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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	165161	A. BUILDING ______ B. WING ______	C 01/31/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
TOUCHSTONE HEALTHCARE COMMUNITY	1800 INDIAN HILLS DRIVE SIOUX CITY, IA 51104

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F 000	INITIAL COMMENTS Correction date 2/15/19 for F689 2/25/19 for remaining Ftags. Complaint 79842-C was substantiated. Complaint 80404-C was substantiated. Self Report 80564-I was substantiated. Self Report 80785-I was substantiated. Complaint 80949-C was substantiated. See the Code of Federal Regulations (42CFR) Part 483, Subpart B-C.	F 000		
F 677 SS=D	ADL Care Provided for Dependent Residents CFR(s): 483.24(a)(2) §483.24(a)(2) A resident who is unable to carry out activities of daily living receives the necessary services to maintain good nutrition, grooming, and personal and oral hygiene; This REQUIREMENT is not met as evidenced by: Based on observation, clinical record review, staff interview and facility policy review, the facility failed to ensure that a resident who was unable to carry out activities of daily living received the necessary services to maintain personal hygiene for two of 16 residents reviewed (#6 and #7). The facility identified a census of 76 residents. Findings include: 1. A Minimum Data Set (MDS) assessment dated 1/18/19 assessed Resident #6 with a brief interview for mental status (BIMS) score of 11 (moderate cognitive impairment) The resident	F 677		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE 02/14/2019

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

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F 677	Continued From page 1	F 677		

had no behaviors identified. The resident required extensive staff assistance with bed mobility, transfers, ambulation in room, dressing, toilet use, personal hygiene and bathing. The resident was frequently incontinent of bowel and bladder.

Observation showed on 1/24/19 at 8:22 a.m. the resident on her back in bed. At 8:40 a.m. the resident sat up in bed. At 9 a.m. staff took the resident her breakfast tray and came out of the room. At 9:25 a.m. staff removed the tray and came right back out of the room. At 9:35 a.m., 9:50 a.m. and 10:05 a.m. the resident remained in the same position at the bedside. At 10:10 a.m. the resident stated she needed changing. At that time, Staff C CNA (certified nurse aide) identified herself as in training but as responsible for the resident that morning. She stated she had not assisted the resident with anything yet that day because the resident liked to get up late. At that time, Staff C assisted the resident to the toilet. The resident's brief was wet with urine.

The care plan contained an intervention dated 1/10/19 that identified the resident at risk for skin breakdown due to decreased mobility and incontinence. The care plan did not address toileting the resident until 1/24/19 when an addendum to the care plan directed staff to offer the toilet every 2 hours as needed and if incontinent provide incontinent care.

2. A MDS assessment dated 11/26/18 assessed Resident #7 with impaired long and short term memory and severely impaired decisions. The resident had no behaviors identified. The resident required extensive staff assistance with bed mobility, transfers, dressing, toileting, personal hygiene and bathing. The resident was always

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F 677	Continued From page 2 incontinent of bowel and bladder. On 1/24/19 continuous observation from 8:20 a.m. until 11:54 a.m. revealed from 8:20 a.m. to 10:50 a.m. the resident sat in her wheelchair in the lounge area. At 10:50 a.m. Staff D CNA wheeled the resident into her room and came right back out. Staff D left the resident sitting in her wheelchair next to her bed. No other staff entered the room until 11:28 a.m. when Staff E (charge nurse) gave the resident a nutritional supplement. The surveyor observed Staff E until she finished and Staff E left the room and did not assist the resident to use the toilet. No staff entered the room after that until 11:54 a.m. when Staff D entered and came right out wheeling the resident in her wheelchair to lunch. Staff did not check or change or offer use of the toilet during that time. After the resident went to lunch, the surveyor requested to see any care provided to the resident. At 1:40 p.m. Staff D CNA and Staff F CNA transferred the resident to bed 'and checked her for incontinence. The resident's brief was wet with urine, had a strong odor and smeared stool. Upon request, Staff D stated he checked and changed the resident before lunch. The surveyor asked how he did it. He stated he laid the resident in bed and checked and changed her. A care plan dated 11/9/17 identified the resident as incontinent of bowel and bladder. The care plan directed staff to assist the resident with toileting and that the resident wore briefs. The care plan did not contain any toileting plan until an addendum added on 1/24/19 directed staff to check and change the resident approximately every 2 hours and as needed. The facility's policy on ADL Assistance Provided	F 677		

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F 677	Continued From page 3 Per Care Plan, dated 11/16, directed that incontinent residents shall be checked according to care plan and pericare provided between changes. The policy did not identify any type of timeframe to toilet/check and change residents.	F 677		
F 684 SS=D	Quality of Care CFR(s): 483.25 § 483.25 Quality of care Quality of care is a fundamental principle that applies to all treatment and care provided to facility residents. Based on the comprehensive assessment of a resident, the facility must ensure that residents receive treatment and care in accordance with professional standards of practice, the comprehensive person-centered care plan, and the residents' choices. This REQUIREMENT is not met as evidenced by: Based on clinical record review, observation and resident and staff interviews, the facility failed to ensure that residents receive treatment and care in accordance with professional standards of practice, the comprehensive person-centered care plan, and the residents' choices for two of 16 residents reviewed (#4 and #3). The facility reported a census of 76 residents. Findings include: 1. A Minimum Data Set (MDS) dated 1/7/19 assessed Resident #4 with a brief interview for mental status score of 15 (no cognitive impairment). The resident required supervision with toilet use. a. Observation on 1/23/19 at 1:05 p.m. showed the resident seated at the bedside with a cold	F 684		

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F 684	Continued From page 4 plate (cottage cheese and fruit) for lunch. Resident #4 stated he had sores on his bottom that he applied cream to himself. He stated the cream he used was on the bathroom sink. Observation at 3:30 p.m. with Staff B Unit showed a jar of lidocaine with nifidepine on the sink counter with fill date of 12/11/18. The resident did not allow the surveyor or Staff B to check his bottom. A prescription from the physician dated 11/21/18 revealed an order for topical nifedipine 0.3% with benzocaine 20% to apply twice a day to the resident's anal area for ulceration of rectal area. Review of the resident's November 2018 treatment administration record (TAR) revealed staff did not initial application of the medication until 11/27/18. Nursing progress notes dated 11/26/18 at 2:12 p.m. revealed the pharmacy called and informed the facility they could not fill the compound cream ordered due to benzocaine being on back order. The progress notes identified staff spoke with the physician's nurse and the physician would return the call. Following the physician becoming aware the cream she ordered on 11/21/18 was not available, an order dated 11/26/18 at 11:08 p.m. revealed the physician ordered Lidocaine anorectal cream 5% topically twice a day. On 1/28/19 at 10:40 a.m. the pharmacy stated the original fill of the lidocaine/ nifideprine order was 11/26/18 and then refilled on 12/11/18. The record lacked evidence of any assessment of the resident's skin impairments of the anorectal rectal area or any attempt of assessment that	F 684		

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F 684	Continued From page 5 was refused by the resident. A history and physical note identified an office visit on 11/21/18 at 8:38 a.m. Clinic notes revealed the physician saw the resident for ulceration of the rectal mucous membrane. The physician documented localized tenderness during the anorectal exam and perianal tenderness. Physician assessment identified about 6 mucosal ulcerations consistent with chemotherapy side effects. Two ulcerations were quarter sized, one was nickel sized and the others were the sizes of pennies. None were deep enough to have bleeding. The physician discussed with the resident that he needed the cream right away and, that if it got much worse, he would need to get to the hospital. The physician sent the order to the facility via script so he could have it sooner. A phone encounter dated 11/26/18 revealed staff notified the physician Resident #4 did not yet receive the cream she ordered. The physician called the pharmacy who stated they notified the facility on 11/23/18 that the cream was not available. No one notified the physician of this, so the resident was without the medicine until the physician received notice on 11/26/18 at 10:53 a.m. The physician then called the facility. She spoke with Resident #4 and apologized for him not having the cream. She recommended he go to the hospital and he declined. Resident #4 informed the physician the sores on his bottom were bleeding and he felt a lot of pain. The physician asked if he would like pain medication and he said he would. The physician documented she made multiple attempts to speak to the nurse or Director of Nursing per phone and could not reach them. She also asked them to call back.	F 684		

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F 684	Continued From page 6 She did not get a call back on 11/26/18 or 11/27/18. b. Nursing progress notes dated 12/2/18 identified Resident #4 got in an altercation with another resident and received a 2.5 centimeter (cm.) by 3.5 cm. to the right lower extremity. There was no follow up assessment to the skin tear available. On 1/29/19 at 1 p.m. Staff B unit manager stated she could not find any skin assessments for the resident for the anorectal area or right lower extremity. 2. The MDS dated 12/12/18 assessed Resident #3 with impaired short and long term memory and severely impaired decision making skills. The resident required extensive staff assistance with bed mobility, transfers, ambulation in room, dressing, toilet use and personal hygiene and total assistance with bathing. The resident was frequently incontinent of bowel and bladder. A facility self report to the State agency with submission date of 12/16/18 revealed Resident #3's family reported another resident touched Resident #3's breast inappropriately. The resident's did not contain documentation of the incident and did not identify staff assessed the resident following the incident. On 1/29/19 at 2:12 p.m. Staff H LPN (licensed practical nurse) stated the resident's family brought the issue up to her. It was unclear when the incident occurred. Staff H stated she did not assess the resident because she knew the resident was OK.	F 684		

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F 684	Continued From page 7 Review of the facility resident to resident altercation policy revealed the policy did not direct staff to assess residents after alleged incident. The policy directed staff to complete an incident report. On 1/24/19, the surveyor requested all incident reports for the resident and there was no incident report regarding the incident. On 1/29/19 at 2:32 p.m. the Administrator stated it would be an expectation to assess the resident after an allegation.	F 684		
F 686 SS=D	Treatment/Svcs to Prevent/Heal Pressure Ulcer CFR(s): 483.25(b)(1)(i)(ii) §483.25(b) Skin Integrity §483.25(b)(1) Pressure ulcers. Based on the comprehensive assessment of a resident, the facility must ensure that- (i) A resident receives care, consistent with professional standards of practice, to prevent pressure ulcers and does not develop pressure ulcers unless the individual's clinical condition demonstrates that they were unavoidable; and (ii) A resident with pressure ulcers receives necessary treatment and services, consistent with professional standards of practice, to promote healing, prevent infection and prevent new ulcers from developing. This REQUIREMENT is not met as evidenced by: Based on clinical record review, observation and staff and resident interviews, the facility failed to ensure that 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 for two	F 686		

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F 686	Continued From page 8 of 16 residents reviewed (Residents #5 and #6). The facility identified a census of 76 residents. Findings include: 1. The Minimum Data Set (MDS) dated 10/25/18 assessed Resident #5 with a brief interview for mental status (BIMS) score of 15 (no cognitive impairment). The resident had no behavioral symptoms identified. The resident required extensive staff assistance with transfers, ambulation in room, dressing, toilet use and bathing. The resident had occasional bladder incontinence. Observation on 1/23/19 at 1:20 p.m. showed Resident #5 seated in a recliner in her room without pressure reduction. At that time, the resident stated she entered the facility a week ago to regain her strength. She stated she had a sores on her bottom; there was a patch on one of the sores but not the other one. She had waited for the nurse to come apply the other patch for quite awhile now. On the same date at 1:50 p.m. Resident #5 stated the patch was coming off that morning so Staff A LPN (licensed practical nurse) took it off that morning. Resident #5 had the sores when she came to the facility from the hospital and required the assistance of one staff to ambulate. At that time, Staff A assisted the resident to stand to apply the new Mepilex patch. Observation showed the left buttock without a patch. Staff A applied new patches to both buttocks. Both buttocks had small open areas surrounded by redness. The resident remained in the recliner without pressure reduction at 2:37 p.m. 3 p.m. and 4 p.m. observations. On 1/24/19 at 9:03 a.m., observation showed the resident in the recliner without pressure reduction at all	F 686		

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F 686	Continued From page 9 observations until 2:30 p.m. when the surveyor spoke with the facility regarding no pressure reduction in the recliner. A comprehensive evaluation of skin inspection and risk factors identified the resident with a Braden score of 19, indicating no risk for ulcers. However, an initial assessment dated 1/16/19 revealed the resident entered the facility with a 1 centimeter (cm) by 1 cm. Stage 2 pressure sore on the right buttock and a 1.5 cm. by 3 cm. Stage 2 pressure sore on the left buttock. The RN (registered nurse) analysis of risk factors and interventions recorded the skin needs to be inspected weekly for 4 weeks, change dressing every 3 days and as needed and her dressings to remain clean, dry and intact. A weekly wound documentation form dated 1/23/19 assessed the right buttock wound to measure 0.5 cm. by 1 cm. and the left buttock wound to measure 1.2 cm. by 2.5 cm. A nutritional assessment completed on 1/22/19 did not identify pressure sores. An updated nutritional assessment dated 1/23/19 revealed Resident #5 did not have pressure areas. The resident's care plan dated 1/18/19 identified she had the risk for skin breakdown due to occasional dribbling. The resident admitted with pressure sores to the right and left buttocks. The care plan directed staff to complete treatments as ordered and complete weekly skin assessments. The care plan did not identify pressure reduction to the recliner until an addendum added on 1/25/19 that directed staff to apply pressure reduction to her recliner. The care plan documented the resident could reposition self.	F 686		

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F 686	Continued From page 10 2. The MDS dated 1/18/19 assessed Resident #6 with a BIMS score of 11 (moderate cognitive impairment). The resident had no behavioral symptoms identified. The resident required extensive staff assistance with bed mobility, transfers, ambulation in room, dressing, toilet use, personal hygiene and bathing. The resident had frequent incontinence of bowel and bladder. Review of the January 2019 TAR revealed an order for Mepilex to the right upper buttock and to apply it in the morning every 3 days. There was no discontinuation order included. On 1/23/19 at 1:50 p.m. observation with Staff G LPN revealed no Mepilex in place on the resident's bottom. The area did not appear open but contained fragile skin. The resident said it hurts sometimes. A weekly wound form dated 1/23/19 identified the area as healed by Staff B unit manager. On 1/24/19 at 11:40 a.m. Staff B stated she completed the weekly wound form after the surveyor observed the right upper buttock area. Staff B stated the resident needs to continue with Mepilex to protect the area; the area is fragile. The resident has schizophrenia and rocks back and forth so the Mepilex is needed for protection. On 1/29/19 at 3:42 p.m. during the exit conference, Staff B denied saying the resident still needed Mepilex. At 4 p.m. of the same date Staff B stated what she meant was that she planned to have staff fax the physician to report the area had healed with a request to keep the order to protect the area due to the resident	F 686		

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F 686	Continued From page 11 rocking back and forth. Staff B produced a fax dated 1/24/19 stating the information.	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 interviews, the facility failed to ensure that the resident environment remained as free of accident hazards as possible and that each resident received adequate supervision and assistance devices to prevent accidents for one of nine residents reviewed for nursing supervision. Resident #1 required the assistance of one staff to transfer and ambulate (walk). The resident was known to not wait for assistance or use the call light and facility staff failed to increase resident monitoring despite the knowledge. The resident fell five times and developed two fractures within a month. The facility identified a census of 76 residents. Findings include: 1. The Minimum Data Set (MDS) dated 12/10/18 assessed Resident #1 with a brief interview for mental status (BIMS) score of 11 (moderate cognitive and memory impairment). The resident had an indicator of delirium; fluctuating	F 689		

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F 689	Continued From page 12	F 689		

disorganized thinking. The resident had no behavioral symptoms identified. Resident #1 required supervision with bed mobility, transfers, ambulation in the room and corridor, dressing, toilet use and personal hygiene. A balance during transitions and walking test revealed the resident as unsteady with all activities, but he could stabilize himself without staff assistance. The resident utilized a walker for mobility. The resident was continent of bowel and bladder. The resident had diagnoses that included dementia and Parkinson's disease. The resident had one fall without injury since admission to the facility on 11/26/18.

A care plan dated 11/26/18 identified the resident at risk for falls related to diagnoses of Lewy Body dementia and weakness. The resident was at risk due to the medications he took and due to noncompliance for waiting for assistance. The care plan also identified the resident as alert and oriented with episodes of forgetfulness especially with short term recall ability. The resident also had difficulty finishing his thoughts. The care plan identified the following directives on the following dates:
11/26/18 - The resident ambulated with assistance of one and a walker.
11/26/18 - Provide therapy services as ordered.
The care plan identified the resident needed assistance to use the toilet but did not document the presence of a toilet use plan.

Review of the resident's Incident Reports, Progress Notes and Care Plans revealed the following information:

a. On 11/26/18 at 10:20 p.m. staff found the resident on his floor next to the bed. The resident

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
TOUCHSTONE HEALTHCARE COMMUNITY	1800 INDIAN HILLS DRIVE SIOUX CITY, IA 51104

(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 689	Continued From page 13 stated he got up to close the door. Staff assessed the resident and documented a cause for concern. Staff contacted the on-call doctor then sent the resident to the ER (emergency room) and he returned to the facility. On 11/27/18, staff educated the resident to use the call light and wait for assistance as an intervention following the fall. b. On 12/4/18 at 1:15 p.m. staff found Resident #1 lying on his left side in front of the toilet with his upper body lying in the adjacent room. The resident stated he knelt over the toilet to vomit and lost his balance. Staff documented the resident did not receive injury. On 12/5/18, the facility added an intervention following the incident regarding a choking episode with ST (speech therapy) to evaluate his swallowing. Progress notes documented: - 12/10/18 at 5:07 p.m. Resident #1 required the assistance of one with a walker and was noncompliant and ambulated independently with the walker. - 12/11/18 7:47 p.m. Resident #1 was full weight bearing and used a walker and the assistance of one for ambulation. Staff noted him to be noncompliant twice this shift and walking unassisted in his room. - 12/15/18 at 11:06 a.m. Resident #1 was full weight bearing with the assistance of one and front wheel walker. Resident # 1 displayed noncompliance with asking for or waiting for help. - 12/15/18 at 8:57 p.m. Resident #1 ambulated independently with a walker and was not compliant with the assistance of one. - 12/16/18 at 10:05 p.m. Resident #1 needed the assistance of one but was noncompliant.	F 689		

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F 689	Continued From page 14 c. On 12/17/18 at 4:40 a.m. staff found the resident laying on his back in the bathroom floor with his walker on top of him. The resident stated he tried to grab the door knob and must have slipped. The resident stated he had ankle pain and rated the pain at 6 out of 10 with 10 being the worst imaginable pain. The resident could move the foot and his ankle appeared swollen. Staff documented predisposing situation factors of the fall as improper footwear and ambulating without assistance (the resident had bare feet). The resident refused transfer to the ER. Staff educated him on the use and purpose of the call light. Staff offered the resident nonskid socks. He stated he had some and didn't like to sleep in socks. Staff notified the Physician Assistant (PA) that Resident #1 refused further assessment at this time. The PA directed staff to monitor, elevate and ice as needed. At 12:03 p.m. staff received the OK for an X-ray of the left ankle. On the same date at 2 p.m. the resident's left ankle was x-rayed. A 4:19 p.m. X-ray report documented the resident had a left ankle fracture. The resident transported to ER for evaluation. At 6:35 p.m. the resident returned to the facility via facility bus wearing a Cam (supportive) boot. On 12/17/18, staff added an intervention on that Resident #1 had gripper socks to wear and to check on resident frequently through the night (Note - during interview on 1/29/19 at 1:08 p.m. the Director of Nursing {DON} identified "check frequently" as not having a specific timeframe. Staff should look in when going by the room). On 12/18/18 at 12:30 p.m. the resident had an appointment with an orthopedic surgeon and returned at 3:45 p.m. with orders for a pre-surgical appointment on 12/19/18 with same day surgery to repair the left ankle fracture on	F 689		

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F 689	Continued From page 15 12/20/18. d. On 12/20/18 at 6:05 a.m. staff went to answer the resident's call light and found him sitting on the floor in front of the room door with his wheelchair in front of him. The resident stated he needed the bathroom and used his wheelchair to walk and he slipped. The resident activated the call light but didn't want to wait for help. Staff educated the resident on waiting for help. On 12/20/18, staff documented the intervention for OT (occupational therapy) to work with resident on safe transfers and resident has been educated numerous times to wait for assistance and to use his call light. Resident #1 remained noncompliant with waiting for assistance. On 1/29/19 the Administrator gave the resident a paper that identified the resident as already receiving OT services when the fall occurred. e. On 12/30/18 at 12:52 p.m. staff heard the resident yell and looked down the hallway. Staff observed the resident lying on the floor outside his room. The resident reported a 10 pain level. His left leg appeared rotated outward and he appeared to have pain when his legs were moved. Staff called 911 and the resident transferred to ER for further evaluation. Staff assisted the resident 20 minutes prior with the urinal and last observed him in his recliner with his feet elevated and call light in reach. The call light was not on when the resident fell. The resident could not give an explanation of what he was doing when he self transferred from the recliner. During interview on 1/28/19 at 3:50 p.m. Staff I LPN (licensed practical nurse) stated she worked the day of the 12/30/18 incident. She heard a	F 689		

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F 689	Continued From page 16 scream and found that Resident #1 had gotten out of his recliner, walked and fell. The resident was in a lot of pain. Staff I stated she helped the resident with the urinal about 20 minutes prior to the fall and then left in the recliner covered with a blanket. The resident denied he needed anything else. Staff I stated the resident did seem more confused. He still tried to get up alone after he returned 12/17/18 following his ankle fracture. A hospital History and Physical dated 12/30/18 identified the resident with a left femur intertrochanteric fracture after a fall. The X-ray showed a trochanter fracture of the proximal left femur with moderate varus angulation. The resident also had a fall two weeks ago with a fracture to the left ankle. A hospital Discharge Summary dated 1/6/19 identified the resident fell and broke his left hip and two weeks prior fractured his left ankle and had ORIF (open reduction and internal fixation) done at the time. After admission the resident developed acute delirium from the pain and psychotropic medications. He underwent a left hemi-arthroplasty successfully and did very well for the first few days post op until he developed respiratory distress on 1/4/19 and passed away on 1/6/19. The summary identified the immediate cause of death as acute respiratory distress due to recurrent aspiration pneumonia, acute respiratory distress and acute delirium and an underlying cause of end stage dementia due to Lewy body dementia. During interview on 1/29/19 at 1:25 p.m. the Care Plan Nurse stated there was nothing on the care plan to direct staff to watch the resident closer. Staff educated the resident to use the call light.	F 689		

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F 804 SS=E	Nutritive Value/Appear, Palatable/Prefer Temp CFR(s): 483.60(d)(1)(2) §483.60(d) Food and drink Each resident receives and the facility provides- §483.60(d)(1) Food prepared by methods that conserve nutritive value, flavor, and appearance; §483.60(d)(2) Food and drink that is palatable, attractive, and at a safe and appetizing temperature. This REQUIREMENT is not met as evidenced by: Based on observation, record review and staff interview, the facility failed to provide hot food items at or above 140 degrees Fahrenheit (F) and cold items at or below 41 degrees (F) to promote palatability and reduce the potential for food borne illness. The facility identified a census of 76 residents. Findings include: 1. Observation showed on 1/24/19 at 8:34 a.m. Resident #8 received her breakfast meal. At the time it was served, the egg temperature measured 119.6 degrees per facility thermometer. During observation on 1/24/19 at 9:25 a.m. the dietary staff brought out 5 breakfast trays. After staff passed all but the last tray, the temperature was checked on the last tray.. The temperatures of the last tray tested per facility thermometer measured: a. Egg 104.7 degrees b. Ham 99.1 degrees c. Hot cereal 145.9 degrees d. White milk 47.3 degrees	F 804		

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F 804	Continued From page 18 During observation of the lunch tray delivery on 1/24/19 at 1:05 p.m. 5 trays came out per cart. The temperatures of the last tray tested per facility thermometer measured: a. Potato 145 degrees b. Meatloaf 118.7 degrees c. Milk 48.2 degrees Resident interviews revealed the following information: a. On 1/23/19 at 1:50 p.m. Resident #5 stated the food isn't always hot. b. On 1/23/19 at 1:05 p.m. Resident #4 sat at the bedside with a cold plate (cottage cheese and fruit) for lunch. The resident stated he got a cold plate for lunch and supper because the hot food is cold so he just asks for a cold plate. c. On 1/23/19 at 11:53 a.m. Resident #9 stated the food isn't always the right temperature.	F 804		

F 677

Immediate corrective action:

Resident #6's care plan was updated to reflect toileting plan 1/24/19.

Resident #7's care plan was updated to reflect toileting plan 1/24/19.

Action as it applies to others:

All residents audited to ensure toileting needs are addressed on care plan.

Education provided to Nurse leadership regarding ensuring toileting needs are addressed on resident care plans.

Education provided to direct care staff regarding assisting residents with toileting.

Date of completion: 2/25/19

Recurrence will be prevented by:

Weekly audits of resident care plans will be completed to ensure toileting is addressed x4 weeks. The results of these audits will be brought to QAPI Committee for review and recommendation.

The correction will be monitored by:

DON/Designee

F684

Immediate corrective action:

Resident #4 order for medicated cream was received and has been followed since 11/26/18.

Resident #4 has refused assessment of the skin impairments to his anorectal area staff will continue to attempt assessment and refusals will be documented.

Resident #3 passed away 12/20/18.

Action as it applies to others:

Skin sweep conducted of all units to ensure residents were assessed for any skin impairments.

Skin sheets started for any skin impairments to ensure weekly follow up documentation.

Education provided to nursing staff regarding skin impairment identification and monitoring system.

Date of completion: 2/25/19

Recurrence will be prevented by:

Weekly audits skin sheets will be completed x4 weeks to ensure skin impairments are being assessed on a weekly basis. The results of these audits will be brought to QAPI committee for review and recommendation.

The correction will be monitored by:

DON/Designee

F 686

Immediate corrective action:

Resident #5 has a pressure reduction cushion present in recliner since 1/23/19.

Resident #5 RD assessment has been updated to address pressure areas.

Resident #6 is receiving dressings as ordered.

Action as it applies to others:

All residents that are assessed as at risk for skin breakdown were audited to ensure pressure reduction devices are in place.

Education provided to nursing staff regarding the use of pressure reduction devices.

Education provided to licensed nurses regarding dressings as ordered.

RD responsible for incorrect documentation was removed from facility.

Date of completion: 2/25/19

Recurrence will be prevented by:

Weekly audits of pressure reduction devices and wound care dressings will be completed to ensure they are in place as ordered or care planned.

Weekly audits of RD nutritional needs assessments will be completed to ensure skin impairments are recognized on the assessment.

The results of these audits will be brought to QAPI Committee for review & recommendation.

The correction will be monitored by:

DON/Designee

F 689

Immediate corrective action:

Resident #1 discharged from facility 12/30/18.

Action as it applies to others:

Residents who are assessed as at risk for falls audited to ensure appropriate fall interventions are care planned.

QIO contacted to explore additional education related to fall interventions.

Education will be provided to licensed nurses regarding when and how to increase resident supervision when indicated. Staff will receive this education prior to their next shift worked.

Date of completion: 2/15/19

Recurrence will be prevented by:

Weekly audits of falls and care planned interventions will be completed x4 weeks to ensure that appropriate interventions were in place and followed. The results of these audits will be brought to QAPI committee for review and recommendation.

The correction will be monitored by:

DON/Designee

F 804

Immediate corrective action:

Hot and cold food/beverage items are being served at the appropriate temperatures.

Action as it applies to others:

New thermal bases and lids were purchased to hold heat for room tray service.

Cold Items will be stored in an ice bath until they are delivered to residents.

Education provided to dietary staff regarding hot and cold item storage and delivery.

Date of completion: 2/25/19

Recurrence will be prevented by:

Weekly audits of room trays will be completed x4 weeks to ensure appropriate temperatures. The results of these audits will be brought to QAPI committee for review & recommendation.

The correction will be monitored by:

Administrator/Designee