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F 000	INITIAL COMMENTS Correction date May 12, 2019 The following deficiencies were identified during the facility's annual survey and investigation of # 81815-C, # 82065-C, # 81818-I and # 82163-I. Complaint # 79692-C was not substantiated. See Code of Federal Regulations (42CFR) Part 483, subpart B-C.)	F 000		
F 576 SS=D	Right to Forms of Communication w/ Privacy CFR(s): 483.10(g)(6)-(9) §483.10(g)(6) The resident has the right to have reasonable access to the use of a telephone, including TTY and TDD services, and a place in the facility where calls can be made without being overheard. This includes the right to retain and use a cellular phone at the resident's own expense. §483.10(g)(7) The facility must protect and facilitate that resident's right to communicate with individuals and entities within and external to the facility, including reasonable access to: (i) A telephone, including TTY and TDD services; (ii) The internet, to the extent available to the facility; and (iii) Stationery, postage, writing implements and the ability to send mail. §483.10(g)(8) The resident has the right to send and receive mail, and to receive letters, packages and other materials delivered to the facility for the resident through a means other than a postal service, including the right to:	F 576		

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

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

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F 576	Continued From page 1 (i) Privacy of such communications consistent with this section; and (ii) Access to stationery, postage, and writing implements at the resident's own expense. §483.10(g)(9) The resident has the right to have reasonable access to and privacy in their use of electronic communications such as email and video communications and for internet research. (i) If the access is available to the facility (ii) At the resident's expense, if any additional expense is incurred by the facility to provide such access to the resident. (iii) Such use must comply with State and Federal law. This REQUIREMENT is not met as evidenced by: Based on clinical record review and staff and resident interviews, the facility failed to assure residents received their mail unopened for 1 of 3 residents reviewed (Resident #27). The facility reported a census of 37 residents. Findings include: According to the Minimum Data Set (MDS) assessment, dated 2/27/19, Resident #27 scored 15 on the Brief Interview for Mental Status (BIMS) indicating no cognitive impairment. The resident's diagnoses included diabetes. During an interview on 4/1/19 at 4:15 p.m. Resident #27 stated a friend sent her a money order and she didn't receive it. She found out someone opened her mail and deposited it in the facility account without her consent or knowledge. She stated the Community Liaison knew about it. During an interview on 4/2/19 at 11:45 a.m. the	F 576		

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Community Liason stated Resident #27 had brought up to another facility reviewing her for admission, that this facility stole $300 from her. She and the previous Office Manager went to the resident's room and showed her the check stub where she received reimbursement for the $300. The Community Liaison called the Previous Office Manager and put him on speaker phone. He said the previous Administrator accidentally opened the resident's mail and then inadvertently deposited the check or money order in the facility's account rather than the resident trust account. When they talked with the resident she preferred to have a check to deposit into her personal account and they did that. He stated the whole incident with opening the mail and depositing it happened before he started.

On 4/3/19 at 8:17 a.m. the facility's Nurse Consultant stated they did a mock survey at the facility after the incident with the mail. Resident #27 talked to them about it. She stated a staff member did open the letter, but stated it was in care of the facility. She did not know why they did not take the money order to the resident or how it was deposited into the facility account. She stated they gave the resident a check for the amount of the money order and apologized for the incident.

During an interview on 4/3/19 at 12:45 p.m. the previous Administrator stated she was filling in for the office manager and a letter did get opened containing a check for Resident #27. She did not know who opened it, but they felt it was payment for her rent and deposited into the facility account. She did not recall how the envelope was addressed, but they did do a concern form and reimbursed the money to the resident. She

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F 576	Continued From page 3 stated she did not know it was a money order or that it was made payable to the resident; they apologized to the resident.	F 576		
F 582 SS=D	Medicaid/Medicare Coverage/Liability Notice CFR(s): 483.10(g)(17)(18)(i)-(v) §483.10(g)(17) The facility must-- (i) Inform each Medicaid-eligible resident, in writing, at the time of admission to the nursing facility and when the resident becomes eligible for Medicaid of- (A) The items and services that are included in nursing facility services under the State plan and for which the resident may not be charged; (B) Those other items and services that the facility offers and for which the resident may be charged, and the amount of charges for those services; and (ii) Inform each Medicaid-eligible resident when changes are made to the items and services specified in §483.10(g)(17)(i)(A) and (B) of this section. §483.10(g)(18) The facility must inform each resident before, or at the time of admission, and periodically during the resident's stay, of services available in the facility and of charges for those services, including any charges for services not covered under Medicare/ Medicaid or by the facility's per diem rate. (i) Where changes in coverage are made to items and services covered by Medicare and/or by the Medicaid State plan, the facility must provide notice to residents of the change as soon as is reasonably possible. (ii) Where changes are made to charges for other items and services that the facility offers, the facility must inform the resident in writing at least	F 582		

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F 582	Continued From page 4 60 days prior to implementation of the change. (iii) If a resident dies or is hospitalized or is transferred and does not return to the facility, the facility must refund to the resident, resident representative, or estate, as applicable, any deposit or charges already paid, less the facility's per diem rate, for the days the resident actually resided or reserved or retained a bed in the facility, regardless of any minimum stay or discharge notice requirements. (iv) The facility must refund to the resident or resident representative any and all refunds due the resident within 30 days from the resident's date of discharge from the facility. (v) The terms of an admission contract by or on behalf of an individual seeking admission to the facility must not conflict with the requirements of these regulations. This REQUIREMENT is not met as evidenced by: Based on clinical record review and staff interview, the facility failed to provide 3 of 3 sampled residents the required forms for Medicare Liability Notices and Beneficiary Appeals when skilled services had been exhausted or services no longer covered (Residents #32, #244 and #245). The facility reported a census of 37 residents. Findings Include: 1. Record review for Resident #32 indicated he received skilled services from 1-28-19 to 2-4-19. The facility did not provide the resident with the Notice of Medicare Provider non coverage, CMS form #10123 or Skilled Nursing Facility Advance Beneficiary Notice of Non Coverage (SNFABN), CMS form #10055.	F 582		

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F 582	Continued From page 5 2. Record review for Resident #244 indicated the resident received skilled services from 10-2-18 to 10-9-18. The facility failed to provide the resident with the Notice of Medicare Provider non coverage, CMS form #10123 or Skilled Nursing Facility Advance Beneficiary Notice of Non Coverage (SNFABN), CMS form #10055. 3. Record review for Resident #245 indicated she received skilled services from 10-10-18 to 11-8-18. The facility completed form #10123 giving 24 hours notice to the resident, but failed to provide form #10055 to the resident or her representative. On 4-2-19 at 3:45 PM, the MDS Coordinator acknowledged the lack of forms #10123 and #10055 provided to the above residents when their skilled services exhausted. The MDS Coordinator failed to give 2 residents either form and failed to give the required 48 hour notice to the 3rd resident. She knew she should have given them the forms CMS #10123 and CMS #10055. The MDS Coordinator stated she been given several different things to do here at the facility plus work the floor.	F 582		
F 584 SS=D	Safe/Clean/Comfortable/Homelike Environment CFR(s): 483.10(i)(1)-(7) §483.10(i) Safe Environment. The resident has a right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely. The facility must provide- §483.10(i)(1) A safe, clean, comfortable, and homelike environment, allowing the resident to	F 584		

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use his or her personal belongings to the extent possible.
(i) This includes ensuring that the resident can receive care and services safely and that the physical layout of the facility maximizes resident independence and does not pose a safety risk.
(ii) The facility shall exercise reasonable care for the protection of the resident's property from loss or theft.

§483.10(i)(2) Housekeeping and maintenance services necessary to maintain a sanitary, orderly, and comfortable interior;

§483.10(i)(3) Clean bed and bath linens that are in good condition;

§483.10(i)(4) Private closet space in each resident room, as specified in §483.90 (e)(2)(iv);

§483.10(i)(5) Adequate and comfortable lighting levels in all areas;

§483.10(i)(6) Comfortable and safe temperature levels. Facilities initially certified after October 1, 1990 must maintain a temperature range of 71 to 81°F; and

§483.10(i)(7) For the maintenance of comfortable sound levels.
This REQUIREMENT is not met as evidenced by:
Based on clinical record review, resident interview, staff interview, and facility record review, the facility failed to timely and thoroughly investigate the loss of resident belongings for 2 of 17 residents who reported lost items (Resident #7, #42). The facility reported a census of 37 residents.

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Findings include:

1. The Minimum Data Set (MDS) assessment dated 3-23-19 for Resident # 7 identified a Brief Interview for Mental Status (BIMS) score of 15 without signs/symptoms of delirium. A score of 15 indicated intact memory and cognition. The MDS recorded the resident exhibited no behavioral symptoms during the 7-day assessment period.

The clinical record documented Resident #7 reported missing her upper denture plate on 10-23-18 to the MDS Coordinator. The document recorded an outcome the facility would replace the plate as staff could not locate the upper partial plate.

On 4-1-19 at 3:00 p.m., Resident # 7 reported her upper partial denture plate and her eyeglasses were missing. She remembered telling a staff member but could not remember who or their title. She could not remember when she reported the partial plate missing but knew it was before the holidays last year. The resident's eyeglasses had been missing just for a couple of weeks; she told a staff member but could not recall who.

On 4-3-19 at 9:19 AM, the Regional Nurse Consultant acknowledged the resident's missing dentures and eyeglasses. These would be paid for and an email was sent to the corporate office requesting payment on 4-2-19. The facility planned to receive an overnight check, per the facility's accountant.
2. The MDS assessment dated 2/15/19 documented Resident #42 had BIMS score of 15,

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F 584	Continued From page 8 indicating intact memory and cognition. The MDS indicated Resident #42 rated that care of her personal belongings or things while in the facility as very important. During an interview on 4/1/19 at 1:50 PM, Resident #42 reported she had a white t-shirt with Tucson Sam and various colors missing. The resident reported the shirt had sentimental value since a family member had passed away. The resident reported the shirt as missing for a couple of weeks, and she had reported the missing item to staff at the facility. The resident reported she had looked in the laundry's lost and found area and could not locate the shirt. During an interview 4/3/19 at 7:48 AM, the Regional Nurse Consultant reported finding no grievance form for Resident # 42 regarding a missing shirt. The Regional Nurse Consultant stated staff had filled out a grievance form on 4/2/19 after the surveyor inquired about the missing belongings. The Regional Nurse Consultant reported staff had looked for the shirt and a pair of black pants and checked the laundry area. If items were not found, the facility planned to replace the items.	F 584		
F 606 SS=D	Not Employ/Engage Staff w/ Adverse Actions CFR(s): 483.12(a)(3)(4) §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	F 606		

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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 personnel file reviews, facility policy review and staff interview, the facility failed to assure all employees have an Iowa criminal background check and abuse registry checks completed prior to working in the facility one of 6 current employees sampled (Staff M). The facility identified a census of 37.

Findings include:

1. The personnel file for Staff M, CNA, documented a hire date of 3/8/19. The file failed to contain criminal background and abuse registry checks done prior to hire.

The facility's Abuse Prevention, Identification, Investigation, and Reporting Policy Procedure effective 6/21/17 directed the following:
Employee Screening:
1. The facility will conducted and Iowa criminal record check and dependent adult/child abuse registry check on all prospective employees and other individuals engaged to provide services to

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F 606	Continued From page 10 residents, prior to hire, in the manner prescribed under 481 Iowa Administrative Code 58.11(3). During interview on 4/5/19 at 10:10 AM, the Administrator stated he could not say why personnel files were not complete because he did not start as Administrator until mid-March of this year. He stated the facility had initiated obtaining all missing forms identified.	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 §483.12(b)(3) Include training as required at paragraph §483.95, This REQUIREMENT is not met as evidenced by: Based on personnel file reviews, facility policy review and staff interview, the facility failed to provide dependent adult abuse training within 6 months of hire for 1 of 6 current employees sampled (Staff A and K). Additionally the facility failed to obtain an evaluation by the Department of Human Services (DHS) prior to hire to determine if an employee with a criminal history could work in the facility for 1 of 6 current employees sampled (Staff A). The facility identified a census of 37.	F 607		

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Findings include:

1. The personnel file for Staff A, certified nursing assistant (CNA) documented a hire date of 9/23/18. The file did not contain documentation of dependent adult abuse training.

The Single Contact License and Background Check dated 9/19/18 indicated a possible criminal hit for Staff A which required the Department of Criminal Investigation (DCI) to clarify if the prospective employee did or did not have a criminal history. The facility did not receive Form S from DCI confirming no criminal history until 9/25/18, 2 days after the facility hired Staff A.

2. The personnel file for Staff K, CNA, documented a hire date of 9/18/15. The file contained documentation that Staff K did not complete dependent adult abuse training until 6/2/17.

The facility's Abuse Prevention, Identification, Investigation, and Reporting Policy Procedure effective 6/21/17 directed the following:
Training of Employees: Upon initial employment, each employee shall be provided with a copy of the facility's policies and procedures relating to abuse identification and reporting requirements. Each employee shall be required to complete 2 hours of training relating to the identification and reporting of dependent adult abuse within six months.

During interview on 4/5/19 at 10:10 AM the Administrator stated he could not say why personnel files were not complete because he did not start as Administrator until mid-March of this year. He stated the facility has initiated obtaining

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F 607	Continued From page 12 all missing forms identified.	F 607		
F 622 SS=B	Transfer and Discharge Requirements CFR(s): 483.15(c)(1)(i)(ii)(2)(i)-(iii) §483.15(c) Transfer and discharge- §483.15(c)(1) Facility requirements- (i) The facility must permit each resident to remain in the facility, and not transfer or discharge the resident from the facility unless- (A) The transfer or discharge is necessary for the resident's welfare and the resident's needs cannot be met in the facility; (B) The transfer or discharge is appropriate because the resident's health has improved sufficiently so the resident no longer needs the services provided by the facility; (C) The safety of individuals in the facility is endangered due to the clinical or behavioral status of the resident; (D) The health of individuals in the facility would otherwise be endangered; (E) The resident has failed, after reasonable and appropriate notice, to pay for (or to have paid under Medicare or Medicaid) a stay at the facility. Nonpayment applies if the resident does not submit the necessary paperwork for third party payment or after the third party, including Medicare or Medicaid, denies the claim and the resident refuses to pay for his or her stay. For a resident who becomes eligible for Medicaid after admission to a facility, the facility may charge a resident only allowable charges under Medicaid; or (F) The facility ceases to operate. (ii) The facility may not transfer or discharge the resident while the appeal is pending, pursuant to § 431.230 of this chapter, when a resident exercises his or her right to appeal a transfer or	F 622		

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 622	Continued From page 13 discharge notice from the facility pursuant to § 431.220(a)(3) of this chapter, unless the failure to discharge or transfer would endanger the health or safety of the resident or other individuals in the facility. The facility must document the danger that failure to transfer or discharge would pose. §483.15(c)(2) Documentation. When the facility transfers or discharges a resident under any of the circumstances specified in paragraphs (c)(1)(i)(A) through (F) of this section, the facility must ensure that the transfer or discharge is documented in the resident's medical record and appropriate information is communicated to the receiving health care institution or provider. (i) Documentation in the resident's medical record must include: (A) The basis for the transfer per paragraph (c)(1)(i) of this section. (B) In the case of paragraph (c)(1)(i)(A) of this section, the specific resident need(s) that cannot be met, facility attempts to meet the resident needs, and the service available at the receiving facility to meet the need(s). (ii) The documentation required by paragraph (c)(2)(i) of this section must be made by- (A) The resident's physician when transfer or discharge is necessary under paragraph (c) (1) (A) or (B) of this section; and (B) A physician when transfer or discharge is necessary under paragraph (c)(1)(i)(C) or (D) of this section. (iii) Information provided to the receiving provider must include a minimum of the following: (A) Contact information of the practitioner responsible for the care of the resident. (B) Resident representative information including	F 622		

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F 622	Continued From page 14 contact information (C) Advance Directive information (D) All special instructions or precautions for ongoing care, as appropriate. (E) Comprehensive care plan goals; (F) All other necessary information, including a copy of the resident's discharge summary, consistent with §483.21(c)(2) as applicable, and any other documentation, as applicable, to ensure a safe and effective transition of care. This REQUIREMENT is not met as evidenced by: Based on clinical record review and staff interview, the facility failed to provide discharge and medical information to the receiving health care institution at the time of discharge for one of three residents reviewed who transferred to the hospital (Resident #34). The facility reported a census of 37 residents. Findings include: 1. Review of the Minimum Data Set (MDS) assessment dated 3/22/19 revealed Resident #34 re-entered the facility from the hospital on 3/15/19. Review of the facility's electronic medical record Census List revealed Resident #34 transferred to the hospital on 3/11/19, and re-admitted to the facility on 3/15/19. The clinical record lacked documentation of information sent with the resident when she transferred to the hospital on 3/11/19. During an interview 4/3/19 at 8:25 AM, Staff I, Registered Nurse reported the nurses fill out a transfer form whenever they send a resident to	F 622		

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	165540	A. BUILDING ______ B. WING ______	04/12/2019

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

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F 622	Continued From page 15 the hospital, and a copy of the transfer form is retained in the resident's medical record. On 4/4/19 at 11:00 AM, the MDS Coordinator reported no transfer form could be found for Resident #34 when she transferred to the hospital on 3/11/19. The MDS Coordinator reported they were uncertain if the nurse had filled out a transfer form.	F 622		
F 625 SS=B	Notice of Bed Hold Policy Before/Upon Trnsfr CFR(s): 483.15(d)(1)(2) §483.15(d) Notice of bed-hold policy and return- §483.15(d)(1) Notice before transfer. Before a nursing facility transfers a resident to a hospital or the resident goes on therapeutic leave, the nursing facility must provide written information to the resident or resident representative that specifies- (i) The duration of the state bed-hold policy, if any, during which the resident is permitted to return and resume residence in the nursing facility; (ii) The reserve bed payment policy in the state plan, under § 447.40 of this chapter, if any; (iii) The nursing facility's policies regarding bed-hold periods, which must be consistent with paragraph (e)(1) of this section, permitting a resident to return; and (iv) The information specified in paragraph (e)(1) of this section. §483.15(d)(2) Bed-hold notice upon transfer. At the time of transfer of a resident for hospitalization or therapeutic leave, a nursing facility must provide to the resident and the resident representative written notice which	F 625		

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F 625	Continued From page 16 specifies the duration of the bed-hold policy described in paragraph (d)(1) of this section. This REQUIREMENT is not met as evidenced by: Based on clinical record review, staff interview and facility policy review, the facility failed to provide notice to the resident and/or representative of the facility's bed-hold policy prior to and upon transfer to the hospital for two of three residents reviewed for transfers to the hospital or another facility (Residents #34 and #41). The facility reported a census of 37 residents. Findings include: 1. The MDS (Minimum Data Set) assessment dated 3/22/19 documented Resident #34 had diagnoses of pneumonia, diabetes, hip fracture, chronic lung disease, and depression. The MDS recorded Resident #34 had most recently re-entered the facility on 3/15/19 from the hospital. Review of the Census list for Resident #34 revealed Resident #34 discharged from the facility to the hospital on 3/11/19. The clinical record and progress notes dated 3/11/19 to 3/15/19 lacked documentation of any explanation of the bed hold notification to the resident or the resident's representative when she discharged to the hospital. During an interview 4/3/19 at 8:25 AM, Staff I, Registered Nurse reported the nurses fill out a transfer form whenever they send a resident to the hospital but the nurses did not provide bed hold information to the resident or her	F 625		

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representative. Staff I thought the Director of Nursing or the Administrator provided the bed hold information to the resident or her representative.

During an interview 4/3/19 at 11:20 AM, the Community Liaison Director reported she provided bed hold information to the resident or their representative whenever a resident admitted to the facility, and had the resident or their representative sign a bed hold policy form at that time. The Community Liaison Director stated if a resident transferred to the hospital or another facility at a later date, then the charge nurse provided information to the resident or the resident's representative about the bed hold policy.

During an interview 4/3/19 at 11:34 AM, the Regional Nurse Consultant reported the nursing staff marked a box on the transfer form about bed hold information provided to the resident whenever a resident had transferred to the hospital. If family is not present at the time of transfer, then the nurse contacted the family and reviewed the bed hold policy.

On 4/4/19 at 11:00 AM, the MDS Coordinator reported they could not find a transfer form for Resident # 34 when she transferred to the hospital on 3/11/19. The MDS Coordinator stated she was uncertain if nursing staff had completed a transfer form for Resident #34.

2. According to the MDS assessment dated 2/26/19, Resident #41 scored 9 on the Brief Interview for Mental Status (BIMS) indicating cognitive impairment. The assessment documented the resident was discharged and the

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F 625	Continued From page 18 facility anticipated her return. A Progress Note dated 2/26/19 at 5:07 p.m. documented Resident #41 admitted to the hospital. The clinical record lacked bed hold information to the resident or his representative. During an interview on 4/3/19 at 4:40 p.m. the Nurse Consultant stated she could find no bed hold for the resident. The facility's Bed-Hold Policy revised 11/28/17 documented before transferring the resident to a hospital, or allowing a resident to go on therapeutic leave absence, the resident, family member, or resident representative would be notified in writing of the resident bed-hold policy. At the time of the notice the resident, family member, or resident representative would be required to indicate bed-hold preferences, and acknowledge the choice in writing, if applicable. In the event a resident required emergency transfer to hospital, the resident, family member, or resident representative would be notified as soon as practicable.	F 625		
F 645 SS=D	PASARR Screening for MD & ID CFR(s): 483.20(k)(1)-(3) §483.20(k) Preadmission Screening for individuals with a mental disorder and individuals with intellectual disability. §483.20(k)(1) A nursing facility must not admit, on or after January 1, 1989, any new residents with: (i) Mental disorder as defined in paragraph (k)(3)(i) of this section, unless the State mental health authority has determined, based on an independent physical and mental evaluation	F 645		

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performed by a person or entity other than the State mental health authority, prior to admission,
(A) That, because of the physical and mental condition of the individual, the individual requires the level of services provided by a nursing facility; and
(B) If the individual requires such level of services, whether the individual requires specialized services; or
(ii) Intellectual disability, as defined in paragraph (k)(3)(ii) of this section, unless the State intellectual disability or developmental disability authority has determined prior to admission-
(A) That, because of the physical and mental condition of the individual, the individual requires the level of services provided by a nursing facility; and
(B) If the individual requires such level of services, whether the individual requires specialized services for intellectual disability.

§483.20(k)(2) Exceptions. For purposes of this section-
(i)The preadmission screening program under paragraph(k)(1) of this section need not provide for determinations in the case of the readmission to a nursing facility of an individual who, after being admitted to the nursing facility, was transferred for care in a hospital.
(ii) The State may choose not to apply the preadmission screening program under paragraph (k)(1) of this section to the admission to a nursing facility of an individual-
(A) Who is admitted to the facility directly from a hospital after receiving acute inpatient care at the hospital,
(B) Who requires nursing facility services for the condition for which the individual received care in

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the hospital, and
(C) Whose attending physician has certified, before admission to the facility that the individual is likely to require less than 30 days of nursing facility services.

§483.20(k)(3) Definition. For purposes of this section-
(i) An individual is considered to have a mental disorder if the individual has a serious mental disorder defined in 483.102(b)(1).
(ii) An individual is considered to have an intellectual disability if the individual has an intellectual disability as defined in §483.102(b)(3) or is a person with a related condition as described in 435.1010 of this chapter.
This REQUIREMENT is not met as evidenced by:
Based on clinical record review and staff interviews, the facility failed to complete a follow-up and resubmit to ASCEND for placement and services according to the Preadmission Screening and Resident Review (PASRR) for 1 of 1 residents that required a re-evaluation (Residents #32). The facility reported a census of 37 residents the time of the survey.

Findings include:

1. A Minimum Data Set (MDS) assessment dated 2-28-19 for Resident #32 documented diagnoses of diabetes mellitus, depression and schizophrenia.

Resident # 32 had a PASRR completed on 11-1-18, which provided a negative Level I screening. The ASCEND report showed the PASRR would need to be re-submitted if resident was suspected of having a major mental illness

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F 645	Continued From page 21 or exhibit a significant change in treatment needs. An interview on 4-2-19 at 5:03 PM with the Regional Corporate Nurse Consultant acknowledged the lack of a Level II screening. Resident #32 had diagnosis of depression and schizophrenia and received Haldol (an antipsychotic medication). Expectations are that a Level II should have been re-submitted for evaluation.	F 645		
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	F 655		

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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 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 clinical record review and resident and staff interviews, the facility failed to ensure residents received information on their initial plans for service and care delivery for five of five residents reviewed who admitted to the facility in the past year (Residents #34, #37, #42, #27 and #41), and failed to complete a care plan within 48 hours of admission for one of five newly-admitted residents reviewed (Resident #41). The facility reported a census of 37 residents.

Findings include:

1. The 5-day admission Minimum Data Set (MDS) assessment dated 3/22/19 documented Resident #34 had diagnoses that included pneumonia, diabetes mellitus, hip fracture, chronic obstructive pulmonary disease (COPD) and depression. The MDS revealed a brief interview for mental status (BIMS) score of 15,

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indicating intact memory and cognition. The MDS indicated the resident admitted to the facility on 1/4/19.

Review of the baseline care plan created on 1/5/19 revealed Resident #34 had the following focus areas:
a. Diagnoses of hip fracture, COPD, diabetes, and end stage renal disease.
b. Required assistance with ADL's (activities of daily living) and used an assistive device
c. At risk for bleeding related to anticoagulant use
d. At risk for complications from dialysis treatments
e. At risk for falls
f. Pain
g. Alteration in skin integrity

The record lacked documentation that facility staff reviewed the initial care plan with the resident or her representative or provided a copy of the baseline care plan to the resident or her representative.

During an interview 4/3/19 at 2:59 PM, the MDS Coordinator reported she had just implemented a process for reviewing a resident's care plan with the resident and/or family on 3/25/19. Prior to this date, the facility had not reviewed or given a copy the baseline plan of care to the residents or their family members.

2. The MDS assessment dated 3/21/19 documented Resident #37 had diagnoses pneumonia, diabetes, fracture, depression, and repeated falls. The MDS revealed the resident scored 15 on the BIMS assessment, indicating intact memory and cognition. The MDS indicated she entered the facility on 2/21/19.

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

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The care plan dated 3/1/19 recorded Resident #37 had the following focus areas:
a. The risk for nutritional deficits related to diagnoses of diabetes and morbid obesity.
b. The risk for a decline in psychosocial wellbeing and activity level due to weakness

The clinical record lacked documentation the facility had reviewed the initial care plan with the resident or resident's representative or had provided a copy of the baseline care plan to the resident or their representative.

3. The admission MDS assessment dated 2/15/19 documented Resident #42 had diagnoses that included heart failure, hypertension (high blood pressure), and a pubis (pelvic) fracture. The resident had a BIMS score of 15, indicating intact memory and cognition. The MDS indicated the resident admitted to the facility on 2/8/19.

The care plan dated 2/8/19 recorded Resident #42 had the following focus areas:
a. Required assistance with ADL's due to a fractured hip
b. At risk for nutritional deficits related to pelvic fracture.
c. At risk for skin breakdown
d. Potential for alterations in bowel patterns
e. Had an indwelling urinary catheter due to neurogenic bladder
f. Took psychotropic medications
g. Desire for discharge to home

The record lacked documentation the facility had reviewed the initial care plan with the resident or resident's representative or had provided a copy of the baseline care plan to the resident or their

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F 655	Continued From page 25 representative. 4. According to the MDS assessment dated 7/2/18, Resident #27 entered the facility on 6/25/18. The facility provided a baseline Care Plan initiated on 6/27/18. The clinical record lacked any documentation that staff provided the resident or her representative a summary of the baseline care plan. During an interview on 4/3/19 at 3:22 p.m. the Assistant Director of Nursing (ADON) stated she did not provide a written summary of the baseline care plan. 5. According to the MDS assessment dated 10/17/18, Resident #41 entered the facility 10/10/18. The facility provided a Care Plan initiated 10/13/18, more than 48 hours after the admission. During an interview on 4/3/19 at 3:22 p.m. the ADON stated she did not have a baseline care plan completed within 48 hours of the resident's admission. She did not give a written summary of the resident's care plan to the resident or his representative. The facility's Care Planning Policy and Procedure effective 11/28/16 documented a baseline care plan for each resident would be developed within 48 hours of admission which included instructions needed to provide effective and person centered care that met professional standards of practice. The resident, the resident's family and/or the resident's representative would be provided a	F 655		

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F 655	Continued From page 26 summary of the baseline care plan to be signed by the resident or the resident representative.	F 655		
F 656 SS=D	Develop/Implement Comprehensive Care Plan CFR(s): 483.21(b)(1) §483.21(b) Comprehensive Care Plans §483.21(b)(1) The facility must develop and implement a comprehensive person-centered care plan for each resident, consistent with the resident rights set forth at §483.10(c)(2) and §483.10(c)(3), that includes measurable objectives and timeframes to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment. The comprehensive care plan must describe the following - (i) The services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §483.24, §483.25 or §483.40; and (ii) Any services that would otherwise be required under §483.24, §483.25 or §483.40 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(c)(6). (iii) Any specialized services or specialized rehabilitative services the nursing facility will provide as a result of PASARR recommendations. If a facility disagrees with the findings of the PASARR, it must indicate its rationale in the resident's medical record. (iv)In consultation with the resident and the resident's representative(s)- (A) The resident's goals for admission and desired outcomes. (B) The resident's preference and potential for future discharge. Facilities must document whether the resident's desire to return to the	F 656		

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community was assessed and any referrals to local contact agencies and/or other appropriate entities, for this purpose.
(C) Discharge plans in the comprehensive care plan, as appropriate, in accordance with the requirements set forth in paragraph (c) of this section.
This REQUIREMENT is not met as evidenced by:
Based on clinical record review, observations and staff interviews, the facility failed to develop and implement a comprehensive person centered care plan for two of 17 residents reviewed (Residents #37 and #35). The facility identified a census of 37.

Findings include:

1. The admission Minimum Data Set (MDS) assessment dated 2/28/19 identified Resident #37 had diagnoses that included pneumonia, hypertension (high blood pressure), diabetes, fractured pelvis, depression, and repeated falls. The resident had a brief interview for mental status (BIMS) score of 15, which indicated intact memory and cognition. Resident #37 required the assistance of two staff for bed mobility, the assistance of one staff for transfers, walking in the room, and with toilet use. The MDS documented the resident took insulin, an antidepressant, an anticoagulant (blood thinner), a diuretic, and opioid seven of seven days during the look-back period.

The Care Area Assessment summary (a tool used in the development of the resident's care plan) triggered ADL function, falls, and psychotropic medication use as problem areas that needed addressed.

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The Care Plan dated 3/1/19 revealed focus areas for Resident # 37 that included a risk for nutritional deficits and psychosocial well-being and activity level. The care plan lacked information which pertained to ADL needs, fall interventions, high risk medications such as insulin, diuretics, anticoagulant, or antipsychotic medications, and staff directives for management or care of a resident who had a pelvic fracture, pneumonia or diabetes.

Review of the Order Summary report dated 2/21/19 revealed Resident #37 had the following orders:
a. Monitor for signs of bleeding every shift while she received anticoagulant therapy
b. Victoza insulin 1.8 milligrams (mg) subcutaneously (SQ) daily and novolog insulin per sliding scale for diabetes
c. Furosemide 20 mg daily for CHF (congestive heart failure)
d. Eliquis (an anticoagulant) 5 mg twice a day for atrial fibrillation
e. Daily weight weekly and as needed
f. Cymbalta 60 mg daily for depression
g. Trazodone 150 mg every evening for sleep
h. Monitor and record pain scale
i. Monitor behaviors and side effects every shift.

During an interview 4/3/19 at 2:50 PM, the Regional Nurse Director reported when a resident admitted to the facility, nursing staff initiated an "admission bundle" assessment in the electronic health record. The Regional Nurse Director reported when the nurse filled out the admission questions and assessment information, additional questions or categories opened up, and then the nurse marked the focus or problem areas, which

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then initiated the care plan and intervention areas. The nurse then entered specific goals and specific interventions on the care plan.

During an interview 4/3/19 at 2:59 PM the MDS Coordinator reported she should have initated the "admission bundle assessment", not the "readmission bundle assessment" for Resident # 37. Resident #37 had been at the facility before but had discharged from the facility. The MDS Coordinator reported the admission bundle had similar assessment categories as the readmission bundle assessment but when the resident readmitted, the computer software continued with the resident's previous admission care plan. The readmission bundle had only some of the categories which then initiated only certain areas on the baseline care plan.

2. The MDS assessment dated 4-4-19 documented diagnoses for Resident #35 that included Parkinson's disease, malignant neoplasm of right breast, repeated falls and difficulty in walking.

The resident's care plan dated 7-26-17 directed staff to use the assistance of 2 and an EZ Stand (a transfer assistance device) for transfers.

Observation on 4-2-19 at 9:24 AM revealed Staff M, Certified Nurses Assistant (CNA) and Staff O, CNA placed a gait belt around the resident's waist while she sat in the wheelchair. The staff then transferred her to bed. The observation revealed an EZ Stand sling in the resident's chair.

Interview on 4-2-19 at 9:45 AM with Staff M, CNA and Staff O, CNA acknowledged the transfer and stated they both started working here 10 days

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ago. They stated they used a cheat sheet the first day or two but have not used anything in the last few days that directed staff on how to provide care to residents.

Interview on 4-2-19 at 3:34 PM with the MDS Coordinator revealed CNA's are to be using a pocket care plan and the nurses update those as needed. Moving forward, the facility discussed the possibility of CNA's using the actual Kardex off the computer. The expectations are for CNA's to follow resident care plans.

F 658 SS=E — F 658

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 clinical record review, observation, staff interview and facility policy review, facility staff failed to provide services that met professional standards by not flushing a gastric tube as ordered, failing to provide medications as ordered and administration of medications outside of the time parameters of medication administration for 6 of 17 residents reviewed (Residents # 9, # 27, # 16,# 37,# 33 and # 38). The facility reported a census of 37 residents.

Findings Include:

1. According to the Minimum Data Set (MDS) assessment, dated 12/28/18, Resident #9 scored 14 on the Brief Interview for Mental Status (BIMS)

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indicating no cognitive impairment. The resident's diagnoses included chronic obstructive pulmonary disease.

The current Care Plan revised 7/19/18 identified the resident on pain medication related to chronic back pain. The interventions included to administer medication as ordered.

A Prescription dated 1/23/19 directed the resident to receive Methadone 5 mg (milligrams), 1 at 8 a.m. and 1 at 8 p.m.

A Physician Visit form dated 3/22/19 documented the problem evaluated; chronic pain. The orders included to continue Methadone and MS Contin unchanged.

A Methadone Administration record showed the resident received the Methadone:

a. 3/27/19 at 10:30 a.m. and 4:31 p.m.
b. 3/28/19 at 8:26 a.m. and 3:49 p.m.
c. 3/29/19 at 9:20 a.m. and 5:26 p.m.
d. 3/31/19 at 8:28 a.m. and 3:05 p.m.
e. 4/1/19 at 9:05 a.m. and 3:48 p.m.

During an interview on 4/2/19 at 11:30 a.m. the Director of Nursing (DON) stated they changed the times of the Methadone when they implemented ranges. She said they did not get a physician's order to change the Methadone administration from every 12 hours.

The Progress Notes dated 4/2/19 At 11:52 a.m. documented a call to the pharmacy to determine how the script was written for Methadone and then called the prescribing provider to clarify. The provider would prefer to have it given at 8 a.m. and 8 p.m.

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2. According to the MDS assessment dated 2/27/19, Resident #27 scored 15 on the BIMS test indicating no cognitive impairment. The resident's diagnoses included diabetes.

The current Care Plan created 6/27/18 identified the resident had a diagnosis of diabetes mellitus which placed her at risk for medical complications. The interventions included to administer medications as ordered by the physician.

a. The Medication Administration Record (MAR) for March 2019 lacked documentation of the resident receiving her bedtime (HS) insulin on 3/28/19.

The MAR for April 2019 showed the residents insulin changed 4/1/19 from one brand to another. The record showed the resident received no insulin the eve of 4/1/19.

During an interview on 4/2/19 at 1:07 p.m. at 11:25 Staff B Licensed Practical Nurse (LPN) stated they received new orders previously to change the residents insulin to another brand because her insurance would not pay for it. She ran out of the previous insulin, ordered the new insulin and changed the MAR. She checked the MAR and stated the resident did not receive insulin 4/1/19. She said when she put the order in it automatically put a start date for 4/2/19. She said the resident should have received insulin the evening of 4/1/19.

b. During an interview on 4/1/19 at 4:21 p.m. the resident stated she did not get her insulin until nearly midnight the previous night, and she

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F 658	Continued From page 33 usually got it around 9 p.m. The MAR for March 2019 showed the resident received Tresiba 14 units at the following times for the HS pass: a. 3/18/19 at 11:11 p.m. b. 3/22/19 at 10:23 p.m. c. 3/23/19 at 10:27 p.m. e. 3/29/19 on 3/30/19 at 12:42 a.m. f. 3/31/19 at 11:27 p.m. On 4/3/19 at 1:30 p.m. Staff I Registered Nurse (RN) stated the resident should have received the insulin the evening of 3/28/19 and 4/1/19, and they were med errors. She stated meds on the range for administration should be administered in that time frame. The facility Liberalized Medication Pass Policy and Procedure guidelines effective 11/28/17 directed the HS pass administered from 7 p.m. to 10 p.m. The 6 rights for passing medications included the right time either per the resident or physician requirement. 3. The MDS assessment dated 3/1/19 for Resident # 33 identified a BIMS score of 15 without signs/symptoms of delirium. The MDS documented diagnoses that included heart failure and diabetes mellitus. The care plan focus area revised 3/24/17 identified the resident received anti-anxiety medication of lorazepam and had a diagnosis of diabetes mellitus. The care plan intervention revised 4/20/17 directed staff to obtain Accuchecks (test to monitor blood sugar levels) as ordered by the physician. The intervention created 7/17/17 instructed staff to observe the	F 658		

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F 658	Continued From page 34 resident's blood glucose monitoring for excursions not too wide. The intervention revised 11/25/17 directed staff to administer medications as ordered by the physician . The Medication Review Report dated 2/27/19 documented active orders for the following medications: a. lorazepam 0.5 mg (milligram) tab, give 1 tab by mouth 2 times a day for anxiety b. Accuchecks 2 times a day c. glipizide 5 mg tab, give 2.5 mg (1/2 tab) by mouth 2 times a day for diabetes; please give with dinner The MARs for March and April 2019 both recorded the following medications scheduled and administered on the HS Pa (bedtime med pass): a. lorazepam 0.5 mg tab, give 1 tab by mouth 2 times a day for anxiety b. Accuchecks 2 times a day c. glipizide 5 mg tab, give 2.5 mg (1/2 tab) by mouth 2 times a day for diabetes; please give with dinner On 4/1/19 at 1:13 p.m., Resident # 33 reported she did not get help promptly with her medications. Resident # 33 stated the night before she did not receive her medications until 11:30 p.m. and a time before that at midnight. Resident # 33 said she should get her medications at 8:00 p.m., bedtime. According to the facility medication pass times, HS Pa medication pass should occur between 7:00 p.m. to 10 p.m. According to the Medication Audit Report printed	F 658		

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4/3/19, the following medications given outside of the ordered parameters in the 2 week look back period:

a. lorazepam 0.5 mg tab, give 1 tab by mouth 2 times a day for anxiety
3/18 at 11:23 p.m., 3/20 at 12:18 a.m., 3/23 at 11:39 p.m., 3/24 at 10:27 p.m., 3/25 at 10:07 p.m., 3/29 at 10:42 p.m., 4/1 at 12:15 a.m., 4/1 at 10:18 p.m.

b. Accu checks 2 times a day
3/19 at 12:18 a.m., 3/20 at 12:14 a.m., 3/23 at 11:54 p.m., 3/24 at 10:31 p.m., 3/25 at 10:02 p.m., 3/28 at 10:02 p.m., 3/29 at 10:39 p.m., 4/1 at 12:25 a.m., 4/1 at 10:22 p.m.

c. glipizide 5 mg tab, give 2.5 mg (1/2 tab) by mouth 2 times a day for diabetes; please give with dinner (should be given at the supper meal)
3/20 at 1:09 a.m., 3/20 at 8:21 p.m., 3/21 at 8:46 p.m., 3/22 at 8:14 p.m., 3/25 at 10:07 p.m., 3/26 at 8:11 p.m., 3/27 at 8:25 p.m., 3/28 at 9:58 p.m., 3/29 at 10:42 p.m., 3/30 at 8:29 p.m., 4/1 at 12:15 a.m., 4/1 at 10:18 p.m., 4/2 at 8:30 p.m.

4. The MDS assessment dated 3/6/19 for Resident #38 documented diagnoses that included heart failure, neurogenic bladder, diabetes mellitus, hyperlipidemia (high cholesterol), anxiety disorder, and chronic kidney disease stage 3 (moderate).

The care plan focus area dated 11/16/17 identified a diagnosis of diabetes mellitus. The focus area revised 1/20/17 identified the resident received anti-anxiety medications and directed staff to give the medications as ordered by the physician.

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The MARs for March and April 2019 both recorded the following medications scheduled and administered on the HS Pa (bedtime med pass):
a. cardura (heart medication) 8 mg (milligram) tab, give 1 tab by mouth at bedtime for heart failure
b. cetirizine HCl (antihistamine medication) 10 mg tablet, give 1 tablet by mouth at bedtime for allergies
c. flomax (helps urine flow) 0.4 mg capsule, give 1 capsule by mouth at bedtime related to enlarged prostate without lower urinary tract symptoms
d. gabapentin (nerve pain medication) 600 mg tab, give 1 tablet by mouth 3 times a day for neuropathy (scheduled at 7:00 p.m.)
e. latanoprost solution (eye medication), instill 1 drop in both eyes at bedtime for glaucoma
f. levemir solution (insulin medication), inject 18 units subcutaneously 1 time a day for diabetes
g. ativan (antianxiety medication also known as lorazepam) 0.5 mg tab, give 0.25 mg by mouth at bedtime for anxiety - may have between hours of 6:00 to 9:00 p.m.
h. lorazepam 0.5 mg tab, give 1 tablet by mouth 1 time a day for anxiety (scheduled for midnight)
i. lovastatin (cholesterol mediation) 40 mg tab, give 1 tablet by mouth at bedtime related to hyperlipidemia
j. singulair (antihistamine medication) 10 mg tab, give 1 tablet by mouth at bedtime for allergies
k. azopt suspension 1 % (eye medication), instill 1 drop in both eyes 2 times a day for glaucoma
l. potassium chloride ER (extended release) 10 mEq (milliequivalents) tab, give 1 tablet by mouth 2 times a day for supplement
m. timolol maleate solution 0.5 % (eye

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F 658	Continued From page 37 medication), instill 1 drop in both eyes 2 times a day for glaucoma n. simethicone (antigas medication) 125 mg tab, give 1 tablet by mouth 3 times a day for gas/bloating o. accucheck (blood sugar monitoring test) 4 times a day for diabetes According to the Medication Audit Report printed 4/3/19, the following medications given outside of the ordered parameters: Scheduled 3/23/19 medications given at 11:20 p.m. to 11:35 p.m. - a. cardura 8 mg tab b. cetirizine HCl 10 mg tablet c. flomax 0.4 mg capsule d. gabapentin 600 mg tab e. latanoprost solution 1 drop in both eyes f. levemir solution, 18 units subcutaneously g. lorazepam 0.25 mg - (may have between hours of 6:00 to 9:00 p.m. but given at 11:20 p.m.) h. lorazepam 0.5 mg tab (scheduled for midnight given 3/24/19 at 12:14 a.m., too close to other dose) i. lovastatin 40 mg tab j. singulair 10 mg tab k. azopt suspension 1 % 1 drop in both eyes l. potassium chloride ER 10 mEq tab m. timolol maleate solution 0.5 % 1 drop in both eyes n. simethicone 125 mg tab o. accucheck done Scheduled 3/27/19 medication given 3/28/19 at 12:16 a.m. - a. levemir solution, 18 units subcutaneously Scheduled 3/28/19 medications given 3/29/19 at	F 658		

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1:16 a.m. to 1:38 a.m. -
a. cardura 8 mg tab
b. cetirizine HCl 10 mg tablet
c. flomax 0.4 mg capsule
d. gabapentin 600 mg tab
e. latanoprost solution 1 drop in both eyes
f. levemir solution, 18 units subcutaneously
g. lorazepam 0.25 mg - (may have between hours of 6:00 to 9:00 p.m. but given at 1:22 a.m.)
h. lorazepam 0.5 mg tab (scheduled for midnight given 3/29/19 at 1:45 a.m., too close to other dose)
i. lovastatin 40 mg tab
j. singulair 10 mg tab
k. azopt suspension 1 % 1 drop in both eyes
l. potassium chloride ER 10 mEq tab
m. timolol maleate solution 0.5 % 1 drop in both eyes
n. simethicone 125 mg tab
o. accucheck done

On 4/3/19 at 3:30 p.m., the Nurse Consultant acknowledged the information on the Medication Audit report of medications being passed outside of time parameters.

5. The MDS assessment dated 3/21/19 recorded Resident #37 had diagnoses of diabetes mellitus. The MDS assessment indicated the resident received insulin during the past seven days of the look-back period.

The Order Summary Report dated 4/3/19 revealed an order for victoza insulin 1.8 milligrams (mg) subcutaneously (SQ) daily had a start date 2/21/19, and novolog insulin per sliding scale had a start date 2/22/19 for diabetes.

The Medication Administration Audit Report 3/25 -

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F 658	Continued From page 39 4/3/19 revealed the following: Novolog per Sliding Scale: Scheduled For: Date/Time Administered Time Documented 08:00 PM 3/25/2019 12:06 AM 3/25/2019 12:07 AM 08:00 PM 3/27/2019 11:03 PM 3/27/2019 11:05 PM 08:00 PM 3/28/2019 10:41 PM 3/28/2019 10:41 PM Tresiba 60 units SQ Scheduled For: Date/Time Administered Time Documented HS (7-10 PM) 3/25/2019 12:06 AM 3/25/2019 12:07 AM HS 3/27/2019 11:05 PM 3/27/2019 11:05 PM HS 3/28/2019 10:40 PM 3/28/2019 10:41 PM HS (3/31/19) 4/1/2019 02:42 AM 4/1/2019 02:47 AM HS 4/3/2019 11:09 PM 4/3/2019 11:09 PM 6. The MDS assessment dated 1/16/19 recorded Resident #16 had diagnoses of diabetes mellitus, cerebrovascular accident, and a gastrostomy tube (a tube in the stomach used for feedings). The MDS documented the resident required extensive assistance of two staff for bed mobility, transfers, and toileting. The MDS assessment indicated the resident received insulin during the seven of seven days during the look-back period. The Care Plan revised on 1/16/19 revealed the resident received tube feedings five times daily with 75 cubic centimeters (cc's) of water flushed before and after feedings. The care plan	F 658		

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F 658	Continued From page 40 documented the resident had a risk for falls and required assistance of one staff for toileting and transfers. The resident had diabetes and needed medications administered as ordered by the physician. The Medication Administration Record (MAR) 3/1 - 4/3/19 revealed the resident's PEG tube needed flushed with 75 cc's of water before and after feedings five times a day, and had a start date 1/1/17. The MAR had an order for victoza (insulin) 1.2 mg (0.2 milliliters (ml)) SQ daily and tresiba (insulin) 40 units SQ daily for diabetes. The Physician's Order Summary Report dated 4/3/19 revealed the following: a. Flush PEG tube with 75 cc's of water before and after feedings five times a day. b. Victoza flexpen 0.2 ml SQ daily for diabetes c. Tresiba flexpen 40 units SQ daily for diabetes During observation 4/3/19 at 9:39 AM, Staff W, Licensed Practical Nurse (LPN) flushed Resident #16's PEG tube with 30 ml of water then connected the enteral feeding tube to the PEG tube. At the time, Staff W reported she normally flushed Resident #16's PEG tube with 30 ml of water before and after enteral feedings. At 10:34 AM, Staff W removed the enteral feeding tube from the PEG tube, attached a syringe to the PEG tube, and flushed the PEG tube with 40 ml of water. Staff W removed the syringe and clamped the PEG tube. During an interview 4/1/19 at 2:32 PM, Resident #16 had an enteral feeding connected to her PEG tube. The resident reported she had gone to the hospital three times in the past 9 months for a clogged g-tube.	F 658		

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b. The Physical Therapy (PT) discharge summary dated 1/16/19 documented the resident needed an EZ stand for transfers.

During observation on 4/3/19 at 12:05 PM, Staff J, Certified Nursing Assistant (CNA), placed a gait belt around Resident #16's waist. Staff J and Staff U, CNA, transferred the resident from the bed to the wheelchair using the gait belt. At 12:15 PM, Staff U and Staff J held the gait belt and stood the resident by the toilet. After Staff U performed pericare, staff used the gait belt and transferred the resident into the wheelchair.

During an interview 4/1/19 at 2:32 PM, Resident #16 reported staff had used an EZ stand for transfers and she needed two staff assistance for toilet use.

During an interview 4/3/19 at 9:25 AM, Staff V, Occupational Therapy, confirmed Resident #16 had discharged from PT on 1/16/19, and the therapist had recommended the resident use an EZ stand for transfers.

During an interview, 4/3/19 at 12:25 PM, Staff U, CNA, reported she looked at the plan of care or kardex on the electronic health record for information on how a resident transferred and the level of assistance required for each resident. Staff U reported the MDS Coordinator updated the kardex or plan of care.

On 4/3/19 at 12:33 PM, Staff V, OT, provided a copy of the therapy recommendations for Resident # 16. Staff V reported when Resident #16 discharged from therapy, they had recommended an EZ stand for safe transfers.

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Staff V reported the resident had some behaviors and it depended upon which staff had helped her whether she used a gait belt or an EZ stand for transfers. Staff V reported if the resident had a condition change or functional ability improved then therapy re-evaluated the resident's transfer status for safety of the resident and staff.

c. The Medication Administration Audit Report 3/25 - 4/3/19 revealed the following information regarding the resident receiving medications outside of of scheduled administration times:

Victoza 0.2 cc SQ:

Time Scheduled	Date/Time Administered	Time Documented
7:00-10:00 PM	3/26/2019 11:33 PM	3/26/2019 11:33 PM
7:00-10:00 PM	3/27/2019 10:56 PM	3/27/2019 10:56 PM
7:00-10:00 PM	3/29/2019 11:14 PM	3/29/2019 11:14 PM
7:00-10:00 PM	3/31/2019 10:54 PM	3/31/2019 10:54 PM
7:00-10:00 PM	4/2/2019 11:44 PM	4/2/2019 11:50 PM
7:00-10:00 PM	4/3/2019 11:52 PM	4/3/2019 11:59 PM

Tresiba 40 units SQ:

Time Scheduled	Date/Time Administered	Time Documented
7:00-10:00 PM	3/26/2019 11:32 PM	3/26/2019 11:33 PM
7:00-10:00 PM	3/27/2019 10:56 PM	3/27/2019 10:56 PM
7:00-10:00 PM	3/29/2019 11:14 PM	3/29/2019 11:14 PM
7:00-10:00 PM	3/31/2019 10:54 PM	3/31/2019 10:54 PM

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F 658	Continued From page 43 7:00-10:00 PM 4/2/2019 11:45 PM 4/2/2019 11:50 PM 7:00-10:00 PM 4/3/2019 11:52 PM 4/3/2019 11:59 PM	F 658		
F 661 SS=B	Discharge Summary CFR(s): 483.21(c)(2)(i)-(iv) §483.21(c)(2) Discharge Summary When the facility anticipates discharge, a resident must have a discharge summary that includes, but is not limited to, the following: (i) A recapitulation of the resident's stay that includes, but is not limited to, diagnoses, course of illness/treatment or therapy, and pertinent lab, radiology, and consultation results. (ii) A final summary of the resident's status to include items in paragraph (b)(1) of §483.20, at the time of the discharge that is available for release to authorized persons and agencies, with the consent of the resident or resident's representative. (iii) Reconciliation of all pre-discharge medications with the resident's post-discharge medications (both prescribed and over-the-counter). (iv) A post-discharge plan of care that is developed with the participation of the resident and, with the resident's consent, the resident representative(s), which will assist the resident to adjust to his or her new living environment. The post-discharge plan of care must indicate where the individual plans to reside, any arrangements that have been made for the resident's follow up care and any post-discharge medical and non-medical services. This REQUIREMENT is not met as evidenced by: Based on clinical record review and interview,	F 661		

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the facility lacked a discharge summary including a recapitulation of a resident's stay for 1 of 1 residents reviewed in the closed record sample (Resident #44). The facility reported a census of 37 residents.

Findings:

1. The MDS (Minimum Data Set) assessment dated 1-17-19, listed diagnoses for Resident #44 that included spinal stenosis and cervicalgia.

A Standard Assessment documented the next final discharge summary/recapitulation of stay 76 days overdue.

The facility lacked documentation of a discharge summary including a recapitulation of the resident's stay.

An interview on 4-3-19 at 10:30 am with the Regional Nurse Consultant acknowledged the missing documentation of resident belongings and lack of notation of meds being destroyed. The clinical record review lacked a recapitulation.

F 677 SS=E — ADL Care Provided for Dependent Residents CFR(s): 483.24(a)(2) — F 677

§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 clinical record review, observations and staff interviews, the facility failed to provide the necessary services for grooming for six of 17 residents reviewed (Residents #9, #14, #27, #5,

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#38 and # 41). The facility reported a census of 37 residents.

Findings included:

1. According to the Minimum Data Set (MDS) assessment dated 12/28/18, Resident #9 scored 14 on the Brief Interview for Mental Status (BIMS) indicating no cognitive or memory impairment. The assessment documented and required the assistance of one with bathing. The resident's diagnoses included chronic obstructive pulmonary disease.

The current Care Plan initiated 7/19/18 identified Resident #9 had an activity of daily living (ADL) self care performance deficit. The interventions included to provide the resident with a sponge bath when a full bath or shower could not be tolerated.

The Resident Bath/Skin Assessments documented Resident #9 had a whirlpool bath on 3/14/19. The Task document for the past 30 days for baths planned on Tuesday and Friday, no additional baths were given.

2. According to the MDS assessment dated 2/27/19, Resident #27 scored 15 on the BIMS indicating no cognitive impairment. The resident required physical help with part of bathing and her diagnoses included diabetes.

a. The current Physician's Orders showed the resident had an order for TED hose (antiembolism stockings) on in the a.m. and off at bedtime with a start date of 6/25/18. (The facility Liberalized Medication Pass Policy and Procedure guidelines effective 11/28/17 directed

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F 677	Continued From page 46 the a.m. hours as 6 to 10 a.m.) The Care Plan revised on 7/2/18 identified the resident with mild edema to both lower extremities. The interventions instructed to assist the resident with applying TEDS as ordered, initiated 6/27/18. During an interview on 4/1/19 at 4:20 p.m. Resident #27 stated she did most of her own care but could not put on or take off her compression hose. During observation on 4/2/19 at 7:48 a.m. Resident #27 sat in the recliner with no compression socks on. At 8:08 a.m. the resident sat at the breakfast table in her scooter with no compression socks on. At 9:30, 10:12 and 11:35 a.m. the resident sat in her room with no compression socks on. Resident #27 stated she called for someone to put them on, but they had not done it yet. At 12 p.m. the resident had the stockings on. b. The current Care Plan revised 12/13/18 identified the resident required assistance with activities of daily living. The interventions directed that she preferred complete bathing with the assistance of one. During an interview on 4/1/19 at 4:21 p.m. Resident #27 stated she went 2 weeks without a bath because a male CNA was giving them and she wanted a female to do her bath. so they put down that she refused the bath. The Resident Bath/Skin Assessment's documented she refused a bath on 3/22/19 and had a shower on 4/1/19. The Task document for	F 677		

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baths planned on Monday and Thursday included a shower on 3/9/19 and 3/15/19, with a refusal on 3/28/19 (no bath from 3/15 to 4/1/19).

3. According to the MDS assessment dated 3/14/19, Resident #41 scored 9 on the Brief Interview for Mental Status (BIMS) indicating cognitive impairment. Bathing did not occur during the assessment period.

The current Care Plan initiated 10/13/18 identified he required assistance with ADL's due to weakness and pain. The care plan did not address bathing needs.

The Task document for bathing/showers completed Wednesday and Saturday included refusal of a bath on 3/9, 3/13, 3/15, 3/20, 3/22, 3/27, and 4/3/19. The clinical record lacked documentation of any type of bathing for the resident.

During an interview on 4/4/19 at 9:10 a.m. Staff I Registered Nurse (RN) stated the CNA's are to fill out a bath form the day of the resident's bath. If a resident refuses, staff are to re-approach at least 1 more time. She said if a resident refused a tub bath or shower they should do a bed bath and document it. She said if a female resident did not wish to have a male resident give a bath, a female CNA should do the bath.

4. The MDS assessment dated 3/14/19 for Resident # 5 identified a BIMS score of 9, indicating moderate cognitive impairment. The resident required the assistance of 2 with dressing, personal hygiene and bathing. The MDS documented diagnoses that included Alzheimer's disease and need for assistance with

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F 677	Continued From page 48 personal cares. The care plan focus area revised 12/13/18 identified Resident #9 required assistance with ADL's due to cognitive decline and physical debility. The care plan directed staff to provide the assistance of 1 to 2 persons for dressing, personal hygiene and oral cares. In a family interview on 4/1/19 at 12:57 p.m., Resident # 5's wife reported the resident had not been getting showers routinely but then it got better after she got on the staff to get them done. Observation on 4/2/19 at 8:52 a.m. revealed Resident # 5's hair appeared uncombed and unkempt, as if slept on, and he had growth of beard stubble as if not cleanly shaven for day or 2. On 4/2/19 at 5:30 p.m., the MDS Coordinator stated staff documented bathing in the blue shower book kept at the nurses station. The aides filled out a form to document completion of bathing, placed it in the blue book, then the information eventually transferred into the computer chart. Staff B, Licensed Practical Nurse (LPN), stated the system of putting charting into the electronic system was new and a work in progress. Staff B stated some aides had access to computer charting and some aides did not. Staff B confirmed all aides still completed a paper form documentation of bathing activity as they transitioned to computer charting. Observation of the shower book for March and April 2019 contained no paper forms for Resident #5. Review of the electronic clinical record revealed	F 677		

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documentation of bathing activity under the task tab. The documentation recorded the resident received a shower 4 times in the past 30 days: 3/9/19, 3/12/19, 3/15/19, and 3/22/19. The task titled Bathing/Showers recorded the resident to receive bathing on Wednesdays and Saturdays.

5. The MDS assessment dated 3/6/19 for Resident #38 revealed the resident required the assistance of 2 with dressing and personal hygiene and that bathing did not occur during the 7-day look back period. The MDS documented diagnoses that included heart failure and diabetes mellitus.

The care plan focus area revised on 7/5/16 identified an ADL's self care performance deficit related to mobility issues and heart failure. The care plan directed staff to provide the assistance of one for hygiene and oral cares.

Observation on 4/2/19 at 8:37 a.m. revealed Resident # 38's hair as uncombed with the hair on the back of his head going in all different directions and appearing to be slept on. Resident # 38's fingernails appeared dirty.

Review on 4/2/19 at 5:30 p.m. revealed the shower book at the nurses station for March and April 2019 contained no paper forms for Resident #38.

Review of the electronic clinical record revealed documentation of bathing activity under the task tab. The documentation recorded Resident #38 received a bed bath 3 times in the past 30 days: 3/21/19, 3/26/19, and 3/29/19. The task titled Bathing/Showers recorded the resident to receive bathing on Tuesdays and Fridays.

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F 677	Continued From page 50 6. The MDS assessment dated 1/13/19 documented Resident #14 had a BIMS score of 13, indicating intact memory and cognition. The resident diagnoses that included weakness, age-related physical debility, and need for assistance with personal care. During observation on 4/2/19 at 8:21 a.m. the resident wore thick protection sleeves to both arms that showed darkened brown spots on multiple areas of the sleeves. Observation on 4/2/19 at 11:35 a.m. revealed the resident continued to wear thick protection sleeves to both arms which showed darkened brown spots on multiple areas of the sleeves. The brown spots ranged from dime small areas to large areas. During interview on 4/3/19 at 10:45 a.m. Staff J. Certified Nurse's Aide (CNA) stated she sent the sleeves to the wash when she did the resident's bath. She stated each resident took a bath twice a week so they would be changed at least twice a week. She reported the facility stored extras sleeves in the shower room and in the clean utility.	F 677		
F 678 SS=D	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	F 678		

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F 678	Continued From page 51 by: Based on personnel file reviews, facility record review and staff interview, the facility failed to ensure staff trained in cardiopulmonary resuscitation (CPR) on duty at all times for 1 of 2 current licensed nurse files reviewed. Staff B. The facility identified a census of 37. Findings include: 1. The personnel file for Staff B, licensed practical nurse (LPN) documented a hire date of 4/12/17. The file contained a Basic Life Support card which documented Staff B completed the cognitive and skills evaluation in accordance with the curriculum of the American Heart Association Basic Life Support (CPR and automated external defibrillator (AED) Program with a recommended renewal date of 2/28/19. During interview on 4/2/19 at 2:05 PM Staff B presented a certificate stat she completed an online course for Health Care Provider CPR completed 4/1/19. Staff B stated she did not realize her previous certification had gone past the recommended renewal date until alerted by the administrator so she competed the course online. Staff B stated unawareness the online CPR education does not meet the requirement for initial certification or re-certification as it does not have a hands-on skill practice and in-person skills assessment component. Review of the payroll record for Staff B and nursing schedule review from 3/1-4/1/19 revealed she worked as charge nurse 3/9, 3/10, 3/23 and 3/24 when no other certified nursing staff were on duty. The facility identified 14 residents who requested CPR be initiated if indicated.	F 678		

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F 684 SS=J	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 care plan, and the residents' choices. This REQUIREMENT is not met as evidenced by: Based on clinical record review and staff interviews, the facility failed to ensure Resident #243 received an appropriate food texture. Resident #243 had a history of eating so rapidly that she placed whole servings of food in her mouth . The care plan directed staff to provide a mechanical soft (ground meat) diet to prevent choking, to sit at an assisted table to have staff more immediately involved and aware of her dining need for timely cueing and assistance as needed. Resident #243 received a whole sausage on a bun on 3/22/19, choked and went into cardiac arrest, which resulted in an immediate jeopardy to resident health and safety. In addition, based on clinical record review, observation, and staff interview, the facility failed to complete comprehensive assessments of a burn, failed to complete treatments as ordered by the physician and failed to assess for the safety of drinking hot beverages for one of one residents reviewed for skin conditions (Resident #38). The sample consisted of 17 total residents and the facility identified a census of 37 residents. Findings include:	F 684		

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F 684	Continued From page 53 1. The Medical Diagnosis list for Resident #243 documented diagnoses that included bipolar disorder, dementia in other diseases and dysphagia in the oropharyngeal phase (characterized by difficulty initiating a swallow and may be accompanied by nasopharyngeal regurgitation, aspiration, and a sensation of residual food remaining in the pharynx). The Minimum Data Set (MDS) assessment dated 2/26/19 for Resident #243 documented a Brief Interview of Mental Status (BIMS) score of 14 which indicated intact memory and cognition. The resident required the assistance of one with eating and received a mechanically altered diet which required a change in texture of food or liquids. The care plan problem initiated 8/17/17 documented Resident #243 had a habit of eating so rapidly that she places whole servings in her mouth at times. The care plan directed staff to serve her a mechanical soft diet to prevent choking, seat the resident at an assisted table to have staff more immediately involved and aware of her dining needs for timely cueing and assistance and she would be encouraged by staff to take reasonable-sized bites with the goal for resident to not choke on foods. The Speech Therapy (ST) Plan of Care dated 3/27/18 documented the resident with an impulsive rate of intake, which affected her safety during oral intake. The resident had severe confusion and required moderate cues for safety during most tasks. The ST Patient Discharge Instructions dated 4/6/18 documented the resident would remain in the long term care facility and sit at a table with constant supervision	F 684		

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F 684	Continued From page 54 during the meal. The Progress Notes entry completed by the Director of Nursing (DON) on 3/22/19 at 7:15 PM documented while she assisted staff with evening meal service, she heard the charge nurse yelling for her to help her. She saw the charge nurse remove Resident #243 from the dining room by wheelchair and the charge nurse told her the resident was choking. The resident's face showed central cyanosis (a bluish discoloration of the skin due to lack of oxygen in the bloodstream). The DON performed the Heimlich maneuver unsuccessfully, removed large chunks of smoked sausage from the resident's mouth with a finger sweep and suctioned out additional chunks but could not establish an open airway. The resident became nonresponsive, staff assisted her to the floor and performed abdominal compressions/thrusts in order to dislodge the obstruction. The DON could no longer palpate (feel) a carotid (neck) pulse on the resident. Emergency responders placed a heart monitor on the resident which showed a flat line and rescue measures were terminated. During interview on 3/27/19 at 5:10 PM the DON stated she received a complaint from a family member about slow evening meal service in the afternoon of 3/22/19. Before she left for the day she decided to observe evening meal service. She stated meal service had not yet started and was about 15 minutes after it should have started, so she entered the kitchen and told Staff C, Cook, she would assist with passing resident meals and instructed Staff E, certified nursing assistant (CNA) to go to an assisted resident table. She stated Staff C handed her a plate which contained a whole smoked sausage on a	F 684		

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F 684	Continued From page 55 bun, identified it was for Resident #243, who sat at a table of residents who required cueing and supervision, and then handed her a plate with a riblet patty on a bun and identified it was for another resident at the same table. The DON stated she delivered the plates to the 2 residents. She stated another staff member sat at a table for residents who require physical assistance to eat, which was next to the table where Resident #243 sat. Staff E, CNA, stood directly behind the resident when she served the plate. Later in the interview, she stated there was not another CNA at this table, but the family member of another resident instead. The DON returned to the kitchen to get more plates and when she re-entered the dining room she saw Staff B, licensed practical nurse (LPN) pushing Resident #243 out of the dining room in her wheelchair. Staff B called for her to help and stated the resident was choking. Staff E was no longer in the dining room. She stated she looked at the resident and saw she was cyanotic and had 'scared deer in the headlight look' but the resident tracked her with her eyes. The resident had 'huge' chunks of meat in her mouth; she removed most of them and performed the Heimlich maneuver at least 3 times while the resident remained seated in the wheelchair. The resident lost consciousness and staff assisted her to the floor and she started chest compressions in order to dislodge the obstruction. She also suctioned Resident #243 but only got out a few tiny chunks. When EMS personnel arrived they also tried compressions but were unsuccessful. EMS personnel placed a heart monitor on the resident which showed she had no pulse so rescue attempts were terminated. The DON stated she she had been employed for a month at the time of the incident and was not familiar with resident	F 684		

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diet orders or individual care plan directives for nutrition. There were no cards or slips in the kitchen which could be used to check the resident's diet prior to service. Since she saw Staff E standing behind Resident #243's chair when she delivered the plate she thought she would be supervising the residents at this table.

During interview on 3/28/19 at 1:05 PM, a resident's family member who sits at Resident #243's table 2 meals a day to assist her spouse, stated she sat directly across from Resident #243. She stated no staff member was present at the table and Staff E sat at the other table with his back toward them. She stated she looked over and saw Resident #243 was shaking, had her head back and had a 'funny' color to her face. She asked the resident if she was okay and she shook her head no. She immediately told Staff E to check on the resident and he summoned the nurse right away. The visitor stated normally a CNA sits at the table and constantly cues Resident #243 to slow down when eating. The visitor stated she had heard staff say the resident had packed her mouth full of food before.

During interview on 3/28/19 at 2:51 PM Staff D, CNA stated she entered the dining room to seat a resident at a table. She said she stood behind Resident #243 very briefly right after the DON served her plate. Staff D stated Resident #243 picked up the polish sausage and started to 'chow down on it' but she did not know the resident's diet order, She stated she had been employed about a month and when she first started she thought it was a red flag the facility did not use diet cards for staff to make sure residents are served the correct diet because she felt it was important to do so. She stated the

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F 684	Continued From page 57 MDS Coordinator came to her and said there were other residents to get up so she left the dining room. Staff D stated Staff E sat at one assisted table and there was no staff at Resident #243's table. During interview on 3/27/19 at 6:28 PM Staff C stated the DON came into the kitchen right before meal service and told her she would pass the plates to the residents after she served them. She stated the main course entree choice was either a riblet patty or bun length sausages. Resident #243 had a mechanical soft diet order and she recalled she had ordered the riblet patty. Staff C said the riblet patty almost fell apart so it did not require grinding. Staff C prepared a plate with a riblet patty for Resident #243 and a plate with a whole sausage on it for another resident at that table who had a regular diet order. She handed the plates to the DON one at a time and said the resident's name at the same time. Staff C stated the cook has a list of resident diets and their choices they refer to when serving but no diet cards or tray slips were used for staff to check to make sure they received the right diet. Staff C stated normally the dietary aide serves all the resident plates and they are familiar with resident diets and restrictions. During interview on 4/4/19 at 11:15 AM the Dietary Services Manager (DSM) stated she expects the cook to prepare plates for residents and the dietary aide to serve them because she feels it reduces the incidence of mistakes. The night of the incident with Resident #243 the DON came into the kitchen and pressured Staff C to begin serving and stated she would pass out the plates. Staff C had a list of resident diets and their choice of entree and her dietary aides are	F 684		

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very familiar with resident diet and restrictions.

During interview on 4/3/19 at 2:00 PM, Staff F, dietary aide, stated she had just finished meal service in the other area of the facility and started getting room trays ready when the DON came in and took over passing out resident plates in the dining room. Staff F delivered the room trays and when she came back to the kitchen she starting passing out plates in the dining room. Staff F stated she is very familiar with resident diets and nutritional requirements and restrictions and she had also been instructed the residents seated at the assisted tables could not be served until staff are seated at them and the nurse had her medication cart at the side of the doorway.

The Quality Assurance (QA) meeting minutes dated 1/16/19 contained a notation regarding starting the use of dietary cards. The DSM stated she had discussed this idea in the QA meeting because if new staff or non-dietary staff members were passing trays they would have a reference as to which resident the plate is for and could check their diet orders but she failed to initiate them at that time.

The facility abated the immediate jeopardy situation on 3/28/19 through the following actions:
1. Identification of all resident diet orders and implemented the use of dietary cards for each meal service.
2. Implementation of an audit tool to assure residents receive the proper diet.
3. Educated all staff to the use of the diet cards and the use of audit tool.
4. Educated all staff of the expectation to have no less than 2 CNA's available and present at the full assist and cue

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assist table.
5. Educated dietary staff to assure the meal served is in accordance with the spreadsheet for the ordered diets.

2. The MDS assessment dated 3/6/19 for Resident #38 recorded he required the assistance of 2 persons for bed mobility, dressing, hygiene, and supervision from 1 person during eating. The MDS documented diagnoses that included heart failure, diabetes mellitus, and chronic kidney disease stage 3 (moderate).

The care plan focus area revised 3/12/19 identified the resident as at risk for impaired skin integrity related to CHF (congestive heart failure), chronic kidney disease, and mobility issues. The care plan documented 3/12/19 a burn to the resident's right thigh. The care plan directed staff to complete weekly skin assessments per facility policy. The care plan documented education provided to the dietary staff related to the use of lidded/sip cups for all fluids; if resident refused lidded cup, staff directed to notify charge nurse and/or Dietary Manager (DM)/Director of Nursing (DON).

The Progress Notes dated 3/12/19 at 6:30 p.m. documented that morning at breakfast the resident spilled a glass of hot coffee on his lap causing a 14.6 cm (centimeter) by 9.3 cm burn to his right thigh. The entry recorded the area formed a couple of blisters in the burned area. The physician examined the resident and ordered application of Silverstat antibacterial gel to the area daily. The entry recorded the resident care planned to have cups with lids on them (sippy cup) at meals.

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The Progress Notes dated 3/13/19 at 5:45 a.m. documented the dressing intact to the right thigh and that Resident #38 denied pain to the area.

The Non-Pressure Wound Sheet dated 3/14/19 at 10:00 a.m. documented a second degree burn acquired on 3/12/19 that measured 6.6 cm by 15.5 cm by 0.2 cm (length x width x depth). The assessment documented serous (bloody) exudate present in small amount with the wound bed 100% epithelial (type of tissue) and skin replaced over opened blister as able. The assessment recorded the physician notified on 3/12/19 at 9:00 a.m. and treatment of silver STAT to area, cover with foam for protection and secure with king/tape. The assessment documented the resident experienced pain with the dressing change.

The Progress Notes dated 3/16/19 at 4:01 a.m. documented the dressing changed to the burn on the resident's thigh, the resident complained of pain post dressing change, PRN (as needed) pain meds given, and relief noted.

The Progress Notes dated 3/17/19 at 3:53 a.m. documented the dressing changed to the burn on the resident's right thigh, blisters to burn site open and draining, and the resident complained of pain post dressing change with PRN pain meds given with some relief. At 3:10 p.m., the notes documented the dressing changed to the right upper thigh burn, area open and red, blisters ruptured, and the area sore/painful. The entry recorded the surrounding tissue inflamed and red. The entry documented the nurse would call the doctor's office in the AM to update them on the healing process.

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F 684	Continued From page 61 The clinical record lacked documentation of the doctor's office being called on 3/17/19. The Progress Notes dated 3/18/19 at 2:56 a.m. documented the dressing changed to the burn on the resident's thigh, no blisters, open red area drained serosanguinous (bloody wound drainage) fluid, and the resident complained of pain post dressing change; PRN pain meds given with relief. The Progress Notes dated 3/19/19 at 12:48 p.m. documented Resident #38 returned from the physician visit with new orders for the treatment to the right groin burn. The physician ordered the area washed with soap and water, apply Silvadene (burn cream) to 4 by 4 (gauze square) then apply the 4 by 4s to the wound and wrap with Kerlix (type of rolled gauze); do not use telfa (type of bandage). The physician orders signed 3/19/19 documented the right groin burn slowly improving. The new orders for treatment written for change right groin wound dressing BID (twice a day), cleanse with soap and waster then apply Silvadene to 4 by 4s then apply to burn and wrap with Kerlex; no telfa. The Progress Notes dated 3/21/19 at 2:48 a.m. documented the resident with increased pain to the burn area, PRN pain medication given, and relief noted. The clinical record lacked any documentation of assessments of the burn on the right thigh from 3/21/19 through 4/3/19. The Treatment Administration Records (TARs) for March and April 2019 revealed the following dates	F 684		

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the treatments not completed as ordered:
a. Cleanse right thigh and groin with soap and water apply Silverstat antibacterial gel 2 times a day for burn; started 3/12/19 and discontinued 3/19/19:
3/13 PM, 3/14 AM, 3/15 AM, 3/16 AM, 3/18 AM and PM.
b. Cleanse burn wound to right thigh with soap and water. Apply Silvadene to 4x4 then apply 4x4s to wound. Wrap with Kerlix. DO NOT APPLY TELFA. 2 times a day, started 3/19/19:
3/23 AM, 3/24 PM, 3/25 AM, 3/26 PM, 3/27 PM, 3/30 PM, 4/2 PM

Observation on 4/2/19 at 8:27 a.m. revealed Resident # 38 in the dining room awaiting breakfast meal service. Resident # 38 asked for assistance to open a 2 handled, lidded coffee cup to add water due to it being hot. Staff J, Certified Nurse Aide (CNA), assisted the resident to add water to cool down the coffee. During the observation, Resident # 38 dropped the lidded coffee cup 3 times onto the table and the lid prevented a spill. Resident #38 dropped the cup as he nodded back off to sleep during the meal service.

Observation on 4/3/19 at 7:58 a.m. revealed Staff J and Staff U, CNA, entered Resident # 38's room to assist with morning cares. Staff J removed a blanket to reveal the resident wore a light gray short sleeved T-shirt and an incontinence brief only, legs with socks on and an Ace wrap on the left lower extremity. A burn marked area covered the right upper thigh spanning from outer to inner thigh and top of thigh near groin to halfway down to the knee. The edges of the area were flaky, appeared pink color like scar tissue, superficial in depth, and no

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F 684	Continued From page 63 treatment dressing in place or residual treatment creams visible to the area. No evidence of any removed dressings observed in the room. Staff U stated the original burn produced blisters to the thigh. On 4/4/19 at 11:00 a.m., Staff I, Registered Nurse (RN), confirmed if the TAR had been left blank then it indicated the treatment as not completed as ordered. Staff I reported there were days treatments was not completed due to only being staffed with one nurse and not enough staff or time to complete the treatments. Staff I always told the nurses if they didn't actually complete the treatment then they should not sign it off. Staff I stated she had been a floor nurse, then off for 12 days, and when she returned the week of 4/1/19 she got moved to be the Interim Director of Nursing (IDON).	F 684		
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 clinical record review, observation, staff interview, facility record review, and review of manufacturer's guidelines, the facility failed to inspect equipment prior to transfer to ensure safe transfer technique utilized for 1 of 4 residents who transferred with the use of a mechanical lift	F 689		

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(Resident #15). In addition, failed staff failed to lock a medication cart prior to leaving the cart unattended. The facility reported a census of 37 residents.

Findings include:

The Minimum Data Set (MDS) assessment dated 1/15/19 for Resident #15 identified a Brief Interview for Mental Status (BIMS) score of 11 without signs/symptoms of delirium. A score of 11 indicated moderate cognitive impairment. The MDS revealed the resident required the extensive physical assistance of 2 persons for transfers.

The care plan focus area dated 1/9/19 identified the resident required assistance with ADL's (Activities of Daily Living) due to abnormalities of gait and mobility issues. The care plan directed staff to complete transfers with a hoyer (mechanical lift) and assistance of 2 persons.

Observation on 4/3/19 at 11:12 a.m. revealed Staff U, Certified Nurse Aide (CNA), transported and Staff J, CNA, went to Resident # 15 's room to assist the resident with a hoyer transfer. Staff U connected a mesh, yellow trimmed hoyer sling to the holding hooks on the hoyer machine. The hoyer transfer bar contained 6 connection points, 3 on each side of the resident's body. Staff U connected both sides with a gray loop on the top, gray loop in the middle, and red loop on the bottom. The gray loop on the top left side of the resident shredded. Staff U proceeded to start the transfer and began to raise the lift bar requiring the surveyor to intervene due to the risk of fall if the loop continued to tear. The surveyor instructed the staff must get another sling. Staff U and Staff J responded no one really checked

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the hoyer slings for wear and tear. Both staff stated they did not check slings for wear and tear, and Staff U commented the facility always told them never throw anything away. Staff J left then returned with another mesh sling. Staff U and Staff J connected the new mesh, yellow trimmed sling. The surveyor again had to stop the transfer as it began due to a loop ripped on the top left side of the sling. At 11:23 a.m. Staff J left the room to find a nurse for instruction. At 11:26 a.m., Staff J returned to the resident's room and reported Staff I, Registered Nurse (RN), was looking for another Hoyer sling. Staff J told Staff U they would go transfer another resident who needed Hoyer transfer assistance while waiting for Staff I. At 11:34 a.m., Staff U and Staff J returned to the room with a new sling, mesh with red trim, and stated Staff I found a new sling and checked the loops for wear and tear. Staff U and Staff J positioned the sling under the resident while she sat in the wheelchair and criss-crossed the sling between the legs. Staff connected red loops on the bottom, gray loops in middle, and gray loops on the top both sides. Staff U and Staff J completed the rest of the transfer assistance without incident.

On 4/3/19 at 11:45 a.m., a report was given to the Nurse Consultant of the 2 hoyer slings with compromised integrity of the loops being ripped and frayed The Nurse Consultant immediately directed the Administrator to tell the staff to not transfer any resident until staff checked all slings in the facility for wear, tear, and safety of use.

On 4/3/19 at 12:10 p.m., the Laundry Supervisor reported she had no slings in laundry. The Laundry Supervisor reported she washed slings then hung them up to air day. She had no

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knowledge of who would be responsible for monitoring when slings were put into use, how long they used the slings, or who would check the slings for wear and tear prior to use. The Laundry Supervisor stated that would be a nursing responsibility.

On 4/3/19 at 12:15 p.m., Staff Q, Certified Medication Aide (CMA), stated she did not know who would be responsible to check Hoyer slings for wear and tear. Staff Q stated she did not think there was a system in place and if she were to transfer a resident and notice a tear, she would just remove the sling from use.

On 4/3/19 at 12:20 p.m., the Nurse Consultant reported the facility had 4 residents in the building who required a Hoyer transfer. The Nurse Consultant stated the facility had checked the integrity of the slings underneath each of the 4 residents and no other sling concerns were found.

On 4/3/19 at 1:10 p.m., the Nurse Consultant reported the facility ordered 1 sling for each resident and 1 spare. The Nurse Consultant reported the 4 residents who transferred utilizing a Hoyer machine were Residents #38, #15, #21, and #35. The Nurse Consultant stated she was going to have Staff I start training staff on how to select slings and check for wear and tear. The Nurse Consultant stated nursing staff are responsible to not use a Hoyer or Hoyer sling if it is not in working order. The Nurse Consultant stated laundry staff also should be a point of reference to check slings when laundered. The Nurse Consultant commented she did not know why the loops had frayed as the facility just purchased the hoyer machines and slings in

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The facility policy and procedure dated 11/28/17 titled Mechanical Lift (Hoyer and Stand-Up) included the following documentation:
Policy - It is the policy of this facility to assure that when a Hoyer Lift is needed for the transfer of a resident, that it is used in accordance with the manufacturer's guidelines to assure safety during the transfer.
Using a Mechanical lift - Steps in the Procedure
i. Attach the sling to the lift. Be sure the hooks are placed so that they are facing away from the resident.
j. Instruct the resident to fold both arms across his or her chest, if possible.
k. Elevate sling a few inches off the bed before moving the resident and ensure that the sling is properly connected to the hooks of the swivel bar.

The manufacturer's guidelines included the following documentation:
Section I - General Guidelines
After each laundering (in accordance with instructions on the sling), inspect sling(s) for wear, tears, and loose stitching.
Bleached, torn, cut, frayed, or broken slings are unsafe and could result in injury. Discard immediately.

2. Observation on 4/2/19 at 9:05 a.m. revealed Staff S, RN (Registered Nurse) walked away from the 800 hall unlocked medication cart. At 9:45 AM, the 800 hall medication cart was unlocked, unattended and out of the view of staff.

On 4/3/19, the Administrator stated the facility had no policy regarding locking the medication cart as this would be standard practice.

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F 690 SS=D	Bowel/Bladder Incontinence, Catheter, UTI CFR(s): 483.25(e)(1)-(3) §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 clinical record review, family interview,	F 690		

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F 690	Continued From page 69 resident interview, observation, and staff interview, the facility failed to assist a resident to toilet in the bathroom versus a bed pan and failed to complete bladder & bowel assessments for the incontinent resident in an effort to maintain or reduce the frequency of incontinence 1 of 5 residents reviewed for bladder and bowel assessments (Resident #15). The facility reported a census of 37 residents. Findings include: The Minimum Data Set (MDS) assessment dated 1/15/19 for Resident # 15 identified a Brief Interview for Mental Status (BIMS) score of 11 without signs/symptoms of delirium; a score of 11 indicated moderate cognitive impairment. The MDS recorded the resident required the extensive assistance of 2 for toilet use, personal hygiene, and transfers. The resident experienced frequent episodes of urinary and bowel incontinence. The 3/27/19 MDS documented diagnoses that included diabetes mellitus, difficulty walking, and unsteadiness on feet. The care plan focus area dated 1/9/19 identified the resident incontinent of bowel, incontinent of urine related to mobility issues, and required assistance with toileting. The care plan directed staff to keep the resident's call light within reach for resident to use to notify nursing if she had to toilet or had an incontinence episode. The care plan revision dated 1/16/19 informed staff the resident required the extensive assist of 2 persons for toileting tasks. The care plan directed staff to assist the resident to the bathroom as per scheduled toileting program and to see the program for specific plan of care. The care plan revision dated 2/1/19 informed staff the	F 690		

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resident's bowel incontinence related to medication use and decreased control. The revision directed staff to toilet the resident at the same time each day as the resident usually had a bowel movement on the bed pan.

The clinical record lacked documentation of a toileting program.

On 4/1/19 at 3:40 p.m., a family member reported concerns with the facility's staffing level and their mom not getting changed enough. The family member stated they often found their parent soaked with urine and her brief saturated. When the resident put her call light on, staff came into her room, shut off the light, then didn't come back. The family member thought the resident may feel bad about asking for assistance because the resident knew staff busy or the resident put her call light on, waited a long time to get help, then wet herself.

On 4/2/19 at 3:15 p.m., Resident # 15 stated the facility was short on help and she had to wait for at least 30 minutes for staff assistance. Resident # 15 reported she had an accident waiting for assistance. Resident # 15 stated she had trouble controlling her urine, got constipated easily, and wore depends. Resident # 15 commented staff tell her to go in her brief when they couldn't get help to assist her. Resident # 15 reported she usually used the bedpan.

On 4/3/19 at 9:35 a.m., Staff U, Certified Nurse Aide (CNA), stated Resident # 15 last assisted with toileting right after breakfast. Staff U estimated Resident # 15 would need assist again around 11:00 a.m.

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On 4/3/19 at 11:00 a.m. Staff U reported she was assisting another resident and then she planned to assist Resident # 15 with toileting.

Observation on 4/3/19 at 11:05 a.m., revealed Resident # 15 in her room and the call light not on. Resident # 15 commented she had already told staff she needed to go to the bathroom. Resident # 15 did not know how long before the interview she requested to go to the bathroom, but stated staff turned off her call light when she told them and stated they would be back. Resident # 15 responded she did not know how long she had been waiting.

Observation on 4/3/19 at 11:10 a.m. revealed Staff U transported another resident in a wheelchair to the dining room. Staff J, CNA, ambulated at the nurses station. Staff U approached and asked Staff J if she had the hoyer (mechanical lift). Staff U went to Resident # 15 's room to prepare supplies, washed hands, and donned gloves. At 11:12 a.m., Staff J joined Staff U in the resident's room with the hoyer machine. Staff U connected the hoyer machine but the transfer needed stopped twice due to safety concerns with the slings. At 11:23 a.m. Staff J left the room to find a nurse for instruction as they had no other slings available for the transfer. At 11:26 a.m., Staff J reported Staff I, Registered Nurse (RN), looking for another hoyer sling and it would take awhile. Staff J and Staff U left the resident's room to help a different resident to transfer. At 11:34 a.m., Staff U and Staff J returned to Resident # 15's room with a new sling and transferred the resident to the bed. During the transfer, Staff U stated to the resident, you're leaking; the resident responded, yes. Staff U stated the resident did not use the bathroom toilet

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F 690	Continued From page 72 but sometimes needed the bed pan. Resident stated, I told you girls I needed to pee. Staff J asked, do you still need to go or did we wait too long? Resident # 15 responded, too long but would try to use the bed pan. Staff U obtained the bed pan and Staff J placed it under the resident in the bed. Both Staff U and Staff J confirmed the resident's incontinence brief wet with urine. Staff covered the resident with a blanket and sat the head of the bed up a little. Resident # 15 reported she wasn't doing anything and would need to wait till after lunch. Staff removed the bed pan and placed a new incontinence brief on the resident. The clinical record lacked documentation of bladder and bowel assessments. In an interview on 4/4/19 at 11:35 a.m., the Nurse Consultant confirmed Resident # 15 's clinical record lacked a comprehensive bladder and bowel assessment.	F 690		
F 695 SS=D	Respiratory/Tracheostomy Care and Suctioning CFR(s): 483.25(i) § 483.25(i) Respiratory care, including tracheostomy care and tracheal suctioning. The facility must ensure that a resident who needs respiratory care, including tracheostomy care and tracheal suctioning, is provided such care, consistent with professional standards of practice, the comprehensive person-centered care plan, the residents' goals and preferences, and 483.65 of this subpart. This REQUIREMENT is not met as evidenced by: Based on clinical record review, observation, and staff interview, the facility failed to assess a	F 695		

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F 695	Continued From page 73 resident's oxygen levels to determine if oxygen needed to be applied for 1 of 1 residents reviewed for respiratory care (Resident #38). The facility reported a census of 37 residents. Findings include: The Minimum Data Set (MDS) assessment dated 3/6/19 for Resident #38 identified a Brief Interview for Mental Status (BIMS) score of 15 without; a score of 15 indicated intact memory and cognition. The resident required the assistance of 2 persons for bed mobility, dressing, and personal hygiene. The MDS documented diagnoses that included heart failure, diabetes mellitus, and chronic kidney disease stage 3 (moderate). The MDS identified the resident received oxygen treatment while a resident at the facility. The care plan focus area revised 7/5/16 identified a risk for fluid volume overload related to diagnosis of CHF (Congestive Heart Failure). The revision dated 11/27/17 directed staff to observe for edema, shortness of breath, and increased weight notifying the physician as needed. The care plan lacked documentation pertaining to the use of oxygen. The physician fax dated 1/28/19 documented the resident's family were concerned the resident had decreased O2 (oxygen) levels during the day. The fax recorded the resident's O2 sat (measurement or oxygen in the blood) at 93% but the resident tired easily and complained of being very tired frequently. The physician wrote an order for oxygen to keep O2 sats greater than 90%.	F 695		

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F 695	Continued From page 74 The Progress Notes dated 1/31/19 at 4:38 a.m. documented the resident had increased pain in both legs over the past couple days, as needed pain medication given with relief, episodes of incontinence which were new for the resident, more shaky than usual with increased confusion, and trouble maintaining conversations with staff. The entry recorded the resident kept his bi-pap (a non-invasive form of therapy for patients suffering from sleep apnea) on for 6 hours then just wanted to wear oxygen per nasal cannula with oxygen sats ranging from 99% with bi-pap to 97% with 2 to 3 liters of oxygen. The entry documented the resident had a doctors appointment to evaluate those issues later in the day. The Physician Visit dated 1/31/19 documented the resident's O2 (oxygen) levels dropped with sleep and ordered the use of oxygen at 2 L/M (liters per minute) and to give the physician an update the next week. The Progress Notes dated 2/1/19 at 5:34 a.m. documented the resident wore his Bi-Pap machine for 7 hours then switched to the nasal cannula oxygen around 5:00 a.m. The Progress Notes dated 2/2/19 thru 4/3/19 lacked documentation of assessments of the resident's respiratory status or oxygen saturation levels (also known as pulse ox reading). The Medication Administration Records (MARs) and Treatment Administration Records (TARs) for January, February, March, and April 2019 all lacked documentation of an assessment to measure an O2 sat reading on any day to determine if the resident required the use of	F 695		

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F 695	Continued From page 75 oxygen. The MARs/TARs all indicated no oxygen used PRN (as needed), only 2 times a day while napping. Observation on 4/2/19 at 8:46 a.m. revealed Resident # 38 easily nodded back off to sleep during the meal service several times and dropping his coffee cup and phone during use. At 9:26 a.m. Resident # 38 slowly self propelled his wheelchair out of the dining room and nodded off to sleep frequently between movements. Observation on 4/3/19 at 7:50 a.m. revealed Resident # 38 sat in recliner in room, eyes closed, and rested soundly with deep breaths. The oxygen concentrator was on in his room, but the resident did not wear a nasal cannula to deliver oxygen. The oxygen level had been set at 3.25 liters and the nasal cannula tubing laid in the open bedside table drawer; Resident # 38 did not rouse to call of his name. Observation on 4/3/19 at 7:58 a.m. revealed Staff J, Certified Nurse Aide (CNA), and Staff U, CNA, entered Resident # 38's room to assist with morning cares. Staff U rubbed Resident # 38's arm to arouse the resident, and Resident # 38 responded with grogginess then rubbed his eyes. Staff did not turn off the oxygen concentrator or apply the oxygen. Resident # 38 fell back to sleep easily and repeatedly thru cares nodding off. On 4/4/19 at 11:00 a.m., Staff I, Registered Nurse (RN), stated she clarified Resident # 38 's oxygen order. Staff I stated the nurses now needed to check pulse ox saturation levels every shift to apply oxygen to keep O2 sats above 90% if needed. Staff I confirmed if the TAR left blank	F 695		

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F 695	Continued From page 76 then it indicated the treatment not completed as ordered. On 4/4/19 at 8:24 a.m., the Nurse Consultant stated if the doctor wrote an order for specific pulse ox value she would expect the nursing staff to be assessing pulse ox readings to determine if the resident needed the oxygen applied.	F 695		
F 698 SS=D	Dialysis CFR(s): 483.25(l) §483.25(l) Dialysis. The facility must ensure that residents who require dialysis receive such services, consistent with professional standards of practice, the comprehensive person-centered care plan, and the residents' goals and preferences. This REQUIREMENT is not met as evidenced by: Based on clinical record review, observation, resident interview, and staff interview, the facility failed to consistently complete full nursing assessments and monitoring of residents before and after going to outpatient dialysis treatments for 2 of 2 residents reviewed on dialysis (Residents #23 and #34). The facility reported a census of 37 residents. Findings include: 1. The Minimum Data Set (MDS) assessment dated 2/13/19 for Resident #23 identified a Brief Interview for Mental Status (BIMS) score of 15, indicating intact memory and cognition. The MDS documented diagnoses that included diabetes and chronic kidney disease stage 4 (severe). The resident received dialysis treatments while at the facility.	F 698		

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The care plan focus area revised 2/4/16 identified the resident needed hemodialysis (the process of running the blood through an external machine to rid the blood of toxins) related to end stage kidney disease. The care plan directed staff to:
a. check and change dressing after dialysis at access site; document
b. obtain vital signs and weight per protocol; report significant changes in pulse, respirations and BP immediately

Review of the 2019 calendar revealed the resident should have gone to dialysis on the following Monday/Wednesday/Fridays in the month of March and April: 3/4, 3/6, 3/8, 3/11, 3/13, 3/15, 3/18, 3/20, 3/22, 3/25, 3/27, 3/29, and 4/1.

Review of her clinical record revealed no full, pre, and post assessments documented on the above dates.

The Progress Notes dated 3/15/19 at 1:17 p.m. documented while the at dialysis, the resident's access site infiltrated and she had to stop dialysis. The dialysis center called the facility to give orders and report the a high potassium level for the resident. The note recorded facility staff would monitor the resident closely upon return from dialysis. The Progress Notes lacked documentation of the resident's return from dialysis on 3/15/19 or a correlating post-assessment.

The Progress Notes dated 3/28/19 at 12:37 p.m. documented the resident returned from the hospital after surgical placement of a new fistula (abnormal connection between an artery and a

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vein surgically created for dialysis).

The Progress Notes dated 3/29/19 at 11:36 a.m. documented the dialysis center nurse called and stated the resident's fistula infiltrated twice. The dialysis center nurse reported the resident's potassium level high and ordered the resident not to have high potassium level foods over the weekend. The dialysis center nurse further informed the resident ordered to have medications on Saturday and Sunday used to lower potassium levels (Valtesa and Kayexalate). The Progress Notes lacked documentation of the resident's return from dialysis on 3/29/19 or a correlating post-assessment.

On 4/1/19 at 2:24 p.m. observation revealed Resident # 23 out of building at dialysis.

On 4/2/19 at 9:50 a.m., Resident # 23 stated she went to dialysis treatments on Monday, Wednesday, and Friday. Resident # 23 stated sometimes staff asked her how it was going before or after treatment.

On 4/2/19 at 5:25 p.m., Staff B, Licensed Practical Nurse (LPN), stated that all documentation pertaining to assessments before and after dialysis by facility staff would be in the electronic clinical record. Staff B stated the dialysis center sent back paper assessment documentation the dialysis center completed and facility staff filed those papers into the hard chart (paper clinical record). Staff B reported the nurses completed assessments of the fistula sites and documented those assessments on the MAR/TAR (Medication Administration Record/Treatment Administration Record). When asked if pre- and post- dialysis assessments

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were completed by the nurses, Staff B referred only to the checks of the fistulas.

On 4/2/19 at 5:55 p.m., the Nurse Consultant stated the nurses should be documenting pre-and post- dialysis assessments in the electronic clinical record under Progress Notes. The Nurse Consultant stated the nurses documented checks of the fistulas on the MARS but all other assessments should be documented in Progress Notes. The Nurse Consultant acknowledged she would have expected staff to do increased nursing assessments of a new fistula site for Resident # 23 as well as documented monitoring of the resident's intake of potassium related to the dialysis center's communication 3/29/19.

2. The MDS assessment dated 3/22/19, documented Resident #34 had diagnoses of hypertension (high blood pressure) and diabetes mellitus. The assessment documented Resident #34 required dialysis.

The care plan updated on 2/1/19 revealed Resident #34 had end stage renal disease, chronic kidney disease, a fistula in her left arm, and required renal (kidney) dialysis. The care plan revealed the resident had dialysis on Tuesdays, Thursdays, and Saturdays. The staff directives included no blood pressure in the left arm, observe for pain at the fistula site, vital signs as ordered, weigh the resident monthly, and labs as ordered.

The Order Summary report dated 4/3/19 recorded Resident #34 had an AV (arteriovenous) fistula (to allow access for hemodialysis) three times a week on Mondays, Wednesdays, and Fridays. The order included monitoring for bruit

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F 698	Continued From page 80 and thrill, redness, swelling, pain or bleeding from the fistula site each shift. Review of the resident's clinical record revealed she received dialysis on Mondays, Wednesdays and Fridays and her clinical record lacked documentation of pre or post dialysis assessments. During an interview 4/01/19 at 1:27 PM, Resident #34 reported she had dialysis treatments every Monday, Wednesday, and Friday.	F 698		
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.	F 725		

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F 725	Continued From page 81 §483.35(a)(2) Except when waived under 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 clinical record review, observation, and resident, family and staff interviews, the facility failed to provide sufficient staff to assure prompt answering of the call light for 6 of 17 residents reviewed (Residents #27, #25, #29, #15, #33 and #5) and for 4 of 5 residents who attended the group interview. The facility reported a census of 37 residents. Findings include: 1. According to the Minimum Data Set (MDS) assessment, dated 2/27/19, Resident #27 scored 15 on the Brief Interview for Mental Status (BIMS) indicating no cognitive impairment. The resident's diagnoses included diabetes. During an interview on 4/1/19 at 4:20 p.m. the Resident #27 stated she wet on the floor and put her call light on. No one came so she cleaned it up herself. She said it took an hour or two before someone asked if she needed something and she said she took care of it herself. 2. During an observation on 4/2/19 at 6:23 a.m. Resident #25's call light on for 20 min per the call light alert system. 3. During an observation on 4/3/19 at 7:15 a.m. Resident #29's call light on for 17 minutes per the call light alert system. 4. During a confidential group interview on 4/2/19	F 725		

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at 3:15 p.m. 4 of 5 residents present stated the facility had long call light response times. One resident stated putting the call light on for her spouse and waiting 1-1/2 hours for help. The resident said at times the staff said they would be back in a minute and turn the light off and the resident turned it right back on or they did not return for 1/2 hour. Another resident stated when he the call light on for his spouse who needed to use an inhaler, he usually went and got it because it took them too long.

During an interview on 4/3/19 at 9:34 a.m. the Administrator stated they had no way to look back at call light response times.

The facility's Call Lights Policy and Procedure effective 11/28/16 documented the policy would be to assure each resident had ready access to obtain needed assistance. The call light communication system would be a direct link to a centralized staff location. The procedure included the call lights would be answered in a timely fashion.
5. The MDS assessment dated 12/12/18 recorded Resident #16 had a BIMS score of 15, indicating intact memory and cognition. The MDS indicated Resident #16 had diagnoses of cerebrovascular accident (stroke) and dysphagia.

Review of transfer forms located in Resident #16's chart revealed the resident sent to the Emergency Department for a plugged G-tube (gastrostomy tube in the stomach used for feeding) on 7/4/18, 12/22/18, and 2/22/19.

During an interview 4/1/19 at 2:32 PM, Resident # 16 reported it took an hour before staff responded and assisted her to the bathroom or flush her

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PEG (gastric) tube after an enteral feeding had completed. The resident reported she had a stroke and had required assistance with activities of daily living and with her feedings. The resident reported she had transferred to the Emergency Department a few times due to her PEG tube being clogged and she thought this was caused from staff not flushing her PEG tube in a timely manner. The resident reported she looked at her television to know the amount of time it took before staff responded.

During an interview 4/3/19 at 9:39 AM, Staff W, Licensed Practical Nurse (LPN) reported Resident #16's PEG tube had clogged when staff hadn't gotten back and flushed the PEG tube ports timely. The resident had gone to the Emergency Department after the tube had clogged.

6. The MDS assessment dated 3/1/19 for Resident # 33 identified a BIMS score of 15 without signs/symptoms of delirium. A score of 15 indicated intact cognition.

In an interview on 4/1/19 at 1:13 p.m., Resident #33 stated there was not enough help to get assistance promptly. Resident #33 reported the previous night she took her pills at 11:30 p.m. and another recent night she received her bedtime medications at midnight. Resident #33 stated she was supposed to get medications around 8 p.m. or bedtime.

7. In a family member interview on 4/1/19 at 12:50 p.m., Resident #5 's wife reported sometimes it took 1.5 hours to get the call light answered, depending on who worked. Resident #5 's wife stated staff would shut the call light off,

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F 725	Continued From page 84 say they'd be back in a minute, left, then did not come back. Resident #5's wife stated 2 aides (Certified Nurse Aides) to put 30 people to bed was just not enough help to get people into bed timely.	F 725		
F 727 SS=D	RN 8 Hrs/7 days/Wk, Full Time DON CFR(s): 483.35(b)(1)-(3) §483.35(b) Registered nurse §483.35(b)(1) Except when waived under paragraph (e) or (f) of this section, the facility must use the services of a registered nurse for at least 8 consecutive hours a day, 7 days a week. §483.35(b)(2) Except when waived under paragraph (e) or (f) of this section, the facility must designate a registered nurse to serve as the director of nursing on a full time basis. §483.35(b)(3) The director of nursing may serve as a charge nurse only when the facility has an average daily occupancy of 60 or fewer residents. This REQUIREMENT is not met as evidenced by: Based on facility schedule reviews and staff interview, the facility failed to assure a registered nurse (RN) on duty 8 hours daily 7 days per week. The facility identified a census of 37. Findings include: 1, Review of the facility's nursing staff schedule dated 3/1 through 4/4/19 revealed no RN on duty on Saturday 3/9, Saturday 3/23, Sunday 3/24 and Saturday 3/30/19. During interview on 4/3/19 at 11:20 AM the Administrator stated if there were days on the	F 727		

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F 727	Continued From page 85 schedule where no RN was assigned he would assume the RN Director of Nursing (DON) or RN MDS Coordinator were here. Review of the scheduled revealed neither the DON or the MDS Coordinator were assigned to work on the above-listed dates.	F 727		
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 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	F 729		

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F 729	Continued From page 86 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 personnel file reviews and interview, the facility failed to obtain registry verification of certified nursing assistants (CNA's) prior to hire for 3 of 4 currently employed CNA's. The facility identified a census of 37. Findings include: 1. The personnel file for Staff K, CNA, documented a hire date of 9/8/15. The file failed to contain a direct care worker (DCW) registry check prior to hire to assure the prospective employee meets the competency evaluation requirements. 2. The personnel file for Staff L, CNA, documented a hire date of 7/7/17. The file failed to contain a DCW registry check prior to hire to assure the prospective employee meets the competency evaluation requirements. 3. The personnel file for Staff M, CNA, documented a hire date of 3/8/19. The file failed to contain a DCW registry check prior to hire to assure the prospective employee meets the competency evaluation requirements. During interview on 4/5/19 at 10:10 AM the Administrator stated he is unable to say why personnel files were not complete because he did not start as Administrator until mid-March of this year. He stated the facility has initiated obtaining	F 729		

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all missing forms identified.

F 730 SS=D

Nurse Aide Peform Review-12 hr/yr In-Service
CFR(s): 483.35(d)(7)

§483.35(d)(7) Regular in-service education.
The facility must complete a performance review of every nurse aide at least once every 12 months, and must provide regular in-service education based on the outcome of these reviews. In-service training must comply with the requirements of §483.95(g).
This REQUIREMENT is not met as evidenced by:
Based on personnel file reviews and staff interview, the facility failed to assure all certified nursing assistants (CNA's) receive 12 hours of inservice education yearly for 2 of 2 sampled CNA's employed greater than 1 year (Staff K and L). Additionally the facility failed to complete an annual performance evaluation for 1 of 2 CNA's employed greater than 1 year (Staff L). The facility identified a census of 37.

Findings include:

1. The personnel file for Staff K, CNA, documented a hire date of 9/8/15. Review of the facility's inservice records from 4/1/18-4/1/19 revealed Staff K attended 1-hour inservice training sessions on 4/24/18, 8/22/18 and 12/7/18.

2. The personnel file for Staff L, CNA, documented a hire date of 7/7/17. Review of the facility's inservice records from 4/1/18-4/1/19 revealed Staff K attended 1-hour inservice training sessions on 4/30/18 and 8/22/18.

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F 730	Continued From page 88 Staff L's personnel file contained a performance evaluation signed by the employee and her supervisor on 10/5/18 but had none of the 11 areas to evaluated completed. The form only contained the notation to increase Staff L's hourly wage by 2%. During interview on 4/5/19 at 10:10 AM the Administrator stated he is unable to say why personnel files were not complete because he did not start as Administrator until mid-March of this year. He stated the facility has initiated obtaining all missing forms identified.	F 730		
F 732 SS=C	Posted Nurse Staffing Information CFR(s): 483.35(g)(1)-(4) §483.35(g) Nurse Staffing Information. §483.35(g)(1) Data requirements. The facility must post the following information on a daily basis: (i) Facility name. (ii) The current date. (iii) The total number and the actual hours worked by the following categories of licensed and unlicensed nursing staff directly responsible for resident care per shift: (A) Registered nurses. (B) Licensed practical nurses or licensed vocational nurses (as defined under State law). (C) Certified nurse aides. (iv) Resident census. §483.35(g)(2) Posting requirements. (i) The facility must post the nurse staffing data specified in paragraph (g)(1) of this section on a daily basis at the beginning of each shift. (ii) Data must be posted as follows: (A) Clear and readable format.	F 732		

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(B) In a prominent place readily accessible to residents and visitors.

§483.35(g)(3) Public access to posted nurse staffing data. The facility must, upon oral or written request, make nurse staffing data available to the public for review at a cost not to exceed the community standard.

§483.35(g)(4) Facility data retention requirements. The facility must maintain the posted daily nurse staffing data for a minimum of 18 months, or as required by State law, whichever is greater.
This REQUIREMENT is not met as evidenced by:
Based on observation and staff interview, the facility failed to post nurse staffing data in a prominent location visible to residents and visitors. The facility reported a census of 37 residents.

Findings include:

Observation on 4/1/19 at 2:10 p.m. revealed no daily staff posting could be found posted at the front entrance or on halls 100, 200 and 300 and no signs available to instruct where to find the posting.

Observation on 4/2/19 at 8:00 a.m. revealed no visible daily staff posting found posted anywhere throughout the building.

Observation on 4/2/19 at 1:00 p.m. revealed no visible daily staff posting found posted anywhere throughout the building. The front nurses station had a paper turned upside down behind the nurses station that contained the daily staff

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F 732	Continued From page 90 posting. The paper was not readily visible to residents or visitors. Observation on 4/3/19 at 10:14 a.m. revealed no visible daily staff posting found throughout the building. The Administrator stated they kept the posting at the nurses station, hung behind the desk. Observation revealed the posting visible only to nurses who sat at the desk and not to residents, visitors, or the general public.	F 732		
F 758 SS=D	Free from Unnec Psychotropic Meds/PRN Use CFR(s): 483.45(c)(3)(e)(1)-(5) §483.45(e) Psychotropic Drugs. §483.45(c)(3) A psychotropic drug is any drug that affects brain activities associated with mental processes and behavior. These drugs include, but are not limited to, drugs in the following categories: (i) Anti-psychotic; (ii) Anti-depressant; (iii) Anti-anxiety; and (iv) Hypnotic Based on a comprehensive assessment of a resident, the facility must ensure that--- §483.45(e)(1) Residents who have not used psychotropic drugs are not given these drugs unless the medication is necessary to treat a specific condition as diagnosed and documented in the clinical record; §483.45(e)(2) Residents who use psychotropic drugs receive gradual dose reductions, and behavioral interventions, unless clinically contraindicated, in an effort to discontinue these drugs;	F 758		

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§483.45(e)(3) Residents do not receive psychotropic drugs pursuant to a PRN order unless that medication is necessary to treat a diagnosed specific condition that is documented in the clinical record; and

§483.45(e)(4) PRN orders for psychotropic drugs are limited to 14 days. Except as provided in §483.45(e)(5), if the attending physician or prescribing practitioner believes that it is appropriate for the PRN order to be extended beyond 14 days, he or she should document their rationale in the resident's medical record and indicate the duration for the PRN order.

§483.45(e)(5) PRN orders for anti-psychotic drugs are limited to 14 days and cannot be renewed unless the attending physician or prescribing practitioner evaluates the resident for the appropriateness of that medication.
This REQUIREMENT is not met as evidenced by:
Based on clinical record review, observation, and staff interview, the facility failed to document a rationale for not reducing the dose of an antianxiety or antidepressant medication and failed to correctly implement an antianxiety medication order for 1 of 5 residents reviewed for unnecessary medications (Resident #38). The facility reported a census of 37 residents.

Findings include:

The Minimum Data Set (MDS) assessment dated 3/6/19 for Resident # 38 documented diagnoses that included heart failure, diabetes mellitus, chronic kidney disease stage 3 (moderate), anxiety disorder, and depression. The MDS

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recorded the resident received antianxiety and antidepressant medications during 7 of 7 days of the assessment reference period.

The care plan focus area revised 1/3/17 identified Resident #38 used antidepressant medication related to depression. The focus area revised 1/20/17 recorded he used antianxiety medications related to an anxiety disorder. The care plan directed staff to observe for side effects that included drowsiness, lack of energy, clumsiness, and slow reflexes. The care plan informed the pharmacy to review medications routinely with recommendations as indicated and quarterly and as needed GDRs (Gradual Dose Reductions) as per facility policy.

The Order Summary Report signed by the physician 8/13/18 documented an active order for:
a. Ativan 0.5 mg (milligram) tab, give 0.25 mg by mouth at bedtime for anxiety between the hours of 6:00 p.m. to 9:00 p.m. The order originally started 5/8/17.
b. Cymbalta delayed release (DR) particles 60 mg capsule, give 1 capsule by mouth 1 time a day related to major depressive disorder. The order originally started 1/1/17.

The Progress Notes dated 9/21/18 at 2:29 p.m. documented the nurse spoke to clinic staff to see if the order for scheduled Ativan (antianxiety medication, or lorazepam) at 3:00 p.m. and she awaited a return call.

The physician phone order dated 9/24/18 at 2:34 p.m. documented an order for lorazepam 0.5 mg tablet, give 1 tablet by mouth 1 time a day.

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F 758	Continued From page 93 The September 2018 Medication Administration Record (MAR) reflected the new Ativan order scheduled and given daily at midnight rather than the regularly requested time of 3:00 p.m. The clinical record lacked documentation of signs/symptoms of anxiety displayed at 3:00 p.m. or midnight to indicate the use of an antianxiety medication. The Progress Notes dated 10/5/18 at 11:50 a.m. documented a fax received from the doctor related to if the resident needed a dose reduction on Cymbalta (antidepressant medication) and Ativan; the physician replied no. The pharmacy recommendation dated 9/20/18, signed by the physician 10/5/19, documented the resident took Cymbalta 60 mg every day for depression and Ativan 0.25 mg at HS (bedtime) and 0.5 mg every day. The recommendation documented no dosage reduction warranted at that time and it did not document a reason or rationale why. Review of the January, February, March, and April 2019 MARs revealed the resident continued to receive the Ativan daily as scheduled at midnight. Observation on 4/1/19 at 1:53 p.m. revealed Resident # 38 laid in bed sleeping soundly and did not rouse to the call of his name. Observation on 4/2/19 at 8:46 a.m. revealed Resident # 38 easily nodded back off to sleep during the meal service several times dropping his coffee cup and phone during use. At 9:26 a.m. Resident # 38 slowly self propelled his	F 758		

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wheelchair out of the dining room and nodded off to sleep frequently between movements.

The Medication Administration Audit Report printed 4/3/19 revealed the resident received his scheduled midnight dose of Ativan 0.5 mg on 4/2/19 at 5:15 a.m. The report recorded the resident received his scheduled lorazepam 0.25 mg dose to be given between hours of 6:00 to 9:00 p.m. daily outside of the ordered parameters on the following dates: 3/23/19 at 11:20 p.m., 3/25/19 at 9:49 p.m., 3/29/19 at 1:22 a.m., 4/1/19 at 9:57 p.m., and 4/2/19 at 9:54 p.m.

Observation on 4/3/19 at 7:50 a.m. revealed Resident # 38 sat in the recliner in his room, eyes closed, and resting soundly with deep breaths. Resident # 38 did not rouse to call of his name.

Observation on 4/3/19 at 7:58 a.m. revealed Staff J, Certified Nurse Aide (CNA), and Staff U, CNA, entered Resident # 38's room to assist with morning cares. Resident # 38 fell back to sleep easily and repeatedly through the cares, nodding off.

The physician phone order dated 4/3/19 at 3:14 p.m. documented the lorazepam 0.5 mg table, give 1 tablet by mouth 1 time a day for anxiety discontinued.

On 4/3/19 at 3:30 p.m., the Nurse Consultant stated the clinical record should reflect why the resident needed the antianxiety medications. The Nurse Consultant reported she had nursing staff contact the doctor to see if the scheduled midnight Ativan dose was needed and the doctor discontinued the medication.

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F 758	Continued From page 95 On 4/4/19 at 11:35 a.m., the Nurse Consultant confirmed the GDR form for Ativan and Cymbalta would need a rationale for not following the pharmacist recommendation to reduce dosage.	F 758		
F 761 SS=D	Label/Store Drugs and Biologicals CFR(s): 483.45(g)(h)(1)(2) §483.45(g) Labeling of Drugs and Biologicals Drugs and biologicals used in the facility must be labeled in accordance with currently accepted professional principles, and include the appropriate accessory and cautionary instructions, and the expiration date when applicable. §483.45(h) Storage of Drugs and Biologicals §483.45(h)(1) In accordance with State and Federal laws, the facility must store all drugs and biologicals in locked compartments under proper temperature controls, and permit only authorized personnel to have access to the keys. §483.45(h)(2) The facility must provide separately locked, permanently affixed compartments for storage of controlled drugs listed in Schedule II of the Comprehensive Drug Abuse Prevention and Control Act of 1976 and other drugs subject to abuse, except when the facility uses single unit package drug distribution systems in which the quantity stored is minimal and a missing dose can be readily detected. This REQUIREMENT is not met as evidenced by: Based on observations, staff interviews, and facility policy review, facility staff failed to store drugs in accordance with currently accepted professional principles. The facility reported a	F 761		

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F 761	Continued From page 96 census of 37 residents. Findings include: 1. Observation on 4/3/19 at 9:35 a.m. revealed a locked toolbox in the locked medication room. Staff I, RN (Registered Nurse) asked the other nurses about the count sheet for the medications contained in the toolbox. Staff P, RN, Staff Q, RN and Staff W, LPN (Licensed Practical Nurse) replied they had not seen the count sheet nor counted the medications in the toolbox. An observation on 4/3/19 at 9:38 a.m revealed a card of lorazepam (antianxiety) 0.5 mg which contained 28 tablets and a card of Tramadol (pain med) 50 mg that contained 12 tablets. An interview on 4/3/19 at 9:40 a.m. with Staff I revealed the expectation of staff to count the medication at the start of their shift. The facility's undated Controlled Substance Policy instructed: Point #9 - Nursing staff must count controlled drugs at the end of each shift. Part of this count would include reviewing the packaging of the medication to assure that it remains sealed without proper documentation to indicate that a medication had been removed and pharmacy is aware. The nurse coming on duty and the nurse going off duty must make the count together. Any discrepancies must be investigated and reported immediately to the Director of Nursing.	F 761		
F 812 SS=E	Food Procurement,Store/Prepare/Serve-Sanitary CFR(s): 483.60(i)(1)(2)	F 812		

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§483.60(i) Food safety requirements.
The facility must -

§483.60(i)(1) - Procure food from sources approved or considered satisfactory by federal, state or local authorities.
(i) This may include food items obtained directly from local producers, subject to applicable State and local laws or regulations.
(ii) This provision does not prohibit or prevent facilities from using produce grown in facility gardens, subject to compliance with applicable safe growing and food-handling practices.
(iii) This provision does not preclude residents from consuming foods not procured by the facility.

§483.60(i)(2) - Store, prepare, distribute and serve food in accordance with professional standards for food service safety.
This REQUIREMENT is not met as evidenced by:
Based on observation and staff interview, the facility failed to have sanitizable cutting boards and failed to ensured staff sanitized their hands after contamination in order to prevent food borne illness. The facility reported a census of 37 residents.

Findings include:

1. During observation on 4-1-19 at 10:20 am with the Certified Dietary Manager (CDM) , 7 cutting boards, which measured approximately 18 inches x 12 inches, showed visible deep grooves, discoloration and a fuzzy surface on all boards. One cutting board, measuring approximately 24 inches x 18 inches, contained visible deep grooves, discoloration and a fuzzy surface.

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F 812	Continued From page 98 On 4-2-19 at 10:25 am, the CDM acknowledged the grooves and fuzz and overall condition of all cuttings boards as not being sanitizable. The CDM stated that new ones would be obtained today. No facility policy was provided. 2. During observation of the lunch meal service on 4/2/19 at 12:05 PM, Staff T, Dietary Volunteer, lifted the lid of a garbage can in the Staging Kitchen and threw away a slice of wheat bread a resident didn't want. Staff T then touched other surfaces including the menu cards and resident plates of food with her soiled hand. During an interview 4/03/19 at 10:00 AM, the CDM reported she had no policy for handwashing or gloving in the kitchen. The CDM reported she expected staff washed their hands after contaminated and before touching clean surfaces or food. The CDM reported she provided verbal training for volunteer staff on what to do or not do when they provided assistance serving plates of food, and when hand sanitization would be required.	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.	F 839		

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F 839	Continued From page 99 This REQUIREMENT is not met as evidenced by: Based on personnel file reviews, facility policy review and staff interview, the facility failed to verify nursing licensure prior to hire for 1 of 2 current nurses reviewed (Staff B). The facility identified a census of 37. Findings include: 1. The personnel file for Staff B, licensed practical nurse (LPN), documented a hire date of 4/12/17 and contained no verification of her license until 5/2/17. The facility's Abuse Prevention, Identification, Investigation and Reporting Policy effective 6/21/17 directs the following: Employee Screening: 3. For those 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 finding of abuse, neglect, exploitation, or mistreatment of residents or misappropriation of resident property, During interview on 4/5/19 at 10:10 AM the Administrator stated he could not say why personnel files were not complete because he did not start as Administrator until mid-March of this year. He stated the facility had initated obtaining all missing forms identified.	F 839		
F 880 SS=D	Infection Prevention & Control CFR(s): 483.80(a)(1)(2)(4)(e)(f)	F 880		

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§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, 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:

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(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 corrective actions taken by the facility.

§483.80(e) Linens.
Personnel must handle, store, process, and transport linens so as to prevent the spread of infection.

§483.80(f) Annual review.
The facility will conduct an annual review of its IPCP and update their program, as necessary.
This REQUIREMENT is not met as evidenced by:
Based on clinical record review, observation, and staff interview, the facility failed to assure staff utilized infection control procedures for 2 of 17 residents reviewed (Residents #14 and #31). The facility reported a census of 37 residents.

The findings include:

1. The Minimum Data Set (MDS) assessment dated 1/13/19 showed Resident #14 had a Brief Interview of Mental Status (BIMS) score of 13,

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indicating intact memory and cognition. The resident had diagnoses of age-related physical debility and weakness and need for assistance with personal cares.

The resident's care plan initiated on 1/13/17 indicated Resident #14 with occasional bladder incontinence with a goal to be free from skin breakdown due to incontinence and brief use through the review date. Interventions documented that Resident #14 used large disposable briefs and staff needed to assist her with perineal care as she could not help with cares.

During an observation on 4/2/19 at 8:07 a.m., Staff M, Certified Nurse's Aide (CNA) and Staff O, CNA, assisted Resident #14 to the bathroom. Upon standing the resident, Staff M noted a wet area to the left side of the resident's pants. When Resident #14 and Staff M arrived at the toilet, Staff M noted the resident to be incontinent of stool and urine. Staff M helped Resident #14 sit on the toilet, then cleaned up the floor and then removed the resident's clothes without hand hygiene or changing gloves. Staff O placed dirty laundry into a plastic bag and then began to cleanse the resident's groin and bottom with wipes without completing hand hygiene or changing gloves. Staff O moved in and assisted the resident with putting on clean clothes. Staff O pulled walker over to the resident and had the resident stand up. Staff M then helped the resident with cleaning the buttock area while the resident stood. Staff O then assisted to pull up the resident's pants. Staff M removed her gloves and walked the resident to her wheelchair, while Staff O washed her hands. After helping the resident into the wheelchair, Staff M washed her

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F 880	Continued From page 103 hands, reapplied gloves and then assisted the resident in changing her top. 2. The MDS assessment dated 3/14/19 showed Resident #31 scored 15 on the BIMS test, indicating intact memory and cognition. The resident diagnoses that included Type 2 Diabetes Mellitus without complications and need for assistance with personal cares. During an observation on 4/3/19 at 8:40 a.m. Staff R, Registered Nurse (RN), reported Resident #31's blood sugar measured 191, and per the Medication Administration Record, the resident is to receive three units of Novolog Insulin 100 units/ml. Before setting up the medication Staff R completed hand hygiene with hand sanitizer, then applied gloves to her hands. Staff R then cleaned the vial top with alcohol, rechecked the order, prepared the syringe, inserted three units of air into the vial and drew up 3 units of Novolog insulin. Staff R locked the medication cart, locked the computer screen and left the medication cart. Staff R then pulled up the bottom of the syringe to cover the needle. With the same pair of gloves on, she knocked on the resident's door and asked to enter. She instructed the resident she planned to give him insulin and then received his approval. Staff R, without any hand hygiene or a change of gloves, then cleansed the skin on the back of the resident's right upper arm and injected the insulin. Staff R exited the room, placed the used syringe into the sharps container and then removed her gloves. Afterwards she went to the medication room, but still did not complete hand hygiene. During an interview on 4/4/19 at 8:20 a.m. with the Nurse Consultant, Registered Nurse (RN),	F 880		

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F 880	Continued From page 104 she stated the expectation for staff to wash their hands and change their gloves after cleaning stool off the floor. She would expect staff to clean their hands after completing cares of a dirty area before moving on to a clean area. She also indicated that she would expect staff to do hand hygiene after preparing the insulin and administering the insulin. The facility's Handwashing/Hand Hygiene Policy and Procedure with an effective date of 11/28/16 instructed that all personnel shall follow the handwashing/hand hygiene procedures to help prevent the spread of infections to other personnel, residents, and visitors. An alcohol-based hand rub may be used in lieu of soap, unless hands are visibly soiled. Hand Hygiene should be the final step after removing and disposing of personal protective equipment. The use of gloves does not replace hand washing/hand hygiene.	F 880		
F 919 SS=D	Resident Call System CFR(s): 483.90(g)(2) §483.90(g) Resident Call System The facility must be adequately equipped to allow residents to call for staff assistance through a communication system which relays the call directly to a staff member or to a centralized staff work area. §483.90(g)(2) Toilet and bathing facilities. This REQUIREMENT is not met as evidenced by: Based on observation and staff interview, the facility failed to assure all accessible toilet facilities were adequately equipped to allow residents to call for staff assistance. The facility	F 919		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	165540	A. BUILDING ______ B. WING ______	04/12/2019

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 919	Continued From page 105 reported a census of 37 residents. Findings include: During an observation on 4/1/19 at 1:25 p.m. the men's and women's bathrooms between the 100 and 200 halls by the nurse's station were unlocked. Neither bathroom had a call light. During an interview on 4/1/19 at 1:48 p.m. the Administrator confirmed the bathrooms were open for use with no call light and that residents could use them.	F 919		

DEPARTMENT OF INSPECTIONS AND APPEALS

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	IA1075	A. BUILDING: ____ B. WING ____	04/12/2019

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) COMPLETE DATE
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 personnel file reviews and staff interview, the facility failed to assure all employee have a physical examination prior to hire for 1 of 2 employees sampled that were hired since the facility's last annual survey (Staff A). The facility identified a census of 37. Findings include: 1. The personnel file for Staff A, certified nursing assistant, documented a hire date of 9/23/18. The file did not contain documentation of a physical examination completed prior to hire. During interview on 4/5/19 at 10:10 AM the Administrator stated he could not say why personnel files were not complete because he did not start as Administrator until mid-March of this year. He stated the facility has initiated obtaining all missing forms identified.	L 190		
L 191	58.10(3)b 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: b. Employees shall have a physical examination at least every four years.	L 191		

DIVISION OF HEALTH FACILITIES - STATE OF IOWA

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	IA1075	A. BUILDING: ______ B. WING ______	04/12/2019

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

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L 191	Continued From page 1 This Statute is not met as evidenced by: Based on personnel file reviews and staff interview, the facility failed to assure all employees received a physical examination every 4 years for 2 of 2 employee sampled who have been employed more than 4 years (Staff K and N). The facility identified a census of 37. Findings include: 1. The personnel file for Staff K, certified nursing assistant (CNA) documented a rehire date of 9/18/15. The file contained one physical examination dated 5/31/11. During interview on 4/5/19 at 10:10 AM the Administrator stated he could not say why personnel files were not complete because he did not start as Administrator until mid-March of this year. He stated the facility has initiated obtaining all missing forms identified.	L 191		
L 435	58.20(13) Duties of health service supervisor 481-58.20(135C) Duties of health service supervisor. Every nursing facility shall have a health service supervisor who shall: 58.20(13) Evaluate in writing the performance of each individual on the health care staff on at least an annual basis. This evaluation shall be available for review in the facility to the department; (III) This Statute is not met as evidenced by: Based on personnel file reviews and interview, facility staff failed to complete a written	L 435		

DEPARTMENT OF INSPECTIONS AND APPEALS

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	IA1075	A. BUILDING: ___ B. WING ___	04/12/2019

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) COMPLETE DATE
L 435	Continued From page 2 performance evaluation for 2 of 2 licensed nurses employed greater than 1 year (Staff B and N) The facility identified a census of 37. Findings include: 1. The personnel file for Staff B, licensed practical nurse (LPN) documented a hire date of 4/12/17. The personnel file contained no yearly performance evaluations. 2. The personnel file for Staff N, LPN documented a hire date of 1/18/13. The file did not contain a yearly performance evaluation after one completed on 12/18/15. During interview on 4/5/19 at 10:10 AM, the Administrator stated he could not say why personnel files were not complete because he did not start as Administrator until mid-March of this year. He stated the facility has initiated obtaining all missing forms identified.	L 435		
L1093	58.12(1)l Admission, transfer, and discharge 58.12(135C) Admission, transfer, and discharge. 58.12(1) General admission policies. l. For all residents residing in a health care facility receiving reimbursement through the medical assistance program under Iowa Code chapter 249A on July 1, 2003, and all others subsequently admitted, the facility shall collect and report information regarding the resident's eligibility or potential eligibility for benefits through the Federal Department of Veterans Affairs as requested by the Iowa commission on Veterans Affairs. The facility shall collect and report the information on	L1093		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	IA1075	A. BUILDING: ______ B. WING ______	04/12/2019

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

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L1093	Continued From page 3	L1093		

forms and by the procedures prescribed by the Iowa commissions on veterans affairs. Where appropriate, the facility may also report such information to the Iowa department of human services. In the event that a resident is unable to assist the facility in obtaining the information, the facility shall seek the requested information from the resident's family members or responsible party.

For all new admissions, the facility shall collect and report the required information regarding the resident's eligibility or potential eligibility to the Iowa commission on veterans affairs within 30 days of the resident's admission. For residents residing in the facility as of July 1, 2003, and prior to May 5, 2004, the facility shall collect and report the required information regarding the resident' s eligibility or potential eligibility to the Iowa commission on veterans affairs within 90 days after May 5, 2004.

If a resident is eligible for benefits through the federal Department of Affairs or other third-party payor, the facility shall seek reimbursement from such benefits to the maximum extent available before seeking reimbursement from the medical assistance program established under Iowa Code chapter 249A.

The provisions of this paragraph shall not apply to the admission of an individual as a resident to a state mental health institute for acute psychiatric care or to the admission of an individual to the Iowa Veterans Home. (II,III)

This Statute is not met as evidenced by:
Based on clinical record review and staff interviews, the facility failed to check for Veteran's Benefits Eligibility for 2 out of 5 residents reviewed (Residents #8 and #41). The facility reported a census of 37.

DEPARTMENT OF INSPECTIONS AND APPEALS

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	IA1075	A. BUILDING: ______ B. WING ______	04/12/2019

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L1093	Continued From page 4	L1093		

Findings Include:

Review of records for the residents checked for eligibility for Veteran's Benefits revealed the following information:
a. Resident #8 admitted on 12-15-16 and had been a Veteran. He had not been reported to the Iowa Department of Veteran's Affairs (VA) as a resident residing in the facility and to check to see if he qualified for any benefits from the VA.
b. Resident #41 admitted on 10-10-18 and had been a Veteran in the Army. He had not been reported to the Iowa VA as a resident residing in the facility and to check to see if he qualified for any benefits from the VA.

During an interview on 4-2-19 at 3:45 PM the Minimum Data Set Coordinator (MDS) stated she is the one responsible at this time for the submission of the Veterans Eligibility. The MDS Coordinator stated she failed to submit 2 Veterans to VA to see if benefits were available.

On 4-3-19 at 9:43 a.m., the Administrator stated the facility did not have a formal policy in regards to VA Eligibility verification, it is just a practice.

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	IA1075	A. BUILDING: ______ B. WING ______	04/12/2019

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S 115	59.5(1) Baseline TB screening procedures 481-59.5(135B,135C) Baseline TB screening procedures for health care facilities and hospitals. 59.5(1) All HCWs shall receive baseline TB screening upon hire. Baseline TB screening consists of two components: (1) assessing for current symptoms of active TB disease and (2) using a two-step TST or a single IGRA to test for infection with M. tuberculosis. This REQUIREMENT is not met as evidenced by: Based on personnel record reviews, facility policy review and staff interview, the facility failed to assure all staff receive baseline tuberculosis screening upon hire as outlined in Iowa Administrative Code (IAC) 59. 5(1) for 4 of 6 current employee personnel files reviewed (Staff A, B, K and M). The facility identified a census of 37. Findings include: 1. The personnel file for Staff A, certified nursing assistant (CNA) documented a hire date of 9/23/18. The Employee TB (tuberculosis) Testing Record documented an initial Tuberculin Skin Testing (TST) administered on 9/19/18 with a negative result on 9/22/18. The form did not contain documentation of a second step TST. 2. The personnel file for Staff B, licensed practical nurse (LPN) documented a hire date of 4/12/17. The Skin Test Intradermal TB form documented an initial TST administered 1/17/17 with a	S 115		

DEPARTMENT OF INSPECTIONS AND APPEALS

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	IA1075	A. BUILDING: ____ B. WING ____	**04/12/2019**

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

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S 115	Continued From page 1	S 115		

negative result on 1/19/17. The form did not contain documentation of a second step TST.

3. The personnel file for Staff K, CNA documented a hire date of 9/8/15. The file contained documentation of a TST administered 1/6/12 with a negative result on 1/8/12, a TST administered 2/11/13 with a negative result on 2/14/13, and a TST administered 2/7/14 with a negative result on 2/9/14. The form failed to contain documentation of a testing upon hire 9/8/15.

4. The personnel file for Staff M, CNA, documented a hire date of 3/8/19 and contained no record of TB testing being done.

The facility Tuberculosis Screen for Employees policy dated November, 2018 directed the following for new employees:
Screening New Employees:
b. The employee may begin working with residents after a negative TST (i.e. first step) or a negative IGRA (a blood test, or Interferon Gamma Release Assay to find out if you have TB germs in your body). The second TST may be performed after the employee starts working with residents.

During interview on 4/5/19 at 10:10 AM the Administrator stated he could not say why personnel files were not complete because he did not start as Administrator until mid-March of this year. He stated the facility has initiated obtaining all missing forms identified.

Countryside Health Care Center Plan of Correction

Annual Survey Dates 3.26.19-4.12.19

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

F576 Right to Forms of Communication

The facility does ensure the Residents' rights to send and receive mail. Privacy of such communications is consistent w/ this section.

a. Resident # 27 received an apology and resolution for the error in opening mail without permission.
b. All Residents have the potential to be affected. Our Residents Rights Policy reflects this expectation. An audit tool was created.
c. Staff were educated regarding Residents' Right to Privacy in all communications via phone, mail, email, and Internet.
d. The Life Enrichment Director will audit compliance weekly x4, monthly x2 with results forwarded to the QA Committee for further review and recommendation.
e. Responsible Party: Life Enrichment Director
f. Compliance Date: 5.12.19

F582 Liability Notice

The facility will inform each Resident before, or at time of admission, and periodically during the Resident's stay, of services available in the facility and of charges for those services not covered under Medicare/Medicaid or by the facility's per diem rate.

a. For Residents #32, 244, 245 they were not denied services nor billed incorrectly for services received.
b. All Residents have the potential to be affected. An audit/log and a designated binder was created to track and file that all Residents, pending Medicare A discharge will receive the appropriate skilled discharge forms to include the reason for said discharge and options to appeal end of services.
c. The MDS nurse and Business Office Manager were educated on providing the appropriate notices of Medicare Coverage Discharge at the appropriate time frames.
d. An audit tool was created, and designated binder was established and will be audited by the LNHA/DON/ Designee weekly x4, monthly x4 with results forwarded to the QA Committee for further review and recommendations.
e. Responsible Party: LNHA/DON/Designee
f. Compliance Date: 5.12.19

F584 Safe/Clean/ Homelike Environment

The facility will provide a safe, clean, comfortable, and homelike environment, allowing Residents to use his or her personal belongings to the extent possible.

a. For Residents # 7 dentures have been replaced and/reimbursed at facility expense. Resident # 7 glasses were found. Resident # 42 declined reimbursement but asked that facility notify if item is located.
b. All Residents have the potential to be affected. The IMG Grievance Policy was reviewed to ensure that allows for Residents to make the facility aware of lost and/or missing items and for the facility to take appropriate actions to provide acceptable resolutions. No changes were required.
c. Staff were educated on the facility Grievance Policy, the location of Grievance Forms, and the proper disposition of those forms. It was reviewed with staff that missing items that cannot be located will be replaced/reimbursed whenever it is determined that the facility has responsibility.
d. All Resident Grievance Forms will be reviewed by the LNHA at Morning Stand Up and assigned to staff for follow up. In the event items cannot be located the LNHA will determine if replacement is the responsibility of the facility. The form will then reflect the final disposition of the Grievance and all forms will be retained in a binder by the LNHA. The nature and disposition of Grievances will be forwarded to the QA Committee for further review and recommendations.
e. Responsible Party: LNHA
f. Compliance Date: 5.12.19

F606 Not Employ/Engage Staff w/ Adverse Actions

The facility will ensure that all current staff and future employees of facility have been reviewed for background checks in accordance with facility's abuse prevention, identification, investigation and reporting policy and procedure.

a. No direct residents were identified to be affected by deficient practice. However, all residents have the potential to be affected.
b. An audit was created to monitor employee files and discrepancies were remedied, by 4.23.19. Audit revealed employee M required 2nd step verification, which was completed prior to hire, but was not provided to surveyor at time of survey.
c. The ADMIN and Business Office Manager have been educated on the abuse prevention, identification, investigation and reporting policy and procedure; and will complete audits and verification for all future employees prior to hire.
d. The business office manager will audit a selection of employee files monthly and will ensure an annual review of all staff is completed. Results of audits will be brought to the QA/IDT for review, and intervention if applicable.
e. Responsible Party: LNHA/Business Office Manager/Designee
f. Compliance Date: 4.23.19

F607 Develop/Implement Abuse Neglect Policies

The facility will ensure that all staff have received their dependent adult abuse training within six months of hire, for new employees and for all other employees by the date of alleged compliance.

Facility will ensure that employees with possible criminal hits on their Single Contact License and Background checks, receive form S from DCI confirming no criminal history prior to hire.

a. No direct residents were identified to be affected by deficient practice. However, all residents have the potential to be affected.
b. An audit was created to monitor employee files dependent adult abuse training, hits on background checks and receipt of form S from DCI prior to hire.
c. The ADMIN and Business Office Manager have been educated on the abuse prevention, identification, investigation and reporting policy and procedure; and will complete audits and verification of current/future employees prior to hire.
d. The business office manager will audit a selection of employee files monthly and will ensure an annual review of all staff is completed. Results of audits will be brought to the QA/IDT for review, and intervention until substantial compliance is achieved.
e. Responsible Party: Business Office Manager/Designee
f. Compliance Date: 5.12.19

F622 Transfer and Discharge Requirements

When the facility transfers or discharges a Resident, we will ensure that the transfer discharge is documented in the Resident's medical record and appropriate information is communicated to the receiving health care institution or provider.

a. Resident # 34 did not have appropriate documentation that information was communicated as the nurse did not retain a copy of the discharge form.
b. All Residents have the potential to be affected. The DON/Designee will be notified of all Resident Acute transfers at the time of transfer to ensure that appropriate documentation is being provided to the receiving health care institution or provider.
c. Licensed Nursing Staff have been educated that the DON/Designee needs to be notified of all Acute Transfers. They have been educated to use the Acute Transfer Form and to include copies of the Resident's care plan and Physician Orders w/ all transfers and to retain a copy of the Acute Transfer Form for the Resident's Record.
d. The DON/Designee will audit all Residents' post-acute transfer to ensure that appropriate information followed the Resident to the receiving health care institution or provider. Issues with non-compliance will be addressed w/ specific responsible personnel and forwarded to the QA Committee for further review and recommendations.
e. Responsible Party: DON/Designee
f. Compliance Date: 5.12.19

F625 Notice of Bed Hold Policy Before/Upon Transfer

The facility will provide a bed hold policy notice to the Resident/representative when transferring to the hospital.

a. Residents # 34 and 41 were not given appropriate Bed Hold Notice but they were readmitted back to the facility and did not incur any additional charges to maintain their bed from the time of discharge.
b. All Residents have the potential to be affected. A review of all discharges for the Bed Hold Policy has been added to the Morning Stand Up Agenda. Copies of the Bed Hold Policy has been attached to all Acute Transfer Forms at the Nursing Stations.
c. Appropriate staff has been educated regarding the process of providing and documenting the Bed Hold Policy.
d. The DON/Designee will audit compliance weekly x4, monthlyx2 and results will be forwarded to the QA Committee for further review and recommendations.
e. Responsible Party: DON/Designee
f. Compliance Date: 5.12.19

F645 Preadmission Screening for individuals with mental disorder (MD) and individuals with intellectual disability (ID).

The facility will screen Residents for MD or ID prior to admission and individuals identified w/ MD or ID are evaluated and receive care and services in the most integrated setting appropriate to their needs.

a. Resident # 32 screening was resubmitted.
b. All Residents have the potential to be affected. An audit was created to ensure that screenings are completed appropriately, preadmission and post admission when Residents' changes require resubmission.
c. The Community Liaison and MDS Nurse have been educated regarding the preadmission screening requirements.
d. An audit tool has been created to be completed by the DON/Designee weekly x4, monthly x2 and results will be forwarded to the QA Committee for further review and recommendations.
e. Responsible Party: DON/Designee
f. Compliance Date: 5.12.19

F655 Baseline Care Plan

The facility will develop and implement a baseline care plan for each Resident that includes instructions needed to provide effective person-centered care.

a. The care plans for Residents # 27, 34, 37, 41, and 42 have been developed, are person-centered and have been reviewed with the Resident/Resident Representative. #42 discharged.
b. All Residents have the potential to be affected. An audit has been developed to ensure that all baseline care plans are developed within 48 hours and reviewed w/ the Resident/Resident Representative.
c. The MDS nurse has been educated on the requirement for the baseline care plan to be developed within 48 hours and to be reviewed w/ the Resident/Resident Representative.
d. Audits will be completed by the MDS Nurse weekly x4, monthly x2 and results will be forwarded to the QA Committee for further review and recommendations.
e. Responsible Party: DON/ Designee
f. Compliance Date: 5.12.19

F656 Develop/Implementation Comprehensive Care Plans

The facility will develop and implement a comprehensive person-centered care plan for each Resident.

a. Residents # 35 and 37 have had comprehensive person-centered care plans developed and implemented.
b. All Residents have the potential to be affected. The MDS Nurse will audit each Resident care plan to ensure that they person-centered and implemented. Following completion of the initial facility wide audit each care plan will be reviewed/audited a minimum of quarterly.
c. The MDS Nurse and nursing staff have been educated on the requirement of comprehensive person-centered care plans and the implementation of said care plans. The PCC Kardex is being implemented and posted in residents' closets to communicate care plan interventions to front line staff.
d. An audit will be completed weekly x4 and monthly x2 to ensure facility wide compliance and then quarterly for Resident specific care plans. The results will be forwarded to the QA Committee for further review and recommendations.
e. Responsible Party: DON/Designee
f. Compliance Date: 5.12.19

F658 Services Provided Meet Professional Standards

The services provided or arranged by this facility, as outlined by the comprehensive care plan, must meet the professional standards of quality.

a. Residents # 9, 16, 27, 33, 37, 38 have had their care plans reviewed to ensure that they are being implemented in accordance w/ professional standards to include timely administration of medications, G.T. flushes in accordance w/ MD orders, and transfer assistance according to plan of care.
b. All Residents have the potential to be affected. An audit tool has been created to address the specific concerns regarding professional standards of quality to include passing medications within time frames, complete treatments as ordered, gastric tube flushes, transfer assistance according to plan of care.
c. Staff has been educated on the specific concerns regarding professional standards of quality.
d. Audits will be completed weekly x4, monthly x2 with results forwarded to the QA Committee for further review and recommendations.
e. Responsible Party: DON/Designee
f. Compliance Date: 5.12.19

F661 Discharge Summary

When the facility anticipates a discharge, a Resident must have a discharge summary that includes, a recapitulation of stay, a final summary, reconciliation of discharge medications, disposition of personal belongings, and a post discharge plan.

a. Resident # 44 has had a recapitulation of stay and discharge summary completed.
b. All Residents have the potential to be affected. An audit tool has been created to ensure that all requirements of the discharge summary are met.
c. Staff has been educated on the requirements of the discharge summary.
d. Audits will be completed weekly x4 and monthly x2 with results forwarded to the QA Committee for further review and recommendations.
e. Responsible Party: DON/Designee
f. Compliance Date: 5.12.19

F677 Activities of Daily Living

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.

a. Residents # 5, 9, 14, 27, 38, 41 receive the necessary assistance to carry out activities of daily living.
b. All Residents have the potential to be affected. An audit tool has been created to ensure that all Residents receive assistance w/ necessary ADLs such as bathing, clean clothing, Ted Hose/ grooming/hygiene.
c. Staff has been educated on their responsibilities to provide the necessary assistance with ADLs.
d. Audits will be completed weekly x4 and monthly x2 with results forwarded to the QA Committee for further review and recommendations.
e. Responsible Party: DON/Designee
f. Compliance Date: 5.12.19

Multiples

F678 Cardio-Pulmonary Resuscitation (CPR)

The facility will ensure that staff trained in cardiopulmonary resuscitation (CPR) are always on duty and that their certification/recertification includes hands on skill practice and an in-person skills assessment component.

a. No direct residents were identified to be affected by deficient practice. However, all residents have the potential to be affected.
b. An audit was created to monitor employee files for CPR certifications and discrepancies were remedied, by 4.23.19.
c. The ADMIN and Business Office Manager and Director of Nursing have been educated on the audit and requirement for CPR certified staff to be available and on duty at all times in the building.
d. The business office manager will audit employee files for CPR certification and will alert staff member and Director of Nursing of the need for renewals. Results of audits will be brought to the QA/IDT for review, and intervention if applicable. Director of Nursing will audit the employee schedule to ensure that a CPR certified member of staff is available and on duty at all times.
e. Responsible Party: Director of Nursing/Designee and Business Office Manager/Designee
f. Compliance Date: 5.12.19

F684 Quality of Care

Based on the comprehensive assessment of a Resident, the facility will ensure that the Residents receive treatment and care in accordance with professional standards of practice, the comprehensive person-centered care plan, and the Residents' choices.

a. Resident # 243 Expired. Resident # 38 has non-pressure skin assessments completed and documented weekly.
b. All Residents have the potential to be affected. Identification of all resident diet orders and implemented the use of dietary cards for each meal service. Implemented an audit tool to assure that residents receive the proper diet. All residents had a "hot beverage" assessment completed. An audit tool has been created to monitor completion of weekly skin assessments and documentation.
c. Staff has been educated regarding the use of diet cards and dietary audit tool, expectations to have no less than 2 staff available and present at the full assist and cue assist table, to plate and serve food in accordance with the spread sheet for ordered diets, completing and documenting of weekly skin assessments.
d. An audit to ensure completion of weekly skin assessments/documentation will be performed weekly x4 and monthly x2 with results forwarded to the QA Committee for further review and recommendations.
e. Responsible Party: DON/Designee
f. Compliance Date: 4.23.19

F689 Free of Accidents/Supervision/Devices

The facility will ensure that the Resident environment remains as free of accidents and hazards as is possible.

a. Resident # 15 Immediately received a new sling, in good repair for use with mechanical lift.
b. All mechanical lift residents have the potential to be affected. All slings immediately inspected. New slings were ordered. Audits were developed to monitor sling safety and proper transfer technique. All medication carts were audited and found to have locking mechanisms in good working order.
c. Staff were trained on mechanical lifts and the inspection of slings to determine their safety for use to include laundry and nursing. Licensed Staff were educated on the locking and securing of medication carts.
d. Audits will be completed weekly x4 and monthly x2 and on-going with results forwarded to the QA Committee for further review and recommendations.
e. Responsible Party: LNHA/DON/Designee
f. Compliance Date: 5.12.19

F690 Incontinence, Bowel and Bladder

The facility will ensure that a Resident who is continent of bowel and bladder on admission receives services and assistance to maintain continence unless his or her clinical condition is or becomes such that continence is not possible.

a. Resident # 15 has had a bowel and bladder assessment completed and her care plan reviewed and revised.
b. All Residents have the potential to be affected. All residents will have their bowel and bladder function assessed quarterly with appropriate updates to their care plan. Changes to bowel and bladder status will receive additional bowel and bladder assessment. All Residents were reviewed to ensure the accuracy of their bowel and bladder care plans.
c. Staff was educated on the need to complete the B&B portion of the Users Defined Assessments as scheduled and to implement the care plan as written.
d. Audits will be completed weekly x4 and monthly x2 with the results forwarded to the QA Committee for further review and recommendations.
e. Responsible Party: DON/Designee
f. Compliance Date: 5.12.19

F695 Respiratory Care

The facility will ensure that a Resident who needs respiratory care is provided such care, consistent with professional standards of practice, the comprehensive person-centered care plan, the Residents' goals and preferences.

a. Resident # 38 has had his Oxygen order clarified and Pulse Oxygen Saturations added to the q shift and PRN.
b. All Resident requiring respiratory services have the potential to be affected. All Residents receiving respiratory services had their orders and care plans reviewed to ensure they are consistent with professional standards of practice. An audit tool has been created to monitor Oxygen orders/respiratory care.
c. Staff have been educated on complete oxygen orders and the need to monitor Pulse Oxygen Saturations for titrated Oxygen orders.
d. Audits will be completed Weekly x4 and monthly x2 with the results forwarded to the QA Committee for further review and recommendations.
e. Responsible Party: DON/Designee
f. Compliance Date: 5.12.19

F698 Dialysis

The facility will ensure that Residents who require dialysis receive such services, consistent with professional standards of practice, the comprehensive person-centered care plan, and the Resident's goals and preferences.

a. Residents # 23 and 34 do receive post dialysis assessments and required aftercare/monitoring
b. All dialysis Residents have the potential to be affected. A post dialysis assessment guide has been developed and is present on the resident's electronic medical record. An audit tool was created to monitor completion of post dialysis assessments.
c. Staff has been educated on post dialysis assessment and documentation.
d. Audits will be completed weekly x4 and monthly x2 with the results forwarded to the QA Committee for further review and recommendations.
e. Responsible Party: DON/Designee
f. Compliance Date: 5.12.19

F725 Sufficient Nursing Staff

The facility does have sufficient nursing staff to provide nursing services to attain or maintain the highest practicable physical, mental, and psychosocial well-being of each Resident, as determined by Resident assessments and individual care plans.

a. Residents #16, 25, 27, 29 are provided nursing services to attain and/or maintain their highest practicable level of function to include timely answering of call lights and medications & procedures administered in accordance with MD orders and plan of care.
b. Staffing patterns have been reviewed and are sufficient to meet Residents' needs. Staffing patterns will be adjusted to reflect acuity.
c. Staff was educated on the prompt answering of call light in addition to ancillary staff to meet non-nursing requests. Call lights are to remain on until the need is met.
d. Call Light response time audits will be completed weekly x4, monthly x2, on-going and as needed with results forwarded to the QA Committee for further review and recommendations.
e. Responsible Party: DON/Designee
f. Compliance Date: 5.12.19

F727 RN 8 Consecutive Hours/Day and 7 Days/Week

The facility will assure that registered nurse (RN) coverage is provided and on duty 8 consecutive hours per day, 7 days per week.

a. No direct residents were identified to be affected by deficient practice. However, all residents have the potential to be affected.
b. An audit was created to monitor the nursing schedule to ensure that an RN is provided and on duty 8 hours per day, 7 days per week.
c. Director of Nursing and MDS has been educated on RN coverage regulation and facility expectation.
d. The Director of Nursing and ADMIN will audit the nursing schedule routinely to ensure RN coverage is maintained at a rate of 8 hours per day, 7 days per week. Results of audits will be brought to the QA/IDT for review, and intervention until substantial compliance is achieved.
e. Responsible Party: Director of Nursing/ADMIN
f. Compliance Date: 5.12.19

F729 Nurse Aide Registry Verification, Retraining

The facility will obtain DCW registry verification of certified nursing assistants prior to hire.

a. No direct residents were identified to be affected by deficient practice. However, all residents have the potential to be affected.
b. An audit was created to monitor employee files for DCW verification prior to date of hire.
c. Director of Nursing and Business Office Manager have been educated on DCW verification for Certified Nurses' Aides prior to date of hire.
d. The Business Office Manager and/or ADMIN will audit employee files prior to hire for DCW registry checks. Results of audits will be brought to the QA/IDT for review, and intervention until substantial compliance is achieved.
e. Responsible Party: Business Office Manager/ADMIN
f. Compliance Date: 5.12.19

F730 Nurse Aide Performance Review-12 hr/yr in-service

The facility will assure all certified nursing assistants receive 12 hours of in-service education on an annual basis.

The facility will assure all certified nursing assistants receive an annual performance evaluation.

a. No direct residents were identified to be affected by deficient practice. However, all residents have the potential to be affected.
b. An audit was created to monitor certified nurses' aide in-service education to assure 12 hours of education are completed by all CNAs annually. Additionally, the audit will review annual anniversaries for CNAs and will alert supervisor to provide all CNAs annual performance reviews.
c. Director of Nursing and Business Office Manager have been educated on audit completion for annual performance reviews and 12-hour in-service regulatory expectations.
d. The Director of Nursing and Business Office Manager will implement audit to assure 12 hours of in-service education and performance reviews are completed annually.
e. Responsible Party: Director of Nursing/Business Office Manager.
f. Compliance Date: 5.12.19

F732 Posted Nursing Staffing Information

The facility must post the nursing staffing data, on a daily basis at the beginning of the shift.

a. No Residents directly affected.
b. The Daily Nursing Staffing Posting will be posted daily at each entrance every morning, with changes to staffing noted as they occur.
c. ~~Nursing Administration and Weekend Managers were educated on the Daily Nursing Staffing Posting, the requirements, and the locations of the posting.~~
d. The Postings will be retained in a binder and will be forwarded to the QA committee for further review and recommendations.
e. Responsible Party: DON/Designee
f. Compliance Date: 5.12.19

F758 Unnecessary Psychotropic Medication

Residents who use psychotropic drugs receive gradual dose reductions, and behavioral interventions, unless clinically contraindicated, in an effort to discontinue these drugs.

a. Resident # 38 has had his midnight dose of Ativan discontinued.
b. All Residents on psychotropic medication have the potential to be affected. All Residents' on psychotropic medications were reviewed and appropriate and required GDRs were requested including rationales where GDRs were declined. An audit tool was created.
c. Staff was educated that all requests for psychotropic medications require input from the interdisciplinary team. All new orders, current orders, and GDRs for psychotropic medications will be reviewed by the IDT.
d. Audits for Psychotropic GDRs will be completed weekly x4, monthly x2 and ongoing with results forwarded to the QA Committee for further review and recommendations.
e. Responsible Party: DON/Designee
f. Compliance Date: 5.12.19

F761 Labeling of Drugs and Biologicals

Drugs and biologicals used in the facility are labeled and stored in accordance with currently accepted professional principles.

a. No specific residents documented
b. All Residents' medications have the potential to be affected. All Scheduled 2, 3, and 4 medications will be counted at change of shift and with exchange of keys. All Scheduled 2, 3, and 4 medications will be secured behind a double lock system.
c. Staff have been educated on the need to complete a thorough controlled substance count with each exchange of keys and to maintain all controlled substances behind a double lock system.
d. Audits of the controlled substance monitoring and storage will be conducted weekly x4, monthly x2 and ongoing to ensure continued compliance with results forwarded to the QA Committee for further review and recommendations.
e. Responsible Party: DON/Designee
f. Compliance Date: 5.12.19

F812 Food Procurement Store/Prepare/Serve-Sanitary

The facility will store, prepare, distribute and serve food in accordance with professional standards for food service safety.

a. All the Residents have the ability to be affected.
b. The cutting boards were replaced on 4.2.19. Hand Hygiene signs/reminders have been placed.
c. The CDM will audit cutting boards and other food preparation equipment to ensure that it is maintained in sanitary condition. Staff have been educated on proper handwashing requirements.
d. Routine inspections of equipment will occur daily. Records will be retained and available for review by the QA Committee. Handwashing audits will be done weekly x4, monthly x2 with results forwarded to the QA Committee for further review and recommendations.
e. Responsible Party: CDM/Designee
f. Compliance Date: 5.12.19

F839 Staff Qualifications

The facility will assure license verification of staff prior to hire date.

a. No direct residents were identified to be affected by deficient practice. However, all residents have the potential to be affected.
b. An audit was created to monitor employee files for licensure verification prior to date of hire.
c. Director of Nursing and Business Office Manager have been educated on licensure verification prior to date of hire.
d. The Business Office Manager and Director of Nursing will audit employee files prior to hire and will verify current licensure of licensed staff. Results of audits will be brought to the QA/IDT for review, and intervention until substantial compliance is achieved.
e. Responsible Party: Director of Nursing/Business Office Manager
f. Compliance Date: 5.12.19

F880 Infection Control

The facility does 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.

a. Residents # 14 and 31 suffered no negative outcome related to staff hand hygiene.
b. All Residents have the potential to be affected. Current hand hygiene and glove policies were reviewed, and no revisions were required. A hand hygiene and glove usage audit tool were created.
c. Staff was educated on hand hygiene and glove use.
d. Hand hygiene and glove usage audits will be completed weekly x4, monthly x4 and on-going with results forwarded to the QA Committee for further review and recommendations.
e. Responsible Party: DON/Designee
f. Compliance Date: 5.12.19

F919 Resident Call System

The facility is adequately equipped to allow Residents to call for assistance through a communication system which relays calls directly to a staff member or to a centralized work area.

a. No residents were affected.
b. All Residents had the potential to be affected. Keyed locks were obtained and installed to the two lobby restrooms on 4.1.19. All similar type doors were inspected.
c. ~~Maintenance director~~ was educated to ensure that locks be maintained to all public restrooms that do not have a Resident Call System that is installed and functioning.
d. The ~~Maintenance Director~~ will monitor doors to ensure that they have functioning locks. Deviations from norm will be corrected and reported to the QA Committee for further review and recommendations.
e. Responsible Party: Maintenance Director
f. Compliance Date: 5.12.19

Countryside Health Care Center Plan of Correction

Annual Survey Dates 3.26.19-4.12.19

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

Chapter 58 2567

L 190: General policies

The facility will assure all employees have a physical examination prior to hire

a. No direct residents were identified to be affected by deficient practice. However, all residents have the potential to be affected.
b. An audit was created to monitor employee files for physical examinations prior to hire.
c. Business Office Manager has been educated on completion of the audit and the physical examination requirements pre-hire.
d. The Business Office Manager will audit employee files prior to hire. Business Office Manager will alert Nurse Manager of physical examination needs of new hire staff. Nurse Manager will assure completion of examination upon notification. Results of audits will be brought to the QA/IDT for review, and intervention until substantial compliance is achieved.
e. Responsible Party: Director of Nursing/Business Office Manager
f. Compliance Date: 5.12.19

L 191: General policies

The facility will assure all employees have a physical examination every 4 years post hire.

a. No direct residents were identified to be affected by deficient practice. However, all residents have the potential to be affected.
b. An audit was created to monitor employee files for physical examinations every 4 years post hire.

c. Business Office Manager has been educated on completion of the audit and the physical examination requirements every 4 years post hire.
d. The Business Office Manager will audit employee files for four-year physical examination requirement. Business Office Manager will alert Nurse Manager of physical examination needs of existing employees at every consecutive 4 year post hire anniversary. Nurse Manager will assure completion of examination upon notification. Results of audits will be brought to the QA/IDT for review, and intervention until substantial compliance is achieved.
e. Responsible Party: Director of Nursing/Business Office Manager
f. Compliance Date: 5.12.19

L 435: Duties of health services supervisor

The facility will assure all licensed staff receive an annual evaluation.

a. No direct residents were identified to be affected by deficient practice. However, all residents have the potential to be affected.
b. An audit was created to monitor licensed staff employee files for annual evaluations upon employee anniversary.
c. Business Office Manager has been educated on completion of the audit and annual evaluation requirement for licensed staff.
d. The Business Office Manager will audit licensed employee files for annual evaluation requirement. Business Office Manager will alert Nurse Manager of annual evaluation needs. Nurse Manager will assure completion of evaluation upon notification. Results of audits will be brought to the QA/IDT for review, and intervention until substantial compliance is achieved.
e. Responsible Party: Director of Nursing/Business Office Manager
f. Compliance Date: 5.12.19

L 1093: VA Benefits (General admission policies)

The facility will ensure that we submit Residents for Veteran Affairs Benefits.

a. Resident # 8 and 41 were submitted for Veterans Affairs Benefits.
b. All Residents have the potential to be affected. An audit was created to ensure that all Residents are submitted to the Veteran Affairs Benefits and have the Veteran's Eligibility Form Completed.
c. The Business Office Manager and the Community Liaison Director were educated on submitting Residents for Veteran Affairs Benefits and completing the Veteran's Eligibility Form.
d. The LNHA/Designee will audit for compliance weekly x4, monthly x2 with the results forwarded to the QA Committee for further review and recommendation.
e. Responsible Party: LNHA
f. Compliance Date: 5.12.19

Countryside Health Care Center Plan of Correction

Annual Survey Dates 3.26.19-4.12.19

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Chapter 59 2567

S 115: Tuberculosis testing for Health Care Workers (HCW)

The facility will assure all employees receive baseline tuberculosis screening upon hire as outlined in the Iowa Administrative Code 59.5(1).

a. No direct residents were identified to be affected by deficient practice. However, all residents have the potential to be affected.
b. An audit was created to monitor employee files for tuberculosis testing as outlined by the Iowa Administrative Code 59.5(1) utilizing a two-step tuberculosis test.
c. Business Office Manager and Director of Nursing have been educated on completion of the audit and new hire 2 step tuberculosis testing requirement.
d. The Business Office Manager will audit employee files prior to hire for 2 step tuberculosis testing needs. Business Office Manager will alert Nurse Manager of tuberculosis testing needs of new employees. Nurse Manager will assure completion of tuberculosis testing as outlined by the Iowa Administrative Code 59.5(1). Results of audits will be brought to the QA/IDT for review, and intervention until substantial compliance is achieved.
e. Responsible Party: Director of Nursing/Business Office Manager
f. Compliance Date: 5/12/2019