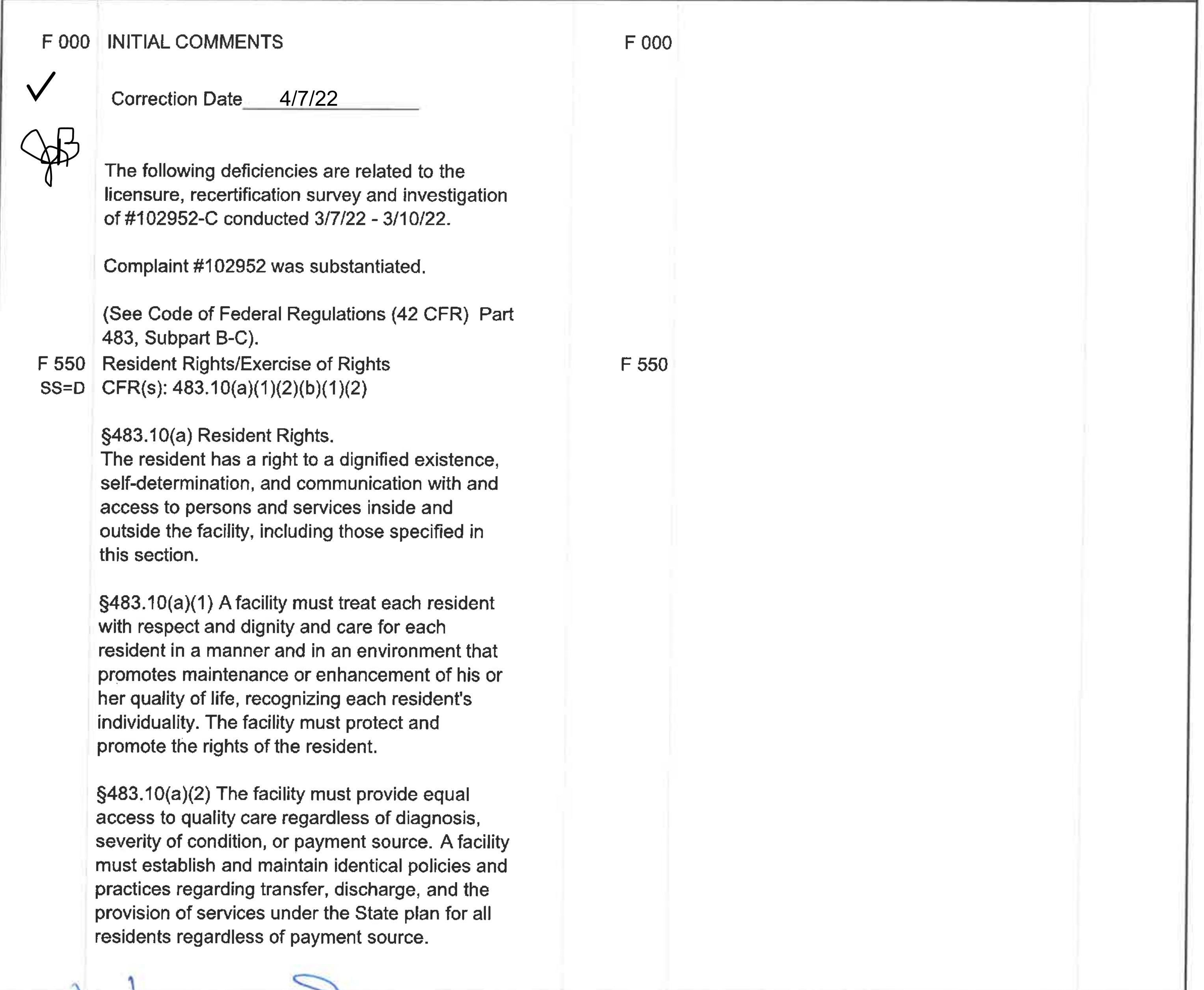
DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 03/24/2022
FORM APPROVED
OMB NO. 0938-0391

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 ______	03/10/2022

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 4/7/22 The following deficiencies are related to the licensure, recertification survey and investigation of #102952-C conducted 3/7/22 - 3/10/22. Complaint #102952 was substantiated. (See Code of Federal Regulations (42 CFR) Part 483, Subpart B-C).	F 000		
F 550 SS=D	Resident Rights/Exercise of Rights CFR(s): 483.10(a)(1)(2)(b)(1)(2) §483.10(a) Resident Rights. The resident has a right to a dignified existence, self-determination, and communication with and access to persons and services inside and outside the facility, including those specified in this section. §483.10(a)(1) A facility must treat each resident with respect and dignity and care for each resident in a manner and in an environment that promotes maintenance or enhancement of his or her quality of life, recognizing each resident's individuality. The facility must protect and promote the rights of the resident. §483.10(a)(2) The facility must provide equal access to quality care regardless of diagnosis, severity of condition, or payment source. A facility must establish and maintain identical policies and practices regarding transfer, discharge, and the provision of services under the State plan for all residents regardless of payment source.	F 550		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Schmidt | TITLE: administrator | (X6) DATE: 03/24/2022

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.

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 ______	03/10/2022

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 550	Continued From page 1	F 550		

§483.10(b) Exercise of Rights.
The resident has the right to exercise his or her rights as a resident of the facility and as a citizen or resident of the United States.

§483.10(b)(1) The facility must ensure that the resident can exercise his or her rights without interference, coercion, discrimination, or reprisal from the facility.

§483.10(b)(2) The resident has the right to be free of interference, coercion, discrimination, and reprisal from the facility in exercising his or her rights and to be supported by the facility in the exercise of his or her rights as required under this subpart.
This REQUIREMENT is not met as evidenced by:
Based on clinical record reviews, observations, facility policy review, resident and staff interviews, the facility failed to promote dignity by covering a urinary drainage bag for 1 of 17 Residents (Residents #111) sampled for dignity. The facility identified a census of 130 residents.

Findings include:

The Minimum Data Set (MDS) Assessment dated 2/7/22 showed a Brief Interview for Mental Status (BIMS) score of 14 indicating intact cognitive functioning. The resident required extensive assistance of one person for toilet use and personal hygiene. The MDS identified that the resident utilized (used) an indwelling suprapubic (through the abdomen to the bladder) urinary catheter for a diagnosis of neurogenic bladder.

The Care Plan Focused area revised 6/17/20, identified the resident was at risk for

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 ______	03/10/2022

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 550	Continued From page 2 complications related to use of a suprapubic catheter due to a diagnosis of benign prostatic hypertrophy (BPH) with obstructive uropathy. The Care Plan lacked interventions directing the staff to cover the urinary drainage bag with a dignity cover. During an observation on 3/7/22 at 1:00 p.m. Staff B, Certified Nursing Assistant, (CNA), assisted the resident back to his room. The urinary drainage bag hung off the right side of the reclining wheelchair with the urinary drainage bag 3/4 full of yellow urine. There was no privacy bag observed covering the drainage bag. During an interview on 3/7/22 at 1:10 p.m. Resident #111 stated it bothers him a little bit that others could see the urine in his bag. He reported he never knew if they covered the bag. During an observation on 3/8/22 at 7:37 a.m. the resident sat in the reclining wheelchair by the Oaks elevator with the urinary drainage bag. The urinary drainage bag was uncovered, hanging from the right side of his wheelchair with the urinary drainage bag was 1/4 full of yellow urine. Three other residents, not included in the sample, were observed sitting in the hallway area by the elevator. During an observation on 3/8/22 at 8:10 a.m. the resident sat in the reclining wheelchair, in the first floor dining room with his urinary drainage bag uncovered hanging off the right side of the wheelchair. The urinary bag had yellow urine 1/4 full in the urinary drainage bag visible. Twenty-seven residents were present in the dining room. Eleven residents were facing the resident where the urinary drainage bag could be	F 550		

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 ______	03/10/2022

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 550	Continued From page 3	F 550		

visualized.

On 3/8/22 at 8:13 a.m. Staff A, Licensed Social Worker, walked in to the dining room to inform another resident that she had a box for her. She stood 10 feet from Resident #111, and she did not address the resident's uncovered urinary drainage bag.

An observation on 3/8/22 at 8:14 a.m. revealed the Provisional Administrator walked around the dining room talking with residents. She stood approximately 10 feet from Resident #111 and did not intervene to cover the urinary drainage bag for dignity.

During an observation on 3/8/22 at 8:25 a.m. Staff C, Certified Nursing Assistant (CNA)/Restorative Aide (RA), moved the Resident's wheelchair to the side of the dining room table so that she could sit in a chair on the right side of the wheelchair near the uncovered urinary drainage bag. The urinary drainage bag hung down from the wheelchair uncovered and was 1/4 full of yellow urine. Staff B proceeded to assist the resident with breakfast without addressing the urinary drainage bag.

During an interview on 3/8/22 at 1:57 p.m. Staff G, CNA, reported that urinary drainage bags should be emptied at the end of each shift and the bags should always be covered with a privacy cover.

During an interview on 3/8/22 at 1:58 p.m. Staff H, Licensed Practical Nurse, (LPN), reported the CNA's should empty the urinary drainge bags at the end of the shift and the drainage bag should be covered.

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 ______	03/10/2022

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 550	Continued From page 4 On 3/9/22 at 9:36 a.m. Staff C and Staff F, CNA/RA, entered Resident #111's room to perform the restorative nursing exercise program. The resident's door was opened to the hallway with the uncovered urinary drainage bag hanging off of the outer bed frame visible from the open room door draining 100 milliliters (ML) of dark amber urine. During an interview on 3/10/22 at 7:27 a.m. the Director of Nursing, (DON), reported she expects a dignity bag to be over the urinary drainage bags for dignity. She stated she needs to put a performance improvement program (PIP) in place, educate the staff regarding dignity, and catheter care going forward. At 7:39 a.m. the DON stated the drainage bags should be covered and that the facility had dignity bag covers available. The Resident's Bill of Rights, revised 11/16, provided by the facility, under section 1. Resdent's Rights (1) documented the facility must treat each resident with respect and dignity and care for each resident in a manner and in an environment that promotes maintenance or enhancement of his or her quality of life, recognizing each resident's individuality. The facility must protect and promote the rights of the resident. The undated Catheter - Emptying of policy provided by the facility lacked direction of when to use a privacy bag for urinary drainage bags.	F 550		
F 558 SS=D	Reasonable Accommodations Needs/Preferences CFR(s): 483.10(e)(3)	F 558		

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 ______	03/10/2022

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 558	Continued From page 5	F 558		

§483.10(e)(3) The right to reside and receive services in the facility with reasonable accommodation of resident needs and preferences except when to do so would endanger the health or safety of the resident or other residents.
This REQUIREMENT is not met as evidenced by:
Based on clinical record reviews, observations, and staff interviews the facility failed to provide reasonable accommodations for use of a call light while a dependent resident was in his bedroom with the door closed for 1 of 8 dependent residents reviewed (Resident #100). The facility reported a census of 130 residents.

Findings include:

The Minimum Data Set (MDS) dated 1/22/22 for Resident #100 documented a Brief Interview of Mental Status (BIMS) score of nine (9), indicating moderately impaired cognition. The MDS directed that the resident needed limited assistance (resident highly involved in activity; staff provide guided maneuvering "movement" of limbs or other non-weight-bearing assistance) of one (1) staff and total dependence (full staff performance every time during entire 7-day period) of two (2) staff for assistance. The MDS documented that Resident #10 had a Stage three (3) pressure ulcer (full thickness skin and tissue loss).

During an observation on 3/7/22 at 11:14 AM noted Resident #100's call light hanging over the call light box on the wall and not within his reach. During the observation, Resident #100 was observed laying on his right side in the bed, approximately 8 feet away from the call light.

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 ______	03/10/2022

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 558 — Continued From page 6 — F 558

During a follow-up observation on 3/7/22 at 11:40 AM witnessed Resident #100 leaving his room for meal service.

During an interview on 3/10/22 at 10:40 AM the Director of Nursing (DON) revealed that she would expect for a call light to be in reach at all times while Resident #100 was in his room.

F 607 SS=D — Develop/Implement Abuse/Neglect Policies CFR(s): 483.12(b)(1)-(3) — F 607

§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 employee record review, policy review and staff interviews, the facility failed to complete a background employment check within 30 days of hire for 1 of 5 employee (Staff D) files reviewed. The facility identified a census of 130 residents.

Findings include:

The New Hires since 3/7/21 list provided by the facility, documented Staff D, Certified Nursing Assistant, (CNA), with a hire date of 7/20/21.

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 ______	03/10/2022

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 607	Continued From page 7 Staff D's Single Contact License and Background Check dated 6/11/21 show that the background check was complete as of 6/11/21. The Criminal History Background Check section indicated that further research was required and to await for the final response for criminal history. The Single Contact License and Background Check printed 6/14/21 recorded the status complete 6/14/21 with no criminal history (CCH) record found. Staff D's personnel record lacked a background check completed within 30 days of the hire date of 7/20/21. During an interview on 3/9/22 at 11:18 a.m. Staff E, Office Manager, reported that the background check has to be completed within 30 days of the actual hire date. Staff E explained that if it was outside of that timeframe, the background checks would have to be redone. During an interview on 3/9/22 at 11:19 a.m. the Provisional Administrator stated the background checks have to be completed within 30 days of hire. The Abuse Prevention, Identification, Investigation and Reporting Policy, revised 7/6/21 included a Policy Statement that all resident have the right to be free from abuse, neglect, misappropriation of resident property, exploitation, corporal punishment, involuntary seclusions, and any physical or chemical restraint not required to treat the resident's medical symptoms. Residents must not be subject to abuse by anyone, including but not limited to, facility staff, other residents, consultants or	F 607		

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 ______	03/10/2022

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 607	Continued From page 8	F 607		

volunteers, staff of other agencies serving the resident, family members or legal guardians, friends, or other individuals. It shall be the policy of this facility to implement written procedures that prohibit abuse, neglect, exploitation and misappropriation of resident property. These procedures shall include screening.

The Abuse, Prevention, Identification, Investigation and Reporting Policy Employee Screening documented that the facility should screen all potential employees for a history of abuse, neglect exploitation, misappropriation of property, or mistreatment of residents. The facility would not employ or otherwise engage individuals who; (i) have been found guilty of resident abuse, neglect, exploitation, misappropriation of property, or mistreatment by a court of law; (ii) have had a finding entered into the State Nurse Aide Registry of misappropriation of their property, or (iii) have a disciplinary action in affect against their professional license by a State licensure body as a result of a finding of abuse, neglect, exploitation, mistreatment of residents or misappropriation of resident property. This will be accomplished through (including maintaining documentation of such results):
1. The facility will conduct an Iowa Criminal record check and department adult/child abuse registry check on all prospective employees and other individuals engaged to provide services, prior to hire, in the manner prescribed under 481 Iowa Administrative Code 58.11(3). The facility will conduct a criminal record check and dependent adult/child abuse registry check on all current employees and other individuals engaged to provide services to residents who have criminal convictions or founded abuse determinations after hire, or where the facility received credible

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 ______	03/10/2022

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 607	Continued From page 9 information that an employee has had a criminal conviction or a founded abuse determination subsequent to hire. See Iowa Code 135C.33(7). 2. For those prospective employees and other individuals engaged to provide services who hold certificates, the facility will conduct a check with the appropriate registry to assure there is no finding of abuse, neglect, exploitation, or treatment of resident or misappropriation of resident property. The Policy lacked documentation of the time frame for completing employee background checks. The Employee Handbook, revised 2/8/20, provided by the facility, under Employee Background Checks, Page 10 of 66, documented the Facility conducts background checks on applicants considered for employment and reserves the right to recheck the background of current employees.	F 607		
F 622 SS=D	Transfer and Discharge Requirements CFR(s): 483.15(c)(1)(i)(ii)(2)(i)-(iii) §483.15(c) Transfer and discharge- §483.15(c)(1) Facility requirements- (i) The facility must permit each resident to remain in the facility, and not transfer or discharge the resident from the facility unless- (A) The transfer or discharge is necessary for the resident's welfare and the resident's needs cannot be met in the facility; (B) The transfer or discharge is appropriate because the resident's health has improved sufficiently so the resident no longer needs the services provided by the facility; (C) The safety of individuals in the facility is	F 622		

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 ______	03/10/2022

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 622	Continued From page 10 endangered due to the clinical or behavioral status of the resident; (D) The health of individuals in the facility would otherwise be endangered; (E) The resident has failed, after reasonable and appropriate notice, to pay for (or to have paid under Medicare or Medicaid) a stay at the facility. Nonpayment applies if the resident does not submit the necessary paperwork for third party payment or after the third party, including Medicare or Medicaid, denies the claim and the resident refuses to pay for his or her stay. For a resident who becomes eligible for Medicaid after admission to a facility, the facility may charge a resident only allowable charges under Medicaid; or (F) The facility ceases to operate. (ii) The facility may not transfer or discharge the resident while the appeal is pending, pursuant to § 431.230 of this chapter, when a resident exercises his or her right to appeal a transfer or discharge notice from the facility pursuant to § 431.220(a)(3) of this chapter, unless the failure to discharge or transfer would endanger the health or safety of the resident or other individuals in the facility. The facility must document the danger that failure to transfer or discharge would pose. §483.15(c)(2) Documentation. When the facility transfers or discharges a resident under any of the circumstances specified in paragraphs (c)(1)(i)(A) through (F) of this section, the facility must ensure that the transfer or discharge is documented in the resident's medical record and appropriate information is communicated to the receiving health care institution or provider. (i) Documentation in the resident's medical record	F 622		

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 ______	03/10/2022

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 622	Continued From page 11 must include: (A) The basis for the transfer per paragraph (c)(1)(i) of this section. (B) In the case of paragraph (c)(1)(i)(A) of this section, the specific resident need(s) that cannot be met, facility attempts to meet the resident needs, and the service available at the receiving facility to meet the need(s). (ii) The documentation required by paragraph (c)(2)(i) of this section must be made by- (A) The resident's physician when transfer or discharge is necessary under paragraph (c) (1) (A) or (B) of this section; and (B) A physician when transfer or discharge is necessary under paragraph (c)(1)(i)(C) or (D) of this section. (iii) Information provided to the receiving provider must include a minimum of the following: (A) Contact information of the practitioner responsible for the care of the resident. (B) Resident representative information including contact information (C) Advance Directive information (D) All special instructions or precautions for ongoing care, as appropriate. (E) Comprehensive care plan goals; (F) All other necessary information, including a copy of the resident's discharge summary, consistent with §483.21(c)(2) as applicable, and any other documentation, as applicable, to ensure a safe and effective transition of care. This REQUIREMENT is not met as evidenced by: Based on clinical record reviews, staff interviews, and policy review; the facility failed to document in the resident's record a transfer form given to the receiving Emergency Department (ED). The facility failed to provided at minimum the following: contact information of the practitioner	F 622		

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 ______	03/10/2022

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 622	Continued From page 12 responsible for the care of the resident, the Resident's Representative information including contact information, Advance Directive information, all special instructions or precautions for ongoing care, as appropriate, comprehensive care plan goals, all other necessary information, and any other documentation, as applicable, to ensure a safe and effective transition of care for 1 of 2 residents reviewed (Resident #34). The facility reported a census of 130 residents. Findings include: Resident #34's Minimum Data Set (MDS) assessment dated 9/10/21 directed that the resident required extensive assistance of one person for bed mobility, transfers, walking in their room, walking in the corridor, toilet use, personal hygiene, locomotion on and off unit. The MDS documented an admission date to the facility on 12/11/20. The MDS assessment dated 12/17/21 indicated the resident's most recent admission/entry or reentry to the facility was on 12/11/21. The MDS documented the resident returned to the facility from an acute hospital. Resident #34's census report revealed the following recent ED visits: A. On 12/9/21 Resident #34 discharged to the hospital B. On 12/11/21 Resident #34 returned to the facility C. On 2/9/22 Resident #34 discharged to the hospital D. On 2/15/22 Resident #34 return to the facility Resident #204's progress notes lacked	F 622		

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 ______	03/10/2022

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 622 — Continued From page 13 — F 622

documentation of records sent to the ED when resident transferred on 12/9/21 and 2/9/22.

Resident #204's electronic Forms lacked a transfer or discharge form for the 12/9/21 and the 2/9/22 ED visits.

During an interview on 3/10/22 at 10:47 AM the Director of Nursing (DON) revealed she expected at a minimum the facility nurse would send a resident to ED with their:
1. Medication Administration Record (MAR)
2. Treatment Administration Record (TAR)
3. Admission record (face sheet)
4. IPOST (code status)
5. Transfer report relaying in writing what was going on and the reason for evaluation
6. Copy of the bed hold
The DON added that the nurse was to call the receiving ED and give report about the resident, notify the resident's family of what was going on with a request of the bed hold if needed, and then make a progress note documenting what they sent with the resident.

F 625 SS=D — Notice of Bed Hold Policy Before/Upon Trnsfr — F 625
CFR(s): 483.15(d)(1)(2)

§483.15(d) Notice of bed-hold policy and return-

§483.15(d)(1) Notice before transfer. Before a nursing facility transfers a resident to a hospital or the resident goes on therapeutic leave, the nursing facility must provide written information to the resident or resident representative that specifies-
(i) The duration of the state bed-hold policy, if any, during which the resident is permitted to return and resume residence in the nursing

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 ______	03/10/2022

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 625	Continued From page 14	F 625		

facility;
(ii) The reserve bed payment policy in the state plan, under § 447.40 of this chapter, if any;
(iii) The nursing facility's policies regarding bed-hold periods, which must be consistent with paragraph (e)(1) of this section, permitting a resident to return; and
(iv) The information specified in paragraph (e)(1) of this section.

§483.15(d)(2) Bed-hold notice upon transfer. At the time of transfer of a resident for hospitalization or therapeutic leave, a nursing facility must provide to the resident and the resident representative written notice which specifies the duration of the bed-hold policy described in paragraph (d)(1) of this section.
This REQUIREMENT is not met as evidenced by:
Based on record review, staff interview and facility policy review, the facility failed to notify a resident and/or resident representative of the facilities bed hold policy, including reserve bed payment, during hospitalization for 2 of 2 residents reviewed for hospitalization (Resident #34 and #125). The facility reported a census of 130 residents.

Findings include:

1. An admission Minimum Data Set (MDS), dated 9/10/21 for Resident #34, documented the resident admitted to the facility on 12/11/20.

The MDS assessment dated 12/17/21 indicated the resident's most recent admission/entry or reentry to the facility was on 12/11/21. The MDS documented that the resident returned to the facility from an acute hospital.

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 ______	03/10/2022

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 625	Continued From page 15 Resident #34's electronic health records (EHR) Census List reviewed on 3/8/22 revealed that he was sent to the hospital on 12/9/21 and returned to the facility on 12/11/21. Resident #34's EHR of the MDS logs revealed the following completed assessments dates with description: a. 12/9/21 - Discharge return anticipated b. 12/11/21 - Entry The record review of Resident #34's Progress Notes for December 21 lacked documentation of notification to the family of the bed hold policy. During an interview on 2/10/22 at 10:48 AM the Director of Nursing (DON) revealed she would expect the nurse on duty to send a bed hold with the resident to the ED and document it in the resident's chart. The undated facility policy and procedure labeled Resident Discharge/Bed Holds indicated that when a resident transfers to a hospital a Bed Hold will be initiated by charge nurse as appropriate or when approved by the family.	F 625		
F 637 SS=B	Comprehensive Assessment After Signifcant Chg CFR(s): 483.20(b)(2)(ii) §483.20(b)(2)(ii) Within 14 days after the facility determines, or should have determined, that there has been a significant change in the resident's physical or mental condition. (For purpose of this section, a "significant change" means a major decline or improvement in the	F 637		

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 ______	03/10/2022

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 637		F 637		

Continued From page 16
resident's status that will not normally resolve itself without further intervention by staff or by implementing standard disease-related clinical interventions, that has an impact on more than one area of the resident's health status, and requires interdisciplinary review or revision of the care plan, or both.)
This REQUIREMENT is not met as evidenced by:
Based on record review and staff interviews the facility failed to complete a significant change in status Minimum Data Set (MDS) assessment within 14 days for 2 of 4 residents reviewed for Hospice services (Resident #100 and #116). The facility reported a census of 130 residents.

Findings include:

1. A letter dated 2/7/22 from Resident #100's hospice provider to the facility documented that Resident #100 started Hospice on 1/5/22.

The record review completed on 3/10/22 of Resident #100's Electronic Health Record (EHR) documented a significant change in status MDS Assessment Reference Date (ARD) of 1/19/22. Resident #100's 1/19/22 significant change MDS assessment showed a completion date of 2/16/22.

The Form Warnings Report for Resident #100's MDS assessment dated 1/19/22 revealed Staff I, Registered Nurse (RN), acknowledged two (2) warnings on 2/16/22 that the MDS completion date minus the ARD (1/19/22) should be less than or equal to (<=) 14 days (2/16/22 - 1/19/22 = 28 days). Staff I acknowledged 2 additional warnings on 2/16/22 that the Care Area Assessment (CAA) completion date minus the ARD should be <= 14

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 ______	03/10/2022

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 637	Continued From page 17	F 637		

days (2/16/22 - 1/19/22 = 28 days).

2. The Election of Medicaid Hospice Benefit dated 2/23/22 for Resident #116 documented that the resident started hospice services on 2/23/22.

The record review completed on 3/10/22 of Resident #116's Electronic Health Record (EHR) lacked documentation of a significant change MDS assessment. The most recent MDS assessment complete date was 2/8/22 of a Quarterly MDS assessment.

The Resident Assessment Instrument (RAI) manual dated 10/17 in Chapter 2, instructs facilities to follow the guidelines below:
A Significant Change in Status Assessment (SCSA) is required to be performed when a terminally ill resident enrolls in a hospice program (Medicare-certified or State-licensed hospice provider) or changes hospice providers and remains a resident at the nursing home. The ARD must be within 14 days from the effective date of the hospice election (which can be the same or later than the date of the hospice election statement, but not earlier than). A SCSA must be performed regardless of whether an assessment was recently conducted on the resident. This is to ensure a coordinated plan of care between the hospice and nursing home is in place. A Medicare-certified hospice must conduct an assessment at the initiation of its services. This is an appropriate time for the nursing home to evaluate the MDS information to determine if it reflects the current condition of the resident, since the nursing home remains responsible for providing necessary care and services to assist the resident in achieving his/her highest practicable well-being at whatever stage of the

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 ______	03/10/2022

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 637	Continued From page 18 disease process the resident is experiencing. During an interview on 3/9/22 at 10:57 AM the Director of Nursing remarked that she would expect a SCSA be completed with all Hospice admissions and for staff to follow the RAI manual.	F 637		
F 640 SS=B	Encoding/Transmitting Resident Assessments CFR(s): 483.20(f)(1)-(4) §483.20(f) Automated data processing requirement- §483.20(f)(1) Encoding data. Within 7 days after a facility completes a resident's assessment, a facility must encode the following information for each resident in the facility: (i) Admission assessment. (ii) Annual assessment updates. (iii) Significant change in status assessments. (iv) Quarterly review assessments. (v) A subset of items upon a resident's transfer, reentry, discharge, and death. (vi) Background (face-sheet) information, if there is no admission assessment. §483.20(f)(2) Transmitting data. Within 7 days after a facility completes a resident's assessment, a facility must be capable of transmitting to the CMS System information for each resident contained in the MDS in a format that conforms to standard record layouts and data dictionaries, and that passes standardized edits defined by CMS and the State. §483.20(f)(3) Transmittal requirements. Within 14 days after a facility completes a resident's assessment, a facility must electronically transmit encoded, accurate, and complete MDS data to the CMS System, including the following:	F 640		

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 ______	03/10/2022

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 640	Continued From page 19	F 640		

(i)Admission assessment.
(ii) Annual assessment.
(iii) Significant change in status assessment.
(iv) Significant correction of prior full assessment.
(v) Significant correction of prior quarterly assessment.
(vi) Quarterly review.
(vii) A subset of items upon a resident's transfer, reentry, discharge, and death.
(viii) Background (face-sheet) information, for an initial transmission of MDS data on resident that does not have an admission assessment.

§483.20(f)(4) Data format. The facility must transmit data in the format specified by CMS or, for a State which has an alternate RAI approved by CMS, in the format specified by the State and approved by CMS.
This REQUIREMENT is not met as evidenced by:
Based on record review, Resident Assessment Instrument Manual (RAI) and staff interviews the facility failed to transmit a Minimum Data Set (MDS) assessment as directed in the RAI Manual to the Centers of Medicare and Medicaid Services (CMS) for 5 of 5 residents reviewed (Resident #1, #2, #4, #5, and #15). The facility reported a census of 130 residents.

Findings include:

1. The Electronic Health Record (EHF) Minimum Data Set (MDS) Assessment History documented Resident #1 had a Quarterly MDS assessment dated 1/4/22 with a status of accepted. The Assessment History indicated that the Quarterly MDS assessment dated 1/4/22 was included in the batch submitted that was approved on 3/7/22.

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 ______	03/10/2022

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 640		F 640		

Continued From page 20

The MDS Assessment submission date was more than 14 days after the completion date of the assessment.

2. The EHR MDS tab documented Resident #2 had a Discharge Return Not Anticipated Assessment dated 11/15/21 with the status of export ready.

3. The MDS Assessment History documented Resident #4 had a Quarterly MDS dated 1/18/22 indicated a status of export ready. The Assessment History recorded the assessment was never added to a batch.

4. The EHR MDS Assessment History documented Resident #5 had a Quarterly MDS dated 1/18/22 with the status of completed. The Assessment History record the assessment was never added to a batch.

5. The EHR MDS Assessment History documented Resident #15 had a Quarterly MDS dated 2/15/22 indicated a status of export ready. The Assessment History recorded the assessment was never added to a batch.

During an interview on 3/8/22 at 2:27 p.m. Staff J, Registered Nurse/MDS Coordinator, reported that she generally went through every few days to see what MDS assessments needed to be submitted. In the MDS tab of the EHR there was a section where you could hit the "new" button and add the MDS assessments that are export ready into a batch file, then those MDS will submit to the database. Staff J stated there was a CASPER (Certification And Survey Provider Enhanced Reports. These are reports that are compiled using facility submitted MDS data to demonstrate

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 ______	03/10/2022

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 640	Continued From page 21	F 640		

the facilities performance) report that can tell them if there was a late MDS. The old Director Of Nursing, (DON), had access into the CASPER reports. The new DON was working on getting access to use CASPER. Staff J wasn't aware if the facility EHR had anything in place to notify if an assessment that was late. Staff I didn't think the EHR system could let a MDS be late. Staff I thought they might have something through another system. Staff J remarked that the previous MDS Coordinator said they use the CASPER report to know if a MDS was submitted late.

During an interview on 3/10/22 at 7:29 a.m. the DON declared that the MDS should be submitted on time. There was no reason now that the pandemic (1135) wavier was done that the records should be late. The DON explained that she expected the MDS to be submitted timely.

The Long Term Care Facility Resident Assessment Instrument 3.0 User's Manual, Version 1.17.1, October 2019, Chapter 5 Submission and Correction of the MDS Assessments, page 5-3, documents Transmitting Data: Submission files are transmitted to the Quality Improvement and Evaluation System (QIES) Assessment Submission and Processing (ASAP) system using the Center for Medicare and Medicaid Services (CMS) wide area network. Providers must transmit all sections of the MDS 3.0 required for their State-specific instrument, including the Care Area Assessment (CAA) Summary (Section V) and all tracking or correction information. Transmission requirements apply to all MDS 3.0 records used to meet both federal and state requirements. Care plans are not required to be transmitted.

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 ______	03/10/2022

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 640	Continued From page 22 Page 5-4 further defines a Quarterly and discharge MDS assessments are to be submitted 14 days after the final completion date at Z0500B. The MDS Submission/Transmission Policy and Procedure, dated 1/1/19, provided by the facility documented a purpose to ensure MDS assessments were transmitted to the QIES timely. The Procedure documented "Transmitted" means electronically transmitting to the QIES ASAP System, an MDS record that passes CMS' standard edits and is accepted into the system, within 14 days of the final completion date, or event date in the case of Entry and Death in Facility situations, of the record. "Tranmitting data" refers to electronically sending encoded MDS information, from the facility to the QIES ASAP System. Guidance 483.20(f)(1-4). Facilities are required to encode MDS data for each resident in the facility. Facilities are required to electronically transmit MDS data to the CMS System for each resident in the facility. The CMS System for MDS data is named the QIES ASAP System.	F 640		
F 641 SS=B	Accuracy of Assessments CFR(s): 483.20(g) §483.20(g) Accuracy of Assessments. The assessment must accurately reflect the resident's status. This REQUIREMENT is not met as evidenced by: Based on record review, staff interviews, and policy review the facility failed to accurately reflect a residents PASRR level II status outcome on the Minimum Data Set (MDS) assessment for 1 of 1 residents reviewed (Resident #34). The facility also failed to accurately code the presence of a	F 641		

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 ______	03/10/2022

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 641 Continued From page 23 F 641

pressure ulcer on the MDS for 1 of 4 residents reviewed for pressure ulcers (Resident #55). The facility reported a census of 130 residents.

Findings include:

1. Record review on 03/09/2022 of Resident #34 census documented he was admitted to the facility on 12/11/2020.

Record review of a document titled Notice of PASRR Level II Outcome dated 12/11/20 for Resident #34 documented that he is a PASRR Level II.

Record Review of Resident #34 Minimum Data Set (MDS) with an Advance Reference Date (ARD) of 12/17/2021 documented the resident was not a PASRR Level II.

Interview with the Director of Nursing (DON) on 03/09/2022 at 10:55 AM revealed she would of expected the facilities contracted MDS Coordinator to code the PASRR level II on the MDS and follow the Resident Assessment Instrument (RAI) manual.

2. The Minimum Data Set (MDS) Assessment dated 1/3/22 for Resident #55 showed a Brief Interview for Mental Status (BIMS) Score of 9

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 ______	03/10/2022

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 641		F 641		

Continued From page 24
indicating moderate cognitive loss. The resident required total assist of two staff for bed mobility, transfer, dressing, toileting and personal hygiene. The MDS listed a diagnosis of Non-Alzheimer's Dementia, hypertension, bipolar, and paroxysmal atrial fibrillation. The MDS lacked documentation under section M0100 Determination of Pressure Ulcer/Injury Risk and M0300 a-g Current Number of Unhealed Pressure Ulcer/Injuries at Each Stage. The MDS documented the resident as receiving pressure ulcer/injury care.

A Nursing Progress Note dated 12/29/21 at 8:05 a.m. documented a Note Text: resident has a 4 x 4 blister like area to left heel. put soft buddy boots on and elevated legs. Primary Care Provider notified with no new orders.

A Weekly Pressure Injury Record documented the presence of a pressure ulcer to the left heel per the Point Click Care Notes as of 12/29/21.

During an interview on 3/10/22 at 7:30 a.m. the Director of Nursing, (DON), reported she expects the MDS to be filled out completely, comprehensively according to documentation, closed, locked and submitted on time.

The MDS Accuracy of Transmission Policy, dated 1/2019, provided by the facility documented the assessment must accurately reflect the resident's status. "Accurate" means that the encoded MDS data matches the MDS form in the clinical record. And the information accurately reflects the resident's status as of the Assessment Reference Date (ARD) to assure that each resident receives an accurate assessment, reflective of the resident's status at the time of the assessment, by staff qualified to assess relevant care areas

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 ______	03/10/2022

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 641	Continued From page 25 and are knowledgeable about the resident's status, needs, strengths and areas of decline.	F 641		
F 644 SS=D	Coordination of PASARR and Assessments CFR(s): 483.20(e)(1)(2) §483.20(e) Coordination. A facility must coordinate assessments with the pre-admission screening and resident review (PASARR) program under Medicaid in subpart C of this part to the maximum extent practicable to avoid duplicative testing and effort. Coordination includes: §483.20(e)(1)Incorporating the recommendations from the PASARR level II determination and the PASARR evaluation report into a resident's assessment, care planning, and transitions of care. §483.20(e)(2) Referring all level II residents and all residents with newly evident or possible serious mental disorder, intellectual disability, or a related condition for level II resident review upon a significant change in status assessment. This REQUIREMENT is not met as evidenced by: Based on clinical record reviews, staff interviews, and policy review; the facility failed to implement specialized services from a Preadmission Screening and Resident Review (PASRR) assessment completed on the date of admission for 1 of 1 residents reviewed (Resident #34). In addition the facility failed to resubmit a 60 day convalescent PASRR for a resident to be reviewed after a 60 day stay at the facility for 1 of 1 resident reviewed (Resident #33) for PASRR assessment. The facility reported a census of 130 residents.	F 644		

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 ______	03/10/2022

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 644	Continued From page 26	F 644		

Continued From page 26

Findings include:

1. Resident #34's Admission Record printed on 3/8/22 documented the following diagnoses; symptoms and signs involving cognitive functions and awareness, major depressive disorder, and adult failure to thrive.

The Notice of PASRR Level 2 (II) Outcome dated 12/11/20 instructed that Resident #34 needed the following specialized services:

a. Ongoing psychiatric medication management by a psychiatrist or psychiatric Advanced Registered Nurse Practitioner, ARNP, (to evaluate response and effectiveness of psychotropic medication on target symptoms, modify medication orders, and to evaluate the ongoing need for additional behavioral health services)

b. Individual therapy by a licensed behavioral health professional.

The Care Plan provided by the facility on 3/8/22 lacked implementation and documentation of the specialized services as instructed by PASRR for the facility to provide.

During an interview on 3/8/22 at 3:52 PM the Provisional Administrator revealed they were implementing a PASRR policy effective that day, but the facility didn't have one before that day.

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 ______	03/10/2022

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 644	Continued From page 27	F 644		

2. Resident #33's Census report showed they admitted to the facility on 9/20/21.

The Notice of PASRR Level One Screen Outcome dated 9/20/21 for Resident #33 documented the PASRR Level One Determination as a Convalescence Categorical with a suspected or confirmed PASRR condition of mental health disability. The PASSR documented an approval period of 60 days. The PASRR documented Resident #33 could be admitted to a Medicaid certified nursing facility for up to 60 calendar days. If the stay goes beyond 60 calendar days, a nursing facility representative must submit a Status Change Level One. A PASRR Resident Review would be required before the 60th day.

During an interview on 3/8/22 at 1:50 p.m. Staff A, Licensed Social Worker, reported she was working on updating Resident #33's new PASRR as of 3/8/22. She stated when a resident first admits to the facility, if they need an updated PASRR she puts a reminder on the calendar about three weeks out from when the PASRR is due. Staff A wasn't sure how the PASRR got missed. She was not sure if the facility had a PASRR policy.

During an interview on 3/8/22 at 2:22 p.m. the Provisional Administrator stated she would expect the PASRR to be completed upon admission and be reviewed by the Social Worker. She would expect the Social Worker to follow up on the PASRR as indicated. The Provisional Administrator would allow each Social Worker to have their own system on how they tracked any needed follow-up.

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 ______	03/10/2022

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 644	Continued From page 28 The PASRR Policy dated 3/8/22, documented it was required that all residents admitted to the facility have a PASRR on file and that the approval period was active and valid. The Policy Procedure outlined the following A. If a short-term approval was granted, the social worker(s) will follow up appropriately with a calendar reminder on paper and/or a computer reminder to ensure the PASRR remained in an approval period. B. A PASRR that was nearing the expiration approval period, should not be submitted any later than two weeks before its expiration date. C. The Administrator and/or DON would follow-up monthly during the Quality Assurance and Performance Improvement (QAPI) committee to ensure PASRR's were submitted in a timely manner.	F 644		
F 656 SS=D	Develop/Implement Comprehensive Care Plan CFR(s): 483.21(b)(1) §483.21(b) Comprehensive Care Plans §483.21(b)(1) The facility must develop and implement a comprehensive person-centered care plan for each resident, consistent with the resident rights set forth at §483.10(c)(2) and §483.10(c)(3), that includes measurable objectives and timeframes to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment. The comprehensive care plan must describe the following - (i) The services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §483.24, §483.25 or §483.40; and (ii) Any services that would otherwise be required	F 656		

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 ______	03/10/2022

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 656	Continued From page 29 under §483.24, §483.25 or §483.40 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(c)(6). (iii) Any specialized services or specialized rehabilitative services the nursing facility will provide as a result of PASARR recommendations. If a facility disagrees with the findings of the PASARR, it must indicate its rationale in the resident's medical record. (iv)In consultation with the resident and the resident's representative(s)- (A) The resident's goals for admission and desired outcomes. (B) The resident's preference and potential for future discharge. Facilities must document whether the resident's desire to return to the community was assessed and any referrals to local contact agencies and/or other appropriate entities, for this purpose. (C) Discharge plans in the comprehensive care plan, as appropriate, in accordance with the requirements set forth in paragraph (c) of this section. This REQUIREMENT is not met as evidenced by: Based on clinical record reviews, observation, policy review and staff interviews, the facility failed to develop a comprehensive care plan for a resident that developed a unstageable pressure injury to the left heel for 1 of 1 residents (Resident #55) reviewed. The facility identified a sample of 130 residents. Findings include: The Minimum Data Set (MDS) Assessment dated 1/3/22 showed a Brief Interview for Mental Status (BIMS) Score of 9 indicating moderate cognitive	F 656		

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 ______	03/10/2022

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 656	Continued From page 30 loss. The resident required total assist of two staff for bed mobility, transfer, dressing, toileting and personal hygiene. The MDS listed a diagnosis of Non-Alzheimer's dementia, hypertension, bipolar, and paroxysmal atrial fibrillation. The MDS documented the resident as receiving pressure ulcer/injury care. During an interview on 3/8/22 at 9:24 AM, Resident #55 explained that the staff repositioned her when she wanted to be moved. During the interview Resident #55 had heel boots on. During an observation on 3/9/22 at 9:58 AM Resident #55 sat in bed, looking at book wearing heel boots on both of her feet. The Nursing Progress Note dated 12/29/21 at 8:05 a.m. documented that Resident #55 had four by four (4 x 4) blister-ike area to her left heel. Staff were to put soft buddy boots on her and elevate her legs. The Primary Care Provider responded to the facility notification with no new orders. The Care Plan dated 3/8/22 documented Resident #55 with an actual impairment to her skin integrity related to decreased mobility. Resident #55 had an unstageable pressure ulcer to the left heel. The Focus and interventions were recorded as initiated on 3/8/22. The Care Plan directed the following interventions: a. Avoid scratching and keep hands and body parts from excessive moisture. Keep fingernails short. b. Encourage good nutrition and hydration in order to promote healthier skin. c. Follow facility protocols for treatment of injury. d. Followed by contracted Wound Nurse	F 656		

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 ______	03/10/2022

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 656	Continued From page 31 e. Monitor and document the location, size, and treatment of her skin injury. Report abnormalities, failure to heal, signs and symptoms of infection, maceration to medical doctor. f. Use caution during transfers and bed mobility to prevent striking arms, legs, and hands against any sharp or hard surface. During an interview on 3/9/22 at approximately 7:50 a.m. the Director of Nursing, (DON), reported she would not be surprised if the care plan was completed on 3/8/22 as she knows the MDS Coordinator was behind. During a follow-up interview on 3/10/22 at 7:32 a.m. the DON reported that the care plan was a working tool that needed to be completed based on the MDS and updated as the resident's changes occur. The care plan needed to be completed and revised timely. The Interim and Comprehensive Care Plans Policy, dated 1/19, provided by the facility documented the facility would develop an Interim Care Plan upon admission followed by a Comprehensive Care Plan for each resident. The Comprehensive Care Plan must include measurable objectives and timetables to meet the resident's medical, nursing and mental and psychosocial needs that were identified in the Comprehensive Assessment. The facility's interdisciplinary team in conjunction with the resident, resident's family, surrogate, or representative, as appropriate, would develop quantifiable objectives for the highest level of functioning the resident may be expected to attain, based on the Comprehensive assessments and the Care Area Assessments.	F 656		

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 ______	03/10/2022

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 657	Continued From page 32	F 657		
F 657 SS=D	Care Plan Timing and Revision CFR(s): 483.21(b)(2)(i)-(iii) §483.21(b) Comprehensive Care Plans §483.21(b)(2) A comprehensive care plan must be- (i) Developed within 7 days after completion of the comprehensive assessment. (ii) Prepared by an interdisciplinary team, that includes but is not limited to-- (A) The attending physician. (B) A registered nurse with responsibility for the resident. (C) A nurse aide with responsibility for the resident. (D) A member of food and nutrition services staff. (E) To the extent practicable, the participation of the resident and the resident's representative(s). An explanation must be included in a resident's medical record if the participation of the resident and their resident representative is determined not practicable for the development of the resident's care plan. (F) Other appropriate staff or professionals in disciplines as determined by the resident's needs or as requested by the resident. (iii)Reviewed and revised by the interdisciplinary team after each assessment, including both the comprehensive and quarterly review assessments. This REQUIREMENT is not met as evidenced by: Based on record review, staff interviews, and policy review the facility failed to revise a care plan within 7 days from the completion date of a Significant Change in Status Assessment (SCSA) Minimum Data Set (MDS) for 1 of 1 residents reviewed (Resident #100). The facility also failed to revise 1 of 1 care plans for the use of a super	F 657		

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 ______	03/10/2022

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 657		F 657		

Continued From page 33
pubic catheter (Resident #111). The facility reported a census of 130 residents.

Findings include:

1. Resident #16's SCSA MDS with an Assessment Reference Date (ARD) of 1/19/22 documented completion of the assessment on 2/16/22. In addition, the MDS documented the resident's recent entry date as 6/28/20.

Resident #100's current Care Plan printed on 3/9/22 revealed the facility implemented a Focused area related to hospice on the date of review of 3/9/22.

The Resident Assessment Instrument (RAI) manual, Chapter 4, documented that facilities are to complete care plan revisions within 7 days of the SCSA MDS completion date (2/16/22).

During an interview on 3/10/22 at 10:45 AM the Director of Nursing revealed that the care plan should of been revised in January 2022.
2. The MDS dated 2/7/22 for Resident #111 showed a Brief Interview for Mental Status (BIMS) score of 14, indicating intact cognitive functioning. The resident required extensive assistance with dressing, toilet use, and personal hygiene. The MDS listed a diagnosis of neurogenic bladder and identified the use of a suprapubic catheter.

The Medication Review Report signed by the Provider on 2/9/22 listed the following physician orders:
1. Suprapubic Catheter: change catheter monthly with 20 French (FR) 10 cubic centimeters (cc) every evening shift

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 ______	03/10/2022

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 657	Continued From page 34	F 657		

starting on the 11th and ending on the 11th every month for catheter change. Start date 2/11/22.
2. Order suprapubic catheter change supplies from the resident's medical supply company. Change the catheter on the 11th one time a day starting on the 9th and ending on the 9th every month. Start date 2/9/22.

The January 2022 Treatment Administration Record (TAR) documented the following physician order: Suprapubic catheter: Change catheter monthly with 20 FR 10 cc every evening shift starting on the 3rd and ending on the 3rd every month for catheter change. Start date 12/07/21. Discontinue date 1/11/22. The nursing staff signed off the catheter changes for the 20 FR 10 cc suprapubic catheter for 1/3/22.

The February 2022 TAR documented the nursing staff ordered the suprapubic catheter supplies from the pharmacy on 2/1/22. The order to changed the suprapubic catheter was document as a 5 (hold/see progress notes) on 2/11/22.

The March 2022 TAR documented the nursing staff ordered the suprapubic catheter supplies from the pharmacy on 3/1/22. The order to change the catheter on 3/11/22 lacked documentation of completion.

A Care Plan Progress Note dated 2/17/22 at 12:47 p.m. documented the Resident had a care plan conference. The care plan note lacked documentation to support the resident utilized a suprapubic catheter, change in physician orders or need for revision of the care plan.

The Care Plan revised 6/17/20 documented Resident #111 at risk for complications related to

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 ______	03/10/2022

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 657	Continued From page 35 use of a suprapubic catheter due to a diagnosis of benign prostatic hytropertrophy. The Care Plan intervention revised on 10/5/19 indicated that the resident used a size 16 FR Foley catheter with 10 cc balloon. The Facility failed to revise the care plan with the new physician order for the 20 FR 10 cc suprapubic catheter. During an interview on 3/10/22 at 7:32 a.m. the Director of Nursing, (DON), reported the care plan is a working tool that needs to be completed based on the MDS and updated as resident changes occur. The care plan needs to be done timely and revised timely. The Interim and Comprehensive Care Plans Policy, dated 1/19, provided by the facility documented that the Comprehensive Care Plans would be reviewed and updated every quarter (90 days) at a minimum. The facility may need to review the care plans more frequently based on changes in the resident's condition and/or newly developed health/psychosocial well-being issues. The policy continued that the facility MDS/Care Plan Coordinators and ancillary MDS staff would attend the department head meeting with an in-depth review of the 24 hour report and would establish a new plan of care and/or make revisions to the existing care plans to address any acute condition changes or exacerbation of chronic issues that may need revisions to the problem, goals and/or interventions.	F 657		
F 658 SS=D	Services Provided Meet Professional Standards CFR(s): 483.21(b)(3)(i) §483.21(b)(3) Comprehensive Care Plans	F 658		

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 ______	03/10/2022

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 658		F 658		

Continued From page 36
The services provided or arranged by the facility, as outlined by the comprehensive care plan, must-
(i) Meet professional standards of quality.
This REQUIREMENT is not met as evidenced by:
Based on observation, clinical record review, policy and staff interview the facility failed to monitor and assess a skin condition for 1 of 1 resident reviewed (Resident #86). The facility reported a census of 130.

Finding include:

Resident #86's Admission Minimum Data Set (MDS) dated 7/28/21 documented diagnoses that included type 2 diabetes mellitus with diabetic foot ulcer, anxiety disorder, and Lichen planus (inflammatory condition of the skin and mucous membranes). The MDS documented a Brief Interview for Mental Status (BIMS) score of 15, indicating no cognitive impairment. The MDS documented the resident had diabetic foot ulcers, nonsurgical dressings other than to feet, application of ointment other than to feet, application of dressings to feet.

During an observation on 3/8/22 at 9:38 AM noted Resident #86's bilateral (both) lower legs appear red with dressings in place.

The resident's MDS dated 10/25/21 documented a BIMS of 15. The resident had nonsurgical dressings other than to feet, application of ointment other than to feet and application of dressings to feet.

The resident's MDS dated 1/11/22 documented a BIMS of 15. The resident had open lesions on the

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 ______	03/10/2022

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 658	Continued From page 37 foot, open lesions other than ulcers, cuts, and rashes. The MDS documented nutritional or hydration interventions to manage skin problems. The MDS documented application of nonsurgical dressing other than to feet, application of ointment other than to feet and application of dressing to feet. The Care Plan Focused area revised on 1/2/22 indicated Resident #86 had increased nutrient needs related to Lichen Planus as evidenced by (AEB) skin wound. The first Goal revised 3/10/22 documented an A1C (diabetic glucose lab test) lab result less than or equal to 7. The second Goal revised 3/10/22 directed for Resident #86 to accept supplements as ordered. Interventions included provide diet as ordered. The Care Plan Focused area revised 12/31/21 documented that Resident #86 had an actual impairment to her skin integrity related to Lichen Planus and poor wound healing related to diabetes mellitus type II. The Focused area continued to state that when Resident #86's had a history of wounds to both of her lower legs. When the wounds heal, Resident #86 will often manually reopen them. This Focused area include a Goal revised 3/10/22 of no complications related to bilateral lower extremity wounds. The intervention dated 11/23/21 included to monitor and document location, size and treatment of skin injury. Report abnormalities, failure to heal, signs and symptoms of infection, maceration to the medical doctor (MD). The Physician Orders signed by the MD on 10/14/21 included an order dated 8/20/21 to cleanse legs, foot, and arms with soap and water, then pat dry. Once dry apply Vaseline ointment in	F 658		

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 ______	03/10/2022

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 658	Continued From page 38	F 658		

equal parts to wounds twice daily. Cover with ABD (dressing) and secure with paper tape. The Physician Orders included an order dated 9/9/21 to dress Resident #86's right plantar (bottom of foot) foot ulcer (wound) with medihoney gauze and secure with paper tape daily.

During an interview on 3/8/22 at 2:55 p.m. the Director of Nursing (DON) reported she couldn't find skin sheets for Resident #86.

The facility provided the following information at exit of survey, they reported that the ARNP saw the resident for her skin and the facility didn't do assessments.
Resident #86's Wound Follow-up Visit reports showed the following information
A. 10/13/21 included a diagnosis of excoriation (skin-picking disorder), poor compliance, and a self-care deficit.
1. Bilateral Lower extremities etiology (cause) indicated Lichen Planus and skin excoriation disorder - left ankle measure three by 10 by 0.1 centimeters (3x10x0.1 cm), left dorsal foot 5x2.5 cm, right lateral ankle (6x9x0.1 cm), right calf eschars lat 2x3 cm, med 1.2x4 cm. The wound bed was red and granular except for the eschars. The wound had moderate serous exudate (drainage) and didn't have an odor. The peri-wound (skin around the wound) showed some slight surrounding maceration, scarring, and discoloration of a chronic (long-term) nature. No plan documented.
2. Bilateral arms etiology excoriation disorder - the left arm wound measured 1x2 cm and the right arm measured 3x2.5 cm. The wound bed was dry, pink, without odor or drainage, and with some eschars.The peri-wound was scarring with chronic discoloration.. The Assessment and Plan

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 ______	03/10/2022

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 658	Continued From page 39 section directed that the open wounds involving multiple regions of upper and lower extremities to discontinue vaseline, use aquaphor daily after cleaning, and apply mupurocin () to eschars twice daily with no dressings needed. The MD discussed poor compliance with Resident #86 and explained the risk of life threatening infections and even amputations. B. 11/3/21 1. Bilateral Lower extremities etiology (cause) indicated Lichen Planus and skin excoriation disorder - left lateral leg measured 8x6.0x0.1 cm, left dorsal foot 4x3x0.1 cm, right lateral leg (8x6x0.1 cm), right anterior leg 2x7x0.1 cm, right dorsal foot 1.0x2x0.1 cm. The wound bed was granular. The wound had moderate serosanguinous exudate and didn't have an odor. The peri-wound showed scarring and discoloration of a chronic nature. No plan documented. 2. Bilateral arms etiology Lichen Planus and excoriation disorder - no measurements done. The wound bed was granular, without odor, and with small serosanguinous exudate.The peri-wound was scarring and with chronic discoloration.. The Assessment and Plan indicated no new orders. C. 11/24/21 - the wounds had worsened and were surrounded with crusting blood. Resident #86 reported that the staff didn't apply dressings to her lower extremities because they misread the order regarding no dressings to the arms. Resident #86 refuses to allow staff to clean the wounds well as she refuses showers often. 1. Bilateral Lower extremities etiology (cause) indicated Lichen Planus and skin excoriation disorder - left ankle measure three by 3.5x7 cm, left foot 2x3 cm, right lateral ankle 9x11 cm, right anterior leg 3.5x5 cm, medial 6x4 cm, and right	F 658		

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 ______	03/10/2022

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 658	Continued From page 40 foot measured 1x2.5 cm.. The wound bed was superficial granular with crusted blood. The wound had moderate serous exudate and didn't have an odor. The peri-wound showed some scarring and discoloration of a chronic nature. No plan documented. The Assessment and Plan directed to have a Psych follow-up for excoriation (skin-picking) disorder. The lesions worsened since they were not dressed. 2. Bilateral arms etiology skin excoriation disorder and Lichen Planus - the left arm had three scabbed areas measuring 1 cm, 1 cm, and 0.5 in diameter. The right arm measured 8.5x5 cm. The wound bed was dry, scabbed, without odor, and small sanguinous exuate.The peri-wound was scarring with chronic discoloration. D. 12/15/21 - Resident #86 had small amount of serosanguinoeous drainage on the dressings to her bilateral lower extremities, her arms were open to air with a few scabbed areas on the right arm, left arm looked pretty good. 1. Bilateral Lower extremities etiology indicated Lichen Planus and skin excoriation disorder - left ankle measure three by 10 by 0.1 centimeters (3x10x0.1 cm), left dorsal foot 5x2.5 cm, right shin 7.5x7.5x0.1, right lateral calf 8x1.5x0.1 cm, right medial calf 8x1.5x0.1 cm, and rght foot 1.3x4.0x0.1 cm. The wound bed was granular. The wound had small serosanguineous exudate and didn't have an odor. The peri-wound showed some scarring and discoloration of a chronic nature. 2. Bilateral arms etiology excoriation disorder - the left arm wound measured 1x2 cm and the right arm measured 3x2.5 cm. The wound bed was scabbed with no exudate or odor. The peri-wound was scarred with chronic discoloration. The Assessment and Plan section	F 658		

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 ______	03/10/2022

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 658	Continued From page 41	F 658		

directed to continue the daily dressing with vaseline or aquaphor to the bilateral lower extremities. No dressings needed to the arms unless draining and to see Psych for a follow-up.

E. 1/5/22 - Other than an abrasion from a fall, Resident #86's wounds were pretty much healed. Bilateral lower extremity dressings were in place since the previous day as Resident #86 reported that they weren't changed for two days. The staff reported that she refused showers because she didn't like the staff who would assist her.

1. Bilateral lower extremities etiology indicated Lichen Planus, anxiety, and skin excoriation disorder - left ankle measured three by 5 by 15 centimeters, left foot 6x4 cm, left shin 5.6x6 cm, right lateral extremity 7.5x9.5x0, right anterior leg 8x9 cm, and right medial 9x3.5 cm. The wound bed was granular. The wound had small serosanguineous exudate and didn't have an odor. The peri-wound showed some scarring and discoloration of a chronic nature.

2. Bilateral arms etiology excoriation disorder - the left arm wound healed and the right superior (upper) arm measured 2x1.5 cm and inferior (lower) 3.5x4.5 cm. The wound bed was dry red, with no odor or exudate. The peri-wound was intact with scarring and chronic discoloration. The Assessment and Plan directed to continue Aquaphor Vaseline applied daily after cleansing and shower with warm water, then cover with an ABD dressing secured with paper tape. No dressings needed to the upper extremities. Orders provided that visit included discontinue Mupurocin, triamcinolone, leave Vaseline or Aquaphor at bedside for Resident #86 to apply to itching skin as needed.

F. 1/26/22 - Resident #86 reported that she wasn't getting her dressing changed any more than 2 to 3 times a week. The staff reported that

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 ______	03/10/2022

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 658		F 658		

Continued From page 42

Resident #86 frequently refuses the dressing changes. There was a large amount of foul-smelling tan drainage from the wounds on the right lower extremity, there was extensive erythema (raised red skin) around the wounds which resolved after the wounds were cleaned and left open to air to dry. The wounds on the left lower extremity were healing well. Noted some new areas to the upper right extremity due to a fall.

1. Bilateral lower extremities etiology indicated Lichen Planus, anxiety, and skin excoriation disorder - left lower extremity measured anterior 1.5x4.5x0.1 cm, left medial leg 2.0x1.8x0.1 cm, the wound bed was granular with small serosanguineous exudate, no odor with intact, scarring, and chronic discoloration. The right superior extremity measured 4.0x10.5x0.1 cm, right medial leg 1.5x2.0x0.1 cm, and right ankle 9x7.5x0.1 cm. The wound bed was all granular with large tan serous exudate and slight odor. The peri-wound was intact, scarring, and chronic discoloration. The Assessment and Plan indicate the resident was refusing care per the staff. The right lower extremities were stable, and the left lower extremity was improved. Continue daily changes as ordered. Resident #86 could benefit from compression but she refuses due to being allergic to latex. The new orders directed to start Ampicillin for an oral infection with the Dentist to follow-up.

2. Right upper extremity etiology abrasion - The right superior arm measured 1.5x4.5x0.1 cm, medial arm 2x0x1.8x0.1 cm. The wound bed was pale pink, small serous exudate, and no odor. The peri-wound had scarring and chronic discoloration.

G. 2/16/22 - The wounds on the left lower extremity was nearly healed. The bilateral upper

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 ______	03/10/2022

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 658	Continued From page 43	F 658		

arms looked well there was only a couple of scabs on her right forearm. The Assessment and Plan documented open wounds involving multiple regions of upper and lower extremities. The bilateral upper extremities improved just a couple scabbed areas to the right forearm. Mild rash and dry scaly skin noted. Triamcinolone oint 0.1% to rashes daily for seven days then discontinue.
H. 3/9/22 - The dressings were intact with minimal amount of serosanguineous drainage on removal. Her overall bilateral lower extremity wounds appeared much better. There was no sign of surrounding sign of cellulitis, there was chronic discoloration from recurrent breakdown and self-inflicted itching. The bilateral upper extremities were completely healed there was only one small scabbed area on her right forearm. The Assessment and Plan directed that the open wounds involving multiple regions of the upper and lower extremities were to continue to receive daily cleansing and Vaseline with dry dressings. The upper extremities were healed. The lower extremities were improving without signs or symptoms of infection.

During a follow-up interview on 3/10/22 at 11:30 AM the DON stated there should be weekly documentation. The DON explained that she would expect wounds to be measured, described, and able to see improvement or the nurse should seek a different treatment.

During a follow-up interview on 3/10/22 at 1:11 PM the DON stated she would expect wounds to be documented weekly. She stated she would expect facility policies to be followed by all staff.

The General Wound and Skin Care Guidelines policy dated 1/15 directed to document wound

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 ______	03/10/2022

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 658	Continued From page 44 assessment, treatment performed, and the resident's wound response to treatment on the appropriate documentation form.	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 observation and staff interviews the facility failed to complete hand hygiene and use clean gloves when touching food during the puree process for 16 of 16 residents who receive a puree meal. The facility reported a census of 130 residents. Findings include: The following observation took place on 3/9/22 from 10:03 AM until 10:20 AM of Staff K, Dietary	F 812		

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 ______	03/10/2022

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 812	Continued From page 45 Cook, making 19 servings of pureed ham with bread and butter. Staff K did not wash her hands throughout the entire observation. Staff K applied disposable gloves without hand hygiene observed to both hands then touched a pull out drawer handle. She then preceded to touch a pan and kitchen utensils while adding ham to the puree machine. Staff K then touched the puree machines buttons. Staff K then proceed to touch with both contaminated gloved hands the bread and butter half sandwiches, three at a time, and placed into the puree machine. Staff K then removed her gloves and reviewed the chart to ensure that she used the correct scoop size. Staff K grabbed the appropriate scoop sizes from the bin. Then while touching the scoop and pan, Staff K scooped the purred ham with bread and butter into the designated pan for meal service. Staff K repeated the process by applying gloves without hand hygiene and adding ham to the puree machine. With her unclean hands with new gloves on, Staff K touched the pans and the kitchen utensils. Staff K then grabbed the bread and butter sandwiches with her gloved hand and added them to the puree. Staff K then removed her gloves, then went to review the chart to ensure the proper scoop size. Staff K grabbed the appropriate scoop from the bin and scooped the pureed ham with bread and butter into the designated pan for meal service. During an interview on 3/10/22 at 9:08 AM, the Dietary Manager revealed she would expect Staff K to not use gloves and instead use tongs when adding the bread and butter sandwiches to the pureed ham. The Dietary Manager reported that she completed many audits and training, she didn't think Staff K would have used gloves. The	F 812		

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 ______	03/10/2022

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 812	Continued From page 46 Dietary Manager then added that since Staff K did use gloves she would of expected hand washing after each removal of gloves and before putting on new gloves. The Dietary Manager remarked that she didn't have a policy specific to glove use in the kitchen, but that she would only expect them to use them if unable to use a kitchen utensil.	F 812		
F 880 SS=D	Infection Prevention & Control CFR(s): 483.80(a)(1)(2)(4)(e)(f) §483.80 Infection Control The facility must establish and maintain an infection prevention and control program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of communicable diseases and infections. §483.80(a) Infection prevention and control program. The facility must establish an infection prevention and control program (IPCP) that must include, at a minimum, the following elements: §483.80(a)(1) A system for preventing, identifying, 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	F 880		

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 ______	03/10/2022

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 880 Continued From page 47

possible communicable diseases or infections before they can spread to other persons in the facility;
(ii) When and to whom possible incidents of communicable disease or infections should be reported;
(iii) Standard and transmission-based precautions to be followed to prevent spread of infections;
(iv)When and how isolation should be used for a resident; including but not limited to:
(A) The type and duration of the isolation, depending upon the infectious agent or organism involved, and
(B) A requirement that the isolation should be the least restrictive possible for the resident under the circumstances.
(v) The circumstances under which the facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease; and
(vi)The hand hygiene procedures to be followed by staff involved in direct resident contact.

§483.80(a)(4) A system for recording incidents identified under the facility's IPCP and the corrective actions taken by the facility.

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

§483.80(f) Annual review.
The facility will conduct an annual review of its IPCP and update their program, as necessary.
This REQUIREMENT is not met as evidenced by:
Based on clinical record reviews, observations,

F 880

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 ______	03/10/2022

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 880		F 880		

Continued From page 48
facility policy review and staff interviews, the facility failed to perform hand hygiene before or after donning (putting on) gloves for emptying a urinary drainage bag and between resident care. In addition, the facility failed to change multiple bed linens with yellow dried rings which were in use for resident care and failed to follow proper infection control procedures for emptying catheter bags for 2 of 2 residents reviewed (Resident #104 and #111). The facility identified a census of 130 residents.

Findings include:

1. Resident #104's Minimum Data Set (MDS) assessment dated 2/4/22 documented a Brief Interview for Mental Status (BIMS) score of 15, indicating intact cognition. The resident required extensive assistance for bed mobility, dressing, personal hygiene and toilet use. The MDS listed a diagnosis of end stage renal disease, neurogenic bladder, diabetes mellitus, tubulo-interstitial nephritis, not specific as acute or chronic and identified the presence of a urostomy (an opening in the belly, also known as abdominal wall, that's made during surgery to redirect the urine flow to a urinary drainage pouch or bag). The MDS assessment did not rate the urinary incontinence as the resident had a urinary urostomy.

The Medication Review Report, signed by the Provider on 2/9/22, documented the following physician orders:
1. Change the urinary catheter bed bag monthly on the 14th and 28th of the month on the night shift starting on the 28th and ending on the 18th of every month.
2. Change urostomy bag along with wafer twice weekly on day shift every Tuesday and Friday.

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 ______	03/10/2022

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 880	Continued From page 49	F 880		

The Care Plan, revised 11/1/21, documented Resident #104 had a urostomy for diagnoses of neurogenic bladder and hydronephrosis. The Care Plan directed the staff in the following interventions:
a. Intake and outputs as per policy. Date initiated: 7/25/19
b. Monitor ostomy site for swelling, pain, or redness, and report promptly (quickly) to the medical doctor (MD) with follow up as indicated. Date Initiated: 7/25/19
c. Observe for discomfort, urine color, clarity, amount, odor, and presence of blood. Notify MD of abnormal findings and follow up as indicated. Date Initiated: 7/25/19.
d. Ostomy care: Ostomy bag changed by nurse, empty drainage bag when it becomes approximately 1/3 full to
prevent leakage. Date Initiated: 7/25/19

During an observation on 3/7/22 at 12:17 p.m. Resident #104 laid in her bed supine (on her back). The uncovered urinary drainage bag noted to be 3/4 full of amber colored urine hanging from the right side of the bed frame with the drain tube hanging from the bag in direct contact with the floor below the bed.

During an observation on 3/8/22 at 1:45 p.m. Staff B, Certified Nursing Assistant (CNA), entered Resident #104's room, donned gloves without performing hand hygiene and placed a wash basin on the floor without a clean barrier. Staff B opened the urinary drainage bag valve and drained the urine into the wash basin. Staff B failed to cleanse the urinary drainage bag drain tube with alcohol before closing. Staff B removed gloves, failed to perform hand hygiene after cares

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 ______	03/10/2022

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 880	Continued From page 50 in room 339-A and entered room 345 to empty the urinary drainage bag for Resident #111. During an interview on 3/8/22 at 1:57 p.m. Staff G, CNA, reported urinary drainage bags should be emptied at the end of each shift and the bags should always be covered with a privacy cover. She reported she uses alcohol to cleanse the drain tube before attaching bag to the bag. During an interview on 3/8/22 at 1:58 p.m. Staff H, Licensed Practical Nurse, (LPN), reported that the CNA's should empty the urinary drainage bags at the end of the shift and the drainage bag should be covered. She stated alcohol should be used to clean the draing tube prior to attaching to the urinary bag. During an observation on 3/9/22 at 9:26 a.m. noted a heavy urine smell upon entrance into the resident's room. Staff C, Restorative aide, (RA), placed a pillow case with a basketball sized yellow dried ring on the pillow case under the resident's left calf directly contacting the skin. She pulled the sheet up over the resident's lower body. The sheet had three approximate 5 x 5 inch yellow dried circular areas on the upper part of the sheet covering the resident's mid section. Upon completion of the upper body range of motion, Staff B placed a pillow with a approximate 6 x 7 inch yellow circular dried area on the upper part of the pillow case under the resident's right arm. At 9:30 a.m. Staff F, Restorative Aide, placed the bedside table over the resident to set up for putty therapy. Staff B and Staff F left the room without performing hand hygiene and before entering room 345. Staff B and Staff F did not inform any staff to change Resident #104's linens.	F 880		

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 ______	03/10/2022

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 880	Continued From page 51 During an observation on 3/9/22 at 12:01 p.m. the resident lay in bed eating lunch. The urinary drainage bag lay positioned between the right bed side rail and the mattress bed frame uncovered not below the level of the bladder. During an observation on 3/9/22 at 2:24 p.m. Resident #104's uncovered, urinary drainage bag laid flat directly on the floor beneath her bed. 2. The MDS dated 2/7/22 for Resident #111 showed a BIMS of 14, indicating intact cognition. The resident required extensive assistance of one staff with dressing, toilet use, and personal hygiene. The MDS listed a diagnosis of neurogenic bladder and identified the use of a suprapubic catheter. The Medication Review Report signed by the Provider on 2/9/22 listed the following physician orders: 1. Suprapubic Catheter: change catheter monthly with 20 French (FR) 10 cubic centimeters (cc) every evening shift starting on the 11th and ending on the 11th every month for catheter change. Start date 2/11/22. 2. Order suprapubic catheter change supplies from the resident's medical supply company. Change the catheter on the 11th one time a day starting on the 9th and ending on the 9th every month. Start date 2/9/22. The Care Plan revised 6/17/20 documented Resident #111 at risk for complications related to use of a suprapubic catheter due to a diagnosis of benign prostatic hytropertrophy. The Care Plan directed the staff in the following: a. Change catheter/bag as ordered and per	F 880		

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 ______	03/10/2022

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 880	Continued From page 52	F 880		

Continued From page 52

policy, and as needed.
b. Check tubing for kinks when repositioning each shift.
c. Flush the Foley catheter as ordered by the medical doctor (MD) to prevent sediment associated obstruction.
d. Monitor/document for pain/discomfort due to catheter.
e. Monitor/record/report to MD for signs/symptoms of urinary tract infection: pain, burning, blood tinged urine,
cloudiness, no output, deepening of urine color, increased pulse,increased temp, urinary frequency, foul smelling
urine, fever, chills, altered mental status, change in behavior, change in eating patterns.
f. The resident uses a size 16 French Foley catheter with 10 cubic centimeter (cc) balloon. Position catheter bag and
tubing below the level of the bladder.

During an observation on 3/8/22 at 2:07 p.m. Staff B, C.N.A., left room 339-A without performing hand hygiene and entered Resident #111's room. Staff B donned glove without performing hand hygiene, obtained an unmarked urinal from the bathroom placed directly on the floor below the urinary drainage bag without a clean barrier. Staff B opened the urinary drainage bag drain tube and emptied the urine into the urinal. Without cleansing the urinary drain bag tube with alcohol, Staff B closed and attached the drain tube to the bag. Staff B emptied the contents of the urinal into the toilet. Staff B then placed the used urinal under the bathroom sink faucet touching the urinal to the faucet to put water into the urinal. Staff B swished the water in the urinal and emptied the urinal into the bathroom sink. Staff B rinsed the used urinal a

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 ____	03/10/2022

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 880	Continued From page 53	F 880		

second time with water from the bathroom sink and again emptied the urinal into the bathroom sink. Staff B removed her gloves, failed to perform hand hygiene, and left the room.

During an interview on 3/10/22 at 7:39 AM the Director of Nursing (DON) reported that the facility did a recent education on changing linens. She felt that all nursing staff should have further education on infection control. The urinary drainage bags should have a dignity bag cover, as the facility had dignity bag covers available. The DON expected a clean barrier of a plastic bag to be under a graduate when the urinary drainage bags were emptied, as urine could leak onto the floor, thus causing another infection control issue. She expected staff to use alcohol wipes on the urinary drainage bag valve or drain tube after the bag was emptied. The DON expected staff to perform hand hygiene. She stated nursing would aud later that day on hand hygiene for resident care and emptying urinary drainage bags. The DON reported that they need to provide more education on infection control.

During an interview on 3/10/22 at 7:40 a.m. the Provisional Administrator reported the sheets should be changed when soiled (dirty).

The undated Infection Prevention and Control Program (IPCP) Guidelines Policy provided by the facility documented through means of surveillance, investigation, prevention, control, and reporting, the facility maintains an infection control program that:
1. Provides a safe, sanitary and comfortable environment;
2. Helps prevent the development and transmission of communicable diseases and

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 ______	03/10/2022

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 880	Continued From page 54	F 880		

Continued From page 54
infections and;
3. Balances precautionary measures with promoting individual resident's rights and well-being.

The undated IPCP Policy, Standard Precautions included under Hand Hygiene should be performed:
a. when coming off duty;
b. When hands are visibly soiled (wash with soap and water);
c. Before and after direct resident contact;
d. Before and after performing any invasive procedure (i.e. fingerstick blood sampling);
e. Before and after handling peripheral vascular catheters and other invasive devices;
f. Before and after entering isolation precaution settings;
g. Before and after assisting a resident with personal care;
h. Before and after eating or handling food;
i. Before and after assisting a resident withe meals;
j. Before and after inserting indwelling catheters;
k. Before and after changing dressings;
l. Upon and after coming into contact with a resident's intact skin;
m. After personal use of the toilet;
n. Before and after assist a resident with toileting;
o. After contact with a resident with infectious diarrhea;
p. After blowing or wiping nose;
q. After contact with a resident's mucous membranes and body fluids or excretions;
r. After handling soiled or used linens, dressing, bedpans, catheters, urinals;
s. After handling soiled equipment or utensils;
t. After removing gloves;
u. After completing duty.

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 ______	03/10/2022

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 880	Continued From page 55 The undated Catheter, Emptying of policy, provided by the facility directed the following guidelines: 1. Assemble equipment. 2. Wash hands. 3. Put on gloves 4. Put a plastic bag under the graduate. 5. Remove the catheter bag from protective covering if applicable. 6. Open the drain and let urine run into the graduate. Avoid contaminating the drain. Allow the urine in tubing to drain into the collection bag. 7. Clamp tubing; wipe drain with alcohol swab. 8. Place drain bag in a protective covering if applicable. 9. Measure amount of urine. 10. Remove one glove. 11. Use gloved hand to carry the graduate. 12. Use non-gloved hand to open door, flush stool and turn on and off the faucet. 13. Rinse graduate with water, empty into the bathroom - air dry. 14. Remove glove. Wash hands. 15. Check position of drain bag and tubing to make sure it is positioned correctly; catheter strap on leg, unless contraindicated. 16. Record output, if indicated. 17. Report anything unusual to the charge nurse.	F 880		
F 887 SS=D	COVID-19 Immunization CFR(s): 483.80(d)(3)(i)-(vii) §483.80(d) (3) COVID-19 immunizations. The LTC facility must develop and implement policies and procedures to ensure all the following: (i) When COVID-19 vaccine is available to the	F 887		

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 ______	03/10/2022

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 887	Continued From page 56 facility, each resident and staff member is offered the COVID-19 vaccine unless the immunization is medically contraindicated or the resident or staff member has already been immunized; (ii) Before offering COVID-19 vaccine, all staff members are provided with education regarding the benefits and risks and potential side effects associated with the vaccine; (iii) Before offering COVID-19 vaccine, each resident or the resident representative receives education regarding the benefits and risks and potential side effects associated with the COVID-19 vaccine; (iv) In situations where COVID-19 vaccination requires multiple doses, the resident, resident representative, or staff member is provided with current information regarding those additional doses, including any changes in the benefits or risks and potential side effects associated with the COVID-19 vaccine, before requesting consent for administration of any additional doses; (v) The resident or resident representative, has the opportunity to accept or refuse a COVID-19 vaccine, and change their decision; Note: States that are not subject to the Interim Final Rule - 6 [CMS-3415-IFC], must comply with requirements of 483.80(d)(3)(v) that apply to staff under IFC-5 [CMS-3414-IFC] and (vi) The resident's medical record includes documentation that indicates, at a minimum, the following: (A) That the resident or resident representative was provided education regarding the benefits and potential risks associated with COVID-19 vaccine; and	F 887		

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 ______	03/10/2022

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 887	Continued From page 57	F 887		

(B) Each dose of COVID-19 vaccine administered to the resident; or
(C) If the resident did not receive the COVID-19 vaccine due to medical contraindications or refusal; and
(vii) The facility maintains documentation related to staff COVID-19 vaccination that includes at a minimum, the following:
(A) That staff were provided education regarding the benefits and potential risks associated with COVID-19 vaccine;
(B) Staff were offered the COVID-19 vaccine or information on obtaining COVID-19 vaccine; and
(C) The COVID-19 vaccine status of staff and related information as indicated by the Centers for Disease Control and Prevention's National Healthcare Safety Network (NHSN).
This REQUIREMENT is not met as evidenced by:
Based on clinical record review, facility policy review and staff interview the facility failed to provide and document education regarding the risks, benefits, potential side effects of the novel Coronavirus 2019 (COVID-19) vaccine, signed refusal forms, and/or medical contraindication, for 2 of 5 residents (Residents #45 and #106) reviewed for immunization review. The facility reported a census of 130.

Findings include:

The undated and unlabeled facility provided form indicated it was information on resident vaccines taken from the immunization record in the electronic health record (EHR). The form documented that Resident #45 and Resident #106 didn't have the COVID-19 vaccine.

The review of Resident #45's clinical record on

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 ______	03/10/2022

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 887	Continued From page 58 3/9/22 at 12:40 PM revealed no documentation of education regarding the risks, the benefits, and the potential side effects of the COVID-19 vaccine. The clinical record revealed no medical contraindication. The clinical record revealed no signed declination (formal refusal) form for the COVID-19 vaccine. The review of Resident #106's clinical record on 3/9/22 at 12:40 PM revealed no documentation of education regarding the risks, the benefits, and the potential side effects of the COVID-19 vaccine. The clinical record revealed no medical contraindication. The clinical record revealed no signed declination form for the COVID-19 vaccine. The undated COVID-19 Vaccination policy stated that all residents would be offered the COVID-19 vaccination upon admission. The resident or resident decision maker would sign a consent to receive or decline the vaccination after receiving information regarding the benefits versus the risks of the vaccine. The policy stated vaccinations would be documented in the resident's medical record. During an interview on 3/10/22 at 1:11 PM the Director of Nursing (DON) reported that she would expect the facility policies to be followed by all staff.	F 887		

Pillar of Cedar Valley

1410 W Dunkerton Road

Waterloo IA 50703

Phone: 319 291 2509

Plan of Correction Related to Survey ending March 10, 2022

This plan of correction constitutes Pillar of 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 Cedar Valley continues to meet the applicable provisions of the State and Federal regulations.

FOOO Correction Date: 3/25/22

DPOC Correction Date F880: 4/7/22

F550: Dignity
481—58.45(135C) Dignity preserved. The resident shall be treated with consideration, respect, and full recognition of dignity and individuality, including privacy in treatment and in care for personal needs. (II)

1. Resident #111 urine drain bag was covered immediately with a privacy cover.
2. Education was provided on 3/11/22 that urinary drainage bags should be emptied at the end of each shift and urinary drainage bags should be covered with a privacy cover.
3. An audit was completed on 3/14/22 to ensure dignity bags were in place.
4. The facility will continue to audit weekly x 4 weeks and then PRN audits to be completed to ensure dignity bags are in place covering urine drain bags. Any areas of concern to be addressed through the quality assurance and performance improvement process.

F558: Reasonable Accommodations for Call Light
481—58.20(135C) Duties of health service supervisor. Every nursing facility shall have a health service supervisor who shall:
(2) Plan for and direct the nursing care, services, treatments, procedures, and other services in order that each resident's needs and choices, where practicable, are met; (II, III)

1. DON ensured Resident #100 call light was within reach upon notification of discrepancy.
2. Education was provided on 3/11/22 that call lights should be in reach of residents.
3. The facility completed an audit on 3/11/22 to ensure call lights were within reach of residents.
4. Call light placement audits will be conducted 3 times weekly for 4 weeks beginning on 3/11/22. Random audits will be completed weekly thereafter to ensure compliance.

F607: Background check

1. HR Director immediately added a section on new hire checklist on 3/10/22 for all new hires to list out date that background check was completed to ensure 30-day compliance. HR Director to review all new hires prior to orientation date to ensure background check completed within 30 days.

2. HR Director updated background check policy in employee handbook to specify a timeframe in which the background checks need completed.
3. HR Director to all list background check date on employee workbook next to hire date as a extra precaution.
4. Quarterly, HR Director will do random audits of 10 new hire folders to further ensure compliance with background check timeframe requirements.

F622: Transfer and Discharge requirements

481—58.15(135C) Records.

(2) Resident clinical record. There shall be a separate clinical record for each resident admitted to a nursing facility with all entries current, dated, and signed. (III) The resident clinical record shall include resident's death; (III)

1. Resident #34 was lacking a transfer note for 12/9/21 and 2/9/22; education was given to nurses regarding documentation requirements.
2. 5-minute meeting education provided on 3/14/22 to all licensed nursing staff related to requirements for transfer and discharge requirements.
3. Effective 3/14/22, at daily QA meeting IDT team will discuss prior days transfer out & discharges to ensure proper documentation compliance.
4. Education will be provided to licensed nurses on 3/31/22 regarding proper documentation of change in condition, resident transfer, and what forms should be sent along with who report has been called to at receiving facility.
5. To ensure compliance, all transfers and discharges will be reviewed by the management team during morning stand up each day. Any variances corrected at that time.

F625: Bed Hold

481—58.13(135C) Contracts. Each contract shall:

58.13(7) State the terms of agreement concerning the holding and charging for a bed when a resident is hospitalized or leaves the facility temporarily for recreational or therapeutic reasons. The terms shall contain a provision that the bed will be held at the request of the resident or the resident's responsible party.

1. A bed hold was obtained for resident #34 for December 21, 2021.
2. The facility will ensure a bed hold notice is issued upon transfer for all residents.
3. Effective 3/14/22, at daily QA meeting IDT team will discuss prior days transfer out and therapeutic leaves to ensure a bed hold was completed, proper documentation and notifications as applicable.
4. Education was provided to nurse managers on bed hold policy, and need for oversight and reinforcement of by charge nurses on 3/14/22.
5. To ensure compliance, bed hold completion will be reviewed by the management team during morning stand up each day and any variances will be corrected at that time.
6. Education to be provided to licensed nurses on 3/31/22 regarding bed hold process at time of transfer to hospital or therapeutic leave.

F637: Comprehensive Assessment after a Significant Change

481—58.20(135C) Duties of health service supervisor. Every nursing facility shall have a health service supervisor who shall:
(2) Plan for and direct the nursing care, services, treatments, procedures, and other services in order that each resident's needs and choices, where practicable, are met; (II, III)

1. Resident #100 care plan was updated a time of survey
2. Resident #116 significant change was submitted at time of survey
3. To ensure compliance, the management team will discuss resident change of condition at each morning stand up meeting.
4. MDS consultant did 100% audit on 3/14/22 of current residents to identify that appropriate MDS was completed.

F640: Minimum Data Set Assessment Transmission

481—58.19(135C) Required nursing services for residents. The resident shall receive and the facility shall provide, as appropriate, the following required nursing services under the 24-hour direction of qualified nurses with ancillary coverage as set forth in these rules:
(2) Medication and treatment.

1. Residents #1,2,4,5 and 15 were submitted after the 14 days; education was provided to MDS Coordinator to follow CMS guidelines on transmission and submission deadlines.
2. MDS Coordinator was educated on importance of timely submissions on 3/10/22.
3. Weekly and PRN audits of MDS data submission report to ensure ongoing compliance.
4. Increased MDS FTE to 1.5 to ensure seamless and timely submissions per CMS regulations.

F641: Accuracy of Assessments

481—58.19(135C) Required nursing services for residents. The resident shall receive and the facility shall provide, as appropriate, the following required nursing services under the 24-hour direction of qualified nurses with ancillary coverage as set forth in these rules:
(2) Medication and treatment.

1. A corrected MDS was submitted for resident #34 in relation to the PASRR level on 3/10/22.
2. A modification was completed for resident #55 in relation to section M of pressure injuries.
3. Education provided to MDS coordinator on 3/10/22 regarding MDS Assessment matching PASRR on file.
4. During weekly weights and skin, MDS coordinator will be provided a list of current pressures to ensure accuracy of care plans.
5. MDS Coordinator to complete 100% audit of MDS Assessment to ensure PASSR level matches assessment and care plan.

F644: Preadmission Screening and Resident Review

481—58.9(135C) Administration.
(1) The licensee shall:
b. Be responsible for compliance with all applicable laws and with the rules of the department; (III)

1. Resident #34 care plan was revised on 3/10/22 to show specialized services outlined by PASRR.
2. Resident #33 updated PASRR was submitted on 3/8/22

3. Education was provided 3/11/22 to social workers related to PASRR period requirements.
4. A master PASRR list was created to list out each resident, their PASRR level and expiration date if applicable. Will be reviewed weekly to ensure further compliance.
5. Revisions to the PASRR policy were updated.
6. To ensure further compliance, the management team will add to the morning stand up agenda PASRR expirations to ensure all are within approval period.

F656: Develop and Implement Comprehensive Care Plans

481—58.18(135C) Nursing care.

58.18(1) Individual health care plans shall be based on resident treatment decisions, the nature of the illness or disability, treatment, and care prescribed. Goals shall be developed by each discipline providing service, treatment, and care. These plans shall be in writing, revised as necessary, and kept current. They shall be made available to all those rendering the services and for review by the department. (III)

1. Resident #55 care plan was completed on 3/8/22, however was done late so nothing further needed to be revised in the care plan. See #2 for education provided to coordinator.
2. MDS Coordinator was educated on the importance of updating care plans in a timely manner as these are a working tool to guide the resident's care on 3/10/22.
3. Care plan audit to be completed by MDS coordinator to ensure accuracy of complete and comprehensive plan of care for each individual resident.
4. Any change of conditions, new skin integrity issues, falls, interventions, behaviors, or high-risk medications will be discussed at morning stand up and care plan updated immediately. This will be completed on an ongoing basis.

F657: Care Plan timing and revision

Care Plan Timing and Revision

CFR(s): 483.21(b)(2)(i)-(iii)

§483.21(b) Comprehensive Care Plans

§483.21(b)(2) A comprehensive care plan must

be- (i) Developed within 7 days after completion of the comprehensive assessment. (ii) Prepared by an interdisciplinary team. (iii)Reviewed and revised by the interdisciplinary team after each assessment, including both the comprehensive and quarterly review assessments.

1. Resident #100 care plan was updated on 3/9/22 but assessment was submitted late, education provided.
2. During survey Resident #111 did code and pass away at hospital therefore care plan was discontinued before updates could occur.
3. MDS Coordinator was educated on the importance of updating care plans and revising in a timely fashion on 3/10/22.
4. Care plan audit to be completed by MDS coordinator to ensure all revisions and care plan updates have been completed.
5. Any change of conditions, new skin integrity issues, falls, interventions, behaviors, or high-risk medications will be discussed at morning stand up and care plan updated immediately. This will be completed on an ongoing basis.

6. Weekly audits completed by DON or designee. Any concerns followed up timely. Any areas of concern to be audited and addressed through the quality assurance and performance improvement process.

F658: Professional Standards

481—58.19(135C) Required nursing services for residents. The resident shall receive and the facility shall provide, as appropriate, the following required nursing services under the 24-hour direction of qualified nurses with ancillary coverage as set forth in these rules:

1. Verbal education was provided to nursing staff on 3/14/22 regarding completion of skin sweeps, initiating skin sheets when a new skin integrity issue is identified, and notifying PCP and responsible party.
2. Education reinforced to all licensed nurses on 3/31/22 related to facility policy and procedure regarding skin integrity issues. This will include wound size, location, appearance, presence /absence of drainage and measurements.
3. Weekly skin integrity updates shall be completed according to facility schedule. Should the nurse(s) note no change or wound deterioration in skin condition after 2 weeks, they will contact the primary care provider for further guidance on treatment.
4. Unit nurse managers will monitor skin book weekly and on an ongoing basis to ensure compliance.
5. Weekly audits completed by DON or designee. Any concerns followed up timely. Any areas of concern to be audited and addressed through the quality assurance and performance improvement process.

F812: Food Safety

481—58.24(135C) Dietary.

58.24(5) Food handling, preparation, and service. All food shall be 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) In addition, the following shall apply.

1. Immediate verbal education was provided on /3/9/22 to staff K on appropriate usage of gloves and hand hygiene
2. Education provided to staff on appropriate usage of gloves and hand hygiene.
3. The dietary manager of designee will continue to audit weekly x 4 weeks and then PRN audits to be completed to ensure that staff are following proper procedures.

F880: Infection Control

481—58.10(135C) General policies.

58.10(8) Infection control program. Each facility shall have a written and implemented 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. Resident #104 was provided a dignity bag on 3/9/22, drain bag was secured properly on 3/9/22 and linen was changed on 3/10/22.
2. Resident #111 drain bag was covered as addressed in dignity tag above.

3. Verbal education provided to staff B and F on 3/9/22 related to hand hygiene and proper protocol for emptying drain bags.
4. Education on proper policy and protocol for emptying urinary drainage bags & hand washing will be provided at nursing meeting 3/31/22.
5. Random audits will be completed on the above 3x weekly for 4 weeks beginning on 3/14/22 and then will be conducted on a quarterly basis and PRN to ensure compliance.
6. 3/22/22 all staff provided reminder related to proper hand hygiene, enduring resident sheets are clean and changed when soiled and general infection control reminders were discussed
7. Education on conducting RCA was completed with Telligen on 3/29/22.

F887: COVID-19 Immunizations

481—58.10(135C) General policies.

58.10(8) Infection control program. Each facility shall have a written and implemented 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. Resident #106 – a informed signed consent by Guardian was obtained in December 2020, however resident declines to accept the Covid 19 vaccine. As resident is unable to make his own decisions and has a guardian, the facility will not administer the vaccine against the resident wishes. The guardian is aware that resident is refusing to accept vaccine to date. Resident was provided education on 3/24/22 on the risks and benefits of the Covid 19 vaccine.
2. Resident #45- a signed Covid 19 consent form was obtained.
3. On 3/22/22, all staff were provided education on Covid-19 and getting vaccinated. Staff will continue to be provided Covid-19 education at monthly all staff meetings. The education provided will be the most current education available from CDC.
4. Effective 3/25/22, 2022 a Covid-19 Consent Form and Resident Education is provided upon admission. All residents who have declined the Covid-19 Vaccination will have a consent/declination form scanned into Point Click Care.
5. On 3/24/22 residents who have admitted and declined vaccination that have a POA/Guardian on file have been mailed a Covid-19 education packet and a Covid-19 Consent form.
6. Residents/responsible party who continue to decline Covid-19 Vaccination will be provided education on the Covid-19 vaccination on a quarterly basis.