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	165540	A. BUILDING _____ B. WING _____	04/06/2021

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COUNTRYSIDE HEALTH CARE CENTER	6120 MORNINGSIDE AVENUE SIOUX CITY, IA 51106

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F 000	INITIAL COMMENTS Correction Date_____ A recertification survey and investigation of facility self reports #94538-I and #94812-I and Complaints #94040-C, #94446-C, #94499-C, #94769-C, #95278-C, #95378-C, #95614-C, #95916-C, #96395-C and #96381-C completed 3/22/21 to 4/6/21 resulted in the following deficiencies. Complaint #94040-C was substantiated. Complaint #94446-C was substantiated. Complaint #94499-C was substantiated. Self report #94538-I was not substantiated. Complaint #94769-C was substantiated. Self report #94812-I was substantiated. Complaint #95278-C was substantiated. Complaint #95378-C was substantiated. Complaint #95614-C was substantiated. Complaint #95916-C was substantiated. Complaint #96395-C was substantiated. Complaint #96381-C was substantiated. See Code of Federal Regulations (42CFR) Part 483, Subpart B-C.	F 000		
F 550 SS=D	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	F 550		

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

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resident in a manner and in an environment that promotes maintenance or enhancement of his or her quality of life, recognizing each resident's 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 observation, record review, and staff interview the facility failed to assure dignified treatment for 2 of 9 residents reviewed, failing to answer a resident's calls for help in a timely manner (Resident #2) and failing to empty a urinal (Resident #183). The facility reported a census of 33 residents.

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Findings include:

1. Resident #2's Minimum Data Set (MDS) assessment, dated 1/6/21, assessed the resident with a score of "1" on the Brief Interview for Mental Status (BIMS) indicating severe cognitive impairment. The resident required extensive assistance with activities of daily living (ADL's) including bed mobility, toilet use, and personal hygiene. The resident's diagnoses included stroke and hemiplegia or hemiparesis (paralysis or weakness of 1 side of the body).

The current Care Plan revised 1/14/21 identified the resident with potential for exhibiting behaviors related to cognition. Behaviors exhibited included yelling help instead of using the call light. The goal included the resident would have needs met. Interventions included
changing the resident's position, providing support/comfort, and allowing time to express concerns.

Observation showed on 3/23/21 at 6:55 a.m. the resident hollered "help me" and "hurry up", repeatedly. The resident's door remained closed with no staff on the hall, but the resident's hollering audible from the nurse's station. At 7:18 a.m. Staff F Licensed Practical Nurse (LPN) turned the hall light on and pushed the med cart to the end of the hall. Although the resident continued to call out, she did not stop to check on her. Continuous observation of the hall revealed the resident continued to call out. At 7:42 a.m. Staff J Certified Medication Aide (CMA) and Staff I Certified Nursing Assistant (CNA) entered the resident's room. The resident had her head toward the outside of the bed and feet toward the

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wall. The resident called help me, hurry up for 47 minutes before staff checked on the resident and provided care.

On 3/31/21 at 10:54 a.m. the Director of Nursing (DON) stated she expected staff to check in on the resident in a timely manner when she called out.

2. A MDS assessment tool, dated 11/17/20, for Resident #183 identified the resident with intact cognition and occasional bladder incontinence. The resident admitted to the facility with a fracture and other multiple trauma.

The closed care plan dated 10/23/20 identified the resident required assistance with ADL's (Activities of Daily Living) due to a lower extremity fracture. An intervention dated 10/23/20 revealed the resident had independence with the urinal and directed staff to keep the urinal within reach.

On 3/24/21 at 11:06 a.m., the former resident stated one day he needed to use his full urinal and turned on his call light for someone to empty the urinal for him. The resident stated a staff member came and told the resident it was not her job to empty the urinal. The resident stated he waited 10 to 15 minutes to turn the call light on again, the same staff member entered, and refused to empty the urinal. The resident stated he had to wet through his clothing and was embarrassed. Staff on the next shift came in later and cleaned him up. The resident could not recall the date, time, or shift the incident happened and stated the rest of the staff were nice.

On 3/24/21 at 10:27 a.m., Staff N, CNA (Certified Nurse's Aide) stated she recalled working on

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F 550	Continued From page 4 12/8/20 when the resident stated he used his call light a few weeks prior to ask for help to empty the full urinal he needed to use. The resident stated an evening aide, unsure of her name scared him. The aide entered the room, turned off the call light, and told the resident she would send someone in. The resident turned the call light on again after approximately 20 minutes, the same aide entered the room, and told the resident again that she would send someone in. The resident stated after a couple hours someone from the next shift came in, found him incontinent of urine, and cleaned him up. The resident told Staff N he felt belittled and ashamed. On 3/25/21 at 1:27 a.m., Staff H, CNA, verified she was in the resident's bathroom preparing for cares with Staff N on 12/8/20 and heard the resident tell Staff N a staff member previously refused to empty his full urinal, he had been incontinent, and incontinence unusual for the resident. The undated Resident's Bill of Rights directed staff to treat residents with consideration, respect and dignity considering resident's individuality and preferences.	F 550		
F 558 SS=D	Reasonable Accommodations Needs/Preferences CFR(s): 483.10(e)(3) §483.10(e)(3) The right to reside and receive services in the facility with reasonable accommodation of resident needs and preferences except when to do so would endanger the health or safety of the resident or other residents. This REQUIREMENT is not met as evidenced by:	F 558		

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Based on observation, record review, and staff interview, the facility failed to assure residents had the call light in reach for 2 of 17 residents reviewed (Resident #8 and #14). The facility reported a census of 33 residents.

Findings include:

1. A Minimum Data Set (MDS) assessment, dated 1/20/21, assessed Resident #8 with a Brief Interview for Mental Status (BIMS) of 12 indicating moderate cognitive impairment. The resident required extensive assistance with activities of daily living (ADL's) including bed mobility, transfer and locomotion, and did not ambulate. The resident's diagnoses included a stroke.

The current Care Plan dated 4/13/19 identified the resident with a potential for falls relating to the use of an assistive device for mobility. The interventions included placing the call light in reach and letting the resident feel where staff clipped it due to blindness.

Observation showed on 3/23/21 at 6:10 a.m. the resident laid sideways in bed calling for help. Staff Q Certified Nursing Assistant (CNA) and Staff H CNA went to the resident's room. At 6:55 a.m. the resident sat in the room in the wheelchair, with the call light on the bed under a pillow. At 7:18 a.m. staff passing meds turned the hall light on and pushed the cart to the end of the hall by the resident's room. The resident did not have the call light.

2. A MDS assessment dated 2/8/21, assessed Resident #14 with long and short term memory impairment and moderately impaired skills for

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daily decision making. The resident required extensive assistance with ADL's including bed mobility, transfer, toilet use, dressing, and personal hygiene. The resident's diagnoses included a stroke and dementia.

The current Care Plan identified the resident at risk for falls, revised 1/11/21. The interventions included educating the resident to use the call light if something needed picked up off the floor, and not attempting to pick it up herself.
The current Care Plan identified the resident with visual deficits as evidenced by wearing glasses, revised 8/14/19. The interventions included having the call light within reach at all times.

Observation showed on 3/29/21 at 10:44 a.m. the resident seated in the wheelchair in her room unattended. The call light laid on the bed behind the resident. At 11 a.m. staff got the resident a mask and wheeled her to the dining room.

Observation showed on 3/30/21 at 7:10 a.m. the resident seated in the room in her wheel chair with her back to the television, and the call light on the recliner out of reach. At 7:16 a.m. Staff Q Certified Nursing Assistant went to the resident's room and wheeled her to the dining room. At 8:10 a.m. the resident sat in her room in her wheel chair in front of the television, with the call light on the recliner. At 8:26 a.m. Staff N CNA walked past the residents room, waved, and appeared to talk to the resident, then walked away. The resident did not have the call light. At 8:40 a.m. and 9:06 a.m. the call light remained out of the resident's reach.

On 3/31/21 at 10:54 a.m. the Director of Nursing (DON) stated she expected residents to have the

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F 558	Continued From page 7 call light in reach at all times in their room, wheelchair, recliner, or bed.	F 558		
F 580 SS=D	Notify of Changes (Injury/Decline/Room, etc.) CFR(s): 483.10(g)(14)(i)-(iv)(15) §483.10(g)(14) Notification of Changes. (i) A facility must immediately inform the resident; consult with the resident's physician; and notify, consistent with his or her authority, the resident representative(s) when there is- (A) An accident involving the resident which results in injury and has the potential for requiring physician intervention; (B) A significant change in the resident's physical, 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.	F 580		

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(iv) The facility must record and periodically update the address (mailing and email) and phone number of the resident representative(s).

§483.10(g)(15)
Admission to a composite distinct part. A facility that is a composite distinct part (as defined in §483.5) must disclose in its admission agreement its physical configuration, including the various locations that comprise the composite distinct part, and must specify the policies that apply to room changes between its different locations under §483.15(c)(9).
This REQUIREMENT is not met as evidenced by:
Based on record review and interviews the facility failed to notify the physician of weight loss for 2 of 7 Residents reviewed (Resident # 11 and #22). The facility reported a census of 33 residents.

Findings include:

1. The Minimum Data (MDS) with an Assessment Reference Date of (ARD) of 3/22/21 for Resident #22 showed a Brief Interview for Mental Status (BIMS) score of 07 indicating severe cognitive impairment. The resident had diagnoses that included: acute respiratory failure, diabetes, and muscle weakness. The resident required extensive assistance for transfers, locomotion, and toileting.

The census tab in resident electronic health record (EHR) showed the resident admitted to the facility on 2/19/21.

The EHR showed the resident with a 2/19/21

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admission weight of 167.2 pounds (lb), on 3/2/21 the resident weighed 163.2 lb, on 3/12/21 the resident weighed 158.6 lb, on 3/18/21 the resident weighed 152.0 lb, and on his discharge date of 3/19/21 resident weighed 151.0 lb. On 02/19/2021, the resident weighed 167.2 lbs. On 03/19/2021, the resident weighed 151.0 lb which is a -9.69 % loss in 30 days.

A dietary note dated 3/11/21 at 4:37 p.m. identified the resident's weight as 160.2 lb and treading down. The dietary note revealed the resident's family did not bring in fast food as much and identified weight loss likely due to decreased calories consumed with facility meals vs food brought in. Will continue to monitor weekly in Hydration Assessment Review (HAR)/Nutrition Assessment Review (NAR) .

The HAR/NAR dated 3/4/21 revealed the resident listed as a new admit and weight loss with an admission weight of 167.2 lb on 2/19/21 and weight of 163.2 lb on 3/4/21. HAR/NAR lacked any dietary recommendations or notification to the physician

The HAR/NAR dated 3/11/21 showed the resident lost weight and weighed 160.2 lb on 3/11/21. HAR/NAR lacked any dietary recommendations or notification to the physician.

The HAR/NAR dated 3/18/21 revealed the resident continued to lose weight and weighed 159.5 lb with the reason of weight loss attributed to the family not bringing in fast food as much. HAR/NAR lacked documentation of dietary recommendations or physician notification.

On 3/24/21 at 9:42 a.m. the Dietary Manager

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(DM) stated the facility conducted weekly weight meetings on Thursdays at 1:30 p.m. that included the Director of Nursing (DON), Administrator, the Dietician and the DM. The DM stated that it is the responsibility of each department to do their part of documentation and that the nursing department is responsible for physician notification.

The care plan with initiation date of 2/22/21 revealed a goal of: the resident will be free from significant weight changes through next review.

On 3/25/21 at 9:20 a.m. the dietician revealed she did not have concerns with the resident's weight loss and did not recommend starting supplements. She stated the facility would add the resident to the HAR/NAR to monitor. The dietician stated a significant weight loss sheet is emailed to the Administrator, DON, and DM and staff should notify the physician of the weight loss.

2. The MDS with an ARD of 3/16/21 assessed Resident #11 with a BIMS of 09 indicating moderate cognitive impairment. The MDS identified the resident with diagnoses that included: dementia, assistance with personal care, depression and vitamin D and B12 deficiency. The resident required extensive staff assistance with transfers, locomotion, and bed mobility and supervision with eating.

The resident electronic health record (EHR) showed the following weights: on 10/2/20 169.2 lb, 11/3/20 of 161.2 lb, 12/1/21 157.4 lb, 1/6/21 of 159.4 lb, 2/2/21 of 164.8 lb, 3/2/21 161.7 lb, 3/26/21 146 lb. On 02/25/2021, the resident weighed 163.4 lb and on 03/26/2021, the resident

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weighed 146.2 lb which indicated a -10.53 % loss in thirty days.

The care plan with initiation date of 10/1/17 identified the resident as a weekly weight due to weight fluctuations related to edema and variable meal intakes. The care plan goal: Resident's weight will be maintained through next review period.

Current physician orders showed Resident received Lasix (diuretic) 80 milligrams (mg) one time a day.

The HAR/NAR dated 3/4/21 lacked any documentation of the facility monitoring the resident's weight or notification to physician.

The HAR/NAR dated 3/11/21 lacked any documentation of the facility monitoring the resident's weight or notification to physician.

The HAR/NAR dated 3/18/21 lacked any documentation of the facility monitoring the resident's weight or notification to physician.

The HAR/NAR dated 3/25/21 lacked any documentation of the facility monitoring the resident's weight or notification to physician.

On 3/24/21 at 9:42 AM the DM stated the facility conducts a weekly weight meeting on Thursdays at 1:30 PM that include the Director of Nursing (DON), Administrator, the Dietician and the DM. The DM stated she talked to the Resident and the Resident wishes to lose weight.

There was no evidence in the EHR that the facility discussed losing weight safely with the resident.

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F 580	Continued From page 12 On 3/23/21 at 2:19 p.m. the resident stated that she would like to lose more weight and feels she is fat. On 3/25/21 at 9:20 a.m. the Dietician stated it is the Residents choice to lose weight. She stated no supplements have been tried and she didn't believe the Resident would take them anyway. The Dietician stated nursing would notify the physician of the weight loss. On 3/25/21 at 9:38 a.m. the residents Power of Attorney (POA) stated the resident always had weight issues and had gastric by-pass done years ago. The POA stated the resident will eat if its in front of her and did not intentionally try to lose weight. The POA stated she attended care conferences a month ago and the resident's weight was not discussed. The POA stated the facility did not contact her regarding the residents weight loss and she did not know how much weight the resident lost. The POA would expect and would want the resident to receive supplements for her weight loss. The POA stated the last time she saw the resident, she could tell the resident lost a lot of weight. A Charting and Documentation policy dated 7/2017 revealed the facility would notify family, physician or other staff if indicated and document. On 3/30/21 at 3:31 p.m. the Administrator stated the facility did no have a policy for when to notify the physician of weight loss.	F 580		
F 606 SS=D	Not Employ/Engage Staff w/ Adverse Actions CFR(s): 483.12(a)(3)(4)	F 606		

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F 606	Continued From page 13 §483.12(a) The facility must- §483.12(a)(3) Not employ or otherwise engage individuals who- (i) Have been found guilty of abuse, neglect, exploitation, misappropriation of property, or mistreatment by a court of law; (ii) Have had a finding entered into the State nurse aide registry concerning abuse, neglect, exploitation, mistreatment of residents or misappropriation of their property; or (iii) Have a disciplinary action in effect against his or her professional license by a state licensure body as a result of a finding of abuse, neglect, exploitation, mistreatment of residents or misappropriation of resident property. §483.12(a)(4) Report to the State nurse aide registry or licensing authorities any knowledge it has of actions by a court of law against an employee, which would indicate unfitness for service as a nurse aide or other facility staff. This REQUIREMENT is not met as evidenced by: Based on record review and staff interview, the facility failed to request a Department of Human Services (DHS) evaluation for 1 of 3 staff identified with a criminal background. Facility census was thirty-three (33) residents. Findings include: 1. An undated, untitled list of employee hire dates revealed the facility hired Staff B Certified Nurse Aide (CNA)11/19/20. The Double Check USA criminal background report dated 11/16/20, for Staff B, identified 3 misdemeanor convictions which included theft and assault. The personnel record lacked documentation of a DHS evaluation	F 606		

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F 606	Continued From page 14 of the convictions. On 3/29/21 at 2 pm., the Administrator revealed no DHS evaluation completed in response to the Double Check USA findings. Facility policy titled Abuse Prevention, Identification, Investigation, and Reporting Policy and Procedure, effective 6/21/2017, revealed the facility would conduct an Iowa criminal record check and dependent adult/child abuse registry check on all prospective employees and other individuals engaged to provide services to residents, prior to hire, in the manner prescribed under 481 Iowa Administrative Code 58.11(3). The facility would conduct a criminal record check and dependent adult/child abuse registry check on all current employees and other individuals engaged to provide services to residents who have a criminal conviction or founded abuse determination after hire,or when the facility received credible information that an employee had a criminal conviction or a founded abuse determination subsequent to hire. See Iowa Code 135.33(7).	F 606		
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	F 607		

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F 607	Continued From page 15 §483.12(b)(3) Include training as required at paragraph §483.95, This REQUIREMENT is not met as evidenced by: Based on personnel file review and staff interview, the facility failed to provide mandatory dependent adult abuse training within 6 months of hire and every 5 years for 1 out of 7 newly hired employees (Staff C) The facility reported a census of 33 residents. Findings include: 1. A computer generated list of new hires provided by the facility (untitled and undated) revealed Staff C, Certified Nurses Aide (CNA), hired on 3/20/20. The personnel file lacked documentation of mandatory dependent adult abuse training within 6 months of hire. On 3/29/21 at 2 p.m., the Administrator verified no documentation available that identified Staff C completed mandatory adult abuse training. The facility Abuse Prevention, Identification, and Reporting Policy and Procedure, with a revision date of 7/21/17, documented staff are required to complete 2 hours of training for dependent adult abuse within 6 months of hire and an additional 2 hours of training every 5 years.	F 607		
F 641 SS=D	Accuracy of Assessments CFR(s): 483.20(g) §483.20(g) Accuracy of Assessments. The assessment must accurately reflect the resident's status. This REQUIREMENT is not met as evidenced by:	F 641		

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Based on record review and staff interview, the facility failed to accurately complete the Minimum Data Set (MDS) assessment for 2 of 17 residents reviewed (Resident #25 and #34). The facility reported a census of 33 residents.

Findings include:

1. A Minimum Data Set (MDS) assessment, dated 9/1/20, assessed Resident #25 with a Brief Interview for Mental Status (BIMS) of 15 (no cognitive impairment). The MDS documented the resident not considered by the Level 2 Preadmission Screening and Resident Review (PASRR) to have serious mental illness. The resident's diagnoses included schizophrenia.

A PASRR notice of nursing facility approval dated 4/8/19 documented the resident met the criteria for having a diagnosis of mental illness defined by PASRR.

On 3/30/21 at 12:55 a.m. the Administrator stated they discovered the error and planned a correction.

2. A MDS assessment, dated 1/25/21, assessed Resident #34 with a score of 15 on the BIMS indicating no cognitive impairment. The resident's diagnoses included diabetes.

A Progress Notes dated 2/5/21 at 12:27 p.m. documented the resident discharged home at 12:25 p.m. The resident accompanied by family, left with all belongings and home medications in her possession.

The MDS dated 2/5/21 documented the resident discharged to an acute care hospital.

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F 641	Continued From page 17 On 3/30/21 at 12:55 a.m. the Administrator confirmed the resident discharged home, not the hospital.	F 641		
F 655 SS=E	Baseline Care Plan CFR(s): 483.21(a)(1)-(3) §483.21 Comprehensive Person-Centered Care Planning §483.21(a) Baseline Care Plans §483.21(a)(1) The facility must develop and implement a baseline care plan for each resident that includes the instructions needed to provide effective and person-centered care of the resident that meet professional standards of quality care. The baseline care plan must- (i) Be developed within 48 hours of a resident's admission. (ii) Include the minimum healthcare information necessary to properly care for a resident including, but not limited to- (A) Initial goals based on admission orders. (B) Physician orders. (C) Dietary orders. (D) Therapy services. (E) Social services. (F) PASARR recommendation, if applicable. §483.21(a)(2) The facility may develop a comprehensive care plan in place of the baseline care plan if the comprehensive care plan- (i) Is developed within 48 hours of the resident's admission. (ii) Meets the requirements set forth in paragraph (b) of this section (excepting paragraph (b)(2)(i) of this section). §483.21(a)(3) The facility must provide the	F 655		

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resident and their representative with a summary of the baseline care plan that includes but is not limited to:
(i) The initial goals of the resident.
(ii) A summary of the resident's medications and dietary instructions.
(iii) Any services and treatments to be administered by the facility and personnel acting on behalf of the facility.
(iv) Any updated information based on the details of the comprehensive care plan, as necessary.
This REQUIREMENT is not met as evidenced by:
Based on record review and staff interview, the facility failed to provide the resident and/or their representative with a copy of the baseline care plan and medication list following admission to the facility for 4 of 4 residents reviewed (Resident #15, #28, #133 and #23). The facility reported a census of 33 residents.

Findings include:

1. A Minimum Data Set (MDS) assessment, dated 5/10/20 assessed Resident #15 with a score of 15 on the Brief Interview for Mental Status (BIMS) indicating no cognitive impairment. The resident entered the facility on 5/7/20. The resident's diagnoses included cellulitis.

The resident's Care Plan showed initiation of the baseline care plan on 5/7/20.

The clinical record lacked documentation the facility reviewed the baseline care plan or provided a copy to the resident or his representative.

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2. A MDS assessment dated 9/12/20, assessed Resident #28 with a score of 15 on the BIMS indicating no cognitive impairment. The resident entered the facility on 9/1/20. The resident's diagnoses included a stroke.

A Care Conference note dated 9/16/20 at 3:03 p.m. documented the resident in attendance. The note lacked documentation the facility reviewed the care plan or provided a copy to the resident or his representative.

3. A MDS assessment dated 1/26/21, assessed Resident #133 with a score of 7 on the BIMS indicating severe cognitive impairment. The resident admitted to the facility on 1/5/21 and reentered 1/23/21. The resident's diagnoses included diabetes.

The resident's Care Plan showed initiation of the baseline care plan on 1/5/21.

The clinical record lacked documentation the facility reviewed the baseline care plan or provided a copy to the resident or her representative.

4. A MDS assessment tool dated 2/25/21, assessed Resident #23 with severely impaired cognition. The resident admitted to the facility on 12/21/20, and had a reentry date of 2/22/21.

The resident's record lacked documentation the facility provided the resident and/or their representative with a copy of the baseline care plan and medications after admission on 12/21/20.

On 3/30/21 at 11:30 a.m., the Nurse Consultant

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F 655	Continued From page 20 stated she performed a mock survey at the facility the end of December 2020 and found the staff did not give a copy of care plans and medications to any of the residents and/or the resident's representative after admission.	F 655		
F 658 SS=D	Services Provided Meet Professional Standards CFR(s): 483.21(b)(3)(i) §483.21(b)(3) Comprehensive Care Plans The services provided or arranged by the facility, as outlined by the comprehensive care plan, must- (i) Meet professional standards of quality. This REQUIREMENT is not met as evidenced by: Based on observation, record review, staff interviews, and policy/procedure review, the facility failed to follow professional standards of care for medication/treatment administration for 2 residents observed (Resident #2 and Resident #6), and failed to apply compression stockings for 1 resident (Resident #14). The facility reported a census of 33 residents. Findings include: 1. A Minimum Data Set (MDS) assessment tool dated 1/6/21, assessed Resident #2 with severely impaired cognition and diagnoses that included: stroke and feeding tube. The March 2021 Treatment Administration Record (TAR) directed staff to apply Antifungal Powder (same as Nystatin), start date 3/19/21, to the resident's feeding tube site twice daily and cover with a dressing. Observation showed on 3/24/21 at 12:55 p.m.,	F 658		

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Staff F, LPN (Licensed Practical Nurse) wash her hands, apply gloves, and use a gauze sponge and wound cleanser to clean around the resident's feeding tube site. Staff F dried the area with a clean gauze pad, applied Triple Antibiotic Ointment to the reddened area around the feeding tube site, and placed a clean gauze sponge on the feeding tube site.

On 3/24/21 at 1:45 p.m. Staff F stated she used the wrong treatment when she applied Triple Antibiotic Ointment around the resident's feeding tube site instead of the physician ordered Nystatin (an antifungal) Powder.

The facility Liberalized Medications Pass Policy & Procedure, dated November 28, 2017, directed staff to Follow the 6 Rights of medication administration: right drug, right dose, right route, right resident, right time, and right documentation.

2. A MDS tool dated 1/14/21, assessed Resident #6 with intact cognition and diagnoses that included diabetes.

The resident's March 2021 Medication Administration Record (MAR) directed staff to administer Aspart Insulin (same as Novolog) 2 units subcutaneous (SQ) before meals when the resident's blood sugar resulted in a reading of 151 to 200.

Observation showed on 3/24/21 at 7:20 a.m., Staff G, RN (Registered Nurse) check the resident's blood sugar and verify the result of 171. Staff G stated the resident required 2 units of insulin according to a sliding scale.

Observation showed on 3/24/21 at 7:30 a.m.,

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Staff G verified the resident's insulin dose on the MAR. Staff G used a Novolog Insulin Flexpen, attached a needle to the pen without cleaning the end of the pen, and selected 2 units on the Insulin pen. Staff G failed to prime the pen by wasting 2 units of Novolog before administering the Novolog to the resident at 7:35 a.m. Staff G stated the facility changed pharmacies about a month prior and she understood Insulin pens only needed priming/wasting 2 units when first opened.

On 3/25/21 at 8:45 a.m., Staff M RN verified Novolog Flexpen required priming or wasting 2 units prior to each dose and planned to educate all nursing staff today.

3. A MDS assessment, dated 2/8/21, assessed Resident #14 with long and short term memory problems and moderately impaired skills for daily decision making. The resident required extensive assistance with activities of daily living including dressing. The resident's diagnoses included stroke and dementia.

Physician orders with start date of 10/12/19 directed staff to apply compression stockings to the resident's lower extremities during the day and off at bedtime.

Observations:
a. On 3/23/21 at 6:24 a.m. Staff H CNA applied loose fitting, polka dot socks (no compression stockings).
b. On 3/24/21 at 7:17 a.m. the resident up and dressed, wearing loose fitting socks. At 11:33 a.m. the resident continued to wear loose fitting socks.
c. On 3/25/21 at 07:21 a.m. the resident sat in

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F 658	Continued From page 23 the dining room in her wheelchair, wearing loose fitting socks. At 11:22 a.m. the resident continued to wear loose fitting socks. d. On 3/29/21 at 10:44 a.m. the resident sat in the wheelchair in her room wearing loose fitting socks. The Treatment Administration Record (TAR) documented the resident wore the compression stockings 3/23, 25, and 29/21. On 03/29/21 at 4:13 p.m. the Nurse Consultant confirmed the resident did not wear compression stockings on those dates.	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 personal and oral hygiene; This REQUIREMENT is not met as evidenced by: Based on observation, record review and staff interview, the facility failed to provide complete and appropriate incontinent care for 2 of 4 residents reviewed (Resident #2 and #14). The facility reported a census of 33 residents Findings include: 1. A Minimum Data Set (MDS) assessment dated 1/6/21, assessed Resident #2 with a score 1 on the Brief Interview for Mental Status (BIMS) test indicating severe cognitive impairment. The resident required extensive assistance with activities of daily living (ADL's) including bed mobility, toilet use, and personal hygiene. The	F 677		

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resident's diagnoses included stroke and hemiplegia or hemiparesis.

The current Care Plan identified the resident required assist with ADL's due to a stroke, weakness, and decreased mobility. The resident preferred to complete toileting tasks with extensive assistance of 2 staff.
The Care Plan identified the resident at risk for alteration in skin integrity/breakdown due to limited mobility and bowel and bladder incontinence. The interventions included providing peri-care after bowel and bladder incontinence episodes.

Observation showed on 03/23/21 at 7:42 a.m. Staff J Certified Nursing Assistant (CNA) and Staff I CNA provide care. The resident had urine incontinence. Staff J wiped the resident in front and into the vaginal area multiple times without turning the cloth. She did not clean the groins or lower abdomen. Staff rolled the resident to her right and wiped the anal area and buttocks.

2. A MDS assessment dated 2/8/21, assessed Resident #14 with long and short term memory problems and moderately impaired skills for daily decision making.. The resident required extensive staff assistance with ADL's including dressing. The resident's diagnoses included a stroke and dementia.

The current Care revised 2/9/21 identified the resident at risk for alterations in skin integrity/breakdown due to incontinence of bowel and bladder, and needing assistance with ADL's. Interventions included providing pericare immediately after incontinent episodes.

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F 677	Continued From page 25 Observation showed on 03/23/21 at 6:24 a.m. Staff H CNA provide incontinent care. The resident had urine incontinence. Staff H wiped the resident 2 times in front, one time in the back, over the anal area and crease, with no cleaning of the buttocks that had contact with the incontinent pad. On 3/31/21 at 10:54 a.m. the Director of Nursing (DON) stated she expected staff to clean all areas in contact with the incontinent pad, and not wipe repeatedly with the same side of the cloth.	F 677		
F 678 SS=J	Cardio-Pulmonary Resuscitation (CPR) CFR(s): 483.24(a)(3) §483.24(a)(3) Personnel provide basic life support, including CPR, to a resident requiring such emergency care prior to the arrival of emergency medical personnel and subject to related physician orders and the resident's advance directives. This REQUIREMENT is not met as evidenced by: Based on closed record review, staff interview, facility record review and policy review, the facility failed to initiate CPR (cardiopulmonary resuscitation) immediately after the absence of pulse and respirations for a resident identified with a Full Code status (Resident #184). Staff waited 20 to 30 minutes before initiating CPR. On 3/25/21, 20 out of 34 residents requested CPR. (Resident #184). The facility reported a census of 33 residents upon entrance to the facility on 3/22/21. Findings include:	F 678	Past noncompliance: no plan of correction required.	

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A Medicare 5 day Minimum Data Set (MDS) assessment dated 12/8/20, revealed Resident #184 unable to complete a Brief Interview for Mental Status. The resident had short and long term memory impairment, severely impaired cognitive skills for daily decision making, no speech, and rarely understood or made self understood. The MDS revealed the resident required extensive assistance of 2 or more staff for bed mobility, transfers, toilet use, and personal hygiene, and used a wheel chair for mobility. The MDS revealed the resident had an indwelling catheter, feeding tube, and weighed 142 pounds. The MDS documented the resident's diagnoses included debility, cardiopulmonary condition, anemia, hypertension, diabetes, hyperlipidemia (high blood cholesterol), cerebrovascular accident (CVA), transient ischemic attack (TIA), or stroke, hemiplegia or hemiparesis (paralysis or weakness on one side of the body), brain stem stroke syndrome, dysphagia (difficulty swallowing), and a tracheostomy (a hole in the throat to assist with breathing).

A Policy For Resuscitative Services/Cardiopulmonary Resuscitation (CPR) undated form defined CPR as mechanical procedures used to restore life or consciousness to a person apparently dead or without respirations, pulse, and blood pressure. The policy documented on 9/12/16, a nurse explained the policy to the resident and the resident signed she wished staff to perform CPR in the event her heart and breathing stopped.

A care plan focus area, dated 9/26/16, revealed the resident utilized a feeding tube for complete nutritional support.

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The care plan focus area dated 9/26/16 identified an ADL (Activities of Daily Living) self care performance deficit related to a stroke and left non-dominant side hemiparesis. The care plan instructed staff to provide assistance with dressing, oral care, bowel incontinence, toileting, pericare, and transfers.

A care plan focus area dated 11/8/20 identified the resident diagnosed with Covid-19, at risk for respiratory distress and hypoxia, and identified the resident's Full Code Status.

A care plan focus area, dated 12/9/20, identified the resident had a tracheostomy (trach) due to impaired breathing. The care plan directed staff to keep the trach ties secured (12/9/20) and the resident received Oxygen (O2) therapy via the trach per cannula/cover (12/10/20).

Nursing Progress documented the following:
a. On 11/7/20 at 2:53 a.m. the resident in room 828L, the COVID-19 unit, after testing positive, without fever, O2 saturation 95% on room air, lung sounds diminished and will continue to monitor.
b. On 11/7/20 at 7:00 a.m. the resident currently on droplet precautions, with a fever, and the physician and family notified.
c. On 11/7/20 at 4:04 p.m., the resident without a fever, new onset of nasal congestion and cough noted, and the physician and family notified. A Daily Skilled Charting on 11/7/20 at 4:08 p.m. revealed the resident without breathing difficulty.
d. On 11/7/20 at 10:09 p.m. the resident had a low grade fever of 99.2, Tylenol given, and temperature down to 98.2.
e. On 11/8/20 at 12:39 a.m., the resident's O2

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saturation 83% on room air and an order for O2 at 2 to 4 liters per nasal cannula obtained to keep the O2 saturations above 95%. Staff applied O2 at 2.5 liters initially, increased the O2 to 3 liters and the resident's O2 increased to 96%. The resident had wheezing and rhonchi (abnormal lung sounds) in the lungs. The nurse notified the physician and family and the resident sent to the Emergency Room (ER). The resident returned from the ER with new orders for Dexamethasone (a steroid used for inflammation) 6 mg. (milligrams) daily for 10 days and O2 orders and the physician had no concerns with the resident's laboratory and x-ray results.

f. On 11/12/20 at 10:51 p.m., the nurse notified the doctor office the resident had elevated temperatures with staff administering Tylenol (antipyretic) every 4 hours and the resident vomited a greenish material. The office said to call if the resident's O2 saturations dropped below 90%.

g. On 11/15/20 at 11:58 p.m. the resident had labored breathing, the resident had removed the oxygen, the O2 saturation read 68% and the O2 increased to 5 liters increasing the O2 saturation to 92%. The resident's lungs sounded abnormal with rales and rhonchi throughout and suction attempted with no results. The resident's family notified and the resident transferred to the hospital.

h. On 11/20/20 at 6:57 p.m. a staff nurse called the hospital for a report. The resident on a ventilator to help her breathing and weaning trials unsuccessful.

i. On 12/4/20 at 8:49 p.m. the resident had returned to the facility, the resident had a tracheostomy, received O2 at 3 liters via the trach, and the nurse suctioned the trach 4 times due to increased secretions.

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Nursing Progress Notes entries on 12/9/20 at 12:35 p.m., 12/10/20 at 12:44 p.m. and 2:49 p.m., and 12/11/20 at 4:48 p.m. and 6:30 a.m. documented the resident without a fever and no intestinal, respiratory or muscular symptoms, noted.

A Social Services Note, dated 12/10/21 at 12:44 p.m. documented hospice services discussed with the resident's family and the family planned to discuss options.

On 12/12/20 at 6:16 p.m. the former DON (Director of Nursing) documented for 12/11/20, no time, she checked on the resident after 7:00 p.m. and the resident alert, responding, without respiratory distress, Oxygen saturation rate 97%, and the resident repositioned. The DON documented the resident's blood sugar checked at 7:40 p.m., the result 131, and the resident without signs of respiratory distress. The DON documented she entered the resident's room between 9:30 and 9:40 p.m., found the resident without a pulse, respirations, and the body cold. The DON attempted to notify the family, the doctor, and emergency services called. The DON documented CPR started and attempts to resuscitate unsuccessful.

The facility Cardiopulmonary Resuscitation and Basic Life Support Policy and Procedure with an effective date of 12/12/18 documented the following.
a. The purpose of the policy directed staff guidelines for the initiation of CPR when residents had a sudden cardiac arrest.
b. Key staff needed to maintain American Red Cross or American Heart Association if Basic Life

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Support.
c. The staff nurse responsible to initiate and direct CPR for any resident indicating in writing a request for full code status.
d. When staff found a resident unresponsive and not breathing normally a licensed staff certified in CPR/Basic Life Support need to initiate CPR unless a DNR order and advanced directive existed that specifically prohibited CPR and external defibrillation.

Staff Having Knowledge of the Incident
Interviews:

On 3/25/21 at 10:46 a.m., Staff S CMA (certified medication aide) stated he worked the evening shift the night the resident passed away. Staff S stated he last saw the resident around 7:40 p.m. when he checked the residents blood sugar and pulse oximeter reading. Staff S stated the resident appeared happy, smiled at him, and appeared to have no concerns. Staff S stated he saw the DON entering the resident's room around 9:30 p.m. to administer the medications he had crushed and previously prepared. The DON emerged from the room and told Staff S the resident passed away and asked him to get a stethoscope and finish her medication pass. Staff S stated he completed the medication pass in 10 to 15 minutes, returned to the resident's room, and the DON asked him what she should do because the resident's status full code. Staff S stated the DON decided to wait until Staff R arrived
and stated 30 minutes possibly passed before Staff R arrived and they initiated CPR. Staff S identified the resident's coloring as white when he first saw the resident after she stopped breathing.

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On 3/25/21 at 9:42 a.m., Staff R stated she arrived at the facility at approximately 9:55 p.m. on 12/11/20 to work the night shift. Staff R stated the former DON screened her for Covid-19, let her in the facility, and asked when to start CPR when a resident already felt cold. The former DON informed Staff R of the resident she referred to and Staff R realized the resident had a full code status. At that time, Staff R instructed the DON to begin CPR, and Staff R called emergency services. Staff R then went to the resident's room, deflated the air mattress on the bed, applied the ambu bag to the resident's trach and began rescue breathing while the DON performed chest compressions. Staff R stated emergency services (EMS) arrived and took over CPR. Staff R stated when she got to the room, the resident looked yellow, knew the resident deceased for awhile, and the body without firmness, stiffness or rigor. Staff R stated Staff S, CMA (Certified Medication Aide) thought CPR possibly delayed 30 to 45 minutes after the DON found the resident deceased. Staff S told Staff R the DON decided to wait until Staff R arrived for work to find out if CPR needed started.

In a follow up interview on 3/25/21 at 11:30 a.m., Staff R, RN, stated the resident received Oxygen (O2) therapy through the trach and required frequent suctioning. The resident wore a continuous pulse oximeter on her finger that alarmed when the resident's O2 saturation rate fell below 90%. Staff R stated the alarm sounded frequently at one time and toward the end the resident coughed up more secretions on her own rather than suctioning inside the trach. Staff R stated when she arrived in the resident's room on the night of 12/11/20, she observed the resident's O2 and the tubing in the trash that the DON

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already removed.

On 3/25/21 at 8:14 a.m., Staff M, RN, confirmed the resident had a delay in CPR initiation when found deceased. Staff M stated she was on the telephone with Staff R while Staff R drove to work at the facility on 12/11/20 around 10:00 p.m. Staff M stated Staff R, RN, told her when she arrived at the facility, the former DON, let her in and asked when to start CPR if a resident lost their color. Staff M stated Staff R told the DON the resident's code status "full code" and she needed to initiate CPR while Staff R called emergency services. Staff M stated Staff R needed to deflate the air mattress on the resident's bed when she arrived in the room to assist with CPR.

On 3/25/21 at 10:09 a.m., the former DON stated while passing medications the evening of 12/11/20, she found the resident not breathing and waited a few minutes to initiate CPR. The DON stated she had a poor memory and the Administrator had her statement. The DON stated the pulse oximeter normally sounded when the resident's O2 saturation level dropped and she could not remember if the pulse oximeter alarm sounded or sounding when she found the resident not breathing and without a heart beat. The DON stated the resident's body felt cold, she hollered for Staff S, attempted to call the Administrator and the previous DON (Staff M) with no response, called the physician, and while on hold realized the resident had a full code status. The DON stated the door bell rang at that time, she let Staff R in, could not recall if she screened her, informed Staff R she found the resident not breathing and without a pulse. The DON stated Staff R called for emergency help and she went to initiate CPR until the emergency

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help arrived and took over. The DON stated she completed documentation, left the facility, and did not recall if she returned at any time after that. The DON stated again her memory poor. The DON stated she wrote her statement the next morning and sent the statement to the Administrator via email.

In a follow up interview on 3/25/21 at 12:41 p.m., the former DON verified the resident wore O2 via her trach and she had removed the O2 and pulse oximeter after using a stethoscope to confirm the resident had no pulse and stopped breathing. The DON stated 7 to 10 minutes possibly passed after she found the resident and initiated CPR.

On 12/12/20, the former DON wrote and gave her statement on the delay in starting CPR on the resident the evening of 12/11/20. The DON wrote between 9:30 and 9:40 p.m., she found the resident properly aligned in bed and appeared not breathing. The DON hollered for Staff S to bring a stethoscope, listened for a heart beat for approximately 1 minute and did not hear anything, felt for a pulse and did not feel anything, and the resident's skin felt cold with no rigor mortis. The DON stated she sent a text to the Administrator at 9:43 p.m. and Staff M at 9:45 p.m. with no response received. The DON stated Staff S completed a blood sugar check on the resident at 7:40 p.m. and no concerns identified with the resident at that time. The DON stated she went back to the resident's room to turn off machines, removed the O2 and pulse oximeter sensor, which read no sensor, or something similar. The DON stated she called and left messages for 2 family members. The DON stated after calling the family, she called the physician on call number and while on hold she

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remembered the resident's full code status. The DON stated she hung up the phone, left for the resident's room to start CPR and the door bell rang. She answered the door bell and let Staff R in the door at approximately 9:50 p.m. The DON stated she asked Staff R if she needed to start CPR if she found a resident's body cold. Staff R told her to start CPR, and Staff R called EMS. The DON wrote she lowered the head of the bed, straddled the resident and began chest compressions. Staff R came to the room deflated the air mattress on the bed, placed the ambu bag to the trach, and CPR continued until EMS arrived and took over. The DON stated she left before completing documentation as Staff R came and told her she needed to leave the building.

The investigation record had a copy of the DON's Basic Life Support card with an issue date of 8/29/19 and a recommended renewal date of 8/21.

On 3/24/21 at 3:40 p.m., the Administrator stated the facility investigated the resident's delay in initiation of CPR and terminated the former DON. The Administrator stated at the time of death the resident had a full code status. Staff discussed hospice with a family member the day prior to the resident's death, the family member declined hospice at the time, and stated a family discussion needed. The Administrator verified EMS took over CPR upon arrival to the facility on 12/11/20 and the resident did not survive. The Administrator stated the former DON realized about 2 minutes after finding the resident deceased she was a full code and started CPR. The DON stated the resident's body felt cold and showed signs of being deceased for awhile.

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On 3/25/21 at 2:35 p.m., the Nurse Consultant stated she completed an interview with the former DON on 12/12/20 after the resident passed away. The Nurse Consultant stated the Administrator, the Corporate Vice President of this region, and the former DON met on 12/10/20 and discussed the resident's full code status and hospice in order to assist the family with making a well informed decision about code status. The Nurse Consultant stated the former business office manager knew the family and discussed hospice and a no code status and the family planned to discuss the issues. The Nurse Consultant stated the former DON aware the resident had a full code status at the meeting on 12/10/20.

Other staff:

On 3/25/21 at 8:05 a.m., Staff F, LPN (Licensed Practical Nurse), stated there are several ways to find out if a resident's code status. Staff F stated she can check the hard chart, the electronic record, or the report sheet kept on top of the medication cart listing the resident's names and code status. Staff F stated a D after the resident's name meant DNR and an F after the name meant resuscitate. Staff F stated she could verify CPR status within 30 seconds when unsure of the status. Staff F stated she did not recall any time staff delayed initiating CPR at the facility.

On 3/25/21 at 8:10 a.m., Staff G, RN (Registered Nurse) identified CPR status as easy to verify by checking the sheet on the medication cart with the resident names and code status and by checking the chart or electronic record. Staff G verified all the staff knew of delays in Resident #184 receiving CPR. Staff G stated the former DON allowed the resident's readmission on

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12/4/20 and the former DON verified the resident's code status because the resident had a trach. On 3/25/21 at 1:20 p.m., Staff G stated she would provide CPR any time she found a resident had passed away including if rigor present.

On 3/25/21 at 1:13 p.m., Staff F stated she would begin CPR when a resident found unresponsive no matter how long the resident passed away and would continue CPR until emergency help arrived.

On 3/25/21 at 2:29 p.m., Staff T, RN, stated she would start CPR for residents with a full code status including if rigor (rigidity) or lividity (a bruising appearance on the skin after death) present.

On 3/25/21 at 2:26 p.m., the Nurse Consultant verified the facility policy, Cardiopulmonary Resuscitation and Basic Life Support Policy and Procedure dated 12/12/18 had not been updated or revised after the delay in CPR on 12/11/20 and remains in effect. On 3/25/21 at 3:35 p.m., the Nurse Consultant stated the facility reviewed the policy with nursing staff after the delay in CPR initiation, including when not to start CPR, but did not update the policy. The Nurse Consultant had the facility investigation with a topic, Criteria for Not Starting CPR, and this criteria had not been added to the CPR policy. The criteria directed staff to begin CPR in all patients in cardiac arrest unless the person had a valid DNR and the person had signs of irreversible death, rigor mortis, decapitation, or dependent (lower body) lividity. The policy did not address when staff should start CPR after the found a resident not breathing and without a heartbeat.

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F 678	Continued From page 37 EMS Report: The EMS report identified the facility called for assistance at 9:57 p.m. on 12/11/20. The report indicated staff last saw the resident around 9 p.m. and did not know when the resident suffered cardiac arrest. The estimated time from collapse to CPR was 20 minutes. EMS arrived and found 2 nurses performing CPR on the resident in bed. EMS moved the resident to the floor. All attempts at resuscitation were unsuccessful and the resident declared dead at 10 p.m. Abatement: The failure to initiate CPR immediately upon finding a full code resident without a pulse and not breathing resulted in immediate jeopardy (IJ). The facility removed the IJ 12/14/20 after they reeducated staff on CPR procedures, reviewed policy and procedure for CPR and conducted audits for CPR certification, audits that all residents have advanced directives and review of nursing schedule to ensure a CPR certified staff always on duty. This resulted in IJ past noncompliance. Surveyors onsite ensured all corrections completed. The State Agency informed the facility of the past noncompliance IJ on 3/25/21 at 4 p.m.	F 678		
F 684 SS=D	Quality of Care CFR(s): 483.25 § 483.25 Quality of care Quality of care is a fundamental principle that applies to all treatment and care provided to facility residents. Based on the comprehensive assessment of a resident, the facility must ensure that residents receive treatment and care in accordance with professional standards of practice, the comprehensive person-centered	F 684		

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care plan, and the residents' choices.
This REQUIREMENT is not met as evidenced by:
Based on observation, record review, staff interview, and policy/procedure, the facility failed to completely assess a resident after a fall from the bed to the floor for 1 of 8 residents reviewed with falls (Resident #23). The facility reported a census of 33 residents.

Findings include:

1. A Minimum Data Set (MDS) assessment tool dated 2/25/21, assessed Resident #23 with severely impaired cognition. The resident required extensive staff assistance with bed mobility and transfers, and used a wheel chair for mobility. The MDS revealed the resident's diagnoses included a stroke and legal blindness.

A Fall Follow Up-UDA (user defined assessment), dated 3/18/21, revealed the resident scored 19 and a score of 10 or higher indicated a high risk for falls.

The resident's care plan, with a date of 1/11/21, revealed the resident at risk for falls due to a CVA (Cerebral Vascular Accident-stroke), deconditioning, and osteoporosis. The care plan revealed the resident with previous falls on 2/10/21, 2/13/21, 2/16/21, 3/12/21, 3/14/21, and 3/18/21. Interventions included a low bed, room by nurse's station, a floor mat by the bed, and allow the resident to lay on a floor mattress when restless.

Observation showed on 3/24/21 at 6:32 a.m. the resident on the floor and under her bed against the wall. The surveyor alerted staff. Staff F, LPN

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F 684	Continued From page 39 (Licensed Practical Nurse), Staff G, RN (Registered Nurse), and the DON (Director of Nursing) immediately went to the resident's room and completed a physical assessment. The resident stated she felt fine and without pain. Staff D and Staff K, CNA's (Certified Nurse Aide's) brought a full body lift into the room at 6:40 a.m., placed a sling under the resident, and transferred the resident from the floor to the bed. The DON, Staff G, and Staff F left the room. The CNA's provided bowel and bladder incontinence care, dressed the resident, and used the full body lift to transfer the resident from the bed to her wheel chair. At 7:00 a.m. the staff wheeled the resident out of the room to wait by the nurse's station for breakfast. Continuous observation revealed no vital signs or neurological tests completed after the fall. Continuous observation 3/24/21 at 7:05 a.m., revealed no vital signs and neurological checks completed after the fall. On 3/24/21 at 7:08 a.m., the DON stated a nurse needs to assess vital signs and neurological checks right away after an unwitnessed fall and went to assess the resident. An Assessing Falls and Their Causes policy and procedure, with a revision date of March 2018, directed staff to obtain and record vital signs when safe after a fall.	F 684		
F 686 SS=D	Treatment/Svcs to Prevent/Heal Pressure Ulcer CFR(s): 483.25(b)(1)(i)(ii) §483.25(b) Skin Integrity §483.25(b)(1) Pressure ulcers. Based on the comprehensive assessment of a	F 686		

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resident, the facility must ensure that-
(i) A resident receives care, consistent with professional standards of practice, to prevent pressure ulcers and does not develop pressure ulcers unless the individual's clinical condition demonstrates that they were unavoidable; and
(ii) A resident with pressure ulcers receives necessary treatment and services, consistent with professional standards of practice, to promote healing, prevent infection and prevent new ulcers from developing.
This REQUIREMENT is not met as evidenced by:
Based on record review and staff interview, the facility failed to provide adequate assessment, and assure necessary treatment and services to prevent pressure ulcers and promote healing for 1 of 5 residents reviewed (Resident #133). The facility reported a census of 33 residents.

Findings include:

A Minimum Data Set (MDS) assessment, dated 1/26/21, assessed Resident #133 with a Brief Interview for Mental Status (BIMS) score of 7 indicating severe cognitive impairment. The resident required extensive staff assistance with activities of daily living including bed mobility, transfer, dressing, eating, toilet use, and personal hygiene. The resident's diagnoses included diabetes. The MDS documented the resident without pressure ulcers, but documented the resident with an open lesion. Interventions included a pressure reduction mattress and chair cushion. The MDS did not indicate the resident had a turn/reposition program.

The MDS described the following pressure sores:
a Stage I: intact skin with non-blanchable

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redness of a localized area usually over a bony prominence. Darkly pigmented skin may not have a visible blanching; in dark skin tones only it may appear with persistent blue or purple hues.

b. Stage II: partial thickness loss of dermis presenting as a shallow open ulcer with a red or pink wound bed, without slough. May also present as an intact or open/ruptured blister.

c. Stage III: full thickness tissue loss. Subcutaneous fat may be visible but bone, tendon or muscle not exposed. Slough may be present but does not obscure the depth of tissue loss. May include undermining and tunneling.

d. Stage IV: full thickness tissue loss with exposed bone, tendon or muscle. Slough or eschar may be present on some parts of the wound bed. Often includes undermining and tunneling.

e. Unstageable: known but not stageable due to coverage of wound bed by slough and/or eschar.

Background Information:
A palliative care consult note encounter date 1/18/21 revealed the resident hospitalized 3 times since 12/25/20. Hospitalized 12/25/20 to 1/5/21 for complication associated with COVID-19, diabetes and urinary tract infection (UTI). Hospitalized 1/10/21 to 1/15/21 and return to facility 1/15/21. Hospitalized 1/18/21 with a mental status change. Admitted to the hospital for pulmonary emboli, dehydration and UTI. Readmitted to the facility from the 1/18/21 hospital on 1/23/21.

A hospital Physician Transfer Order Report dated 1/5/21 included facility readmission orders for buttock wound care:

a. Clean with Sage barrier wipes.
b. Apply Triad to buttocks and wound area.

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F 686	Continued From page 42 c. Strict side to side reposition schedule. d. Should be in the chair or supine for meals only and no more than 1 hour at a time. A Weekly Nursing Skin Assessment dated 1/5/21 identified the resident with redness and skin breakdown on the sacral area. No measurements assessed. The Care Plan dated 1/5/21 identified the resident at risk for alterations in skin integrity/breakdown. The interventions included applying protective ointment to prevent skin breakdown, a pressure reducing cushion on the chair, a pressure reducing mattress on the bed, referral to the dietician if indicated, repositioning frequently when in the wheelchair, treatments as ordered, turning and repositioning as indicated, and weekly skin assessments. A Dietary Full Review dated 1/7/21 at 11:30 a.m. documented the resident's protein needs 52-65 grams at (0.8-1.0 grams/kilogram). The review lacked identification of any skin issues. The Census page showed the resident out of the facility 1/10-15/21, and 1/18-23/21 (hospitalized). An after visit summary dated 1/15/21 identified the facility should apply triad wound dressing daily (no location identified) upon her return to the facility on that date. Hospital notes dated 1/14/21 identified a wound present that was also present during a previous hospitalization 12/25/20-1/5/21. The area located on the coccyx and measured 4.2 cm. by 3.5 cm. with a depth of 0.2 cm. on 1/14/21. A facsimile (fax) dated 1/18/21 informed the physician the resident's periarea and buttocks free of redness and open areas and requested Triad cream PRN (as needed). The physician	F 686		

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responded yes.

A Braden scale (for predicting pressure sore risk) dated 1/23/21 showed the resident had a score of 12 indicating a high risk for developing pressure ulcers.

A fax dated 1/24/21 notified the physician the resident readmitted to the facility with an order for Triad Hydrophilic Wound Paste to the perineal area and buttocks daily and as needed (PRN). The facility nurse documented both areas were clear, and questioned if they could change the treatment to PRN. The physician responded yes.

A Dietary Full Review Assessment dated 1/26/21 at 11:03 a.m. documented the resident did not have pressure areas noted.

A Non Pressure Wound Sheet dated 1/29/21 documented the resident had a 3 by 1.4 cm area of the right buttock acquired in the facility. The document indicated a request out for treatment, and pressure relief devices in use "not applicable".

A Non Pressure Wound Sheet dated 1/29/21 documented the resident had a 2 by 1 cm open lesion of the left buttock acquired in the facility. Pressure relief devices in use marked "not applicable". The document indicated the physician, dietary, and responsible party notified at 12:30 p.m.

A fax dated 1/29/21 notified the physician the resident had an open area of the left buttock measuring 2 by 1 cm, and an open area of the right buttock measuring 3 by 1.4 cm. Both areas were superficial, and questioned if they could

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apply Calmoseptine 2 times a day and PRN. The physician responded they could.

Review of the January 2021 and February MAR and TAR showed the facility did not start the Calmoseptine until 8 p.m. on 2/1/21.

A Braden scale dated 1/30/21 showed the resident had a score of 12 indicating a high risk for developing pressure ulcers.

The Hydration Assessment Review (HAR)/Nutrition Assessment Review (NAR) report dated 2/4/21 lacked identification of the skin impairments.

A Non Pressure Wound Sheet dated 2/5/21 documented the resident had a 3 by 1.2 cm reddened area of the right buttock. The document lacked identification of pressure relief devices in use.

A Non Pressure Wound Sheet dated 2/6/21 documented the resident had a 1.8 by 1 cm open lesion of the left buttock, with no documentation of pressure relief devices in use.

A Braden scale dated 2/6/21 showed the resident had a score of 11 indicating a high risk for developing pressure ulcers.

The clinical record lacked an assessment of the skin impairments from 2/6 to 20/21.

A Non Pressure Wound Sheet dated 2/20/21 documented the resident had a 4.7 by 606 (6.6) cm full thickness wound of the buttocks, 100% slough (necrotic tissue) covered, acquired in house 1/29/21. No pressure relief devices were

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identified. The document indicated a fax to the physician for orders.

A fax dated 2/20/21 notified the physician the pressure ulcer to the resident's buttocks increased in size. The fax included discontinuing Calmoseptine to the buttocks, cleansing the wound with normal saline, patting dry, applying Therahoney gel to the wound bed, nickel thickness, covering with Mepilex, and changing daily and PRN. The resident to remain off of her buttocks as much as possible.

The clinical record lacked notification of the family or dietary of the declining pressure ulcer.

The Treatment Administration Record showed the order for cleansing the buttocks with normal saline, patting dry, applying Therahoney gel to the wound bed, nickel thickness, and covering with Mepilex daily and PRN, every day shift for pressure ulcer starting 2/21/21.

CNA task documentation for January 2021 and February 2021 did not identify the task of repositioning.

The Progress Notes dated 2/25/21 at 4:05 p.m. documented the resident discharged home via facility transportation. The resident's family member given medication list and signed understanding all medications, doses, and frequencies. A follow up appointment set up with the Physician, and family aware. Sent resident home with 3-64 oz containers of thickened beverages and a can of powder thickener, insulins, medications, and wound treatment to assure the resident had everything she needed at home. The nurse spoke with the Physician about

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concerns regarding the resident being dependent assist and now on insulin. The Physician stated he would monitor the patient closely. The facility would also follow up with the resident and family to make sure the resident did well. They set up Home Health care.

The Resident Medication List included the buttocks wound treatment on page 1. The resident's family signed page 3.

The clinical record lacked documentation the facility provided instructions for the family for pressure relief/reduction, or nutrition needs with pressure sores.

A Discharge Summary/Recapitulation of Stay, resident information page dated 2/25/21 documented the resident discharged 2/25/21. The summary documented not applicable in the space for describing any special procedures, precautions, skin or wound care at the time of discharge.

Home Health documentation of the resident's skin 2/26/21 included the left buttock measured 4 by 2.5 cm, and the right buttock measured 5 by 4 cm, both with sloughing tissue.

On 3/23/21 at 3:11 p.m. the resident's family member stated when the resident came home she had a major wound on her buttocks. The facility did not notified him of the area. When they changed her they found the area on her backside. He said the ulcer caused the resident pain. A wound nurse came to see the resident.

On 3/24/21 at 9:42 a.m. the resident's Home Health Nurse (HHN) stated they first saw the

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resident on 2/26/21 (the day after discharging from the facility). The facility had not informed them the resident had a pressure ulcer. They found out about it on the first visit. The HHN stated the pressure ulcer's were unstageable due to slough and eschar (necrotic tissue). The wound nurse saw the resident to provide education.

On 3/24/21 at 1 p.m. Staff D Certified Nursing Assistant (CNA) stated the resident would get up for breakfast, and after breakfast they would transfer her to the recliner. She sat in the wheelchair for lunch, and laid down after lunch. She did not know the resident had skin issues.

On 3/24/21 at 2:35 p.m. Staff M Registered Nurse (RN) previous interim Director of Nursing (DON) (documented the discharge progress note) stated they had some confusion about sheering being pressure. She said she did not know the resident had a pressure area. They were supposed to notify the DON of pressure sores for staging. She said they should assess a pressure area before a resident discharged.

On 3/24/21 at 3 p.m. Staff F Licensed Practical Nurse (LPN) stated there had been a change and some non-pressure skin issues had to be changed to pressure assessments. On subsequent interview 3/29/21 at 12:54 p.m. Staff F stated she did not think when she documented the open areas on 1/29/21 they were pressure ulcers, but could not say the cause, because she had not marked it on the assessment. She said she normally called the doctor and the family of a new area and documented in the progress notes. She said the resident had a cushion in the chair, but could not remember if she had an air

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mattress. If not she had the standard pressure reduction mattress. She said normally they repositioned residents every 2 hours. She said she did not think there would be a documented turn/reposition program.

On 3/24/21 at 3:09 p.m. Staff G RN (completed the 2/20/21 skin assessment) stated they were told they were not allowed to stage pressure ulcers. She said the ulcer appeared black with some red. On 2/20/21 she put an air mattress on the resident's bed, and made sure she had a cushion in her chair and recliner. She said she told staff the resident should lay down at least every 2 hours.

On 3/25/21 at 1:35 p.m. Staff H CNA stated she did not recall much about the resident having wounds on her buttocks or her daily routine.

On 3/29/21 at 11:13 a.m. the Administrator stated she did not know the resident had a pressure area.

On 3/29/21 at 12 p.m. Staff I CNA stated she knew the resident had open areas of the buttocks. She said when they laid her down, they positioned side to side. She had seen her in the recliner at times. She sat in the wheelchair for meals.

On 3/29/21 at 1:20 p.m. the Dietary Supervisor stated she didn't think she knew the resident had a skin issue. She did not recall being told.

During an interview on 3/31/21 at 07:20 a.m. Staff J Certified Medication Aide (CMA) stated she did the resident's treatments. She said there were some treatments they (CMA's) were not allowed

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to do, but they could do hers. She said the treatment had been Calmoseptine, but then it changed. She said she had been telling the nurses about the area getting fairly good sized, and appearing blackish in color. She said the only thing she knew they did for the ulcer was the treatment. She said the resident would sit up in the mornings in the wheel chair or recliner, and would lay down after lunch.

The facility Pressure Ulcers/Skin Breakdown -Clinical Protocol revised April 2018 documented the nursing staff and practitioner would assess and document an individual's significant risk factors for developing pressure ulcers, for example immobility, recent weight loss, or a history of pressure ulcers.
In addition, the nurse should describe and document/report the following:
a. Full assessment of pressure sore including location, stage, length, width, and depth, exudates or presence of necrotic tissue:
b. Pain present;
c. Resident's mobility status;
d. Current treatments including support surfaces;
e. All active diagnoses.
Although poor nutritional status associated with increased risk of pressure ulcer development, no specific nutritional interventions clearly prevented or healed pressure ulcers. Beyond trying to maintain a stable weight and providing approximately 1.2 to 1.5 gm/kg protein daily, there were no routine pressure ulcer specific nutritional measures for those with risk for developing a pressure ulcer.

The facility Interdepartmental Notification of Diet (Including Changes and Reports) revised October

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F 686	Continued From page 50 2017 included nursing services world notify the physician and dietician when a nutritional problem (weight loss, pressure ulcer, eating problem, etc.) had been identified and collaborate with the dietician and physician to initiate an appropriate process of clinical review for causes of the nutritional problem.	F 686		
F 689 SS=D	Free of Accident Hazards/Supervision/Devices CFR(s): 483.25(d)(1)(2) §483.25(d) Accidents. The facility must ensure that - §483.25(d)(1) The resident environment remains as free of accident hazards as is possible; and §483.25(d)(2)Each resident receives adequate supervision and assistance devices to prevent accidents. This REQUIREMENT is not met as evidenced by: Based on observation, record review and staff interview, the facility failed to provide adequate supervision during a full body lift transfer for 1 of 8 residents reviewed (Resident #13), and failed to implement interventions identified to prevent falls for 2 of 8 residents reviewed (Resident #8 and #14). The facility reported a census of 33 residents. Findings include: 1. A Minimum Data Set (MDS) assessment tool, dated 2/8/21, revealed Resident #13 with moderately impaired cognition, required extensive staff assistance of 2 or more persons with bed mobility, transfers, toilet use, and personal hygiene. The resident's diagnoses included unspecified polyneuropathy.	F 689		

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The resident's care plan with a created date of 10/18/19, revealed the resident required staff assistance with ADL's (Activities of Daily Living) due to decreased mobility and weakness. An intervention directed staff the resident preferred to transfer with a stand lift.

A Nursing Progress Notes entry, dated 3/5/21 at 9:45 p.m. documented a CNA (Certified Nurse's Aide) reported she attempted to transfer from the recliner to bed with a full body lift without the sling straps crossed and the resident began to slip from the full body lift sling. The CNA reported she could not lower the resident back into the recliner and she had to lower the resident completely to the floor. The nurse documented an assessment completed, the resident had no visible injury, vital signs stable. and neurological checks initiated with no changes found.

A Fall Incident, completed by Staff R, RN (Registered Nurse), documented the CNA transferred the resident with a full body lift without the sling leg straps crossed, during the transfer the resident leaned too far forward, and the CNA had to lower the resident to the floor. Staff R documented immediate action included education on full body lift sling and safety. Staff R documented the CNA performed a return demonstration on sling placement and verified understanding on how to use the full body lift safely.

The resident's care plan with a revision date of 3/8/21, revealed the resident at risk for falls due to muscle wasting and atrophy and directed staff the resident preferred to use a stand lift for transfers and an entry dated 3/8/21 directed staff

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educated on how to use a full body lift for transfers (after the fall on 3/5/21).

On 3/31/21 at 2:22 p.m., the Administrator verified the agency CNA transferred the resident alone on 3/5/21.

On 3/31/21 at 2:24 p.m., the Nurse Consultant verified all mechanical lifts require 2 staff for transfers.

On 3/31/21 at 2:40 p.m., Staff W, agency CNA, stated staff reviewed how to use full body lifts each time she worked at a new facility and was taught at this facility around 3/1/21. 2021

On 3/31/21 at 2:44 p.m., Staff V, agency CNA, stated she had worked at this facility for a long time. Staff V stated she had always used a sling with straps/loops that crossed at the legs because this type of sling worked best for Resident #13.

On 3/31/21 at 2:53 p.m., Staff G, RN (Registered Nurse) stated she had not been trained recently on use of slings and unaware if other facility staff trained.

On 3/31/21 at 5:08 p.m., the Administrator stated the facility had an orientation sheet for new agency staff when they work at the facility the first time and the charge nurse needed to review this with new agency staff. The Administrator stated she was unable to verify if Staff U, CNA (Certified Nurse's Assistant, signed an orientation sheet. The Administrator verified Staff U transferred the resident alone with a full body lift on 3/5/21.

On 3/31/21 at 7:48 p.m., Staff R, RN, verified

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Staff U transferred the resident alone on 3/5/21 while using a full body lift. Staff R went to the resident's room with Staff U and observed the resident on the floor. The resident did not have no new pain complaints and no injuries. Staff U stated she believed the resident had a scoop sling (no need to cross the lower straps) and the resident had a cross leg sling underneath. Staff R stated the facility had both types of slings. Staff R stated the facility required 2 staff to transfer residents with any type of mechanical lift, and Staff U verified she knew, and apologized.

On 4/1/21 at 12:05 p.m. Staff Q, CNA, stated she worked for the facility. Staff Q stated all CNA's, including agency, know transferring residents with lifts requires 2 staff. Staff Q verified the facility had 2 types of lift slings, with and without leg straps that cross. Staff Q stated she could not verify how a decision made on which type of sling to use, sometimes go by the resident's size.

On 4/1/21 at 12:10 p.m. Staff X, facility CNA, stated she always transferred a resident with a mechanical lift with 2 staff. Staff X stated the facility had 2 types of slings, with and without leg straps that cross and when she transfers a resident that tends to lean forward, she used a sling with straps that cross.

A facility undated Orientation for Agency CNA's, To be Completed Prior to the First Shift on the Floor, directed 2 staff always required for transfers with mechanical lifts, including stand and full body lifts, no exceptions.

2. A MDS assessment, dated 1/20/21 assessed Resident #8 with a Brief Interview for Mental Status (BIMS) score of 12 indicating moderate

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cognitive impairment. The resident required extensive staff assistance with activities of daily living including bed mobility, transfer and locomotion, and did not ambulate. The resident's diagnoses included a stroke.

The current Care Plan dated 4/13/19 identified potential for falls related to the use of an assistive device for mobility. The interventions included placing the call light in reach and let the resident feel where staff clipped the call light due to blindness when sitting in her recliner chair or laying in her bed when in room, and not leaving her seated in her wheelchair.

Observation showed on 3/23/21 at 6:10 a.m. the resident laid sideways in bed calling for help. Staff Q Certified Nursing Assistant (CNA) and Staff H CNA went to the resident's room. At 6:55 a.m. the resident sat in the room in the wheelchair, with the call light on the bed under a pillow. At 7:18 a.m. staff passing meds turned the hall light on and pushed the cart to the end of the hall by the resident's room. The resident did not have the call light.

3. A MDS assessment, dated 2/8/21 assessed Resident #14 with long and short term memory problems and moderately impaired skills for daily decision making. The resident required extensive assistance with activities of daily living including bed mobility, transfer, dressing, toilet use and personal hygiene. The resident's diagnoses included a stroke and dementia.

The current Care Plan identified the resident at risk for falls revised 1/11/21. The interventions included educating the resident to use call light if she needed something picked up from the floor,

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F 689	Continued From page 55 and not do not attempt to pick it up herself, educating family to notify staff when leaving so staff could assist the resident into her chair or bed, not leaving the resident in the wheelchair in her room unattended. The current Care Plan identified the resident had visual deficits as evidenced by wearing glasses revised 8/14/19. The interventions included having the call light within reach at all times. Observation showed on 3/29/21 at 10:44 a.m. the resident sat in the wheelchair in her room unattended. The call light laid on the bed behind the resident and unavailable to her. Observation showed on 3/30/21 at 7:10 a.m. the resident sitting in the room in her wheel chair with her back to the television, and the call light on the recliner out of reach. At 7:16 a.m. Staff Q Certified Nursing Assistant went to the resident's room and wheeled her to the dining room. At 8:10 a.m. the resident sat in her room in her wheel chair in front of the television (unattended), with the call light on the recliner. At 8:26 a.m. Staff N CNA walked past the residents room, waved, and appeared to talk to the resident, then walked away. The resident did not have the call light. At 8:40 a.m. and 9:06 a.m. the resident was still without the call light and unattended in her wheelchair. On 3/31/21 at 10:54 a.m. the Director of Nursing (DON) stated she expected residents to have the call light in reach at all times in their room, wheelchair, recliner, or bed.	F 689		
F 690 SS=D	Bowel/Bladder Incontinence, Catheter, UTI CFR(s): 483.25(e)(1)-(3)	F 690		

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F 690	Continued From page 56 §483.25(e) Incontinence. §483.25(e)(1) The facility must ensure that resident who is continent of bladder and bowel on admission receives services and assistance to maintain continence unless his or her clinical condition is or becomes such that continence is not possible to maintain. §483.25(e)(2)For a resident with urinary incontinence, based on the resident's comprehensive assessment, the facility must ensure that- (i) A resident who enters the facility without an indwelling catheter is not catheterized unless the resident's clinical condition demonstrates that catheterization was necessary; (ii) A resident who enters the facility with an indwelling catheter or subsequently receives one is assessed for removal of the catheter as soon as possible unless the resident's clinical condition demonstrates that catheterization is necessary; and (iii) A resident who is incontinent of bladder receives appropriate treatment and services to prevent urinary tract infections and to restore continence to the extent possible. §483.25(e)(3) For a resident with fecal incontinence, based on the resident's comprehensive assessment, the facility must ensure that a resident who is incontinent of bowel receives appropriate treatment and services to restore as much normal bowel function as possible. This REQUIREMENT is not met as evidenced by: Based on record review, observation, staff interviews, and policy/procedure review, the facility failed to provide care for 1 of 2 residents	F 690		

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with a catheter to prevent infection (Resident #13). The facility reported a census of 33 residents.

Findings include:

1. A Minimum Data Set (MDS) assessment tool, dated 2/8/21, revealed Resident #13 with moderately impaired cognition. The resident required extensive staff assistance with toilet use and personal hygiene. The resident utilized an indwelling catheter. The resident's diagnoses included: renal insufficiency and diabetes.

The resident's care plan with a revision date of 1/19/21, revealed the resident utilized a catheter due to bladder outlet obstruction. The care plan directed staff to provide care according to the facility policy.

a. Observation showed on 3/24/21 at 12:20 p.m., Staff D, CNA (Certified Nurse's Aide) provide catheter care for the resident. Staff D wore gloves and used a disposable cloth to clean the meatus from front to back, used a clean area of the same cloth and cleaned the catheter tubing in a back and forth motion 2 times near the meatus.

A Catheter Care, Urinary policy and procedure, with a revision date of September 2014 directed staff to clean the catheter tubing from the insertion site to approximately 4 inches away from the meatus.

b. Observation showed on 3/22/21 at 11:30 a.m. and 2:45 p.m., 3/24/21 at 12:20 p.m., and 3/29/21 at 2:48 p.m., the resident's catheter bag inside a privacy bag and the privacy bag rested on the floor.

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A Catheter Care, Urinary policy and Procedure, with a revision date of September 2014 directed staff to keep catheter tubing and the drainage bag off the floor.

2. An MDS assessment tool, dated 2/25/21, revealed Resident #23 with severely impaired cognition. The resident required extensive staff assistance with toilet use and personal hygiene, and diagnoses included a stroke.

The resident's care plan, with a revision date of 1/11/21, revealed the resident required assistance with Activities of Daily Living (ADL) due to a previous CVA (Cerebral Vascular Accident-stroke).

Observation showed on 3/24/21 at 6:40 a.m., Staff D and Staff K, CNA, use a full body lift and transferred the resident from the floor to the bed after a fall and provided incontinence care for the resident. Staff identified the resident as incontinent of bowel and bladder. Staff D wore gloves, used several disposable cloths and cleaned the bowel movement off the resident in the appropriate manner, Staff D changed gloves, failed to sanitize or wash her hands and provided anterior perineal care for the resident. Staff D assisted Staff K with the full body lift by putting the straps from the lift sling on the lift and operated the lift with the same gloves used for anterior perineal care to transfer the resident to her wheel chair. Staff D removed her gloves and washed her hands after assisting with bagging the laundry and the trash.

A Personal Protective Equipment-Using Gloves policy and procedure, with a revision date of

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F 690	Continued From page 59 September 2020, directed staff to wash their hands after removing gloves.	F 690		
F 692 SS=E	Nutrition/Hydration Status Maintenance CFR(s): 483.25(g)(1)-(3) §483.25(g) Assisted nutrition and hydration. (Includes naso-gastric and gastrostomy tubes, both percutaneous endoscopic gastrostomy and percutaneous endoscopic jejunostomy, and enteral fluids). Based on a resident's comprehensive assessment, the facility must ensure that a resident- §483.25(g)(1) Maintains acceptable parameters of nutritional status, such as usual body weight or desirable body weight range and electrolyte balance, unless the resident's clinical condition demonstrates that this is not possible or resident preferences indicate otherwise; §483.25(g)(2) Is offered sufficient fluid intake to maintain proper hydration and health; §483.25(g)(3) Is offered a therapeutic diet when there is a nutritional problem and the health care provider orders a therapeutic diet. This REQUIREMENT is not met as evidenced by: Based on observation, record review, resident, staff and power of attorney interview, the facility failed to maintain acceptable parameters of nutritional status, such as usual body weight or desirable body weight range and electrolyte balance, unless the resident's clinical condition demonstrated it as not possible or resident preferences indicate otherwise for 4 out of 4 residents reviewed (#11, #22, #30, and #14), and failed to assure acceptable parameters of	F 692		

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hydration status for 1 of 6 residents reviewed (Resident #17). The facility reports a census of 33 residents.

Findings Include:

1. The Minimum Data Set (MDS) with an Assessment Reference Date of (ARD) of 3/16/21 for Resident #11 showed a Brief Interview Status Score (BIMS) of 09 indicating moderate cognitive impairment. The MDS revealed the resident to have diagnoses of dementia, depression and vitamin D and B12 deficiency. The resident required extensive staff assistance for transfers, locomotion, and bed mobility and supervision with eating.

Resident #11's electronic health record (EHR) showed the following weights on the following dates: 10/2/20 169.2 pounds (lb), 11/3/20 of 161.2 lb, 12/1/21 157.4 lb, 1/6/21 of 159.4 lb, 2/2/21 of 164.8 lb, 3/2/21 161.7 lb, 3/26/21 146 lb . On 02/25/2021, the resident weighed 163.4 lb and on 03/26/2021, the resident weighed 146.2 lb which indicating a -10.53 % loss in thirty days.

The care plan with an initiation date of 10/1/17 identified the resident as a weekly weight due to weight fluctuations related to edema and variable meal intakes. The goal was: resident will maintain weight through next review period.

Physician orders showed Resident is taking Lasix 80 mg one time a day.

A Hydration assessment review and nutrition assessment review (HAR/NAR) dated 3/4/21 lacked any documentation of the resident's weight monitored or notification to physician.

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A HAR/NAR dated 3/11/21 lacked any documentation of the resident's weight monitored or notification to physician.

A HAR/NAR dated 3/18/21 lacked any documentation of the resident's weight monitored or notification to physician.

A HAR/NAR dated 3/25/21 lacked any documentation of the residents weight monitored or notification to physician.

On 3/24/21 at 9:42 a.m. the Dietary Manager (DM) stated the facility conducts a weekly weight meeting on Thursdays at 1:30 p.m. that includes the Director of Nursing (DON), Administrator, the Dietician and the DM. The DM stated she spoke to the resident and the resident wanted to lose weight.

On 3/23/21 at 2:19 p.m. the resident stated she would like to lose more weight and feels she is fat.

On 3/25/21 at 9:20 a.m. the Dietician stated it is the Residents choice to lose weight. She stated no supplements have been tried and she didn't believe the Resident would take them anyway. The Dietician stated nursing would notify the physician of the weight loss.

On 3/25/21 at 9:38 a.m. the residents Power of Attorney (POA) stated the resident always had weight issues and had gastric by-pass done years ago. The POA stated the resident will eat if its in front of her and did not intentionally try to lose weight. The POA stated she attended care conferences a month ago and the resident's

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weight was not discussed. The POA stated the facility did not contact her regarding the residents weight loss and she did not know how much weight the resident lost. The POA would expect and would want the resident to receive supplements for her weight loss. The POA stated the last time she saw the resident, she could tell the resident lost a lot of weight.

Progress notes dated 3/26/21 at 1:09 p.m. stated the bath aid notified the dietary manager that the resident's weight was down another 3 lb. The DM spoke to the resident who stated she would eat more if they gave her macaroni and cheese, cheese sticks, potato salad, pizza, etc.

2. The MDS with an ARD of 3/22/21 for Resident #22 showed a BIMS score of 07 indicating severe cognitive impairment. The resident had diagnoses that included: acute respiratory failure, diabetes, and muscle weakness. The resident required extensive assistance for transfers, locomotion, and toileting.

The census tab in resident electronic health record (EHR) showed the resident admitted to the facility on 2/19/21.

The EHR showed the resident with a 2/19/21 admission weight of 167.2 lb, on 3/2/21 the resident weighed 163.2 lb, on 3/12/21 the resident weighed 158.6 lb, on 3/18/21 the resident weighed 152.0 lb, and on his discharge date of 3/19/21 resident weighed 151.0 lb. On 02/19/2021, the resident weighed 167.2 lbs. On 03/19/2021, the resident weighed 151.0 lb which is a -9.69 % loss in 30 days.

A dietary note dated 3/11/21 at 4:37 p.m.

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identified the resident's weight as 160.2 lb and trending down. The dietary note revealed the resident's family did not bring in fast food as much and identified weight loss likely due to decreased calories consumed with facility meals vs food brought in. Will continue to monitor weekly in Hydration Assessment Review (HAR)/Nutrition Assessment Review (NAR) .

The HAR/NAR dated 3/4/21 revealed the resident listed as a new admit and weight loss with an admission weight of 167.2 lb on 2/19/21 and weight of 163.2 lb on 3/4/21. HAR/NAR lacked any dietary recommendations or notification to the physician

The HAR/NAR dated 3/11/21 showed the resident lost weight and weighed 160.2 lb on 3/11/21. HAR/NAR lacked any dietary recommendations or notification to the physician.

The HAR/NAR dated 3/18/21 revealed the resident continued to lose weight and weighed 159.5 lb with the reason of weight loss attributed to the family not bringing in fast food as much. HAR/NAR lacked documentation of dietary recommendations or physician notification.

On 3/24/21 at 9:42 a.m. the Dietary Manager (DM) stated the facility conducted weekly weight meetings on Thursdays at 1:30 p.m. that included the Director of Nursing (DON), Administrator, the Dietician and the DM. The DM stated that it is the responsibility of each department to do their part of documentation and that the nursing department is responsible for physician notification.

The care plan with initiation date of 2/22/21

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revealed a goal of: the resident will be free from significant weight changes through next review.

On 3/25/21 at 9:20 a.m. the dietician revealed she did not have concerns with the resident's weight loss and did not recommend starting supplements. She stated the facility would add the resident to the HAR/NAR to monitor. The dietician stated a significant weight loss sheet is emailed to the Administrator, DON, and DM and staff should notify the physician of the weight loss.

3. The MDS with an ARD of 3/5/21 for Resident #30 shows a BIMS score of 01 indicating severe cognitive impact. The MDS revealed diagnoses that included: dementia, dysphagia, and depression. The resident required extensive staff assistance for bed mobility and, locomotion and limited assistance of one staff with eating.

The care plan with initiation date of 6/3/19 identified the resident to complete eating tasks independently with cueing and cue card available to remind resident to take 2 bites and 1 drink per speech therapy (ST) recommendations.

Observation showed on 3/25/21 at 12:06 p.m. the resident in a recliner with food tray on the bedside table in front of her eating with no supervision. The food tray lacked a cue card to take two bites and then a drink. The resident's room lacked any cue card or sign to direct the resident to take two bites and then a drink while eating.

Observation showed on 3/31/21 at 11:54 a.m. the resident in her room sitting in her recliner with her lunch meal on a tray on the bedside table placed in front of her. The tray did not contain a cue card

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with eating strategies nor were any eating strategies located in the room.

On 3/25/21 at 10:13 a.m. the resident's POA stated they are worried nobody watches the resident eat due to her eating in her room. The POA stated the resident has ground meat and is a choking risk and ST indicated the resident should take a bite and then a drink at mealtime. The POA stated she use to come and sit with the resident during meals to make sure she was monitored but due to visitation restriction she is unable to come every day.

Physician orders revealed an order for regular, ground meat texture, and regular fluid consistency.

A Fax Cover Sheet sent by Physical Therapy (PT) dated 6/17/19 stated ST evaluated and treated the resident due to concerns with a choking incident and possible cognition issues. The resident admitted to facility on 6/3/19.

A ST treatment note dated 6/28/19 identified the resident required moderate to maximum visual and verbal cues to remember to use compensatory strategies to alternate liquids and solids, small bites, and swallow before next bite.

A therapy to nursing communication form dated 7/2/19 revealed the resident occasionally ate fast and tool large bites. Cues needed to inform the resident to slow down, take small bites and sips, and to take a drink after every 1 to 2 bites as needed. The form contained signatures of therapist and Nursing.

ST Progress notes and a Discharge Summary

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dated 7/3/19 identified the resident demonstrated the ability to safely swallow 1 teaspoon of regular diet when using compensatory strategies from trained staff or caregivers giving verbal instructions/cueing 25 percent of the time.

Interdepartmental Notification of Diet (Including changes and Reports) dated 10/2017 stated nursing services shall notify the physician and dietitian when a nutritional problem (weight loss, pressure ulcer, eating problems, and etc.) identified and shall collaborate with the dietitian and physician to initiate an appropriate process of clinical review for causes of the nutritional problem.

4. On 3/31/21 at 10:57 AM the DON stated the dietician would send a significant weight change notice to her and then she would notify the nursing staff and would expect the nursing staff to notify the physician of the changes and to ask for any recommendations. The DON stated that all residents who needed assistance with eating would go out to the dining room. The DON stated that she was not aware of any ST recommendations or that the Resident needed a cue card or cueing from staff for safe eating.

5. A MDS assessment dated 2/8/21, assessed Resident #14 with long and short term memory problems and moderately impaired skills for daily decision making.. The resident required extensive staff assistance with activities of daily living including dressing. The resident's diagnoses included a stroke and dementia. The resident had a weight loss of 5% in 1 month or 10% in 6 months.

The current Care Plan revised 8/14/19 identified

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the resident at risk for nutritional deficits related to dementia and a history of hip fracture. The interventions included the registered dietician would evaluate and make diet change recommendations as needed (PRN), the resident would receive a general/regular diet, offer substitute as needed (PRN), house supplement, supercereal, Magic Cup, and weights as directed.

A Weight Change Note dated 12/3/20 at 4:13 p.m. documented the resident's weight: 113.4 lb and down 11.1% in 180 days. The resident had diagnosis of COVID-19 and recovered. The resident received house supplement 120 ml 3 times a day (TID), supercereal, and Remeron (antidepressant).

A Weight Change Note dated 1/8/21 at 10:52 a.m. documented the resident's weight 112.2 lb, down 7.7% in 90 days and down 14.5% in 180 days. Weight loss due to diagnosis of Covid and stable since. The resident continued on House Supplement 120 ml TID, supercereal, and Remeron. No changes needed, they would continue to monitor.

A Weight Change Note dated 2/4/21 at 2:59 p.m. documented the resident's weight 110 lb, down 13.4% in 180 days. The weight loss due to diagnosis of Covid and stable since. The resident continued on house supplement 120 ml TID, supercereal, and Remeron. No changes were needed, they would continue to monitor weekly on HAR/NAR.

The Medication Administration Record (MAR) showed an order for House Supplement 120 cc TID three times a day for variable intakes starting 1/08/20. Staff documented a check mark on the

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MAR to indicate they gave the resident the house supplement at 7 a.m. 1 p.m. and 7:30 p.m. but documentation lacked how much of the supplement the resident consumed,

The clinical record lacked documentation the facility notified the physician or the family of the significant weight loss identified on 12/3/20, 1/8/21, or 2/4/21, or an evaluation of the interventions in place for weight loss.

A Dietary Note dated 3/25/21 at 2:06 p.m. documented the resident's weight 104.9 lb down 3 lb for the week. The resident continued to not eat meals well. She remained on house supplement 120 ml TID, supercereal, and Magic Cup 2 times a day for increased calories/protein and on Remeron since 3/2020. The Dietician recommended Megace to help stimulate appetite.

Observation showed on 03/25/21 at 11:52 a.m. the resident with her lunch and a chocolate magic cup. The resident only had a bite or 2 of the magic cup.

On 3/24/21 at 3:09 p.m. Staff G Registered Nurse (RN) stated sometimes the resident took the (house) supplement well in the morning, and not so good in the afternoon.

On 3/29/21 at 1:20 p.m. the Dietary Supervisor stated they tried the Magic Cup because the resident's weight declined. She stated the resident received super cereal with added powdered milk, brown sugar and butter. She said they did not document how much of the Magic Cup the resident took at each meal, and would not know unless she asked staff. She could not say how much of the house supplement she took

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if not documented. She said she only talked with family during care conference. She could not say who would notify the physician or family of significant weight losses, but she thought nursing would.

6. A MDS assessment dated 2/17/21, assessed Resident #17 with a BIMS of 15 indicating no cognitive impairment. The resident required supervision with eating and drinking The resident's diagnoses included chronic obstructive pulmonary disease and heart failure.

The Physician's Orders included a fluid restriction of 2 liters per day every shift for congestive heart failure (CHF) active on 5/29/19, and weight every Tuesday. Staff would notify the physician of a weight increase greater than 5 pounds in the morning every Tuesday, for fluid retention, active on 9/22/20.

On 3/30/21 at 1:29 p.m. the Administrator identified staff documented fluid intakes for meals d in Point Click Care (PCC) under tasks and she thought the fluid intake between meals located under fluids.

The Tasks tab documented fluid intake under amount of meal eaten for the last 30 days.

The PRN fluid intake contained no documentation of fluid intakes between meals the last 30 days.

The clinical record lacked documentation of the total amount of daily fluids consumed by the resident.

The Weights and Vital record showed the resident weighed 178.5 lb on 3/17/21 and 183.7

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F 692	Continued From page 70 lb on 3/24/21 a gain of 5.2 lb. The clinical record lacked documentation of physician notification of the weight gain. Observation showed on 3/3/21 at 8:35 a.m. the resident drank from the water pitcher on the bedside table. At 9:29 a.m. the resident received 3 glasses liquids with breakfast, 2 smaller ones and a larger glass of water, and the water pitcher empty. On 3/30/21 at 11:20 a.m. Staff N Certified Nursing Assistant (CNA) stated they filled water pitchers every shift. She pulled out the liner in the pitcher to determine the pitcher held 800 cc's. On 3/30/21 at 3:55 p.m. the Director of Nursing (DON) stated if not documented in the progress notes, they did not notify the physician of the weight gain. On 3/31/21 at 10:54 a.m. the DON stated they would change practice due to the fluid restriction and provide documentation of the breakdown of amount fluids given at meals and the amount from nursing and snacks.	F 692		
F 712 SS=E	Physician Visits-Frequency/Timeliness/Alt NPP CFR(s): 483.30(c)(1)-(4) §483.30(c) Frequency of physician visits §483.30(c)(1) The residents must be seen by a physician at least once every 30 days for the first 90 days after admission, and at least once every 60 thereafter. §483.30(c)(2) A physician visit is considered timely if it occurs not later than 10 days after the	F 712		

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date the visit was required.

§483.30(c)(3) Except as provided in paragraphs (c)(4) and (f) of this section, all required physician visits must be made by the physician personally.

§483.30(c)(4) At the option of the physician, required visits in SNFs, after the initial visit, may alternate between personal visits by the physician and visits by a physician assistant, nurse practitioner or clinical nurse specialist in accordance with paragraph (e) of this section.
This REQUIREMENT is not met as evidenced by:
Based on staff interviews and record review the facility failed to ensure the physician saw the resident at least once every thirty days for the first ninety (90) days after admission, and at least once every sixty (60) days thereafter for 5 out of 5 Residents reviewed (#20, #4, #25, #17, and #30). Facility reports a census of 33 residents.

Findings Include:

1. A Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of 2/18/21 for Resident #20 revealed a Brief Interview for Mental Status (BIMS) score of 14 indicating intact cognitive. The resident required extensive assistance of 2 staff for transfers, bed mobility, and locomotion. The resident had diagnoses that included: dementia, diabetes, and malignant neoplasm of the upper outer quadrant of left breast. The resident admitted to the facility on 7/19/19.

Progress notes dated 2/25/21 at 8:15 a.m. identified the resident as out of the facility for an appointment with the Nurse Practitioner (NP) via

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the facility van.

Progress notes dated 10/19/20 at 10:06 p.m. identified a telehealth visit with NP today. Orders received for Unna boot and cover with ace wraps, leave on for seven days then remove. Son notified.

An email dated 3/23/21 at 6:04 p.m. from the NP revealed the NP saw the resident on 2/25/21, prior to that visit the NP saw the resident on 6/9/20.

2. A MDS with an ARD of 1/20/21 for Resident #4 revealed a BIMS score of 13 indicating intact cognition. The resident required extensive assistance of 2 staff for transfers and ambulation, and supervision with eating. The resident has a diagnoses that included: Parkinson's disease, convulsions, and hypertension. The resident admitted to the facility on 10/1/20.

Progress notes dated 1/14/21 at 8:15 a.m. identified the resident out to an appointment with the NP via the facility van.

Progress notes dated 2/25/21 at 8:15 a.m. identified the resident out to appointment with the NP via the facility van.

Progress notes dated 3/22/21 at 8:09 p.m. revealed the resident went to NP's office for an appointment.

An email dated 3/23/21 at 6:04 p.m. from the NP revealed the NP saw Resident #4 on 2/25/21, prior to that visit the NP saw the resident on 1/14/21 and 8/10/20.

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3. A MDS with an ARD of 3/12/21 for Resident #25 revealed a BIMS score of 15 indicating intact cognition. The resident required limited assistance of 1 staff for transfers, ambulation, and bed mobility. The resident had a diagnoses of; hypertension, pain, and depression. The resident admitted to the facility 2/8/17.

Progress notes dated 12/15/20 at 11:54 a.m. revealed the resident went to an appointment with the NP today. Niece notified.

An email dated 3/23/21 at 6:04 p.m. from the NP identified the resident last seen on 12/15/21, prior to that the NP last saw the resident on 6/9/20.

4. A MDS with an ARD of 2/17/21 for Resident #17 revealed a BIMS score of 15 indicating intact cognition. The resident required limited assistance of 1 staff with transfers, ambulation, and bed mobility. The resident had diagnoses of chronic obstructive pulmonary disease, kidney failure, and congestive heart failure. The resident admitted to the facility 11/28/18.

Progress notes dated 9/18/20 at 10:15 a.m. identified the resident out of the facility at an appointment with the NP via facility van.

An email dated 3/23/21 at 6:04 p.m. from the NP revealed the resident seen by the NP on 2/22/21, prior to that visit the NP saw the resident on 9/18/21 and 6/9/20.

5. The MDS with an ARD of 3/5/21 for Resident #30 revealed a BIMS score of 01 indicating severely impaired cognition. The resident required limited assistance of 1 staff for transfers, ambulation, and dressing. The resident had

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diagnoses that included: dementia, hypertension, and depression. The resident admitted to the facility 6/3/19.

An email dated 3/23/21 at 6:04 p.m. from the NP identified the resident last seen by the NP on 2/11/21, prior to that visit the NP last saw the resident on 11/17/21, 9/22/20, and 6/9/20

6. Interview with the NP on 3/23/21 at 8:53 a.m. revealed the NP has five residents at the facility that she is responsible for. The NP stated she is required to complete visits on her residents every 60 days. The NP stated she has not been to the facility since July 2021 and her office tried several times to schedule a time for rounds and nobody returned her calls. The NP stated she tried to set up round times in September, November, and January. Her office sent a letter to the facility requesting appointments scheduled at her office to get in compliance with the 60 day physician regulation. The NP stated she received fax information from the facility but no communication regarding visits.

On 3/24/21 at 10:57 a.m. the Director of Nursing (DON) stated she is currently not tracking the 60 day physician visits but is planning on adding it to the things she needs to implement. The DON does expect the physician to make rounds or office visits every 60 days and did not know about any past communication the NP office had with the facility regarding setting up a rounding time for the NP to see residents as DON is new to the facility.

Review of Physician Services policy dated April 2013 revealed the physician will perform pertinent, timely medical assessments; prescribe

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F 712	Continued From page 75 an appropriate medical regimen, provide adequate, timely information about the resident's condition and medical needs, visit the resident at appropriate intervals and ensure adequate alternative coverage. Physician visits, frequency of visits, emergency care of residents, etc. are provided in accordance with current OBRA regulations and facility policy. Consultative services shall be made available from community based consultants or from a local hospital or medical center.	F 712		
F 725 SS=E	Sufficient Nursing Staff CFR(s): 483.35(a)(1)(2) §483.35(a) Sufficient Staff. The facility must have sufficient nursing staff with the appropriate competencies and skills sets to provide nursing and related services to assure resident safety and attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident, as determined by resident assessments and individual plans of care and considering the number, acuity and diagnoses of the facility's resident population in accordance with the facility assessment required at §483.70(e). §483.35(a)(1) The facility must provide services by sufficient numbers of each of the following types of personnel on a 24-hour basis to provide nursing care to all residents in accordance with resident care plans: (i) Except when waived under paragraph (e) of this section, licensed nurses; and (ii) Other nursing personnel, including but not limited to nurse aides. §483.35(a)(2) Except when waived under	F 725		

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paragraph (e) of this section, the facility must designate a licensed nurse to serve as a charge nurse on each tour of duty.
This REQUIREMENT is not met as evidenced by:
Based on observation, record review, and staff interview, the facility failed to assure sufficient qualified nursing staff available at all times to provide nursing and related services to meet the residents' needs by answering call lights in a timely manner for 2 of 6 residents reviewed (Resident #3 and #136) and during random observations. The facility reported a census of 33 residents.

Findings Include:

1. A Minimum Data Set (MDS) with an Assessment Reference Date of (ARD) of 3/17/21 for Resident #3 revealed a Brief Interview Status Score (BIMS) of 15 indicating intact cognition. The resident had diagnoses that included: spondylosis with myelopathy of the thoracic region, neurogenic bowel, muscle weakness, and diabetes. The resident required extensive assistance of two staff for transfers, locomotion, and toileting. The resident utilized an EZ-stand for transfers. The MDS identified the resident as occasionally incontinent of bowel.

During a Resident Council meeting on 3/29/21 at 1:52 p.m. Resident #3 stated sometimes he waits over an hour after activating his call light for someone to arrive and assist him. He stated that on 3/29/21 he had to wait for 40 minutes. Resident #3 stated sometimes he times the staff by looking at his clock when he activates the call light and then notices the time when they come to assist him. Resident #3 stated sometimes it takes

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too long for the staff to come when he needs to use the restroom, that he just ends up going in his pants.

Review of care plan with an initiation date of 12/15/20, showed the resident needs assistance of two staff with the use of an EZ-stand for toileting tasks.

On 3/30/21 at 2:43 p.m., the Administrator stated the facility did not have a policy for call light response.

2. During continuous observation 3/24/21 beginning at 2:25 p.m., the call light above the door of resident rooms 110, 118, and 218 and the call light board by the nurse's station revealed the call lights remained on for longer than 15 min. The call light bell sounded and Staff F, LPN (Licensed Practical Nurse), Staff G, RN (Registered Nurse), Staff O, LPN, and Staff P, RN, remained at the nurse's station for report at change of shift. None of the staff attempted to respond to the call lights.

a. Observation 3/24/21 at 2:25 p.m. revealed the call light board read 8 minutes wait time for Room #110. Staff G walked by the room when the call light board read 24 minutes and at 28 minutes Staff G and Staff J CNA (Certified Nurse's Aide) entered the resident's room and turned off the call light.

b. Observation 3/24/21 at 2:25 p.m. revealed the call light board read 12 minutes wait time for Room #118. Observation revealed a staff member turned the call light off when the call light board read 17 minutes.

c. Observation 3/24/21 at 2:25 p.m., revealed the

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F 725	Continued From page 78 call light board read 11 minutes wait time for Room #218. Staff J came by the nurse's station and stated she planned to help the staff answer the call light after she obtained isolation gowns to enter. Staff J entered the room when the call light board read 20 minutes and turned off the call light. 3. A MDS assessment, dated 1/20/21, revealed Resident #136 had BIMS of 14 indicating no cognitive impairment. The resident's diagnoses included: diverticulitis of the large intestine with perforation. Observation showed on 3/25/21 at 6:45 a.m. the resident had the call light on. The board at the nurse's station showed the call light had been on for 46 minutes. Three Certified Nursing Assistant's (CNA's) were at the nurse's station talking. Staff J Certified Medication Aide (CMA) went to the resident's room. On 3/25/21 at 8:08 a.m. the resident stated it took a long time for staff to answer the call light that a.m.	F 725		
F 729 SS=D	Nurse Aide Registry Verification, Retraining CFR(s): 483.35(d)(4)-(6) §483.35(d)(4) Registry verification. Before allowing an individual to serve as a nurse aide, a facility must receive registry verification that the individual has met competency evaluation requirements unless- (i) The individual is a full-time employee in a training and competency evaluation program approved by the State; or (ii)The individual can prove that he or she has recently successfully completed a training and	F 729		

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competency evaluation program or competency evaluation program approved by the State and has not yet been included in the registry. Facilities must follow up to ensure that such an individual actually becomes registered.

§483.35(d)(5) Multi-State registry verification.
Before allowing an individual to serve as a nurse aide, a facility must seek information from every State registry established under sections 1819(e)(2)(A) or 1919(e)(2)(A) of the Act that the facility believes will include information on the individual.

§483.35(d)(6) Required retraining.
If, since an individual's most recent completion of a training and competency evaluation program, there has been a continuous period of 24 consecutive months during none of which the individual provided nursing or nursing-related services for monetary compensation, the individual must complete a new training and competency evaluation program or a new competency evaluation program.
This REQUIREMENT is not met as evidenced by:
Based on record review and staff interview, the facility failed to verify an active Certified Nursing Assistant (CNA) certification for 3 out of 5 newly hired employees (Staff B, Staff D, Staff E) reviewed. The facility reported a census of 33 residents.

Findings include:

1. An untitled, undated list of employee start dates revealed Staff B; hired as a CNA on 11/19/20. The file lacked any documentation of a CNA certificate or a Direct Care Worker Search, conducted thru the Department of Inspections

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and Appeals (DIA).

On 3/29/21 at 2 p.m. , the Administrator stated Staff B did not have a Certified Nurse Aide certificate on file for date of hire.

2. The computer generated list of new hires provided by the facility (untitled and undated) revealed Staff D, CNA, hired on 7/13/20. The Nurse Aide Verification dated 3/21/21 documented Staff D an active CNA. The personnel lacked documentation of verification of Staff D as a CNA at the time of hire.

On 3/29/21 at 2:00 p.m., the Administrator reported Staff D did not have a Certified Nurse Aide Certificate record for date of hire.

3. A computer generated list of new hires provided by the facility (untitled and undated) revealed Staff E, CNA, hired on 11/19/20. The Nurse Aide Verification dated 3/21/21 documented Staff D an active CNA. The personnel lacked documentation of verification of Staff D as a CNA at the time of hire.

On 3/29/21 at 2:00 p.m., the Administrator reported Staff E did not have a Certified Nurse Aide Certificate records for date of hire.

4. Facility policy, Abuse Prevention, Identification, Investigation, and Reporting Policy and Procedure, effective 6/21/2017, revealed for those prospective employees and other individuals engaged to provide services who certifications (e.g.- certified nurses ' aides), the facility will conduct a check with the appropriate registry to assure that there is no finding of abuse, neglect, exploration, mistreatment of

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F 729	Continued From page 81 residents of misappropriation of residents or property.	F 729		
F 757 SS=J	Drug Regimen is Free from Unnecessary Drugs CFR(s): 483.45(d)(1)-(6) §483.45(d) Unnecessary Drugs-General. Each resident's drug regimen must be free from unnecessary drugs. An unnecessary drug is any drug when used- §483.45(d)(1) In excessive dose (including duplicate drug therapy); or §483.45(d)(2) For excessive duration; or §483.45(d)(3) Without adequate monitoring; or §483.45(d)(4) Without adequate indications for its use; or §483.45(d)(5) In the presence of adverse consequences which indicate the dose should be reduced or discontinued; or §483.45(d)(6) Any combinations of the reasons stated in paragraphs (d)(1) through (5) of this section. This REQUIREMENT is not met as evidenced by: Based on record review and staff interview, the facility failed to provide adequate monitoring of a resident taking antidiabetic medications, resulting in a rehospitalization with diabetic ketoacidosis for 1 resident reviewed (Resident #133). The facility reported a census of 33 residents, and 16 residents with a diagnosis of diabetes. Findings include:	F 757	Past noncompliance: no plan of correction required.	

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A Minimum Data Set (MDS) assessment, dated 1/26/21, revealed Resident #133 scored 7 on the Brief Interview for Mental Status (BIMS) indicating severe cognitive impairment. The resident required extensive assistance with activities of daily living including bed mobility, transfer, dressing, eating, toilet use, and personal hygiene. The resident's diagnoses included diabetes. The resident admitted to the facility 1/5/21.

A Physician Transfer Order Report dated 1/5/21 documented the resident's diagnoses included diabetic ketoacidosis (serious complication of diabetes). The orders included checking the resident's blood sugar 4 times a day, before meals and at bedtime, and notifying the Primary Care Physician if the blood glucose registered less than 70 or greater than 400. The resident's orders included antidiabetic medications, including Metformin and Glyburide.

The January Medication Administration Record (MAR) and Treatment Administration Record (TAR) lacked blood sugar checks from 1/5/21 to 1/10/21.

The resident's blood sugar summary page lacked blood sugars from 1/5/21 to 1/10/21.

Progress Notes dated 1/10/21 at 12:51 p.m. documented the Certified Medication Aide (CMA) called the nurse to the resident's room. The resident presented unresponsive with skin warm and clammy. A blood sugar check read "high". The facility reported the resident's condition to the physician with orders received to transport the resident to the emergency room (ER). The facility called 911. The resident transported to the ER by

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ambulance, and the resident's family notified.

Progress Notes dated 1/10/21 at 9:55 p.m. documented a call to the hospital who reported the resident in the intensive care unit (ICU) 2. The nurse explained the resident received an insulin drip. The resident arrived at the ER with a blood sugar of 700. Her blood sugars improved and last Accucheck at 144. The nurse described the resident as lethargic, on a bicarb drip to improve her electrolyte imbalance, and stable at the time.

An After Visit Hospital Summary dated 1/15/21 (for the 1/10-15/21 hospitalization) documented the resident in the hospital for diabetic ketoacidosis. The history included on admission the resident's labs consistent with diabetic ketoacidosis. The resident's blood sugar registered at 729. The resident's active problems included diabetic ketoacidosis, acute metabolic encephalopathy (disturbance in brain function) likely in the setting of diabetic ketoacidosis, urinary tract infection (UTI), and possible pneumonia. The resident presented very somnolent (abnormally drowsy). She had metabolic acidosis (too much acid in body), bicarb 17 (low), glucose 729, lactic acidosis (lactic acid buildup), beta hydroxybutyrate (ketone present during diabetic ketoacidosis) elevated to 10.32.

On 3/24/21 at 9:34 a.m. the current Director of Nursing (DON) stated they caught the lack of blood sugars on a mock survey and developed a plan of correction. She said she did not know why the blood sugars were not done (she had only been at the facility a short time). She did not think they would have documented blood sugars anywhere else.

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On 3/24/21 at 1:20 p.m. the Physician's office nurse a Registered Nurse (RN) said the Physician answered yes to whether the diabetic ketoacidosis could have been prevented if the blood sugars had been checked, and yes to it being life threatening.

On 3/24/21 at 2:35 p.m. Staff M Registered Nurse (RN), the previous DON stated she missed the order for the Accuchecks on the orders when the resident admitted on 1/5/21. She discovered it the following day (1/11/21) after the resident rehospitalized with ketoacidosis. She said she reviewed the medications and diet on the transfer form but the Accucheck order was further down and missed it. She said they educated all nurses, and checked orders for all residents with diabetes when she discovered the error.

On 3/24/21 at 3 p.m. Staff F Licensed Practical Nurse (LPN) stated the day the resident transferred to the hospital (1/10/21) she was unresponsive. Staff F checked a blood sugar at the time, but had not checked it before the episode. She did not know the resident had an order for Accuchecks. She said after the event she received education on double checking orders to assure all are noted.

Abatement:
The failure to note the Accucheck order and complete the Accuchecks as ordered resulted in immediate jeopardy(IJ). The facility removed the IJ 1/12/21 after they reeducated staff on double checking orders and signs of hyper/hypoglycemia, reviewed policy and procedure, and conducted audits for blood sugar check orders on current residents that had a

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F 757	Continued From page 85 diagnosis of diabetes. This resulted in IJ past noncompliance. Surveyors onsite ensured all corrections completed. The State Agency informed the facility of the past noncompliance IJ on 3/25/21 at 9:30 a.m.	F 757		
F 804 SS=D	Nutritive Value/Appear, Palatable/Prefer Temp CFR(s): 483.60(d)(1)(2) §483.60(d) Food and drink Each resident receives and the facility provides- §483.60(d)(1) Food prepared by methods that conserve nutritive value, flavor, and appearance; §483.60(d)(2) Food and drink that is palatable, attractive, and at a safe and appetizing temperature. This REQUIREMENT is not met as evidenced by: Based on observation, policy and professional reference reviews, the facility failed to hold hot food at a temperature high enough to ensure prevention of bacterial pathogen growth. The facility reported a census of 33 residents. Findings include: The FDA 2013 Food Code, deemed that a standard practice in the foodservice industry is all potentially hazardous hot food must be held for service at a minimum of 135 degrees Fahrenheit on a steam table. Food temperatures beginning on steam table were: Puree potatoes were 200 degrees, puree chicken was 165 degrees, and green beans were 190 degrees.	F 804		

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F 804	Continued From page 86 Final serving temperatures on the steam table were: puree potatoes at 160 degrees, puree chicken at 165 degrees, puree green beans were 145 degrees, Potatoes were 150 degrees, green beans were 165 degrees, Fried chicken was 132 degrees, and ground meat was 135 degrees. Room trays were placed on food cart with no covers directly over the food, the food cart did have a door on the cart but was left open during placing all the tray in the cart and when delivering the trays to the residents rooms. The final hall to receive room trays was Hall 3. The cook checked the temperatures of a tray on the food cart. Food temperatures were: Fried chicken 100 degrees, potatoes were 125 degrees, green beans were 125 degrees. Staff continued to serve room trays from food carts without reheating. Review of Food Temperature Policy and Procedure dated 1/30/20 stated hot foods must read no less than 140 degrees when residents served; cold food temperatures should be below 41 degrees when served. The food service manager must be informed of any temperature not within acceptable range and the appropriate action must be taken to ensure food safety. Staff should immediately reheated the food to an internal temperature of greater than 165 degrees and held for 15 seconds before serving to residents.	F 804		
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	F 812		

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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, the facility failed to assure adequate cleaning practices in the kitchen, and appropriate hand hygiene during meal service. The facility reported a census of 33 residents.

Findings Include:

Observation showed on 3/22/21 at 10:45 a.m. the stainless steel lower cabinets contained thick splatters on the front of the doors. The top ledge of the cabinet doors contained crumbs of food. The left side of the oven contained a thick layer of grime down the side of it. The kitchen had food crumbs on the floor throughout the kitchen and in the kitchen office. The ice machine located on the South wall had white residue on the outside of the machine.

Observation showed on 3/23/21 at 9:49 a.m. Staff Y cook placed her hands inside of the puree mixer to adjust the blades after touching food containers, opening drawers to obtain scoop and

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F 812	Continued From page 88 spatula and taking used containers to the sink. The cook did not wear gloves and was not observed washing her hands during the whole puree process. Observation showed on 3/23/21 at 12:44 p.m. the kitchen the shelf above the grill contained a thick layer of dust. The top of the oven contained a thick layer of dust, there were crumbs on the floor.	F 812		
F 839 SS=D	Staff Qualifications CFR(s): 483.70(f)(1)(2) §483.70(f) Staff qualifications. §483.70(f)(1) The facility must employ on a full-time, part-time or consultant basis those professionals necessary to carry out the provisions of these requirements. §483.70(f)(2) Professional staff must be licensed, certified, or registered in accordance with applicable State laws. This REQUIREMENT is not met as evidenced by: Based on record review and staff interview, the facility failed to verify an active nursing license for 1 out of 2 newly hired employees (Staff A) reviewed. The facility reported a census of 33 residents. Findings include: 1. An untitled, undated list of employee start dates revealed Staff A, a Licensed Practical Nurse (LPN) hired on 7/11/19 with expiration date for the LPN license 10/31/19. Staff A became a licensed Registered Nurse (RN) effective 3/16/20. There was no documentation of any active	F 839		

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F 839	Continued From page 89 nursing license for the period of 10/31/19 thru 03/16/20. On 3/29/21 at 2 p.m., the Administrator acknowledged the lack of documentation of a valid license for Staff A, for the period identified. Facility policy, Abuse Prevention, Identification, Investigation, and Reporting Policy and Procedure, effective 6/21/2017, revealed prospective employees and other individuals engaged to provide services who hold licenses(e.g.-administrators, nurses, dieticians, therapists, etc.) the facility will conduct a check with the appropriate licensing boards to assure that there are no disciplinary actions in effect against the applicant ' s professional license by any state licensure body as a result of a finding of abuse, neglect, exploitation, or mistreatment of residents or misappropriation of resident property.	F 839		
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		

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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

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	165540	A. BUILDING _____ B. WING _____	04/06/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
COUNTRYSIDE HEALTH CARE CENTER	6120 MORNINGSIDE AVENUE SIOUX CITY, IA 51106

(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 91 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 record review, observation, staff interview and policy/procedure review, the facility failed to provide care for 6 of 17 residents in a manner to prevent infection (Resident #3, #9, #5, #7, #13, and #6). The facility reported a census of 33 residents. Findings include: 1. A Minimum Data Set (MDS) with an Assessment Reference Date of (ARD) of 3/17/21 for Resident #3 revealed a Brief Interview Status Score (BIMS) of 15 indicating intact cognition. The MDS showed the resident to have diagnoses of: spondylosis with myelopathy of the thoracic region, neurogenic bowel, muscle weakness, and diabetes. The resident required extensive assistance with two staff for transfers, locomotion, and toileting. The resident used an EZ-stand for transfers. Observation showed on 3/22/21 at 11:57 a.m. the resident with a catheter in place and foley bag clipped under his wheelchair in a privacy bag with the tubing looped and lying on the floor.	F 880		

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Observation showed on 3/23/21 at 2:38 p.m. the resident in his room self-propelling his wheel chair to the doorway with the Foley bag under his wheelchair in a privacy bag with the tubing dragging on the ground.

Observation showed on 3/24/21 showed at 11:50 a.m. the resident sitting in his wheelchair in his room with the catheter bag under the wheelchair in a privacy bag and catheter tubing sitting on the floor.

2. A MDS with an ARD of 1/21/21 for Resident #9 revealed a BIMS of 10 indicating moderate cogntive impairment. The resident had diagnoses that included: dementia, Multiple Sclerosis (MS), and neuromuscular dysfunction of the bladder. The resident required extensive assistance of two staff for transfers, dressing and bed mobility. The resident uses a Hoyer mechanical lift to get in and out of Bed.

A care plan showed the resident currently had a Foley catheter as ordered due to MS and neurogenic bladder with urine retention.

Observation showed on 3/22/21 at 12:36 p.m. the Resident seated in his room in his recliner with the Foley bag uncovered and sitting on the floor, visible from the hallway.

Observation showed on 3/23/21 at 7:21 a.m. the resident assisted by Staff H Certified Nursing Aid (CNA) who pushed the resident in his wheelchair to the dining room with the Foley bag under the wheelchair and the tubing dragging on the ground.

A catheter care policy dated 9/2014 directed staff

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to ensure catheter tubing and drainage bag are kept off the floor.

3. A MDS with an ARD of 1/14/21 for Resident #5 revealed a BIMS of 09 indicating moderate cognitive impairment. The resident had diagnoses that included: dementia, hemiplegia, and diabetes. The resident required extensive assistance with two staff for transfers, dressing and bed mobility. The resident used a Hoyer lift for transfers.

Observation showed on 3/25/21 at 8:04 a.m. Staff H CNA assisted Staff K CNA with the resident's peri care. Both staff sanitized hands and applied gloves, the resident disrobed and staff performed pericare. Both staff removed gloves and sanitized hands and applied new gloves, placed a new brief and dressed the resident. Both staff removed gloves and sanitized their hands and made the resident comfortable. Staff H wore a disposable face mask during the cares that was placed below her nose during the time cares provided to the resident.

Review of CDC guidelines at website www.cdc.gov/coronavirus/2019 states that masks should have two or more layers of washable or breathable material, completely cover your nose and mouth, fit snug against the sides of your face and not have gaps and also contain a nose wire to prevent air from leaking out of the top of the mask.

4. A MDS assessment, dated 1/16/21, revealed Resident #7 scored 1 on the BIMS indicating severe cognitive impairment. The resident required extensive assistance with activities of daily living including bed mobility, toilet use, and

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personal hygiene. The resident's diagnoses included stroke.

The Diagnosis Record showed the resident had cellulitis of the left lower extremity.

A Physician's Orders record included the resident had Methecillin Resistant Staphyloccocus Aureus (MRSA) of the wound,

Observation showed on 3/25/21 at 12:47 p.m. Staff G Registered Nurse (RN) performd wound care, with Staff J Certified Medication Aide (CME) assisting. Staff set up supplies on a barrier. Staff G removed the dressing to the left lower leg then changed gloves and washed her hands. The upper portion of the dressing appeared greenish in color. The wound appeared like large craters with red bases. Staff G put on gloves and got down on the floor, touching the floor with her right gloved hand. Staff G changed the right glove with the left gloved hand with no hand hygiene. She cleaned the wound areas with peroxide, then normal saline. Staff G applied Zinc to the periwound areas with the right hand then changed the right glove with no hand hygiene, and placed dakin's soaked gauze over the wounds, covered with ABD's (dressings), wrapped with kling, and taped. She put on the resident's shoes, changed gloves with no hand hygiene, and applied ointment to a scabbed area of the right lower leg. She removed gloves, gathered trash, and left the room with no hand hygiene.

Facility policy Personal Protective Equipment-Using Gloves, revised September 2010 directed staff to wash hands after removing gloves (gloves do not replace handwashing).

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The Handwashing/Hand Hygiene Policy and Procedure revised 11/28/16 documented the use of gloves did not replace hand washing/hand hygiene.

CDC Hand Hygiene Recommendations for Healthcare Providers dated 1/8/21 revealed multiple opportunities for hand hygiene may occur during a single care episode. Gloves are not a substitute for hand hygiene. If your task requires gloves, perform hand hygiene prior to donning gloves, before touching the patient or patient environment and immediately after removing gloves.

5. A Minimum Data Set (MDS) assessment tool, dated 2/8/21, revealed Resident #13 with moderately impaired cognition.

A care plan, with a revision date of 12/31/21, identified the resident had skin breakdown due to decreased mobility and to apply protective ointment.

A March 2021 Treatment Administration Record (TAR) directed staff to apply Calmoseptine to the resident's buttocks twice daily.

Observation revealed on 3/29/21 at 5:17 p.m. Staff F LPN (Licensed Practical Nurse) wore gloves and applied Calazime to the open areas on the resident's buttocks, changed gloves, and failed to sanitize or wash her hands in between. Staff F placed the Calazime tube on top of the full body lift sling on top of the resident's bed and the resident on the sling. Staff F pulled up the resident's pants, picked up the Calazime tube, and put the tube in her pocket. Staff F washed

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her hands and returned the Calazime to storage.

6. An MDS assessment tool, dated 1/14/21, documented Resident #6 with intact cognition and diagnoses included sleep apnea.

The resident's March 2021 TAR revealed the resident received Oxygen per nasal cannula to keep Oxygen saturation rate greater than 90% and to change the Oxygen tubing every week on Thursday. The TAR had an entry on 3/18/21 (night shift 3/19/21) and 3/25/21 identifying staff had changed the tubing.

On 3/22/21 at 4:00 p.m. the resident stated she used the oxygen tubing almost every night and observation revealed the tubing and cannula, dated 3/19/21, on the floor.

On 3/23/21 at 10:00 a.m., the resident had the Oxygen on per nasal cannula. The date, 3/19/21, remained on the tubing.

On 3/29/21 at 2:50 a.m. and 3/31/21 at 11:55 a.m., observation revealed the resident gone from the room and the oxygen tubing and cannula on the floor. The tubing had a change date of 3/19/21. Staff G RN (Registered Nurse) verified the Oxygen tubing and cannula, with a change date of 3/19/21, rested on the floor. Staff G changed the tubing.

DEPARTMENT OF INSPECTIONS AND APPEALS

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	IA1075	A. BUILDING: _____ B. WING _____	04/06/2021

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L 190	58.10(3)a General policies 481-58.10(135C) General policies. 58.10(3) There shall be written personnel policies for each facility. Personnel policies shall include the following requirements: a. Employees shall have a physical examination and tuberculin test before employment; (I, II,III) This Statute is not met as evidenced by: Based on record review and staff interview the facility failed to ensure 2 out 5 employees reviewed (Staff B and Staff E) completed a physical examination before employment and to complete tuberculosis (TB) testing at the beginning of employment. Findings Include: Chapter 58, 58.10 (3) states there shall be written personnel policies for each facility. Personnel policies shall include the following requirements: Employees shall have a physical examination before employment, and screening and testing for tuberculosis shall be conducted. Review of personnel records for Staff E lacked documentation of a physical examination before employment. Review of personnel records for Staff B lacked documentation of a physical examination before employment. Review of personnel records for Staff E lacked documentation of any tuberculosis testing. Review of personnel records for Staff B lacked documentation of any tuberculosis testing.	L 190		

DIVISION OF HEALTH FACILITIES - STATE OF IOWA

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

DEPARTMENT OF INSPECTIONS AND APPEALS

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L 190	Continued From page 1 On 3/31/21 at 10:15 a.m., the Administrator stated the facility could not locate documentation to show Staff B and Staff E had physical and TB testing as required.	L 190		