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	165397	A. BUILDING ______ B. WING ______	08/20/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HEARTLAND CARE CENTER	**604 EAST FENTON** **MARCUS, IA 51035**

(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_________ The following deficiencies relate to the annual recertification and state licensure survey completed 8/12/19-8/20/19. See code of Federal Regulations (42CFR) Part 482, Subpart B-C.	F 000		
F 580 SS=D	Notify of Changes (Injury/Decline/Room, etc.) CFR(s): 483.10(g)(14)(i)-(iv)(15) §483.10(g)(14) Notification of Changes. (i) A facility must immediately inform the resident; consult with the resident's physician; and notify, consistent with his or her authority, the resident representative(s) when there is- (A) An accident involving the resident which results in injury and has the potential for requiring physician intervention; (B) A significant change in the resident's physical, mental, or psychosocial status (that is, a deterioration in health, mental, or psychosocial status in either life-threatening conditions or clinical complications); (C) A need to alter treatment significantly (that is, a need to discontinue an existing form of treatment due to adverse consequences, or to commence a new form of treatment); or (D) A decision to transfer or discharge the resident from the facility as specified in §483.15(c)(1)(ii). (ii) When making notification under paragraph (g)(14)(i) of this section, the facility must ensure that all pertinent information specified in §483.15(c)(2) is available and provided upon request to the physician. (iii) The facility must also promptly notify the	F 580		

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.

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F 580	Continued From page 1 resident and the resident representative, if any, when there is- (A) A change in room or roommate assignment as specified in §483.10(e)(6); or (B) A change in resident rights under Federal or State law or regulations as specified in paragraph (e)(10) of this section. (iv) The facility must record and periodically update the address (mailing and email) and phone number of the resident representative(s). §483.10(g)(15) Admission to a composite distinct part. A facility that is a composite distinct part (as defined in §483.5) must disclose in its admission agreement its physical configuration, including the various locations that comprise the composite distinct part, and must specify the policies that apply to room changes between its different locations under §483.15(c)(9). This REQUIREMENT is not met as evidenced by: Based on record review and staff interview, the facility failed to report a change of condition or incident to the family and/or physician for 2 of 13 residents reviewed (Resident #2 and #25). The facility reported a census of 27 residents. Findings include: 1. According to the Minimum Data Set (MDS) assessment dated 5/12/19/18 Resident #2 scored 4 on the Brief Interview for Mental Status (BIMS) indicating severe cognitive impairment. The resident depended on staff for eating and toilet use. The resident's diagnoses included septicemia, urinary tract infection (UTI) and dementia.	F 580		

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A facsimile (fax) dated 7/31/19 notified the physician the resident choked while assisted with her supper meal when eating pureed mandarin oranges. Her face turned red and she coughed after about 5 seconds. The resident had an emesis in her napkin. Staff gave the resident some thickened water and she coughed up a lot of clear phlegm. The resident did this a few more times and finally settled down and received more thickened water and wanted to go to bed. She did not want any more supper.

The clinical record lacked any documentation the facility notified the resident's family about the incident.

During an interview on 8/15/19 at 11:40 a.m. the Director of Nursing (DON) stated she talked to the nurse who documented the choking episode and she did not notify the family. The DON stated she should have notified them.

2. According to the Minimum Data Set (MDS) assessment dated 6/13/19 Resident #25 scored 4 on the Brief Interview for Mental Status (BIMS) indicating severe cognitive impairment. The resident's diagnoses included cancer.

The Care Plan identified the resident at risk for weight loss due to a diagnoses of cancer. The interventions included to monitor weights.

A weight record for June 2019 documented the resident weighed 147#.
A weight record for July 2019 documented the resident weighed 147#.
A weight record for August 2019 documented the resident weighed 138.6# (an 8.4# or 5.71% loss)

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F 580	Continued From page 3 with 5% or greater loss in 1 month indicating a significant loss. The clinical record lacked documentation the physician or the family were notified of the significant weight loss. During an interview on 8/14/19 at 12:45 p.m. the DON stated she could find no indication the the physician or family were notified of the weight loss. During an interview on 8/20/19 at 12:46 p.m. the DON stated she did not have a policy on weight losses or gains, but if a resident lost or gained 5# or more she expected a reweigh and if they reweighed the same, the physician and family notified.	F 580		
F 623 SS=D	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.	F 623		

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§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 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

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F 623	Continued From page 5 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. §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 record review and staff interview the	F 623		

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facility failed to notify the long term care ombudsman of resident transfers for 3 of 3 residents reviewed for hopitalization (Resident #2, #16, and #25). The facility reported a census of 27 residents,

Findings include:

1. According to the Minimum Data Set (MDS) assessment, dated 7/6/19, Resident #2 discharged to the hospital. Another MDS dated 7/9/19 documented the resident's return.

A Notice of Transfer Form to the Long Term Care Ombudsman with an initial date of 4/18/19 and faxed 7/30/19 did not contain the resident's transfer.

2. According to the Minimum Data Set (MDS) assessment, dated 4/25/19, Resident #16 discharged to the hospital. Another MDS dated 4/30/19 documented the resident's return.

A Notice of Transfer Form to the Long Term Care Ombudsman with an initial date of 4/18/19 and faxed 7/30/19 did not contain the resident's transfer.

3. According to the Minimum Data Set (MDS) assessment, dated 7/5/19, Resident #25 discharged to the hospital. Another MDS dated 7/11/19 documented the resident's return.

A Notice of Transfer Form to the Long Term Care Ombudsman with an initial date of 4/18/19 and faxed 7/30/19 did not contain the resident's transfer.

During an interview on 8/13/19 at 2:22 p.m. the

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F 623	Continued From page 7 Director of Nursing stated she did not think they notified the ombudsman of transfers.	F 623		
F 625 SS=D	Notice of Bed Hold Policy Before/Upon Trnsfr CFR(s): 483.15(d)(1)(2) §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 record review and staff interview the facility failed to assure the resident or his representative received information regarding the	F 625		

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F 625	Continued From page 8 bed hold prior to transfer to the hospital for 1 of 3 residents reviewed, (Resident #25). The facility reported a census of 27 residents. Findings include: According to the Minimum Data Set (MDS) assessment, dated 7/5/19, Resident #25 discharged to the hospital. Another MDS dated 7/11/19 documented the resident's return. The facility provided a Bed Hold Notice documenting a verbal to reserve the room received 7/24/19. The notice documented according to the facility bed hold policy, verification of room bed hold must be within a 24 hour period from the time the resident admitted to the hospital. The clinical record lacked a bed hold notice to the resident or his representative within the time frame parameters for the resident's admission to the hospital. During an interview on 8/14/19 at 9:20 a.m. the Administrator stated he didn't know why the bed hold not been done prior to 7/24/19. He said nursing usually did them.	F 625		
F 637 SS=D	Comprehensive Assessment After Signifcant Chg CFR(s): 483.20(b)(2)(ii) §483.20(b)(2)(ii) Within 14 days after the facility determines, or should have determined, that there has been a significant change in the resident's physical or mental condition. (For purpose of this section, a "significant change" means a major decline or improvement in the resident's status that will not normally resolve	F 637		

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F 637	Continued From page 9 itself without further intervention by staff or by implementing standard disease-related clinical interventions, that has an impact on more than one area of the resident's health status, and requires interdisciplinary review or revision of the care plan, or both.) This REQUIREMENT is not met as evidenced by: Based on interviews and record review the facility failed to complete a Significant Change Assessment on a resident who had an improvement in his activities of daily living for one of one residents reviewed, (Resident #15). The facility reported a census of 27. Findings include: The Minimum Data Set (MDS) completed with an Assessment Reference Date (ARD) of 6/23/19 showed Resident #15 had a Brief Interview for Mental Status (BIMS) score of 8, indicating moderate cognitive impairment. The resident required extensive assistance of two staff members for bed mobility. The resident required extensive assistance of one staff with toileting and transfers. The resident had diagnosed peripheral vascular disease and Diabetes Mellitus. The MDS with an ARD of 3/24/19 indicated the resident was total dependence of two staff for transfers, bed mobility, and toileting. The form labeled Nurses Progress Note dated from 6/17/19 through 6/23/19 indicated the resident used a standing mechanical lift for transfers with the extensive assistance of two staff for transfers. The section showing activities of daily living functional status indicated the	F 637		

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resident's condition had improved.

During an interview on 8/14/19 at 1:17 PM the MDS Nurse, Registered Nurse, when asked how she deceided to complete a significant change MDS she stated if a resident had a decline in three areas the Director of Nursing and the MDS Nurse would make the decision together.

F 644 SS=D Coordination of PASARR and Assessments
CFR(s): 483.20(e)(1)(2)

§483.20(e) Coordination.
A facility must coordinate assessments with the pre-admission screening and resident review (PASARR) program under Medicaid in subpart C of this part to the maximum extent practicable to avoid duplicative testing and effort. Coordination includes:

§483.20(e)(1)Incorporating the recommendations from the PASARR level II determination and the PASARR evaluation report into a resident's assessment, care planning, and transitions of care.

§483.20(e)(2) Referring all level II residents and all residents with newly evident or possible serious mental disorder, intellectual disability, or a related condition for level II resident review upon a significant change in status assessment.
This REQUIREMENT is not met as evidenced by:
Based on interviews and record reviews the facility failed to resubmit a Preadmission Screening and Record Review (PASRR) for a resident that had a significant change in mental status for one of one resident's reviewed (Resident #18). The facility reported a census of

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27.

Findings include:

The Minimum Data Set (MDS) completed with an Assessment Reference Date (ARD) date of 7/7/19 showed a Brief Interview for Mental Status (BIMS) score of 15, indicating intact cognition. The resident had diagnoses Spina Bifida, Schizophrenia, and Anxiety with major Depression. The resident used antipsychotics and antidepressant seven of the seven days in the lookback period.

Resident #18 had a PASRR completed on 1/13/17. The section regarding Major Mental Illnesses indicated the resident did not have any major mental illnesses. The section regarding Mental Disorders listed Depression (mild or situational) as the resident's only diagnosis. The section labeled Psychotropic Medications indicated the resident had not been prescribed psychoactive medications at the time.

The Resident's Diagnosis Record Sheet showed a diagnosis of Major Depression with Anxiety, recurrent dated 4/2/18 and diagnosis Schizophrenia dated 4/16/18.

A pharmacy recommendation fax dated 7/2/19 indicated the resident used Latuda (antipsychotic) 20 milligrams (mg) for the diagnosis of Schizophrenia and Lexapro (antidepressant) 20 mg for the diagnosis of Depression.

During an interview on 8/14/19 at 1:52 PM, the Director of Nursing reported she would expect a PASRR to be completed for a significant change or if a resident went to a psychatric hospital.

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F 655 SS=D	Baseline Care Plan CFR(s): 483.21(a)(1)-(3) §483.21 Comprehensive Person-Centered Care Planning §483.21(a) Baseline Care Plans §483.21(a)(1) The facility must develop and implement a baseline care plan for each resident that includes the instructions needed to provide effective and person-centered care of the resident that meet professional standards of quality care. The baseline care plan must- (i) Be developed within 48 hours of a resident's admission. (ii) Include the minimum healthcare information necessary to properly care for a resident including, but not limited to- (A) Initial goals based on admission orders. (B) Physician orders. (C) Dietary orders. (D) Therapy services. (E) Social services. (F) PASARR recommendation, if applicable. §483.21(a)(2) The facility may develop a comprehensive care plan in place of the baseline care plan if the comprehensive care plan- (i) Is developed within 48 hours of the resident's admission. (ii) Meets the requirements set forth in paragraph (b) of this section (excepting paragraph (b)(2)(i) of this section). §483.21(a)(3) The facility must provide the resident and their representative with a summary of the baseline care plan that includes but is not limited to: (i) The initial goals of the resident. (ii) A summary of the resident's medications and dietary instructions.	F 655		

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(iii) Any services and treatments to be administered by the facility and personnel acting on behalf of the facility.
(iv) Any updated information based on the details of the comprehensive care plan, as necessary.
This REQUIREMENT is not met as evidenced by:
Based on staff interviews and record review the facility failed to provide a written summary of the baseline care plan to the resident or the resident's representative for 6 of 9 residents reviewed (Residents #9, #26, #129, #11, #16 and #24). The facility reported a census of 27.

Findings include:

1. The Minimum Data Set (MDS) completed for Resident #9 with an Assessment Reference Date (ARD) of 6/2/19 showed a Brief Interview for Mental Status (BIMS) score of 7, indicating severe cognitive impairment. The resident had an entry date of 1/28/19.

The resident's chart lacked documentation of a written summary of the baseline care plan provided to the family.

During an interview on 8/13/19 at 11:12 AM, the Director of Nursing (DON) reported the resident or her family probably did not get a written summary provided to them.

2. The MDS completed for Resident #26 with an ARD of 7/26/19 showed a BIMS score of 15, indicating intact cognition. The resident had an entry date of 6/19/19.

The resident's chart lacked documentation of the

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F 655	Continued From page 14 resident or the resident's family had received a written summary of the baseline care plan. During an interview on 8/13/19 at 11:16 AM, the DON reported the resident or the resident's family probably did not receive a written summary of the baseline care plan. 3. The MDS completed for Resident #129 with an ARD of 8/13/19 showed a BIMS score of 10, indicating moderate intact cognition. The resident admitted to the facility on 7/31/19. Resident #129's Care Plan showed an initiation date of 7/31/19. The resident's chart lacked documentation of the resident or the resident's family had received a written summary of the baseline care plan. During an interview on 8/13/19 at 11:16 AM, the DON reported the resident or family probably did not get a written summary of the baseline care plan. 4. According to the MDS assessment, dated 6/6/19 Resident #11 admitted to the facility on 5/31/19. The resident had a Care Plan initiated 5/31/19.	F 655		

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The clinical record lacked documentation the facility had provided the resident or her representative a written summary of the baseline care plan.

During an interview on 8/14/19 at 11:00 a.m. the DON stated they had not provided the resident or her representative a summary of the baseline care plan.

5. According to the MDS assessment, dated 12/28/18 Resident #16 admitted to the facility on 12/17/19.

The resident had a Care Plan initiated 12/17/18.

The clinical record lacked documentation the facility had provided the resident or his representative a written summary of the baseline care plan.

During an interview on 8/13/19 at 2:22 p.m. the DON stated she did not have any documentation on giving a baseline care plan summary to the resident or his representative.

6. According to the MDS assessment, dated 7/18/19 Resident #24 admitted to the facility on 7/10/19.

The clinical record contained a baseline care plan dated 7/10/19.

The clinical record lacked documentation the facility had provided the resident or her representative a written summary of the baseline care plan.

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F 655	Continued From page 16 During an interview on 8/14/19 at 9:14 a.m. the DON stated they had not provided the resident or the resident's representative a written summary of the baseline care plan.	F 655		
F 657 SS=E	Care Plan Timing and Revision CFR(s): 483.21(b)(2)(i)-(iii) §483.21(b) Comprehensive Care Plans §483.21(b)(2) A comprehensive care plan must be- (i) Developed within 7 days after completion of the comprehensive assessment. (ii) Prepared by an interdisciplinary team, that includes but is not limited to-- (A) The attending physician. (B) A registered nurse with responsibility for the resident. (C) A nurse aide with responsibility for the resident. (D) A member of food and nutrition services staff. (E) To the extent practicable, the participation of the resident and the resident's representative(s). An explanation must be included in a resident's medical record if the participation of the resident and their resident representative is determined not practicable for the development of the resident's care plan. (F) Other appropriate staff or professionals in disciplines as determined by the resident's needs or as requested by the resident. (iii)Reviewed and revised by the interdisciplinary team after each assessment, including both the comprehensive and quarterly review assessments. This REQUIREMENT is not met as evidenced by: Based on observations, record review, staff and family interviews the facility failed to revise the	F 657		

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resident care plan to correctly reflect the needs of 5 residents reviewed, (Residents # 7, #15, # 9, #26 and #1), and failed to assure the care plan was reviewed and revised with the interdisciplinary team after each assessment for 2 of 13 residents reviewed, (Resident #16 and #24). The facility reported a census of 27.

Findings include:

1. The Minimum Data Set (MDS) completed for Resident #7 with an Assessment Reference Date (ARD) of 6/2/19 indicated the resident had long and short term memory problems. The resident had diagnoses Alzheimer's Disease and depression.

During an observation on 8/12/19 at 12:35 PM noted bilateral side rails to the resident's bed.

The resident's current Care Plan did not include the use side rails.

2. The MDS completed for Resident #15 with ARD of 6/23/19 showed a Brief Interview for Mental Status (BIMS) score of 8, indicating moderate cognitive impairment. The resident required extensive assistance of two staff members for bed mobility. The resident required extensive assistance of one staff with toileting and transfers. The resident had diagnosed peripheral vascular disease and Diabetes Mellitus.

During an observation on 8/12/19 at 3:02 PM noted side rails to bilateral sides of the resident's bed.

Resident #15's current Care Plan lacked

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documentation regarding the use of side rails. The care plan intervention dated 5/6/18 noted the resident required the assistance of one with toileting and peri-care as needed. The intervention dated 5/6/18 noted the resident required two assists with ambulation, one to ambulate the resident and one to follow with the wheelchair. The intervention dated 4/8/19 stated the resident required a standing mechanical lift with staff assistance two for transfers. The resident required the full mechanical lift as needed (PRN) with the assist of two staff.

The Nurses Progress Note dated from 6/17/19 through 6/23/19 indicated the resident used a standing mechanical lift for transfers with the extensive assistance of two staff for transfers. The section showing activities of daily living functional status indicated the resident's condition had improved. The additional comments suggested the resident had some changes in the past quarter. The resident no longer transferred with the full-body mechanical lift. The resident now only required one staff with the standing mechanical lift. The form noted the resident's improvement was related to the healing of sores to his toes and the resident had worked with therapy to improve his strength. The resident was able to ambulate short distances with restorative and was tolerating that well.

3. The MDS completed for Resident #9 with ARD of 6/2/19 showed a BIMS score of 7, indicating severe cognitive impairment. The resident had an entry date of 1/28/19. The resident had diagnoses of hypertension and edema.

During an interview on 8/12/19 at 2:11 PM, the resident's family member reported the resident

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now used a machine to transfer.

Resident #9's Care Plan included a problem dated 1/28/19 and noted the resident required assistance for some ADL's. The interventions included;
1. The resident was independent with toileting after being dressed and undressed.
2. Sometimes the resident needed stand by assistance (SBA) with ambulation in the halls.
3. The resident could be independent in the room with a front wheeled walker (FWW) after dressing and undressing.

During an observation on 8/12/19 at 2:18 PM noted side rails to bilateral sides of the resident's bed.

The Care Plan lacked documentation regarding the use of side rails.

4. The MDS completed for Resident #26 with an ARD of 7/26/19 showed a BIMS score of 15, indicating intact cognition. The resident had an entry date of 6/19/19. The resident had diagnosed Diabetes Mellitus and Neurogenic bladder.

The resident's Care Plan dated 6/19/19 stated the resident required a peg (G) tube for adequate nutritional intake with the intervention of site care of the G-tube daily or as ordered.

During an interview on 08/13/19 at 10:32 AM, Staff B, Licensed Practical Nurs reported the resident no longer had a G-tube.

A Facsmilie dated 8/7/19 noted the resident had the G-tube removed on 8/6/19.

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5. The MDS completed for Resident #18 with an ARD date of 7/7/19 showed a BIMS score of 15, indicating intact cognition.

During an observation on 8/12/19 at 11:16 AM noted side rails to bilateral sides of the bed.

The resident's Care Plan lacked documentation regarding the use side rails.

During an interview on 8/14/19 at 1:15 PM, the MDS Nurse, stated any immediate change to a resident needs put in care plan update book that is taken to report every shift. The MDS Nurse said she updates the care plans every quarter. She stated she knows a lot of them are not updated. The MDS Nurse said she would expect the foley and feeding tube to be discontinued from the care plan if they were no longer in use. The MDS Nurse stated the use of side rails should be on the care plan.

6. According to the MDS assessment, dated 12/28/18 Resident #16 admitted to the facility on

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F 657	Continued From page 21 12/17/18. The resident had a Care Plan initiated on 12/17/18. The clinical record documented care conferences were held on 3/28/19 and 6/20/19 per the Care Plan Conference Summary forms. The clinical record lacked documentation the facilty held a care conference after the resident admitted and completion of the comprehensive assessment 12/28/18. During an interview on 8/13/19 at 2:22 p.m. the Director of Nursing (DON) stated she did not think they had a care conference regarding the resident until March. 7. According to the MDS assessment dated 7/18/19 Resident #24 admitted to the facility 7/10/19, and demonstrated long and short term memory problems and severely impaired skills for daily decision making. The resident's diagnoses included pneumonia, septicemia and a seizure disorder. The clinical record contained a baseline care plan dated 7/10/19 and a comprehensive care plan. The clinical record lacked documentation of a care plan conference. During an interview on 8/14/19 at 9:13 a.m. the DON and MDS coordinator stated they had not had a formal care plan conference (35 days from admit). During an interview on 8/20/19 at 12:56 p.m. the DON stated they should hold a care conference	F 657		

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F 657	Continued From page 22 around 21 days from the resident admission.	F 657		
F 684 SS=J	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 observation, record review and staff interview, the facility failed to provide adequate assessment and timely intervention for 1 of 13 residents reviewed, (Resident #25) which resulted in an immediate jeopardy to residents health and safety. The facility reported a census of 27 residents. Findings include: According to the Minimum Data Set assessment, dated 6/13/19 Resident #25 scored 4 on the Brief Interview for Mental Status indicating severe cognitive impairment. The resident's diagnoses included cancer. The current Care Plan with a problem onset date of 6/5/19 identified the resident with an open lesion of the left ear, with a goal for the area to remain free of infection. The interventions included the resident needed wound care as ordered by the physician, administer pain medication prior to initiating treatment, daily	F 684		

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F 684	Continued From page 23 observation of skin with routine care, monitor for changes in skin status that may indicate worsening of the open lesion and notify the physician. The care plan identified the resident experienced pain in the left ear due to ulcerated area during treatment changes. The interventions included to evaluate pain using the 1-10 scale or the PAINAD (pain scale) score, administer pain medication as ordered, 1 hour prior to the treatment, and monitor for worsening of symptoms and report to the physician. The Nurse's Notes dated 6/5/19 at 4:50 p.m. documented the resident admitted to the facility. The resident had open ulcers to the left ear related to radiation for cancer. The Nurse's Notes dated 6/6/19 at 12:40 p.m. documented a routine dressing change started and noted a large amount of pus and eschar (dead) tissue sloughed off. Consulted with the wound nurse at the hospital and a telephone order received. A Physician's Telephone Order dated 6/6/19 directed to clean the resident's left ear with normal saline, pack with Aquacel AG (sterile dressing with silver), cover with a 4 by 4 dressing every day and as needed. A Physician's Telephone Order dated 6/12/19 directed left ear dressing change 2 times a day. An untitled facility wound form dated 6/24/19 documented the resident had a wound of the left ear and behind the ear. The documentation included the wound not measurable due extreme pain. The wound had large amount green/black	F 684		

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drainage with a yellow base. The wound treated with silver cel packed into the wound and covered with a dressing.

A Physician's Telephone Order dated 6/24/19 directed to discontinue left ear 2 times a day dressing changes and change every day and as needed due to increased pain.

A Patient Transfer Form dated 6/29/19 documented the resident had been very restless and complained of severe head pain. The resident had brain cancer and a necrotic wound of the left ear related to radiation. The resident noted to have apnea every time he fell asleep then bolted up gasping for air and clearing his throat, with a pulse oxygen reading of 70-75% while attempting to rest. Needed assessment for pain management and apnea.

The Emergency Department (ED) Notes dated 6/29/19 at 2:02 p.m. documented the resident brought by ambulance for evaluation and treatment of pain management and respiratory depression. The resident had a wound behind the left ear, a combination of cancer and radiation. An Ear Nose and Throat (ENT) physician consulted and felt conservative management with dressings would be best.

A hospital Plan of Care dated 6/30/19 at 5:34 a.m. documented the left ear wound remained covered with dressing, and reinforced the dressing as needed.

The Discharge Summary dated 7/1/19 at 9:10 a.m. documented the diagnoses included glioblastoma, narcotic induced respiratory depression, and altered level of consciousness.

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The physical exam documented the skin warm to touch, the left ear dressed and had been clean per nursing. The discharge instructions did not include treatment orders.

The Nurse's Notes dated 7/1/19 at 11:28 a.m. documented a call out to the wound center related to the resident's right ear dressing not on when returned from the hospital.

A Resident Assessment Post-Hospital Stay dated 7/1/19 documented the left ear the same as pre-hospital, no change.

The Nurse's Notes dated 7/2/19 at 4 a.m. documented the resident had been restless. The resident did not complain of pain but placed his hand by his ear frequently.

Physician's Orders for 7/1/19-7/31/19 signed by the physician on 7/3/19 included to cleanse the left ear with normal saline, pack with Aquacel Ag, and cover with 4 by 4 and tape daily.

A Treatment Administration Record (TAR) for 7/1-31/19 showed the resident orders included to cleanse the left ear with normal saline, pack with Aquacel AG and cover with 4x4 and tape daily. The TAR showed the treatment for 7/1, 7/2, 7/3, 7/4, and 7/5/19 with initials circled. A PRN Record for 7/2, 7/3, 7/4/19 documented the treatment to the ear held awaiting wound clarification. On 7/5 the TAR documented cleaning the ear.

A Patient Transfer Form dated 7/5/19 documented the resident was in the hospital the previous week and since return they had waited for a wound consult, which they scheduled for

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Monday, 7/8/19. Staff had been cleaning to the best of their ability within the residents pain tolerance. When they cleaned the wound white bugs noted. The clinical record lacked any additional documentation of cleaning the ear from 7/1-5/19.

A hospital surgery report with date of service 7/5/19 at 5:07 p.m. documented the resident presented with ulcer on the left ear for debridement and removal of maggots. The surgery performed included irrigation and debridement of the left side of the nose and left ear ulcer and removal of foreign bodies (maggots). The resident received intravenous sedation and a regional air block (local anesthetics to block sensations of pain), debridement and removal of foreign body.

The Nurse's Notes dated 7/5/19 at 6:30 p.m. documented the resident returned to the facility from the hospital with new orders for treatment to the left ear. Staff called for a nurse to the resident's room at 9:30 p.m. The resident pulled the dressing from the hospital off with maggots noted in the ear and on the resident's shirt. The resident stated he pulled the bandage off because his ear itched. The resident went to the hospital by ambulance.

A Patient Transfer Form Dated 7/5/19 documented the resident had an ear ulceration related to radiation/cancer and developed maggots when left open to air and draining. The resident seen by the surgeon that day and the left ear debrided. The resident returned to the facility and ate supper. At 9:30 p.m. the resident pulled the dressing off of the ear and maggots were noted coming out of his ear and on the dressing.

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A hospital surgery report with date of service 7/6/19 at 9:36 a.m. documented the resident with an ulcer of the left ear had maggots within the ulcer and had debridement the previous day and additional maggots were found and the resident was again brought to the operating room for evacuation of additional maggots. The resident had general anesthesia. Preoperative antibiotics were given. They performed manual removal of the maggots. Anterior to the ear, maggots were extruded from the tissues. The area cleansed with soap and water and irrigated with Dakin's solution to kill any additional eggs or maggots. Suction used to remove additional maggots that had crawled into the ear canal and thoroughly irrigated.

A Wound Assessment per Wound Nurse dated 7/9/19 documented the resident had a 5.5 by 3 cm wound in the back of the ear and the canal had a 5 by 3 cm wound.

A Physician Transfer Order Report printed 7/11/19 documented the resident returned from the hospital with orders for antibiotics and dressing changes.

During an observation on 8/12/19 at 10:35 a.m. the resident laid in bed asleep with a bandage over his left ear. At 1:10 p.m. the resident sat in the recliner with his feet up. The dressing remained to the left ear. At 3:30 p.m. the resident laid in bed toward the right, with the dressing intact.

During observation on 08/13/19 at 8:06 a.m. the resident laid in bed with a dressing covering the entire left ear area. At 11:38 a.m. the ear area

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remained covered. At 2:15 p.m. the ear area covered.

During observation on 8/14/19 at 8:08 a.m. the resident's ear area remained covered.

During an interview on 8/14/19 at 10:23 a.m. the Director of Nursing (DON) stated when the resident returned from the hospital 7/1/19 he did not have a dressing on the left ear. They called to the wound center. She said the ear was draining and that would indicate a need to clean the site. She stated it should have been cleaned and probably dressed. She thought they had an order to leave open after the hospital return 7/1 but had not found it. At 2:04 p.m. the DON stated during the time the ear was left open to air the resident did go outside.

During an interview on 8/15/19 at 8:05 a.m. the DON stated she found no order for the ear to be left open to air, only the documentation by the nurse that he returned from the hospital without a dressing.

During an interview on 8/15/19 at 8:17 a.m. the Administrator stated they found nothing on the hospital information with an order to leave the ear open to air. He said he was sure there were some flies (at that time) it was seasonal, but nothing out of the ordinary.

During an interview on 8/15/19 at 8:29 a.m. Staff B Licensed Practical Nurse (LPN) stated when the resident returned from the hospital on 7/1/19 he did not have a dressing. She said she called the hospital and they left the dressing off so it could dry up, not documented. The wound nurse had not seen the resident while in the hospital or

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made recommendations to leave the wound open. She called the wound center for clarification and they held the dressing. The resident was going to be seen by the wound nurse, but she did not know when. She said they normally call again the next business day if they do not hear back. She said she did have concerns about the ear draining. She stated if the wound drained she cleaned it otherwise she left it alone. She said she was sure there were some flies that time of year, but she did not see any around the resident's ear. She worked 7/5/19 and the resident had drainage and yellow exudate visible on the ear and she went to clean it and saw the maggots kind of swimming around in it.

During an interview on 8/15/19 at 8:55 a.m. Staff C, LPN stated the resident had no dressing to the ear area when he came back from the hospital, so they held the dressing until he could be seen by the wound nurse, she thought July 15th. She stated she worked 7/3/19 and the ear was soupy and she felt a dignity issue so she put an ABD dressing over it. She did nothing else other than cover it. She does not know how long the dressing remained on and did not document any of this. She felt the ear should be covered. She did not note flies in the facility, but the family did take the resident outside.

During an interview on 8/15/19 at 9:20 a.m. Staff D, Certified Nursing Assistant (CNA) stated she remembered seeing the resident without the dressing on around that time but did not see it drain. She stated they had some flies in the facility but nothing out of the ordinary.

During an interview on 8/15/19 at 9:25 a.m. Staff A, CNA stated she assisted the resident out of the

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van the day he returned from the hospital without a dressing. She said she told the nurses he needed a dressing to his ear. She said the ear had a bad odor so she didn't get close enough to see if it was draining. She said it didn't smell that way when it had a dressing on it. She was with Staff B when she saw the maggots. She said she thought Staff B was trying to get rid of the smell, it was pretty powerful. She said the family took him outside the day before. She did not see flies around him.

During an interview on 8/15/19 at 9:32 a.m. Staff F, CNA stated the area looked terrible and it stunk. She did not see anything coming out of it but it looked liked it had puss, and white milky looking. She said she saw 1-2 flies in his room and he complained about flies in his room.

During an interview on 8/15/19 at 10:30 a.m. the Wound Nurse stated she saw the resident in January while the resident was at home and recommended a treatment with a dressing. She was supposed to follow up with the resident but they kept canceling appointments. She did not see the resident again until 7/10/19 (during the hospitalization after the maggot infestation) when the doctor asked her to teach the facility staff how to do a dressing change. She did not see the resident during the 6/29-7/1/19 hospital stay. She said there would have to be extenuating circumstances not to treat and cover a draining wound. She said a wound with a dressing could get maggots, but the fact the resident did not have them when he had a dressing on, and developed them when the area was not treated or dressed certainly showed it increased the risk for them.

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During an interview on 8/15/19 at 11:40 a.m. the DON stated when the resident admitted to the facility he had a cotton ball in his ear and a bandage behind his ear. She called the wound nurse about a treatment, because it drained and she knew he needed a treatment and dressing. She said the family had no complaints about the treatment, telling them whatever needed to be done. She stated it did have a strong odor without the dressing. She said she thought they got an order from the hospital to leave the area open to air, but apparently did not. She concurred the hospital nurse telephone report did not constitute an order. She called to get an order for a wound consult because she thought it needed a treatment, but did not ask to continue the treatment he had prior to the hospitalization. She said the appointment was scheduled for 7/8/19 and by that time the resident was in the hospital.

During an interview on 8/19/19 at 9:59 a.m. the resident's Physician stated he checked the ear wounds when the resident was in the hospital (6/29-7/1/19) and they were covered. He said the wounds should have continued to be treated and covered. The wound nurse had recommended the treatments he had prior to the 6/29/19 hospitalization and it was his understanding they would continue those. He said when you have a wound like that you treat it. He was not aware they had not been doing the treatments from the time he returned from the hospital until the resident came in with the maggots. He said the resident had eaten so they did a local anesthetic for the removal. When he came back again they used a general anesthetic so they could do a more thorough cleaning. He said it was possible to get a maggot infestation in a dressed wound,

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F 684	Continued From page 32 but it would have been much less likely. He had not seen a maggot infestation in a wound being treated and dressed. He said the resident was treated with antibiotics preemptively for the maggots. The facility abated the immediate jeopardy on 8/20/19 by implementing additional policies on the handling of new orders, enhanced their new order checklist, and staff education.	F 684		
F 690 SS=D	Bowel/Bladder Incontinence, Catheter, UTI CFR(s): 483.25(e)(1)-(3) §483.25(e) Incontinence. §483.25(e)(1) The facility must ensure that resident who is continent of bladder and bowel on admission receives services and assistance to maintain continence unless his or her clinical condition is or becomes such that continence is not possible to maintain. §483.25(e)(2)For a resident with urinary incontinence, based on the resident's comprehensive assessment, the facility must ensure that- (i) A resident who enters the facility without an indwelling catheter is not catheterized unless the resident's clinical condition demonstrates that catheterization was necessary; (ii) A resident who enters the facility with an indwelling catheter or subsequently receives one is assessed for removal of the catheter as soon as possible unless the resident's clinical condition demonstrates that catheterization is necessary; and (iii) A resident who is incontinent of bladder receives appropriate treatment and services to prevent urinary tract infections and to restore	F 690		

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continence to the extent possible.

§483.25(e)(3) For a resident with fecal incontinence, based on the resident's comprehensive assessment, the facility must ensure that a resident who is incontinent of bowel receives appropriate treatment and services to restore as much normal bowel function as possible.
This REQUIREMENT is not met as evidenced by:
Based on observation, interviews, and record review, the facility failed to complete appropriate incontinence care on a resident requiring staff assistance with incontinence care for one of one resident reviewed, (Resident #26). The facility reported a census of 27.

Findings include:

The Minimum Data Set completed with an Assessment Reference Date of 7/26/19 showed a Brief Interview for Mental Status score of 15, indicating intact cognition. The resident had an entry date of 6/19/19. The resident had diagnoses of Diabetes Mellitus and Neurogenic bladder.

During an observation on 8/12/19 at 11:31 AM noted Staff A, Certified Nurse's Aide (CNA), remove the resident's soiled pull-up and put on a new pull-up. Staff A changed gloves without hand hygiene. Staff A assisted the resident in a standing position. While the resident was standing, Staff A washed the resident's backside of the perineal area, then without completing hand hygiene or changing gloves cleaned the anterior perineal region of the resident. Staff A then removed gloves, pulled up the resident's pants and offered the resident to wash their

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F 690	Continued From page 34 hands. During an interview on 8/14/19 at 1:18 PM the MDS Nurse, stated she wouldn't expect a CNA to wash the backside of a resident's perineal area then wash the front side. The Nurse Aide Skills Checklist revised 8/02 for Provide Incontinent Care, indicated for the staff to clean a male by pushing back the foreskin - gently wash around the penis and scrotum. Return foreskin to its natural position. Then wash anal area, front to back with warm water or use disposable wipes then discard properly.	F 690		
F 700 SS=D	Bedrails CFR(s): 483.25(n)(1)-(4) §483.25(n) Bed Rails. The facility must attempt to use appropriate alternatives prior to installing a side or bed rail. If a bed or side rail is used, the facility must ensure correct installation, use, and maintenance of bed rails, including but not limited to the following elements. §483.25(n)(1) Assess the resident for risk of entrapment from bed rails prior to installation. §483.25(n)(2) Review the risks and benefits of bed rails with the resident or resident representative and obtain informed consent prior to installation. §483.25(n)(3) Ensure that the bed's dimensions are appropriate for the resident's size and weight. §483.25(n)(4) Follow the manufacturers' recommendations and specifications for installing	F 700		

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F 700	Continued From page 35 and maintaining bed rails. This REQUIREMENT is not met as evidenced by: Based on observations, interviews, and record review, the facility failed to explain the risks and benefits of the use of side rails to 2 of 8 residents reviewed (Residents #7 and #18). Findings include: 1. The Minimum Data Set (MDS) completed for Resident #7 with an Assessment Reference Date (ARD) of 6/2/19 indicated the resident had long and short term memory problems. The resident had diagnoses Alzheimer's Disease and depression. During an observation on 8/12/19 at 12:35 PM noted bilateral side rails to the resident's bed. Resident #7's clinical record lacked consent for use of side rails. During an interview on 8/13/19 at 3:57 PM, The Administrator stated he missed completing the consent and the resident did not have one. The Administrator reported the family comes into the facility frequently and would be able to get one soon. 2. The MDS completed for Resident #18 with an ARD date of 7/7/19 showed a Brief Interview for Mental Status score of 15, indicating intact cognition. During an observation on 8/12/19 at 11:16 AM noted side rails to bilateral sides of the bed.	F 700		

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F 700	Continued From page 36 Resident #18's clinical record lacked documentation of consent for the use of side rails. During an interview on 8/13/19 at 4:19 PM, the Administrator stated he might have missed the resident when updating the side rail consents as he did them on admission and the resident had been in the facility for a while. He stated he would visit with the resident and complete the consent with her. The form labeled Consent for Side Rails, dated 05/04, stated the policy of the facility was to use side rails only after an assessment and care planning deem it appropriate to treat the resident's medical symptoms and assist the resident in attaining or maintaining his or her highest practicable physical and psychosocial well-being, and other methods or interventions were inadequate.	F 700		
F 712 SS=E	Physician Visits-Frequency/Timeliness/Alt NPP CFR(s): 483.30(c)(1)-(4) §483.30(c) Frequency of physician visits §483.30(c)(1) The residents must be seen by a physician at least once every 30 days for the first 90 days after admission, and at least once every 60 thereafter. §483.30(c)(2) A physician visit is considered timely if it occurs not later than 10 days after the date the visit was required. §483.30(c)(3) Except as provided in paragraphs (c)(4) and (f) of this section, all required physician visits must be made by the physician personally.	F 712		

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§483.30(c)(4) At the option of the physician, required visits in SNFs, after the initial visit, may alternate between personal visits by the physician and visits by a physician assistant, nurse practitioner or clinical nurse specialist in accordance with paragraph (e) of this section.
This REQUIREMENT is not met as evidenced by:
Based on record review and staff interview the facility failed to assure residents were seen by a physician at least every 30 days for the first 90 days after admission, and at least every 60 days thereafter for 4 of 5 residents reviewed (Resident #2, #7, #16, and #18). The facility reported a census of 27 residents.

Findings include:

1. According to the Minimum Data Set (MDS) assessment dated 5/12/19 Resident #2 admitted to the facility on 2/14/18.

A Physician's Orders sheet showed the resident was seen by the physician on 2/14/19 and 5/24/19.

The clinical record lacked documentation the resident saw the physician between 2/14/19 and 5/24/19, a 99 day span.

2. According to the MDS assessment, dated 6/2/19 Resident #7 reentered the facility on 3/26/19.

Progress notes showed the resident was seen by the physician on 5/14/19.

A review of the clinical record 8/18/19 revealed the record lacked documentation of a physician

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F 712	Continued From page 38 visit since 5/14/19 (98 days). 3. According to the MDS assessment, dated 12/28/18, Resident #16 admitted to the facility on 12/17/19. A Physician's Orders sheet showed the resident was seen by the physician on 1/22/19 and 3/19/19. The clinical record lacked documentation the resident seen by a physician between 1/22/19 and 3/19/19, 56 days. A Certificate of Care Requirement form for the resident documented the attending physician would visit the resident every 30 days for the first 90 days and every 60 days thereafter. 4. According to the MDS assessment dated 7/7/19, Resident #18 reentered the facility on 2/13/19. A Progress Note dated 5/14/19 documented a physician visit. The clinical record lacked documentation of a physician visit between 2/13/19 and 5/14/19, a 90 day span. During an interview on 8/20/19 at 10:31 AM the Director of Nursing confirmed residents should have a physician visit every 30 days the first 90 days and every 60 days thereafter. She said it is difficult to accomplish that.	F 712		
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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§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

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F 758	Continued From page 40 beyond 14 days, he or she should document their rationale in the resident's medical record and indicate the duration for the PRN order. §483.45(e)(5) PRN orders for anti-psychotic drugs are limited to 14 days and cannot be 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 record review and staff interview the facility failed to assure orders for as needed (PRN) psychotropic drugs were limited to 14 days unless the physician documented a rationale for continuing and a duration for use for 1 of 5 residents reviewed, (Resident #11). The facility reported a census of 27 residents. Findings include: According to the Minimum Data Set assessment, dated 6/6/19, Resident #11 scored 11 on the Brief Interview for Mental Status indicating cognitive impairment. The resident's diagnoses included dementia, annxiety disorder and depression. The resident received antianxiety medications. The Medication Administration Record for 7/1-31/19 showed the resident had an order for Lorazepam (anti-anxiety) 0.5 mg 3 times a day as needed (PRN) with a start date of 6/14/19. The clinical record lacked any documentation of a rationale for continuing the medication or a duration for use. During an interview on 8/14/19 at 11:00 a.m. the Director of Nursing (DON) stated she found no	F 758		

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F 758	Continued From page 41 rationale for continuing the prn medication or a duration for it's use. During an interview on 8/20/19 at 12:19 p.m. the DON stated they did not have a facility policy regarding use of psychotropic medications, they tried to follow the regulation.	F 758		
F 805 SS=D	Food in Form to Meet Individual Needs CFR(s): 483.60(d)(3) §483.60(d) Food and drink Each resident receives and the facility provides- §483.60(d)(3) Food prepared in a form designed to meet individual needs. This REQUIREMENT is not met as evidenced by: Based on observation, record review and staff interview the facility failed to assure residents received therapeutic diets as prescribd for 1 of 13 residents reviewed, (Resident # 24). The facility reported a census of 27 residents, and identified 1 resident on a mechanical soft diet. Findings include: According to the Minimum Data Set assessment dated 7/18/19, Resident #24 demonstrated long and short term memory problems and severely impaired skills for daily decision making. The resident's diagnoses included pneumonia, septicemia and a seizure disorder. A North Hall Plates and Utensils form showed the resident on a mechanical soft diet. According to the menu for Tuesday 8/13/19 the mechanical soft diet included baked sweet potato,	F 805		

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	165397	A. BUILDING ______ B. WING ______	08/20/2019

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F 805	Continued From page 42 no skin. During an observation on 8/13/19 Staff I, Cook served the resident a sweet potato with the skin on. When asked after the resident received the meal, the Dietary Supervisor (DS) stated the resident should not have the skin on, and she removed the skin. During an interview on 8/13/19 at 1:35 p.m. the DS stated staff needed to follow the menu for individual diets. The facility Description of Recommended Diets dated 7/1/17 documented the mechanical soft diet was designed for individuls with difficulty swallowing and/or chewing foods.	F 805		
F 812 SS=D	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 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	F 812		

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F 812	Continued From page 43 standards for food service safety. This REQUIREMENT is not met as evidenced by: Based on observation and record review the facility failed to serve food under sanitary conditions for one meal. The facility reported a census of 27 residents. Findings include: The menu for Tuesday 8/13/19 included a baked sweet potato. During an observation on 8/13/19 during the noon meal service Staff I, Cook started prepping the sweet potatos using the tongs and cutting open with a knife. Then she used her fingernail to hold the potato in place while cutting 4 potatoes, then used her thumb and forefinger to hold the potatoes while cutting. After the meal service in the main dining room, some residents had eaten the potato skin. During an interview on 8/13/19 at 1:35 p.m. the Dietary Supervisor stated staff should not touch food with their bare hands. A facilty Glove-Ology policy documented the FDA Food Code stipulated no bare hand contact with ready to eat foods.	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	F 880		

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F 880	Continued From page 44 development and transmission of communicable 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.	F 880		

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F 880	Continued From page 45	F 880		

(v) The circumstances under which the facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct 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 observations, staff interviews and record review the facility failed to complete appropriate hand hygiene while providing cares to one of one resident reviewed (Resident #7). The facility reported a census of 27.

Findings include:

The Minimum Data Set with a completed Assessment Reference Date of 6/2/19 indicated the resident had long and short term memory problems. The resident had diagnoses Alzheimer's Disease and depression.

During an observation on 8/12/19 at 3:05 PM Staff A, Certified Nurses' Aide (CNA) washed the resident's front side of the perineal area. Then

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F 880	Continued From page 46 without completing hand hygiene or removing gloves, Staff A, comforted Resident #7 with her hand by rubbing the resident's face and arms. During an interview on 8/14/19 at 1:18 PM the MDS Nurse stated she would not expect the staff to remove their gloves and wash their hands before soothing a resident such a rubbing their face or arms. The form labeled Provide Incontinent Care dated 8/02 indicated for staff to remove gloves and wash their hands, then make resident comfortable.	F 880		