STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	165453	A. BUILDING _____ B. WING _____	C 10/29/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PEARL VALLEY REHABILITATION & HEALTHCARE CENTER O	601 E POLK ST WASHINGTON, IA 52353

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 000	INITIAL COMMENTS	F 000		

Correction Date: 12·16·20

A Focused Infection Control survey and investigation of Complaints #91487-C, #93175-C, #93784-C, #94019-C, #94085-C and facility reported incident #94043-I was conducted by the Department of Inspections and Appeals ending 10/29/20 and resulted in the following deficiencies.

Complaints #93175-C, 94019-C, and 94085-C- were substantiated.

Complaint #91487-C, 93784-C were not substantiated.

Facility Reported Incident # 94043-I was not substantiated.

The facility was found not to be in compliance with CMS and Centers for Disease Control and Prevention (CDC) recommended practices to prepare for COVID-19.
Total residents-56

See Federal Code of Regulations (42-CFR) Part 483 Subpart B-C

F 584 SS=D	Safe/Clean/Comfortable/Homelike Environment CFR(s): 483.10(i)(1)-(7)	F 584	

§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-

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
	Provisional Administrator	12/07/2020

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

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§483.10(i)(1) A safe, clean, comfortable, and homelike environment, allowing the resident to 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 observations, policy review and staff interviews, the facility failed to provide a clean, comfortable and homelike environment for one of two shower rooms (600 hall) and one of four resident units (400 hall) The facility identified a

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census of 56 residents.

Findings include:

1. Environmental tour conducted on 10/19/20 at 1:30 p.m., with the Facility's Provisional Administrator and the Assistant Director of Nursing, revealed the following:

a. The tile floor and walls in the 600 Hall shower room contained a black substance that appeared like mold in the tile and grouted areas.

b. The 400 Hall corridor had a strong urine-like odor.

2. During observations 10/19/20 at 3:00 p.m., the 400 Hall corridor and hallway had a strong pungent odor of urine.

3. During observations 10/20/20 at 8:05 a.m., the 400 Hall corridor and hallways had a strong pungent odor of urine.

On 10/29/20 at 8:55 a.m., the Assistant Director of Nursing (ADON) reported housekeeping cleaned the shower room but did not know what the black substance on the shower room tile floor or walls was. The ADON reported the odor in the 400 hall could be from soiled linens or trash kept in the shower room, which is near the 400 hall doorway to the unit. The ADON reported housekeeping took trash from the shower area but maybe the trash required removal more often.

An undated Infection Control Policy and Procedure manual revealed to ensure a safe, clean, and sanitary environment for residents and employees and to minimize the incidence of

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nosocomial infections, an effective germicidal solution in conjunction with a systematized procedure for cleaning areas is used within the facility and/or on the equipment. The prevention and control of contagious disease within the facility lies within each individual, and imperative to follow the infection control procedures in order to limit the number of nosocomial infections.

F 677 SS=D — 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 observation, record review, staff and resident interviews, the facility failed to provide adequate bathing for 1 of 8 sampled (Residents #11). The facility reported a census of 56 residents.

Findings include:

1. The MDS (Minimum Data Set) assessment tool, dated 09/16/2020, listed diagnoses for Resident #11 that included: chronic lung disease, heart failure, and type 2 diabetes. Resident #11 depended completely on assistance of 2 or more staff for bathing, transfers and extensive assistance of 1 for dressing. The resident's Brief Interview for Mental Status (BIMS) score was "15" (no cognitive impairment).

A Task administration schedule for October 2020 revealed baths provided to resident on 10/01/2020, 10/07/2020, 10/10/2020, and

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F 677	Continued From page 4 10/25/2020.	F 677		

The facility policy titled "Bathing/grooming and personal hygiene Policy", dated 08/30/2019 directed staff to complete bathing skin sheets and submit to charge nurse for review and signature. The policy stated each resident should have appropriate personal hygiene and grooming daily to promote health and wellness for each individual. This included oral care, facial grooming, clean attire, nail care if nails are dirty or long and all other personal cares indicated or requested per resident or family.

On 10/21/2020 at 11:05 a.m., Staff A stated baths are documented on bath sheets and on the computer under PRN (as needed) baths. If the resident refused, staff makes 3 attempts, and then the nurse tries to encourage the resident to bathe. Bath refusals are charted on skin assessment sheets and in PCC (electronic health record).

On 10/21/2020 at 1:31 p.m., Staff B stated the facility has a schedule for the aides for showers. The aides document the showers on shower sheets and document in PCC (electronic health record).

On 10/27/2020 at 4:40 p.m., Resident #11 stated she should receive 2 scheduled showers per week, but only received one shower per week on average.

F 684 Quality of Care
SS=D CFR(s): 483.25 — F 684

§ 483.25 Quality of care
Quality of care is a fundamental principle that

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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 observation, clinical record review, policy review, resident and staff interviews, the facility failed to ensure residents had a physician order for a catheter for one of five residents reviewed (Resident #3), failed to assess and document follow up skin assessments for one of nine residents reviewed (Resident #1), failed to follow physician orders to perform a blood glucose check and administer insulin for one of five residents reviewed (Resident #7), and failed to contact the physician when staff failed to check a resident's blood glucose and when staff failed to administer medication as ordered for one of five residents reviewed (Resident #7). The facility reported a census of 56 residents.

Findings include

1. The Minimum Data Assessment (MDS) dated 9/11/20, revealed Resident #3 had diagnoses of septicemia, benign prostatic hyperplasia (BPH) (enlarged prostate), urinary retention, and hematuria (blood in the urine). The MDS indicated the resident utilized an indwelling catheter.

The care plan dated 9/10/20 revealed the resident used a foley catheter due to urinary retention. The care plan directives for staff included: monitor and document intake and

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output as per facility policy, monitor signs and symptoms of discomfort on urination and frequency, and monitor pain or discomfort due to the catheter.

The progress notes revealed the following:
a. On 8/28/20 at 11:15 a.m., resident admitted to facility and has chronic catheter. Resident reported he had catheter for several years but unsure why he had the catheter. Current diagnoses of BPH (benign prostatic hypertrophy) and chronic urinary retention
b. On 9/4/20 at 9:38 a.m., foley catheter changed. The resident had no output during the shift. The nurse flushed the catheter. The catheter appeared patent but no urine returned. Catheter removed and noted sediment at the catheter tip. A #18 catheter inserted with immediate return of 1200 milliliters (ml) urine and a few clots present. The resident reported discomfort with catheter insertion.
c. On 9/23/20 at 11:21 p.m., the resident complained of lower abdominal and pelvic pain. Staff found the resident's catheter and bag out and lying on the walker. Bladder distention noted to pelvic area. The resident pulled the catheter out because it wasn't working. Catheter replaced with #18 french foley catheter with 1300 ml of clear yellow urine drained into the bag.
d. On 9/27/20 at 7:58 a.m., the resident complained of pain and had abdominal distention. The resident stated his catheter was not draining any urine. Resident's abdomen firm to palpation and very little urine in the catheter bag. Catheter irrigated without problem but had no urine return when pulled back on the syringe. Catheter removed and replaced with #18 french foley catheter with 900 ml of clear yellow urine/ minimal sediment return.

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Physician's orders dated 9/1/20, and approved for 60 days, lacked an order for the foley catheter.

The clinical record lacked an order for a catheter or catheter cares for Resident #3.

On 10/22/20 at 10:00 a.m., the Assistant Director of Nursing (ADON) reported the physician's orders in the chart dated 9/1 - 9/30/20 are the only orders for the resident. The ADON acknowledged the facility did not have an order for the resident's catheter or catheter cares, and planned to set up an appointment for the resident to see a urologist.

In an email dated 10/29/20 at 10:18 a.m., the Administrator reported Resident #3 did not have a TAR (treatment administration record).

2. The MDS dated 8/23/20, revealed Resident #1 with diagnoses that included: diabetes, cerebrovascular accident (CVA), non-Alzheimer's dementia, and seizure disorder. The MDS indicated the resident required extensive assistance of one staff for bed mobility, toileting, and personal hygiene. The MDS revealed the resident had moisture associated skin disorder (MASD) and had a risk for pressure ulcers.

The care plan revised 6/4/19, revealed the resident with a potential for skin breakdown related to fragile skin, poor hygiene, and a history of picking. Care plan directives for staff included: monitor and document the location, size, and treatment of the skin injury, and report abnormalities, signs/symptoms of infection, maceration, and failure to heal to the physician.

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Clinical assessments in the electronic health record (EHR) revealed a weekly skin assessment documented on 9/20/20 and 10/24/20.
a. The skin assessment dated 9/20/20 revealed the resident had a 4.5 centimeter (cm) long (L) x 4.5 cm wide (W) bruise to the left posterior forearm, and a 1.5 cm (L) x 1.5 cm (W) x 0.1 cm depth skin tear to the left posterior forearm. The assessment note included the resident information of a history of picking skin/scabs.
b. The skin assessment dated 10/24/20 revealed the resident had skin clear and intact. The assessment note indicated the resident had redness under her folds, but the resident refused an antifungal cream.

The treatment administration record (TAR) dated 9/1 - 9/30/20, lacked treatment or an assessment of the skin tear and bruising that occurred 9/20/20.

The progress notes revealed the following:
a. On 9/20/20 at 8:12 a.m., a small deep purple bruise and small, bleeding, open skin tear noted to Resident #1's left forearm.
b. On 9/21/20 at 10:57 a.m., resident unable to report what happened to her left arm. Bruising measured at 4.5 cm x 4.5 cm, skin tear measuring 1.5 cm x 1.5 cm. Resident noted to pick at skin tear on left arm.
c. On 9/23/20 at 10:30 a.m., additional bruising observed on the right arm. The right posterior forearm contained two small circular purple bruises and the right anterior forearm had one small circular purple bruise measuring approximately 1 cm x 1 cm. A bruise and bleeding skin tear noted on left posterior forearm.

The clinical record lacked additional skin

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assessments for the left forearm skin tear and bruise, and the right forearm bruising.

On 10/28/20 at 10:30 a.m., the Assistant Director of Nursing (ADON) reported no other skin assessments for Resident #3, other than the ones in the EHR dated 9/20/20 and 10/24/20, and the paper bath sheets. The ADON reported the Corporate Nurse told her they needed to start documenting skin assessments weekly. The ADON reported they did not determine how Resident #1's skin injury and bruise occurred on 9/20/20. The ADON stated the resident picked at her skin at times.

A facility policy titled Skin Integrity Assessment dated 1/18/20, revealed it is the protocol of the facility licensed nursing staff and certified nursing assistant to assess resident skin integrity with daily cares and during bathing. Any skin concerns are documented on the appropriate assessment documents and the physician notified of any areas of concern for follow up treatment measures. A skin integrity concern protocol initiated if a skin assessment revealed an area of concern.

3. The MDS assessment tool, dated 10/09/2020 listed diagnoses for Resident #7 that included: diabetes, chronic kidney disease, and hypertension. The MDS stated the resident required limited assistance for bed mobility, transfers, and extensive assistance of 1 for bathing. The MDS listed the resident's BIMS (Brief Interview for Mental Status) score as 15 out of 15, indicating intact cognition.

A physician's order dated 04/09/2020 directed staff to check blood sugar twice per day for type 2 diabetes at 7:00 a.m. and 7:00 p.m.

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A physician's order dated 03/03/2020 directed staff to inject 22 units subcutaneously twice per day for type 2 diabetes at 7:00 a.m. and 7:00 p.m.

The medication administration record (MAR) under ACCUCHECKS - Check Blood Sugar BID revealed on 10/18/2020 in the 7 p.m. box for initials and the blood sugar measurement number the letters N.D.

The medication administration record (MAR) under LEVEMIR 100 Units/ML vial Inject 22 units SQ BID revealed on 10/18/2020 in the 7 p.m. box for initials and blood sugar measurement number the letters N.D.

In an interview on 10/19/2020 at 2:55 p.m., Resident #7 stated that she did not receive her insulin the night before and she reported it to the nurse this morning.

On 10/21/2020 at 1:31 p.m., Staff B LPN (licensed practical nurse) identified the protocol for medication administration as one hour before or 1 hour after to be considered on time. Staff B stated if the medication was missed, Staff should notify the physician.

In an interview on 10/20/2020 at 11:46 a.m., ADON stated the dosing schedule for medication administration is 7 a.m, 11 a.m., 4 p.m., and 7 p.m. The ADON stated there is a window of one hour before those times and one hour after for the medication administration considered timely.

In an interview on 10/28/2020 at 9:48 a.m., the ADON stated that if a medication was missed, the nurse should notify the doctor. The ADON stated

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that she was unaware that an insulin was missed on 10/18/2020 for Resident #7. The ADON stated that if the physician was notified of missed medications, the documentation would be located in the progress notes in PCC. The ADON stated that she did not know what N.D. stood for in the medication administration record.

F 695 SS=D Respiratory/Tracheostomy Care and Suctioning CFR(s): 483.25(i)

F 695

§ 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 observation, record review, policy review, and interviews the facility failed to provide respiratory care consistent with professional standards of practice and the residents' goals and preferences. (Resident #11) The facility reported a census of 56.

Findings include:

The MDS (Minimum Data Set) assessment tool, dated 09/16/2020, listed diagnoses for Resident #11 included: chronic lung disease, heart failure, and type 2 diabetes. Mental Status score is 15 out of 15, indicating intact cognition.

A physician order entry dated 10/21/2020 directed staff to apply BIPAP at night during sleep with 2

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liters of oxygen and refill with distilled water at bedtime.

A physician order entry dated 11/05/2019 directed staff to change oxygen tubing weekly on Sunday one time a day every Sunday for tubing change.

The facility policy titled "Respiratory assessment/treatment/Equipment policy", dated 01/01/2019 directed staff to change tubing per the facility on a weekly basis and directed staff to change the BIPAP filters monthly or per supplier recommendations.

In an email response dated 10/26/2020 at 5:34 p.m., the Administrator stated they did not have a record for Resident #11's oxygen tubing change.

On 10/27/2020 at 4:40 p.m., Resident #11 stated staff did not change the oxygen tubing regularly on Sundays and did not label with initials or date. Resident #11 stated the BIPAP filter had not been changed since before admission of 08/31/2020.

On 10/28/2020 at 9:48 a.m., the Assistant Director of Nursing (ADON) stated the nurses changed the oxygen tubing every Sunday night and as needed. The ADON stated they did not chart they changed the tubing and they did not initial or date the tubing. The ADON stated they did not have a treatment administration record (TAR) for the order. The ADON stated the CPAP/BIPAP maintenance is not documented.

F 880 Infection Prevention & Control — F 880
SS=D CFR(s): 483.80(a)(1)(2)(4)(e)(f)

§483.80 Infection Control
The facility must establish and maintain an

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	165453	A. BUILDING _____ B. WING _____	C 10/29/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PEARL VALLEY REHABILITATION & HEALTHCARE CENTER O	601 E POLK ST WASHINGTON, IA 52353

(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 695	Continued From page 12	F 695		

liters of oxygen and refill with distilled water at bedtime.

A physician order entry dated 11/05/2019 directed staff to change oxygen tubing weekly on Sunday one time a day every Sunday for tubing change.

The facility policy titled "Respiratory assessment/treatment/Equipment policy", dated 01/01/2019 directed staff to change tubing per the facility on a weekly basis and directed staff to change the BIPAP filters monthly or per supplier recommendations.

In an email response dated 10/26/2020 at 5:34 p.m., the Administrator stated they did not have a record for Resident #11's oxygen tubing change.

On 10/27/2020 at 4:40 p.m., Resident #11 stated staff did not change the oxygen tubing regularly on Sundays and did not label with initials or date. Resident #11 stated the BIPAP filter had not been changed since before admission of 08/31/2020.

On 10/28/2020 at 9:48 a.m., the Assistant Director of Nursing (ADON) stated the nurses changed the oxygen tubing every Sunday night and as needed. The ADON stated they did not chart they changed the tubing and they did not initial or date the tubing. The ADON stated they did not have a treatment administration record (TAR) for the order. The ADON stated the CPAP/BIPAP maintenance is not documented.

F 880 Infection Prevention & Control — F 880
SS=D CFR(s): 483.80(a)(1)(2)(4)(e)(f)

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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:
(A) The type and duration of the isolation, depending upon the infectious agent or organism involved, and

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F 880	Continued From page 14	F 880		

(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, observations, staff interviews, and policy review, the facility staff failed to follow infection control practices in order to prevent or reduce the risk of spreading infection and disease for one of eleven residents sampled. (Resident #3) The facility reported a census of 56 residents.

Findings Include:

1. The Minimum Data Assessment (MDS) dated 9/11/20, revealed Resident #3 with diagnoses that included: septicemia, benign prostatic hyperplasia (enlarged prostate), urinary retention, and

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hematuria (blood in the urine). The MDS indicated the resident utilized an indwelling catheter.

The care plan dated 9/10/10 revealed the resident used a foley catheter related to urinary retention. Care plan directives for staff included: monitoring and documenting the intake and output as per facility policy, monitor signs and symptoms of discomfort on urination and frequency, and monitor pain or discomfort due to the catheter.

During observation 10/20/20 at 1:00 p.m., Staff A, Certified Nursing Assistant (CNA) drained urine from Resident #3's catheter into a urinal. Staff A took the urinal into the bathroom, measured the amount of urine in the urinal and emptied the urinal into the toilet. Staff A then walked to the sink in the resident's room, placed the urinal under the sink faucet, filled the urinal ¼ full of water, walked to the bathroom and emptied the urinal in the toilet. Staff A placed the urinal on top of the toilet, removed her gloves, then went and washed her hands in the same sink she obtained water to rinse the urinal.

During an interview 10/21/20 at 1:30 p.m., Staff B, Licensed Practical Nurse, stated staff used a graduate cylinder container when she emptied a catheter, but was not sure if CNA staff rinsed the graduate in the sink or what they did.

During an interview 10/22/20 at 10:00 a.m., the Assistant Director of Nursing reported she expected staff use a glass filled with water and rinse the urinal or graduate container out after using the urinal or graduate used to empty a catheter.

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A facility audit for emptying a urinary drain bag revealed the following procedural steps: after the catheter bag drained into a graduate container or urinal, measure the amount of urine, empty the container into the toilet, use a disposable glass to pour water into the container for rinsing, remove gloves and wash hands

Pearl Valley

Pearl Valley Rehab - Washington
601 E Polk Street
Washington,IA 52353
Phone: 319-653-6526

Facility ID #165453

Provider's Plan of Correction
Date Survey Completed: 10/29/2020

F 000: Initial Comments:

The statements made in this plan of correction are not an admission to and do not constitute an agreement with the alleged deficiencies by Pearl Valley Rehab -Washington. To remain in compliance with State and Federal regulations, the facility has taken or will take the following actions set forth in this plan of correction.

F854

Facility failed to provide a clean, comfortable and homelike environment for one of two shower rooms and one of four resident units. The facility does and will continue to provide clean showers room and homelike units. Shower room will be regrouted and added to the daily cleaning schedule. All trash and solid linens will be removed from the resident areas periodically throughout the day One on one education completed. Facility will perform random audits weekly x4 weeks, bi-weekly x 4 weeks and monthly x1. All findings to be submitted to QAPI and QA for further system improvement implementation.

F677

Facility failed to provide adequate bathing for 1 of 8 residents reviewed.
The facility does and will continue to provide daily grooming/showers twice a week and PRN bathing. All clinical staff have been educated on facility policy and procedures for performing daily grooming. Facility will perform random audits of bathing and resident grooming weekly x4 weeks, bi weekly x 4 weeks and monthly x1. All findings to be submitted to QAPI and QA for further system improvement implementation.

F684

Facility failed to ensure residents had a physician order for a catheter for one of five residents reviewed. Failed to follow physician orders to perform a blood glucose check and administer insulin for one of five residents reviewed. All clinical staff have been educated on facility policy and procedures following physician orders. Facility will perform random audits of physician orders weekly X4 weeks, bi weekly x4 weeks and monthly x1. All findings to be submitted to QAPI and QA for further system improvement implementation.

F695

The facility failed to provide respiratory care consistent with professional standards of practice and the resident's goals and preferences. All clinical staff has been educated on facility policy and procedures regarding disinfection of respiratory equipment. Facility will perform random audits of respiratory care equipment disinfection and cleaning weekly x4 weeks, bi weekly x4 weeks and monthly x1. All findings to be submitted QAPI and QA for further system improvement implementation.

F880

Facility failed to follow infection control practices in order to prevent or reduce the risk of spreading infection and diseases for one of eleven residents reviewed. All clinical staff have been educated on facility's infection control and catheter care policies and procedures. Facility has watched the recommended video of Keeping Covid Out and 1:1 done. Facility will perform random audits of catheter care weekly x 4 weeks, bi weekly x 4 weeks and monthly x1. All findings to be submitted to QAPI and QA for further system improvement implementation.

Date of compliance 12/16/2020.