STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	165266	A. BUILDING _____ B. WING _____	12/05/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HOLY SPIRIT RETIREMENT HOME	1701 WEST 25TH STREET SIOUX CITY, IA 51103

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 000	INITIAL COMMENTS Correction date 1/5/19 The following deficiencies result from the facility's annual health survey and investigation of facility-reported incident # 77939-I. See the Code of Federal Regulations (42CFR) Part 483, Subpart B-C.	F 000		
F 550 SS=D	Resident Rights/Exercise of Rights CFR(s): 483.10(a)(1)(2)(b)(1)(2) §483.10(a) Resident Rights. The resident has a right to a dignified existence, self-determination, and communication with and access to persons and services inside and outside the facility, including those specified in this section. §483.10(a)(1) A facility must treat each resident with respect and dignity and care for each resident in a manner and in an environment that promotes maintenance or enhancement of his or her quality of life, recognizing each resident's individuality. The facility must protect and promote the rights of the resident. §483.10(a)(2) The facility must provide equal access to quality care regardless of diagnosis, severity of condition, or payment source. A facility must establish and maintain identical policies and practices regarding transfer, discharge, and the provision of services under the State plan for all residents regardless of payment source. §483.10(b) Exercise of Rights. The resident has the right to exercise his or her rights as a resident of the facility and as a citizen	F 550		

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

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.

POC accepted 1/2/19 KC

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F 550	Continued From page 1 or resident of the United States. §483.10(b)(1) The facility must ensure that the resident can exercise his or her rights without interference, coercion, discrimination, or reprisal from the facility. §483.10(b)(2) The resident has the right to be free of interference, coercion, discrimination, and reprisal from the facility in exercising his or her rights and to be supported by the facility in the exercise of his or her rights as required under this subpart. This REQUIREMENT is not met as evidenced by: Based on clinical record review, observation, and staff interview, and facility policy review, the facility failed to maintain dignity for one of three residents reviewed with a catheter (Resident's #45). The facility reported a census of 85 residents. Findings include: 1. The Minimum Data Set assessment dated 10/12/18 documented Resident #45 had diagnoses that included cancer, osteoporosis, Non-Alzheimer dementia and anorexia. The assessment recorded a Brief Interview for Mental Status score of 11 which indicated moderately impaired memory and cognitive abilities. The resident required the assistance of one with bed mobility, transfers, toilet use and dressing. The Progress Note dated 11/28/18 at 3:20 p.m. documented.Resident #45 continued to receive Hospice services. A Hospice nurse visited the facility and inserted a 14 french Foley (urinary) catheter for the resident's comfort.	F 550		

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F 550	Continued From page 2 The resident's Care Plan contained a focus are of bladder/bowel with an update of 11/2018 which instructed to assist with Foley cares, record her output and the catheter in place secondary to her overall decline. Observation on 12/03/18 at 9:17 a.m. resident lying in bed, the catheter bag and the tubing on the floor next to the bed with the catheter bag not in a privacy bag. Observation on 12/03/18 at 10:32 a.m., revealed Resident # 45 laying in bed with the catheter tubing and catheter on the floor with no privacy bag over the catheter bag. Observation on 12/03/18 at 1:55 p.m. revealed Resident # 45 lying on the bed facing the hallway with the catheter bag lying on the floor, no covering over the bag and the tubing on the floor. The catheter bag and tubing could be seen by visitors and patients from the resident's doorway. The Indwelling urinary catheter (Foley) care and management procedure dated 12/4/18 by Lippincott Procedures for Indwelling care and management instructed staff to: *Keep the drainage tubing free from kinks and avoid dependent loops. *Keep the drainage bag below the level of the patient's bladder but off of the floor. During an interview on 12/4/18 at 10:00 a.m., the Director of Nursing stated the expectation of staff is to make sure the catheter bag has a privacy cover over it and the catheter tubing is off the floor.	F 550		

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F 623	Continued From page 3	F 623		
F 623 SS=B	Notice Requirements Before Transfer/Discharge CFR(s): 483.15(c)(3)-(6)(8) §483.15(c)(3) Notice before transfer. Before a facility transfers or discharges a resident, the facility must- (i) Notify the resident and the resident's representative(s) of the transfer or discharge and the reasons for the move in writing and in a language and manner they understand. The facility must send a copy of the notice to a representative of the Office of the State Long-Term Care Ombudsman. (ii) Record the reasons for the transfer or discharge in the resident's medical record in accordance with paragraph (c)(2) of this section; and (iii) Include in the notice the items described in paragraph (c)(5) of this section. §483.15(c)(4) Timing of the notice. (i) Except as specified in paragraphs (c)(4)(ii) and (c)(8) of this section, the notice of transfer or discharge required under this section must be made by the facility at least 30 days before the resident is transferred or discharged. (ii) Notice must be made as soon as practicable before transfer or discharge when- (A) The safety of individuals in the facility would be endangered under paragraph (c)(1)(i)(C) of this section; (B) The health of individuals in the facility would be endangered, under paragraph (c)(1)(i)(D) of this section; (C) The resident's health improves sufficiently to allow a more immediate transfer or discharge, under paragraph (c)(1)(i)(B) of this section; (D) An immediate transfer or discharge is	F 623		

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F 623	Continued From page 4 required by the resident's urgent medical needs, under paragraph (c)(1)(i)(A) of this section; or (E) A resident has not resided in the facility for 30 days. §483.15(c)(5) Contents of the notice. The written notice specified in paragraph (c)(3) of this section must include the following: (i) The reason for transfer or discharge; (ii) The effective date of transfer or discharge; (iii) The location to which the resident is transferred or discharged; (iv) A statement of the resident's appeal rights, including the name, address (mailing and email), and telephone number of the entity which receives such requests; and information on how to obtain an appeal form and assistance in completing the form and submitting the appeal hearing request; (v) The name, address (mailing and email) and telephone number of the Office of the State Long-Term Care Ombudsman; (vi) For nursing facility residents with intellectual and developmental disabilities or related disabilities, the mailing and email address and telephone number of the agency responsible for the protection and advocacy of individuals with developmental disabilities established under Part C of the Developmental Disabilities Assistance and Bill of Rights Act of 2000 (Pub. L. 106-402, codified at 42 U.S.C. 15001 et seq.); and (vii) For nursing facility residents with a mental disorder or related disabilities, the mailing and email address and telephone number of the agency responsible for the protection and advocacy of individuals with a mental disorder established under the Protection and Advocacy for Mentally Ill Individuals Act.	F 623		

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F 623	Continued From page 5 §483.15(c)(6) Changes to the notice. If the information in the notice changes prior to effecting the transfer or discharge, the facility must update the recipients of the notice as soon as practicable once the updated information becomes available. §483.15(c)(8) Notice in advance of facility closure In the case of facility closure, the individual who is the administrator of the facility must provide written notification prior to the impending closure to the State Survey Agency, the Office of the State Long-Term Care Ombudsman, residents of the facility, and the resident representatives, as well as the plan for the transfer and adequate relocation of the residents, as required at § 483.70(l). This REQUIREMENT is not met as evidenced by: Based on clinical record review and staff interview, the facility failed to notify the Ombudsman of an emergency transfer and admission to a hospital for one of one resident reviewed for hospitalization (Resident #39). The facility reported a census of 85 residents. Findings included: According to a Progress Notes dated 8/30/18, Resident #39 required transfer and admission to a hospital due to a fall and right hip fracture. According to a Progress Noted dated 9/4/18 at 2:58 P.M., Resident #39 re-admitted to the facility following his hospital stay. During interview on 12/4/18 at 8;25 A.M., the Business Office Manager stated she did not notify	F 623		

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F 623	Continued From page 6 the Ombudsman of Resident # 39's transfer and admission to a hospital until 12/3/18. During interview on 12/04/18 at 3:20 P.M., the Business Office Manager reported she had been trained to report transfers and discharges to the Ombudsman every quarter or every 3 months and had not been aware she needed to report to the Ombudsman beyond every quarter.	F 623		
F 658 SS=D	Services Provided Meet Professional Standards CFR(s): 483.21(b)(3)(i) §483.21(b)(3) Comprehensive Care Plans The services provided or arranged by the facility, as outlined by the comprehensive care plan, must- (i) Meet professional standards of quality. This REQUIREMENT is not met as evidenced by: Based on clinical record review, observation and staff interviews, facility staff failed to observe one resident consume delivered medications (#19) and failed to follow physician orders (#57) for two of 18 residents reviewed. The facility reported a census of 85. Finding Include: 1. According to Resident #19's Minimum Data Set assessment dated 9/4/18, she had a Brief Mental Status (BIMS) score of 15 indicating intact memory and cognitive abilities. The assessment documented her diagnoses included diabetes mellitus (DM), anxiety disorder, depression and insomnia. Observation on 12/3/18 at 8:01 AM revealed Resident # 19 sitting at a table for breakfast.	F 658		

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F 658	Continued From page 7 Resident #19 reached into a small bowl next to her plate, retrieved a pill and took it with her coffee. The bowl now contained a small white pill, a small pink pill and a larger white pill. The breakfast area had no nurses in sight at this time. Resident #19 continued to read the paper and eat her breakfast while the bowl of medications sat next to her plate. At 8:05 AM, Resident #19 took the small white pill and the small pink pill out of the bowl and took them with coffee. One larger white pill remained in bowl. Resident #19 continued to read the paper, finished her breakfast and consumed the last pill at 8:10 AM. At 8:12 AM, Staff F Licensed Practical Nurse (LPN) arrived in the dining room. During an interview on 12/3/18 at 8:12 A.M., Staff F confirmed she was not in the dining room, but attending another resident. Staff F stated she normally placed Resident #19's pills in a bowl because the resident liked it that way. Staff F stated the resident's family usually sat with her while she takes the pills (the observation revealed no family present). Resident #19's Medication Administration Record (MAR) recorded she received the following medications each morning: Tylenol tablet 325 two tablets (for pain) Docusate Sodium Capsule 100 mg (for constipation) Furosemide Tablet 20 mg (diuretic) Levothyroxine Sodium Tablet 75 mcg (for Hypothyroidism) Lisinopril Tablet 5 mg (for Hypertension) Multivitamin Adult Tablet Trimethoprim Tablet 100 mg (Antibiotic) Gas-X Tablet Chewable (Simethicone) (for excessive gas)	F 658		

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F 658	Continued From page 8 During interview on 12/03/18 at 3:28 PM the Director of Nursing stated it would be her expectation the nurse would watch residents take their pills. The facility's Preparation for Medication Administration policy, revised 9/25/15, instructed the resident is always observed after medication administration to ensure complete ingestion of the dose. 2. Resident #57's MDS assessment dated 10/25/18 documented a BIMS of a score of 6, indicating severe cognitive and memory impairment. The resident's diagnoses included obstructive uropathy, DM, Non-Alzheimer's dementia, and senile degeneration of the brain. A Physician Order/Fax dated 4/5/18 directed to change the resident's Miralax (for constipation) 17 grams from QD (once a day) to QOD (every other day). On 10/10/18, Resident # 57 returned to the facility following hospitalization with an order for polyethlene glycol 3350 (or Miralax oral powder) 17 grams by mouth once a day (QD). Resident #57's MAR (Medication Administration Record) documented that from 10/10/18 through 11/9/18, staff administered polyethlene glycol 3350 QOD instead of daily as ordered. Resident #57's Bowel Records dated 10/10 to 11/12/18 lacked documentation that he had hard stools. A Health Status Note dated 11/9/18 at 10:01	F 658		

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F 658	Continued From page 9 documented staff called the resident's wife regarding his Miralax. They determined that when he returned from hospital on 10/10/18, the order for his Miralax was changed to QD instead of QOD and it did not get changed in the system. The note recorded an increase in hard stools (not documented elsewhere) and the physician changed the Miralax order to daily upon return from the hospital. Staff documented sending a fax to the PCP (or Primary Care Physician) with the information as well. On 12/5/18 at 8:33 AM, Staff M Registered Nurse (RN) stated that when Resident # 57 came back from hospital, the order of Miralax order had changed from QOD to QD and was missed. They found the error during a chart review and corrected it. Staff M thought the resident's wife had mentioned his bowel movements were hard.	F 658		
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 clinical record review, observation, facility policy and procedure review and staff interview, the facility failed to provide complete incontinence care for two of two residents reviewed (Residents #63 and #48) and complete baths for one of eight residents reviewed for baths (Resident #55). The facility reported a census of 85 residents. Findings include:	F 677		

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F 677	Continued From page 10 1. The Minimum Data Set (MDS) assessment dated 11/2/18 documented Resident #63 with diagnoses which included Alzheimer's disease, Non-Alzheimer's dementia, anxiety and depression. The MDS documented the resident with short and long term memory impairments and severely impaired decision making abilities. He required the assistance of two with bed mobility, toilet use and personal hygiene. The MDS assessment documented the resident as always incontinent of bladder and bowel. The resident's Care Plan contained a bladder incontinence focus area initiated on 11/8/18 that identified him as incontinent related to confusion, dementia, impaired mobility, and an inability to communicate his needs. The resident's family reported incontinence of bowel and bladder for months prior to admission. Interventions included: a. The resident used disposable briefs; change every a.m. and as needed. Staff may leave the brief off and open to air with a pad when he lay in bed. b. Clean peri-area with each incontinence episode. c. Check every 2-3 hours for incontinence; assist with peri care. d. Change his clothing as needed after incontinence episodes. During an observation on 12/3/18 at 8:00 a.m., Staff D (certified nursing assistant) and Staff E (certified nursing assistant) provided incontinent cares for the resident. Staff D and Staff E put on gloves. Using wet wipes, Staff D cleansed the resident's inner left and right thighs, but failed to cleanse the end of his penis and scrotum. Staff D stated the blue brief was soiled as the strip	F 677		

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F 677	Continued From page 11 down the middle turned blue: when the brief is dry the strip is yellow, the resident's strip was blue. The Perineal care of the male patient dated 12/4/18, from the Lippincott Procedures, instructed in part to clean the penis with the cloth, beginning at the tip and working in a circular motion from the center to the periphery to avoid introducing microorganisms into the urethra. use a clean section of cloth for each stroke to prevent the spread of contaminated secretions or discharge. if the patient is uncircumcised, gently retract the foreskin and clean beneath it. replace the foreskin to avoid constriction of the penis, which causes edema and tissue damage. Using downward strokes toward the scrotum, clean the rest of the penis. Clean the top and sides of the scrotum; handle the scrotum gently. Turn the patient on his side, if possible, to expose the anal area. Clean the bottom of the scrotum and the anal area. 2. The MDS assessment of 10/17/18 documented Resident #48 had diagnoses that included heart failure, diabetes mellitus, Alzheimer's disease, Non-Alzheimer's dementia, anxiety and depression. The MDS documented the resident with a Brief Interview for Mental Status (BIMS) score of 2 which indicated severely impaired memory and cognition. Resident #48 required the assistance of two staff with bed mobility,dressing and toilet use and the assistance of one with personal hygiene. Resident #48 always had incontinence of bowel and bladder. The resident's Care Plan contained a focus area of bladder incontinence secondary to several co-morbidities including diagnosis of vascular dementia, denying being incontinent and refusing	F 677		

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F 677	Continued From page 12 toileting and peri cares. Interventions included: a. Encourage her to use the bedpan as allowed for a bowel movement. b. Use a mild cleansing agent to minimize irritation and dryness of the skin and avoid friction as allowed by the resident. c. Resident #48 used incontinence products for dignity; change them twice a day and as needed. d. The resident's urologist only wants her urine checked only with physiological symptoms of urinary tract infection. Observation on 12/3/18 at 1:30 p.m. revealed Staff D and Staff E provided incontinent cares for the resident after transferring her into bed using a Hoyer (mechanical) lift. Staff D and Staff E put on gloves. Staff D pulled down the resident's slacks exposing a green brief which had a green stripe down the middle; Staff D stated the green stripe meant the brief was wet. Staff E used a wet wipe to complete incontinence care but failed to cleanse the resident's left and right outer hips during the care. 3. The MDS assessment dated 10/25/18 documented Resident 55's diagnoses included high blood pressure, diabetes mellitus, anxiety disorder. The assessment documented a BIMS score of 13, indicative of full cognition. The MDS documented the resident required physical help with part of bathing. During interview on 12/3/18 at 12:51 P.M., Resident #55 reported being scheduled for a bath every Monday and Thursday, he had not received his bath last night (12/2/18) and staff did not tell him why they did not assist him with his bath.	F 677		

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F 677	Continued From page 13 Review of a Progress note dated 8/23/18, revealed the facility Social Worker (SW) documented Resident #55 spoke to her in regards to only getting one bath a week. The SW documented she told him she would check into the situation. Review of a facility bath schedule revealed the resident scheduled for bathing on Mondays and Thursdays. Review of Resident #55's bath records dated 8/1 - 11/30/18 revealed staff documented the resident's baths on a weekly schedule. Staff documented the resident received one bath only during the following weeks (and no bath during the week of 8/19 - 8/25): 8/5 - 8/11- 1 bath 8/12 - 8/18 - 1 bath 8/19 - 8/25 - 1 bath 9/2 - 9/8 - 1 bath 9/23 - 9/29 - 1 bath 10/7 - 10/13 - 1 bath 11/18- 11/24 -1 bath 11/25 - 12/1- 1 bath During interview on 12/04/18 at 10:52 AM, the Director of Nursing (DON) and the second floor Clinical Care Coordinator confirmed there had been a time when either the facility did not have enough staff to give baths or had trouble tracking down agency staff to document baths. During interview on 12/4/18 at 3:05 P.M. the DON reported she expected staff to bathe each resident two times per week,	F 677		
F 686	Treatment/Svcs to Prevent/Heal Pressure Ulcer	F 686		

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F 686 SS=D	Continued From page 14 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 and family and staff interview, the facility failed to provide interventions to prevent pressure sores from developing for one resident (#45) reviewed with skin breakdown. The facility-provided Matrix identified no pressure sores in the facility. The facility reported a census of 85 residents. Findings include: 1. The admission Minimum Data Set (MDS) assessment dated 10/12/18 identified Resident # 45 admitted to the facility on 10/5/18. Resident #45 had diagnoses that included cancer (with or without metastasis), high blood pressure, hyponatremia, osteoporosis, Non-Alzheimer's dementia, pulmonary hypertension, and a history of metastatic neoplasm of the large intestine. Resident #45 had a Brief Interview for Mental Status Score of 11 which indicated moderately impaired memory and decision making abilities.	F 686		

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F 686	Continued From page 15 The resident required the assistance of one staff for bed mobility and transfers and had occasional incontinence of urine. The assessment documented she had a condition or chronic disease that may result in a life expectancy of less than 6 months. Resident #45 had no pressure ulcers or a risk of developing ulcers during the assessment period, however the Care Assessment Area of the MDS triggered for pressure ulcers. The MDS assessment identifies the following definitions of pressure ulcer staging: Stage 1 Pressure Ulcer: An observable, pressure-related alteration of intact skin, whose indicators as compared to adjacent or opposite area on the body may include changes in one or more of the following parameters: skin temperature (warmth or coolness); tissue consistency (firm or boggy); sensation (pain, itching); and/or a defined area of persistent redness in lightly pigmented skin, whereas in darker skin tones, the ulcer may appear with persistent red, blue, or purple hues. Stage 2 Pressure Ulcer: Partial thickness loss of dermis presenting as a shallow open ulcer with a red-pink wound bed, without slough. May also present as an intact or open/ ruptured blister. Stage 3 Pressure Ulcer: 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 or tunneling. Stage 4 Pressure Ulcer: Full thickness tissue loss with exposed bone, tendon or muscle. Slough or	F 686		

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F 686	Continued From page 16 eschar may be present on some parts of the wound bed. Often includes undermining and tunneling. Unstageable due to Suspected Deep Tissue Injury: Purple or maroon area of discolored intact skin due to damage of underlying soft tissue. The area may be preceded by tissue that is painful, firm, mushy, boggy, warmer or cooler as compared to adjacent tissue. The resident's Baseline Care Plan dated 10/5/18 documented she had no current wounds, a high risk for skin breakdown with a goal to prevent skin breakdown. The resident's skin interventions documented: Turn and reposition per facility policy; Place a specialty pressured reduction mattress; Place a pressure reduction cushion to the wheelchair; Lotion to the resident's entire body daily; She required the assistance of one for bed mobility and transfers. The Care Plan dated 10/18/18 revealed resident had an increased risk of pressure areas related to needing assistance with mobility and her low weight. Resident #45 admitted with multiple bruises and a lesion to the left lower leg (possibly from cancer). On admission her skin is very dry and thin. Her Braden scale (for predicting pressure ulcers) measured 17. Interventions included: Administer treatments as ordered and monitor for effectiveness; Inform the resident/family/caregivers of any new area of skin breakdown; Resident #45 needs a moisturizer applied to her entire body daily. Do not massage over bony	F 686		

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prominences and use a mild cleanser for peri-care/washing;
Teach the resident/family the importance of changing positions for prevention of pressure ulcers. Encourage small frequent position changes;
The resident required a pressure reduction mattress and a pressure reduction cushion to her wheelchair and an addendum dated 11/27/18 documented addition of an air mattress. Under an activities for daily living focus area, staff documented she required the assistance of one to turn and reposition in bed. Staff also documented Resident #45 required a skin inspection on bath days and as needed: observe for redness, open areas, scratches, cuts, bruises, and report changes to the nurse.

The resident's Admission Skin Assessment dated 10/5/18 recorded the resident had no pressure ulcers.

The Braden scale assessment (used for predicting pressure sore risk) completed on 10/5/18, documented Resident #45 had a high risk for pressure sore development.

A Non-pressure Skin Condition report dated 10/5/18 documented the presence of pink blanchable area to gluteal crease, upon admit, with a healed date of 10/19/18.

The Progress note date 10/24/18 at 3:45 p.m. documented the resident received Hospice care. The resident did not feel well: she stayed bed with complaints of an upset stomach and felt weaker.

The Progress note dated 10/26/18 at 2:02 p.m. recorded she continued to receive Hospice care

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F 686	Continued From page 18 and stayed in bed most of the shift. The Progress note dated 11/1/18 at 1:13 p.m.. documented the resident continued on Hospice care and stayed in bed that shift. The Progress note dated 11/6/18 at 6:07 p.m. recorded continued Hospice services and noted she had a small open area to the coccyx. Staff spoke with the Hospice nurse and planned to apply Risamine ointment twice a day (BID). A Weekly Pressure Ulcer Progress Report identified an open area on the coccyx dated 11/6/18 that measured 1.5 centimeters (cm) by 1.0 cm with serosanguineous drainage and pink in color, caused by terminal cancer, with preventive measures to turn and reposition every 2 hours and the doctor notified on 11/7/18. The Progress note dated 11/7/18 at 2:07 p.m., documented open area measures 1.5 by 1.0 cm fax to doctor resident incontinent of bowel and bladder stays in bed. The Progress note dated 11/8/18 at 1:37 p.m., documented a new order for Calmoseptine to the open area. The Progress notes dated 11/15/18 at 6:47 a.m. documented the resident felt weak and slept most of the shift. The Progress note dated 11/21/18 at 2:51 p.m., documented Resident #45 had two new open areas to both buttocks, the areas are moisture related and staff planned to apply Calmoseptine (a skin protectant).	F 686		

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F 686	Continued From page 19 A Non-Pressure Skin Condition Report dated 11/21/18 documented a moisture related right buttock abrasion measuring 0.3 cm by 0.2 cm. Staff documented the area as superficial, the application of cream and notice to Hospice. On 11/27/18 the right buttock abrasion area measured 1.1 cm by 1.0 cm and remained open. Staff applied stomahesive powder, followed by Calmoseptine and documented the wound's progress had deteriorated. A Non-Pressure Skin Condition Report dated 11/21/18 documented a superficial moisture related left buttock abrasion measuring 1.2 cm by 0.9 cm with serosanguineous drainage and a scant amount of exudate. Staff applied cream and notified Hospice staff. On 11/27/18 area measured 0.4 cm by 0.3 cm, remained open and had not improved. The Progress note dated 11/22/18 at 12:14 p.m., documented the resident complained of pain to her bottom. Staff applied Calmoseptine cream, called Hospice and requested an air mattress and received a new order for stomahesive powder. The Progress note dated 11/23/18 at 1:14 p.m., documented Resident #45 complained of pain to her buttocks. Staff repositioned her to the side, but she refused to stay on her side. Staff applied Calmoseptine to the open areas. The Progress note dated 11/25/18 at 1:34 p.m., documented the resident complained of pain to her bottom but would not stay on her side. The Progress note dated 11/27/18 at 1:57 p.m. documented Resident #45 refused to get out of bed.	F 686		

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F 686	Continued From page 20 The Progress note dated 11/27/18 at 9:36 p.m. documented the resident's air mattress delivered to the facility. The Progress notes of 11/28/18 documented staff administered morphine for complaint of pain to the resident's bottom and a urinary catheter inserted for comfort. The Progress note dated 11/30/18 documented morphine given for complaint of pain to her bottom. Interview on 12/2/18 at 2:30 p.m. with the resident's family revealed Resident #45 developed some open sores her bottom. Resident #45 came into the facility with no open areas and had developed them while at the facility. During interview on 12/4/18 at 8:55 a.m., Staff N CMA (Certified Medication Aide) stated that if a resident had a risk for pressure areas, an air mattress would be put on their bed, cushions in their chairs, staff would offload the areas, do toileting schedules, give milk shakes, turn and reposition and keep the resident on their side. These would be some of the preventative ways to keep the resident from developing any open areas. Interview on 12/4/18 at 9:00 a.m. with Staff O RN (Registered Nurse) revealed Resident #45 was a Hospice patient and it is expected for any Hospice resident to get pressure sores due to them being at the end of life and they are here for comfort measures.	F 686		

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F 686	Continued From page 21 During interview on 12/4/18 at 9:58 a.m., the Director of Nursing stated facility staff would be expected to put a turning and repositioning schedule in place or at least a different mattress. They had a difficult time with Hospice bringing an air mattress right away and the pressure area was avoidable for the resident.	F 686		
F 689 SS=G	Free of Accident Hazards/Supervision/Devices CFR(s): 483.25(d)(1)(2) §483.25(d) Accidents. The facility must ensure that - §483.25(d)(1) The resident environment remains as free of accident hazards as is possible; and §483.25(d)(2)Each resident receives adequate supervision and assistance devices to prevent accidents. This REQUIREMENT is not met as evidenced by: Based on clinical record review and staff interview, the facility failed to provide adequate supervision to prevent accidents for 3 of 7 residents sampled for nursing supervision (Residents #232, #44 and #78). The facility reported a census of 85 residents. Findings include: 1. According to the Minimum Data Set (MDS) assessment, dated 7/16/18, Resident #232 scored 5 on the Brief Interview for Mental Status (BIMS) indicating severe cognitive impairment. The resident required the assistance of one for activities of daily living (ADL's) including bed mobility, transfers, ambulation, toilet use and dressing. The resident's diagnoses included Alzheimer's disease, and the resident received	F 689		

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F 689	Continued From page 22 Hospice care. A Fall Risk assessment dated 6/17/18 scored the resident at 80 indicating a high risk for falls. The Care Plan revised on 8/6/18 identified Resident #232 had impaired cognitive function related to periods of confusion and diagnosis of dementia, and extreme restlessness later in the day and at night. The interventions included to keep her safe during periods of extreme confusion and provide 1 to 1 with her as needed. The Care Plan revised on 5/2/18 identified the risk for falls due to a history of falls and cognitive loss. The interventions included use of a bed/chair alarm for safety as she got up without assistance, especially later in the day. The Progress Note dated 7/27/18 at 5:58 p.m. documented at 3:45 p.m. staff observed Resident #232 sitting on the floor beside her bed with her back facing the bedside stand. She stated she sat on the floor while getting out of bed and did not fall and did not hit her head. Resident #232 did not complain of pain or discomfort. The resident had an abrasion on her right lower back measuring 14 cm (centimeters) by 6 cm and a yellowing bruise with small purplish blotches within the bruised area with no firmness noted that measured 6 by 6 cm. A Fall SBAR (Situation, Background, Appearance and Response) form documented the resident last seen 1 hour prior to the fall but lacked any documentation about whether the alarm was on or functioning. The Progress Note dated 8/10/18 at 11:28 a.m. documented the resident fell that morning at the breakfast table, as witnessed by the dietary aide.	F 689		

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The resident stood out of her wheelchair and tried to walk, tripped on the wheelchair pedal and fell on her buttock. A Fall SBAR form dated 8/10/18 described actions to prevent further falls as to put resident in recliner when she finished eating. The form lacked documentation of whether the alarm was on or functioning.

The Progress Note dated 8/10/18 at 11:42 p.m. documented she was found slightly on her right side/back on the floor in front of her bathroom doorway around 5:50 p.m. Staff took her to the bathroom about 10 minutes before the incident. She could not say what she was trying to do when asked her how the fall occurred. Upon assessment, the resident complained of severe pain to the right hip and outward rotation of the right leg. Staff notified Hospice and they came and assessed the resident and directed to send the resident to the hospital. The Hospice nurse also helped the nurse gives the resident an as needed (PRN) Roxanol while this nurse tried to call the on-call doctor. Staff updated the resident's family of the event. The on-call doctor ordered to send the resident to the emergency room for evaluation and paramedics transported her at 7 p.m.. Th nurse called the hospital for an update and learned Resident #232 admitted for a right hip fracture.

A History and Physical dated 8/10/18 documented Resident #232 fell at the nursing home and was not able to ambulate. The assessment included the resident had a right intertrochanteric femur (hip) fracture. The physician documented that surgery was in the resident's best interest because without it she would be unable to ambulate or mobilize.

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F 689	Continued From page 24 During an interview on 12/03/18 at 9:25 a.m. Staff A Dietary Aide stated she is hard of hearing but she can hear the alarms in the dining room. On 8/10/10 the resident was standing up during the meals trying to go on her own. Staff A stated during the morning meal the resident kept standing up. During the noon and the evening meal the resident continued to try and get up. At the evening meal the nurse took the resident back to her room. While she cleaned up at the kitchenette, another resident's husband told her Resident #232 was on the floor. She went to the resident's room and saw her laying on the floor. She did not hear the alarm sounding. She looked for someone to help. She said 1 CNA was giving a shower, the nurse was on break, and she could not find the other CNA. She went to another unit and asked for help. A CNA on the floor stated she could not leave the unit, so she went to the office and they paged for help. She said she asked the husband who told her the resident was on the floor if he heard the alarm, and he said no. During an interview on 12/3/18 at 2:39 p.m. Staff B Certified Nursing Assistant (CNA) stated she did not witness the fall 8/10/18 a.m., but heard about it afterward. She said she worked in a room giving a resident a shower so she did not hear the alarm. Resident #232 had been restless that day, constantly trying to get up. When she was like that they would try to keep her with someone. It would not be safe to leave her in her room in the recliner or the wheelchair, because she would just try and get up. During an interview on 12/4/18 at 11:00 a.m. Staff C CNA stated she worked on 8/10/18 and they would have checked at 2 p.m. to see the resident had the alarm on and it worked. Resident #232	F 689		

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tried to get up without assistance so they kept her where they could see her. She said the last time she saw the resident she sat at the dining room table. At the time of the fall, she gave another resident a whirlpool bath. She did not hear the alarm, but she wouldn't in the whirlpool room.

During an interview on 12/4/18 at 11:12 a.m. Staff G Licensed Practical Nurse (LPN) stated she worked the evening shift on 8/10/18. The resident acted restless and just wanted to walk. She told her she couldn't walk by herself and sat Resident #232 by her until someone could walk with her. The resident continued to attempt to get up and she asked her if she wanted to go to the bathroom. A CNA (Staff H) came by and Staff G asked her to take Resident #232 to the bathroom. She gave another resident medications and then let the CNA know she was going on break. About 10 minutes later she got the call about the fall. She asked Staff H why after she asked her to take the resident to the bathroom she was on the floor by the bathroom door. The CNA told her the resident wanted to watch TV so she left her in the room. Staff G stated the CNA should not have left the resident in the room by herself when she had been making attempts to get up by herself, but the CNA was new and she didn't know.

During an interview on 12/5/18 at 8:24 a.m. Staff K Clinical Coordinator stated if they didn't document whether the alarm was on and sounding (at the time of the incidents) she could not say if it was or not. It would be up to the caregiver to assure the alarm on and working.

At the time of exit Staff H had not returned calls.
2. According to the quarterly MDS assessment dated 10/4/18, Resident #44 had a BIMS score of

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F 689	Continued From page 26 8, indicating moderate cognitive and memory impairment. The MDS indicated Resident #44 required the assistance of two staff for bed mobility, transfers, and toilet use. The MDS listed he had diagnoses that included dementia, Parkinson's disease, seizure disorder, anxiety, depression and insomnia. The MDS recorded Resident #44 fell twice without injury since the previous assessment. Review of Resident #44's care plan recorded he had a long history of falls prior to admission to facility. He has fallen at home and at a previous nursing facility. He has also had falls and been lowered to the floor since admission. He is impulsive and does not always make safe choices. He had a high risk of falls related to Parkinson's disease, depression, anxiety, dementia, and diabetic neuropathy. The care plan listed the following interventions for staff to utilize: Ask and/or encourage him to use the bathroom and then get into recliner after meals, started on 1/21/18; Assist to the bathroom after all meals, started on 10/20/18; Assist with toilet use between 5:00 AM and 6:00 AM, started on 10/23/2018; Place a chair pad alarm to the wheelchair, started on 7/30/18; Educate staff to use a textured bedspread on his bed or one with non-slip materials, started on 10/14/17; Education given to overnight staff that his bed alarm needs to be plugged in when he is bed for the whole shift; Encourage him to sit in the lounge or by nurses desk for closer observation when awake, started	F 689		

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F 689	Continued From page 27 on 9/14/17; Gripper socks on at bed and off in morning, started on 12/6/17; Keep the bed wheels locked; Keep the call light in reach when in his room; Low bed to the floor when resident is resting during the day and at night, started on 5/14/18; Make sure shoes are in good condition. A Progress note dated 7/30/18 documented Resident #44 observed on the floor at 9:00 AM in front of his bed with his back against a side rail and sitting on his buttocks. Resident #44 stated he did not hit his head; he put himself in bed and tried to get back out at the time of the fall. The nurse observed the resident's bed in a high position and his call light not within reach. Resident #44 also had a bed alarm, observed to be off. The nurse educated the Certified Nursing Assistants (CNA) on proper bed positioning and to make sure his call light is within reach. She also educated Resident #44 on the importance of asking staff for help. A Fall SBAR form for Resident #44 recorded the fall occurred on 7/30/18 at 9:00 AM. The resident stated he attempted to get out of bed without requesting help/assistance via the call light. Resident #44 was observed sitting on the floor bedside the bed with his back towards the bed. Resident #44 stated he did not hit his head and had no complaints of pain. When asked to describe what happened, the resident stated he tried to get out of bed and fell straight down onto his bottom; he did not hit his head. The resident's call light was not within reach. The form asked what could have been done to prevent this fall from happening, staff documented having his side rails down, his call light within reach, place	F 689		

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F 689	Continued From page 28 his bed in a low position and have the resident's alarm on. During interview on 12/5/18 at 8:15 AM Staff M Registered Nurse Clinical Care Coordinator stated the resident had tried to self-transfer back to bed and that is when he fell. During interview on 12/05/18 at 8:42 AM, Staff L, LPN (Licensed Practical Nurse) stated Resident #44 told her he put himself back into bed after breaks and self-transferred back to his wheelchair. When she walked in to the room she noted the side rails were up, his bed as not in the lowest position and the alarm not sounding. She stated when staff got him up the morning they did not leave the side rails down, left the bed in the high position and did not turn on the alarm. Staff L believed the alarm is one that staff click on and off. Once the alarm is turned on and pressure is applied the alarm will sound. So if the alarm had been on, it would have sounded when the resident self-transferred to bed and again when he tried to get out of bed. 3. According to the MDS assessment dated 5/24/18, Resident #78 had severely impaired cognitive skills for daily decision-making. The MDS indicated he required the assistance of one staff member for transfers and toilet use. The resident had unsteady balance when moving from a seated to a standing position, moving on and off the toilet and during surface to surface transfers. The resident had diagnoses that included dementia, Parkinson's disease, anxiety and depression. Review of Resident #78's care plan, with a revision date of 8/24/18, revealed he had an	F 689		

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F 689	Continued From page 29	F 689		

increased risk of falls related to use of antidepressant and antipsychotic medications and history of falls prior to admission to the facility. Resident #78 appeared to have balance issues related to visual changes from dementia. He would stop when the color of the floor changed or with a difference in visible texture. He would focus and concentrate on the areas and at times felt the need to touch the area. The care plan listed the following interventions for staff to utilize:
Change the bed pad alarm to a trigger call light, started on 8/28/18;
Educate the resident/family/caregivers about safety reminders and what to do if a fall occurs;
Encourage the resident to sit in a recliner not the love seat when he is wearing windbreaker style pants, beginning 10/10/18;
Ensure Resident #78 wire appropriate footwear; he preferred tennis shoes when walking;
Keep his walkway clear to avoid stumbling, started on 9/10/18;
Lead the resident to less populated areas when he wandered, started on 8/28/18;
Staff re-arranged his room, moved his bed and added a motion sensor night light on 6/16/18;
Staff set up a workspace so Resident #78 may stay busy and not wander into unfamiliar rooms and trip over items, started on 8/1/18;
The resident needs activities that minimize the potential for falls while providing diversion and distraction drawing or music.

An Incident/Accident report for Resident #78 dated 6/16/18 at 10:45 PM documented Resident #78 found standing in his room with blood over her face and hands. Bed alarm was on the bed but not properly attached.

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F 689	Continued From page 30 The Fall SBAR form dated 6/16/18 documented the resident found standing in his room, with blood all over his face and hands which appeared to be coming from the resident's nose at the bridge. Under the appearance section, staff was unable to respond appropriately and found him standing in his room while doing rounds. The form asked what was different this time that may have led to the fall? Staff listed alarm did not function properly and lighting as not appropriate for the room. A Progress Note dated 6/17/18 at 8:33 AM recorded Resident #78 fell in his room at the start of the shift. The evening nurse was with the resident. Staff called his doctor, who gave orders to send the resident to the emergency room to be evaluated and treated for fall injuries. The resident returned to the facility after being evaluated for a broken nose and head injury. Resident #78 had dementia and staff needed to anticipate his needs. An Emergency Department Physician note dated 6/16/18 indicated Resident #78 sustained a nasal bone fracture following a fall at the nursing home. On 12/5/18 at 10:00 AM the DON stated they removed furniture from his room and re-arranged it as part of their root-cause analysis. They also added a wall light. When asked the about the alarm not functioning she stated it was there to alert staff of him moving. He liked to fidget with things and could have moved it (information not relayed on the care plan).	F 689		
F 758 SS=D	Free from Unnec Psychotropic Meds/PRN Use CFR(s): 483.45(c)(3)(e)(1)-(5)	F 758		

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F 758	Continued From page 31 §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 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	F 758		

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F 758	Continued From page 32	F 758		

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 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 a resident did not receive unnecessary medications for one of five sampled residents (#36). The facility reported a census of 85 residents.

Findings include:

Review of the quarterly Minimum Data Set (MDS) dated 9/27/18 revealed Resident #36 had a Brief Interview for Mental Status (BIMS) score of 3, indicating severe cognitive impairment. The MDS diagnoses that included dementia, anxiety, and depression. The MDS indicated she received antipsychotic, antianxiety and antidepressant medications for 7 days during a 7-day review period.

Review of Resident #36's care plan with a revision date of 10/4/18 revealed she had the potential for psychosocial issues due to adjustment to new environment in conjunction with diagnoses of dementia, depression and anxiety. She is currently taking antipsychotic, antianxiety and antidepressant medications for the treatment of depression, anxiety and dementia with behaviors. She also has an as needed (PRN) order for an antianxiety medication. The care plan encouraged staff to

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F 758	Continued From page 33 attempt non-pharmacological interventions, maintain a calm environment and approach to her, monitor her mood and response to medications and review pharmacy consult recommendations, and follow up as indicated. The Medication Review Report dated 8/9/18 directed administration of Ativan 0.5 milligram (mg) every 4 hours as needed (PRN) for anxiety with a start date of 3/22/18. A Progress Note dated 11/19/18 documented the resident's physician visited as she displayed increased anxiety; emotional and crying at times. Resident #36's primary physician charted she had increased anxiety and depressive symptoms and ordered scheduled Ativan 1 mg at 10:00 AM and 4:00 PM (increased from 0.5 mg twice a day). Review of the Medication Administration Record (MAR) for September of 2018 revealed Resident #36 received her PRN Ativan 0.5 mg tablet on 9/7/18. Review of the MAR for October 2018 revealed Resident #36 did not receive a PRN Ativan 0.5 mg tablet during the month. Review of the MAR for November 2018 revealed Resident #36 received a PRN Ativan 0.5 mg tablet on 11/17/18. Review of the MAR for first 4 days of December 2018 revealed Resident #36 did not receive PRN Ativan 0.5 mg tablet during that time. A Note to the Attending Physician/Prescriber documented Resident #36 continued to have an order for Ativan 0.5 mg every 4 hours PRN for	F 758		

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F 758	Continued From page 34 anxiety. The pharmacy requested duration and clinical rationale for the medication. The physician agreed to continue the current order for 6 months due to failed previous reductions and contained a signature date of 9/19/18. On 12/5/18 at 8:15 AM the Director of Nursing (DON) stated she did not thing the facility re-addressed the PRN Ativan order after the scheduled Ativan increased last month.	F 758		
F 803 SS=E	Menus Meet Resident Nds/Prep in Adv/Followed CFR(s): 483.60(c)(1)-(7) §483.60(c) Menus and nutritional adequacy. Menus must- §483.60(c)(1) Meet the nutritional needs of residents in accordance with established national guidelines.; §483.60(c)(2) Be prepared in advance; §483.60(c)(3) Be followed; §483.60(c)(4) Reflect, based on a facility's reasonable efforts, the religious, cultural and ethnic needs of the resident population, as well as input received from residents and resident groups; §483.60(c)(5) Be updated periodically; §483.60(c)(6) Be reviewed by the facility's dietitian or other clinically qualified nutrition professional for nutritional adequacy; and §483.60(c)(7) Nothing in this paragraph should be construed to limit the resident's right to make	F 803		

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F 803	Continued From page 35 personal dietary choices. This REQUIREMENT is not met as evidenced by: Based on observation, record review and staff interview, the facility failed to follow the menu for residents on a pureed diet. The facility reported a census of 85 residents. Findings include: The facility Diet Roster identified 7 residents with orders for pureed food. The menu for Wednesday 12/5/18 for pureed diets included: Pureed choice of hot cereal, Pureed scrambled eggs with cheese, Pureed toast. During an observation and interview on 12/5/18 at 7:12 a.m. Staff J dietary aide brought a plate of pureed food consisting of eggs (stating these were pureed boiled eggs with bread and milk), pureed sausage, and pureed french toast. The entire plate contained syrup. Staff J stated the residents on pureed diets received this daily, with the exception they received pancakes instead of french toast at times.	F 803		
F 812 SS=E	Food Procurement,Store/Prepare/Serve-Sanitary CFR(s): 483.60(i)(1)(2) §483.60(i) Food safety requirements. The facility must - §483.60(i)(1) - Procure food from sources approved or considered satisfactory by federal, state or local authorities. (i) This may include food items obtained directly	F 812		

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F 812	Continued From page 36 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, record review, and staff interview, the facility failed to assure adequate cleaning of food service equipment. The facility reported a census of 85 residents. Findings include: a. An observation on 12/3/18 at 10 a.m. revealed the following: a. The doorway between the walk in refrigeration and freezer had a large buildup of ice and frost and appeared warped at the top. b. The ice machine in the 100 hall dining room had streaks of white running down the sides and a thick lime buildup at the front and all around the edges. The front face piece appeared to be out of place and the area felt gritty to the touch. c. A snack cart in the 100 hall dining room had grime buildup at the connection sites. d. The cart where cake and rolls sat had a buildup of debris at the bottom. During an interview on 12/3/18 at 12:49 p.m. the Administrator stated they had received approval to replace the cooler at the board meeting in	F 812		

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F 812	Continued From page 37 November. She said they had a new ice machine on the property, they had purchased to replace another one and they were able to repair it. During an observation on 12/3/18 at 2:56 p.m. the ice machine had been removed and staff cleaned where it sat. During an interview on 12/4/18 at 9:48 a.m. the Dietary Supervisor (DS) stated they did not have a set date for replacing the cooler. She looked at the snack cart and could remove a dark substance from the connection sites. b. During an observation on 12/4/18 at 4:16 p.m. Staff I dietary aide worked in the kitchen without a hairnet and with hair approximately one inch in length. The DS stated his hair was not long enough to have to wear one. According to the FDA Food Code regarding Hair Restraints, 2-402.11, food employees shall wear hair restraints such as hats, hair coverings or nets, beard restraints, and clothing that covers body hair, that are designed and worn to effectively keep their hair from contacting exposed food, clean equipment, utensils, and linens, and unwrapped single service and single use articles.	F 812		
F 880 SS=D	Infection Prevention & Control CFR(s): 483.80(a)(1)(2)(4)(e)(f) §483.80 Infection Control The facility must establish and maintain an infection prevention and control program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of communicable	F 880		

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F 880	Continued From page 38 diseases and infections. §483.80(a) Infection prevention and control program. The facility must establish an infection prevention and control program (IPCP) that must include, at a minimum, the following elements: §483.80(a)(1) A system for preventing, identifying, reporting, investigating, and controlling infections and communicable diseases for all residents, staff, volunteers, visitors, and other individuals providing services under a contractual arrangement based upon the facility assessment conducted according to §483.70(e) and following accepted national standards; §483.80(a)(2) Written standards, policies, and procedures for the program, which must include, but are not limited to: (i) A system of surveillance designed to identify 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	F 880		

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F 880	Continued From page 39 must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease; and (vi)The hand hygiene procedures to be followed by staff involved in direct resident contact. §483.80(a)(4) A system for recording incidents identified under the facility's IPCP and the corrective actions taken by the facility. §483.80(e) Linens. Personnel must handle, store, process, and transport linens so as to prevent the spread of infection. §483.80(f) Annual review. The facility will conduct an annual review of its IPCP and update their program, as necessary. This REQUIREMENT is not met as evidenced by: Based on clinical record review, observation, facility procedure record review and staff interview, staff failed to maintain infection control practices to during the provision of care for 3 of 16 residents reviewed (Residents #63, #48 and #45). The facility reported a census of 85 residents. Findings include: 1. The Minimum Data Set (MDS) assessment dated 11/2/18 documented Resident #63 with diagnoses which included Alzheimer's disease, Non-Alzheimer's dementia, anxiety and depression. The MDS documented the resident with short and long term memory impairments and severely impaired decision making abilities. He required the assistance of two with bed	F 880		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	165266	A. BUILDING _____ B. WING _____	12/05/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HOLY SPIRIT RETIREMENT HOME	1701 WEST 25TH STREET SIOUX CITY, IA 51103

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 880	Continued From page 40 mobility, toilet use and personal hygiene. The MDS assessment documented the resident as always incontinent of bladder and bowel. The resident's Care Plan contained a bladder incontinence focus area initiated on 11/8/18 that identified him as incontinent related to confusion, dementia, impaired mobility, and an inability to communicate his needs. The resident's family reported incontinence of bowel and bladder for months prior to admission. Interventions included: a. The resident used disposable briefs; change every a.m. and as needed. Staff may leave the brief off and open to air with a pad when he lay in bed. b. Clean peri-area with each incontinence episode. c. Check every 2-3 hours for incontinence; assist with peri care. d. Change his clothing as needed after incontinence episodes During an observation on 12/3/18 at 8:00 a.m., Staff D (CNA or certified nursing assistant) and Staff E (CNA) provided incontinent cares for the resident. Staff D and Staff E put on gloves and Staff D, using wet wipes, cleansed the resident's inner left and right thighs. Staff D and Staff E positioned the resident to the left side as Staff D pushed the soiled blue brief under the resident, took a clean blue brief and placed it under him, took another wet wipe and cleansed his right buttock and coccyx area and then staff rolled him onto the right side. Staff E then pulled the soiled blue brief from underneath the resident and placed it and the soiled blue pad into a clear garbage bag. The observation revealed staff failed to change their gloves between handling soiled and clean linens and briefs.	F 880		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	165266	A. BUILDING _____ B. WING _____	12/05/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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F 880	Continued From page 41 2. The MDS assessment of 10/17/18 documented Resident #48 had diagnoses that included heart failure, diabetes mellitus, Alzheimer's disease, Non-Alzheimer's dementia, anxiety and depression. The MDS documented the resident with a Brief Interview for Mental Status (BIMS) score of 2 which indicated severely impaired memory and cognition. Resident #48 required the assistance of two staff with bed mobility,dressing and toilet use and the assistance of one with personal hygiene. Resident #48 always had incontinence of bowel and bladder. The resident's Care Plan contained a focus area of bladder incontinence secondary to several co-morbidities including diagnosis of vascular dementia, denying being incontinent and refusing toileting and peri cares. Interventions included: a. Encourage her to use the bedpan as allowed for a bowel movement. b. Use a mild cleansing agent to minimize irritation and dryness of the skin and avoid friction as allowed by the resident. c. Resident #48 used incontinence products for dignity; change them twice a day and as needed. d. The resident's urologist only wants her urine checked only with physiological symptoms of urinary tract infection. Observation on 12/03/18 at 1:30 p.m. revealed Staff D and Staff E provided incontinence cares for Resident #48 after transferring her into bed with a Hoyer (mechanical lift). Staff D and Staff E put on gloves and Staff D pulled down the resident's slacks exposing a green brief which showed a green stripe down the middle. Staff D stated the green stripe meant the brief was wet. Staff D and Staff E completed incontinence care	F 880		

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	165266	A. BUILDING _____ B. WING _____	12/05/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HOLY SPIRIT RETIREMENT HOME	1701 WEST 25TH STREET SIOUX CITY, IA 51103

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F 880	Continued From page 42 for the resident but failed to change gloves between handling clean and soiled linen and briefs. The facility's undated Hand Hygiene Procedure and Policy instructed staff to: Practice hand hygiene Whenever hands are visibly dirty or contaminated. Use soap or water Before: Having contact with patient Putting on gloves Inserting any invasive device Manipulating in invasive device After: Having contact with patients skin Having contact with bodily fluids or excretions, non-intact skin, wound Having contact with inanimate objects near a patient Removing gloves Some additional situations that require hand hygiene, but not limited to: Before and after eating or handling food After personal use of toilet After blowing or wiping nose After completing duty. 3. The MDS assessment dated 10/12/18 documented Resident #45 had diagnoses that included cancer, osteoporosis, Non-Alzheimer dementia and anorexia. The assessment recorded a Brief Interview for Mental Status score of 11 which indicated moderately impaired memory and cognitive abilities. The resident required the assistance of one with bed mobility, transfers, toilet use and dressing.	F 880		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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F 880	Continued From page 43 The Progress Note dated 11/28/18 at 3:20 p.m. documented Resident #45 continued to receive Hospice services. A Hospice nurse visited the facility and inserted a 14 french Foley (urinary) catheter for the resident's comfort. The resident's Care Plan contained a focus are of bladder/bowel with an update of 11/2018 which instructed to assist with Foley cares, record her output and the catheter in place secondary to her overall decline. Observation on 12/2/18 at 2:42 p.m. revealed Staff E entered the resident's bathroom, came out with a plastic graduate and placed it on top of the resident's sheet. Staff E kneeled down on the floor next to the catheter bag, removed the catheter bag from the privacy bag and then took the plastic graduate and placed it directly on the floor. Staff E emptied the urine from the catheter bag into the graduate and placed the spout back into the unit. Staff E took the graduate into the bathroom, emptied the resident's urine into the toilet and placed the graduate on top of the back of the toilet.	F 880		

Department of Health and Human Services Division of Health Facilities Plan of Correction (CMS-2567) for Survey Completed on December 5, 2018.

F000 - This response and "Plan of Correction" constitutes Holy Spirit Retirement Community's allegation of compliance, effective, January 5, 2019. Preparation and/or execution of the plan of correction do not constitute admission or agreement by provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. This plan of correction is prepared and/or executed solely because the provisions of federal and state law require it.

F 550 RESIDENT RIGHTS/EXERCISE OF RIGHTS

--Elements detailing how facility will correct this deficiency as it relates to the Individual
A privacy bag was placed on the catheter drainage bag for Resident #45 and tubing positioned off the floor.

--How you will act to protect residents in the future
Ensured all residents with catheters had privacy bags placed over their drainage bags and tubing positioned off floor.

--Measures taken and/or systems altered to ensure that this problem does not recur
DON has held mini inservices the week of 12/17/2018 with the nursing employees of all shifts to reinforce catheter bag covering and proper positioning thereof.

--How facility plans to monitor performance to ensure solutions are permanent
Following inservice education, The DON or designee will audit for proper positioning of foley catheter tubing and use of privacy bags over the foley drainage bags 2x week for 4 weeks, then weekly for 4 weeks, then monthly for 4 months. Results of audits will be taken to QAPI for review/revision as appropriate.

F 623 NOTICE OF REQUIREMENTS BEFORE TRANSFER/DISCHARGE

--Elements detailing how facility will correct this deficiency as it relates to the Individual
Notice of said transfer was updated to the Ombudsman on December 3rd, 2018 once identified during the survey process.

--How you will act to protect residents in the future
The Ombudsman's office was updated with all transfers per policy on 12/03/2018.

--Measures taken and/or systems altered to ensure that this problem does not recur
The BOM and SSD have been re-educated on the timing of notification of the Ombudsman's office of resident transfers and discharges.

--How facility plans to monitor performance to ensure solutions are permanent
The Administrator or designee will audit for 90 days. Results of audits will be taken to QAPI for review/revision as appropriate.

F 658 SERVICES PROVIDED MEET PROFESSIONAL STANDARDS

--Elements detailing how facility will correct this deficiency as it relates to the Individual
Resident #19 is being observed taking her medication by the staff that administers it. Resident #57 is receiving all medications per physician's orders.

--How you will act to protect residents i the future
All staff that administer medications to residents will observe the residents take the medication per policy and physician's orders before leaving the resident. This was reinforced in education on 12/20/2018.

--Measures taken and/or systems altered to ensure that this problem does not recur
Nurses have been re-educated on medication reconciliation and double check of new orders as well as observing residents taking their medications.

--How facility plans to monitor performance to ensure solutions are permanent
Following education, The DON or designee will audit new orders 2x/week for 4 weeks, then weekly for 4 weeks, then monthly x4 to assure orders are transcribed correctly into the resident EMR.

F 677 ADL CARE PROVIDED FOR DEPENEDENT RESIDENTS

--Elements detailing how facility will correct this deficiency as it relates to the Individual
Resident # 63 and #48 are receiving complete incontinence care. Staff D and E were re-educated on performing complete incontinence care. Resident #55 is being offered 2 baths per week.

--How you will act to protect residents in the future
All residents with incontinence will receive complete incontinence care and will be offered at least 2 baths per week.

--Measures taken and/or systems altered to ensure that this problem does not recur
Bathing and incontinence care have been reviewed with the Nurse aides with return competencies on providing complete perineal care. Nursing staff will be re-educated on bath schedules and documentation.

--How facility plans to monitor performance to ensure solutions are permanent

Following education, The DON or designee will audit for complete incontinence care and bathing provided per schedule 2x/week for 4 weeks, then weekly for 4 weeks, then monthly x4. Results of audits will be taken to QAPI for review/revision as appropriate.

F 686 TREATMENT/SVCS TO PREVENT/HEAL PRESSURE ULCER

--Elements detailing how facility will correct this deficiency as it relates to the Individual
Resident #45 expired during survey.

--How you will act to protect residents in the future
All residents at risk for pressure ulcers will be reviewed to assure interventions are in place to prevent pressure ulcers.

--Measures taken and/or systems altered to ensure that this problem does not recur
Nursing staff have been re-educated on interventions to prevent pressure ulcers.

--How facility plans to monitor performance to ensure solutions are permanent
Following education, The DON or designee will complete a random audit to assure interventions are in place to prevent pressure ulcers 2x/week for 4 weeks, then weekly for 4 weeks, then monthly x4. Results of audits will be taken to QAPI for review/revision as appropriate.

F 689 FREE OF ACCIDENT HAZARDS/SUPERVISION DEVICES

--Elements detailing how facility will correct this deficiency as it relates to the Individual
Resident #232 expired prior to the survey. #44 and #78 had their care plans reviewed and updated for fall prevention interventions and staff were reeducated on the interventions.

--How you will act to protect residents in the future
Care plans for all residents at risk for fall have been reviewed for appropriate fall prevention interventions and care plans revised as appropriate

--Measures taken and/or systems altered to ensure that this problem does not recur
Fall prevention and reporting has been reviewed with all Nursing Staff by DON.

--How facility plans to monitor performance to ensure solutions are permanent
Following education, The DON or designee will complete a random audit to assure fall prevention interventions are in place per care plan 2x/week for 4 weeks, then weekly for 4 weeks, then monthly x4. Results of audits will be taken to QAPI for review/revision as appropriate.

F 758 FREE FROM UNNECESSARY PSYCHOTROPIC MEDS/PRN USE

--Elements detailing how facility will correct this deficiency as it relates to the Individual
Request for PRN Ativan for resident #36 to be d/c'd has been sent to Physician. 11/17/2018 was the last documented dose given.

--How you will act to protect residents in the future
All residents with current PRN psychotropic orders will be reviewed to assure medication discontinued after 14 days or reviewed by physician.

--Measures taken and/or systems altered to ensure that this problem does not recur
Licensed nursing staff have been educated on residents receiving new psychotropic PRN medication orders will be limited for up to 14 days initially unless further use is reviewed and ordered by the physician.

--How facility plans to monitor performance to ensure solutions are permanent
Following education, The DON or designee will do a random audit of new psychotropic orders to assure the above process is being completed 2x/week for 4 weeks, then weekly for 4 weeks, then monthly x4. Results of audits will be taken to QAPI for review/revision as appropriate.

F 803 MENUS MEET RESODENT NDS/PREP IN ADV/FOLLOWED

--Elements detailing how facility will correct this deficiency as it relates to the Individual
It was reviewed with staff that Menus for all food consistencies will be consistent and equal and this practice remained throughout the survey process.

--How you will act to protect residents in the future
All residents are receiving food per menu

--Measures taken and/or systems altered to ensure that this problem does not recur
All dietary staff were re-educated on following menu with all consistencies when preparing meals on December 19, 2018.

--How facility plans to monitor performance to ensure solutions are permanent
Following education, the dietary manager or designee will do a random audit to assure residents being served meals per menu 2x/week for 4 weeks, then weekly for 4 weeks, then monthly x4. Results of audits will be taken to QAPI for review/revision as appropriate.

F 812 FOOD PROCUREMENT STORE/PREPARE/SERVE-SANITARY

--Elements detailing how facility will correct this deficiency as it relates to the Individual
Snack cart in 100 hall, cart in kitchen cleaned.

Ice machine in 100 hall cleaned.

Ice build-up around freezer removed.

Staff I educated on wearing hairnet.

--How facility will act to protect residents in the future
All carts cleaning schedule and proper use of hair nets was reviewed with all dietary staff at a department inservice on December 19, 2018

The Ice Machine has been professionally clean until it can be replaced by 01/05/2019.

Ice build-up around freezer door has been removed and further build-up will be prevented. Bids are being secured and a new location for an updated walk-in cooler/freezer is being assessed. The Christmas and New Year's Holidays will delay installation. New equipment ordered by January 5th, 2019.

--Measures taken and/or systems altered to ensure that this problem does not recur
All dietary staff were re-educated on following menu when preparing meals on December 19, 2018.

--How facility plans to monitor performance to ensure solutions are permanent
The dietary manager or designee will do a random audit to assure resident's food is being procured prepared in a sanitary manner and environment by utilizing random audits 2x/week for 4 weeks, then weekly for 4 weeks, then monthly x4. Results of audits will be taken to QAPI for review/revision as appropriate.

F 880 INFECTION PREVENTION & CONTROL

--Elements detailing how facility will correct this deficiency as it relates to the Individual
Staff D and E were re-educated on maintaining infection control during perineal care and catheter care.

--How you will act to protect residents in the future
All nurse aides were re-educated on maintaining infection control during perineal cares and catheter cares during the week of 12/17/2018.

--Measures taken and/or systems altered to ensure that this problem does not recur

DON and/or designee began working with direct care staff on peri-care and catheter care competencies.

--How facility plans to monitor performance to ensure solutions are permanent
Following education, The DON or designee will complete a random audit of perineal and catheter care 2x/week for 4 weeks, then weekly for 4 weeks, then monthly x4 to assure infection control is maintained. Results of audits will be taken to QAPI for review/revision as appropriate.

DEPARTMENT OF INSPECTIONS AND APPEALS

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	IA0425	A. BUILDING: _____ B. WING _____	12/05/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HOLY SPIRIT RETIREMENT HOME	1701 WEST 25TH STREET SIOUX CITY, IA 51103

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N 101	50.7(1) 481- 50.7 (10A,135C) Additional notification. 481-50.7 (10A,135C) Additional notification. The director or the director ' s designee shall be notified within 24 hours, or the next business day, by the most expeditious means available (I,II,III): 50.7(1) Of any accident causing major injury. a. " Major injury " shall be defined as any injury which: (1) Results in death; or (2) Requires admission to a higher level of care for treatment, other than for observation; or (3) Requires consultation with the attending physician, designee of the physician, or physician extender who determines, in writing on a form designated by the department, that an injury is a " major injury " based upon the circumstances of the accident, the previous functional ability of the resident, and the resident ' s prognosis. b. The following are not reportable accidents: (1) An ambulatory resident, as defined in rules 481-57.1(135C), 481-58.1(135C), and 481-63.1(135C), who falls when neither the facility nor its employees have culpability related to the fall, even if the resident sustains a major injury; or (2) Spontaneous fractures; or (3) Hairline fractures. This Statute is not met as evidenced by: Based on clinical record review and staff interview, the facility failed to report a major injury to the Iowa Department of Inspection and	N 101		

DIVISION OF HEALTH FACILITIES - STATE OF IOWA
LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE TITLE (X6) DATE

DEPARTMENT OF INSPECTIONS AND APPEALS

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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N 101	Continued From page 1 Appeals (DIA) according to state law for one of seven residents reviewed for nursing supervision (Resident #4). The facility reported a census of 85 residents. Findings include: The Minimum Data Set (MDS) assessment dated 11/20/18 recorded Resident #4 required the assistance of two staff with transfers and bed mobility. The resident did not walk during the 7 day assessment period. The assessment documented she had diagnoses that included diabetes, generalized muscle weakness, atrial fibrillation, abnormalities of gait and mobility and repeated falls. A nursing Progress Note dated 11/21/18 at 5:20 P.M. documented Resident #4 had been found on the floor in her room at 12:10 P.M. Staff documented the resident could not move her right leg, complained of pain in her right hip and transferred to a local Emergency Room. An Emergency/Trauma Department form dated 11/21/8, revealed the resident sustained a fracture of the tibia (right or left leg not identified). A Major Injury Determination Form dated 11/21/8 at 4:00 P.M., revealed a physician documented after review of the circumstances of the incident that caused the tibia fracture, the physician believed the resident sustained a major injury pursuant to the 481 Iowa Administrative Code. Review of an Online Incident Reporting form, with a print date of 12/3/18, revealed the facility Director of Nursing (DON) reported the above fracture/major injury to DIA on 11/25/18 at 9:50 P.M.	N 101		

DEPARTMENT OF INSPECTIONS AND APPEALS

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N 101	Continued From page 2 During interview on 12/4/18 at 9:55 A.M., the DON stated she had been late reporting the Resident #4's major injury to DIA. She reported being aware of the fall on 11/21/8 and of the physician's determination of major injury on 11/21/18. She stated she had been at home and had difficulty logging on to her computer. She then forgot about submitting the report again until Sunday 11/25/18. During additional interview on 12/4/18 at 3:05 P.M., the DON reported the facility had no specific policy in regards to reporting major injuries to DIA, but they needed to report major injuries according to the state code.	N 101		

Holy Spirit Retirement Home
State Statement of Deficiencies

This response and "Plan of Correction" constitutes Holy Spirit Retirement Home's allegation of compliance, effective, January 5, 2019. Preparation and/or execution of the plan of correction do not constitute admission or agreement by provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. This plan of correction is prepared and/or executed solely because the provisions of federal and state law require it.

50.7(1) 481- 50.7 (10A,135C) Additional notification. 481-50.7 (10A,135C) Additional notification. The director or the director ' s designee shall be notified within 24 hours, or the next business day, by the most expeditious means available (I,II,III):

--Elements detailing how facility will correct this deficiency as it relates to the Individual:
Administration reinforced with DON what incidents and when they are to be reported to DIA per the policy that was intact and appropriate at the time of the incident in question.

--How you will act to protect residents in the future:
DON held mini inservices with the nursing employees of all shifts the week of 12/17/2018 to reinforce the policy of DIA reporting of incidents that include falls.

--Measures taken and/or systems altered to make sure that this problem does not recur
The Administrator or designee will audit reportable incidents for the timeliness of reporting to DIA by three months.

--How facility plans to monitor performance to ensure solutions are permanent
Results of audits will be taken to QAPI for review/revision as appropriate.