STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	165145	A. BUILDING _____ B. WING _____	09/18/2019

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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 000	INITIAL COMMENTS Correction date 10/18/19 The following deficiencies relate to the recertification survey and investigation of Complaints #85087 and #85534. Complaint #85087-C was not substantiated. Self- Report #85534-I was substantiated. Complaint #85783-C was substantiated. See the Code of Federal Regulations (42CFR) Part 483, Subpart B-C.	F 000		
F 678 SS=J	AMENDED 10/07/19 Cardio-Pulmonary Resuscitation (CPR) CFR(s): 483.24(a)(3) §483.24(a)(3) Personnel provide basic life support, including CPR, to a resident requiring such emergency care prior to the arrival of emergency medical personnel and subject to related physician orders and the resident's advance directives. This REQUIREMENT is not met as evidenced by: Based on record review, facility policy review, and staff interviews, the facility failed to provide cardiopulmonary resuscitation (CPR) - medical intervention used to restore circulatory and/or respiratory function that has ceased- immediately after finding a resident without pulse and respirations for 1 of 4 residents reviewed (Resident #185). The facility reported a census of 29 residents.	F 678	Past noncompliance: no plan of correction required.	

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

Administrator 10/9/19

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 678	Continued From page 1 A Minimum Data Set (MDS) with an assessment reference date (ARD) of 8/21/19, documented Resident #185 with a Brief Interview for Mental Status (BIMS) indicating moderate cognitive impairment. The MDS identified the resident required extensive assistance of two staff for bed mobility, transfers, dressing, and toilet use. The resident had diagnoses that included: heart failure, Chronic Obstructive Pulmonary Disease (COPD), and respiratory failure. Resident #185's admission record identified the resident as a "Full Code". A care plan with initiation date of 2/25/19 identified the resident's advanced directives as the resident with "full code status". The care plan directive to staff was "staff will intervene appropriately if resident should need cardiac resuscitation. Nursing Progress notes dated 8/31/19 at 9:14 a.m. and documented by Staff K LPN (licensed practical nurse) identified the entry type as "change of condition". The entry identified on that date at 7:05 a.m. Staff K was summoned to the resident room and found the resident without pulse or respirations. Staff K then went to the nurses station to check the resident's code status and call the physician for further direction. At 7:10 a.m. Staff k notified the physician of the resident's condition and full code status. After a minute or so of hesitation, the physician responded that it was probably too late. Staff k attempted to call the on call nurse and left a message. At 7:26 a.m. Staff K phoned the DON (director of nursing) of the situation. The DON instructed Staff K to start CPR and notify 911. Following the call to the DON, staff initiated CPR and called 911 (21	F 678		

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F 678	Continued From page 2 minutes after assessing the resident without pulse or respirations). At 7:30 a.m. the ambulance arrived and the resident transported to the hospital emergency room (ER) with CPR in progress. On 8/31/19 at 9:02 a.m. the DON documented she spoke with the hospital who informed her the resident expired at 8:27 a.m. On 9/11/19 at 12:24 p.m. Staff H certified medication aide (CMA) on 9/11/19 at 12:24 PM, revealed she last saw Resident #185 on 8/31/19 at about 5:30 AM. The resident talked per usual, skin color appeared normal and Staff H provided check and change cares on him. She reported she did not see any concerns with him. On 9/11/19 at 12:02 p.m. Staff B (CMA) revealed she walked into Resident #185 room on 8/31/19 at 7:05 AM, and noticed the Resident's eyes drooping. Staff B yelled his name and tried rubbing his chest. She reported the resident didn't respond. She stated when she found him he felt warm. She revealed she didn't know the resident's code status when she found him and Staff K (LPN) told her not to start CPR so the certified nurse aides (CNAs) then performed post-mortem cares. She then saw Staff K and the director of nursing (DON) talking on the phone and was told staff needed to start CPR because the resident "is a full code". Staff B and Staff K then proceeded to start CPR on Resident #185. Staff B did not know how much time passed between finding him and starting CPR, but stated it was awhile. During an interview with Staff L (CNA) on 9/17/19 at 8:49 AM, she revealed she assisted with post-mortem cares that included checking and changing the resident. she stated he was still	F 678		

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F 678	Continued From page 3 warm to touch during cares. She revealed the CNAs provided cares prior to staff starting CPR. During an interview with Staff M (CMA) on 9/17/19 at 9:25 AM, revealed on 8/31/19 when she assisted with post-mortem cares for Resident #185 had no changes in skin color and was warm to touch when providing cares sometime after 7:00 AM. During an interview with Staff K LPN on 9/11/19 at 2:35 PM revealed she thought staff called her to Resident #185's room around 7:05 AM on 8/31/19 and found the resident not breathing and without a pulse. Staff K stated it was apparent he was gone (dead) and said she panicked. She stated she checked the resident's code status and saw he was a full code. She called the physician because she wanted further direction as how to proceed. She revealed that the physician never gave an answer either way. Staff K informed surveyor that she should initiate CPR right away on anyone that is a full code. If God forbid it ever happened again, she would handle the situation differently. Staff K denied ever seeing the facility's CPR policy prior to incident. A Basic Life Support form dated 12/6/18 identified that Staff K successfully completed the cognitive and skills evaluation with the curriculum of the American heart Association Basic Life support Program. The form identified that Staff K was certified and approved to perform basic life support (CPR) as of 12/6/18. On 9/17/19 at 10:12 AM, the resident's primary care physician revealed she received a page from the facility at 7:26 AM on 8/31/19 and the physician returned the call shortly after. The physician informed Staff K that it had been a	F 678		

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F 678	Continued From page 4 really long time since 7:05 AM when the resident was found without pulse and respirations, and stated she was unsure if the chances were very high for successfully restarting the resident's heart. The physician informed Staff K that she did not know the facilities policy for CPR. On 9/17/19 at 9:38 AM Staff J registered nurse (RN) revealed on 8/31/19 she checked and assessed Resident #185. She observed no heartbeat and the resident was not breathing. She stated she lost her direction and felt panicked and frozen at the same time. She revealed she told Staff K that maybe she should call the physician. ED (emergency department) notes identified the resident arrived at the ED on 8/31/19 at 8:12 a.m. A provider summary note from the visit revealed resuscitation attempts were initiated in the field. The resident had an unknown downtime. He was intubated in the field and was ventilating well with good air movement. However he had no heart sounds. Aggressive resuscitation was continued. He remained in asystole with no response to resuscitation attempts. Further efforts would be completely futile. resuscitation attempts were stopped and he was pronounced dead. A death certificate revealed the resident expired on 8/31/19 at 8:40 a.m. The immediate cause of death was listed as "cardiopulmonary arrest". Review of the CPR certified staff list revealed Staff J (RN) did not have current CPR certification when the 8/31/19 incident occurred. On 9/17/19 at 12:15 PM, the DON revealed she spoke with Staff K on the phone on 8/31/19 at	F 678		

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F 678	Continued From page 5 7:26 AM, and informed Staff K that she needed to start CPR immediately and call 911. Review of the CPR certified staff list and schedule indicated that two out of 6 staff members working during the incident on 8/31/19 were CPR certified which included Staff K LPN. Review of the CPR/DNR (do not resuscitate) decision form revealed the resident signed the form on 2/21/19 indicating he wanted CPR if his heart stopped beating and/or he stopped breathing. Review of the facilities Nursing Policy and Procedure for Use of Cardiopulmonary Resuscitation (CPR) contained an effective date of August 2018 and revision date of March 2019 The policy identified staff would provide CPR to residents that experienced respiratory or cardiac arrest if they have chosen CPR full code status. On 9/17/19 at 12:15 PM, the DON revealed facility nurses did not receive training prior to the, "Nursing Policy and Procedure for use of Cardiopulmonary Resuscitation (CPR"), put in place August 2018 or with the revision in March 2019. She also revealed the facility did not have any documentation of reviewing the CPR policy with staff. A facility performance improvement plan summary identified revealed facility policy directs staff to initiate cardio pulmonary resuscitation on a resident who indicated they want CPR in even of cardiac arrest. Staff initiated CPR on Resident #185 approximately 20 minutes after they	F 678		

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F 678	Continued From page 6 assessed with was without pulse or respirations. During the investigation, the facility provided a document that revealed 17 of 34 residents requested Full Code/CPR status if their heart stopped and/or breathing ceased. Review of the staff schedule's for the past 90 days revealed that on 8/12/19 Evening shift the facility lacked any CPR certified staff coverage. Abatement: The facility reviewed nursing staff's CPR certification, reviewed charts for code status and provided CPR education August 31-September 2, 2019. The deficient practice detailed above resulted in an immediate jeopardy situation for the facility. This abatement resulted in past noncompliance for the facility.	F 678		
F 688 SS=E	Increase/Prevent Decrease in ROM/Mobility CFR(s): 483.25(c)(1)-(3) §483.25(c) Mobility. §483.25(c)(1) The facility must ensure that a resident who enters the facility without limited range of motion does not experience reduction in range of motion unless the resident's clinical condition demonstrates that a reduction in range of motion is unavoidable; and §483.25(c)(2) A resident with limited range of motion receives appropriate treatment and services to increase range of motion and/or to prevent further decrease in range of motion.	F 688		

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F 688	Continued From page 7 §483.25(c)(3) A resident with limited mobility receives appropriate services, equipment, and assistance to maintain or improve mobility with the maximum practicable independence unless a reduction in mobility is demonstrably unavoidable. This REQUIREMENT is not met as evidenced by: Based on observation, record review and interviews with residents and staff, the facility failed to assure planned restorative programs were carried out for 5 of 12 residents reviewed (Resident #7, Resident #8, Resident #10, Resident #18 and Resident #28). The facility reported a census of 34 residents. Findings included: 1. Resident #7's 6/19/19 MDS (Minimum Data Set) documented the resident required total assistance of staff for transfers and bed mobility. The resident did not ambulate. The MDS documented the resident had limitations in range of motion of both upper and both lower extremities. A Nursing Rehabilitation form directed staff to assist the resident with range of motion exercises to the upper and lower extremities 2-5 times weekly. From 8/13/19 to 9/11/19 staff documented assistance with the exercises only twice. Once on 8/16/19 at 5:27 AM and once on 8/20/19 at 12:38 AM. The record lacked any documentation indicating the resident declined participation in the exercise program. An 8/27/19 Therapy Discharge Notice documented the last day of Occupational Therapy Services had been planned for 8/30/19. It stated splints had been ordered and fitted and a	F 688		

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F 688	Continued From page 8 restorative and splint schedule created. The record lacked any documentation indicating a splinting schedule had been implemented. During observation on 9/10/19 at 2:38 PM 2 hand splints sat on the resident's dresser. When asked resident if she wore the splints she stated she had worn them once. When asked if she objected to wearing them she stated she didn't object but they just didn't put them on her. The resident's hands, wrists and arms appeared severely contracted. The resident's care plan lacked any mention of the splints. The record lacked any documentation indicating staff placed the hand splints. During interview on 9/11/19 at 7:58 AM the resident sat in a wheelchair/ in the dining room fed by staff. The chair slightly reclined and the resident had hands and arms drawn up to her chest. Both hands, fingers and wrists appeared severely contractured. The resident had no splints in place. During 5 additional observations up until 2:17 PM the resident never wore the hand splints. On 9/11/19 at 3:11 PM the DON provided a written statement from Occupational Therapy which stated they filed the discharge instructions in the resident record but failed to tell staff and so the resident had not worn the splints since discharge from therapy. 2. Resident #8's 6/26/19 MDS documented the resident required extensive assistance with bed mobility and transfers. The resident did not ambulate. The resident's Nursing Rehabilitation form directed staff to assist the resident with active range of motion to the right lower extremity	F 688		

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F 688	Continued From page 9 or active assisted range of motion to the left lower extremity 10-20 repetitions each hip and knee flexion/extension; hip abduction/adduction; ankle pumps and bridges 2-5 times weekly. From 8/13/19 to 9/11/19 staff documented no assistance provided with the exercises. The record lacked any documentation indicating the resident declined participation in the exercise program. 3. Resident #10's 7/3/19 MDS documented the resident required extensive assistance with bed mobility, total assistance with transfers and did not ambulate. A 6/28/19 Occupational Therapy Progress Report stated one of the reasons for skilled services had been to design and implement restorative nursing programs (RNPs) in order to enhance the patient's quality of life by improving ability to perform upper body activities of daily living with increased independence and safety. A Nursing Rehabilitation form directed staff to assist the resident with active range of motion/passive range of motion to bilateral shoulders, elbows, wrists and digits. Assist with red theraband exercises for bilateral shoulder flexion, bicep curls, internal and external rotation, horizontal abduction for 1- to 15 repetitions 2-5 times weekly as tolerated. From 8/13/19 to Staff documented assistance provided eleven times all on the over night shift and no other time. 4. Resident #18's 7/17/19 MDS documented he required extensive assistance for bed mobility, total assistance for transfers and did not ambulate. The resident had functional limitations in range of motion of 1 upper and 1 lower extremity. A 2/15/19 Therapy Discharge Notice documented the last day of planned therapy services to be 2/22/19 and stated a plan to set up	F 688		

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F 688	Continued From page 10 a restorative nursing program for range of motion and strengthening. A Therapy Communication sheet dated 2/22/19 directed staff to perform passive range of motion to the left leg including hip flexion, knee flexion/extension and ankle flexion/extension and to attempt to move the leg inward to decrease outward splay. It directed to position at the end with a bolster propping the leg into a more neutral position. The record lacked any documentation indicating staff assisted the resident with any exercise program. During interview on 9/09/19 at 1:41 PM the resident stated 2-3 staff assisted with transfers. The resident stated he didn't do any exercises. During interview on 09/12/19 at 8:27 AM the Director of Nursing stated she couldn't find any documentation indicating a restorative nursing program initiated for the resident. She stated she didn't know why this hadn't been done. 5. Resident #28's Nursing Rehabilitation form directed staff to assist the resident to ambulate with a front wheeled walker and oxygen a distance as tolerated; to assist with seated lower extremity exercises with a 4 pound weight and to assist with theraband exercises to the bilateral upper extremities with verbal cues for 20 repetitions 2-5 times weekly as tolerated. From 8/13/19 to 9/11/19 staff documented assistance provided only 2 times both on the over night shift. During interview on 09/11/19 at 8:19 AM the Director of Nursing (DON) stated they had one aide designated to do restorative treatments 3 times weekly. The rest of the time she worked as a nursing assistant.	F 688		

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F 688	Continued From page 11 During interview on 09/11/19 at 11:31 AM Staff B CNA, Staff B stated she hadn't been able to do restorative treatments for at least a month due to staff being short on the floor. She stated she had only been able to do the treatments as frequently as planned for a couple of weeks 4 to 5 months ago. During interview on 09/12/19 at 7:22 AM the DON stated she spoke with the night shift staff who had documented the restorative treatments done during the night. She stated that had been documented in error. She stated none of those residents received restorative treatments in the prior 30 days.	F 688		
F 761 SS=D	Label/Store Drugs and Biologicals CFR(s): 483.45(g)(h)(1)(2) §483.45(g) Labeling of Drugs and Biologicals Drugs and biologicals used in the facility must be labeled in accordance with currently accepted professional principles, and include the appropriate accessory and cautionary instructions, and the expiration date when applicable. §483.45(h) Storage of Drugs and Biologicals §483.45(h)(1) In accordance with State and Federal laws, the facility must store all drugs and biologicals in locked compartments under proper temperature controls, and permit only authorized personnel to have access to the keys. §483.45(h)(2) The facility must provide separately locked, permanently affixed compartments for storage of controlled drugs listed in Schedule II of the Comprehensive Drug Abuse Prevention and	F 761		

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F 761	Continued From page 12 Control Act of 1976 and other drugs subject to abuse, except when the facility uses single unit package drug distribution systems in which the quantity stored is minimal and a missing dose can be readily detected. This REQUIREMENT is not met as evidenced by: Based on observation, record review and staff interview the facility failed to ensure drugs and biologicals used in the facility were labeled in accordance with currently accepted professional standards for 3 of 34 residents. The facility failed to properly label a medication with the date it was opened for Resident #27, #8 and #15. The facility reported a census of 34 residents. Findings include: In an observation of two of two medication carts on 9/10/19 at 7 AM medication cart #1 contained two opened bottles of Valproate Sodium Solution without a documented opened date. Observation of the second medication cart on 9/10/19 at 7:15 AM, revealed a LiquaCel Liquid (Amino Acids) prescribed for Resident #15 opened and undated. Also in the second medication cart, two stock medications: Gavilax Polyethylene and Robitussin liquid were opened and undated. During a staff interview on 07/10/19 at 7::00 AM staff C, Licensed Practicing Nurse (LPN), acknowledged the opened bottles of Valproate Sodium without a documented opened date. She acknowledged that the bottles should contain a date when opened. On 09/11/19 at 2:00 PM the Director of Nursing	F 761		

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F 761	Continued From page 13 (DON) acknowledged the expectation is for every opened container of medication to contain an opened dated documented on that container.	F 761		
F 803 SS=D	Menus Meet Resident Nds/Prep in Adv/Followed CFR(s): 483.60(c)(1)-(7) §483.60(c) Menus and nutritional adequacy. Menus must- §483.60(c)(1) Meet the nutritional needs of residents in accordance with established national guidelines.; §483.60(c)(2) Be prepared in advance; §483.60(c)(3) Be followed; §483.60(c)(4) Reflect, based on a facility's reasonable efforts, the religious, cultural and ethnic needs of the resident population, as well as input received from residents and resident groups; §483.60(c)(5) Be updated periodically; §483.60(c)(6) Be reviewed by the facility's dietitian or other clinically qualified nutrition professional for nutritional adequacy; and §483.60(c)(7) Nothing in this paragraph should be construed to limit the resident's right to make personal dietary choices. This REQUIREMENT is not met as evidenced by: Based on observation, review of facility menus and staff interview the facility failed to provide full portions of food to 2 of 2 residents receiving pureed diets (Resident #4 and Resident #8). The	F 803		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	165145	A. BUILDING _____ B. WING _____	09/18/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
EMBASSY REHAB AND CARE CENTER	206 PORT NEAL ROAD SERGEANT BLUFF, IA 51054

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F 803	Continued From page 14 facility reported a census of 34 residents. The facility menu for the noon meal on 9/10/19 directed staff to serve cornflake chicken breast 3 ounces, capri vegetable blend 1/2 cup, summer fresh fruit cup 1/2 cup, cheesy rice 1/2 cup and a parsley dinner roll with margarine. During interview on 9/10/19 at 10:17 AM the dietary manager stated they had 2 residents getting pureed diets. She stated they make 1 extra. She stated they served 1/2 cup of each food in pureed form. During observation on 9/10/19 at 10:27 AM Staff A, dietary aide pureed 3 chicken patties with milk. She measured 1 1/2 cups of the puree and emptied it into a square pan. She estimated 1/2 cup remained in the blender bowl then added that to the 1 1/2 cups of puree in the pan. She then measured three 1/2 servings of mixed vegetable and pureed them with milk. She measured the pureed vegetable slightly less than 1 cup. The dietary manager directed her to puree some more vegetable. The dietary aide then pureed three 1/2 cup servings of rice with milk. She measured 1 1/2 cups of the pureed rice leaving some of the puree in the blender bowl. She estimated the amount left in the bowl about 3/4 cups then added that to the pureed rice in a square pan. She then pureed 8 slices of bread with milk and measured the puree 1 1/2 cups with an extra 1/4 cup remaining added to the 1/12 cups in the pan. Then she pureed three 1/2 cup servings of mixed fruit and pureed that with a slice of bread. She then stated the mixture was not enough so added another cup of fruit and 4 more slices of bread as a thickener. The puree measured 1 1/2 cups. She filled 2 small bowls with the pureed fruit. The	F 803		

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F 803	Continued From page 15 dietary aide then pureed another cup of the mixed vegetable which measured 1/2 cup when pureed and added it to the pan with the other pureed vegetable. On 9/10/19 at 12:24 PM the dietary staff served the 2 pureed diets. The chicken, rice, vegetable and bread were all served with 1/2 cup scoops. After serving 1 cup of rice puree remained in the pan and 3/4 cup of chicken remained. 3/4 cup of bread and vegetable also remained in the pan. During interview on 9/10/19 at 1:21 PM the dietary manager agreed the 2 residents with pureed diets hadn't received full servings of chicken or rice, but they had received larger than needed portions of bread and vegetable.	F 803		
F 804 SS=D	Nutritive Value/Appear, Palatable/Prefer Temp CFR(s): 483.60(d)(1)(2) §483.60(d) Food and drink Each resident receives and the facility provides- §483.60(d)(1) Food prepared by methods that conserve nutritive value, flavor, and appearance; §483.60(d)(2) Food and drink that is palatable, attractive, and at a safe and appetizing temperature. This REQUIREMENT is not met as evidenced by: Based on review of facility menus, observation and staff interview the facility failed to serve prepare pureed food in a palatable manner for 2 of 2 residents receiving a pureed diet (Resident #4 and Resident #8). The facility reported a census of 34 residents.	F 804		

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F 804	Continued From page 16 Findings included: The facility menu for the noon meal on 9/10/19 directed staff to serve cornflake chicken breast 3 ounces, capri vegetable blend 1/2 cup, summer fresh fruit cup 1/2 cup, cheesy rice 1/2 cup and a parsley dinner roll with margarine. During interview on 9/10/19 at 10:17 AM the dietary manager stated they had 2 residents getting pureed diets. She stated they make 1 extra and serve 1/2 cup of each food in pureed form. During observation on 9/10/17 at 10:17 AM Staff A, dietary aide pureed three 1/2 cup servings of mixed fruit and pureed that with a slice of bread. She then stated the mixture was not enough so added another cup of fruit and 4 more slices of bread as a thickener. The puree measured 1 1/2 cups. She filled 2 small bowls with the pureed fruit. The surveyor tasted the fruit and bread mixture and found it tasted more like bread than fruit.	F 804		
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	F 812		

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F 812	Continued From page 17 facilities from using produce grown in facility gardens, subject to compliance with applicable safe growing and food-handling practices. (iii) This provision does not preclude residents from consuming foods not procured by the facility. §483.60(i)(2) - Store, prepare, distribute and serve food in accordance with professional standards for food service safety. This REQUIREMENT is not met as evidenced by: Based on observation and staff interviews the facility failed to maintain the ice machine/water dispenser in a sanitary manner. The facility reported a census of 34 residents. Findings included: During initial tour of the facility on 9/9/19 at 9:46 am the ice machine/water dispenser had a build up of lime, rust and discoloration around the ice chute and a build up of lime on the tube/spout of the water dispenser. During interview on the same date at 9:58 AM the dietary manager stated she sometimes wiped down the exterior of the machine but did not clean the inside. During interview at 10:04 AM the maintenance supervisor stated he cleaned the inside of the ice machine regularly but did not clean the chutes or spouts where the ice and water came out of the machine. Subsequently the maintenance supervisor provided logs which showed they cleaned the interior of the machine about every 3 months.	F 812		

DEPARTMENT OF INSPECTIONS AND APPEALS

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	IA0986	A. BUILDING: _____ B. WING _____	C 09/18/2019

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EMBASSY REHAB AND CARE CENTER	206 PORT NEAL ROAD SERGEANT BLUFF, IA 51054

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L 191	58.10(3)b General policies 481-58.10(135C) General policies. 58.10(3) There shall be written personnel policies for each facility. Personnel policies shall include the following requirements: b. Employees shall have a physical examination at least every four years. This Statute is not met as evidenced by: Based on employee file review and policy review the facility failed to test staff using the two-step Tuberculin Skin Test (TST) for 3 of 5 employees reviewed (Staff D, E, and G). Facility provided a phone list with 37 staff members on it. Findings include: Staff D with a hire date of 7/7/17 had step one of Tuberculin (TB) skin test completed on 7/7/17 as indicated on the Record of TB Tests document. The document lacked when the second TB skin test was given. Staff E with a hire date of 9/8/14 had step one TB skin test completed on 9/5/14 as indicated on the record of TB tests document. The document lacked when the second TB skin test was given. Staff G with a hire date of 12/14/15 had step one TB skin test completed on 12/11/15 as indicated on the record of TB tests. The document lacked when the second TB skin test was given. During review of the facility Tuberculin Skin Testing for Health Care Works nursing policy and procedure effective 2018 and revised 7/31/19 indicated staff were to have two-step TST if: 1. No previous result 2. Previous negative result and greater than 12 months prior 3. Previous documented possibly TST result	L 191		

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L 191	Continued From page 1 It also indicated on the policy the facility was to complete the second step 1-3 weeks after the first step. The facility failed to ensure that all staff had a two-step TST completed.	L 191		

F 688

Resident #7, #10, #18 and #28 restorative plans reviewed and currently receiving restorative. Resident # 8 expired on 9/24/19.

All residents residing in the facility have been reviewed on 10/3/19 and those individuals with therapy orders for a restorative program have been identified and currently receiving restorative.

Nursing staff trained on 10/3/19 on restorative modalities and those residents identified requiring restorative.

Audits will be completed weekly for 4 weeks and then monthly for 4 months by DON/Designee. Results will be reported to the QAPI team.

F 761

The identified unmarked medications were removed from the cart on 9/12/19.

Med carts were audited on 9/12/19 for additional medications not dated, those identified also removed from the carts.

Nursing staff trained on 10/3/19 on dating medications that require a date.

Audits will be completed weekly for 4 weeks and then monthly for 4 months by DON/Designee. Results will be reported to the QAPI team.

F 803

Resident #4 and #8 expired on 9/24/19.

All residents residing in the facility diets have been reviewed on 10/3/19

Dietary staff trained 10/09/2019 on proper portions with pureed diets.

Audits will be completed weekly for 4 weeks and then monthly for 4 months by DON/Designee. Results will be reported to the QAPI team.

F 804

Resident #4 and #8 expired on 9/24/19.

All residents residing in the facility diets have been reviewed on 10/3/19

Dietary staff trained 10/09/2019 on palatability of pureed foods.

Audits will be completed weekly for 4 weeks and then monthly for 4 months by DON/Designee. Results will be reported to the QAPI team.

F 812

On 9/9/19 Maintenance Director cleaned the chutes and spouts of ice machine.

Ice machine since survey checked for buildup.

Audits will be completed weekly for 4 weeks and then monthly for 4 months by DON/Designee. Results will be reported to the QAPI team.

Maintenance director revised cleaning logs to include the chutes and spouts on a monthly and prn basis on 10/3/19.

Audits will be completed weekly for 4 weeks and then monthly for 4 months by Maintenance Director/Designee. Results will be reported to QAPI team.

L191

Staff D, E, and G will receive TB skin test between 10/7/19-10/9/19 on the next scheduled day.

All staff files reviewed on 10/3/19 and those identified will receive TB skin test on their next scheduled day to work effective 10/8/19.

Human resources staff trained on 10/3/19 regarding 2 step TB skin test.

Audits will be completed weekly for 4 weeks, then monthly for 4 months by DON/Designee. Results will be reported to QAPI team.