STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	185380	A. BUILDING _____ B. WING _____	07/21/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
STATE CENTER SPECIALTY CARE	702 THIRD STREET NW STATE CENTER, IA 50247

(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 OK TAP Correction Date: 8/12/21 The following deficiencies result from the facility's Recertification Survey and Investigation of Complaint #97362 conducted July 14-21, 2021. The Complaint was not substantiated. (See the Code of Federal Regulations (42CFR) Part 483, Subpart B-C).	F 000	This Plan of Correction is prepared and submitted as required by law. By submitting this Plan of Correction, State Center Specialty Care does not admit that the deficiency listed on this form exist, nor does the facility admit to any statements, findings, facts, or conclusions that form the basis for the alleged deficiency. The facility reserves the right to challenge in legal and/or regulatory or administrative proceedings the deficiency, statements, facts, and conclusions that form the basis for the deficiency.	
F 607 SS=E	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 review, policy review, and Administrator interview, the facility failed to complete required background checks prior to hire for 4 of 5 personnel files reviewed (Staff E, G, H and J), resulting in allowing a staff member (Staff G) with a noted criminal history to work without the required Department of Human Services Review (DHS) authorization for an employee to work in a facility. The facility reported a census of 28 residents.	F 607	**For Citation: F607: Develop/Implement Abuse/ Neglect Policies** This is my credible allegation of compliance to F607: Develop/Implement Abuse/ Neglect Policies. This allegation does not constitute guilt but that the facility is in compliance to F607: Develop/Implement Abuse/ Neglect Policies Staff E, G, H, and J have had all required background checks completed per guidelines	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Chase Oehlert	ADMINISTRATOR	8/12/21

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

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	166390	A. BUILDING _____ B. WING _____	07/21/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
STATE CENTER SPECIALTY CARE	702 THIRD STREET NW STATE CENTER, IA 50247

(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 607	Continued From page 1 Findings include: 1. Review of the facility's Employee Hire List provided, showed Staff E, Housekeeper hired 11/3/20, and the file contained a Single Contact Repository (SING) background check completed 4/7/21, completed 5 months after hired. 2. Review of the facility's Employee Hire List provided, revealed Staff G, Cook, with a documented hire date of 07/29/20 and terminated on 03/28/2021. Staff G's employee file contained a Single Contact Repository (SING) background check completed 4/7/21(over a month after termination date) that indicated the criminal history background check required further research. The employee file showed documentation of further research from the Department of Criminal Investigation (DCI) dated 4/8/21 with an attached record included. The employee file failed to show the facility completed the further required request to DHS to receive authorization for Staff G to work in the facility. The facility allowed Staff G to work approximately 8 months in the facility without the required authorization from DHS. 3. Review of the facility's Employee Hire List provided, revealed Staff H, Dietary Aide, hired 01/21/20, and the file contained a SING background check completed 4/7/21, completed 15 months after hired. 4. Review of the facility's Employee Hire List provided, showed Staff J, Certified Nurse Aide (CNA), hired 12/08/20, and the file contained a	F 607	New Hires will have appropriate background checks completed prior to beginning employment with the facility. Staff was educated on *8/9/2021* on the importance of completing required background checks prior to beginning employment. This education also included the 2nd step of required background checks that are a result of a hit on the potential employee's criminal history portion of the background check. No staff will be allowed to begin employment until all required background checks have been run. The facility's Administrator will audit all potential new hires files to ensure all required background checks have been ran prior to beginning employment. Potential employees will not begin employment until all background checks have been ran and or all 2nd steps of background hits have been cleared for employment. Problems identified by the administrator will be corrected prior to the employee beginning work.	

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	165390	A. BUILDING _____ B. WING _____	07/21/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
STATE CENTER SPECIALTY CARE	702 THIRD STREET NW STATE CENTER, IA 50247

(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 607	Continued From page 2 SING background check completed 4/7/21, completed 4 months after hired. Review of the Dependent Adult Abuse Protocols revised 05/2017, revealed the facility will conduct an Iowa Criminal Record Check and Dependent Adult/Child Abuse Registry Check on all prospective employees and other individuals engaged to provide services to residents, prior to hire. In an interview on 7/19/21 at 2:05 PM, the Administrator acknowledged the past Business Office Manager was not completing SING checks. He stated the previous Office Manager was doing Office of Inspector General (OIG) checks. The Administrator stated they have since identified and corrected the issue. The Administrator further acknowledged Staff G's employee file lacked documentation of further research needed as a result of the SING background check and authorization from Department of Human Service (DHS) to work. Staff E, G, H, and J's SING background checks not completed prior to hire.	F 607	The facility's Stand Up Team will monitor that new employees will have appropriate background checks ran before beginning employment which will also include any 2nd step checks as a result of background check hits. Problems will be corrected as they are observed.	
F 655 SS=D	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-	F 655	**For Citation: F655 Baseline Care Plan** This is my credible allegation of compliance to F655 Baseline Care Plan This allegation does not constitute guilt but that the facility is in compliance to F655 Baseline Care Plan	

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	165390	A. BUILDING _____ B. WING _____	07/21/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
STATE CENTER SPECIALTY CARE	702 THIRD STREET NW STATE CENTER, IA 50247

(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 655	Continued From page 3 (i) Be developed within 48 hours of a resident's admission. (ii) Include the minimum healthcare information necessary to properly care for a resident including, but not limited to- (A) Initial goals based on admission orders. (B) Physician orders. (C) Dietary orders. (D) Therapy services. (E) Social services. (F) PASARR recommendation, if applicable. §483.21(a)(2) The facility may develop a comprehensive care plan in place of the baseline care plan if the comprehensive care plan- (i) Is developed within 48 hours of the resident's admission. (ii) Meets the requirements set forth in paragraph (b) of this section (excepting paragraph (b)(2)(i) of this section). §483.21(a)(3) The facility must provide the 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 reviews, staff interviews, and facility Admission Packet, the facility failed to complete, provide or discuss the Base Line Care Plan for 3 of 7 new residents reviewed (Resident	F 655	Residents 10, 13, and 23 have appropriate care plans in place in their clinical records. New admissions will have baseline care plans in place with in the 48 hours guidelines. The facility will give a summary of the care plan to resident/responsible party and document this process. Staff was educated on the importance of developing a baseline care plan on *8/9/21* which includes the 48 hour time limit. The education also includes the fact a summary of the care plan needs to be offered and or discussed with the family. The discussion with the resident/family will be documented as part of the resident record. The facility's Stand up team will monitor that baseline care plans are completed and the resident/family were offered a summary and or discussion of the baseline care plan. Problems will be corrected as they are observed with appropriate corrective actions	

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	165390	A. BUILDING _____ B. WING _____	07/21/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
STATE CENTER SPECIALTY CARE	702 THIRD STREET NW STATE CENTER, IA 50247

(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 655	Continued From page 4 #10, #13, and #23) within 48 hours of admission to the facility. The facility reported a census of 28 residents. Findings include: 1. The Admission Minimum Data Set (MDS) Assessment dated 5/27/21 revealed Resident # 10 with an admission date of 5/20/21 and diagnoses of end stage renal disease (ESRD), diabetes, transient ischemic attack (TIA), and dependence on renal dialysis. The MDS documented a Brief Interview for Metal Status (BIMS) score of 9, indicating cognitive impairment. The MDS recorded the resident required extensive assistance of one staff for mobility, personal hygiene, total dependence of two staff for transfers, dressing, and toileting, and set up assistance for meals. The MDS recorded the resident had a risk for pressure ulcer, on Dialysis, and took insulin seven of seven days during the look-back period, and on therapy services. The Care Plan initiated 5/20/21 revealed Resident #10, a new admission and had a history of diabetes, TIA/CVA (cerebral vascular accident) (stroke), hypertension (HTN, high blood pressure), ESRD and required hemodialysis, and had a diabetic foot ulcer present upon admission. The Care Plan included the resident used insulin medication and received hemodialysis. The Baseline Care Plan initiated on 5/20/21, showed no documentation that the facility reviewed the Care Plan with the family, resident or the resident's representative. The records lacked documentation of a Care Plan	F 655		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	165390	A. BUILDING _____ B. WING _____	07/21/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
STATE CENTER SPECIALTY CARE	702 THIRD STREET NW STATE CENTER, IA 50247

(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 655	Continued From page 5 Conference Signature Page form which contained a section regarding offering a copy of the Care Plan to the family. Also, no documentation completed from the family regarding if it was offered, accepted or declined. The Progress Notes dated 5/20/21 - 6/1/21 lacked documentation of the Care Plan reviewed with the resident or the resident's representative. An IDT (interdisciplinary) Note dated 6/1/21 at 3:11 PM, documented the resident hard of hearing and had bilateral hearing aids, wore glasses, received Dialysis three times a week, had a diabetic ulcer to his right third toe which required treatment, required staff assistance with transfers, and Physical, Occupational, and Speech Therapy (PT/OT/ST) services in place. The IDT note revealed the Care Plan reviewed. In an interview 7/19/21 at 3:01 PM, the Director of Nursing (DON) stated whenever a resident admitted to the facility, the floor nurse, MDS nurse, or DON completed the Admission Assessment in the Electronic Health Record (EHR), which then triggered focus areas for development of the resident's Care Plan. The DON stated Staff A, MDS Coordinator didn't know she was supposed to close out the Care Plan in the EHR when she started the Comprehensive Care Plan. The DON stated staff went over the Care Plan with the resident or resident's representative, and then an IDT Note or Progress Note written regarding Care Plan reviewed with the resident or representative and a copy of the Care Plan offered. The DON reported she was unable to locate a Care Conference Signature Page form for Resident #10.	F 655		

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	165390	A. BUILDING _____ B. WING _____	07/21/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
STATE CENTER SPECIALTY CARE	702 THIRD STREET NW STATE CENTER, IA 50247

(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 655	Continued From page 6 2. The MDS Assessment dated 6/4/21 revealed Resident #13 admitted to the facility on 5/28/21, with diagnoses of anemia, hypertension (HTN), diabetes, seizure disorder, malnutrition, depression, psychotic disorder, schizophrenia, obstructive sleep apnea, and chronic respiratory failure with hypoxia. The MDS documented the resident had a diabetic foot ulcer, used tobacco, and took antipsychotic, antidepressant, anticoagulant, and diuretic medications seven of seven days during the look back period, and had therapy services. The Care Plan initiated 5/28/21 revealed Resident #13, a new admission, a smoker, had a diabetic foot ulcer, and required ongoing psychiatric medication management. The Baseline Care Plan completed on 5/28/21, showed no documentation that the facility reviewed the Care Plan with the family, resident or the resident's representative. The records lacked documentation of a Care Plan Conference Signature Page form which contained a section regarding offering a copy of the Care Plan to the family. There was no documentation completed from the family regarding if it was offered, accepted or declined. An IDT note dated 6/7/2021 at 11:45 AM, revealed Care Plan reviewed. The Progress Notes dated 5/28/21 - 6/7/21 lacked documentation of the Care Plan reviewed with resident or representative. In an interview 7/19/21 at 3:01 PM, the DON	F 655		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	165390	A. BUILDING _____ B. WING _____	07/21/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
STATE CENTER SPECIALTY CARE	702 THIRD STREET NW STATE CENTER, IA 50247

(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 655	Continued From page 7 reported they were unable to find a care conference signature page for Resident #13. In an interview 7/20/21 at 9:35 AM, Staff A, RN/MDS Coordinator reported unable to find a Care Plan Conference Signature Page for Resident #13. 3. The MDS Assessment dated 6/22/21 revealed Resident #23 admitted to the facility on 6/15/21, with diagnoses of atrial fibrillation, HTN, renal insufficiency, diabetes, and a fractured left fibula (bone in the lower leg). The MDS documented the resident had a BIMS score of 15, which indicated cognition intact. The MDS recorded the resident had total dependence on two staff for bed mobility, transfers, ambulation, dressing, toileting, and hygiene, and required set up assistance for meals. The MDS recorded the resident had impaired range of motion to her lower extremity on one side. The MDS noted the resident took as needed (PRN) pain medication, had shortness of breath with exertion and on oxygen, and had a fall with fracture prior to admission. The MDS documented the resident took insulin, an anticoagulant, and a diuretic seven of seven days during the look back period, and had therapy services. The Care Plan initiated 6/15/21 revealed Resident #23, a new admission and had a recent left lower extremity fracture, diabetes, atrial fibrillation, chronic kidney disease, and hypertension. The Care Plan included the resident had a cast on his left lower extremity, unable to transfer independently, and unable to put weight on his left lower extremity. The Care Plan included the resident on oxygen, eliquis (a blood thinner),	F 655		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	165390	A. BUILDING _____ B. WING _____	07/21/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
STATE CENTER SPECIALTY CARE	702 THIRD STREET NW STATE CENTER, IA 50247

(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 655	Continued From page 8 insulin, and a diuretic. The Baseline Care Plan completed on 6/15/21, showed no documentation that the facility reviewed the Care Plan with the family, resident or the resident's representative. The records lacked documentation of a Care Plan Conference Signature Page Form which contained a section regarding offering a copy of the Care Plan to the family. There was no documentation completed from the family regarding if it was offered, accepted or declined. An IDT note dated 6/25/2021 at 12:40 PM, revealed Care Plan reviewed. The IDT and Progress Notes dated 6/15/21 - 6/29/21 lacked documentation of Care Plan reviewed with resident or representative. In an interview 7/19/21 at 3:01 PM, the DON reported they were unable to find a Care Conference Signature Page for Resident #23. In an interview 7/20/21 at 9:35 AM, Staff A, RN/MDS Coordinator reported unable to find a Care Plan Conference Signature Page for Resident #23. In an interview 7/19/21 at 3:00 PM, the Corporate Consultant reported unable to locate documentation for Baseline Care Plan reviewed for Resident #10, #13, #23. In an interview 7/20/21 at 9:35 AM, Staff A, RN/MDS Coordinator reported she had worked in the MDS Coordinator role for the past 2 years. Staff A reported whenever an Admission	F 655		

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	165390	A. BUILDING _____ B. WING _____	07/21/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
STATE CENTER SPECIALTY CARE	702 THIRD STREET NW STATE CENTER, IA 50247

(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 655	Continued From page 9 Assessment completed, the EHR auto-populated focus areas for the Care Plan. Staff A acknowledged she tried to remember to go over the Care Plan with the resident or the resident's representative in 48 - 72 hours after the resident's admission, and then she filled out Care Plan Conference Signature Page after she when went over the care plan with the resident or their representative. Staff A thought she had filled out the Care Plan Conference Signature Page for Resident #10, #13, and #23, but unable to find the forms. Staff A reported if staff hadn't found the forms, then they didn't have them. In an interview on 7/20/21 at 10:50 AM, Staff A reported they had no policy for Care Plans. Staff A stated they used the Resident Assessment Instrument (RAI) Manual to reference process or requirements for the Care Plans. Resident Bill of Rights dated 1/2017 included in the Admission Packet revealed the resident had the right to participate in the development and implementation of his or her person-centered plan of care, including but not limited to the planning process and the right to meetings, the right to participate in establishment of expected goals and outcomes of care, and the right to be fully informed in a language he/she understood regarding medical condition.	F 655		
F 658 SS=D	Services Provided Meet Professional Standards CFR(s): 483.21(b)(3)(i) §483.21(b)(3) Comprehensive Care Plans The services provided or arranged by the facility, as outlined by the comprehensive care plan, must- (i) Meet professional standards of quality.	F 658	**For Citation: F658 Services Provided Meet Professional Standards** This is my credible allegation of compliance to F658 Services Provided Meet Professional Standards This allegation does not constitute guilt but that the facility is in compliance to F658 Services Provided Meet Professional Standards	

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	165390	A. BUILDING _____ B. WING _____	07/21/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
STATE CENTER SPECIALTY CARE	702 THIRD STREET NW STATE CENTER, IA 50247

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 658	Continued From page 10 This REQUIREMENT is not met as evidenced by: Based on clinical record review, observation, policy review, and staff interviews, the facility failed to ensure staff flushed a gastrostomy (G-tube) (a tube in the stomach) tube before and after medication administration for one of one residents sampled with a G-tube (Resident #14). The facility reported a census of 28 residents. Findings include: A Minimum Data Set (MDS) Assessment dated 5/17/21 documented Resident #14 with diagnosis of malnutrition, non-Alzheimer's dementia, and had a gastrostomy tube. The Care Plan revised on 5/17/21 revealed the resident had a feeding tube to meet nutritional needs. The staff directives included to provide tube feeding and water flushes per Physician Order. The Order Summary Report dated 7/2021 revealed the resident had a Percutaneous Endoscopic Gastrostomy (PEG) (G-tube) feeding tube. The Order Summary Report lacked Physician Orders for water flushes before or after medication administration. The Medication Administration Record (MAR) dated 7/1 - 7/31/21 revealed an enteral feed order to flush the feeding tube with at least 15-30 milliliters (ml) of water before and after administration of feedings three times a day, started on 5/10/21. During observation on 7/15/21 at 11:15 AM, Staff	F 658	Resident #14 is having G-tube flushed appropriately before and after medication administration/tube feeding administration. Residents who require the use of G-tubes are having G-tubes flushed appropriately before and after medication administration/tube feeding administration. Staff was educated on *8/11/21* on the proper procedure for flushing G-tubes for before and after medication administration/tube feeding administration. Staff will be audited on proper G-tube flushing techniques with appropriate corrective actions taken for observed problems during medication administration and tube feeding administration. Nurse management will audit the staff for proper performance of flushing of G-tubes with further education provided for the tube feeding flushes.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	165390	A. BUILDING _____ B. WING _____	07/21/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
STATE CENTER SPECIALTY CARE	702 THIRD STREET NW STATE CENTER, IA 50247

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 658	Continued From page 11 B, Registered Nurse (RN) poured liquid Tylenol into a medication cup and took the medication to the resident's room. Staff B sanitized her hands and donned a pair of gloves. Staff B paused the tube feeding pump, then disconnected the tube feeding from the resident's PEG tube. Staff B attached a syringe to the end of the PEG tube and checked residual. Staff B drew Tylenol 20 ml into the syringe from a medication cup, attached the syringe to the PEG tube, and administered the medication. Staff B removed the syringe from the PEG, turned the sink faucet on with her gloved hand, removed the barrel from the syringe, rinsed the syringe and barrel with water, then plugged the end of the syringe with her gloved finger and obtained 30 ml tap water into the syringe. Staff B then attached the syringe to the end of the PEG tube, flushed the PEG tube with 30 ml water, and attached the tube feeding to the PEG tube. Staff B placed the syringe into a bag by the enteral feeding bag, removed her gloves, and washed her hands. In a policy dated 12/2011 titled Medication Administration through a Feeding Tube revealed a feeding tube needed flushed with at least 15-30 ml of water before and after medication administration. In an interview 7/15/21 at 11:30 AM, Staff B, RN, confirmed she flushed the PEG tube with 30 ml of water after she administrated Resident #14's medication through the PEG tube. In an interview 7/20/21 at 2:10 PM, the Director of Nursing (DON) reported she expected staff flush a feeding tube with at least 10-15 ml water before and after medication administration to prevent the G-tube from getting clogged. The DON reported	F 658	Facility's Stand Up Team will monitor that audit occur and that appropriate corrective actions were taken.	

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	165390	A. BUILDING _____ B. WING _____	07/21/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
STATE CENTER SPECIALTY CARE	702 THIRD STREET NW STATE CENTER, IA 50247

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 658	Continued From page 12 she expected staff used a plastic cup or graduate container for water, draw the amount of water needed from the cup or container, and flush the G-tube before and after a medication administered.	F 658		
F 812 SS=E	Food Procurement,Store/Prepare/Serve-Sanitary CFR(s): 483.60(i)(1)(2) §483.60(i) Food safety requirements. The facility must - §483.60(i)(1) - Procure food from sources approved or considered satisfactory by federal, state or local authorities. (i) This may include food items obtained directly from local producers, subject to applicable State and local laws or regulations. (ii) This provision does not prohibit or prevent facilities from using produce grown in facility gardens, subject to compliance with applicable safe growing and food-handling practices. (iii) This provision does not preclude residents from consuming foods not procured by the facility. §483.60(i)(2) - Store, prepare, distribute and serve food in accordance with professional standards for food service safety. This REQUIREMENT is not met as evidenced by: Based on observations, staff interviews, review of facility cleaning schedules, and policy review, the facility failed to maintain clean and sanitary conditions in the kitchen and failed to label and store food items appropriately in order to reduce the risk of contamination and food-borne illness. The facility identified a census of 28 residents. Findings include:	F 812	**For Citation: F812-(E) Food Procurement,Store/Prepare/Serve-Sanitary** This is my credible allegation of compliance to F812-(E) Food Procurement,Store/Prepare/Serve-Sanitary This allegation does not constitute guilt but that the facility is in compliance to F812-(E) Food Procurement,Store/Prepare/Serve-Sanitary Items in the kitchen are properly labeled and open dated. Food items are stored per food storage guidelines. The kitchen is clean and food storage areas are clean. Staff was educated on appropriate food storage which includes open dating, labeling of food items, and clean food storage areas which also includes clean utensil storage/kitchen area on *8/11/21* Facility continues to work with Exterminators on ridding building of pests. Facility will continue to have building treated routinely to assist in trying to rid the building of pests.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	165390	A. BUILDING _____ B. WING _____	07/21/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
STATE CENTER SPECIALTY CARE	702 THIRD STREET NW STATE CENTER, IA 50247

(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 812	Continued From page 13 Observations during the initial kitchen tour with the Dietary Manager on 07/14/21 beginning at 8:43 AM identified the following concerns: a. The Victory freezer contained one bag of frozen breaded chicken breasts with three remaining and the opened on date worn off and illegible. The Dietary Manager threw the breaded chicken breasts away. b. The Victory freezer contained one bag of frozen skinless chicken breasts that appeared freezer burnt with two remaining. The opened on date worn off and illegible. The Dietary Manager threw away the skinless chicken breasts. c. The Victory freezer contained one bag of frozen omelets with two remaining. The bag was undated, not sealed and open to air in the freezer. The Dietary manager threw away the omelets. d. The Victory freezer contained ½ bag of sausage links with the opened on date worn off and illegible. The Dietary manager stated she would relabel the sausage links. e. The Manitowoc Koolaire refrigerator contained ¼ bag of browning lettuce with the opened on date worn off. The Dietary Manager threw away the lettuce. f. The Manitowoc Koolaire refrigerator contained an unzipped, open to air, zip lock bag of bologna about 1/8 full. The Dietary Manager threw away the bologna. g. The Manitowoc Koolaire refrigerator contained an unzipped, open to air zip lock bag of hot dogs about ½ full. The Dietary Manager threw away the hotdogs. h. The Beverage Air refrigerator contained one 4 once container of Activia strawberry yogurt that expired 06/08/21. The refrigerator also contained four 6 ounce containers of Anderson Erickson cherry vanilla yogurt that expired July 12.	F 812	Facility management will continue to audit the kitchen for appropriately open dated food, appropriately stored food, and clean storage/kitchen areas. Proper correction action/education will continue for observed problems. Facility's Stand Up Team will monitor that audits continue and that appropriate corrective actions/education occur for any observed problems.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	165390	A. BUILDING _____ B. WING _____	07/21/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
STATE CENTER SPECIALTY CARE	702 THIRD STREET NW STATE CENTER, IA 50247

(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 812	Continued From page 14 i. All 11 kitchen cabinets and drawers facing dining area contained what appeared to be mouse droppings. One of the cabinets contained a box with six bags of regular coffee, all with holes chewed through and coffee coming out of the bags. A second cabinet contained a box with five bags of decaffeinated coffee, all with holes chewed through and coffee coming out of bags. Mouse droppings noted on the floor in the corner where the cabinet meets the wall. Mouse droppings observed on the countertop under plastic cutting boards beside a microwave. Mouse droppings observed in a white cabinet under the sink on the back wall of the kitchen. A mousetrap observed in corner on the floor by the hand washing station. j. A fly observed flying in kitchen and landed on gas range, with one other fly noted flying in the air. k. A pegboard by the entry door in the kitchen contained an undated blank weekly cleaning schedule sign off sheet that contained AM and PM cleaning tasks for Cooks and Dietary Aides. l. The ceiling in the walkway by the exit door of the kitchen contained vents covered with dust and hanging dust filaments. The Dietary Manager acknowledged they needed cleaned. A follow up kitchen observation occurred on 07/20/21 at 2:49 PM to review cleanliness of ceiling vents, drawers, and cabinets. The vents remained filled with dust and crusted particles and not cleaned since first observed on 7/14/21. Drawers continued to have mouse feces and had not been cleaned since first observed on 7/14/21. Staff F, Dietary Aide verified the cleaning not completed. A follow up observation on 7/20/21 at 4:00 PM revealed cleaning completed.	F 812		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	165390	A. BUILDING _____ B. WING _____	07/21/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
STATE CENTER SPECIALTY CARE	702 THIRD STREET NW STATE CENTER, IA 50247

(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 812	Continued From page 15 In an interview on 07/14/21 at 10:03 AM, the Dietary Manager reported she lacked knowledge of the coffee found in the kitchen cabinets and said that coffee not used. She noted nothing stored in the kitchen cabinets and kitchen drawers. She said the coffee stored on a shelf, in plastic containers, above the coffee pots. In a follow up interview on 07/14/21 at 12:51 PM, the Dietary Manager stated an awareness of a mouse issue for about 6 months. Maintenance and a pest control company handled pest control concerns. In a follow up interview on 7/15/21 at 1:36 PM, the Dietary Manager provided 5 weeks of cleaning schedules over the last 6 months that she kept in a file cabinet. She acknowledged she did not know what weeks these were for and that staff rarely signed they completed items on the cleaning schedule, but stated they completed the daily cleaning. In an interview on 07/14/21 at 10:12 AM, Staff D, Dietary Aide, stated awareness of the facility problem with mice and droppings in kitchen cabinets and drawers. She said the cabinets and drawers were emptied due to the mouse droppings. Staff D was unaware of coffee stored in two of the cabinets and said that coffee is not used. She commented the coffee is stored on a shelf above the coffee pots. Staff D revealed Maintenance and a pest control service handled pest control concerns. Staff D verified expired yogurt and threw it away. In an interview on 07/20/21 at 11:10 AM, the Dietary Manager stated it would be her expectation to follow the facility policy in regards to food storage and kitchen cleanliness. In an interview on 07/20/21 at 11:16 AM, the	F 812		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	165390	A. BUILDING _____ B. WING _____	07/21/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
STATE CENTER SPECIALTY CARE	702 THIRD STREET NW STATE CENTER, IA 50247

(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 812	Continued From page 16 Administrator stated he would expect facility policies be followed in regards to food storage and kitchen cleanliness. In an interview on 07/20/21 at 4:37 PM, Staff F, Dietary Aide, acknowledged a cleaning schedule checklist normally located behind the kitchen entrance door to complete, but said staff wasn't using or signing off on the checklist. He reported doing the cleaning on the list daily. Review of five undated weekly Cleaning Schedules revealed incomplete daily cleaning checklists for 35 of 35 days. Review of the February 2016 Refrigerated Food Storage policy directed perishable foods be refrigerated in a manner that optimizes food safety, nutrient retention, and aesthetic quality. Refrigerated foods will be covered, labeled, and dated (month, day, year). All pre-dished items will be covered, labeled and dated (month, day, year) to prevent off-flavors, drying, or cross-contamination while refrigerated. The policy further directed use of impervious containers for food storage. Review of the February 2016 Frozen Foods policy directed frozen foods stored in a manner that insures food safety, optimum nutrient retention, and optimum aesthetic quality. All frozen products will be sealed, labeled, and dated (month, date, year). Including items removed from original packaging. Review of the February 2016 Storage of Non-perishable Foods policy directed all non-perishable foods be stored in a manner that maximizes nutrient retention, aesthetic quality,	F 812		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	165390	A. BUILDING _____ B. WING _____	07/21/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
STATE CENTER SPECIALTY CARE	702 THIRD STREET NW STATE CENTER, IA 50247

(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 812	Continued From page 17 and food safety. The policy further directed the storeroom be free from dirt, dust, insects, rodents, or any potential source of contamination. Review of the February 2016 Dietary Services Cleaning Schedule policy directed staff maintain the cleanliness and sanitation of the food service areas through compliance with a written Comprehensive Cleaning Schedule posted in an area that is available to all Dietary Services Employees. The Dietary Services Manager will post the daily, weekly, and monthly cleaning lists with dates of use as appropriate. The policy directed staff to file and keep the cleaning schedule records from annual survey to annual survey.	F 812		
F 925 SS=E	Maintains Effective Pest Control Program CFR(s): 483.90(i)(4) §483.90(i)(4) Maintain an effective pest control program so that the facility is free of pests and rodents. This REQUIREMENT is not met as evidenced by: Based on observation, resident and staff interviews, vendor services, and facility policy review, the facility failed to maintain effective pest control of flies, ants and mice. The facility reported a census of 28 residents. Findings include: 1. Observations revealed the following: a. On 07/14/21 at 9:40 AM, during kitchen tour, observed what appeared to be mouse droppings in all 11 kitchen cabinets and drawers facing dining area. One of the cabinets contained a box with six bags of regular coffee, all with holes	F 925	**For Citation: F 925 Maintains Effective Pest Control Program** This is my credible allegation of compliance to F 925 Maintains Effective Pest Control Program This allegation does not constitute guilt but that the facility is in compliance to F 925 Maintains Effective Pest Control Program Items in the kitchen are properly labeled and This is my credible allegation of compliance to F 925. This allegation does not constitute guilt but that the facility is in compliance to F 925.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	165380	A. BUILDING _____ B. WING _____	07/21/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
STATE CENTER SPECIALTY CARE	702 THIRD STREET NW STATE CENTER, IA 50247

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 925	Continued From page 18 chewed through and coffee coming out of the bag. A second cabinet contained a box with five bags of decaffeinated coffee, all with holes chewed through and coffee coming out of bags. Mouse droppings noted on the floor in the corner where the cabinet meets the wall. Mouse droppings observed on the countertop under plastic cutting boards beside a microwave. Mouse droppings observed in a white cabinet under the sink on the back wall of the kitchen. A mousetrap observed in corner on the floor by the handwashing station. A fly observed flying in kitchen and landed on gas range. b. On 7/14/21 at 11:05 AM, observed what appeared to be mouse droppings in room 29 in the corners of the room, on the floor heaters, and in the closet. c. On 7/14/21 at 11:30 AM, observed what appeared to be mouse droppings on the floor, mouse droppings on the floor heater, and a sticky mousetrap in the corner by the exit door in A hall. d. On 7/14/21 at 11:35 AM, observed what appeared to be mouse droppings by the exit door on the floor and the floor heater in C hall. e. During a Resident Group Meeting in the dining room on 07/14/21 at 2:00 PM observed all residents present (5) and surveyor waving hands in the air swatting multiple flies away throughout the meeting. Flies landed on the dining room tables and residents throughout the 30-minute meeting. In an interview on 07/14/21 at 10:03 AM, the Dietary Manager reported she lacked knowledge of the coffee found in the kitchen cabinets and said that coffee not used. She noted nothing stored in the kitchen cabinets and kitchen drawers. She said the coffee stored on a shelf, in plastic containers, above the coffee pots. In a	F 925	The facility continues to provide routine exterminator treatment to facility to continue to rid the facility of pests such as mice and flies. The facility contacted additional exterminators on 8/6/2021 to get a more aggressive treatment plan for the facility to assist in controlling potential pests in the facility. The facility will continue to treat the building on a routine bases per exterminators plan to assist in controlling pest with in the facility. The facility management will audit the facility and talk with resident regarding any sightings of pests in the facility. The facility will contact exterminators for additional treatments in the facility to again assist in controlling pest in the facility. Facility will continue to document pest control audits along with exterminator notifications/treatments.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	165390	A. BUILDING _____ B. WING _____	07/21/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
STATE CENTER SPECIALTY CARE	702 THIRD STREET NW STATE CENTER, IA 50247

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 925	Continued From page 19 follow up interview on 07/14/21 at 12:51 PM, the Dietary Manager stated awareness of a mouse issue for about 6 months. Maintenance and a pest control company handled pest control concerns. In an interview on 07/14/21 at 10:12 AM, Staff D, Dietary Aide, stated awareness of facility problem with mice and droppings in kitchen cabinets and drawers. She said the cabinets and drawers emptied due to the mouse droppings. She was not aware of coffee stored in two of the cabinets and said that coffee is not used. Staff D noted Maintenance and a pest control service handled pest control concerns. In an interview on 07/14/21 at 11:31 AM, Staff E, Housekeeping/Cook, acknowledged mouse problem in the facility. He said there were multiple mousetraps and a pest control company comes to spray. He reported finding droppings around the facility, especially in rooms where residents store food. During a Resident Group Meeting on 07/14/21 at 2:00 PM, the residents reported on the many flies in the building. The residents felt it was unhealthy and unsanitary. The residents said flies crawl on tables, land on coffee cups and food, and reported a fly concern in resident rooms as well. All residents (5) present stated they have seen a mouse and mouse droppings in the facility. One resident said she saw a mouse in a sticky trap. Another resident reported her roommate's food taken away because a mouse had eaten it. One resident reported seeing a mouse in the shower room. In an interview on 07/15/21 at 10:50 AM, the	F 925	Problems will be corrected as they are observed. The facility's Stand Up Team will monitor that routine treatments take place as well as audit occur along with appropriate corrective actions on audit findings.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	165390	A. BUILDING _____ B. WING _____	07/21/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
STATE CENTER SPECIALTY CARE	702 THIRD STREET NW STATE CENTER, IA 50247

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 925	Continued From page 20 Administrator revealed he is aware of the pest issues. The facility signed a contract with a pest control company to inspect and treat the facility monthly. He stated the pest control company takes care of flies, ants, and mice. Traps are placed on the outside and inside of the building and checked regularly by staff and maintenance. The Administrator further revealed the facility might look into getting a different pest control service. The Administrator stated plans to gut the entire inside of the building and said the corporate office has signed off on the project and he is working with a contractor. In an interview on 7/15/21 at 12:24 PM, the Environmental Supervisor revealed an ongoing issue with mice in the facility. A couple of weeks ago, he called the pest control contractor and asked them to put out more bait traps around the outside of the building. The Environmental Supervisor said he purchased sticky traps for the inside of the building. He reported finding a mouse about twice per week. Pest control comes once per month and sprays. In an interview on 07/20/21 at 8:11 AM, the manager from the contracted pest control company stated awareness of the ongoing problem with mice in the facility. He stated he recently visited the facility June 15, July 1, and July 16. He recently increased frequency of the visits due to ongoing problems with mice. He stated the facility needed repairs to the building. The pest control technician did try to patch up some holes on the outside of the building. They added more bait stations on the outside of building and placed additional traps on the inside of the building in the storage and kitchen area. The manager expressed a need to talk to the	F 925		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	165390	A. BUILDING _____ B. WING _____	07/21/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
STATE CENTER SPECIALTY CARE	702 THIRD STREET NW STATE CENTER, IA 50247

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 925	Continued From page 21 facility and increase frequency of visits to manage the pest control problem. Review of invoices from the pest control company revealed monthly pest inspections 1/7/21, 1/13/21, 2/10/21, 3/10/21, 4/7/21, and 6/12/21.	F 925		
	The facility policy dated March 2013 for Other Environmental Conditions instructed the facility engage in an ongoing and effective pest control program to eradicate and contain common household pests including roaches, ants, mosquitoes, flies, mice, and rats. 2. Observations revealed the following: a. On 7/14/21 at 12:40 PM, Room 26 had a pile of dirt, debris, and what appeared to be mouse droppings on the floor near the door of the room. b. On 7/14/21 at 1:45 PM, a fly flew around Resident #10 as he talked with the surveyor. At the time, the resident reported the facility had a problem with flies. c. On 7/14/21 at 3:05 PM, ants crawled on the floor in the shower stall and flies flew around the shower room on Hall B. d. On 7/15/21 at 7:35 AM, a fly flew around Resident #17 and landed on the dining room table as the resident ate breakfast. e. On 7/15/21 at 12:41 PM, flies flew around the Nurse's Station and landed on the computer/counter. In an interview 7/20/21 at 11:05 AM, Staff C, Housekeeping, reported she had worked at the facility since 4/2021. Staff C reported she cleaned the resident rooms and shower rooms daily. Staff C reported she had seen rodents a couple of times since she worked at the facility and let maintenance or the Administrator know,			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	165390	A. BUILDING _____ B. WING _____	07/21/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
STATE CENTER SPECIALTY CARE	702 THIRD STREET NW STATE CENTER, IA 50247

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 925	Continued From page 22 and a trap was placed in the area. In an interview 7/20/21 at 1:45 PM, the Director of Nursing (DON) acknowledged a problem with files and wondered what other facilities had done to manage or get rid of files.	F 925		