STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155515	A. BUILDING _____ B. WING _____	05/14/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SUNNYCREST NURSING CENTER	461 CRISMAN STREET DYSART, IA 52224

(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 6/14/18 The following deficiencies relate to the facility's annual health survey. (See code of Federal Regulations (42 CFR), Part 483, Subpart B - C)	F 000		
F 644 SS=D	Complaint #75148 was not substantiated. 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 review and staff interview, the facility failed to refer one of one resident reviewed with a qualifying mental illness diagnoses for a level II Pre-Admission Screening and Resident Review (PASARR). (Resident #18)	F 644		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
[signature]	Administrator 06/8/18	05/29/2018

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

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F 644	Continued From page 1 The facility census was 35 residents. Findings include: The Minimum Data Set (MDS) assessment dated 2/22/18, documented Resident #18 had diagnoses of manic depression and required extensive assistance for bed mobility and transfer. Clinical record review revealed a negative level 1 screen outcome dated 12/13/13, which documented the resident had no major mental illnesses to include major depressive disorder and schizophrenia. A diagnoses report for the resident revealed a diagnoses of major depressive disorder with an onset date of 8/3/16. Clinical record review revealed no re-submission of information which included the diagnoses of major depression. On 5/9/18 at 11:16 a.m., the Director of Nursing verified the resident had a diagnoses of major depression added since the level one and no re-submission of the information was submitted.	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	F 656		

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F 656	Continued From page 2 medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment. The comprehensive care plan must describe the following - (i) The services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §483.24, §483.25 or §483.40; and (ii) Any services that would otherwise be required under §483.24, §483.25 or §483.40 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(c)(6). (iii) Any specialized services or specialized rehabilitative services the nursing facility will provide as a result of PASARR recommendations. If a facility disagrees with the findings of the PASARR, it must indicate its rationale in the resident's medical record. (iv)In consultation with the resident and the resident's representative(s)- (A) The resident's goals for admission and desired outcomes. (B) The resident's preference and potential for future discharge. Facilities must document whether the resident's desire to return to the 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 observation, clinical record review and staff interview, the facility failed to follow the plan of care as directed for two of 12 residents reviewed. (Resident #10 & Resident #25) The	F 656		

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F 656	Continued From page 3 facility census was 35 residents. Findings include: 1. The Minimum Data Set (MDS) assessment dated 3/15/18, documented Resident #25 had diagnoses of heart failure, pain and osteoporosis and required extensive assistance with transfers. The care plan dated 4/1/18, revealed directions for the staff to apply a cone (splint) to the left hand for contractures of the 3rd, 4th and 5th digits. The plan of care directed staff to transfer the resident with one staff and a gait belt or if increased weakness transfer with two staff. Observation on 5/7/18 during initial tour revealed the resident did not have the cone in place to the left hand as planned. Observation on 5/8/18 at 9:57 a.m., revealed the resident did not have the cone in place to the left hand as planned. Observation on 5/9/18 at 7:50 a.m., revealed the hand cone for the residents left hand was not in place as directed. Observation on 5/9/18 at 7:50 a.m., revealed Staff B, certified nurse aide, CNA assisted the resident with a transfer to and from the toilet without the use of a gait belt. During interview on 5/9/18 at 8:00 a.m., Staff B revealed being directed by other staff and the resident care plan that the resident declined the use of a gait belt when transferred due to "fragile skin" and preferred the staff to "just guide the backside of the resident".	F 656		

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F 656	Continued From page 4 During interview on 5/10/18 at 8:37 a.m., the Consultant Director of Nursing revealed unawareness of the hand cone and stated all residents were to be transferred with the use of a gait belt. 2. The MDS assessment dated 2/1/18, documented Resident #10 had diagnoses of difficulty walking and reduced mobility and required extensive assistance for ambulation in room and hallway. The care plan updated 11/6/17, included a problem of impaired physical activity/self care deficit related to right sided weakness from cerebrovascular accident and kyphosis. The problem included an intervention for a bed buddy x 1 for boundary and positioning. Observation on 5/8/18 6:29 a.m., revealed the resident laid in bed with no bed buddy pillow. Observation on 5/9/18 at 7:30 a.m., revealed the resident laid in bed with no bed buddy pillow. Observation on 5/10/18 at 6:50 a.m., revealed the resident laid in bed with no bed buddy pillow. During interview on 5/10/18 at 7:30 a.m., the Director of Nursing stated staff would be expected to follow the care plan.	F 656		
F 676 SS=E	Activities Daily Living (ADLs)/Mntn Abilities CFR(s): 483.24(a)(1)(b)(1)-(5)(i)-(iii) §483.24(a) Based on the comprehensive assessment of a resident and consistent with the resident's needs and choices, the facility must	F 676		

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F 676	Continued From page 5 provide the necessary care and services to ensure that a resident's abilities in activities of daily living do not diminish unless circumstances of the individual's clinical condition demonstrate that such diminution was unavoidable. This includes the facility ensuring that: §483.24(a)(1) A resident is given the appropriate treatment and services to maintain or improve his or her ability to carry out the activities of daily living, including those specified in paragraph (b) of this section ... §483.24(b) Activities of daily living. The facility must provide care and services in accordance with paragraph (a) for the following activities of daily living: §483.24(b)(1) Hygiene -bathing, dressing, grooming, and oral care, §483.24(b)(2) Mobility-transfer and ambulation, including walking, §483.24(b)(3) Elimination-toileting, §483.24(b)(4) Dining-eating, including meals and snacks, §483.24(b)(5) Communication, including (i) Speech, (ii) Language, (iii) Other functional communication systems. This REQUIREMENT is not met as evidenced by: Based on observation, clinical record review and staff interview, the facility failed to ensure four of 12 residents reviewed received restorative services as planned to maintain or improve the	F 676		

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F 676	Continued From page 6 resident's ability to carry out activities of daily living. (Resident #25, #23, #22 & #10) The facility census was 35 residents. Findings include: 1. The Minimum Data Set (MDS) assessment dated 3/15/18, documented Resident #25 had diagnoses of heart failure, pain and osteoporosis and had a restorative nursing program to be complete three days per week.. The care plan dated 4/1/18, directed staff to observe and report any decrease of functional abilities and decrease of the resident's range of motion (ROM). The Rehab Aide Functional Maintenance Program undated documented the resident was to receive active range of motion for the hip, knee, abdomen, ankles and shoulders 2-3 times a week. The Restorative Record undated documented all exercises to be provided 2-3 times per week. The document identified the active range of motion was to be given to the hand/wrist and fingers. The form lacked any documentation of the restorative needs provided to the resident. 2. The MDS assessment dated 3/15/18, documented Resident #23 had diagnoses of dysphasia and borderline personality and did not have a restorative program. The care plan dated 4/1/18, documented directions for the staff to complete restorative programs as indicated.	F 676		

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F 676	Continued From page 7 The Rehab Aide Functional Maintenance Program undated documented 3 times a week the resident required active range of motion to the hip, knee, abdomen, ankle. The Restorative Record undated directed staff to complete exercises to the hips, abdomen, ankle, shoulder, gluteal, ball squeeze and passive range of motion to the hands, wrist, and fingers. The form lacked documentation of the therapy needs provided to the resident. 3. The MDS assessment dated 3/16/18, documented Resident #22 had diagnoses of pain in the right hip, left ankle and joints of the left foot, psychotic disorder, diabetes mellitus and dementia and had no restorative program. The care plan dated 3/18/18, revealed directions for staff to complete restorative programs as indicated. The Rehab Aide Functional Maintenance Program dated 2/17/18, lacked frequency per week for the Restorative therapy. The record documented active range of motion to the knee for extensions and passive range of motion to both knees to stretch to extend. The Restorative Record dated March 2018, directed staff to provide exercise on the nu-step for 10 minutes, to sit and stand 4 times, to stretch all extremities to provide active range of motion and walk to dine to all meals daily. The resident received no exercises for the month of March and had four refusals. 4. The MDS assessment dated 2/1/18,	F 676		

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F 676	Continued From page 8	F 676		

documented Resident #10 had diagnoses of difficulty walking and reduced mobility and required extensive assistance for ambulation in room and hallway.

The care plan revised 11/6/17, included a problem of impaired physical activity/self care deficit related to right side weakness from cerebrovascular accident and kyphosis. The problem included an intervention for a restorative program.

The restorative documentation sheet for the month of May 2018, revealed the resident had a walking program set up with platform walker and gait belt, assistance of two, all meals. The form included the following:

-group exercise Monday-Wednesday-Friday

-sit to stands x 10

-5 minute handbike 2

-seated upper extremity exercises

-shoulder shrugs, self active range of motion right upper extremity

-1# weight to left upper extremity, 1 set of 15 repetitions

-shoulder flexion

-chest press

-horizontal shoulder abduction/adduction

-elbow flexion/extension

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F 676	Continued From page 9 -hand/wrist/finger range of motion During observation on 5/8/18 at 8:29 a.m., Staff C, certified nurse aide, CNA completed morning cares and pushed the resident from the room to the dining room in a wheel chair. On 5/9/18 at 10:40 a.m., the Restorative Aide, RA stated they were allotted three days per week to complete the restorative program for all of the residents. The RA stated they felt it was difficult to complete the restorative programs for all of the residents and at times they were pulled to work the floor when they were scheduled to do restorative. The RA stated none of the residents got restorative on those days. The RA stated they had no restorative documentation completed for the resident for the months of March or April because they had not had time to complete it. On 5/9/18 at 4:05 p.m., the consultant Director of Nursing stated the plan would be for the facility not to pull the RA to the floor to work.	F 676		
F 686 SS=D	Treatment/Svcs to Prevent/Heal Pressure Ulcer CFR(s): 483.25(b)(1)(i)(ii) §483.25(b) Skin Integrity §483.25(b)(1) Pressure ulcers. Based on the comprehensive assessment of a resident, the facility must ensure that- (i) A resident receives care, consistent with professional standards of practice, to prevent pressure ulcers and does not develop pressure ulcers unless the individual's clinical condition demonstrates that they were unavoidable; and (ii) A resident with pressure ulcers receives necessary treatment and services, consistent	F 686		

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F 686	Continued From page 10 with professional standards of practice, to promote healing, prevent infection and prevent new ulcers from developing. This REQUIREMENT is not met as evidenced by: Based on observation, clinical record review, and staff interview the facility failed to ensure intervention planned were in place and failed to ensure ongoing assessments of skin issues were documented as required for one of three residents reviewed. (Resident #17). The facility census was 35 residents. Findings include: 1. The Minimum Data Set (MDS) assessment dated 2/22/18, documented Resident #17 had diagnoses of cancer, diabetes mellitus and age-related cognitive decline and required extensive assistance for bed mobility, transfers, toileting and personal hygiene. The MDS documented the resident ambulated with the assistance of one person and was at risk for the development of pressure areas. The MDS documented a pressure reducing device in the chair and a turning and repositioning program. A Braden Scale for Predicting Pressure Sore Risk dated 3/23/18 documented the resident scored a 15 for risk of pressure sores. The form documented the resident had slightly limited sensory perception, occasionally moist skin, occasionally walks, slightly limited mobility, adequate nutrition and a potential friction and shear problem. Review of the resident's care plan with a focus area of potential for impairment to skin integrity related to a decrease in abilities and increase in	F 686		

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F 686	Continued From page 11	F 686		

need for assistance. A revision date on the care plan was 1/16/17 and lists interventions as:
1. Monitor/document/report changes in skin status, appearance, color, or breakdown.
2. Pressure reduction overlay.
3. Roho cushion.
4. Teach resident/family the importance of changing positions for prevention of skin breakdown.
5. Assist/encourage to shift weight/reposition throughout shift.

Nurse progress notes and a Wound Record documented the onset of a pressure area on the right heel and one on the left heel on 2/20/18.

During observation on 5/8/18 at 7:50 a.m., there was no overlay on the mattress as stated on the care plan. The resident's heels were not floated off of the mattress. No devices were noted in the room other than moon boots. Blue moon boots were lying on the bed under the covers when the resident was approached to get up for a shower.

Review of a Wound Record documented a 3.0 centimeter (cm.) x 6.0 cm. black/brown (eschar) pressure area was discovered on the left heel on 2/20/18. Physician was notified. The initial treatment was to swab the wound with Betadine twice daily and for Prafo boots (pressure relieving to the heel area) to be worn.
The Wound Record also documented a clear blister area noted on the right heel on 2/20/18 measuring 6.5 cm. x 7 cm. Documentation revealed the blister popped while staff were applying socks. A Mepilex dressing was applied. Physician was notified.
The Wound Record indicated the treatment to the

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F 686	Continued From page 12	F 686		

left heel was changed on 2/21/18 to swab the wound with Betadine twice daily and wear Prafo boots. The right heel area was documented as a flat blister on 2/28/18 measuring 7.6 x 5.5 cm. Both the left and right heels were assessed weekly with the following measurements:

Left heel:
2/21/18 3.0 x 3.0 cm.
2/28/18 2.7 x 2.1 cm.
3/7/18 2.5 cm. x 2.0 cm
3/14/18 3.5 cm. x 2.5 cm.
3/21/18 4.0 x 3.0 cm.
3/28/18 3.5 x 2.6 cm.
4/2/18 3.2 x 2.5 cm.
4/9/18 3.1 x 2.3 cm
4/16/18 3.2 x 2.5 cm.
4/26/18 3.0 x 2.5 cm.
5/1/18 3.0 x 2.0 cm.
5/8/18 3.2 x 2.4 cm

Right heel:

2/21/18 9.0 cm x 9.0 cm.
2/28/18 7.6 x 5.5 cm
3/7/18 0.4 x 0.4 cm. (inaccurate)
3/14/18 8.0 x 5.0 cm.
3/21/18 8.0 x 5.0 cm.
3/28/18 no measurements/not healed out
4/2/18 no measurements
4/9/18 no measurements
4/16/18 no measurements
4/24/18 no measurements
5/1/18 wound record states no open areas
5/8/18 no open areas

Review of a Non-Pressure Skin Record documented an open area on the top of the left foot noted on 3/13/18. Documentation indicated

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SUNNYCREST NURSING CENTER	401 CRISMAN STREET DYSART, IA 52224

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F 686	Continued From page 13 the area was an open, non-draining blister, dark red/purple in color from the Prafo boot rubbing. The area measured 1.2 cm. x 2.0 cm. Physician was notified and ordered triple antibiotic ointment and a Band-Aid until healed. The treatment was changed to Bactroban on 3/21/18 with a measurement of 2.0 cm x 1.0 cm. with slough. According to the Skin Condition Record on 4/2/18 the left foot area was covered with a dark brown scab 1.0 cm. x 0.7 cm. On 4/9/18 the area divided into two scabbed areas 0.5 cm. x 0.5 cm. and 1.0 cm. x 0.7 cm. The areas were measured weekly and treated BID. Measurements for the two areas on the top of the left foot were: 4/16/18 1.0 cm. x .6 cm. and 2.5 x .5 cm. scabbed area 4/24/18 1.0 cm. x .7 cm and 2.0 x 2.0 cm. scab 5/1/18 1.0 x 1.6 cm. black scab and 0.2 x 0.3 cm. scab 5/8/18 0.9 x 1.4 cm black scab and 0.7 x 0.7 cm scab During interview on 5/8/18 at 2:45 p.m., the Consultant director of nursing stated the heel wounds developed first. Pravo boots were prescribed to prevent pressure on the heels but they rubbed the top of the resident's foot causing the wound on top of the foot to develop. The DON stated they try to float the heels in bed but the resident kicks off the blue moon boots.	F 686		
F 700 SS=K	Bedrails CFR(s): 483.25(n)(1)-(4) §483.25(n) Bed Rails.	F 700		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	165515	A. BUILDING _____ B. WING _____	05/14/2018

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SUNNYCREST NURSING CENTER	401 CRISMAN STREET DYSART, IA 52224

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F 700	Continued From page 14 The facility must attempt to use appropriate alternatives prior to installing a side or bed rail. If a bed or side rail is used, the facility must ensure correct installation, use, and maintenance of bed rails, including but not limited to the following elements. §483.25(n)(1) Assess the resident for risk of entrapment from bed rails prior to installation. §483.25(n)(2) Review the risks and benefits of bed rails with the resident or resident representative and obtain informed consent prior to installation. §483.25(n)(3) Ensure that the bed's dimensions are appropriate for the resident's size and weight. §483.25(n)(4) Follow the manufacturers' recommendations and specifications for installing and maintaining bed rails. This REQUIREMENT is not met as evidenced by: Based on record review, observation, and staff interview, the facility failed to assess bed side rails for the risk of entrapment and failed to ensure bed rails are properly maintained for safety for 16 of 45 resident beds at the facility (#36). Specifically, the facility failed to implement a system to ensure gaps in side rails were not large enough to create the risk for entrapment for Resident #36. The failure to ensure the side rails did not have a large gap which the resident could become entrapped put Resident #36 at risk of serious injury, impairment, or death due to entrapment within the gap, placing the residents in immediate jeopardy. The facility reported a census of 35.	F 700		

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F 700	Continued From page 15 Findings include: 1. Review of the Food and Drug Administration's (FDA) Hospital Bed Safety Workgroup article, "Clinical Guidance For the Assessment and Implementation of Bed Rails In Hospitals, Long Term Care Facilities, and Home Care Settings", dated April 2003, indicated, in pertinent part,"...Use of bed rails should be based on patients' assessed medical needs and should be documented clearly and approved by the interdisciplinary team...Bed rail use for patient's mobility and/or transferring, for example, turning and positioning within the bed and providing a hand-hold for getting into or out of bed, should be accompanied by a care plan...Inspect, evaluate, maintain, and upgrade equipment(beds/mattresses/bed rails) to identify and remove potential fall and entrapment hazards and appropriately match the equipment of patient needs, considering all relevant risk factors...If it is determined that bed rails are required...The mattress to bed rail interface should prevent an individual from falling between the mattress and bed. Maintenance and monitoring of the bed, mattress, and accessories such as patient/caregiver assist items...should be ongoing..." According to the FDA's Guidance for Industry and FDA Staff article, "Hospital Bed System Dimensional and Assessment Guidance to Reduce Entrapment," issued 3/10/06, "For 20 years, FDA has received reports in which vulnerable patients have become entrapped in hospital beds while undergoing care and treatment in health care facilities. The term "entrapment" describes an event in which a patient/resident is caught, trapped, or entangled	F 700		

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F 700	Continued From page 16	F 700		

in the space in or about the bed rail, mattress, or hospital bed frame. Patient entrapments may result in deaths and serious injuries. FDA received approximately 691 entrapment reports over a period of 21 years from January 1, 1985 to January 1, 2006. In these reports, 413 people died, 120 were injured, and 158 were near-miss events with no serious injury as a result of intervention. These entrapment events have occurred in openings within the bed rails, between the bed rails and mattresses, under bed rails, between split rails, and between the bed rails and head or foot boards. The population most vulnerable to entrapment are elderly patients and residents, especially those who are frail, confused, restless, or who have uncontrolled body movement. Entrapments have occurred in a variety of patient care settings..."

The MDS (Minimum Data Set) assessment tool with a completion date of 4/19/18 listed diagnoses for Resident #36 that included cancer, Alzheimer's dementia and diabetes. The MDS stated the resident was independent with bed mobility, transfers, ambulation, toileting, and hygiene The MDS stated the residents BIMS (Brief Interview for Mental Status) as 6 out of 15, indicating severely impaired cognition.

A care plan with a review start date of 5/4/18 does not indicate side rails are used.

An observation on 5/9/18 at 6:30 a.m. revealed the resident lying on her back in bed with eyes closed. One side of the bed was against the wall with the side rail up and the outer side of the bed had a top side rail up. Upon further investigation it was noted the side rails were stationary and

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F 700	Continued From page 17 attached to the bed frame and not the mattress frame. An observation on 5/9/18 at 7:30 a.m. revealed the open space in the center of the side rail measured 16 inches horizontally and 7 ½ inches vertically. The maintenance supervisor conducted and concurred with this measurement. The resident was not in the bed at this time. During an interview with the maintenance supervisor at 7:45 a.m., he acknowledged the size of the open space within the side rail could be a hazard. The maintenance supervisor stated there are no log books to identify the measurements of these rails or of the other various types of rails in place though out the facility. He stated he did not know who was responsible for keeping track of the measurements as he has only worked at this facility a few months. Further investigation throughout the facility revealed 15 more beds with the stationary side rails in place. Investigation and measurements conducted with the maintenance supervisor revealed the space within the open area of the side rail changed with different positions of the head of each bed. The beds are hand cranked. With the head of the bed at a 45 degree angle (semi-fowler's position) the space decreased to 5 inches. With the bed fully flat the space remained 9 ½ inches. With the head of the bed in a full upright 90 degree angle (fowler's position) the space decreased to 4 inches. In an interview with Physical Therapy at 9:00 a.m. on 5/10/18, she stated they assess residents for side rails based on whether it helps them get in	F 700		

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F 700	Continued From page 18	F 700		

and out of bed easier and not for issues such as frequent falls. Stated they document their observations in the Physical Therapy notes but do not have a formal assessment tool they use.

In an interview on 5/10/18 at 9:15 a.m. with the Administrator and the Corporate Nurse Consultant/Interim DON, the consultant nurse provided an email she had sent on 11/2/17 from another facility with the packet of information from Direct Supply which directed side rails should not have an opening or gap greater than 4 ¾ inches. The Consultant RN acknowledged the facility failed to implement a process to assure side rail compliance.

The facility Administrator and Consultant RN/Interim Director of Nursing (DON) were informed of the Immediate Jeopardy on 5/9/18 at 10:30 a.m., due to the risk of entrapment for Resident #36 from a side rail gap measuring 14 inches by 9 1/2 inches, and the facility's lack of a process in place to determine side rail safety.

The Immediate Jeopardy was abated on 5/9/18 at 2:40 pm by implementation of the following actions:

The facility removed all stationary side rails with a gap measuring 14 inches by 9 1/2 inches from facility beds. The facility planned to perform and document monthly safety checks of all beds and side rails. The Administrator planned to develop the monitoring tool to log the safety checks and measurements. The Maintenance Director was provided education of safe measurements for side rail gaps. Facility staff that were on duty on 5/9/18 were provided training on the rationale for stationary side rail removal and notified they are

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F 700	Continued From page 19 not to change beds or adjust side rails in the facility without direction from the interdisciplinary team. All other staff will be trained the next time they are on duty. The Administrator provided a copy of the facility's side rail assessment form which will include room number, type of side rail if used or the absence of side rails, the type of bed, measurements of openings in the rails as well as the space between the mattress and rails, and mattress and headboard. During an interview at 9:30 a.m. on 5/10/18, the Consultant Nurse/Interim DON stated she or the other Interim DON (Staff D) will complete side rail assessments on all current residents within the next week, on all new admissions, and quarterly on all residents or with any changes in resident's needs. Consultant RN stated side rail assessment forms will also be audited monthly for four months to assure completion.	F 700		
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,	F 880		

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F 880	Continued From page 20 reporting, investigating, and controlling infections and communicable diseases for all residents, staff, volunteers, visitors, and other individuals providing services under a contractual arrangement based upon the facility assessment conducted according to §483.70(e) and following accepted national standards; §483.80(a)(2) Written standards, policies, and procedures for the program, which must include, but are not limited to: (i) A system of surveillance designed to identify possible communicable diseases or infections before they can spread to other persons in the facility; (ii) When and to whom possible incidents of communicable disease or infections should be reported; (iii) Standard and transmission-based precautions to be followed to prevent spread of infections; (iv)When and how isolation should be used for a resident; including but not limited to: (A) The type and duration of the isolation, depending upon the infectious agent or organism involved, and (B) A requirement that the isolation should be the least restrictive possible for the resident under the circumstances. (v) The circumstances under which the facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct 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	F 880		

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F 880	Continued From page 21 corrective actions taken by the facility. §483.80(e) Linens. Personnel must handle, store, process, and transport linens so as to prevent the spread of infection. §483.80(f) Annual review. The facility will conduct an annual review of its IPCP and update their program, as necessary. This REQUIREMENT is not met as evidenced by: Based on observation, clinical record review and staff interview, the facility failed to utilize proper infection control technique when providing personal cares to two of four residents observed. (Resident #10 & #17) The facility census was 35 residents. Findings include: 1. The Minimum Data Set (MDS) assessment dated 2/22/18, documented Resident #17 had diagnoses of obstructive uropathy, diabetes mellitus and age related cognitive decline and required extensive assistance for bed mobility, transfers, toileting and personal hygiene. During observation on 5/8/18 at 10:00 a.m., Staff A, Certified Nurse Aide, CNA, washed her hands and donned gloves and assisted the resident to the bedside commode. Staff A removed an incontinence brief that was soiled with a large loose bowel movement, removed her gloves, and washed her hands. Staff A donned new gloves and placed a clean incontinence brief on the resident, loosely securing it until hygiene was completed. Staff A assisted the resident to stand using the gait belt and walker again. Staff A used	F 880		

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F 880	Continued From page 22	F 880		

two wash cloths-one to wash and one to rinse resident's perineal area. Staff A did not cleanse the resident's leg creases or across the frontal perineal area. Staff A washed the resident from the back reaching up through the legs to cleanse the urethral area from the front to the back. The resident had a large loose bowel movement on the commode. Visible continued smearing of fecal matter was observed on the final swipe of the posterior perineal area using the second washcloth. After all clean surfaces of the second washcloth had been used, Staff A continued to wipe the resident's posterior perineal area with the soiled cloth. With the same gloves on, Staff A pulled up the incontinence brief and resident's shorts, assisted the to ambulate to the bed and sit down. Staff A removed the soiled gloves and washed her hands. Staff A assisted resident to lay down and placed moon boots on her feet.

Review of an undated procedure guideline labeled Perineal Care directs staff to wash the frontal perineal area first and use a new cloth for the anal area.

During interview on 5/10/18 at 7:15 a.m., Consultant Director of Nursing (DON) stated staff should use as many washcloths as they need to get the resident clean after toileting and they would turn the cloth with each swipe.

2. The MDS assessment dated 2/1/18, documented Resident #10 had diagnoses of difficulty walking and reduced mobility and required extensive assistance for ambulation in room and hallway.

On 5/8/18 at 8:29 a.m., Staff C, CNA wore gloves and used a cloth to cleanse the residents left

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F 880	Continued From page 23 groin, right groin and through the center of the perineal area. Staff C failed to remove their gloves and proceeded to touch the residents wheel chair handle, wheel chair brake, the residents legs, a tube of barrier cream, a container of powder and then applied barrier cream to the residents perineal area and powder to the residents under pants. Wearing the same gloves, Staff C supported the resident with a hand on the residents back as Staff A, CNA placed a gait belt on the resident. Staff C, wearing the same gloves assisted the resident to stand and after completing posterior perineal cares Staff C removed their gloves. During interview on 5/10/18 at 9:00 a.m., the Consultant DON stated staff should remove their gloves immediately after personal cares was completed.	F 880		

F000

This plan of correction constitutes our creditable Allegation of Compliance. Preparation of/or execution does not constitute admission or agreement by the provider of the conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because it is required by the provision of the federal and state laws.

All citations will be in compliance on June 14th.

F644

The tag for coordination of PASARR and Assessments stated that a level II PASSAR was not completed for a resident. The social services employee was trained on 6/5/18 on how to complete PASSAR's and will now complete all PASSAR's. A PASSAR was completed for resident #18 on 6/7/18. All staff were educated on when a PASSR must be completed for a current resident and when a new resident's PASSR must be completed and signed that they understand. Any staff that have not signed will not be able to work until they have signed. Staff were educated on when to get a new PASSAR completed at the in-service on May 17th. PASSAR completion will be assessed by the Quality Assurance committee and checked quarterly.

F656

The tag for Develop and Implement Comprehensive Care Plans found that two residents care plans were not followed correctly. Resident # 25 was care planned to have a cone on her left hand. The resident refuses the cone consistently and she puts her own napkin in her left hand therefore the cone was discharged from her care plan on 5/11/18. It was also found that resident #25 was improperly transferred. The second resident care plan that was not followed was resident #10 did not have her buddy pillow. Resident #10 no longer uses a buddy pillow and that was discharged from her care plan as well. Staff were educated that they must follow the care plan correctly and signed that they understood. Any staff that have not signed will not be able to work until they have signed. For the next four weeks the DON will pick three to four care plans at random to audit to ensure compliance. All care plans will be reviewed by the care plan team at care conferences to ensure consistent cares is being given.

F676

The tag for Activities of Daily Living/Mntn Abilities found that four residents did not receive restorative services as planned. Residents #25, #23, #22, and #10 will have restorative services provided as per their care plan. The restorative aide was educated about keeping up with her paperwork regarding restorative work and following the care plan of each resident regarding restorative care. All staff were educated that restorative must be done and documented and staff signed that they understand. Any staff that have not signed will not be able to work until they have signed. Staff were educated on restorative aide programs at the in-service on May 17th. The restorative care will be audited by the DON/or designated representative weekly for

four weeks. The QA committee will assess the audits to decide if further action needs to be taken.

F686

The tag treatment/Svcs to prevent/Heal pressure ulcers found that one resident did not have ongoing assessments of skin issues and did not document a way to prevent skin issues. Resident #17 will receive the proper care they deserve and will have prevention plans in place to prevent future skin issues. All staff were educated that measures must be put in place to prevent pressure ulcers for all residents at risk for development and staff signed that they understand. Any staff that have not signed will not be able to work until they have signed. Staff were educated that, all residents who are at risk for pressure ulcers must have a prevention plan in place, at the in-service on May 17th. The at risk patient's preventative measures will be audited by the DON/or designated representative. The DON's findings will be reviewed quarterly by the Quality Assurance committee to assure compliance.

F700

The tag Resident safety stating that all residents shall be protected against physical or environmental hazards to themselves. The sixteen bedrails that were found in non-compliance were immediately removed from the bed. Any bed rails that need to be placed on a resident's bed must be approved by the care plan team. When a new resident is admitted a nurse must do a bed rail assessment. If a resident is in need of a bed rail the maintenance director must complete an assessment to make sure they are put on correctly and make sure there are zero potentially hazardous zones. All staff were educated on bed rail usage and procedure and signed that they understand. Any staff that have not signed will not be able to work until they have signed. Staff were educated on the proper steps to take to get bed rails for a resident's bed at the in-service on May 17th. Assessments by both the nurses and the maintenance director will be brought to the Quality assurance meetings and checked quarterly.

F880

The tag Infection Prevention & Control found that infection control procedures were not utilized on two residents. Residents #10 and #17 moving forward these residents and all residents will be protected from infection through proper infection control procedures. All staff were educated that proper infection control protocol must be used when preforming cares on residents and staff signed that they understand. Any staff that have not signed will not be able to work until they have signed. Staff were educated that all cares performed by staff must follow proper infection control protocol and all residents should be protected from infection at the in-service on May 17th. The DON/ nurse will audit cares to ensure infection control is being implemented. The DON will bring the results to the quarterly Quality Assurance meetings to ensure compliance.