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

10/30/18 P6

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	165343	A. BUILDING _____ B. WING _____	10/04/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PARK VIEW REHABILITATION CENTER	601 PARK AVENUE SAC CITY, IA 50583

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F 000	INITIAL COMMENTS F686: 10/19/18 F644, 690, 811+812: 11/3/18 Correction date_____ The following deficiencies are the result of the recertification survey completed 10/1-4/18. See Code of Federal Regulations (42CFR) Part 483, Subpart B-C.	F 000		
F 644 SS=D	Coordination of PASARR and Assessments CFR(s): 483.20(e)(1)(2) §483.20(e) Coordination. A facility must coordinate assessments with the pre-admission screening and resident review (PASARR) program under Medicaid in subpart C of this part to the maximum extent practicable to avoid duplicative testing and effort. Coordination includes: §483.20(e)(1)Incorporating the recommendations from the PASARR level II determination and the PASARR evaluation report into a resident's assessment, care planning, and transitions of care. §483.20(e)(2) Referring all level II residents and all residents with newly evident or possible serious mental disorder, intellectual disability, or a related condition for level II resident review upon a significant change in status assessment. This REQUIREMENT is not met as evidenced by: Based on record review and staff interview the facility failed to repeat a Level 1 Preadmission Screening and Resident Review (PASRR) when a resident had a diagnosed and treated mental disorder not documented on the previous PASRR for 1 resident reviewed for PASRR (Resident	F 644		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE — TITLE — (X6) DATE

RN/LHHA — 10/19/18

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F 644	Continued From page 1	F 644		

#39). The facility reported a census of 46 residents.

Findings include:

According to the Minimum Data Set (MDS) assessment dated 9/6/18, Resident #39 scored 5 on the Brief Interview for Mental Status (BIMS) indicating severe cognitive impairment. The resident's diagnoses included Alzheimer's, depression, and psychotic disorder.

A Notice of Level 1 Screen Outcome dated 9/10/12 documented the resident had no major mental illnesses (including psychotic/delusional disorder).

The Interdisciplinary Progress (IDP) Notes dated 8/14/17 at 4 p.m. documented the physician saw the resident on rounds with a new order for Seroquel (antipsychotic medication).

The IDP notes dated 8/25/17 documented a facsimile (fax) returned from the physician with a diagnosis of delusions for the Seroquel use.

The resident's Diagnosis Report dated 10/3/18 showed the resident had a diagnosis of delusional disorder.

During an interview on 10/2/18 at 12:41 p.m. the Social Worker stated at one time the company who contracted to do level 1 and 2 screens told them to hold off on resubmitting unless a major mental disorder, and they were waiting to hear when to do that. The Administrator stated they also thought the resident's behaviors and delusions were related to her dementia. They both acknowledged she had received

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F 644	Continued From page 2 antipsychotic medications for the delusions/behaviors.	F 644		
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 observation, record review, and staff interview, the facility failed to assure adequate pressure reduction interventions and complete a dietary assessment related to the new onset of pressure ulcers for 1 of 4 residents reviewed (Resident #12). The facility reported a census of 46 residents. Findings include: According to the Minimum Data Set (MDS) assessment dated 7/19/18, Resident #12 demonstrated long and short term memory problems and moderately impaired skills for daily decision making. The resident required extensive assistance with bed mobility, transfer, dressing, and personal hygiene. The resident's diagnoses	F 686		

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F 686	Continued From page 3	F 686		

included non-Alzheimer's dementia. The resident had no pressure ulcers but had the risk for developing pressure ulcers.

The MDS described pressure sores as the following:
Stage I is an intact skin with non-blanchable redness of a localized area usually over a bony prominence. Darkly pigmented skin may not have a visible blanching; in dark skin tones only it may appear with persistent blue or purple hues.
Stage II is partial thickness loss of dermis presenting as a shallow open ulcer with a red or pink wound bed, without slough. May also present as an intact or open/ruptured blister.
Stage III Full thickness tissue loss. Subcutaneous fat may be visible but bone, tendon or muscle is not exposed. Slough may be present but does not obscure the depth of tissue
loss. May include undermining and tunneling.
Stage IV is full thickness tissue loss with exposed bone, tendon or muscle. Slough or eschar may be present on some parts of the wound bed. Often includes undermining and tunneling.
Unstageable: known but not stageable due to coverage of wound bed by slough and/or eschar.

The Progress Notes dated 8/23/18 at 10:36 a.m. documented the resident transferred to the hospital. At 2:45 p.m. the facility inquired about the resident and found he admitted for observation.

A Plan of Care from the resident's hospital stay dated 8/23/18 at 3:44 p.m. documented the resident's heels were scaly and purple in color. The resident repositioned every 2 hours and heels elevated/floated on a pillow.

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A Progress Note dated 8/25/18 and faxed 8/25/18 notified the physician the resident returned from the hospital with a blister like stage 2 area of the left heel measuring 3.5 by 3 cm. The resident had an open area of the scrotum and the coccyx with 1 by 1 and 1 by 0.5 cm purple areas that were suspected deep tissue injury. They would encourage the resident to float heel when in bed.

A Braden Scale For Predicting Pressure Ulcer Risk dated 8/25/18 scored the resident at 13 indicating moderate risk. The assessment included the resident had very limited mobility, making occasional slight changes in body or extremity position but unable to make frequent or significant changes independently, and had a problem with friction and shear.

The undated Care Plan with a goal target date of 8/31/18 identified the resident with the potential for pressure ulcer with interventions including to attempt to float heels with a pillow when in bed as allowed, cushion in wheelchair, and pressure relieving mattress on the bed.
The care plan included the intervention for supplement for weight maintenance and skin healing (interventions in place prior to the new pressure ulcer development).

During an interview on 10/2/18 at 2:03 p.m. Staff B Registered Nurse (RN) stated the resident had a standard pressure reduction mattress on return from the hospital.

The Care Plan lacked any new interventions for pressure reduction related to the new pressure ulcers, or interventions for protecting the heels when not in bed. The clinical record lacked documentation of whether they were able to float

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the resident's heels, or of a turning or repositioning program.

A Progress Note dated 9/12/17, communication with the physician at 2:42 p.m. documented the resident's left heel, stage 2 pressure area had opened up, and a large skin flap came off. There was a new area on the resident's right heel, a stage 1, skin intact over the site, non blanchable area 2 by 1.8 cm and a new area over the outer aspect of the right foot, measuring 2 by 1 cm, dark purple, also a stage 1.

A Weekly Pressure Ulcer Progress Report dated 9/12/18 documented the right heel measured 2 by 1.8 cm, dark purple, stage 1. The report defined suspected deep tissue injury: purple or maroon localized area of discolored intact skin or blood filled blister due to damage of underlying soft tissue from pressure and or shear.

The Progress Note dated 9/12/17 included in a facsimile (fax) on 9/17/18 notified the physician of the 9/12/18 documentation and questioned if he would like to continue the treatment, and the right foot was open to air. The note documented blue boots would be utilized at all times to decrease pressure with a foot cradle on the bed.

An Edit Intervention document showed the blue boots on at all times, initiated 9/12/18 (the date the pressure ulcer of the right heel discovered).

A Nursing Home visit dated 9/25/18 documented the resident seen for follow up of ulcers of both heels. Both heels had necrotic (dead) tissue, with the plan to have a wound care consult for the heel ulcers.

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A Progress Note dated 9/28/18 at 2:22 p.m. documented the resident out of the facility to the wound clinic at 11:40 and returned at 1:10 p.m. The resident returned with orders for a pressure relief mattress to bed, heel lift boots at all times, and keep pressure off areas at all times. The physician also wrote treatment orders and new orders for Zinc, vitamin C and Arginaid daily (supplements for wound healing).

A Wound Clinic History and Physical dated 9/28/18 documented the resident's principle problem a stage 3 pressure area of the right heel, with active problems of unstageable pressure ulcers of the right and left heels. During the visit the ulcers were debrided to excise the eschar (necrotic tissue) and exudate from the ulcer surface. Complete removal of the material required extension into and including removing underlying subcutaneous tissue. The depth increased over 0.2 cm with the debridement. The physician recommended continuing the blue boots to help avoid pressure on the area, and also recommended zinc, vitamin C and Arginaid daily to promote healing.

The facility clinical record lacked a dietary assessment to determine the resident's nutritional needs related to the development of the pressure ulcers.

Discharge Instructions dated 9/28/18 included to keep pressure off areas at all times, and please provide the resident with an air mattress.

During an interview on 10/2/18 at 2:03 p.m. Staff B Registered Nurse (RN) stated they were trying to float the resident's heels when he returned from the hospital (8/25/18) and then they got the

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heel boots 9/12/18 (when the new ulcer to the right heel identified).

During an interview on 10/2/18 at 2:57 p.m. the Corporate Nurse stated the air mattress was initiated 9/28/18 after the physician recommendation. They didn't have specific documentation on the floating of the heels, except what was in the progress notes. She did not think he was on a specific repositioning program.

During an observation on 10/3/18 at 8:10 a.m. Staff C Licensed Practical Nurse (LPN), and Staff D Certified Nursing Assistant (CNA) assisted with the dressing change to the resident's heels. The resident laid in bed slightly to the right with a pillow under his legs, and his knees bent. Staff removed the heel boots, and with them off, the resident's heels pressed on the mattress (with the pillow in place under the legs). The left heel ulcer had a black necrotic area surrounded by pink open skin. Staff C confirmed the necrotic tissue. Staff C completed the dressing change using clean technique. Staff C did the same treatment to the lateral right heel ulcer. The ulcer had black necrotic tissue at the upper ridge of the ulcer with the remaining tissue of the ulcer pink.

During an interview on 10/3/18 at 8:55 a.m. Staff D stated working at the facility for about 2 years. She stated prior to the heel boots the resident usually had a pillow under his legs, but he also often had his knees bent the way they were this morning. She said if he was on his side his heels were off the mattress.

During an interview on 10/3/18 at 1:44 p.m. Staff E CNA stated (prior to the blue boots) they would put a pillow under the resident's legs in bed, but

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he was stiff and bent his legs so his heels would be on the mattress. It was difficult to float them.

During an interview on 10/3/18 at 12:22 p.m. the Director of Nursing (DON) stated the dietician had not assessed the resident in regards to the new pressure ulcers. She stated they usually had the dietician assess a resident with a pressure sore when noted.

Review of a Pressure Ulcer Risk Assessment and Documentation policy and Procedure updated January 2011, identified the following: Residents will be assessed upon admission and re-admission for potential risk factors that may contribute to pressure ulcer development and interventions will be implemented to reduce that risk.
The assigned nurse will complete the Admission and Readmission Pressure Ulcer Risk assessment tool on new admission and readmissions.
Determine the factors/conditions that place the resident at risk for developing pressure ulcers.
List any additional risk factors/conditions.
Determine interventions in conjunction with each risk factor that has potential to reduce both the likelihood of pressure ulcer development and/or improve the clinical condition of the resident.
Review the risk factors and interventions with the resident and /or responsible party.
The following interventions may be incorporated as deemed pertinent to the resident's condition:
Assist with repositioning immobile residents a minimum of approximately every two hours.
Positioning devices such as pillows or foam wedges may be used to keep bony prominence from direct contact with each other.
May use pillows under the calves of the residents

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F 686	Continued From page 9 who are immobile to relieve pressure on the heels or suspend heels off the foot of the bed. May use mechanical lifting devices, draw sheets or pads to move residents in bed who cannot assist during transfers and position changes to reduce friction/shearing. Assess nutrition and hydration needs quarterly/significant change to maintain skin integrity; encourage foods/fluids. May use pressure reduction mattress to bed and pressure reduction device to chair. Assess any new pressure ulcer as soon as discovered and document. Notify the dietary manager manager and she will be responsible to initiate dietary interventions. Update the care plan to reflect new interventions to aid in the healing process.	F 686		
F 690 SS=D	Bowel/Bladder Incontinence, Catheter, UTI CFR(s): 483.25(e)(1)-(3) §483.25(e) Incontinence. §483.25(e)(1) The facility must ensure that resident who is continent of bladder and bowel on admission receives services and assistance to maintain continence unless his or her clinical condition is or becomes such that continence is not possible to maintain. §483.25(e)(2)For a resident with urinary incontinence, based on the resident's comprehensive assessment, the facility must ensure that- (i) A resident who enters the facility without an indwelling catheter is not catheterized unless the resident's clinical condition demonstrates that catheterization was necessary; (ii) A resident who enters the facility with an indwelling catheter or subsequently receives one	F 690		

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F 690	Continued From page 10	F 690		

is assessed for removal of the catheter as soon as possible unless the resident's clinical condition demonstrates that catheterization is necessary; and
(iii) A resident who is incontinent of bladder receives appropriate treatment and services to prevent urinary tract infections and to restore continence to the extent possible.

§483.25(e)(3) For a resident with fecal incontinence, based on the resident's comprehensive assessment, the facility must ensure that a resident who is incontinent of bowel receives appropriate treatment and services to restore as much normal bowel function as possible.
This REQUIREMENT is not met as evidenced by:
Based on observation, record review and staff interview, the facility failed to provide incontinent care in a manner to prevent urinary tract infection (UTI) for 2 of 9 residents reviewed (Resident #10 and #20). The facility reported a census of 46 residents.

Findings include:

1. According to the Minimum Data Set (MDS) assessment, dated 7/19/18, Resident #10 scored 7 on the Brief Interview for Mental Status (BIMS) indicating severe cognitive impairment. The resident required limited assistance with toilet use and personal hygiene. The resident's diagnoses included UTI and dementia.

Urine Culture reports dated 3/2/18, 6/22/18, and 9/13/18 showed the resident had Escherichia-coli (found in the bowel) growth in the urine sample and the resident treated with antibiotics for UTI.

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The current Care Plan with a goal target date of 10/21/18 identified the resident needed assistance with ADL's related to dementia. The interventions included the resident was assist of 1 for toileting and peri cares as needed.

During an observation on 10/2/18 at 7:38 a.m. Staff D Certified Nursing Assistant (CNA) assisted the resident to the bathroom. After toileting Staff D wiped the resident's buttock and anal areas, turning the wash cloth with both (gloved) hands after each wipe, then wiped the front perineal area with a different cloth, but wearing the same gloves.

During an interview on 10/3/18 at 10:40 a.m. the Corporate Nurse stated they did not have a policy on incontinent care, would go by the standard of practice. She stated she would expect staff to clean the front perineal area first wiping front to back. If they started cleaning in the back (buttock/anal area) she would expect staff to change gloves before cleaning the front.

2. According to the MDS assessment, dated 8/3/18, Resident #20 scored 8 on the BIMS indicating severe cognitive impairment. The resident required limited assistance with toilet use. The resident's diagnoses included dementia.

The Care Plan with a goal target date of 11/22/18 identified the resident needed occasional assistance with activities of daily living. The interventions included she occasionally dribbled urine and needed reminders to change at times and needed incontinent cares provided as needed.

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F 690	Continued From page 12	F 690		

During an observation on 10/2/18 7:10 a.m. Staff E and Staff D CNA's assisted the resident with a.m. cares, and the DON observed. After toileting, Staff D washed the resident's buttocks and anal area with a washcloth, turning the cloth with both hands between wipes, then washed the front groins and genital area with a different washcloth but wearing the same gloves.

F 811 SS=D Feeding Asst/Training/Supervision/Resident CFR(s): 483.60(h)(1)-(3) — F 811

§483.60(h) Paid feeding assistants-
§483.60(h)(1) State approved training course. A facility may use a paid feeding assistant, as defined in § 488.301 of this chapter, if-
(i) The feeding assistant has successfully completed a State-approved training course that meets the requirements of §483.160 before feeding residents; and
(ii) The use of feeding assistants is consistent with State law.

§483.60(h)(2) Supervision.
(i) A feeding assistant must work under the supervision of a registered nurse (RN) or licensed practical nurse (LPN).
(ii) In an emergency, a feeding assistant must call a supervisory nurse for help.

§483.60(h)(3) Resident selection criteria.
(i) A facility must ensure that a feeding assistant provides dining assistance only for residents who have no complicated feeding problems.
(ii) Complicated feeding problems include, but are not limited to, difficulty swallowing, recurrent lung aspirations, and tube or parenteral/IV feedings.
(iii) The facility must base resident selection on

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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 811	Continued From page 13	F 811		

the interdisciplinary team's assessment and the resident's latest assessment and plan of care. Appropriateness for this program should be reflected in the comprehensive care plan.
This REQUIREMENT is not met as evidenced by:
Based on record review and staff interview, the facility failed to assure a paid nutritional assistant (PNA) provided dining assistance only to those residents with no complicated feeding problems for 1 resident reviewed (Resident #12). The facility reported a census of 46 residents.

Findings include:

According to the Minimum Data Set (MDS) assessment dated 7/19/18, Resident #12 demonstrated long and short term memory problems and moderately impaired skills for daily decision making. The resident required limited assistance with eating. The resident's diagnoses included non-Alzheimer's dementia.

A Progress Note dated 8/25/18 documented the resident returned from the hospital with a diagnosis of aspiration pneumonia.

A PNA (Pain Nutritional Assistant) Resident Dining Assessment dated 8/25/18 documented the interdisciplinary team decided the resident was not appropriate to be fed by a PNA.

A Progress Note dated 8/26/18 at 12:47 p.m. documented notification by the PNA the resident pocketed food at meal times.

A Progress Note dated 9/2/18 at 8:42 p.m. documented the resident continued with complications with eating with the PNA. The

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	165343	A. BUILDING _____ B. WING _____	10/04/2018

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F 811	Continued From page 14	F 811		

resident would not chew and seemed fatigued during the meal.

A Progress Note dated 9/3/18 at 1:32 p.m. documented the resident had difficulty chewing food items, ongoing, and the PNA reported the resident would pocket food items with any texture, that pureed and thickened liquids accepted. The resident would have a speech therapy evaluation early in the week for the resident's safety.

A Speech Therapy Evaluation and Plan of Treatment documented the resident referred for dysphagia due to new onset of pocketing requiring a need for eval to determine least restrictive diet. Over the weekend the resident's diet down graded to puree by nursing due to safety concerns. The risk factors included aspiration, weight loss, and malnutrition.

During an interview on 10/2/18 1:56 PM Staff B Registered Nurse (RN) stated when the resident returned from the hospital on 8/25/18 she put in place the intervention for a Certified Nursing Assistant (CNA) to assist the resident with eating. The PNA's should not have assisted the resident after he returned.

The facility policy for Pain Nutritional Assistant revised 7/16 documented PNA's may be used to provide dining assistance to those residents clinically assesed as not needing a nurse or nurse aide if speech therapy and the facility have determined the resident did not have evidence of current symptoms of choking or aspiration (which would make the resident difficult to feed).

F 812 Food Procurement,Store/Prepare/Serve-Sanitary F 812

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	165343	A. BUILDING _____ B. WING _____	10/04/2018

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F 812 SS=D	Continued From page 15 CFR(s): 483.60(i)(1)(2)	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 and staff interview the facility failed to serve food under sanitary conditions while assisting resident to dine (Resident #10). The facility census was 46 residents.

Findings include:

During observation of the lunch meal service on 10/1/18 Staff A was observed wearing gloves to assist Resident #10 to dine. At 11:55 a.m. Staff A observed touching left wheelchair pedal and left wheelchair hand grip of Resident #29, sitting to right of Staff A, and assisted Resident #29 to the table. Staff A then assisted Resident #10 to eat garlic toast by touching garlic toast with the same

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CENTERS FOR MEDICARE & MEDICAID SERVICES

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gloves utilized to assist Resident #29, lifted garlic toast to resident's mouth and resident ate garlic toast. Staff A removed gloves and utilized hand sanitizer at 12:07 p.m. after assisted Resident #10 to dine.

In an interview on 10/1/18 at 12:13 p.m. Staff A confirmed using gloved hands to touch resident #29 wheelchair pedal and wheelchair hand grip. Staff A confirmed using same gloved hands to assist Resident #10 to eat garlic toast by touching garlic toast with unchanged gloves. Staff A agreed touching wheelchair pedal and wheelchair hand grip contaminates gloves and gloves should have been changed.

In an interview with Director of Nursing 10/3/18 at 7:46 a.m. confirmed staff should change gloves prior to assisting residents to dine after touching potentially contaminated objects.

RE: Plan of Correction related to Annual Survey completed October 4th, 2018

Preparation and implementation of the plan of correction should not be construed as an admission of the deficiencies cited. This plan of correction is prepared solely because it is required under federal or state law.

F000 Correction date for F686: October 19th, 2018

F686 Treatment/Services to Prevent/Heal Pressure Ulcer

Based on the comprehensive assessment of a resident, the facility ensures that a resident who enters the facility without pressure sores does not develop pressure sores unless the individual's clinical condition demonstrates that they are unavoidable; and a resident having pressure sores receives necessary treatment and services to promote healing, prevent infection and prevent new sores from developing.

The facility is disputing this deficiency, and is submitting a response with additional information in a separate document. However, for the required Plan of Correction, the facility submits the following:

1. The dietician completed an assessment for Resident #12 on 10/4/18.
2. The facility has policies and procedures in place for pressure injury risk assessment and implementation of interventions to decrease risk of pressure injury. The assigned nurse will complete the Admission and Readmission Pressure Ulcer Risk Assessment tool at the time of an initial admission or readmission. The facility will continue to place appropriate preventive interventions on the care plan to reduce the risk of developing pressure sores. The care providers will continue to perform daily skin monitoring with cares. Residents with current pressure areas were reviewed with the interdisciplinary team (including dietician) on 10/17/18 to assure appropriate preventive interventions are in place.
3. Risk factors for pressure ulcer injury are reviewed through the interdisciplinary care planning process conducted quarterly and with a change in a resident's condition. Progression of healing of existing pressure injuries is evaluated weekly during an interdisciplinary team (including the dietitian) meeting held expressly for the purpose of monitoring the effectiveness of the interventions that are currently in place, and to make changes to the plan of care as deemed appropriate based on that review.-The dietician will assess any new pressure areas since her last visit at each current visit.

4. Weekly for four weeks, and then monthly for 3 months, the Director of Nursing, or her designee, will audit the pressure ulcer risk assessments for all new and readmissions that have been completed since last review to ensure that interventions that were deemed to be appropriate through the risk assessment are included in the resident's plan of care. The Dietician, or her designee, will audit to ensure a dietician has assessed all new pressure areas from their last visit weekly for four weeks, and then monthly for 3 months. The results of the audits will be reviewed as part of our on-going quality assurance process, and the frequency of reviews thereafter will be based on the outcomes of these audits.

F000 Correction date for F644, F690, F811, and F812: November 3, 2018

F644 Coordination of PASARR and Assessments

The facility coordinates assessments with the pre-admission screening and resident review (PASARR) program; including when residents have 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

1. A new Level I was submitted for Resident #39 on 10/16/18. The PASRR Level I outcome was *No Status Change*.
2. From 10/16/18 to 11/2/18 the Social Worker will review current residents for any indications that a new Level I review was applicable to ensure compliance with PASARR screening.
3. On 10/22/18 the Social Worker attended the annual PASARR state training. The Social Worker will continue to review the need for a new Level I PASARR screening at each quarterly/yearly and significant change assessments, as well as an ongoing review of new psychotropic medication orders and assessment interdisciplinary notes.
4. Weekly for four weeks, and then monthly for 3 months, the Social Worker, or her designee will complete random audits of interdisciplinary progress notes, and new medication orders related to a significant change or newly evident mental disorder ensuring a new Level I status review was completed when indicated. The results of the audits will be reviewed as part of our on-going quality assurance process, and the frequency of reviews thereafter will be based on the outcomes of these audits.

F690 Bowel/Bladder Incontinence, Catheter, UTI

1. Caregiver staff was assigned Relias education training: *Preventing Urinary Tract Infections* due to be completed 10/15/18.
2. A caregiver staff in-service is scheduled to be completed on 11/1/18-which will include incontinence care training with return demonstration.
3. Weekly for four weeks, and then monthly for 3 months, the RN Care Coordinators, or their designee will complete random audits of incontinence care. The results of the audits will be reviewed as part of our on-going quality assurance process, and the frequency of reviews thereafter will be based on the outcomes of these audits.

F811 Feeding Asst/Training/supervision/Resident

1. Resident #12 is care planned to receive dining assistance by a Certified Nursing Assistant.
2. The facility has policies and procedures in place for training and utilizing Paid Nutritional Assistants for residents who have been assessed as not requiring the dining assistance of a licensed nurse or certified nurse aide. Residents will be reassessed at least every 90 days or as changes occur in their medical condition as per OBRA guidelines. A list of those residents needing dining assistance by a licensed nurse or certified nurse aide will be available to staff.
3. A nursing staff in-service is scheduled to be completed on 11/1/18 which will include education on the completion of *PNA-Resident Dining Assessment,* and the communication process of residents who are unable to utilize a PNA.
4. Weekly for four weeks, and then monthly for 3 months, the RN Care Coordinators, or their designee will complete random audits of the dining experience including those assisted by a PNA. The results of the audits will be reviewed as part of our on-going quality assurance process, and the frequency of reviews thereafter will be based on the outcomes of these audits.

F812 Food Procurement, Store/Prepare/Serve-Sanitary

1. Staff A was educated on safe food handling on 10/1/18.
2. The facility currently has an implemented state-approved Paid Nutritional Assistant program which includes safe food handling, and return demonstration of skills during lab. This will continue to be the facility practice. A skills lab fair will be added to each PNA's annual competency review.
3. A nursing staff and PNA in-service is scheduled to be completed on 11/1/18 to include reviewing of safe food handling with skills lab and return demonstration by employees.
4. Weekly for four weeks, and then monthly for 3 months, the Administrator, or her designee will complete random audits of the dining experience to include safe food handling. The results of the audits will be reviewed as part of our on-going quality assurance process, and the frequency of reviews thereafter will be based on the outcomes of these audits.