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

PRINTED: 07/03/2018
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
	165385	A. BUILDING ______ B. WING ______	06/14/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GRANDVIEW HEIGHTS INC	910 EAST OLIVE MARSHALLTOWN, IA 50158

(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 YKK 7/11/18	INITIAL COMMENTS Correction date 7/5/2018 The following deficiencies relate to the facility's annual health survey. (See Code of Federal Regulations (42CFR) Part 483, Subpart B -C).	F 000		
F 567 SS=D	Protection/Management of Personal Funds CFR(s): 483.10(f)(10(i)(ii) §483.10(f)(10) The resident has a right to manage his or her financial affairs. This includes the right to know, in advance, what charges a facility may impose against a resident's personal funds. (i) The facility must not require residents to deposit their personal funds with the facility. If a resident chooses to deposit personal funds with the facility, upon written authorization of a resident, the facility must act as a fiduciary of the resident's funds and hold, safeguard, manage, and account for the personal funds of the resident deposited with the facility, as specified in this section. (ii) Deposit of Funds. (A) In general: Except as set out in paragraph (f)(l0)(ii)(B) of this section, the facility must deposit any residents' personal funds in excess of $100 in an interest bearing account (or accounts) that is separate from any of the facility's operating accounts, and that credits all interest earned on resident's funds to that account. (In pooled accounts, there must be a separate accounting for each resident's share.) The facility must maintain a resident's personal funds that do not exceed $100 in a non-interest bearing account, interest-bearing account, or petty cash fund. (B) Residents whose care is funded by Medicaid: The facility must deposit the residents' personal	F 567	See Attached	7/11/18

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Daniel M. [illegible], MSL
TITLE: Administrator
(X6) DATE: 7/13/18

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 567	Continued From page 1 funds in excess of $50 in an interest bearing account (or accounts) that is separate from any of the facility's operating accounts, and that credits all interest earned on resident's funds to that account. (In pooled accounts, there must be a separate accounting for each resident's share.) The facility must maintain personal funds that do not exceed $50 in a noninterest bearing account, interest-bearing account, or petty cash fund. This REQUIREMENT is not met as evidenced by: Based on observation, clinical record review, facility policy review, resident and staff interview, the facility failed to ensure residents had access to personal funds on weekends for one of two residents reviewed (Resident #21). The facility census was 92 residents. Findings include: 1. The Minimum Data Set (MDS) assessment dated 5/23/18, documented Resident #21 had a Brief Interview for Mental Status (BIMS) score of 15, indicating intact cognition. During interview on 6/12/18 at 9:50 a.m., the resident stated being able to get money out of their account from the facility, but was unable to get money on the weekends. During interview on 6/13/18 at 1:00 p.m., the Administrator stated residents were informed they were not able to get money on the weekends. Residents were told to let the facility know by Friday they would like money out of their account and the facility would get the money ready for the resident. The facility would either give the money to the resident on Friday or place the money in an envelope and lock it in the medication room to be	F 567		

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F 567	Continued From page 2 distributed to the resident over the weekend. Facility policy related to resident trust accounts does not address residents not being able to receive funds on weekends.	F 567		
F 578 SS=D	Request/Refuse/Dscntnue Trmnt;Formlte Adv Dir CFR(s): 483.10(c)(6)(8)(g)(12)(i)-(v) §483.10(c)(6) The right to request, refuse, and/or discontinue treatment, to participate in or refuse to participate in experimental research, and to formulate an advance directive. §483.10(c)(8) Nothing in this paragraph should be construed as the right of the resident to receive the provision of medical treatment or medical services deemed medically unnecessary or inappropriate. §483.10(g)(12) The facility must comply with the requirements specified in 42 CFR part 489, subpart I (Advance Directives). (i) These requirements include provisions to inform and provide written information to all adult residents concerning the right to accept or refuse medical or surgical treatment and, at the resident's option, formulate an advance directive. (ii) This includes a written description of the facility's policies to implement advance directives and applicable State law. (iii) Facilities are permitted to contract with other entities to furnish this information but are still legally responsible for ensuring that the requirements of this section are met. (iv) If an adult individual is incapacitated at the time of admission and is unable to receive information or articulate whether or not he or she has executed an advance directive, the facility	F 578	See Attached	6/14/18

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F 578	Continued From page 3 may give advance directive information to the individual's resident representative in accordance with State Law. (v) The facility is not relieved of its obligation to provide this information to the individual once he or she is able to receive such information. Follow-up procedures must be in place to provide the information to the individual directly at the appropriate time. This REQUIREMENT is not met as evidenced by: Based on clinical record review and staff interview, the facility failed to ensure the residents choice for resuscitation was documented correctly for one of 24 residents reviewed. (Resident #33) The facility census was 92 residents. Findings include: 1. The Minimum Data Set dated 3/28/18, documented Resident #33 had diagnoses of depression and asthma and had Brief Interview for Mental Status score of 15, indicating intact cognition. A Code Status Request form in the residents hard chart revealed the resident had signed a do not resuscitate (no CPR) request on 2/2/18. A medication review report in the residents electronic health record signed 3/1/18, revealed the resident had an order for full code and no withholdings (do cardiopulmonary resuscitation-CPR) if needed. During interview on 6/12/18 at 9:48 a.m., Staff B, Registered Nurse described the protocol if a resident was found with no vital signs. Staff B	F 578		

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F 578	Continued From page 4 pointed to a list of residents that hung at the nurses station that would need CPR. The list included Resident #33. Staff B stated they would initiate CPR because the resident had been listed as full code. Staff B stated the resident had a red sticker on the back of their chart which also meant full code so could use that. The surveyor asked if the resident had a written directive in the hard chart. Staff B stated the resident did and proceeded open the residents chart and stated the residents advanced directive indicated the resident wanted to be a do not resuscitate (no CPR). Staff B stated they had been the one who signed it in February so should have changed it on list and sticker.	F 578		
F 584 SS=D	Safe/Clean/Comfortable/Homelike Environment CFR(s): 483.10(i)(1)-(7) §483.10(i) Safe Environment. The resident has a right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely. The facility must provide- §483.10(i)(1) A safe, clean, comfortable, and homelike environment, allowing the resident to use his or her personal belongings to the extent possible. (i) This includes ensuring that the resident can receive care and services safely and that the physical layout of the facility maximizes resident independence and does not pose a safety risk. (ii) The facility shall exercise reasonable care for the protection of the resident's property from loss or theft. §483.10(i)(2) Housekeeping and maintenance	F 584	See Attached	6/15/18

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F 584	Continued From page 5	F 584		

services necessary to maintain a sanitary, orderly, and comfortable interior;

§483.10(i)(3) Clean bed and bath linens that are in good condition;

§483.10(i)(4) Private closet space in each resident room, as specified in §483.90 (e)(2)(iv);

§483.10(i)(5) Adequate and comfortable lighting levels in all areas;

§483.10(i)(6) Comfortable and safe temperature levels. Facilities initially certified after October 1, 1990 must maintain a temperature range of 71 to 81°F; and

§483.10(i)(7) For the maintenance of comfortable sound levels.
This REQUIREMENT is not met as evidenced by:
Based on observation and staff interview, the facility failed to maintain the resident lounge area of the Chronically Confused and Demented Illness (CCDI) unit in a sanitary and homelike manner. The facility census was 92 residents.

Findings include:

On 6/12/18 at 8:04 a.m., observation revealed eleven recliners in the CCDI unit lounge area all with incontinence soaker pads on the seats, two of the pads had visible areas with stains yellow and brown in color. A leather rocker recliner had a dried brownish substance along the right front back of the chair and dried food along the side of the chair.

On 6/13/18 at 7:00 a.m., observation revealed

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F 584	Continued From page 6 one of the incontinence soaker pads covered a recliner chair in the unit was wet. No resident sat in the chair at the time. At 9:20 a.m., observation revealed the chairs had food debris and stains on the incontinence soaker pads. On 6/14/18 at 11:20 a.m., the Director of Nursing stated they did not know why the chairs all had soaker pads on them but that was not facility policy and chairs were to be cleaned when soiled. The Director of Nursing stated they had staff remove the soaker pads.	F 584		
F 677 SS=D	ADL Care Provided for Dependent Residents CFR(s): 483.24(a)(2) §483.24(a)(2) A resident who is unable to carry out activities of daily living receives the necessary services to maintain good nutrition, grooming, and personal and oral hygiene; This REQUIREMENT is not met as evidenced by: Based on observation, clinical record review and staff interview, the facility failed to complete incontinence cares for three of seven residents observed in a manner to prevent the spread of infection, odors and skin breakdown. (Resident #62, #191& #77) The facility census was 92 residents. Findings include: 1. The minimum data set (MDS) assessment dated 5/2/18, documented Resident #62 had diagnoses of Alzheimer's disease and osteoarthritis and was frequently incontinent of	F 677	See Attached	6/15/18

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F 677	Continued From page 7	F 677		

urine and required limited assistance for personal hygiene.

The care plan revised 5/7/18, included a problem of activity of daily living self care performance deficit. The problem included an intervention to assist the resident at least once per shift with perineal care and a brief change if needed.

On 6/13/18 at 7:19 a.m., the resident laid in bed as Staff G, Certified Nurse Aide, CNA removed an incontinent brief visibly wet. Staff G verified the brief was wet with urine. Staff G cleansed the residents anterior perineal area, turned the resident to the right and cleansed over the rectal area. Observation revealed the residents gluteal fold was reddened. Staff F, CNA assisted the resident with a clean incontinent brief and finished dressing the resident. Observation revealed no cleansing of the residents bilateral hips or buttocks prior to dressing the resident.

2. The admission record face sheet documented Resident #191 was admitted 6/4/18 and had diagnoses of unspecified dementia without behavioral disturbance and generalized anxiety disorder.

The baseline care plan dated 6/4/18, included a directive of assistance of two for toileting.

On 6/13/18 at 9:56 a.m., Staff G, CNA and Staff F, CNA assisted the resident to stand after using the commode. During the observation Staff F used a cloth rag and made three back to front wipes over the rectal area towards the front of the perineal area.

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F 677	Continued From page 8 On 6/13/18 at 11:24 a.m., the Director of Nursing, DON stated the facility did not do frequent perineal care audits but staff was educated they were not to wipe back to front when completing perineal cares. The DON verified all areas in contact with urine was to be cleansed. A facility Incontinent Care Protocol dated 4/17, included a directive in bold print to never contaminate a clean area by cleaning back to front. The policy included a directive to wipe front to back on each buttock with single swipes, and wash hip areas and all areas that brief covers that could be soiled. 3. The MDS assessment dated 5/30/18, documented Resident #77 had a diagnosis of Non-Alzheimer's dementia and required extensive assistance for transfer, locomotion on unit, bed mobility, dressing, personal hygiene and toileting and was frequently incontinent of urine and bowel. Resident care plan last revised 6/12/18 directed staff to assist the resident with personal hygiene cares and with toileting. Observation on 6/13/18 at 7:06 a.m., revealed Staff R, CNA and Staff J, CNA assisted the resident to the bathroom. Observation revealed the resident had a bowel movement in the toilet. The resident was assisted to a standing position as Staff J cleansed the residents buttock area using a back to front motion with the wash cloth. During interview immediately after cares were provided, Staff H, registered nurse, RN stated staff was to wash residents from the front to the back.	F 677		

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F 686 SS=G	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 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 clinical record review, observation and staff interviews, the facility failed to ensure completion of initial and/or ongoing assessments and interventions to identify, prevent or promote healing of areas of altered skin integrity for two of two residents reviewed (Residents #291 and #23). The facility identified a census of 92. Findings include: 1. The Minimum Data Set (MDS) assessment for Resident #291, dated 5/28/18, recorded diagnoses of enterocolitis due to clostridium difficile (an infection of the colon by the bacteria known as c-diff), acute respiratory failure, fluid overload, severe protein calorie malnutrition, arthritis, high blood pressure and cirrhosis (liver damage). The MDS documented the resident required the physical assistance of two for bed mobility, toilet use and transfer and the assistance of one for dressing and personal	F 686	See Attached	6/15/18

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F 686	Continued From page 10	F 686		

hygiene. The resident ate independently following set up. The MDS documented the resident had frequent incontinence of bowel and had an indwelling catheter for urination. The assessment also recorded Resident #291 had three Stage 2 pressure ulcers with one present on resident's admission date, 5/11/18.

The resident's care plan dated 5/30/18 included a focus area of actual pressure ulcers and he had the potential of further pressure ulcer development related to impaired mobility, incontinent of bowel, varied oral intakes and low albumin and protein levels. The resident received comfort care. The care plan documented the goal that his pressure ulcers would show signs of healing and remain free of infection. Documented interventions instructed to assess, record and monitor the resident's wound healing per protocol, report improvements and declines to the medical doctor and assist resident to turn and reposition frequently. On 6/12/18, staff added the intervention to use a turn sheet and heel boots at all times.

A Braden Scale for predicting pressure sore risk dated 6/6/18 documented the resident scored a 13, which identified the resident to be at risk for developing a pressure sore.

During observation on 6/12/18 at 8:14 A.M, with Staff C, Registered Nurse Unit Manager /Quality Assurance, Resident #291 lay flat on his back in his bed a pillow had been placed under his knees and his heels lay directly against the mattress. The resident had a square skin dressing in place on the right inner ankle with a date of 6/8/18. His left great toe appeared reddened. The resident also had a bright red rash on his groin area on

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F 686	Continued From page 11	F 686		

both buttocks and down the back of both thighs. The observation revealed five skin dressing patches on his back and one on his sacral area. One patch had a date of application of 6/7/18 and the remaining five showed no date. The patch on the sacral area was contaminated with BM.

Record review showed the resident had a pressure wound identified on right inner foot and no treatment order could be found on the current Treatment Administration Record (TAR). The TAR also contained no treatment direction for the sacral area or rash to groin and buttocks.

During an observation on 6/12/18 at 11:20 AM, the resident lay flat on his back with his heels directly on the mattress. Staff B, Registered Nurse (RN) entered the room, washed her hands and donned gloves. She prepared a clean surface barrier and laid out wound treatment supplies. Staff C, RN Unit Manager/ Quality Assurance entered room as an observer.

a. Staff B removed the Kerrafoam (a wound protection dressing) dated as applied on 6/8/18 from the resident's right ankle. Clear drainage ran down the side of the resident's ankle onto the bedding. Staff B measured the ankle wound, identified as pressure wound, with a paper measure strip that she laid against the wound. The wound measured 1.7 centimeters (cm) X 2.7 cm and had a shallow ulcer with a red and yellow wound bed. Staff B moved toward resident's back to start the treatment. On request, Staff B lifted resident's feet and revealed black eschar (a collection of dead tissue that is within a wound, flush with the skin surface and reflects deep tissue damage) on both heels. She touched the reddened left great toe, which had crossed over

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F 686	Continued From page 12 the second toe and separated them. An open area with a red wound bed and a small amount of drainage was against the second left toe. Staff B replaced resident's heels back directly on the mattress. b. Staff B then removed the Kerrafoam dressing close to resident's right shoulder blade. The dressing covered a linear open area that appeared to be from abrasion, tearing or shearing. Staff B cleansed and re-dressed this open area. c. Staff B removed the next dressing, below the first, which showed two circular areas that appeared to be abrasion, shear or skin tear. Staff B cleansed and re-dressed the open areas. d. The next dressing lower towards his spine was removed and showed a circular open area with a moderate amount of serous sanguineous (watery blood fluid) drainage. Staff B cleansed and re-dressed the open area. e. The next dressing fell on the resident's midback spine and when removed, revealed a softball size reddened area with two eschar areas one on each side of the resident's spine. Staff B cleansed the area and placed Aqaucel (an antimicrobial which inhibits the growth of microorganisms) and Kerrafoam dressing on this area. f. The next dressing lower on the spine recorded an applied date of 6/7/18. Staff B removed the dressing revealing a pink/red wound bed which she cleansed and covered with a new Kerrafoam dressing. g. The bottom dressing showed no date and was on the sacral region (lowest area of spine). Removal of the dressing showed an ulcer with a red wound bed and serous sanguineous drainage present. Staff B cleansed the wound and covered it with a Kerrafoam dressing. Then Staff C stated	F 686		

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F 686	Continued From page 13 she was not aware of this last pressure area and the facility did not have a skin tracking sheet for it. Staff B did not measure it and Staff C requested she measure this wound (2.0 cm by 1.7 cm). Staff B then repositioned resident on his back, with his heels directly on the mattress, removed her gloves, washed her hands and left the resident's room. In an immediate interview, Staff C stated she would expect Staff B to measure a wound without being prompted. Staff C stated Staff B failed to assess and measure the three new areas on the resident's heels and between his right great and little toe. Staff C measured the new areas to send information to physician. The resident's left heel wound measured 2.2 by 0.5 cm, his right heel wound measured 3.0 by 1.5 cm and the wound to the second toe of his left foot measured 0.7 cm by 0.7 cm. Review of the Weekly Pressure Ulcer Record revealed resident had a pressure identified area on right inner foot noted on 5/23/18. The resident's TAR documented no treatment order. Review of the current TART revealed no treatment for the covered sacral wound or the rash to the resident's groin and buttocks. A room care plan utilized by the Certified Nurse Aides (CNA) directed to use heel boots. Staff completed three Weekly pressure ulcer records at this time: a. A weekly pressure ulcer record documented the date of onset for a stage 2 lower spine pressure ulcer as 5/11/18 with the next assessment on 5/23/18 then weekly through 6/6/18. This pressure area measured 0.5 cm by 1.0 cm with a dark purple surrounding area measuring 3.5 cm by 2.4 cm. b. A weekly pressure ulcer record identified a	F 686		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	165385	A. BUILDING ____ B. WING ____	06/14/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GRANDVIEW HEIGHTS INC	910 EAST OLIVE MARSHALLTOWN, IA 50158

(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 686	Continued From page 14 Stage 2 right inner foot with a date of onset on 5/23/18 and listed preventative measures to include heel boots. Weekly assessments were documented with the last one reading measurements of 1.7 cm by 2.2 cm. and the facility would be faxing physician for a new order. c. A weekly pressure ulcer record identified a Stage 2 upper spine pressure area with date of onset as 5/23/18. Weekly assessments completed through 6/6/18. This pressure area measured 1.2 cm by 0.7 cm. d. No weekly pressure ulcer record was in place for the pressure ulcer covered on the resident's sacral area. Staff sent a Routine Physician Notification form dated 4/23/18 (an error as the resident entered the facility on 5/11/18) on 5/23/18. It was returned with the word yes and without the physicians' signature. This notification requested treatment for open areas, with new areas identified as right inner foot and mid spine. The order showed a notation date of 5/24/18. The TAR showed this order to read foam dressing, apply to open areas topically every other day to promote wound healing, apply to spine, upper right back, and abdominal fold. It failed to include the area of the right inner foot. On 6/13/18, Staff C provided a weekly pressure ulcer record that had been initiated for the sacrum wound. It identified a Stage 2 wound that measured 2.0 cm by 1.7 cm. Weekly pressure ulcer records had also been started for the bilateral heel pressure area and the pressure found on the right foot second toe. She provided a paper faxed to the physician with updated condition of the resident's skin. The physician provided for new orders.	F 686		

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	165385	A. BUILDING ______ B. WING ______	06/14/2018

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F 686	Continued From page 15	F 686		

The facility's Wound/Dressing change protocol dated 2/27/15 directed to verify treatment on TAR, date and initial any new dressing replaced and conduct weekly measurements to monitor for any changes.

On 6/12/18 at 12:39 P.M., Staff C stated she would expect all pressure and open wound areas to have been assessed and the assessment sent to the physician for treatment orders. She would expect skin to be assessed for new and worsening areas of pressure. She would expect a resident's heels to be protected and recommended the patient have a turning sheet for repositioning. She stated she had been gone for three weeks and generally does the skin assessments. She had expected the RN charge nurses to monitor and assess for skin changes while she was off but felt it had not been done effectively. She would expect a barrier cream to be used by CNA staff and or a treatment would be in place for the excoriated areas to his groin and buttock.

During an interview with the Director of Nursing (DON) on 6/13/18 at 3:50 P.M., she stated she would expect skin assessments to be timely and accurate even when the Unit Manager was off. She stated she felt there had been a system failure while the Unit Manager was off. She would expect new skin conditions to be assessed and the physician to be informed.

During a phone interview on 6/14/18 at 11:55 AM, the resident's primary Physician stated he would expect new skin issues to be assessed by the nurses and treated for residents even if they were on comfort care.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	165385	A. BUILDING ____ B. WING ____	06/14/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GRANDVIEW HEIGHTS INC	910 EAST OLIVE MARSHALLTOWN, IA 50158

(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 686 Continued From page 16 F 686

2. The MDS assessment for Resident #23, dated 3/21/18, documented her diagnoses included Alzheimer's disease, depression, rheumatoid arthritis and osteoarthritis. The MDS documented the resident as at risk for developing pressure ulcers and without ulcers at the time of the assessment. Resident #23 required the physical assistance of two for bed mobility and transfers and the physical assistance of one with dressing.

The resident's care plan, initiated on 3/31/17, recorded a focus area of the potential for pressure ulcer development related to decreased mobility and incontinence. Staff added an intervention on 4/23/18 to apply heel boots on at all times and Resident #23 should not wear shoes.

A Weekly Pressure Ulcer Record documented the resident developed a pressure sore on the right outer heel on 4/23/18. The record documented the area had been a Stage 2 wound and measured 1.0 centimeters (cm) x 0.7 cm, an intact blister.

A Weekly Pressure Ulcer Record documented the resident developed a pressure sore on the left outer heel on 4/23/18. The record documented the area had been a Stage 2 wound and measured 3.5 cm x 3.0 cm, an intact blister.

A Weekly Pressure Ulcer Record documented Resident #23 developed a pressure sore on the left inner heel on 4/23/18. The record documented the area had been a Stage 2 wound and measured 2.0 cm x 2.0 cm, an intact blister.

On 6/13/18 at 10:18 a.m., Staff C, RN assessed the resident's heels with findings as follows:

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	165385	A. BUILDING ______ B. WING ______	06/14/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GRANDVIEW HEIGHTS INC	910 EAST OLIVE MARSHALLTOWN, IA 50158

(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 686	Continued From page 17 a. Right outer heel - Stage 2, 0.8 cm x 1.0 cm.; Staff C stated the area had begun as fluid filled blister. b. Left outer heel - Stage 2, dark color, 3.5 cm x 3.0 cm; Staff C stated the wound could be eschar and the resident complained of pain when Staff C touched it. c. Left inner heel - Stage 2 a dry hardened area, 1.4 cm x 1.5 cm. The resident moaned when socks were placed on after Staff C assessed the areas. During interview on 6/13/18 at 10:39 a.m., Staff C stated the heel lift boots were not implemented until after the resident developed blisters to both heels. When asked why the heel lift boots had not placed prior or an intervention to float the resident's heels, Staff C stated the resident had not been at risk for pressure sores. The surveyor and Staff C reviewed the resident's MDS assessment and Braden scale which documented a risk of developing pressure sores. Staff C stated she had not been aware of that. On 6/13/18 at 11:24 a.m., the DON stated the floor nurses completed the Braden assessments and they should have notified the nurse manager.	F 686		
F 758 SS=D	Free from Unnec Psychotropic Meds/PRN Use CFR(s): 483.45(c)(3)(e)(1)-(5) §483.45(e) Psychotropic Drugs. §483.45(c)(3) A psychotropic drug is any drug that affects brain activities associated with mental processes and behavior. These drugs include, but are not limited to, drugs in the following	F 758	See Attached	7/12/18

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	165385	A. BUILDING ____ B. WING ____	06/14/2018

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GRANDVIEW HEIGHTS INC	910 EAST OLIVE MARSHALLTOWN, IA 50158

(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 758	Continued From page 18	F 758		

categories:
(i) Anti-psychotic;
(ii) Anti-depressant;
(iii) Anti-anxiety; and
(iv) Hypnotic

Based on a comprehensive assessment of a resident, the facility must ensure that---

§483.45(e)(1) Residents who have not used psychotropic drugs are not given these drugs unless the medication is necessary to treat a specific condition as diagnosed and documented in the clinical record;

§483.45(e)(2) Residents who use psychotropic drugs receive gradual dose reductions, and behavioral interventions, unless clinically contraindicated, in an effort to discontinue these drugs;

§483.45(e)(3) Residents do not receive psychotropic drugs pursuant to a PRN order unless that medication is necessary to treat a diagnosed specific condition that is documented in the clinical record; and

§483.45(e)(4) PRN orders for psychotropic drugs are limited to 14 days. Except as provided in §483.45(e)(5), if the attending physician or prescribing practitioner believes that it is appropriate for the PRN order to be extended beyond 14 days, he or she should document their rationale in the resident's medical record and indicate the duration for the PRN order.

§483.45(e)(5) PRN orders for anti-psychotic drugs are limited to 14 days and cannot be

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	165385	A. BUILDING ______ B. WING ______	06/14/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GRANDVIEW HEIGHTS INC	910 EAST OLIVE MARSHALLTOWN, IA 50158

(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 758	Continued From page 19	F 758		

renewed unless the attending physician or prescribing practitioner evaluates the resident for the appropriateness of that medication.
This REQUIREMENT is not met as evidenced by:
Based on clinical record review and staff interview, the facility failed to ensure staff attempted alternative interventions prior to the administration of a psychotropic medication for one of six residents reviewed. (Resident #191) The facility census was 92 residents.

Findings include:

1. The admission record face sheet for Resident #191 documented an admission date of 6/4/18 and had diagnoses of unspecified dementia without behavioral disturbance and generalized anxiety disorder.

A Medication Review Report signed 6/13/18, included an order for Lorazepam (Ativan, anti-anxiety) tablet 0.5 milligrams (mg) give 0.5 tablet by mouth every 6 hours as needed for anxiety until 6/14/18.

The Medication Administration Record (MAR) for the month of June 2018, included an order for Lorazepam tablet 0.5 mg give 0.5 tablet by mouth every 6 hours as needed for anxiety until 6/14/18, with an initial start date of 6/4/18. A review of the MAR revealed the resident received the as needed Lorazepam on the following dates:

-6/4 at 5:21 p.m.

-6/5 at 1:24 a.m., 8:05 a.m., 6:02 p.m.

- 6/6 at 8:18 a.m., 2:41 p.m., 8:59 p.m.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	165385	A. BUILDING ______ B. WING ______	06/14/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GRANDVIEW HEIGHTS INC	**910 EAST OLIVE MARSHALLTOWN, IA 50158**

(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 758	Continued From page 20	F 758		

-6/7 at 6:45 a.m., 1:00 p.m., 7:00 p.m.

-6/8 at 7:30 a.m,., 1:22 p.m., 7:21 p.m.

-6/9 at 1:23 a.m., 2:58 p.m.

-6/10 at 7:10 a.m., 4:17 p.m.

-6/11 at 4:21 p.m.

-6/12 at 2:43 p.m., 9:19 p.m.

A review of the progress notes revealed the following:

-6/4 8:53 p.m., resident very feisty and attempts to get up without assistance. Resident very talkative also. Administered as needed Ativan (Lorazepam) at 5:25 p.m..

-6/5 1:38 p.m., resident has had periods of yelling out and asking to go home. Does well with 1:1 activity. Ativan 0.25 mg given x 1 this shift.

-6/5 8:59 p.m., administered as needed Ativan at 6:00 p.m. for increased anxiety. Much 1:1 provided to resident by different staff members and effective for short periods.

-6/6 2:01 p.m., does well with 1:1 activity. Ativan 0.25 mg given x 1 this shift.

-6/7 1:37 p.m., Ativan 0.25 mg given x 2 this shift due to increased anxiety and restlessness and was effective with 1:00 dose.

On 6/13/18 at 11:24 a.m., the facility Director of

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	165385	A. BUILDING ____ B. WING ____	06/14/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GRANDVIEW HEIGHTS INC	910 EAST OLIVE MARSHALLTOWN, IA 50158

(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 758	Continued From page 21 Nursing, DON verified staff should have attempted at least three alternative interventions prior to Ativan use and should have documented them in the progress notes. The DON stated they could not find adequate documentation of for each administration of the as needed psychotropic.	F 758		
F 808 SS=D	Therapeutic Diet Prescribed by Physician CFR(s): 483.60(e)(1)(2) §483.60(e) Therapeutic Diets §483.60(e)(1) Therapeutic diets must be prescribed by the attending physician. §483.60(e)(2) The attending physician may delegate to a registered or licensed dietitian the task of prescribing a resident's diet, including a therapeutic diet, to the extent allowed by State law. This REQUIREMENT is not met as evidenced by: Based on observation, record review and staff interview the facility failed to serve food in correct ordered diet to meet nutritional needs of 1 of 1 resident observed during meal time. (#291) The facility reported a census of 92 residents. The Minimum Data Set (MDS) assessment for Resident #291 dated 5/28/18, included diagnoses of enterocolitis due to clostridium difficile (c-diff) (an infection of the colon by the bacteria known as c-diff), acute respiratory failure, fluid overload, severe protein calorie malnutrition, arthritis, high blood pressure and cirrhosis(liver damage). The MDS documented the resident required extensive assistance of two for bed mobility, toilet use, transfer and extensive assist of one for dressing and personal hygiene. It documented resident	F 808	See Attached	6/15/18

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	165385	A. BUILDING ______ B. WING ______	06/14/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GRANDVIEW HEIGHTS INC	910 EAST OLIVE MARSHALLTOWN, IA 50158

(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 808	Continued From page 22 was independent for eating with set up. The MDS documented the resident had no natural teeth or teeth fragments. It failed to show the resident needed an altered diet. The Care Plan dated 5/30/18 included an intervention to serve diet as ordered by physician. During an observation on 6/13/18 at 9:00 AM, Resident was in bed, head of bed raised, resident tipped to one side and slouched down in bed. The tray table pushed over resident at eye height, on plate was and egg and an uncut slice of ham, an uncovered bowl applesauce and 2 drinks with straws. Resident was unable to get to his breakfast, stated it is too heavy for me to lift. Stated he needed help getting scooted up, questioned if could someone help him. On 06/13/18 at 9:05 AM, Staff C accompanied surveyor into the patient room. She stated the patient needed to be repositioned and help with eating. She reported she had advised care givers he needed assistance with his meals yesterday as he is getting weaker. She would have expected a caregiver to be in the room to assist resident. A routine physician notification dated 5/25/18 documented resident was unable to eat meals at current texture due to dentures not fitting properly. It requested an order for a mechanical soft diet. The request was signed as a physician order dated 5/25/18. In an interview on 6/14/18 at 1:37 PM the Director of Nursing reported diet orders should be followed and passed on to dietary with changes. She called the dietary manager and was advised the order in the kitchen directed to serve a regular diet.	F 808		
F 812 SS=F	Food Procurement,Store/Prepare/Serve-Sanitary CFR(s): 483.60(i)(1)(2)	F 812	See Attached	7/12/18

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	165385	A. BUILDING ______ B. WING ______	06/14/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GRANDVIEW HEIGHTS INC	910 EAST OLIVE MARSHALLTOWN, IA 50158

(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 23	F 812		

§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, facility policy review and staff interview, the facility failed to maintain clean and sanitary kitchen, failed to properly sanitize the dining room tables and failed to ensure hot foods were maintained at or above 140 degrees Fahrenheit (F) in order to reduce the risk of food borne illness. The facility identified a census of 92 residents.

Findings include:

1. Observation with the Dietary Supervisor on 6/11/18 at 8:50 a.m., identified the following concerns:
a. The metal cart by the dishwashing area and ice machine had gray, fuzzy particles and dust on and in-between the metal shelving. The cart

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	165385	A. BUILDING ______ B. WING ______	06/14/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GRANDVIEW HEIGHTS INC	910 EAST OLIVE MARSHALLTOWN, IA 50158

(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 24 contained clean dishes ready for use. b. A curtain with a heavy buildup of a fuzzy gray particles and dark black dust hung by the window and a metal cart with clean dishes. c. The ice machine had white corroded and blackened areas on the inner, upper sides of the ice machine above the door hinge. At the time, the Dietary Supervisor reported maintenance staff had responsibility for cleaning the ice machine. The Dietary Supervisor reported she had no idea of when maintenance staff had last cleaned the ice machine. d. The Vulcan oven had a large amount of black carbon build-up and baked on food particles on the interior wall and bottom of the oven. At the time the Dietary Supervisor reported food had cooked over and staff had not cleaned the oven. e. The lids and container for the bulk flour and sugar stored under the food preparation area had a greasy, sticky substance on the top and sides of the container and a dried, yellow substance splattered on the outside. f. A window screen by the cook stove had dust and cotton particles adhered to it. g. The ceiling air vent above the food steam table had a large amount of dust and grayish fuzzy particles. h. The floor by the stove and under the refrigerators and freezer had food crumbs and blackened areas. i. The refrigerator had a styrofoam ice cream cup lying under it. On 6/11/18 at 10:08 a.m., the Dietary Supervisor showed the surveyor a blank copy of the kitchen cleaning schedule, and reported she planned to look for previous cleaning schedules completed by staff.	F 812		

F 812 Continued From page 25 F 812

During interview on 6/11/18 at 11:20 a.m., the Maintenance Supervisor reported he checked the ice machine each month and descaled the machine when needed. At 11:30 a.m., the Maintenance Supervisor reported he had last descaled the ice machine on 4/6/18. The Maintenance Supervisor confirmed the interior wall of the ice machine had a black substance and white corroded areas.

In a document titled Cook Cleaning Schedule revealed the following assignments needed completed once a week:
Cook 1 - clean the two right ovens and drip pan
Cook 2 - clean the two left ovens and drip pan
Cook 3 - clean the right side stovetops and backsplash
Cook 4 - clean the left side stovetops and backsplash
Cook 5 - clean both steamtable inside and outside
Cook 6 - clean vent hood and all filters
Cook 7 - clean coffee and cocoa machine, steamer and grill

The cleaning schedule contained no information regarding cleaning items such as floors, ceiling vents, metal carts or shelves, food storage containers, or windows/window coverings.

2. On 6/11/18 at 12:21 p.m., observation revealed dry cereal on the floor of the kitchenette area in the Chronically Confused and Demented Illness (CCDI) unit. Observation revealed a large amount food debris on a shelf in front of and under a built in oven.

On 6/12/18 at 12:30 p.m., observation revealed

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	165385	A. BUILDING ______ B. WING ______	06/14/2018

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(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 26	F 812		

Continued From page 26

the dry cereal and food debris in front of and under the oven remained.

During interview on 6/13/18 at 11:24 p.m., the Director of Nursing stated housekeeping staff was responsible for cleaning the dining room in the CCDI unit after meals.

3. During observation on 6/12/18 at 2:49 p.m., Staff G, Certified Nurse Aide used a disposable Sani Cloth Plus wipe to cleanse four of the dining room tables in the Chronically Confused and Demented Illness (CCDI) unit.

During interview immediately after the observation Staff G verified they had used the Sani Cloth Plus wipes to sanitize the tables.

A review of the instructions on the back of Sani Cloth container revealed a warning the cloths were intended for non food contact surfaces only.

A facility policy for dining room tables dated 2/2016, included the following directives:

-wash tables (tops, edges, and underneath table top) using hot detergent solution and clean cloth.

-rinse with clean, warm water and clean cloth

-sanitize using sanitizing solution and clean cloth

-allow to air dry.

On 6/13/18 at 11:24 a.m., the Director of Nursing stated they were not sure of the policy for sanitizing tables in the CCDI unit but housekeeping staff were responsible for that.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	165385	A. BUILDING ______ B. WING ______	06/14/2018

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GRANDVIEW HEIGHTS INC	**910 EAST OLIVE** **MARSHALLTOWN, IA 50158**

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F 812	Continued From page 27 On 6/14/18 at 2:00 p.m., the Director of Nursing stated dietary staff had provided staff in the CCDI unit with the proper supplies to sanitize tables after meals. 4. During observation of the noon meal service on 6/11/18 at 12:57 p.m., Staff E, Dietary Cook confirmed she had served the last plate of food for residents in the Main Dining Room and room trays were completed. Staff E checked temperatures of the remaining food in the warming cart as follows: a. pureed vegetable = 119 degrees (F) (Fahrenheit) b. pureed pasta/chicken Alfredo = 134 degrees (F) c. ground chicken Alfredo = 124.6 degrees (F) During interview on 6/12/18 at 2:30 p.m., the Dietary Supervisor reported she expected food temperatures to be maintained at 140 degrees (F) or greater when served.	F 812		
F 880 SS=E	Infection Prevention & Control CFR(s): 483.80(a)(1)(2)(4)(e)(f) §483.80 Infection Control The facility must establish and maintain an infection prevention and control program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of communicable diseases and infections. §483.80(a) Infection prevention and control	F 880	See Attached	6/15/18

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	165385	A. BUILDING ______ B. WING ______	06/14/2018

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F 880	Continued From page 28	F 880		

program.
The facility must establish an infection prevention and control program (IPCP) that must include, at a minimum, the following elements:

§483.80(a)(1) A system for preventing, identifying, reporting, investigating, and controlling infections and communicable diseases for all residents, staff, volunteers, visitors, and other individuals providing services under a contractual arrangement based upon the facility assessment conducted according to §483.70(e) and following accepted national standards;

§483.80(a)(2) Written standards, policies, and procedures for the program, which must include, but are not limited to:
(i) A system of surveillance designed to identify possible communicable diseases or infections before they can spread to other persons in the facility;
(ii) When and to whom possible incidents of communicable disease or infections should be reported;
(iii) Standard and transmission-based precautions to be followed to prevent spread of infections;
(iv)When and how isolation should be used for a resident; including but not limited to:
(A) The type and duration of the isolation, depending upon the infectious agent or organism involved, and
(B) A requirement that the isolation should be the least restrictive possible for the resident under the circumstances.
(v) The circumstances under which the facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct

DEPARTMENT OF HEALTH AND HUMAN SERVICES
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F 880	Continued From page 29	F 880		

Continued From page 29
contact will transmit the disease; and
(vi)The hand hygiene procedures to be followed by staff involved in direct resident contact.

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

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

§483.80(f) Annual review.
The facility will conduct an annual review of its IPCP and update their program, as necessary.
This REQUIREMENT is not met as evidenced by:
Based on observation, clinical record review and staff interview, the facility failed to utilize proper infection control technique for two of two residents in contact isolation. (Resident #70 & #291) The facility census was 92 residents.

Findings include:

1. During observation on 6/12/18 at 10:59 a.m., Staff P, environmental aide entered room number 107, that was in contact isolation for clostridium difficile. Staff P donned gloves and utilized a broom, dust pan and a mop in the room while moving the chair, garbage can and isolation clothing bin. After cleaning the room, Staff P placed the broom, dust pan and mop back on the cart in the hallway without sanitizing, removed her gloves and walked across the hallway to room 104 and washed her hands. Staff P proceeded to room 103 and utilized the same dust pan and broom without sanitizing prior to entering room.

DEPARTMENT OF HEALTH AND HUMAN SERVICES
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F 880	Continued From page 30	F 880		

Continued From page 30

During interview immediately after cleaning room 103, Staff P confirmed she did not properly clean the mop, broom or dust pan after use in room 107 or before entering room 103. Staff Q, assistant environmental supervisor stated it was her expectation that items brought into an isolation room utilized for cleaning the room would be disinfected prior to moving to another room.

2. The Minimum Data Set (MDS) assessment dated 5/28/18, documented Resident #291 had diagnoses of enterocolitis due to clostridium difficile (c-diff) and required extensive assistance for bed mobility, toilet use, transfer and extensive assistance for dressing and personal hygiene and was frequently incontinent of bowel and had an indwelling catheter.

Observation on 6/12/18 at 8:14 a.m., Staff O, certified nurse aide, CNA, Staff N, CNA and Staff I, CNA prepared to enter the resident's room. Staff entered the room donned with gloves, gowns and face masks as the resident was in contact isolation. Staff C, Registered Nurse, RN, Unit Manager accompanied staff into the room to observe. Resident was in bed unshaven, with dry yellow crust around his eyes, his lips were dry and had crust in the corners. Staff I removed a pillow from under the residents knees that had bowel movement on it. Staff I removed the pillow case and placed it in the resident's side chair. Staff I touched the tray table and the divider curtain with the same gloved hands. The resident had a large, loose, mustard yellow colored, malodorous stool. Staff N placed a plastic bag that contained clean wet washcloths and an empty plastic bag for soiled cloths on the bed. Staff O proceeded to cleanse area around the catheter, down and away from catheter entrance.

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F 880	Continued From page 31 A bright red excoriated rash was noted on the residents groin area spreading down both inner thighs. Staff O continued to clean with a washcloth and placed the soiled washcloth into the clean washcloth bag. Staff O removed the soiled washcloth from the bag and placed it into the soiled cloth bag and continued to use washcloths contaminated from the soiled cloth to provide cares. When new washcloths were needed they were obtained and placed into the clean bag that was contaminated. Staff I bagged the soiled linens, removed her gloves and rinsed her hands in the sink and did not use soap. Staff I donned gloves picked up a soiled item, removed her gown, face covering and placed them directly onto the floor in residents room and exited the room to gather sheets and supplies. Staff I returned and failed to don a gown or face mask and continued to assist with hands on care. Staff O and Staff I assisted the resident to turn onto his right side, as he was unable to turn himself, to continue to cleanse the stool. Staff I and Staff O worked to remove the soiled fitted sheet that was wet, the mattress underneath the sheet was stained and wet. The clean sheet was placed onto the mattress. After completing cares staff removed gloves, and PPE washed hands and took the soiled bags out of room. During interview on 6/12/18 at 8:50 a.m., Staff C reported she assisted with the training on hand washing and infection control and reported she would expect hand sanitation to be used anytime a caregiver enters and exits a room for cares, changes gloves, moves from a clean to soiled area and provided care to a patient. She would expect a staff member entering a precaution room to follow the precautions stated for that particular resident, including to don gloves, face	F 880		

F 880 Continued From page 32 F 880

mask and gown for cares. She would expect staff to wash hands when reentering a room and before exiting after cares using soap and water. She would expect a soiled mattress and pillow to be cleansed with appropriate available cleanser prior to covering with clean linens

3. The MDS assessment dated 5/6/18, documented Resident #70 had diagnoses of cancer, non-Alzheimer's Dementia and Parkinson's disease and required extensive assistance for transfer, toilet use and personal hygiene.

Observation on 6/11/18 at 10:59 a.m., Staff L Certified Medication Aide, and Staff M Certified Nurse Aide, CNA donned gloves, masks and gowns and assisted the resident into the bathroom to be toileted. Staff L assisted the resident with removing their pants and brief and sat the resident onto the toilet. Staff L went into the bedroom touching the doorknob and returned to assist the resident in bathroom. When finished Staff L pulled up the brief and adjusted the residents clothing. Staff L touched the wheelchair arm rest and handles, pushed resident to doorway, opened door and pushed residents wheelchair into the hallway without leaving the room. Staff L and Staff M removed all PPE and washed their hands.

During interview on 6/11/18 at 11:20 a.m., Staff H, Registered Nurse Unit Manager, reported she would expect hand washing with glove change and when providing cares going from soiled to clean. She would expect a resident with C-diff, taken to the bathroom would have their hands washed before leaving the room.

Grandview Heights Rehab & Healthcare

Plan of Correction (2567 Responses)

910 E. Olive Street

Marshalltown, Iowa 50158

The annual regulatory and certification survey was conducted at this facility from June 11-14, 2018. The following narratives, represent the facility's response to the formal statement of deficiencies and constitutes the facility's credible plan of compliance and on-going service delivery to persons being served at Grandview Heights Rehab & Healthcare.

F000 The following deficiencies relate to the facility's annual health survey. (see Code of federal Regulations (42CDFR) Part 483, Subpart B-C). Correction Date: 7/5/2018

F567 Protection/Management of Personal funds

Grandview Heights Rehab & Healthcare has and will continue to act as a fiduciary of resident's funds to hold, safeguard, manage, and account for such personal funds deposited with the facility by/or in the name of the resident. Those residents who have deposited funds will be able to access such funds daily from the business office. For unplanned access to deposited funds on week-ends they will be directed to the East Nursing Station where funds will be available on request. Week-end requested funds will be documented on a petty cash voucher that the resident will sign at the time of distribution and placed in the cashbox provided. Funds can only be distributed to residents who have funds on deposit with the facility. The Cashbox will be reconciled on Fridays and Mondays by the Business Office. A roster of eligible residents and their Friday balances will be provided with the cashbox. The Business Office Manager and/or designee will monitor for implementation. Correction Date: 7/1/2018

F578 Request/Refuse/Discontinue Treatment; Formulation of Advance Directives

Grandview Heights Rehab & Healthcare has and will continue to document and update Advance Directives for all residents admitted to the facility. Licensed Nursing staff are responsible for all admissions and re-admissions to the facility. The protocol for admission is documented on an admission or re-admission checklist (included) and the reminder has been included in "bold" print to highlight attention to the action. The assigned Quality Assurance Registered Nurse completes audits on all admissions and re-admissions and checks for proper completion and reconciliation of a resident's code status. The Quality Assurance audit and the Admission or Re-admission checklist is finally submitted to the Director of Nursing Services for final review. The resident's code status is also discussed, and documented at the time of initial and subsequent quarterly care conferences. This implementation will be monitored for accuracy by the Director of Nursing Services. Correction Date: 6/14/2018

Grandview Heights Rehab & Healthcare Plan of Correction (2567 Responses)

Survey June 11-14, 2018

F584 Safe/Clean/Comfortable/Homelike Environment

Grandview Heights Rehab & Healthcare has been and will continue to provide a safe, clean and homelike environment for the residents to live in. We have heightened the awareness of all staff members to stay alert to issues that might detract from this objective. All staff will again review generalized tidiness and cleanliness at the quarterly all staff in-service to be held on July 19th, 2018. Emphasis has been on personal hygiene more frequently, rather than reactionary, having to respond to hygiene accidents. Staff have been re-educated that the use of soaker pads on all seating services is unacceptable. If a particular resident is going through a period such as a UTI and is more prone to having an accident, a seat size pad may be used for their comfort, however the pad must be removed when the resident is moved, or has moved on. Staff have been instructed to provide hygiene opportunities more frequently. The Housekeeping TEAM Leader and Environmental Services Supervisor will conduct 2x daily audits of commons areas to ensure that they are in acceptable condition for cleanliness for 4 weeks, 1x daily audits for 4 weeks, 3x weekly audits for 4 weeks, and then 2x weekly audits. This action and implementation will be monitored by the Environmental Services Supervisor.

Correction Date: 6/15/2018

F677 ADL Care Provided for Dependent Residents

All direct care staff have been educated on the proper protocol for completing pericare during shift reports following exit on 6/14/2018. Pericare audits were initiated at that time. Formal audits are being distributed by the Human Resource Manager daily for licensed nursing staff to complete formal pericare audits on certified nursing assistants, during their tour of duty and turn back to HR by shifts end. 2nd Shift audits are being distributed by HR and are to be turned in to the RN House Supervisor by the end of the 2nd shift. All certified nursing assistants who do not pass the audit are assigned to watch the Relias Pericare video on-line and will be re-audited. HR will track completion of assigned Relias videos for completion as assigned. Staff that fail a subsequent audit will be issued a disciplinary notice and re-assigned to again watch the Relias video as assigned. This protocol will continue until all staff have successfully completed pericare audits, and then they will be audited intermittently. All Agency staff will also be audited for proper completion of pericare, and should they fail an audit they will be reported to their Agency for corrective action. If the agency fails to implement follow-up training they will be assigned to view the Relias pericare video on their time at Grandview Heights prior to starting an assigned shift. The HR Manager is conducting 3 training sessions on 7/19/18. This action plan will be monitored by the HR Manager and Director of Nursing Services.

Correction Date: 6/15/2018

Grandview Heights Rehab & Healthcare Plan of Correction (2567 Response)

F686 Treatment / Services to Prevent /Heal Pressure Ulcer Correction Date: 6/15/2018

Grandview Heights Rehab & Healthcare has and will continue to use an active intervention protocol related to known and discovered skin issues. The Braden Assessment shall continue to be utilized to determine patient's potential risk for skin issues. Per Grandview Heights Rehab & Healthcare's policy, Braden Assessments are completed upon admission and weekly x3 . They will convert to quarterly assessments thereafter.

-The QA Nurses will track the completion of Braden Assessments (whether new admits or quarterly assessments).

-Upon completion of a Braden Assessment, the QA Nurse will audit the Braden score of the resident and ensure that appropriate interventions have been put in place for those individuals identified at moderate to high risk of developing pressure areas.

-An intervention tool has been provided to all nurses to use as a guide for appropriate interventions for those at risk of developing pressure areas.

-After the QA Nurse has completed their audit of the Braden score and interventions, the audit will be turned into the Director of Nursing Services for review.

When a nurse is aware of a new wound (ST, bruise, rash, pressure ulcer, etc.) the following steps will be taken;

-Documentation of said area in nurses notes

-Corresponding skin sheet filled out (non-pressure or pressure) with a copy of the skin sheet provided to the QA Nurse.

-Order obtained for treatment of said area and treatment placed on area

-Notification of resident and /or resident's representative of area and treatment to area

Upon receipt of the skin sheet, the QA Nurse will do the following;

-Ensure an appropriate treatment has been ordered and applied to the area

-A weekly audit of existing wounds will be completed by the QA Nurse and will include;

*Proper Documentation

*Orders pertaining to wound

*Visualization of the wound to assess for improvement/worsening of area

*Effectiveness of the treatment -Audit Form Turned into Director of Nursing

Grandview Heights Rehab & Healthcare   Plan of Correction (2567 Response)

F758 Free from Unnecessary Psychotropic Medications and PRN Use

All licensed professional nursing staff have been educated and re-educated that Grandview Heights Rehab & Healthcare's protocol for PRN medication Psychotropics is, staff MUST have attempted at least three interventions prior to administration of the psychotropic. To this end, Grandview Heights Rehab & Healthcare has made an adjustment in our electronic medical records software that requires the administering nurse MUST document 3 interventions prior to being able to document administration of the PRN psychotropic. The Director of Nursing Services is responsible for monitoring that this medical records adaptation is functioning appropriately. Correction Date: 7/12/2018

F808 Therapeutic Diet Prescribed by Physician

Grandview Heights Rehab & Healthcare has and will continue to serve meals according to physician orders , inclusive of texture adjustments. A dietary card is created for each resident in our care and clearly specifies the specifics of the diet order, inclusive of texture adjustments for nutrition and for hydration. All serving dietary staff have been educated in the proper set up of resident's meal service, inclusive of texture adjustments. Correct implementation will be monitored by the Dietary Supervisor and the Consultant Dietitian on a weekly basis. Correction Date: 6/15/2018

F812 Food Procurement, Store/Prepare/Serve-Sanitary

The staff of the dietary department of Grandview Heights Rehab & Healthcare have ALL been re-educated of the importance of doing a complete job in the execution of their duties, inclusive of proper storage of food and drink, preparation of food and drink, and use of sanitary protocols and cleaning schedules to ensure that they are preparing food and drink in a safe and sanitary manner. Cleaning schedules have been completed and re-introduced to all dietary staff and the Food Service Supervisor will be having them completed daily and weekly, and turning them into the Administrator. The Consultant Dietitian has been instructed to do a weekly cleaning/sanitation audit, go over his findings with the Food Service Supervisor and turn it into the Administrator. Implementation will be monitored by the Administrator Correction Date: 7/12/2018

Sanitary Service

All certified nursing assistants, housekeepers, and dietary staff were educated on the proper solution and manner of wiping off tables for mealtime service. The protocol will be monitored 2x weekly by the Dietary Services Supervisor, 2x weekly by the Housekeeping TEAM Leader, and 2x weekly by the Environmental Services Supervisor. Correction Date: 6/15/2018

Grandview Heights Rehab & Healthcare Plan of Correction (2567 Response)

F880 Infection Prevention & Control

#1 All Housekeeping staff have been re-educated on the importance of infection prevention and control of infection management related to Housekeeping Services. To that end, they are now doing any and all rooms that are set up for isolation as the last rooms in their rotation so they are not exposing others to the source of infection control / management. They also have been educated and instructed in the protocol of spraying their equipment (brooms, dust pans, mops, etc) with Fusion (a Clorox based product) and bagging the equipment for the product per manufacturers recommendations to have full effect. Implementation monitored by Housekeeping TEAM Leader intermittently.

Correction Date: 6/15/2018

#2 & #3 All Nursing Staff has been reminded of their roles in Infection Control for management and prevention. Infection Control audits will distributed by the Human Resource Manager to Nurse Managers for completion with all certified nursing assistants. Staff members who do not pass the audit will be assigned a Relias on-line training course on Contact Isolation, or other Infection Control course to complete. HR will monitor completion of courses and if the staff member fails the subsequent audit, they will be issued a disciplinary notice and re-assigned to watch the Relias on-line course again. Agency staff working in the facility will also be audited for accuracy of protocols and if they fail an audit they will be reported to their Agency and assigned to complete the on-line Relias course. Implementation monitored by the Human Resource Manager. Correction Date: 6/15/2018

Daniel M. Larmore, MS   7/13/2018

Daniel M. Larmore, MS   Date

Administrator