STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	165307	A. BUILDING _____ B. WING _____	01/06/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PILLAR OF CEDAR VALLEY	1410 WEST DUNKERTON ROAD WATERLOO, IA 50703

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 000	INITIAL COMMENTS Correction Date: F692 1/31/22 F584, F677, F812, F880 2/10/22 A Focused COVID-19 Infection Control Survey and an investigation of Complaints #99318, #99881, #100321 and #101015 and a Facility Self-Reported Incident #100386 was conducted by the Department of Inspections and Appeals on 12/15/21 - 1/6/22. The facility was not found in substantial compliance with CMS and Centers for Disease Control and Prevention (CDC) recommended practices to prepare for COVID-19. The Complaints and the Incident were not substantiated. (See Code of Federal Regulations (42CFR) Part 483, Subpart B-C). Facility census - 131	F 000		
F 584 SS=E	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 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.	F 584		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Carla Mahlen | TITLE: MHA UHA Executive Director | (X6) DATE: 01/31/2022 2/10/22

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 584	Continued From page 1 §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 and staff interviews, the facility failed to maintain resident bathrooms in a clean, orderly manner and failed to provide clean linens for Resident #4 and failed to provide clean chairs in the dining room. The facility reported a census of 131. Findings include: 1. Observation on 12/27/21 at 11:22 a.m. revealed the bathroom of Room 334 had a yellow and black discoloration on the floor surrounding the toilet and in front of the sink. In front of the toilet, a ripped piece of brown paper was stuck to the floor. Observation of the bathroom revealed the room void of shelving or anywhere in the	F 584		

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F 584	Continued From page 2 bathroom to place all 4 room occupants personal care items. 2. Observation on 12/27/21 at 9:55 a.m. revealed Resident #4's bed with urine and feces covered sheets. Staff A, CNA (Certified Nursing Assistant) assisted Resident #4 out of bed, covered up the soiled bed sheets with the resident's bed spread and failed to remove the soiled sheets. At 10:15 a.m. Staff A escorted Resident #4 out of her room and into the lounge. Staff A failed to remove the soiled linens from the resident's bed. 3. Observation on 1/4/22 at 9:05 a.m. revealed a total of 35 dining room chairs in the main dining room with a nylon, cloth covering. Observation of the chairs revealed 5 of the 35 chairs had dried food on them and dark brown, feces looking discoloration in the center of the chairs. Observations of 3 chairs in the sun room dining room revealed 1 chair with dried food on the nylon, cloth dining room chair cover. During an interview with Staff J, Plant Supervisor on 1/5/22 at 11:00 a.m., Staff J stated the dietary department is responsible for all cleaning of dining room chairs and housekeeping staff is responsible for the floors. Staff J stated the dietary department only had sanitizer so they must alert the housekeeping staff if dining room chairs need to be shampooed due to incontinence episodes. Staff J stated they do not have the chairs on a regular cleaning schedule but depend on dietary staff to alert them.	F 584		
F 677 SS=D	ADL Care Provided for Dependent Residents CFR(s): 483.24(a)(2) §483.24(a)(2) A resident who is unable to carry	F 677		

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F 677	Continued From page 3 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, staff and resident interviews, observations and review of facility procedures, facility staff failed to provide timely incontinence care in accordance to the resident's plan of care for 3 of 5 residents reviewed for incontinence care (Residents #4, #8 and #9). The facility reported a census of 131. Findings include: 1. According to the Minimum Data Set (MDS) assessment dated 11/15/21, Resident #4 had diagnoses which included late onset Alzheimer's disease, major depressive disorder and dementia with behaviors. The resident required the assistance of 1 staff for transfers, walking, dressing, personal hygiene and bathing. The resident had frequent bowel and bladder incontinence. Resident #4 utilized a walker to move about the facility. The assessment documented the resident with severe cognitive and memory impairment, as evidenced by a Brief Interview for Mental Status (BIMS) score of zero. The resident's Care Plan, revised on 12/2/21, informed staff she had episodes of bladder incontinence related to Alzheimer's disease, confusion and impaired mobility. The resident did not always remember to ask for help with toileting tasks. The care plan directed staff to use disposable incontinence briefs and change her as needed, provide check and change routinely and as required for incontinence, and provide perineal care per policy when wet or soiled and as	F 677		

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F 677	Continued From page 4 needed. The resident required assistance of 1 staff for toilet use and had the ability to walk into the bathroom with her walker and staff assistance. Observation on 12/27/21 at 9:55 a.m. revealed Resident #4 lying in bed, appearing to be asleep. Staff A, CNA (Certified Nursing Assistant) entered the room. Staff a stated it looked like Resident #4 had not been up yet this morning. Staff A assisted the resident to sit up at the side of the bed. The resident's brief was saturated with urine and appeared to contain a large ball of urine-gel in the brief. The observation revealed the resident's bed linens soaked with urine and feces. Resident #4's body had an odor of urine. Staff A assisted the resident up to the bathroom and provided cares while the resident used the bathroom. Staff A also stated the resident did not receive breakfast this morning. 2. The MDS assessment dated 9/6/21 documented Resident's #8 had diagnoses which included viral hepatitis, dementia, Parkinson's disease, anxiety and depression. The resident had a BIMS score of 7 which indicated severe memory and cognitive impairment. The resident required limited assistance of 1 staff for transfers, ambulation, dressing and hygiene. Review of the resident's Care Plan, revised on 4/25/21, indicated Resident #8 with a self-care deficit and that she required supervision and set-up help from the staff to use the toilet. The resident had varying frequency of episodes of bladder incontinence related to the need for assistance with mobility and Parkinson's disease. The Care Plan directed staff to use disposable incontinence briefs and to assist with changing of	F 677		

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F 677	Continued From page 5	F 677		

briefs as needed. The Care Plan alerted the staff the resident with the potential to develop pressure ulcers and other skin injuries related to reduced mobility with prolonged sitting times, the need for assistance with activities of daily living and incontinence of bowel and bladder.

Observation on 12/27/21 at 11:09 a.m. revealed Resident #8 lying in bed with her night clothes on. Staff B, RN (Registered Nurse) and Co-Director of Nurses asked the resident if she had been up yet this morning. Resident #8 replied no but she would like to get up and get dressed. The resident stated she has not had breakfast yet that day. Staff B sat the resident up at the side of the bed, put on her shoes and socks and assisted her to walk into the bathroom. The observation revealed the resident's brief soiled with urine and feces and she had an odor of bowel movement when up and walking into the bathroom. The resident sat on the toilet and Staff B provided cares. Staff B pulled up the resident's pants and noted a bunched up piece of fabric with a rubber band around it. Staff B questioned the purpose of the rubber band and the resident replied that her pants are too big, so this makes them fit better. After cares and assistance dressing, Resident #8 commented that she felt so much better now that she is up.

3. According to the MDS assessment dated 10/25/21, Resident #9 had diagnoses which included dementia, stroke, diabetes mellitus and depression. The resident required limited assistance of 1 staff for transfers, walking, dressing, toilet use and personal hygiene. The MDS documented the resident had frequent urinary incontinence and occasional bowel incontinence. The resident had a BIMS score of

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F 677	Continued From page 6 13, indicating intact memory and cognition. The resident utilized a walker to move about the facility. According to the Care Plan, updated on 11/4/21, Resident #9 had frequent urinary incontinence related to physical debility secondary to a stroke. The Care Plan directed staff to assist the resident to the toilet and/or check and change before and after meals, at bedtime, upon rising in the morning and when she awakens during the night. Staff were also directed to provide hygiene as needed after each incontinence episode, to maintain dignity and to provide an adult incontinence brief. Observation on 12/27/21 at 11:27 a.m. revealed Resident #9 in her bed with her night clothes on. Staff A entered the room and stated the resident had not been up yet today. Staff A assisted the resident with morning cares, sat resident sat up at the side of the bed and put her shoes and socks on. The resident wore a blue brief, saturated with urine, appearing to have a large ball of gel in it. Staff A removed the resident's brief and provided incontinence care. When asked if she had been up this morning, Resident #9 stated no, no one helped her that morning. The resident denied having breakfast that morning when asked. Staff A stood the resident and observation revealed the resident's bed linens as saturated with urine. During an interview with Staff C, CNA/CMA (Certified Medication Aide) on 12/27/21 at 2:25 p.m., Staff C stated she was assigned to the female residents in room 344 this morning. Staff C stated she tried to wake them up about 7:15 a.m. but they didn't want to get up. Staff C commented the residents were sleeping so	F 677		

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F 677	Continued From page 7 soundly, she thought she would come back later. Staff C stated she got so busy and didn't go back in their room to provide cares or get them up. During an interview with Staff D, LPN (Licensed Practical Nurse) on 12/27/21 at 10:28 a.m., stated she was the charge nurse for the residents in room 344 on 12/27/21. Staff D stated she was not aware the residents in room 344 did not receive cares this morning, were not up for the day and not aware they did not receive breakfast this morning. During an interview with Staff B on 12/27/21 at 10:30 a.m., she stated she was unsure the residents would have been up for lunch after what she witnessed this morning. Staff B acknowledged staff failed to provide cares or get the residents up and dressed and taken down to the dining room for breakfast. Review of the facility's undated Incontinence Care Procedure revealed it is the basic responsibility of the licensed nurse and CNAs to provide incontinence care. The purpose of the care is to keep residents' skin clean, dry and free of irritation and odor. The staff can identity skin problems as soon as possible so treatment can be started, to prevent skin breakdown and prevent infection.	F 677		
F 692 SS=G	Nutrition/Hydration Status Maintenance CFR(s): 483.25(g)(1)-(3) §483.25(g) Assisted nutrition and hydration. (Includes naso-gastric and gastrostomy tubes, both percutaneous endoscopic gastrostomy and percutaneous endoscopic jejunostomy, and enteral fluids). Based on a resident's	F 692		

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F 692	Continued From page 8 comprehensive assessment, the facility must ensure that a resident- §483.25(g)(1) Maintains acceptable parameters of nutritional status, such as usual body weight or desirable body weight range and electrolyte balance, unless the resident's clinical condition demonstrates that this is not possible or resident preferences indicate otherwise; §483.25(g)(2) Is offered sufficient fluid intake to maintain proper hydration and health; §483.25(g)(3) Is offered a therapeutic diet when there is a nutritional problem and the health care provider orders a therapeutic diet. This REQUIREMENT is not met as evidenced by: Based on clinical record review, observations and staff and resident interviews, facility staff failed to provide the breakfast meal, failed to always provide interventions to promote nutrition and failed to monitor food consumption for 3 of 3 residents sampled with known weight loss and weight loss interventions in place (Residents #4, #8 and #9). The facility reported a census of 131. Findings include: 1. According to the Minimum Data Set (MDS) assessment dated 11/15/21, Resident #4 had diagnoses which included late onset Alzheimer's disease, major depressive disorder and dementia with behaviors. The resident required the assistance of 1 staff for transfers, walking, dressing, personal hygiene and bathing. Resident #4 utilized a walker to move about the facility. The assessment documented the resident with severe cognitive and memory impairment, as evidenced	F 692		

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by a Brief Interview for Mental Status (BIMS) score of zero. The resident required supervision with eating.

Review of the resident's Care Plan, revised on 12/2/21, revealed the resident with a problem of low body weight related to limited oral intake due to Alzheimer's disease. The resident could feed herself after she received set-up assistance and required cueing from the staff during meals to promote her intake. The Care Plan instructed staff to encourage the resident to accept the ordered supplement and nutrition related medications to maintain an adequate micronutrient intake. The Care Plan also directed staff to monitor the resident's weight and oral intake as ordered by her physician.

Observation on 12/27/21 at 9:55 a.m. revealed Resident #4 lying in bed, appearing to be asleep. Staff A, CNA (Certified Nursing Assistant) entered the room. Staff a stated it looked like Resident #4 had not been up yet this morning. Staff A stated the resident did not receive breakfast this morning.

Review of Resident #4's weight history revealed the following weight measurements:

a. On 6/8/21 the resident weighed 119 pounds.
b. On 7/27/21 the resident weighed 111 pounds.
c. On 8/17/21 the resident weighed 117 pounds.
d. On 9/1/21 the resident weighed 119.5 pounds.
e. On 10/5/21 the resident weighed 121 pounds.
f. On 11/2/21 the resident weighed 123 pounds.
g. On 12/17/21 the resident weighed 118 pounds.

Review of a Nutrition/Dietary Note dated 11/26/21 revealed the resident's weight as under her ideal

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F 692	Continued From page 10 body weight of 123 pounds and she had a 2.5% weight loss in the last month. The Dietician recommended to offer the resident 8 ounces of Ensure (a nutritional supplement) twice daily, to continue to provide meal set up and monitor her oral intake. Review of the Meal Consumption Report dated 12/17/21 - 1/4/22 revealed the staff failed to document meal consumption for 43 out of 60 meals. Review of the Diet Type Report dated 12/15/21 revealed Resident #4 had a regular consistency diet with a house supplement of 4 ounces of Might Shake daily. 2. The MDS assessment dated 9/6/21 documented Resident's #8 had diagnoses which included viral hepatitis, dementia, Parkinson's disease, anxiety and depression. The resident had a BIMS score of 7 which indicated severe memory and cognitive impairment. The resident required limited assistance of 1 staff for transfers, ambulation, dressing and hygiene. The resident required supervision during meals. The resident's Care Plan, revised on 12/8/21, indicated she had an unintended weight loss related to poor appetite as evidenced by meal refusals, trouble swallowing, dementia and a Parkinson's disease diagnosis. The resident required a mechanically altered diet. The Care Plan directed staff to supervise the resident during meals for safety, utilize a lipped plate to promote independence, encourage whole milk at meals, offer a mechanically altered diet as order and to monitor for swallowing problems. The Care Plan also directed staff to offer a snack at	F 692		

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bedtime, to encourage the resident to consume supplements as ordered and honor her food preferences.

Review of the Meal Consumption Report dated 12/17/21 - 1/4/22 revealed the staff failed to document meal consumption for 48 out of 60 meals and during 8 of those meals, the resident consumed less than 25% of her meals.

Observation on 12/27/21 at 11:09 a.m. revealed Resident #8 lying in bed with her night clothes on. Staff B, RN (Registered Nurse) and Co-Director of Nurses asked the resident if she had been up yet this morning. Resident #8 replied no but she would like to get up and get dressed. The resident stated she has not had breakfast yet that day.

Review of the Physician's Order sheet failed to indicate the resident had an order for additional nutritional supplements until 12/27/21.

Review of a Diet Type Report dated 12/15/21 indicated Resident #8 ordered to have a pureed, regular fluid consistency, no added salt diet. The report did not record the resident should have whole milk at meals, that she consumed a supplement or that she utilized a lipped plate.

Observation on 12/27/21 at 11:09 a.m. revealed Staff B assisted the resident to the standing scale and the resident's weight at that time measured 118 pounds.

Review of the resident's weight history revealed the following weight measurements:

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F 692	Continued From page 12 a. On 6/29/21 the resident weighed 147.5 pounds. b. On 7/20/21, the resident weighed 146 pounds. c. On 8/17/21, she weighed 143 pounds. d. On 9/28/21, the resident weighed 150 pounds. e. On 10/26/21, she weighed 129.5 pounds. f. On 11/23/21, the resident weighed 129 pounds. g. On 12/17/21 and 12/27/21, the resident's weight measured 118 pounds. The resident had a total weight loss of 29.5 pounds since 6/21. Observation on 12/27/21 at 11:57 a.m. revealed Resident #8 sitting in a wheelchair in the main dining room waiting to eat lunch. The resident had her head down and she appeared to be asleep. At 12:15 p.m. staff served the resident her noon beverages which she picked up and began to drink immediately. Resident #8 drank a cup of coffee with milk and 1/2 glass of water. The resident pushed herself away from the table and did not eat food at the time. The staff failed to redirect the resident back to the table. Observation on 1/4/22 at 12:13 p.m. revealed dietary staff served Resident #8 a carton of skim milk which the resident readily drank. 3. According to the MDS assessment dated 10/25/21, Resident #9 had diagnoses which included dementia, stroke, diabetes mellitus and depression. The resident required limited assistance of 1 staff for transfers, walking, dressing, toilet use and personal hygiene. The resident had a BIMS score of 13, indicating intact memory and cognition. The resident utilized a walker to move about the facility. The resident required supervision during meals.	F 692		

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	165307	A. BUILDING _____ B. WING _____	01/06/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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F 692	Continued From page 13 The resident's Care Plan, updated on 12/1/21, informed staff the resident had a potential for unintended weight loss related to variable oral intakes and dysphasia. The Care Plan directed staff to supervise the resident during meals, follow safe swallowing techniques, monitor and record meal intakes, offer bed time snack daily, serve supplements as order and to provide her altered diet as prescribed by the physician. Review of the Meal Consumption report dated 12/17/21 - 1/4/22 revealed the staff failed to document meal consumption for 49 out of 60 meals and during 2 of those meals, the resident consumed less than 25% of her meals. Review of a Quarterly Dietary Note dated 12/1/21 revealed the resident's current weight at 136 pounds, down 3.4% in last 6 months. The resident received a pureed diet, had gastroparesis and her meal observations revealed poor overall dietary intakes. The Dietician noted the resident liked to receive her supplements with meals. Review of the Diet Type Report dated 12/15/21 indicated Resident #9 had a regular, pureed with regular consistency liquid diet. The diet order sheet did not indicate the resident received dietary supplements, with or without her meals. Observation on 12/27/21 at 11:27 a.m. revealed Resident #9 in her bed with night clothes on. Staff A entered the room and stated the resident had not been up yet today. When asked if she had been up this morning, Resident #9 stated no, no one helped her that morning. The resident denied having breakfast that morning when	F 692		

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F 692	Continued From page 14 asked. Review of the resident's weight history revealed the following weight measurements: a. On 5/10/21 the resident weighed 140.8 pounds. b. On 6/28/21 the resident weighed 131 pounds c. On 7/29/21 the resident weighed 130 pounds. d. On 8/23/21 she weighed 129 pounds e. On 9/27/21 the resident weighed 127 pounds f. On 10/25/21 the resident weighed 133 pounds g. On 11/16/21 the resident weighed 136 pounds h. On 12/27/21 she weighed 136 pounds. Observation on 12/27/21 at 12:40 p.m. revealed Resident #9 sitting alone in the dining room. The resident consumed a container of vanilla pudding and drank a glass of thickened water independently, but the plate of pureed food in front of the resident was untouched. The dietary staff failed to serve the resident a supplement with this meal. During an interview with Staff G, Food Service Supervisor on 1/4/22 at 1:43 p.m. Staff G stated they do not have a solid method to tell if a resident came to the dining room for a meal. Staff G stated the nursing staff are responsible to fill out the dietary request slips but they are not consistently done. Dietary staff would know at the end of serving a meal, if the dietary slip remained, the resident did not show up for a meal, but stated again the dietary slips are not consistently completed. The facility had no real way to tell if a resident attended a meal. Staff G stated the nursing department is responsible to complete and document the resident's meal consumption for each meal. They are documented in Point	F 692		

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F 692	Continued From page 15 Click Care electronic charting. During an interview with Staff I, Registered Dietician on 1/5/22 at 10:30 a.m. Staff I stated she was aware of the issues regarding Residents #4, #8 and #9 not getting down to breakfast the morning of 12/27/21. Staff I stated she is following all three of the residents for weight loss. Staff I stated the dietary department has system breakdowns and is working with the FSS and other dietary staff to put measures in place to assure the residents get to meals.	F 692		
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 and staff interviews, the facility failed to store food in a safe and sanitary	F 812		

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F 812	Continued From page 16 manner to minimize the possibility of food borne illness and in accordance with food safety guidelines. The facility reported a census of 131 residents. Findings include: Observation and interview on 1/4/22 at 9:16 a.m. with Staff F, Food Service Supervisor (FSS) revealed the following concerns: a. Cooler #1 contained a box of thawed pork chops with approximately 10 thawed chops inside and without a label or date of when thawed. Staff F stated they use Cooler #1 to store prepared food items. Staff F disposed of the thawed meat. Continued observation revealed a plastic bag of thawed chopped ham on the next shelf below the pork chops. The bag of chopped ham had no marked date as to when staff thawed it. Staff F stated she would dispose of the thawed meat. b. Cooler # 3 (the pass-through cooler) stored Styrofoam containers which contained undated lettuce salad. Staff F stated the lettuce was left over from last's night meal and staff failed to date the items when putting them in the fridge. Staff F then discarded the salad. Cooler #3 also stored a 46-ounce container of apple juice, 1/2 full, and not dated when opened, a plastic container of cold meat without a date and a container of an unidentified brown substance without a label to identity it or when staff opened it. c. The walk-in cooler had a 4-shelf metal shelving unit which had on the top shelf a box of thawed chicken breast pieces. The chicken breasts dripped a blood-tinged fluid down to the next shelf which contained a card board box of ham. The	F 812		

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F 812	Continued From page 17 chicken breasts were thawed but without a date to indicate when thawed. The box of ham had a reddish-tinged liquid on it and on the hams. The unit's third shelf had a gray tub that contained a package of lunch meat, undated as to when thawed. The gray tub had the same reddish liquid in it that sat on top of the ham and cardboard box that held them. On the floor of the walk in cooler sat a box of 10-pound tubes of thawed ground beef. The box holding ground beef sat directly on the floor and had 2 - 3 tubes of meat removed from it. The floor of the walk in cooler had food debris scattered on the floor. During an interview with Staff F at the time of the observations, she stated she planned to have a staff meeting regarding dating items when opened and thawed. Staff F stated this had been an ongoing problem with the staff's failure of dating items when opened. During an interview with Staff I, Registered Dietician on 12/15/21 at 2:00 p.m. Staff I acknowledged the dietary department has an issue with sanitation and they are working to make this better.	F 812		
F 880 SS=E	Infection Prevention & Control CFR(s): 483.80(a)(1)(2)(4)(e)(f) §483.80 Infection Control The facility must establish and maintain an infection prevention and control program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of communicable diseases and infections. §483.80(a) Infection prevention and control	F 880		

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F 880	Continued From page 18 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 (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	F 880		

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F 880	Continued From page 19 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 observation, facility policy review and documentation of staff training, facility staff failed to properly wear Personal Protective Equipment in accordance with the national standards and facility policy. The facility reported a census of 131. Findings include: 1. Observation on 12/15/21 at 11:10 a.m. revealed Staff E, CNA (Certified Nursing Assistant) performed a two-person transfer with another staff in the day room on Pines Unit. Staff E failed to wear goggles during this transfer and stood close to the resident's face. 2. Observation on 12/16/21 at 12:44 p.m. revealed Staff F, CMA (Certified Medication Aide) walked out from the elevator onto the second floor without a mask covering her nose and mouth. Once Staff F saw the surveyor standing	F 880		

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F 880	Continued From page 20 by the door, she quickly replaced her mask to cover her mouth and nose. Staff F got off the elevator with another staff member at this time. Residents were noted in the area of the elevator/hall way area at this time. The facility's Standard Precautions Policy and Procedure dated 1/1/19 directed the staff to use standard precautions for all resident care/contact. Personal Protective equipment included gloves, masks, eyewear/face shields to be used when an employee anticipates resident contact. Review of the facility's Nurse/CNA Meeting dated 11/23/21 revealed staff were informed that Personal Protective Equipment is required. Until told otherwise, staff must at a minimum wear goggles or a face shield and a mask.	F 880		

Pillar of Cedar Valley
1410 W. Dunkerton Rd
Waterloo, Iowa 50703
Phone: (319) 291-2509

Plan of correction related to survey ending January 6, 2022

This plan of correction constitutes Pillar of the Cedar Valley's commitment to compliance. Preparation and implementation of the plan of correction should not be construed as an admission of the deficiencies cited. The plan of correction is prepared solely because it is required under federal or state law. Pillar of the Cedar Valley's continues to meet the applicable provisions of the State and Federal regulations.

FOOO Correction Date 1/31/2022

F692: 481—58.19(135C) Required nursing services for residents.

The facility ensures the residents receive the appropriate required nursing services under the 24-hour direction of qualified nurses with ancillary coverage as set forth in these rules 58.19(1) Activities of daily living. Nutrition and meal service. Regular, therapeutic, modified diets, and snacks; (I, II, III)

1. Staff B CO-DON verbally educated Staff C on 12/27/2021 to always provide care and get residents up for meals. If residents refuse she is to notify her supervisor or charge nurse and they will attempt or document the refusal. Staff C was given written education on 2/7/2022. Staff were educated during all staff In-Service on 12/28/2021.

2. Modifiable hard dietary cards were implemented for all residents who eat in the main dining room on 2/1/2022. All remaining dietary cards will alert dietary staff that a resident has not come down to the dining room for the meal. Dietary staff would alert the nurse of the unit for that resident that the resident has not come down for their meal. The nurse would assist the resident to come down to the dining room, or offer them a tray.

3. A 5 Minute Meeting education was conducted by DON and ADON on 2/1/2022 for all nurse units regarding the new process of filling out paper meal consumption sheets. Each unit charge nurse will be responsible for following up on meal documentation and ensure that all residents have been offered their meals. DON or Designee will review meal consumption via EHR on a weekly basis to ensure compliance.

4. For Resident #9, resident was provided supplements as ordered by the nurse at 0900, 1400, 2100.

5. Audits for meal consumption will be documented daily by charge nurse and audited weekly by DON or Designee for 6 weeks. Any issues will be discussed and interventions put into place at monthly quality assurance performance improvement meetings.

FOOO Correction Date 2/10/2022

F677: 481—58.19(135C) Required nursing services for residents.

The facility provides for the residents required nursing services under the 24-hour direction of qualified nurses with ancillary coverage as set forth in these rules: 58.19(1) Activities of daily living. j. Elimination. (3) Care for incontinent residents; (II, III)

1. Staff B CO-DON verbally educated Staff C on 12/27/2021 to always provide care and get residents up for meals. If residents refuse she is to notify her supervisor or charge nurse and they will attempt or document the refusal. Staff C was given written education on 2/7/2022. Nursing staff were educated during all staff In-Service on 12/28/2021.

2. Staff D was verbally educated regarding the responsibility of the charge nurse to ensure the resident received ADL care on 12/27/2021. Staff D was provided written education on 2/7/22.

3. Random audits will be completed on ADL completion 3 times per week times 6 weeks. Any issues will be addressed immediately and interventions discussed at quality assurance performance improvement monthly meeting.

F584:
481—58.31(135C) Housekeeping.
58.31(3) All rooms, corridors, storage areas, linen closets, attics, and basements are kept in a clean, orderly condition, free of unserviceable furniture and equipment and accumulations of refuse. (III) 58.31(8) All furniture, bedding, linens, and equipment are cleaned periodically and before use by another resident. (III)

481—58.33(135C) Laundry.
58.33(5) Bed linens, towels, and washcloths are clean and stain-free. (III)

1. The bathroom floor in room 334 (344) was deep cleaned on 2/4/2022. Bathrooms are cleaned daily by housekeeping staff. Random audit of resident rooms and bathrooms completed daily. Any issues addressed immediately. A bathroom shelf was installed in room 344 on 1/18/2022. Results of audits will be reported at monthly quality assurance performance improvement meeting.

2. Written education was provided to Staff A on 2/7/2022 to ensure she changes bed linens immediately when an issue identified. Education will be completed for all nursing staff on 2/22/2022 at the monthly nursing staff meeting.

3. Dining Room chairs and tables were audited by personnel. This was completed on 2/3/2022. Chairs and tables will be wiped down by dietary staff. Any areas that can't be cleaned will be reported to Housekeeping. This audit will be completed monthly for 3 months.

4. Random audits for bathroom cleaning and linen changes will be completed weekly for 4 weeks by the housekeeping supervisor. Any issues will be addressed immediately and results reported at quality assurance performance improvement meeting.

F812: 481—58.24(135C) Dietary.
58.24(5) Food handling, preparation and service. The facility ensures all food shall is handled, prepared and served in compliance with the requirements of the Food and Drug Administration Food Code adopted under provisions of Iowa Code section 137F.2. (I, II, III)

1. Unsanitary issues discovered during the walk thru with surveyor were remedied immediately.

2. All dietary staff were provided education on 1/10/2022 at a dietary in service labeling and dating items and keeping coolers clean were part of the education provided.

3. The Dietary Manager will complete an audit of the coolers and freezers weekdays for one week. RD will conduct an audit 1 x per week and provide findings to ED or designee and CDM. Any concerns will be corrected and system issues discussed at quality assurance performance improvement monthly meeting.

F880: 481—58.10(135C) General policies.
58.10(8) Infection control program. The facility has written and implemented an infection control and exposure control program with policies and procedures based on the guidelines issued by the Centers for Disease Control and Prevention, U.S. Department of Health and Human Services. (I, II, III) CDC guidelines are available at www.cdc.gov/ncidod/dhqp/index.html.

1. Staff E was an agency CNA. She was educated through her agency of the importance of wearing PPE properly. Staff F was provided written education for not wearing her PPE properly on 1/5/2022. Staff were educated on 12/28/2021 at In Service. All staff working were educated on 1/5/2022. All staff educated via OnShift of the importance of wearing PPE properly on 1/5/2022.

2. Root Cause Analysis training was completed on 2/8/2022. Evidence of completion of training provided to the program coordinator.

4. All staff will be required to watch the videos by 2/15/2022. Evidence of such will be provided to program coordinator.

5. Root Cause Analysis completed 2/10/2022.

6. PPE Disciplinary Process Policy implemented on 2/10/2022. New signage placed on all entrances on 2/10/2022.

5. Random PPE audits for all departments will conducted weekly for 4 weeks. Any issues will be addressed immediately. Results reported at monthly quality assurance performance improvement meeting.