding her concerns. Interview on 10/13/20 at 9:06 AM, Staff R CMA stated she witnessed Staff P CNA throw a bag of garbage at Resident #26. The CMA stated she was unable to recall specific day, however, she reported the incident to the Director of Nursing (DON) at the time of the incident. The CMA stated she felt the DON, at the time, attempted to deal with staff issues. The CMA stated Staff P and herself went into Resident #26 room to provide cares and Staff P just pulled back the covers without explaining to the resident what she was doing, and caused Resident #26, to startle. The CMA stated once the cares were completed Staff P took the bag of garbage and threw it at Resident #26, with the bag of garbage landing on the resident's chest. The CMA stated Resident #26 grabbed the bag of garbage and called Staff P a derogatory name. The CMA stated she picked up the bag of garbage, calmly talked to Resident #26, and covered her prior to leaving the room. The CMA stated as Staff P was leaving the resident's room, she told the CMA to deal with the resident. The CMA stated she wrote a note to the Administrator and DON, at the time, that she needed to speak with them about the Resident #26 and Staff P.	F 609		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	165145	A. BUILDING _____ B. WING _____	C 10/26/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
EMBASSY REHAB AND CARE CENTER	206 PORT NEAL ROAD SERGEANT BLUFF, IA 51054

(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 609	Continued From page 26 Interview on 10/13/20 at 11:35 AM, the Administrator stated she had no idea about the incident between Resident #26 and Staff P CNA. The Administrator continued to state she never heard of this incident and if she knew of it, she would have investigated it. Interview on 10/13/20 at 1:51 PM, the Nurse Consultant/Interim Director of Nursing stated she was did not know of the incident between Resident #26 and Staff P CNA. Interview on 10/26/20 at 9:29 AM, the Administrator stated she expected staff to notify her if they had concerns about staff to resident behavior. The Administrator stated she had not been employed by the facility long in March, and staff would notify the DON at the time of any concerns. The Administrator stated staff are aware that she is on call 24 hours a day, 7 day a week and they are to inform her of any concerns.	F 609		
F 622 SS=D	Transfer and Discharge Requirements CFR(s): 483.15(c)(1)(i)(ii)(2)(i)-(iii) §483.15(c) Transfer and discharge- §483.15(c)(1) Facility requirements- (i) The facility must permit each resident to remain in the facility, and not transfer or discharge the resident from the facility unless- (A) The transfer or discharge is necessary for the resident's welfare and the resident's needs cannot be met in the facility; (B) The transfer or discharge is appropriate because the resident's health has improved sufficiently so the resident no longer needs the services provided by the facility; (C) The safety of individuals in the facility is	F 622	Resident #20 expired at another facility on 10/23/20. Residents that were discharged between 10/26/20 and 11/4/20 will be reviews for completion of discharge transfer for and if applicable the recapitulation of stay.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	165145	A. BUILDING _____ B. WING _____	C 10/26/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
EMBASSY REHAB AND CARE CENTER	206 PORT NEAL ROAD SERGEANT BLUFF, IA 51054

(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 622	Continued From page 27 endangered due to the clinical or behavioral status of the resident; (D) The health of individuals in the facility would otherwise be endangered; (E) The resident has failed, after reasonable and appropriate notice, to pay for (or to have paid under Medicare or Medicaid) a stay at the facility. Nonpayment applies if the resident does not submit the necessary paperwork for third party payment or after the third party, including Medicare or Medicaid, denies the claim and the resident refuses to pay for his or her stay. For a resident who becomes eligible for Medicaid after admission to a facility, the facility may charge a resident only allowable charges under Medicaid; or (F) The facility ceases to operate. (ii) The facility may not transfer or discharge the resident while the appeal is pending, pursuant to § 431.230 of this chapter, when a resident exercises his or her right to appeal a transfer or discharge notice from the facility pursuant to § 431.220(a)(3) of this chapter, unless the failure to discharge or transfer would endanger the health or safety of the resident or other individuals in the facility. The facility must document the danger that failure to transfer or discharge would pose. §483.15(c)(2) Documentation. When the facility transfers or discharges a resident under any of the circumstances specified in paragraphs (c)(1)(i)(A) through (F) of this section, the facility must ensure that the transfer or discharge is documented in the resident's medical record and appropriate information is communicated to the receiving health care institution or provider. (i) Documentation in the resident's medical record	F 622	Professional nursing staff retrained on the following policies: Discharge Plan and Summary, Discharge Planning, Discharge Planning Process and Discharging the Resident. Audits will be completed weekly for 4 weeks and then monthly for 4 months by DON/Designee. Results will be reported to the QAPI team.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	165145	A. BUILDING _____ B. WING _____	C 10/26/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
EMBASSY REHAB AND CARE CENTER	206 PORT NEAL ROAD SERGEANT BLUFF, IA 51054

(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 622	Continued From page 28 must include: (A) The basis for the transfer per paragraph (c)(1)(i) of this section. (B) In the case of paragraph (c)(1)(i)(A) of this section, the specific resident need(s) that cannot be met, facility attempts to meet the resident needs, and the service available at the receiving facility to meet the need(s). (ii) The documentation required by paragraph (c)(2)(i) of this section must be made by- (A) The resident's physician when transfer or discharge is necessary under paragraph (c) (1) (A) or (B) of this section; and (B) A physician when transfer or discharge is necessary under paragraph (c)(1)(i)(C) or (D) of this section. (iii) Information provided to the receiving provider must include a minimum of the following: (A) Contact information of the practitioner responsible for the care of the resident. (B) Resident representative information including contact information (C) Advance Directive information (D) All special instructions or precautions for ongoing care, as appropriate. (E) Comprehensive care plan goals; (F) All other necessary information, including a copy of the resident's discharge summary, consistent with §483.21(c)(2) as applicable, and any other documentation, as applicable, to ensure a safe and effective transition of care. This REQUIREMENT is not met as evidenced by: Based on record review, policy review, and staff interview the facility failed to provide discharge instructions to the resident &/or the resident representative who left the facility against medical advice (AMA) for 1 of 4 discharged residents reviewed (Resident #20). The facility reported a	F 622		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	165145	A. BUILDING _____ B. WING _____	C 10/26/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
EMBASSY REHAB AND CARE CENTER	206 PORT NEAL ROAD SERGEANT BLUFF, IA 51054

(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 622	Continued From page 29 census of 42 residents. Findings include: A Minimum Data Set (MDS) for Resident #20 with a completion date of 9/11/20, listed diagnoses of Wedge compression fracture, Encephalopathy, and Rhabdomyolysis. The MDS scored the resident with a Brief Interview of Mental Status (BIMS) of 12, mild cognitive impairment. The MDS documented the resident as requiring physical assist of one to two staff for bed mobility, transfers, dressing, toileting, and personal hygiene. Care Plan: Care plan problem with initiation date of 9/8/20, plan to return home with a daily visit by visiting angels to get me out of bed. Intervention dated 9/8/20, facility would contact agency prior to discharge to ensure coverage. Care plan problem with initiation date of 9/8/20, alteration in self-care due to requiring assist of one for bathing, dressing, and hygiene. Interventions dated 9/8/20, the resident was to wear a back brace at all times, however, refused; and required assist of 2 for all transfers. Progress Notes: " 9/25/20 at 1:35 PM, General Note, called and updated the residents primary care provider that resident left the facility against medical advice " 9/25/20 at 11:15 PM, Order-Administration note, the resident left facility with her son on the 6 -2 shift against medical advice Clinical record lacked documentation that the resident &/or the resident representative had	F 622		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	165145	A. BUILDING _____ B. WING _____	C 10/26/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
EMBASSY REHAB AND CARE CENTER	206 PORT NEAL ROAD SERGEANT BLUFF, IA 51054

(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 622	Continued From page 30 been instructed on her medications and/or treatments, return of medications to the pharmacy, or that the home care agency contacted regarding the residents discharge. Policies: Discharging the Resident with a revision date of 3/2019, provided guidelines for the discharge process and a complete record of discharge instructions to ensure continuity of care: " Must document if medications were sent with or sent back to the pharmacy " If discharging home; conduct a discharge care conference with the resident/family, instruct resident /responsible person regarding medications, treatments, diet, and other concerns. Nurse will sign discharge to home instructions after understanding is demonstrated " Give original copy of discharge instructions to the resident or responsible party. Keep copy for medical record. " Charge nurse to document in clinical notes date and time of discharge, who accompanied the resident, discharge instructions discussed, and copy given to resident or responsible party " Complete the discharge summary/recapitulation of stay Discharge Against Medical Advice with a revision date of 3/2019, provided guidelines if the resident expressed desire to leave the facility permanently and the physician would not approve discharge orders: " Nursing supervisor or nurse in charge to discuss with the resident &/or the responsible party the medical reasons for nursing home placement and the current plan of care " Have to resident or responsible party sign the	F 622		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	165145	A. BUILDING _____ B. WING _____	C 10/26/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
EMBASSY REHAB AND CARE CENTER	206 PORT NEAL ROAD SERGEANT BLUFF, IA 51054

(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 622	Continued From page 31 against medical advice form, if possible " Medications are not to be sent with the resident if they leave against medical advice " Leaving against medical advice is reportable to the County Social Services Department, Adult Protective Services, or according to state or local regulations On 10/13/20 at 11:24 AM, the Nurse Consultant/Interim Director of Nursing confirmed there was no documentation that the resident &/or the resident representative were instructed on medications &/or treatments, disposition of medications, or a recapitulation of stay for this resident and stated she would expect this to be completed.	F 622		
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 record review and staff interview the facility failed to meet professional standards of care for 1 of 1 residents (Resident #17) reviewed by not having the resident follow-up with the Neurologist as ordered. The facility reported a census of 42 residents. Findings Include: A Minimum Data Set (MDS) for Resident #17 with a completion date of 9/8/20, listed diagnoses of Cerebrovascular Accident, Renal Insufficiency,	F 658	The neurology clinic contacted on 11/9/20 regarding resident #17 missed follow up appointment in January. An audit was completed by 11/10/20 regarding appointment scheduled and attendance, discrepancies addressed. Professional nursing staff retrained on Physician Order Policy on 11/11/20. Audits will be completed weekly for 4 weeks and then monthly for 4 months by DON/Designee. Results will be reported to the QAPI team.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	165145	A. BUILDING _____ B. WING _____	C 10/26/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
EMBASSY REHAB AND CARE CENTER	206 PORT NEAL ROAD SERGEANT BLUFF, IA 51054

(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 658	Continued From page 32 Atrial Fibrillation, and Hypertension. The MDS scored the resident with a Brief Interview of Mental Status (BIMS) of 5, severe cognitive impairment. The MDS documented the resident as requiring physical assist of two staff for bed mobility, transfers, dressing, toileting, and personal hygiene. Progress Note Entry: 10/30/19 at 5:05 PM, the resident returned from appointment with Neurologist with new orders. Physician Clinic Sheet dated 10/30/19, from the Neurologist listed new orders for medications and the resident was to follow-up in 3 months. Interview on 10/13/20 at 2:33 PM, the scheduling department for the Neurologist Office confirmed Resident #17, had appointments and was seen on 7/24/19 at 2:00 PM and 10/30/19 at 1:50 PM. The scheduling department stated the resident was scheduled to be seen on 1/30/20 at 9:00 AM and was a No Show. The scheduling department stated there were no further follow-up appointments scheduled. Interview on 10/15/20 at 10:00 AM, the Nurse Consultant/Interim Director of Nursing confirmed the resident was not seen by the neurologist for his 3 month follow-up from the appointment on 10/30/19, and the facility did not ensure the resident returned for the 1/30/20 appointment.	F 658		
F 677 SS=D	ADL Care Provided for Dependent Residents CFR(s): 483.24(a)(2) §483.24(a)(2) A resident who is unable to carry out activities of daily living receives the necessary services to maintain good nutrition, grooming, and	F 677		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	165145	A. BUILDING _____ B. WING _____	C 10/26/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
EMBASSY REHAB AND CARE CENTER	206 PORT NEAL ROAD SERGEANT BLUFF, IA 51054

(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 677	Continued From page 33 personal and oral hygiene; This REQUIREMENT is not met as evidenced by: Based on clinical record review and staff and resident interview the facility failed to provide baths twice per week for 1 of 3 residents reviewed (Resident #12). The facility reported a census of 42 residents. Findings include: A Minimum Data Set (MDS) with a completion date of 9/8/20, for Resident #12, listed diagnosis of Monoplegia, muscle wasting and atrophy, and hypertension. The Brief Interview for Mental Status (BIMS), documented a score 14 (cognitively intact). The MDS coded the resident as requiring extensive assist of 1 staff for bed mobility, transfers, toilet use, personal hygiene, and bathing. Care Plan: Care Plan focus for dressing/grooming/bathing with initiation date of 10/28/19, revealed Resident #12 required extensive assist of 1 staff for bathing. Review of resident task list revealed Resident #12 required physical help in part of the bathing activity. Review of point of care audit report for the last 30 days revealed the resident received a bath on 9/3/20, 9/10/20, 9/21/20, and 10/1/20. Interview on 9/28/20 at 12:56 PM, Resident #21 stated she had hoped to get her bath today, did not receive baths recently.	F 677	Resident #21 baths to be completed on scheduled bath days. Bath schedule reviewed to ensure baths are on list for completion on 11/9/20. Nursing staff retrained on bath schedule and completion/documentation on 11/11/20. Audits will be completed weekly for 4 weeks and then monthly for 4 months by DON/Designee. Results will be reported to the QAPI team.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	165145	A. BUILDING _____ B. WING _____	C 10/26/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
EMBASSY REHAB AND CARE CENTER	206 PORT NEAL ROAD SERGEANT BLUFF, IA 51054

(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 677	Continued From page 34 Interview on 9/28/20 at 4:37 PM, Staff K Certified Nursing Assistant (CNA) stated baths are not done consistently twice per week, more like 1 time per wk. Interview on 10/1/20 at 12:00 N, Staff D CNA stated she would document in point click care when a resident received a bath. The CNA stated she would document baths given daily and if they are not documented, they were not given. The CNA stated if the resident refused a bath, she would document refusal in point click care. The CNA stated she was out ill for 2 weeks and the aides on the floor tried to give baths. The CNA stated when the CNAs give baths they do not chart in point click care, they would leave her a note of who they got done. Interview on 10/1/20 at 12:47 PM, Staff L Certified Medication Aide (CMA) stated if a CNA or CMA gives a resident a bath while working on the floor, they would document the bath in point click care. The CMA stated if the resident received a bed bath that would be documented in point click care also. The CMA stated staff would not leave a note for baths done, they would chart it. Interview on 10/6/20 at 1:55 PM, Resident #21 stated she was to get her bath today and did not. Resident #21 stated she believed she was to get her baths on Mondays and Thursdays, however, stated she never gets baths anymore. Interview on 10/6/20 at 2:15 PM, Staff M Registered Nurse (RN) stated baths are not getting done twice per week. Interview on 10/13/20 at 1:10 PM, Nurse	F 677		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	165145	A. BUILDING _____ B. WING _____	C 10/26/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
EMBASSY REHAB AND CARE CENTER	206 PORT NEAL ROAD SERGEANT BLUFF, IA 51054

(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 677	Continued From page 35 Consultant/Interim Director of Nursing stated she expected baths to be given at a minimum twice per week. The Nurse Consultant stated residents that are in the isolation wing would only receive bed baths. The Nurse Consultant stated she expected staff to sign off baths in the resident's task in point click care.	F 677		
F 689 SS=G	Free of Accident Hazards/Supervision/Devices CFR(s): 483.25(d)(1)(2) §483.25(d) Accidents. The facility must ensure that - §483.25(d)(1) The resident environment remains as free of accident hazards as is possible; and §483.25(d)(2)Each resident receives adequate supervision and assistance devices to prevent accidents. This REQUIREMENT is not met as evidenced by: Based on observations, clinical record review, policy review, and staff interview the facility failed to adequately supervise residents in the dining room for 1 of 1 residents reviewed (Resident #26), resulted in a second degree burn. The resident received coffee in a cup without a lid and spilled coffee on her lap. Two staff who worked at the facility at the time of the burn revealed the resident was supposed to use a cup with lid at the time. The MDS identified the resident required supervision of 1 staff with meals. The incident report identified no witnesses to the incident, indicating no supervision when the incident occurred. The facility reported a census of 42 residents. Findings include:	F 689	Resident #26 expired on 10/15/20 @1651. All residents residing in the building will have a current hot liquid safety assessment will be reviewed and interventions placed for that resident. All new admissions or readmissions will be assessed upon admission into the building. Each resident will have quarterly hot liquid assessment and review of current interventions quarterly and with significant changes by 11/11/20. Nursing staff retrained on 11/11/20 on hot liquid assessment completion and identification of interventions based on the assessment. Audits will be completed weekly for 4 weeks and then monthly for 4 months by DON/Designee. Results will be reported to the QAPI team.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	165145	A. BUILDING _____ B. WING _____	C 10/26/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
EMBASSY REHAB AND CARE CENTER	206 PORT NEAL ROAD SERGEANT BLUFF, IA 51054

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 689	Continued From page 36 Resident #26's Minimum Data Set (MDS) with a completion date of 8/17/20, listed diagnosis of Alzheimer's Dementia, Non Alzheimer's Dementia, Anxiety, and Hypertension. The MDS identified the resident with short term and long term memory impairment. The MDS coded the resident as requiring extensive assist of 2 staff for bed mobility, transfers, dressing, toileting, and personal hygiene. The MDS coded the resident as requiring limited assist of one staff for eating. The MDS identified the resident received a mechanically altered diet. Care Plan: Care plan focus area diagnosis of Alzheimer's and anxiety with initiation date of 11/29/17, identified the resident displayed signs of agitation, restlessness, pacing, repetitive questions, raised voice, refusing cares, and becoming combative with staff and other residents. Interventions included: Ativan (antianxiety) scheduled every day (10/9/19), went to Hope Harbor to monitor behaviors and medications (10/7/19), room moved to another hallway that was quiet as noise agitated me at times (8/8/19), encouraged to remain in the hallway of current room (11/10/19), encouraged to sit in recliner to look outside and watch television (8/8/19), encouraged to sit at nurses station, away from flow of traffic to maintain personal space (7/3/19), assess, identify, & resolve why agitated (11/29/17), remain calm and speak with low tone and slow rate (11/29/17), and allow adequate personal space (11/29/17). Care plan focus area Activities of daily living with initiation date of 11/30/17, identified the resident required extensive assist due to diagnosis	F 689	Requesting for IDR of F-tag 689 Free of Accident/Hazards/ Supervision/Devices. According to the deficiency the facility failed to adequately supervise residents in the dining room for 1 of 1 resident, resident #26. According to the deficiency two previous staff members of whom no longer work at the facility today at the time of the burn revealed the resident was to use a cup with a lid at the time. Based on clinical review of resident chart and care plan indicate no evidence identified cup. See attached care plan. The LPN Staff U stated she did not remember if staff sat with resident however, nurse consultant who was the interim DON at the time states that either nursing staff or dining staff are in the dining room are in the dining room whenever residents are in there -therefore resident was surprised.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	165145	A. BUILDING _____ B. WING _____	C 10/26/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
EMBASSY REHAB AND CARE CENTER	206 PORT NEAL ROAD SERGEANT BLUFF, IA 51054

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 689	Continued From page 37 progression. Care plan focus area diet/eating with initiation date of 11/30/17, identified the resident as independent with eating and on a general dysphagia advanced diet with ground meat and nectar thick liquids. Intervention included, staff to monitor for changes in ability to eat independently or safely (11/30/17). Hot Liquid Safety Review Assessment dated 8/11/20 with lock date of 8/12/20, identified the need for care plan interventions to protect the resident while consuming hot liquids due to vision impairment, cognition, mood, contractures, mobility, and musculoskeletal. This was the only Hot Liquid Safety Review in the residents' clinical record. Incident report dated 4/17/20 at 5:52 AM, revealed the resident was in the dining room and spilled coffee on her lap. Resident Description: resident unable to give description. Immediate Action Taken: area assessed and Tegaderm (transparent dressing) applied over fluid filled blister measuring 4.7 x 2.8. Injuries observed at time of incident: blister front of right thigh. Level of Pain, Level of Consciousness, and Mobility all left blank. Mental Status: orientated to person. Notes: No complaints of pain to the area. Injuries Report Post Incident: no injuries observed post incident. Predisposing Environmental Factors left blank. Predisposing Physiological Factors: confused, incontinent, and impaired memory. Predisposing Situation Factors left blank. Witnesses: No witnesses found. Agencies/People Notified: Fax sent to the physician 4/17/20 at 5:54 AM. Progress Notes:	F 689	The LPN Staff U also indicates that at the time of the burn there was no concern with her spilling liquids as she drank thickened liquids. This is documented on page 47 of the statement of deficiencies. She also indicate she did not go get a lidded cup at the lids were difficult to remove as indicated on page 47 of the statement of deficiencies. This indicates that the nurse Staff U was not concerned about the risk of burn and did not attempt to obtain lidded cup. Interview with dietary manager conducted on 10/14/20 on page 46 of the statement of deficiencies was not hired until 5/14/20 therefore unable to speak to specific resident concern. Review of time sheet of dietary staffing working on 4/17/20. Based on the above information request severity be lowered.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	165145	A. BUILDING _____ B. WING _____	C 10/26/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
EMBASSY REHAB AND CARE CENTER	206 PORT NEAL ROAD SERGEANT BLUFF, IA 51054

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 689	Continued From page 38 " 4/17/20 at 5:54 AM, the resident hollered to get out of her room and staff took her to the dining room. The resident asked for a cup of coffee and staff provided her with a cup of thickened coffee. The resident took sips of coffee and missed the table, and dropped the coffee on her lap resulting in a fluid filled blister measuring 4.7 x 2.8, which was covered with Tegaderm (transparent dressing). " 4/18/20 at 3:58 AM, no dressing noted to blister area, open and dry. No drainage noted. New Tegaderm applied. Blister area slightly red. No complaints of pain. " 4/18/20 at 7:47 PM, blister to upper anterior right thigh with Tegaderm intact. Blister had popped, area is red, non-tender and not warm to touch. " 4/24/20 at 4:36 AM, dressing to right thigh off and soiled with drainage. Noted purulent drainage to burn area. Area cleansed and left open to air. Blister open area measures 6 centimeters (cm) x 3.3 cm. Red area that measures 13.5 cm x 3.8 cm in length across the thigh. Resident denies pain, temperature 96.9 degrees Fahrenheit. Faxed the resident's primary care physician related to blister infection. " 4/24/20 at 9:51 AM, notified the resident's primary care provider regarding blister area right thigh has purulent drainage with skin around area red. " 4/24/20 at 11:36 AM, new orders for Carnation Instant breakfast daily (to increase protein) and Silvadene (topical antibiotic cream used to treat burns and reduce the change of infection) to right thigh blister 2 times a day for 5 days. " 4/26/20 3:38 AM, burn continues to right anterior thigh. Dressing dry and intact. Redness continues surrounding burn area. At 12:45 AM,	F 689		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	165145	A. BUILDING _____ B. WING _____	C 10/26/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
EMBASSY REHAB AND CARE CENTER	206 PORT NEAL ROAD SERGEANT BLUFF, IA 51054

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 689	Continued From page 39 the resident did request pain medication for back discomfort. Temperature 97.5 degrees Fahrenheit. " 4/27/20 at 6:01 AM, continued with burn to right anterior thigh. Dressing dry and intact. No complaints of leg pain. Redness much improved to thigh surrounding burn. No complaints of pain. Temperature 97.0 degrees Fahrenheit. " 4/28/20 4:31 PM, the resident's primary care provider to see resident and new orders received for treatment to right thigh burn. Silvadene 2 times a day and cover with gauze and tap for 14 days and then call with update " 4/29/20 at 1:40 AM, continued to have burn right anterior thigh. Dressing dry and intact. No complaints of leg pain. No calling out at this time. Temperature 96.9 degrees Fahrenheit. Resting quietly in bed. " 4/29/20 3:32 AM, another small blister to the residents' right anterior thigh, measuring 0.5 cm x 1.4 cm. Blister is slightly to the left of previous burn. Area covered with Tegaderm for protection. No redness noted. Fax sent to the resident's primary care provider. " 4/30/20 at 12:54 AM, the resident arouses easily. Respirations easy, no complaints of pain. Dressing to right thigh blister dry and intact, no redness noted. " 4/30/20 at 11:13 AM, new order received related to new blister found to right thigh. Treat area the same as the other wound and will see in one week. " 5/7/20 at 3:16 PM, the resident was seen by primary care provider on 5/6/20 and will fax any new orders. " 5/13/20 at 11:04 AM, notified the residents' primary care provider with an update on right thigh burn. The resident's primary care provider saw resident on round and assessed area.	F 689		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	165145	A. BUILDING _____ B. WING _____	C 10/26/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
EMBASSY REHAB AND CARE CENTER	206 PORT NEAL ROAD SERGEANT BLUFF, IA 51054

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 689	Continued From page 40 " 5/13/20 at 10:49 PM, discontinue Silvadene treatment and start new treatment per the resident's primary care provider. " 6/3/20 at 10:07 AM, treatment to right thigh burn cleanse with normal saline, cover slough with Santyl (cream applied to severe burns to help remove dead skin tissue), cover with gauze soaked in Dakin's solution (strong antiseptic used to kill bacteria) and cover with additional gauze and tape. " 6/4/20 at 10:02 AM, received new order to discontinue right thigh wound treatment and leave open to air " 6/10/20 at 12:39 PM, the resident's primary care provider to see resident, no new orders. Initial Weekly Wound Documentation dated 4/17/20 at 5:57 AM, right thigh blister measuring 4.7 cm x 2.8 cm, no drainage, no odor, wound edges intact. Tegaderm applied & notified PCP. Initial Weekly Wound Documentation dated 4/29/20 at 4:55 AM, right thigh blister measuring 0.5 cm x 1.4 cm, no drainage, no odor, pink wound edges, blister not open, fax sent to PCP Weekly Wound Forms: " 4/21/20 at 11:58 PM, right thigh blister measuring 4.2 cm x 2.6 cm, no drainage, no odor, wound edges intact & pink, improved, no pain associated with wound. Cover with tegaderm, blister had popped, skin surrounding slightly pink. Area cleansed and left open to air, notified PCP " 4/28/20 at 11:17 AM, right thigh blister measuring 5.5 cm x 1.5 cm, scant amount of serosanguinous (blood and clear yellow liquid) drainage, no odor, improved, no pain associated with wound. Silvadene to burn, blister no longer	F 689		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	165145	A. BUILDING _____ B. WING _____	C 10/26/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
EMBASSY REHAB AND CARE CENTER	206 PORT NEAL ROAD SERGEANT BLUFF, IA 51054

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 689	Continued From page 41 fluid filled. Area appears to be drying up, cream applied. Resident tolerates well and no complaints of pain or discomfort. " 5/5/20 at 10:27 AM, right thigh burn measuring 5.1 cm x 2.0 cm, scant amount serosanguinous drainage, no change, no pain associated with wound. Apply Silvadene cream to right thigh burn and cover with gauze. " 5/11/20 at 10:53 AM, right thigh blister measuring 3 cm x 1 cm, yes slough, no odor, pink edges, improved, no pain associated with wound. Silvadene cream to right thigh burn. Blister no longer fluid filled. Area appears to be drying up, cream applied. Resident tolerates well. No complaints of pain or discomfort. ARNP to send new orders for treatment. " 5/11/20 at 10:57 AM, right thigh blister measuring 0.5 cm x 1.3 cm, no drainage no odor, edges intact, no change, blister remains, and no pain associated with wound. " 5/19/20 at 6:42 AM, right thigh burn measuring 4 cm x 1.5 cm, scant amount serosanguinous drainage, no change, no pain associated with wound. Apply Silvadene and cover with gauze. " 5/26/20 at 3:36 PM, right thigh burn measuring 3 cm x 1.5 cm, scan amount serosanguinous drainage, no odor, edges intact, improved, no pain associated with wound. Cleanse with normal saline, cover slough with Santyl, cover with gauze soaked Dakin's solution and cover with gauze and tape " 6/10/20 at 11:34 AM, right thigh burn measuring 0 x 0, no drainage, no odor, edges intact and dry, area healed. ARNP at facility and assessed area, healed. Leave open to air. Physician Notes: " 4/17/20 fax sent notifying primary care	F 689		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	165145	A. BUILDING _____ B. WING _____	C 10/26/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
EMBASSY REHAB AND CARE CENTER	206 PORT NEAL ROAD SERGEANT BLUFF, IA 51054

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 689	Continued From page 42 provider (PCP) of initial burn to right thigh, no new orders " 4/24/20 at 10:41 AM, new order from Advanced Registered Nurse Practitioner (ARNP) for Silvadene Cream, two times a day for 5 days or until healed " 4/28/20 resident seen by ARNP, treatment order clarification Silvadene two times a day for 14 days and call with update in 14 days and labs ordered for in 2 weeks. " 4/29/20 fax sent notifying the resident's PCP of new blister to right thigh, same as treatment ordered " 5/13/20 at 3:39 PM, new order from ARNP to stop Silvadene and start twice daily cleanse with normal saline, cover slough with Santyl, cover with gauze soaked in Dakin's solution and cover with gauze and tape. " 5/26/20 the resident seen by ARNP for wound follow up. Burn to right upper thigh with healed blister above larger wound. Wound with less slough today, will continue current treatment for another week. Resident denies any pain. The resident is calm and cooperative during wound care. Second degree burn on upper right thigh approximately 2.5 cm x 1.5 cm with yellow slough. A small white blister in the middle of the burn. Small blister above larger wound is healed with scab. Some serous drainage. " 6/4/20 order received from ARNP to leave right thigh open to air and discontinue Santyl and Dakin's solution " 6/10/20 the resident seen by ARNP for wound follow up. Right thigh wound is healed, will leave open to air. Second degree burn on upper thigh is healed with scar tissue noted. Classifications of Burns: " First degree (superficial) burn - affect only the	F 689		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	165145	A. BUILDING _____ B. WING _____	C 10/26/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
EMBASSY REHAB AND CARE CENTER	206 PORT NEAL ROAD SERGEANT BLUFF, IA 51054

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 689	Continued From page 43 outer layer of skin, the epidermis. The burn site is red, painful, dry, and with no blisters. Mild sunburn is an example. Long term tissue damage is rare and often consists of an increase or decrease in the skin color. " Second degree (partial thickness) burn - involve the epidermis and part of the lower layer of skin, the dermis. The burn site looks red, blistered, and may be swollen and painful. " Third degree (full thickness) burn - destroy the epidermis and dermis. They may go into the innermost layer of skin, the subcutaneous tissue. The burn site may look white or blackened and charred. " Fourth degree burn - go through both layers of the skin and underlying tissue as well as deeper tissue, possibly involving muscle and bone. There is no feeling in the area since the nerve endings are destroyed. Observations on 9/28/20/20 at: " 12:45 PM, well-groomed resident was sitting in recliner, covered with blanket, feet elevated and CNA assisting with dinner. Liquids were in small Styrofoam cups with lids. " 1:06 PM, staff no longer present and the resident continues to sit in recliner with feet elevated, blanket on, and call light in reach " 4:21 PM, the resident was sitting in recliner, covered with blanket, feet elevated, and call light in reach. Tray table beside resident with a tall Styrofoam cup with lid and straw present Observations on 9/29/20 at: " 9:16 AM, well-groomed resident sitting in wheelchair with tray table in front of her. Feet dependent on pedals with green foam boots on bilaterally. Call light in reach.	F 689		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	165145	A. BUILDING _____ B. WING _____	C 10/26/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
EMBASSY REHAB AND CARE CENTER	206 PORT NEAL ROAD SERGEANT BLUFF, IA 51054

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 689	Continued From page 44 " 3:20 PM, the resident was sitting in wheelchair with green foam boots on bilateral lower extremities and pillow under left arm. Observed staff stand the resident in the EZ-stand lift and provide cares prior to returning to transferring the resident to the recliner. Waffle type cushion noted in wheelchair and moved to recliner with the resident. Feet elevated and green foam boots replaced to bilateral lower extremities and call light in reach. " 4:18 PM, resident sitting in recliner with feet elevated, call light in reach, and green foam boots on. The resident smiles and waves. Observations on 9/30/20 at 8:42 AM, well-groomed resident sitting in wheelchair beside the bed with green foam boots on bilaterally. Styrofoam breakfast container on tray table in front of the resident, 75% eaten. The resident was wiping her hands with a napkin and requesting a wet cloth. Observations on 10/1/20 at: " 8:50 AM, the well-groomed resident sitting in wheelchair beside bed. Tray table in front of resident with tall Styrofoam cup with lid and straw containing water and a small Styrofoam cup with lid containing coffee. Call light in reach. " 12:29 PM, Staff L Certified Medication Aide (CMA) delivered residents lunch in Styrofoam container and sat down to assist with eating. Observation on 10/15/20 at 8:38 AM, resident lying in bed on her right side facing into the room. Head of bed slightly elevated, eyes closed, mouth open, and oxygen on. Staff H Licensed Practical Nurse (LPN) stated the resident was unresponsive at this time.	F 689		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	165145	A. BUILDING _____ B. WING _____	C 10/26/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
EMBASSY REHAB AND CARE CENTER	206 PORT NEAL ROAD SERGEANT BLUFF, IA 51054

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 689	Continued From page 45 Coffee temperature in the carafe on 10/14/20 at 11:58 AM, 167.4 degrees Fahrenheit. Interview on 10/14/20 at 11:25 AM, Nurse Consultant/Interim Director of Nursing (DON) stated the resident received coffee in a regular coffee mug on 4/17/20 when the spill occurred. The Nurse Consultant stated she did not know if any staff supervised the resident at the time she spilled the coffee in her lap. The Nurse Consultant stated after the incident, the facility bought coffee cups with lids and all residents then only received coffee in cups with lids. The Nurse Consultant stated she did not know would got coffee for the resident on the morning of 4/17/20, (if it would have been nursing staff or dietary staff). Questioned the Nurse Consultant about the resident requiring supervision with eating and she stated dietary staff reports to work at 6:00 AM, and they would worked in the dining room setting tables at the time of the incident. The Nurse Consultant stated if no dietary staff worked in the area then nursing staff would have been with the resident. The Nurse Consultant stated she did not know of other incidents of residents burned with spilled coffee. The Nurse Consultant identified the resident as independent with drinking and normally drank coffee. The Nurse Consultant stated intervention put into place, to prevent further burns from occurring, all coffee served with a lid. The Nurse Consultant stated the facility should have notified the resident's responsible party of the resident burning her leg. Interview on 10/14/20 at 11:58 AM, Staff T Dietary Manager stated due to residents currently being served in their rooms, coffee is sent out in carafe and staff pours the coffee into a Styrofoam cup if the resident request coffee. The Dietary Manager	F 689		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	165145	A. BUILDING _____ B. WING _____	C 10/26/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
EMBASSY REHAB AND CARE CENTER	206 PORT NEAL ROAD SERGEANT BLUFF, IA 51054

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 689	Continued From page 46	F 689		

stated he did not know if staff placed lids on the small Styrofoam cups of coffee when taken into residents room. The Dietary Manager stated when residents come to the dining room for meals, they are served coffee per request and no lids. The Dietary Manager stated the residents that require assist with meals are served coffee with a lid. The Dietary Manager stated Resident #26 was given a sippy cup for her coffee when she would come to the dining room.

Interview on 10/14/20 at 2:02 PM, Staff U LPN (nurse when incident occurred) stated she did not remember if staff sat with the resident or if the resident sat by herself in the dining room when the coffee spill occurred on 4/17/20. The LPN stated she did not remember if dietary staff were in the dining room at the time, however, stated the dietary staff would not have assisted anyway. The LPN stated the nursing staff often have to cook breakfast for the residents because dietary staff did not show up for work at 6 AM. The LPN stated she would have initially cleansed the burn with normal saline, pat dry, and then apply the tegaderm. The LPN stated the resident was up frequently during the night and had her days and nights mixed around due to confusion. The LPN stated it was normal for Resident #26 to go out to the dining room and have coffee. The LPN stated due to the time of day, she believed staff would get the resident up for the day, and take her to the dining room for coffee. The LPN stated there were no concerns with the resident spilling her coffee because she drank thickened liquids and she would have gotten a handled cup with a lid. The Surveyor read the progress note entry to the LPN and she stated the Resident #26 did not have the two handled lidded cup because the lids don't come off easily.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	165145	A. BUILDING _____ B. WING _____	C 10/26/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
EMBASSY REHAB AND CARE CENTER	206 PORT NEAL ROAD SERGEANT BLUFF, IA 51054

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 689	Continued From page 47 Interview on 10/15/20 at 8:53 AM, Staff V Dietary Aide stated she worked at the facility for a year and that Resident #26, received thickened liquids during the time she worked at the facility. The Dietary aide stated during Staff V's time at the facility, Resident #26 received coffee in a cup with a lid. Interview on 10/26/20 at 9:40 AM, the Nurse Consultant/Interim DON stated after Resident #26 sustained the burn to her right thigh, staff provided her coffee in a lidded cup. Questioned the Nurse Consultant that 2 staff members stated Resident #26, already used lidded cup for coffee prior to the burn to her right thigh. The Nurse consultant stated when she got to the facility the resident did not use lidded cups for her coffee and was unsure where staff had gotten that information from.	F 689		
F 880 SS=E	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		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	165145	A. BUILDING _____ B. WING _____	C 10/26/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
EMBASSY REHAB AND CARE CENTER	206 PORT NEAL ROAD SERGEANT BLUFF, IA 51054

(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 48 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	Resident #2, #12, and #15 completed Required COVID Isolation requirement and all currently residing in their respective rooms as of 11/3/20. Review completed of all residents residing transmission-based precautions completed by 11/10/20. Facility staff retrained on Infection Prevention and Control Policies and Procedures for Suspected/Confirmed cases of COVID 19 including identification and isolation of respiratory symptoms of unknown origin. Audits will be completed weekly for 4 weeks and then monthly for 4 months by DON/Designee. Results will be reported to the QAPI team.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	165145	A. BUILDING _____ B. WING _____	C 10/26/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
EMBASSY REHAB AND CARE CENTER	206 PORT NEAL ROAD SERGEANT BLUFF, IA 51054

(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 49 corrective actions taken by the facility. §483.80(e) Linens. Personnel must handle, store, process, and transport linens so as to prevent the spread of infection. §483.80(f) Annual review. The facility will conduct an annual review of its IPCP and update their program, as necessary. This REQUIREMENT is not met as evidenced by: Based on observation, record review, facility policy review, and staff interview, the facility failed to implement transmission based precautions for residents with acute respiratory symptoms for 3 of 8 residents reviewed (Residents #2, #12, & #15) and failed to implement proper infection control measures during medication pass for 1 of 4 residents reviewed (Resident #15). The facility reported a census of 42 residents. Findings Include: 1. A Minimum Data Set (MDS), with a completion date of 10/9/20, for Resident #2, listed diagnoses of Acute Kidney Failure, renal insufficiency, and Diabetes Mellitus. The Brief Interview for Mental Status (BIMS) revealed a score of 15 (cognitive intact). The MDS documented the resident as requiring extensive assist of two staff for bed mobility, transfers, dressing, toileting, and personal hygiene. Progress Notes: " 8/19/20 at 1:34 PM, the resident complained of not feeling well. Noted cough with moderate amount of green phlegm. The resident complained of pain all over and loose stools. As	F 880		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	165145	A. BUILDING _____ B. WING _____	C 10/26/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
EMBASSY REHAB AND CARE CENTER	206 PORT NEAL ROAD SERGEANT BLUFF, IA 51054

(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 50 needed medications administered included: Acetaminophen (analgesic), DuoNeb nebulizer (bronchodilator), and Immodium (for diarrhea) " 8/19/20 at 5:52 PM, the resident complained of not feeling well " 8/20/20 at 12:00 N, the resident had moderate amount of emesis, complained of diarrhea and not feeling well. The resident's primary care provider was notified. " 8/30/20 at 6:18 PM, the resident reported mild cough and sleepiness " 8/31/20 at 11:25 AM, the resident reported moderate cough with moderate amount green phlegm. Lung sounds revealed wheezes and as needed nebulizer give. The resident's primary care provider was notified. " 8/31/20 at 6:22 PM, the resident returned from Urgent Care with instructions to administer over the counter cough medication currently ordered, fluids, and rest. The resident had been tested for the Coronavirus (COVID-19) while at Urgent Care. " 9/2/20 at 10:32 PM, received notification COVID-19 not detected (from test completed on 8/31/20 at Urgent Care) " 9/4/20 at 11:02 PM, the resident complained of cough and tickle at the back of throat. Cough medication administered and offered hot tea and honey. " 9/5/20 at 12:32 PM, the resident complained of occasional cough and body aches with Acetaminophen being administered " 9/8/20 at 2:12 PM, noted the resident to have cough and lung sounds diminished " 9/9/20 at 2:15 PM, the resident complained of cough, lung sounds diminished with crackles " 9/10/20 at 3:10 PM, the resident request breathing treatment due to cough and shortness of breath	F 880		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	165145	A. BUILDING _____ B. WING _____	C 10/26/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
EMBASSY REHAB AND CARE CENTER	206 PORT NEAL ROAD SERGEANT BLUFF, IA 51054

(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 51 " 9/11/20 at 3:52 PM, the resident reported cough with phlegm at times " 9/13/20 at 2:03 PM, the resident reported congested cough, lung sounds diminished and color pale " 9/13/20 at 2:05 PM, Administrator and Director of Nursing (DON) here and aware of resident status " 9/13/20 at 2:07 PM, explained to the resident the need to transfer to private room due to COVID-19 symptoms and agrees. The resident moved to room 18 and quarantine due to symptoms " 9/20/20 at 10:13 AM, COVID-19 test complete " 9/21/20 at 5:26 PM, the Administrator notified the resident's son that resident tested positive for COVID-19 during baseline testing completed on 9/14/20. August and September 2020, Medication Administration Record (MAR) revealed order to monitor and report new onset of the following symptoms including: " Temperature greater than 100.0 " Temperature of 2.4 over baseline " 3 or more temperatures 99.1 or higher in 24 hours " Chills " Cough " Shortness of breath " Difficulty with breathing " Fatigue " Muscle or body aches " Headache " Loss of taste or smell " Sore throat " Congestion or runny nose " Nausea or vomiting	F 880		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	165145	A. BUILDING _____ B. WING _____	C 10/26/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
EMBASSY REHAB AND CARE CENTER	206 PORT NEAL ROAD SERGEANT BLUFF, IA 51054

(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 52 " Diarrhea If any of these symptoms noted, isolate immediately, call physician, and complete COVID-19 progress note. Policy: Document titled Isolation Guidance for Admit, Readmit, and other dated 6/18/20, had instructions for Current Resident Illness. The document instructed that when a current resident develops undiagnosed symptoms of temperature above 100.0, more than 2 readings of a temperature greater of 99.0, new onset of oxygen saturations below 90%, cough, shortness of breath, new or worsening malaise, headache, dizziness, nausea, vomiting, diarrhea, loss of taste or smell: " Seek testing for influenza, Strep throat, COVID-19 " If possible, move to single room near the end of the hall or on a step down unit for residents not in general population or in COVID-19 confirmed area " Monitor symptoms every shift " Isolation: gloves, gown, masks with face shield or N95 with goggles or face shield, mandatory N95 for aerosol generating procedures " If you determine that a resident with a new onset of symptoms is not suspected to have COVID-19, document in the medical chart your reason for not placing the resident on isolation for COVID-19 The facility failed to isolate the resident on 8/19/20 when COVID-19 symptoms were first identified. The resident continued to display COVID-19 symptoms even after testing negative	F 880		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	165145	A. BUILDING _____ B. WING _____	C 10/26/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
EMBASSY REHAB AND CARE CENTER	206 PORT NEAL ROAD SERGEANT BLUFF, IA 51054

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 880	Continued From page 53 on 8/31/20, however, was not isolated until 9/13/20. The resident was not tested again until 9/20/20 during the facility baseline testing, even with displaying positive COVID-19 symptoms and resulted in being positive for COVID-19. Interview 9/23/20 at 1:25 PM, the Nurse Consultant/Interim DON stated the resident had diagnosis of Wegener's Granulomatosis (rare multi-system autoimmune disease that causes inflammation of blood vessels; and can affect ears, nose, throat, lungs and kidneys) and it is not unusual for the resident to have respiratory issues. The Nurse consultant stated staff updated the resident's primary care provider and no new orders due to diagnosis. The Nurse consultant stated it was not unusual for the resident to have a cough, diarrhea, or emesis, and her temperature spiked which was a change so staff sent the resident to Urgent Care at that time. The Nurse Consultant stated Resident #2, was not isolated due to her respiratory symptoms being related to her diagnosis. 2. A MDS with a completion date of 9/8/20, for Resident #12, listed diagnosis of Monoplegia, muscle wasting and atrophy, and hypertension. The BIMS documented a 14 indicating cognitively intact. The MDS coded the resident as requiring extensive assist of 1 staff for bed mobility, transfers, toilet use, personal hygiene, and bathing. Progress Notes: " 9/18/20 at 7:30 AM, the resident reported barky cough, with as needed cough medication and acetaminophen being administered " 9/24/20 at 6:02 AM, the resident continued with congested deep harsh barky cough	F 880		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	165145	A. BUILDING _____ B. WING _____	C 10/26/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
EMBASSY REHAB AND CARE CENTER	206 PORT NEAL ROAD SERGEANT BLUFF, IA 51054

(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 54 " 9/25/20 at 10:00 AM, the resident in bed with head of bed elevated, lung sounds clear, congested cough, and resident complained of sore throat " 9/25/20 at 11:30 AM, the resident moved to room 14 and COVID-19 precautions initiated " 9/25/20 at 2:45 PM, updated the resident's primary care provider and sent to Urgent Care " 9/25/20 at 8:59 PM, the resident returned with chest x-ray revealing no abnormalities and COVID-19 test completed " 9/30/20 at 9:15 AM, notified the resident was COVID-19 positive September 2020, MAR revealed order to monitor and report new onset of the following symptoms including: " Temperature greater than 100.0 " Temperature of 2.4 over baseline " 3 or more temperatures 99.1 or higher in 24 hours " Chills " Cough " Shortness of breath " Difficulty with breathing " Fatigue " Muscle or body aches " Headache " Loss of taste or smell " Sore throat " Congestion or runny nose " Nausea or vomiting " Diarrhea If any of these symptoms noted, isolate immediately, call physician, and complete COVID-19 progress note. The resident was documented as having the identified symptoms on 9/16/20, 9/20/20, 9/22/20,	F 880		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	165145	A. BUILDING _____ B. WING _____	C 10/26/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
EMBASSY REHAB AND CARE CENTER	206 PORT NEAL ROAD SERGEANT BLUFF, IA 51054

(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 55 9/23/20, and 9/25/20. The September 2020, MAR revealed the resident received cough medication, at least daily, for complaints of cough on 9/17/20 and 9/19-25/20. Policy: Document titled Isolation Guidance for Admit, Readmit, and other dated 6/18/20, had instructions for Current Resident Illness. The document instructed that when a current resident develops undiagnosed symptoms of temperature above 100.0, more than 2 readings of a temperature greater of 99.0, new onset of oxygen saturations below 90%, cough, shortness of breath, new or worsening malaise, headache, dizziness, nausea, vomiting, diarrhea, loss of taste or smell: " Seek testing for influenza, Strep throat, COVID-19 " If possible, move to single room near the end of the hall or on a step down unit for residents not in general population or in COVID-19 confirmed area " Monitor symptoms every shift " Isolation: gloves, gown, masks with face shield or N95 with goggles or face shield, mandatory N95 for aerosol generating procedures " If you determine that a resident with a new onset of symptoms is not suspected to have COVID-19, document in the medical chart your reason for not placing the resident on isolation for COVID-19 The facility failed to isolate the resident on 9/16/20, when COVID-19 symptoms were first identified. The resident was not isolated until	F 880		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	165145	A. BUILDING _____ B. WING _____	C 10/26/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
EMBASSY REHAB AND CARE CENTER	206 PORT NEAL ROAD SERGEANT BLUFF, IA 51054

(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 56 9/25/20. Interview on 10/13/20 at 1:10 PM, the Nurse Consultant/Interim DON confirmed the facility did not isolate Resident #12 when COVID-19 symptoms were identified on 9/16/20. 3. A MDS with a completion date of 10/9/20, for Resident #15, listed diagnosis of Cerebrovascular Accident, Diabetes Mellitus, Pneumonia, and COVID-19. The BIMS documented a 6, indicating severe cognitive impairment. The MDS coded the resident as requiring extensive assist of 2 staff for bed mobility, dressing, toilet use, and personal hygiene. The MDS coded the resident being dependent on staff for transfers and eating. The resident was coded as having a feeding tube in place. Progress Notes: " 9/30/20 at 1:43 PM, the resident returned from having feeding tube replaced. Noted lung sounds coarse and notified the resident's primary care provider " 10/1/20 at 1:37 PM, the resident continues on antibiotic for upper respiratory infection. Lung sounds revealed crackles and congested cough noted. " 10/2/20 at 6:53 AM, antibiotic for upper respiratory infection, lung sounds revealed crackles and good coughing noted " 10/2/20 at 2:00 PM, occasional loose cough " 10/3/20 at 2:00 PM, audible coarseness lung sounds, 2 strong coughs and clears his cough " 10/5/20 at 4:21 PM, frothy white sputum noted, rhonchi all lung fields, and temperature 99.3. Abbott test completed and tested positive for COVID-19. Notified the resident's primary care provider and moved to isolation.	F 880		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	165145	A. BUILDING _____ B. WING _____	C 10/26/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
EMBASSY REHAB AND CARE CENTER	206 PORT NEAL ROAD SERGEANT BLUFF, IA 51054

(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 57 October 2020, MAR revealed order dated 10/1/20, Amoxicillin Suspension (antibiotic) 400 milligrams (mg)/5 milliliters (ml) give 7 ml three times a day for 10 days. October 2020, MAR revealed order to monitor and report new onset of the following symptoms including: " Temperature greater than 100.0 " Temperature of 2.4 over baseline " 3 or more temperatures 99.1 or higher in 24 hours " Chills " Cough " Shortness of breath " Difficulty with breathing " Fatigue " Muscle or body aches " Headache " Loss of taste or smell " Sore throat " Congestion or runny nose " Nausea or vomiting " Diarrhea If any of these symptoms noted, isolate immediately, call physician, and complete COVID-19 progress note. Policy: Document titled Isolation Guidance for Admit, Readmit, and other dated 6/18/20, had instructions for Current Resident Illness. The document instructed that when a current resident develops undiagnosed symptoms of temperature above 100.0, more than 2 readings of a temperature greater of 99.0, new onset of oxygen saturations below 90%, cough, shortness of	F 880		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	165145	A. BUILDING _____ B. WING _____	C 10/26/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
EMBASSY REHAB AND CARE CENTER	206 PORT NEAL ROAD SERGEANT BLUFF, IA 51054

(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 58 breath, new or worsening malaise, headache, dizziness, nausea, vomiting, diarrhea, loss of taste or smell: " Seek testing for influenza, Strep throat, COVID-19 " If possible, move to single room near the end of the hall or on a step down unit for residents not in general population or in COVID-19 confirmed area " Monitor symptoms every shift " Isolation: gloves, gown, masks with face shield or N95 with goggles or face shield, mandatory N95 for aerosol generating procedures " If you determine that a resident with a new onset of symptoms is not suspected to have COVID-19, document in the medical chart your reason for not placing the resident on isolation for COVID-19 The facility failed to isolate the resident on 10/1/20, when COVID-19 symptoms were first identified. The resident was not isolated until tested positive for COVID-19 on 10/5/20. Observation on 10/8/20 at 8:47 AM, Staff N Licensed Practical Nurse (LPN) administered Resident #15's medications while donned in full Personal Protective Equipment (PPE) due to the resident being COVID-19 positive. During the medication pass the LPN knocked off her face shield, causing it to land on the floor, and then proceeded to wipe her forehead multiple times with the bottom and the sleeve of the disposable gown. The LPN then proceeded to replace the face shield that had been on the floor without disinfecting it first. Interview on 10/8/20 at 9:35 AM, Staff N LPN	F 880		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	165145	A. BUILDING _____ B. WING _____	C 10/26/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
EMBASSY REHAB AND CARE CENTER	206 PORT NEAL ROAD SERGEANT BLUFF, IA 51054

(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 59 confirmed she knocked off her face shield, put it back on without disinfecting it, and used her disposable gown to wipe her forehead multiple times. The LPN stated she should not have wiped her face with the disposable gown and should have replaced her face shield after it dropped on the floor. The LPN stated she should have left the room, changed her PPE, and then returned to the room to finish with the resident's medication administration. On 9/22/20 at 10:35 a.m. the Administrator and interim Director of Nursing identified 2 residents as COVID positive and 1 in isolation due to elevated temperature and 1 resident recovered..	F 880		
F 925 SS=E	Maintains Effective Pest Control Program CFR(s): 483.90(i)(4) §483.90(i)(4) Maintain an effective pest control program so that the facility is free of pests and rodents. This REQUIREMENT is not met as evidenced by: Based on record review, policy review, resident and staff interviews, the facility failed to maintain an effective pest control program to remain free of pests and rodents. The facility reported a census of 42 residents. Findings include: 1. An Minimum Data Set (MDS) with a completion date of 9/29/20, for Resident #21 identified the resident with a Brief Interview for Mental Status (BIMS) of 15, cognitively intact. Interview on 9/30/20 at 9:30 AM, Resident #21,	F 925	Maintenance Director will inspect Resident #21 and #24 rooms on 11/9/20 for evidence of pest- none detected. Maintenance Director will inspect all resident rooms throughout the facility to make sure that all rooms are always insect and rodent free by 11/9/20. Facility staff retrained on Pest Control Policy on 11/11/20. Audits will be completed weekly for 4 weeks and then monthly for 4 months by DON/ Designee. Results will be reported to the QAPI team.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	165145	A. BUILDING _____ B. WING _____	C 10/26/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
EMBASSY REHAB AND CARE CENTER	206 PORT NEAL ROAD SERGEANT BLUFF, IA 51054

(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 925	Continued From page 60 stated she had mice in her drawers that ate her snacks. Resident #21, stated she informed staff of the mice issue. 2. An MDS with a completion date of 8/24/20, for Resident #24, identified the resident with a BIMS of 13, cognitively intact. Interview on 9/28/20 at 12:51 PM, Resident #24, stated he did have mice in his room and the Maintenance director placed sticky pads. Review of monthly Ecolab Pest Control invoices from 5/14/20 - 9/2/20, lacked documentation that the facility staff identified a concern with mice. Target pests for: May was spiders, June was ants, July was ants, August was ants and beetles, and September was ants. Document titled Pest Control Policy with a revision date 3/2019, stated: " The facility would have a pest control contract that provided frequent treatment of the environment for pests " The contract would allow for additional visits when a problem was detected " Monitoring of the environment would be done by the facility staff " Pest control problems would be reportedly promptly to the contractor " The facility used Ecolab pest control company to ensure ongoing attention to the prevention of rodents and insects Interview on 9/24/20 at 9:06 AM, Ecolab Pest Control confirmed he visits the facility monthly for pest control. The Ecolab Pest Control stated he did not visit the facility in March or April due to the facility being in lockdown, however, he did return	F 925		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	165145	A. BUILDING _____ B. WING _____	C 10/26/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
EMBASSY REHAB AND CARE CENTER	206 PORT NEAL ROAD SERGEANT BLUFF, IA 51054

(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 925	Continued From page 61 in May and that while he was in the facility, no one had voiced a concern to him regarding issues with mice. Interview on 9/24/20 at 10:45 AM, Staff A Certified Medication Aide (CMA) stated she observed mice in the breakroom of the facility about a month ago, however, was unsure if it was dead or alive. The CMA stated she notified housekeeping of the mice in the breakroom. Interview on 9/24/20 at 10:59 AM, Staff B Certified Nursing Assistant (CNA) stated she observed dead mice in traps in the facility breakroom. The CNA stated she had informed Staff C, the Maintenance director. Interview on 9/24/20 at 12:23 PM, Staff H Licensed Practical Nurse (LPN) stated she knew of mice in the breakroom and that was why the Maintenance director removed the snack machine. Interview on 9/24/20 at 12:58 PM, Staff D CNA, stated Resident #24, informed her he saw mice in his drawers and under his bed. Interview on 9/24/20 at 1:15 PM, Staff C Maintenance director stated he started working at the facility approximately 4 months ago and identified a mouse issue at that time. The Maintenance director stated he caught mice on sticky pads in resident rooms and in the facility breakroom. The Maintenance director stated the Administrator knew of the mouse issue in the facility and discussed it with Ecolab Pest Control. The Maintenance director stated Ecolab Pest Control informed him there were traps set outside and they spray for everything.	F 925		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	165145	A. BUILDING _____ B. WING _____	C 10/26/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
EMBASSY REHAB AND CARE CENTER	206 PORT NEAL ROAD SERGEANT BLUFF, IA 51054

(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 925	Continued From page 62 Interview on 9/29/20 at 4:32 PM, Staff E CMA stated she had a mouse run across the top of her foot in Resident #24's room. The CMA stated Resident #21, complained mice ate the snacks in her drawers. Interview on 9/30/20 at 1:41 PM, Staff I CNA stated the facility put mouse traps out due to reports of mice in the facility. The CNA stated the snack machine removed from the breakroom due to the mouse issue. Interview on 10/1/20 at 8:00 AM, Staff J LPN, stated she caught a mouse on the night shift in the hallway and turned it loose outside. The LPN stated the Administrator was aware of the mice issue in the facility. Interview on 10/6/20 at 2:20 PM, Staff F Registered Nurse (RN) stated he observed mice in the facility for the last few months. Interview on 10/7/20 at 3:30 PM, the Administrator stated she was not aware of a mouse issue at the facility and had not called and informed Ecolab Pest Control. The Administrator identified one mouse in the facility and it had been caught. The Administrator stated the staff could have discussed it with the Maintenance director, however, she had not been informed. The Administrator stated she was not aware of mice being in the breakroom or in the resident rooms. Interview on 10/8/20 at 8:11 AM, Staff G Housekeeping/Laundry Supervisor stated she observed mice in resident rooms and in the facility breakroom off/on in the last year. The	F 925		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	165145	A. BUILDING _____ B. WING _____	C 10/26/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
EMBASSY REHAB AND CARE CENTER	206 PORT NEAL ROAD SERGEANT BLUFF, IA 51054

(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 925	Continued From page 63 Housekeeping/Laundry Supervisor stated the Maintenance director and Administrator knew of the mice issues.	F 925		

Person completing form:_____ Date of audit:_____

Direction: Review documentation in medical record and determine if condition change has occurred and notification complete.

Resident Name	Date of notes reviewed	Condition change identified	Notification to Physician/ Date and time	Notification of family date and time	On charting sheet	Pass/Fail	Signature		

REPORT RESULTS OF AUDITS TO THE QAPI COMMITTEE

F-tag 580 Notify of Change (Injury/Decline/Room)

Person completing form:_____ Date of audit:_____

Direction: Complete weekly with any incidents (falls, Skins, Resident to Resident, Behaviors)

Resident Name	Incident documented in notes	Risk Management completed	Date	Type of Incident	New intervention added to care plan	Physician Notified	Family Notified	Staff Name	

REPORT RESULTS OF AUDITS TO THE QAPI COMMITTEE **F-Tag 689 Free of Accident/Hazards/Supervision/Devices Provide additional information on back of form if needed.**

Person completing form:_____ Date of audit:_____

Direction: Complete weekly with any incidents (falls, Skins, Resident to Resident, Behaviors)

Resident Name	Incident documented in notes	Risk Management completed	Date	Type of Incident	New intervention added to care plan	Physician Notified	Family Notified	Staff Name	

REPORT RESULTS OF AUDITS TO THE QAPI COMMITTEE **F-Tag 689 Free of Accident/Hazards/Supervision/Devices Provide additional information on back of form if needed.**

11/12/2020

Person completing form:_____ Date of audit:_____

Direction: Please complete weekly for identification of residents with respiratory symptoms

Resident	Elevated temp/decr oxygen sat/chills	Cough, sore throat congestion runny nose	SOB/diff breathing	Fatigue/ muscle aches	Headache	Loss of taste or smell	N/V/D	Move to isolation	Staff Name

REPORT RESULTS OF AUDITS TO THE QAPI COMMITTEE **F-tag 880 Infection Control Practices/Prevention?//**

Person completing form:_____ Date of audit:_____

Direction: Complete with discharge planned/unplanned, admission

Resident Name	Date Discharged	Discharge Form Complete and date	Recap of stay completed	Date of admission	Discharge plan identified/ date	Staff Name	Date		

REPORT RESULTS OF AUDITS TO THE QAPI COMMITTEE **F-TAG 622 Transfers and Discharge Requirements**

Person completing form:_____ Date of audit:_____

Directions: Complete following day after baths are done.

Resident	Bath Day	Completed (y or n)	Documented in PCC	Staff Name					

REPORT RESULTS OF AUDITS TO THE QAPI COMMITTEE **F-TAG 677 ADL Care Provided for Dependent Residents**

Person completing form:_____ Date of audit:_____

Direction: Complete at the end of the week regarding appointments scheduled

Resident Name	Date of Appointment	Resident Attended Appt (y or n)	Orders received	Processed	Return Appt on calendar	Staff Name			

REPORT RESULTS OF AUDITS TO THE QAPI COMMITTEE **F-TAG 658 Services Provided Meet Professional Standards**

Person completing form:_____ Date of audit:_____

Direction: To be completed as directed for pest control

Resident Name	Room Number	Presence pests and rodents	Y	N	Cause Identified		Intervention implemented		Staff

REPORT RESULTS OF AUDITS TO THE QAPI COMMITTEE

Person completing form:_____ Date of audit:_____

Direction: Complete the abuse quiz attached

Staff Name	Question Asked	Question Asked	Question Asked	Question Asked	Question Asked	Question Asked			

REPORT RESULTS OF AUDITS TO THE QAPI COMMITTEE

F tag 550 Resident Rights/Exercise of Rights

Person completing form:_____ Date of audit:_____

Direction: Complete

Resident	Date of Change of Payer Status	Payer Change	Responsible Party Contacted	Pharmacy Change (y or n)	Staff Name				

REPORT RESULTS OF AUDITS TO THE QAPI COMMITTEE

F-TAG 552 Right to be informed/Make Treatment Decisions

Root Cause Anaylsis

Problem

Residents not placed in isolation based on assessment and identification of symptoms that possibly could be Covid based.

Root causes

- Knowledge deficit
    - Signs and Symptoms of Covid
    - Understanding of disease process vs chronic disease
    - Isolation Procedure
    - Utilization of point of care testing vs PVR testing