STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	165197	A. BUILDING _____ B. WING _____	06/27/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CEDAR FALLS HEALTH CARE CENTER	1728 WEST EIGHTH STREET CEDAR FALLS, IA 50613

(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: 07/30/19	F 000	Please See attached Plan of Correction.	
VKK	The following deficiencies relate to the facility's annual health survey and investigation of incident #83898. (See Code of Federal Regulations (42CFR) Part 483, Subpart B-C.) Complaint #80874 was not substantiated.			
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	F 623		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Debbie Dirks, LNHA | TITLE: Administrator | (X6) DATE: 07/30/2019

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 623	Continued From page 1 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 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	F 623		

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F 623	Continued From page 2 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. §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 Long Term Care Ombudsman office of resident transfers to the hospital for four of four residents reviewed. (Resident #2, #12, #20 & #26). The facility census was 56 residents. Findings include: 1. Clinical record review revealed Resident #20	F 623		

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F 623	Continued From page 3 was transferred from the facility to the hospital and admitted on 5/16/19 for treatment and discharged from the hospital and returned to the facility on 5/19/19. During interview on 6/26/19 at 8:30 a.m., the Administrator stated a report was sent at the end of each month to the Long Term Care Ombudsman office to report all transfers and discharges from the facility for that month, review of the report for May 2019 did not contain the name and transfer date of the resident. 2. Clinical record review revealed Resident #26 transferred from the facility to the hospital and was admitted on 4/1/19 for treatment and discharged from the hospital and returned to the facility on 4/3/19. The facility report to the Long Term Care Ombudsman office for April 2019, failed to contain the residents name and transfer date. 3 Resident #12 was transfer to the local hospital on 5/11/19 and returned on 5/15/19. Progress notes from 5/11-15/19 lacked documentation regarding Ombudsman notification. 4 Resident #2 was transferred to the local hospital on 11/6/18 and returned on 11/20/18. Progress notes from 11/7-20/19 lacked documentation regarding Ombudsman notification.	F 623		
F 625 SS=B	Notice of Bed Hold Policy Before/Upon Trnsfr CFR(s): 483.15(d)(1)(2)	F 625		

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F 625	Continued From page 4 §483.15(d) Notice of bed-hold policy and return- §483.15(d)(1) Notice before transfer. Before a nursing facility transfers a resident to a hospital or the resident goes on therapeutic leave, the nursing facility must provide written information to the resident or resident representative that specifies- (i) The duration of the state bed-hold policy, if any, during which the resident is permitted to return and resume residence in the nursing facility; (ii) The reserve bed payment policy in the state plan, under § 447.40 of this chapter, if any; (iii) The nursing facility's policies regarding bed-hold periods, which must be consistent with paragraph (e)(1) of this section, permitting a resident to return; and (iv) The information specified in paragraph (e)(1) of this section. §483.15(d)(2) Bed-hold notice upon transfer. At the time of transfer of a resident for hospitalization or therapeutic leave, a nursing facility must provide to the resident and the resident representative written notice which specifies the duration of the bed-hold policy described in paragraph (d)(1) of this section. This REQUIREMENT is not met as evidenced by: Based on clinical record review and staff interview, the facility failed to notify the resident and or resident representative of bed hold for four of four residents reviewed. (Resident #12, #2, #20, and #26). The facility census was 56 residents. Findings include:	F 625		

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F 625	Continued From page 5 1. The Detailed Census Report indicated Resident #12 was discharged to the local hospital on 5/11/19 and returned 5/15/19. The progress notes from 5/11-15/19 lacked documentation of bed hold notification. 2. The Detail Census Report indicated Resident #2 was discharged to the local hospital on 11/6/18 and returned 11/20/18. The progress notes from 11/7-20/18 lacked documentation of bed hold notification. Resident #2 discharged to the local hospital on 6/14/19 and returned 6/20/19. The progress notes from 6/14-20/10 lacked documentation of bed hold notification. During interview on 6/26/19 at 7:25 a.m., the Director of Nursing (DON), revealed they did not provide bed hold notification, but hope to implement it at a staff meeting. 3. Clinical record review revealed Resident #20 transferred to the hospital and admitted for treatment on 5/16/19 and returned to the facility on 5/19/19. Clinical record lacked documentation the resident or resident representative was offered a Bed Hold. 4. Clinical record review revealed Resident #26 transferred to the hospital and admitted for treatment on 4/1/19 and returned to the facility on 4/3/19. Clinical record lacked documentation the resident or resident representative was offered a Bed Hold.	F 625		
F 644 SS=B	Coordination of PASARR and Assessments CFR(s): 483.20(e)(1)(2)	F 644		

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F 644	Continued From page 6 §483.20(e) Coordination. A facility must coordinate assessments with the pre-admission screening and resident review (PASARR) program under Medicaid in subpart C of this part to the maximum extent practicable to avoid duplicative testing and effort. Coordination includes: §483.20(e)(1)Incorporating the recommendations from the PASARR level II determination and the PASARR evaluation report into a resident's assessment, care planning, and transitions of care. §483.20(e)(2) Referring all level II residents and all residents with newly evident or possible serious mental disorder, intellectual disability, or a related condition for level II resident review upon a significant change in status assessment. This REQUIREMENT is not met as evidenced by: Based on clinical record review and staff interviews, the facility failed to care plan specialized services documented in the PASRR (Pre Admission Screening and Resident Review) Level 2 for one of 20 residents reviewed. (Resident #34). The facility reported a census of 56 residents. Findings include: 1. Clinical record review revealed Resident #34 with a PASRR determination date of 6/2/16. Review of specialized services indicated a need for a psychiatrist to evaluate the effectiveness of psychotropic medication. The resident's current care plan lacked the start date of service and the duration of the service.	F 644		

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F 645	Continued From page 7	F 645		
F 645 SS=D	PASARR Screening for MD & ID CFR(s): 483.20(k)(1)-(3) §483.20(k) Preadmission Screening for individuals with a mental disorder and individuals with intellectual disability. §483.20(k)(1) A nursing facility must not admit, on or after January 1, 1989, any new residents with: (i) Mental disorder as defined in paragraph (k)(3)(i) of this section, unless the State mental health authority has determined, based on an independent physical and mental evaluation performed by a person or entity other than the State mental health authority, prior to admission, (A) That, because of the physical and mental condition of the individual, the individual requires the level of services provided by a nursing facility; and (B) If the individual requires such level of services, whether the individual requires specialized services; or (ii) Intellectual disability, as defined in paragraph (k)(3)(ii) of this section, unless the State intellectual disability or developmental disability authority has determined prior to admission- (A) That, because of the physical and mental condition of the individual, the individual requires the level of services provided by a nursing facility; and (B) If the individual requires such level of services, whether the individual requires specialized services for intellectual disability. §483.20(k)(2) Exceptions. For purposes of this section- (i)The preadmission screening program under paragraph(k)(1) of this section need not provide	F 645		

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F 645	Continued From page 8	F 645		

for determinations in the case of the readmission to a nursing facility of an individual who, after being admitted to the nursing facility, was transferred for care in a hospital.
(ii) The State may choose not to apply the preadmission screening program under paragraph (k)(1) of this section to the admission to a nursing facility of an individual-
(A) Who is admitted to the facility directly from a hospital after receiving acute inpatient care at the hospital,
(B) Who requires nursing facility services for the condition for which the individual received care in the hospital, and
(C) Whose attending physician has certified, before admission to the facility that the individual is likely to require less than 30 days of nursing facility services.

§483.20(k)(3) Definition. For purposes of this section-
(i) An individual is considered to have a mental disorder if the individual has a serious mental disorder defined in 483.102(b)(1).
(ii) An individual is considered to have an intellectual disability if the individual has an intellectual disability as defined in §483.102(b)(3) or is a person with a related condition as described in 435.1010 of this chapter.
This REQUIREMENT is not met as evidenced by:
Based on clinical record review and staff interview, the facility failed to submit one of 14 residents reviewed for a Level II PASSR evaluation when the resident had a condition change that required the evaluation. (Resident #57). The facility census was 56 residents.

Findings include:

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F 645	Continued From page 9 1. Clinical record review revealed Resident #57 had an admission date of 7/31/17 with a Level I PASRR (Preadmission Screening and Resident Review) completed on 7/31/17. Under "Mental Illness" it was marked "No" indicating the resident had no Major Mental Illness and the result of the Level I PASRR was "Negative" indicating no Level II PASRR screening was required. The Electronic Medical Record revealed a diagnosis list contained Major Depressive Disorder, Recurrent and review of physician orders and the current Medication Administration Record revealed the resident on a antidepressant medication with a start date of 9/19/18. During interview on 6/26/19, the Corporate Nurse Consultant acknowledged the diagnosis of Major Depressive Disorder, Recurrent should have triggered a Level I PASRR to be resubmitted and would have called for a Level II PASRR.	F 645		
F 689 SS=J	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 observation, record review, facility policy and staff interviews the facility failed to ensure that each resident receives adequate	F 689		

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F 689	Continued From page 10 supervision to prevent elopement for 1 of 13 residents (Resident #48), identified by the facility at increased risk for elopement, who exited the facility unsupervised, which resulted in an immediate jeopardy to residents health and safety. The facility reported a census of 56 residents. 1. Resident #48 had a Minimum Data Set (MDS) assessment dated 5/9/19, that documented a diagnosis of anxiety disorder, Schizophrenia and Schizoaffective disorder, bipolar type and a score of 4 of 15 on a BIMS (brief interview for mental status) test which indicated severely impaired cognition. The MDS documented no wandering and independent with ambulation in room and corridor. A care plan dated as initiated 4/29/19 identified a focus area titled resident is an elopement risk/wanderer as evidenced by disoriented to place, impaired safety awareness, resident wanders aimlessly with interventions that included attempt to distract from wandering by offering pleasant diversions, structured activities food, conversation, television, book of which resident prefers. A revision date of 6/4/19 established a goal that the resident will not leave facility unattended through the review date. Interventions include that included if resident expresses desire to leave facility due to missing friends/family, assist with calling family/friends. Intervene to assure safety and notify nurse if notice resident is attempting to remove Wander Guard device. Invite to scheduled activities. Resident my have staff or responsible party to go outside. Encourage to be properly dressed for inclement weather if resident insists on going outside. Elopement Risk form and/or face sheet with	F 689		

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F 689	Continued From page 11	F 689		

photo is placed in the Elopement Book at each nurses station. Repeat Wandering and at Risk for Elopement assessment routinely and with significant change in condition. Wander Alert-wander guard applied, check placement and function every shift.

A Progress note dated 6/2/19 at 3:55 p.m., documented Staff B (licensed practical nurse) observed resident sitting on the couch in the lobby at 3:45 p.m. Staff A (certified nursing assistant) was in room A1 doing a 1-1 with a resident, Staff A asked if someone would sit with the resident while Staff A went to the kitchen for ice. Staff B sat in room A1 for less than 5 minutes. When Staff B and Staff A switched back Staff A observed out the window that resident was outside. Staff A and Staff B asked if resident was OK, and where they were going. Resident stated "You cant touch me". Staff A and Staff B both stated "We wont". Staff A using a calming speech and redirection to convince resident to follow staff back inside. Resident reassured by promising they could talk to the social worker on Monday. "I want to go home. I want to go to my house on 22nd street. I don't want to be trapped here". Calming speech and redirection to get resident to come back in with Staff B and Staff A. Wander guard in place and functioning. Head to toe assessment complete. No abnormal findings.

An incident summary with no date, documented on Sunday 6/2/19 between 3:45 p.m., and 3:50 p.m., resident was observed in the front facility parking lot by Staff A. The resident had a BIMS score of 4, for which indicated severely impaired for decision making abilities. Staff A saw the resident from the window of room A1 and upon arriving outside to redirect the resident with Staff

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F 689	Continued From page 12	F 689		

B, the resident had opened a door to a van sitting in the parking lot belonging to another resident family member. Resident was dressed in pants and a light weight long sleeved shirt with tennis shoes on. Resident had 4 wheeled walker with as well. The outside temperature at the time the resident was noted to be outside was 75 degrees Fahrenheit. No rain or inclement weather noted. Staff A and Staff B immediately went outside to accompany the resident back into the facility. Resident was noted to be a bit upset but did not resist retuning to the building. Head to toe assessment of resident completed by Staff B, with no injuries noted. Proper placement and function of resident wander guard verified at this time. Wander guard system and door alarms checked for proper functioning as well. Staff re-education provided on elopement policy and procedures.

A Wandering and at Risk for Elopement form dated 6/2/19, identified the resident with a score of 9 for which indicated resident is at moderate risk for wandering.

A Wandering and at Risk for Elopement form dated 4/11/19, identified the resident with a score of 10, for which indicated resident is at moderate risk for wandering.

Review of the Alarm Protocol with an issued date of 6/25/19, had a purpose to maintain residents safety by responding to door alarms and assessing the reason for the alarm. Guidelines include:
*Staff are expected to respond to ALL door alarms at All times.
*The following steps will be taken when a door alarm sounds.

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 689	Continued From page 13 1. The alarm panel will be checked by staff to identify which door is sounding. 2. Staff will respond to the door alarm, to assess the cause of the sounding alarm, including a visual assessment of the area outside of the door. 3. If the cause of the sounding alarm is not identified, staff will conduct a visualized resident count and document the resident count using the daily census sheet. 4. The Missing Resident Protocol will be implemented by staff in the event that a resident is observed outside the secured doors or if the resident count is inaccurate. During an interview on 6/24/19 at 3:42 p.m., Staff A (certified nursing assistant) stated that she was doing a 1-1 on a resident in room A1, for which is the east side of the south hallway, facing the parking lot, she stated that the resident wanted a glass of ice so she asked Staff B (licensed practical nurse) to take over the 1-1 while she ran to the kitchen to get some ice. Staff A stated as she was going by the smokers door (south door on the center hallway) alarms were sounding and she didn't think anything about the alarms sounding and proceeded to go by the A-B nurses station (on the east side of the facility) and passed right by the wander guard door alarm panel (on the north wall of the A-B nurses station) and walked into the resident room when Staff A looked out the window facing the parking lot and saw a resident attempting to get into a van. Staff A ran out of the room and yelled at Staff B that a resident was in the parking lot outside. Staff A and Staff B went and pushed the codes on the left and right side of the front exit doors to silence the alarms and proceeded to go outside and persuade the resident back into the facility.	F 689		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	165197	A. BUILDING _____ B. WING _____	06/27/2019

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F 689	Continued From page 14	F 689		

Staff A admitted that she had failed to look at the wanderguard panel on the north wall behind the A-B nurses station and just felt it was the door that the smokers were coming in.

During an interview on 6/24/19 at 3:45 p.m., Staff B stated that the resident was last seen sitting in A-B lobby area on a love seat. Staff B stated that Staff A asked if she would take over the 1-1 on the resident in room A1. Staff A came back to the room with in 1-2 minutes and Staff B walked out of the room, got to the front entrance of the facility and Staff A came running out of A1 room and stated that a resident was outside in the parking lot attempting to get in a van. Staff A and Staff B went out the front doors after punching in the codes to silence the alarms and proceeded to assist the resident back into the facility.

During an environmental tour on 6/24/19 at 4:00 p.m., the Administrator demonstrated the actions the staff and resident had taken and the route the resident took on 6/2/19 after exiting the facility and assisted to measure the distances as described below:

The distance from where the resident was last seen to the parked van in the parking lot was 73 surveyor steps, from the parked van, stepping over a 5 1/2 inch cement parking curb was 36 more surveyor steps to a 4 lane highway (Hudson Road) for which cars and delivery trucks were traveling by at 35 mile per hour.

The Nation Weather Service Forecast Office for 6/2/19, documented the temperature at 77 degrees Fahrenheit.

The immediate jeopardy was abated on

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F 689	Continued From page 15 6/25/2019. The facility abated the IJ by reeducating staff on the process for elopement and establishing written process for staff when the alarm sounds. The facility also conducted elopement drills.	F 689		
F 698 SS=D	Dialysis CFR(s): 483.25(l) §483.25(l) Dialysis. The facility must ensure that residents who require dialysis receive such services, consistent with professional standards of practice, the comprehensive person-centered care plan, and the residents' goals and preferences. This REQUIREMENT is not met as evidenced by: Based on observation, clinical record review and staff interview, the facility failed to complete nursing assessments and monitoring of resident's before and after going to outpatient dialysis for two of two residents receiving dialysis services (Resident #34 & #57) The facility census was 56 residents. Findings include: 1. The Admission Record dated 6/26/19, documented Resident #34 had diagnosis of end stage renal disease and type II diabetes mellitus with diabetic chronic kidney disease. The Minimum Data Set (MDS)assessment indicated the resident received dialysis. During interview on 6/25/19 at 1:27 p.m., Staff C, registered nurse, RN revealed the resident went out for dialysis on Tuesday, Thursday and Saturday.	F 698		

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F 698	Continued From page 16 Review of residents medication record, treatment record and clinical record for the month of June revealed no completed pre and post dialysis assessments on dialysis days. During interview on 6/26/19 at 7:22 a.m., the Director of Nursing (DON) reveled there was no assessments completed. 2. Clinical record review revealed Resident #57 had diagnoses of End Stage Renal Disease requiring the resident to have hemodialysis completed three times a week on Monday, Wednesday and Friday. Clinical record review lacked documentation of a pre-dialysis and/or post-dialysis assessment completed after hemodialysis.	F 698		
F 727 SS=B	RN 8 Hrs/7 days/Wk, Full Time DON CFR(s): 483.35(b)(1)-(3) §483.35(b) Registered nurse §483.35(b)(1) Except when waived under paragraph (e) or (f) of this section, the facility must use the services of a registered nurse for at least 8 consecutive hours a day, 7 days a week. §483.35(b)(2) Except when waived under paragraph (e) or (f) of this section, the facility must designate a registered nurse to serve as the director of nursing on a full time basis. §483.35(b)(3) The director of nursing may serve as a charge nurse only when the facility has an average daily occupancy of 60 or fewer residents. This REQUIREMENT is not met as evidenced by:	F 727		

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F 727	Continued From page 17 Based on facility schedule review and staff interview, the facility failed to provide eight consecutive hours of Registered Nurse, RN, coverage seven days a week. The facility census was 56 residents. Findings include: Review of the nursing schedule for May 1, 2019 through May 31, 2019, revealed no RN coverage for a eight hour time period on May 27, 2019. RN coverage was for 4.25 hours only. During interview on 6/24/19 at 2:22 p.m., the business office manager stated the facility only had 4.25 hours of RN coverage on that day. During interview on 6/25/19 at 1:46 p.m., the business office manager stated that two nurses had switched days and one nurse was an Licensed Practical Nurse and the other nurse was a Registered Nurse and the director of nursing confirmed the facility failed to have 8 hours of RN coverage for May 27, 2019.	F 727		
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 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	F 812		

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F 812	Continued From page 18 gardens, subject to compliance with applicable safe growing and food-handling practices. (iii) This provision does not preclude residents from consuming foods not procured by the facility. §483.60(i)(2) - Store, prepare, distribute and serve food in accordance with professional standards for food service safety. This REQUIREMENT is not met as evidenced by: Based on observation and staff interview, the facility failed to maintain a clean and sanitary kitchen. The facility census was 56 residents. Findings include: 1. Observation on 6/24/19 at 9:50 a.m., revealed ten gray colored cookie sheets in a cabinet ready for use with carbon on the outside and inside of the sheets. Cupboards on the north side of the dining room had eight door and 12 drawers covered with a red sticky substance and brownish dried debris on the outside of the cabinet doors and drawers. During interview on 6/25/18 at 12:20 p.m., the dietary manager confirmed the doors and drawers required cleaning and placed them on the cleaning schedule.	F 812		

This plan of correction does not constitute an admission or agreement by Cedar Falls Health Care Center of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. This plan of correction is prepared solely because it is required by State and Federal Law. This plan of correction shall serve as Cedar Falls Health Care Center's credible allegation of compliance. All deficiencies will be corrected no later than by ~~July 30, 2019~~. 6/25/19

F 623

- On 7-24-19 the Ombudsman was notified of discharges for residents #2, #12, #20 & #26.
- Residents discharged/transferred to the hospital since 3-4-19 were reviewed and Ombudsman notification completed.
- Administrator was re-educated on 7-23-19 by Regional Nurse Consultant regarding where in PCC to find data listing discharges and hospital transfers. Administrator/Designee will notify Ombudsman of discharges and transfers every 30 days.
- Administrator/Designee will audit compliance with Ombudsman notification monthly x 3 months. Results of all audits will be taken to the monthly QAPI meeting for review/discussion. Administrator is responsible for ongoing compliance.
- Compliance date is July 30, 2019.

F625

- The Director of Nursing notified the responsible party for residents #2, #12, #20 & #26 of the bed hold policy on or before 7-25-19.
- Residents that left the facility for medical or therapeutic leave since 6/27/19 have been contacted and given the facility bed hold policy information.
- Licensed Nurses were re-educated on 7/25/19 on requirements of notification of bed hold policy for the resident at the time of transfer to a hospital or therapeutic leave.
- The Administrator/Designee will perform audits for compliance with bed hold policy weekly x12 weeks. Results of audits will be taken to the facility QAPI meeting for review/discussion. The Administrator is responsible for ongoing compliance.
- Compliance date is July 30, 2019

F644

- Care plan was reviewed and updated with PASRR compliant data on or before 7-29-19 for resident #34
- Care plans for residents with Level II PASRR will be reviewed and updated with PASRR complaint data on or before 7-29-19.
- Regional Nurse Consultant provided re-education on 7-25-19 for Social Services and Director of Nursing regarding requirements of PASRR Compliant care plans.
- The Social Services Director/Designee will perform monthly audits x3 months to ensure residents PASRR care plans are updated with current PASRR information. Results of audits will be taken to the facility QAPI meeting for review/discussion. The Social Services Director is responsible for ongoing compliance.
- Compliance date is July 30, 2019.

F 645

- On June 29, 2019 the Social Services Director added the diagnosis of Major Depressive Disorder to resident # 57 PASRR and resubmitted it to Ascend.
- On or before 7-29-19 the Social Services Director reviewed, updated and resubmitted PASRR data to Ascend for residents with change of condition since 3-1-19.
- On 6-29-19 the Social Services Director was re-educated on PASRR diagnosis and change of condition requirements.
- The Social Services Director/Designee will audit resident change of condition and PASRR updates weekly x 12 weeks. Results of audits will be taken to facility QAPI meeting for review/discussion. The Social Services Director is responsible for ongoing compliance.
- Compliance date is July 30, 2019.

F689

- Resident #1 was identified in the front parking area and returned to the center by the licensed nurse on 06/02/19. An assessment was conducted by the licensed nurse on 06/02/19 and no injury was identified. The physician and the family were notified of the event on 06/02/19 by the licensed nurse.

- An immediate validation of resident census was completed by the nursing staff on 06/02/19 and all residents were accounted for. An audit of residents at risk for elopement was completed by the Director of Nursing/designee by 06/03/19 to validate required elements of documentation were in place (care plan, photo, elopement assessment). Outstanding items identified were corrected at the time of identification. An audit of environmental modifications was completed on 06/03/19 by the Maintenance Director/designee to validate alarms were sounding as intended.
- Facility staff were re-educated by the Administrator/designee regarding the centers policy for abuse on 06/03/19. Facility staff were re-educated regarding the centers process for elopement management by the Director of Nursing on 06/03/19. Elopement drills have been conducted to test the staff's response to sounding alarms and elopement on 06/03/19 at 1330, 06/03/19 at 1615, 06/03/19 at 0445, 06/04/19 at 0810 by the Director of Nursing/designee. A written process has been developed outlining instructions for staff when an alarm sounds, and staff have been educated to and provided copies of this process.
- The facility Administrator and the Director of Nursing will complete audits daily for 7 days, weekly for 3 weeks, and monthly for 2 months to validate staff continue to follow the centers policy for abuse, follow the centers process for elopement and respond to alarms as required. The results of these audits will be brought to the QAPI meeting monthly for 3 months and as needed for review and recommendations. The Administrator is responsible for ongoing compliance.
- Date of compliance 06/25/19

F 698

- Pre and post dialysis assessments are being completed for residents # 34 & #57.
- New residents on dialysis will have pre and post dialysis assessments completed.
- On 7-25-19 the licensed nurses were re-educated regarding dialysis assessments.
- The Director of Nursing/Designee will audit dialysis assessments 3x/week for one month then weekly x 8 weeks. Results of audits will be taken to the facility QAPI meeting for review/discussion. The Director of Nursing is responsible for ongoing compliance.
- Compliance date is July 30, 2019.

F 727

- The registered nurse responsible for RN coverage is specified on the daily schedule sheet by the Director of Nursing.
- Nurse schedule reviewed and verified RN coverage is scheduled daily by the Director of Nursing.

- On 6-28-19 the licensed nurses were re-educated regarding procedure for trading shifts.

- The Director of Nursing/Designee will audit daily sheets weekly x 12 weeks. Results of audits will be taken to the facility QAPI meeting for review/discussion. The Director of Nursing is responsible for ongoing compliance.

- Compliance date is July 30, 2019

F812

- New cookie sheets were ordered and received on 6-28-19. On 6-25-19 the Dietary Manager cleaned and degreased the cupboards on the north side of the dining room.

- On 6-25-19 the kitchen daily cleaning schedule was updated to include the dining room cupboards and monitoring of carbon build up on cookware.

- The kitchen staff was re-educated on cleaning schedule and monitoring condition of cookware on or before 7-29-19.

- The Dietary Manager/Designee will audit cleanliness and condition of cookware weekly x 12 weeks. Results of audits will be taken to the facility QAPI meeting for review/discussion. The Dietary Manager is responsible for ongoing compliance.

- Compliance date is July 30, 2019.