STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	165232	A. BUILDING _____ B. WING _____	01/07/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
FRIENDSHIP HOME ASSOCIATION	714 DIVISION AUDUBON, IA 50025

(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: 1-29-21 The facility's annual recertification survey was completed 1-7-21 and resulted in the following deficiencies.. (See Code of Federal Regulations (42CFR) Part 483, Subpart B -C).	F 000		
F 607 SS=D	Develop/Implement Abuse/Neglect Policies CFR(s): 483.12(b)(1)-(3) §483.12(b) The facility must develop and implement written policies and procedures that: §483.12(b)(1) Prohibit and prevent abuse, neglect, and exploitation of residents and misappropriation of resident property, §483.12(b)(2) Establish policies and procedures to investigate any such allegations, and §483.12(b)(3) Include training as required at paragraph §483.95, This REQUIREMENT is not met as evidenced by: Based on personnel file reviews, policy review, and staff interview the facility failed to obtain a complete criminal background check within 30 days prior to the date of hire for 1 of 5 currently employed staff (Staff B). The facility reported a census of 37 residents. Findings include: The personnel file for Staff B, Certified Nurse's Aide (CNA), documented a hire date of 11/8/20. The file contained a criminal background check	F 607		

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

Administrator 1/29/21

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

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F 607	Continued From page 1 dated 11/9/20, with documentation that there was an error running license or abuse registries check and to try later. The Sex Offender Registry results revealed database unavailable and directed the facility to try again later. On 1/5/21 at 5:30 PM, the Administrator confirmed Staff B's criminal background check was incomplete, with no results for the Sex Offender Registry. On 1/6/21 at 9:00 AM, the Administrator stated she received confirmation from the Division of Criminal Investigation, Sex Offender Registry; as of today's date Staff B was not on the Sex Offender Registry Public Website. Email dated 1/6/21 at 8:45 AM, confirmed this notification. On 1/6/21 at 2:10 PM, the Administrator stated the facility did not have a policy in place regarding Criminal Background Checks prior to employment. The Administrator stated the facility had a new hire checklist in place that indicates what is required prior to hire and prior staff to starting employment. The Administrator stated she had confidence in her team that the re-check was completed. The Administrator stated it had never been the practice of the facility to hire or start employment for staff without the new hire paperwork completed. Interview on 1/7/21 at 10:23 AM the Administrator stated the facility did have, and provided, a policy regarding background checks prior to staff employment. Policy titled Background Screening Investigations undated, stated the personnel/human resource director or designee would conduct employment	F 607		

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F 607	Continued From page 2 background checks on persons making application for employment with the facility. Such investigation would be initiated within two days of employment or offer of employment. Inquiries concerning nursing services employee background investigation screenings should be referred to the director of nursing.	F 607		
F 625 SS=D	Notice of Bed Hold Policy Before/Upon Trnsfr CFR(s): 483.15(d)(1)(2) §483.15(d) Notice of bed-hold policy and return- §483.15(d)(1) Notice before transfer. Before a nursing facility transfers a resident to a hospital or the resident goes on therapeutic leave, the nursing facility must provide written information to the resident or resident representative that specifies- (i) The duration of the state bed-hold policy, if any, during which the resident is permitted to return and resume residence in the nursing facility; (ii) The reserve bed payment policy in the state plan, under § 447.40 of this chapter, if any; (iii) The nursing facility's policies regarding bed-hold periods, which must be consistent with paragraph (e)(1) of this section, permitting a resident to return; and (iv) The information specified in paragraph (e)(1) of this section. §483.15(d)(2) Bed-hold notice upon transfer. At the time of transfer of a resident for hospitalization or therapeutic leave, a nursing facility must provide to the resident and the resident representative written notice which specifies the duration of the bed-hold policy described in paragraph (d)(1) of this section.	F 625		

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F 625	Continued From page 3 This REQUIREMENT is not met as evidenced by: Based on record review and staff interview, the facility failed to notify the resident or their representative of the bed hold policy for 1 of 2 residents reviewed (#33). The facility reported a census of 37 residents. Findings include: A Minimum Data Set (MDS) for Resident #33 with a completion date of 12/22/20 listed diagnoses of Coronary Artery Disease, Chronic Obstructive Pulmonary Disease, and Coronavirus (COVID-19). The BIMS documented the resident with a Brief Interview for Mental Status (BIMS) score of 15, cognitively intact. During initial pool screening on 1/4/21 at 1:48 PM, the resident stated he admitted to the facility 12/9/20 after hospitalization for COVID-19. The resident stated he had a recent re-hospitalized from 12/18/20 - 12/20/20, did not know of a bed hold. Census screen in the resident's Electronic Health Record revealed the resident admitted to the facility on 12/9/20, was discharged with return anticipated on 12/18/20, and returned to the facility on 12/20/20. Progress notes revealed: " 12/18/20 at 10:00 AM, the resident transported to the Hospital Emergency Room (ER) " 12/18/20 at 12:21 PM, call placed to the ER for an update " 12/18/20 at 2:30 PM, the resident admitted for observation at the hospital and discharged	F 625		

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F 625	Continued From page 4 from skilled care The clinical record lacked documentation of the notification of the resident or their representative regarding the bed hold policy. Document titled Bed Hold/Readmission in the Admission packet, undated, stated the facility would hold a resident's bed space upon the verbal/and or written request of the resident or responsible party according to the provisions of the admission agreement when the resident is temporarily out of the facility for medical or therapeutic reasons. The form gave the option to consent or decline a bed hold along with requiring a signature of the resident or their representative. Document titled Admission Agreement undated, stated: " if a resident has a temporary absence from the facility for medical treatment the facility would provide written information to the resident specifying the duration of the bed hold policy under applicable government regulations and the facilities policies regarding bed hold periods " the facility shall ask the resident or their representative if they wish the facility to hold open the bed " the facility would document in the resident's record the fact that such information was given and the response of the resident or their representative On 1/5/21 at 1:14 PM, the Director of Nursing (DON) stated the nurses on the floor would complete the bed hold and document in the resident's medical record. The DON stated with the Coronavirus the facility could not get the form signed. The DON stated a bed hold was not	F 625		

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F 625	Continued From page 5 required for Resident #33, due the resident on skilled level of care and discharged from the facility when he transferred to the hospital. On 1/6/21 at 5:10 PM, the Administrator stated the facility had been instructed by the Nurse Consultant to discharge residents who were on Medicare skilled care and transferred to the hospital. The Administrator stated when the residents on Medicare skilled care are placed on observation at the hospital, the facility was billed for that hospital stay due to the resident's Medicare skilled care status. According to the state operations manual, when a resident residing in a skilled nursing facility under Medicare is hospitalized or takes therapeutic leave, Medicare will not pay to hold the bed. Facility policies may allow the resident to pay privately to hold his or her bed. While the provisions of the regulation specifically address bed-hold under Medicaid law, facilities must make all residents aware in writing of their policies related to holding beds during absences from the facility.	F 625		
F 656 SS=D	Develop/Implement Comprehensive Care Plan CFR(s): 483.21(b)(1) §483.21(b) Comprehensive Care Plans §483.21(b)(1) The facility must develop and implement a comprehensive person-centered care plan for each resident, consistent with the resident rights set forth at §483.10(c)(2) and §483.10(c)(3), that includes measurable objectives and timeframes to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment. The comprehensive care plan must	F 656		

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F 656	Continued From page 6 describe the following - (i) The services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §483.24, §483.25 or §483.40; and (ii) Any services that would otherwise be required under §483.24, §483.25 or §483.40 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(c)(6). (iii) Any specialized services or specialized rehabilitative services the nursing facility will provide as a result of PASARR recommendations. If a facility disagrees with the findings of the PASARR, it must indicate its rationale in the resident's medical record. (iv)In consultation with the resident and the resident's representative(s)- (A) The resident's goals for admission and desired outcomes. (B) The resident's preference and potential for future discharge. Facilities must document whether the resident's desire to return to the community was assessed and any referrals to local contact agencies and/or other appropriate entities, for this purpose. (C) Discharge plans in the comprehensive care plan, as appropriate, in accordance with the requirements set forth in paragraph (c) of this section. This REQUIREMENT is not met as evidenced by: Based on observation, clinical record review, and staff interview the facility failed to ensure the comprehensive care plan was developed and updated for 1 of 1 residents reviewed that were new admissions to the facility (Resident #33). The facility reported a census of 37 residents.	F 656		

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F 656	Continued From page 7 Findings include: A Minimum Data Set (MDS) for Resident #33 with a completion date of 12/22/20, listed diagnoses of Coronary Artery Disease, Chronic Obstructive Pulmonary Disease, and Coronavirus (COVID-19). The MDS documented the resident with a Brief Interview for Mental Status (BIMS) score of 15, cognitively intact. The MDS coded that the resident needed set-up with bed mobility and transfer, independent with dressing and toileting, and supervision of one staff for personal hygiene. Clinical record documented the resident admitted to the facility on 12/9/20, transferred to the hospital 12/18/20, and returned to the facility on 12/20/20. Medication List revealed an order for Eliquis (blood thinner) 5 milligrams (mg) twice a day for 23 days, with a start date of 12/26/20. Review of the baseline care plan with an admit date of 12/9/20, failed to identify the resident being on Eliquis. On 1/6/21 at 1:45 PM, the MDS Coordinator stated she would have a comprehensive care plan completed for new admissions to the facility 21 days after admission. The MDS Coordinator stated she updated the resident's baseline care plan as needed until they completed the comprehensive care plan. The MDS Coordinator stated the care plan should contain the order for Eliquis, as it was the practice of the facility to include all black box warning medications with side effects to monitor for on the care plans.	F 656		

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F 812	Continued From page 8	F 812		
F 812 SS=D	Food Procurement,Store/Prepare/Serve-Sanitary CFR(s): 483.60(i)(1)(2) §483.60(i) Food safety requirements. The facility must - §483.60(i)(1) - Procure food from sources approved or considered satisfactory by federal, state or local authorities. (i) This may include food items obtained directly from local producers, subject to applicable State and local laws or regulations. (ii) This provision does not prohibit or prevent facilities from using produce grown in facility gardens, subject to compliance with applicable safe growing and food-handling practices. (iii) This provision does not preclude residents from consuming foods not procured by the facility. §483.60(i)(2) - Store, prepare, distribute and serve food in accordance with professional standards for food service safety. This REQUIREMENT is not met as evidenced by: Based on observation, policy review, and staff interview, dietary staff failed to serve food under sanitary conditions, in order to reduce the risk of contamination and foodborne illness at 1 of 1 meals observed. The facility reported a census of 37 residents. Findings included: During an observation of the lunch meal served on 1/6/21, at 12:35 PM, Staff A, Dietary Aide (DA), donned a glove on her right hand and placed a slice of bread on a plate, with the gloved hand. Staff A, DA, proceeded to touch the serving utensils, and again touch a slice of bread with the	F 812		

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F 812	Continued From page 9	F 812		

same gloved hand, 3 more times. Staff A, DA, scooped pureed carrots out of a mold onto a plate with the same gloved hand. Staff A, DA, doffed the glove and donned a new glove, without washing her hands. Staff A touched the serving utensils and then a slice of bread with the same gloved hand.

Review of an undated facility policy titled, "Bare Hand Contact with Food and Use of Plastic Gloves" documented: Gloved hands are considered a food contact surface that can get contaminated or soiled. If used, single use gloves shall be used for only one task (such as working with ready-to-eat food) and discarded when damaged or soiled, or when interruptions occur in the operation. Hands are to be washed when entering the kitchen and before putting on the single-use gloves and after removing single use gloves.

During an interview on 1/6/21 at 3:50 PM, the Dietary Manager acknowledged her expectation for glove use to include washing hands between donning and doffing gloves, use the gloves for one task only, and other surfaces should not be touched prior to handling ready-to-eat food.

The 2013 Food Code, published by the Food and Drug Administration and considered a standard of practice for the food service industry, includes the following requirements: 1) Single-use gloves are to be used for only one task, such as working with ready-to-eat food and for no other purpose, and discarded when damaged or soiled, or when interruptions occur in the operation, 2) prohibits food employees from bare hand contact with ready-to-eat food (unless washing fruits and vegetables) and requires food employees to wash

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F 812	Continued From page 10 their hands immediately before engaging in food preparation, including before donning gloves for working with food, in order to prevent cross contamination when changing tasks.	F 812		

Plan of Correction
Friendship Home Association
Survey: January 4, 2021 – January 7, 2021
Correction Date: 01/29/21

The preparation of the following plan of correction for this deficiency does not constitute and should not be interpreted as an admission nor an agreement by the facility of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction prepared for these deficiencies were executed solely because provisions of State and Federal law require it.

A plan of correction for the deficiencies must be submitted by **1-31-21.**

607 -- Elements detailing how you will correct the deficiency as it relates to the individual;

January 21, 2021 amended existing checklist procedure to clarify hand-offs between hiring manager and Occupational Development and Learning Director and clarify requirements necessary to complete before hire date.

-- How you will act to protect residents in similar situations;

January 21, 2021 new hire checklist updated requiring both Occupational Development and Learning Director and hiring Department Head to both sign off and date final background check review. Policy and procedure developed and distributed for all department heads.

-- Include measures you will take or systems you will alter to ensure that the problem does not recur; and

October 2020, restructure of business office to develop job role. Occupational Development and Learning Director focused on new hire screening, onboarding training,

-- How you plan to monitor performance to make sure that solutions are permanent.

QAPI in progress since November 2020 to address new hire experience including action items to improve handoffs between hiring manager and Occupational Development and Learning Director. Background screening process expectations implemented.

625 -- Elements detailing how you will correct the deficiency as it relates to the individual;

January 20, 2021 Amend bed hold form to include Med A status residents.

-- How you will act to protect residents in similar situations;

January 20,2021 meeting held to finalize bed hold form with amended language. Charge nurses educated on changes and how to complete the form. Policy and procedure reviewed and updated in nursing policy and procures binder.

-- Include measures you will take or systems you will alter to ensure that the problem does not recur; and

Communication posted in nurses stations detailing mandatory use of bed hold form for residents on hospital leave and therapeutic leave.

-- How you plan to monitor performance to make sure that solutions are permanent.

Accounting Manager audits all transfer statuses minimum of once a month prior to submitting Ombudsman report.

656 -- Elements detailing how you will correct the deficiency as it relates to the individual;

January 6, 2021 resident careplan updated with language to monitor symptoms for bleeding relative to Eliquis order.

-- How you will act to protect residents in similar situations;

MDS Coordinator or RN to update careplan per return orders following a readmission from hospital leave.

-- Include measures you will take or systems you will alter to ensure that the problem does not recur; and

MDS Coordinator or DON or RN to do daily audit of prior days orders to ensure careplans are current.

-- How you plan to monitor performance to make sure that solutions are permanent.

QAPI in action. MDS to include review of CP and findings in MDS report at quarterly QAA meetings.

812 -- Elements detailing how you will correct the deficiency as it relates to the individual;

January 6, 2021 Dietary Manager completed one on one education with staff member on appropriate glove usage and hand washing procedures.

-- How you will act to protect residents in similar situations;

Glovology program started in dietary department December 23, 2020. All staff education on hand washing January 19, 2021.

-- Include measures you will take or systems you will alter to ensure that the problem does not recur; and

Dietary Manager conducted education with all cooks regarding service preparation. Cooks sign off on education including service set up with extra utensils.

-- How you plan to monitor performance to make sure that solutions are permanent.

Dietary Manager to schedule monthly all department staff education on handwashing and glove usage. Register Dietician and/or Dietary Manager to report on quarterly observation of dietary staff glove usage, hand washing, and any education at QAA meetings.