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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	165267	A. BUILDING _____ B. WING _____	02/20/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MAPLE HEIGHTS	2 SUNRISE AVENUE MAPLETON, IA 51034

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F 000	INITIAL COMMENTS Correction Date 2/26/20 for F689 3/4/20 for all other deficiencies A recertification survey and investigation of Self Report 87273-I conducted on 2/17-20/2020 resulted in the following deficiencies. Self Report 82273-I was substantiated. See Code of Federal Regulations (42CFR), Part 483, Subpart B - C.	F 000		
F 689 SS=G	Free of Accident Hazards/Supervision/Devices CFR(s): 483.25(d)(1)(2) §483.25(d) Accidents. The facility must ensure that - §483.25(d)(1) The resident environment remains as free of accident hazards as is possible; and §483.25(d)(2)Each resident receives adequate supervision and assistance devices to prevent accidents. This REQUIREMENT is not met as evidenced by: Based on observation, record review, and staff interview, the facility failed to assure adequate supervision to prevent falls with injury for 1 of 3 residents reviewed (Resident #13). The resident fell 9/25/19 when the alarm did not sound. The facility did not know why the alarm did not sound. They replaced it with the same type of alarm. The resident fell 10/29/19 and fractured a hip when the alarm did not sound. The facility did not know why the alarm did not sound in either situation and still use the same type of alarm for the resident. The facility reported a census of 43 residents.	F 689		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
		02/25/2020

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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Findings include:

According to the Minimum Data Set (MDS) assessment dated 9/5/19, Resident #13 scored 6 on the Brief Interview for Mental Status (BIMS) indicating severe cognitive impairment. The resident required extensive assistance with bed mobility, transfer and ambulation, and diagnoses included dementia.

The Initial Admission Care Plan dated 6/7/19 indicated the resident transferred and ambulated independently.

A Resident Incident Report dated 6/21/19 at 8:31 a.m. documented the resident sustained a fall and transferred to the emergency room (ER) for presumed right hip fracture.

A Discharge Document dated 6/25/19 documented the resident had right hip arthroplasty (replacement) to repair the hip fracture.

The Initial Admission Care Plan dated 6/7/19 included interventions for motion alarm when in room, and chair alarm in wheelchair initiated 6/27/19.

The Care Plan initiated 6/28/19 identified the resident received skilled care following hospitalization for hip repair after a fracture. The care plan on page 2 had written in motion sensor, seat alarm.

A Resident Incident Report dated 9/25/19 at 5:50 a.m. documented it appeared the resident took himself to the bathroom without assist and

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walker, opened the bathroom curtain, lost balance and fell. The report indicated the resident went from the chair without assist. They issued of a new alarm because his had a delay.

A statement dated 9/25/19 documented Staff M Certified Nursing Assistant (CNA) went to the resident's room when the alarm sounded and took him to the bathroom and then back to bed and set the alarm.

During an interview on 2/19/20 at 5:06 p.m. Staff M stated when the resident fell in September she had toileted him about 5:30 a.m. assisted him back to bed and reset the alarm (indicating the resident got up from the bed versus the chair). She had no idea why the alarm did not sound, it was a mystery.

The Interdisciplinary Notes dated 9/25/19 at 9:51 a.m. documented the resident's alarm on and working at 5:30 a.m. At the time of the fall the alarm did not work and had a delay, so replaced.

During an interview on 2/18/20 at 5:14 p.m. Staff E CNA stated the day in September the resident fell she just started her shift and did room checks when she found the resident on the floor. She didn't remember anything else about it.

During an interview on 2/19/20 at 10:36 a.m. Staff A Registered Nurse (RN) stated she worked at the facility until 11/28/19. She stated she really couldn't remember but she thought (9/25/19) they heard a crash and and the resident had gotten up trying to go to the bathroom. She had no idea when he last toileted. She said they did not know why the alarm did not sound so they got another one.

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The Care Plan initiated 9/26/19 identified the resident with poor safety awareness and a risk for falls. The interventions included to remind him to call for assist with ambulation and transfers, use a wheel chair for long distance mobility, seat alarm for use in wheel chair, motion sensor for use in room.

A Resident Incident Report dated 10/29/19 at 3:30 a.m. documented resident heard yelling for help, the nurse found him on the floor lying on his left side in front of his bed. The resident stated he tried to up and get ready for work. He said he turned the light on and fell. The resident went to the hospital for evaluation. The Interdisciplinary Notes dated 10/29/19 at 7:17 a.m. documented at 3:30 a.m. the nurse could hear "help me" coming from hall 3. She went down the hall and noted the resident on the floor in front of his bed. His head laid toward the head of the bed with his legs curled up by his recliner and the alarm by his feet. The alarm did not sound. The resident complained his left hip hurt like hell. The resident stated he thought he broke something. The resident transferred to the ER for evaluation.

A Hospital Consultation Report dated 10/29/19 documented the resident fell trying to get out of bed independently. The resident had left hip pain, difficulty getting up and weight bearing. Radiographs obtained revealed a left displaced femoral neck fracture. The resident noted he had a left broken hip and reported some discomfort, particularly with movement. The resident would proceed with left hip hemiarthroplasty.

A Physical Therapy Plan of Care dated 11/3/19 documented the resident hospitalized 10/29/19 to

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11/1/19. The resident suffered a left hip fracture on 10/29/19 as a result of a fall when the resident tried to get out of bed independently. They surgically repaired the fracture.

During an observation on 2/17/20 at 1:35 p.m. the resident had a motion sensor box on the floor to the right of his recliner.

During an interview on 2/17/20 at 1:05 p.m. Staff C Licensed Practical Nurse (LPN) stated she worked the night the resident fell and fractured. She said the Certified Nursing Assistant (CNA) Staff D took the resident to the bathroom 15-20 minutes earlier, and he went back to bed. She said the CNA said he set the alarm off at that time. Staff C didn't know, but thought the resident may have been bare foot at the time of the fall. She said the CNA would have put gripper socks on when she took him to the bathroom. It wasn't uncommon for him to get up during the night. She said the alarm did not sound when the resident got up, but it sounded when she walked by it, and she said it was placed in a position it should have sounded when the resident put his feet down. She said he laid on the floor with his head by the bed and feet toward the door. She heard they had trouble with those type of alarms sounding before. She said sometimes they needed a new battery, but they would usually beep when the battery got low, and that did not happen.

During an interview on 2/17/20 at 1:55 p.m. Staff D CNA stated the night the resident fell she responded to his alarm about 15 minutes before the fall. She put his slippers on and he urinated in the bathroom toilet and then went back to bed. She said she double checked the alarm by

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pressing the button and heard it in the resident's room and at the nurse's station.
She took another resident to the bathroom and walked down hall 3 when Staff C called her in the room. The resident laid on the floor with his head and back toward the bed and his feet toward the door. She said the alarm did not sound until Staff C walked in the room. The alarm box had been set so it faced alongside the bed. They did not figure out why the alarm did not sound. She said someone told her once that another alarm did that. It did not beep indicating low batteries. She said they did routine every 30 minute checks prior to that and now do every 15 minute walk through. She said the resident usually slept until around 3 am, went back to bed and ready to get up around 5 am.

During an observation on 2/18/20 at 9:59 a.m. the resident remained in bed with an alarm box on the mat beside and at the head of the bed. The alarm did not sound when the surveyor entered the room. Staff G CNA stated she had shut the alarm off to do cares.

During an interview on 2/18/20 at 4:02 p.m. the Director of Nursing (DON) stated the alarm that did not sound on the 9/25/19 fall was the same type used during the most recent fall fracture. She stated they got a new alarm after the 9/25/19 fall. They did not determine why the alarm did not sound.

During an observation/interview on 2/19/20 at 7:36 a.m. the Assistant DON (ADON) demonstrated the motion sensor alarm. The box for the room had an on off on one side and a reset on the other. The box outside the room had an on/off switch (and had a flashing light when

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F 689	Continued From page 6 on). Both needed to be on to sound. They would hit the reset button on the box in the room when they were leaving the room. During an interview on 2/20/20 at 8:13 a.m. the DON stated they did not do a reenactment of the incident on 9/25/19 with the CNA to see if she reset the alarm correctly. She said she did not call the company to try and find out if they had been notified of issues with the alarm not sounding. She said if you have a home alarm and it doesn't work you replace it. She said each shift checks the alarms at shift change for functioning. She said at the time of the September fall they did a med review with the pharmacy and changed the time of the resident's Tamsulosin so maybe he would not need to get up to toilet as much.	F 689		
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	F 690		

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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 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, record review and staff interview, the facility failed to assure appropriate care to prevent infections for 2 of 2 residents with a catheter (Resident #7 and Resident #9) and 1 of 5 residents with incontinent care (Resident #13). The facility reported a census of 43 residents.

Findings include:

1. According to the Minimum Data Set (MDS) assessment dated 11/20/19, Resident #7 scored 6 on the Brief Interview for Mental Status (BIMS) indicating severe cognitive impairment. The resident required extensive assistance with toilet use and personal hygiene. Diagnoses included dementia and Parkinson's disease.

The current care plan dated 12/10/19 identified the resident with a catheter in place due to urinary

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retention. The interventions included the resident needed extensive assistance with toileting and dependent for catheter.

During an observation on 2/19/20 at 6:32 a.m. Staff B LPN (licensed practical nurse) prepared supplies and went to the resident's room (to irrigate her catheter). Staff B washed her hands, put on gloves, and did various things including getting in the drawer under sink for trash bags. Staff B changed gloves with no hand hygiene. Staff B put the siderail down, adjusted the resident's pajama top and buttoned it up before disconnecting the tubing from the catheter and flushing the catheter. Staff B cleansed the tip of the catheter tubing and reconnected it to the catheter.

2. According to the MDS assessment dated 11/20/19 Resident #7 scored 6 on the BIMS indicating severe cognitive impairment. The resident required extensive assistance with toilet use and personal hygiene. The resident had an indwelling urinary catheter, and diagnoses included urinary tract infection (UTI).

The current care plan dated 12/10/19 identified the resident with an indwelling urinary catheter for many years. The interventions included to flush the catheter with 120-180 cc's of acetic acid daily and every 6 hours as needed. The resident did not always meet the clinical criteria of UTI, but may still need treatment.

A hospital Discharge Summary dated 11/12/19 documented the resident's diagnoses included UTI and sepsis.

A Physician's Telephone Order dated 2/8/20 at

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3:30 p.m. directed the resident's new order for Cefdnir (antibiotic) 300 mg 2 times a day for 7 days for UTI.

A urine culture collected 2/11/20 showed the resident had greater than 100,000 Pseudomonas Aeruginosa (commonly found in the environment) indicating infection.

A Physician's Telephone Order dated 2/14/20 at 3 p.m. directed to discontinue the Cefdnir and start Cipro (antibiotic) 500 mg 2 times a day for 7 days.

During an observation on 2/18/20 at 8:25 a.m. staff attempted to stand the resident to walk and the resident would not stand. Staff G Certified Nursing Assistant (CNA) laid the dignity bag holding the catheter bag on the floor with the catheter tubing laying on the floor. The tubing continued to touch the floor while Staff G tied it to the underside of the wheel chair.

During an observation on 2/19/20 at 6:10 am Staff B gathered supplies and went to the resident's room to irrigate his catheter. Staff B wore gloves when moving the bed and picked up a pen off the floor. Staff B changed her gloves with no hand hygiene and irrigated the catheter.

3. According to the MDS assessment dated 9/5/19 Resident #13 scored 6 on the BIMS indicating severe cognitive impairment. The resident required extensive assistance with bed mobility, transfer and ambulation, and diagnoses included dementia.

The current care plan dated 12/19/19 identified the resident not always aware of toileting needs and could be incontinent. The interventions

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F 690	Continued From page 10 included encouraging toilet use before and after meals and activities, at bedtime and as needed through the night, and assist of 1 with toileting and related hygiene. During an observation on 2/18/20 at 9:59 a.m. Staff G put washcloths in the resident's sink and ran water over them. When ready to do pericare, the resident's foot was off the bed. Staff F CNA pushed the resident's foot over touching the bottom of his shoe with her right hand. She then provided pericare including the genital area with her right hand without changing the gloves. During an interview on 2/19/20 at 11:11 AM the Director of Nursing (DON) and Assistant DON (ADON) agreed the hand washing policy included to assure hands did not touch the sink because it was dirty, therefore washcloths should not be placed in the sink to wet them for resident care, catheter tubing should be kept off the floor, although difficult at times, hand hygiene should be completed between all glove changes, and they should have clean gloves on when performing pericare and catheter care. According to the Centers for Disease Control (CDC) and Prevention multiple opportunities for hand hygiene may occur during a single care episode. The clinical indications for hand hygiene included immediately after glove removal. The CDC document reads: Always clean your hands after removing gloves. Dirty gloves can soil hands.	F 690		
F 761 SS=E	Label/Store Drugs and Biologicals CFR(s): 483.45(g)(h)(1)(2) §483.45(g) Labeling of Drugs and Biologicals	F 761		

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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 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, clinical review and staff interview the facility failed to discard outdated medications for 3 of 43 residents (Resident #15, Resident #38, Resident #19), and failed to securely store drugs subject to abuse for 5 of 43 residents (Resident #13, Resident #193, Resident #37, Resident #34, Resident #42). The facility reported a census of 43 residents.

Findings include:

In an observation of one out of three medication carts on 2/17/20 at 12:37 PM Registered Nurse

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(RN) Staff L was administering the afternoon medications. Upon inspection of the medication cart it was revealed that a saline nasal spray for Resident #15 had been opened and dated 3/25/19, the expiration date was 10/2019. A review of the record showed that the resident was admitted to the facility on 12/18/18. The clinical record showed a physician's order dated 3/25/19 for AYR saline nasal gel spray, each nares one time daily.

Upon further inspection of the medication cart it was discovered that Resident #38 had five individual sample packs in with her medication cassettes. Each of the packets contained two soft-gel tablets. Staff J, RN stated that the resident received these samples from the optometrist. Upon further investigation it was discovered that the expiration date on the packets was December of 2019. A review of the clinical record revealed that Resident #38 admitted to the facility on 8/21/17. The record showed a doctor's order dated 5/20/19 for Preservation AREDS 2 soft gel- take one orally (PO) every (Q) day/eye vitamin, may use sample supply.

The medication cart also contained a cassette of Acetaminophen 500 milligrams (mg) for Resident #19. The expiration date on the medication was January of 2020. A review of the Medication Administration Record (MAR) revealed that the resident received the medication on February 12, 2020. The clinical record showed a doctor's order on 4/5/17 for: Acetaminophen 500 milligrams (mg.) tab one tab PO every 6 hours as needed (PRN) for pain.

In an interview with registered nurse (RN) Staff J on 2/17/2020 at 12:57 PM she stated the nurse

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MAPLE HEIGHTS	2 SUNRISE AVENUE MAPLETON, IA 51034

(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
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administering the medications should have discovered the outdated medications.

In a second observation of the three medication carts on 2/19/20 at 11:55 AM it was discovered that antianxiety medications were kept under one lock. The scheduled and PRN (as needed) antianxiety medications were kept in cassettes with individual compartments for each dose. According to the Assistant Director of Nursing (ADON) in an interview 2/19/20 at 3:06, the routines is for the scheduled medications to be replaced every two weeks but the PRN cassettes were only renewed as needed. The facility had no process in place to keep a count of the PRN antianxiety drugs. A chart review revealed the physician's orders for some of the PRN antianxiety had expired.

On 2/19/20 at 12:00 PM, Staff K, RN reviewed the electronic clinical record for doctor's orders, as the surveyor took out cassettes of PRN medications from the medication cart. The following was discovered:

A cassette of Ativan (antianxiety) 0.5 mg PRN for Resident #13 with 11 pills in the cassette. The last doctor's order for this medication was initiated on 12/9/19 and had expired on 12/23/19.

A cassette of Ativan 0.5 mg PRN twice a day (BID) for Resident #193. The doctor's order for this medication expired on 2/18/20 and the cassette contained remaining 15 tablets.

A cassette of Ativan 0.5 mg every 6 hours PRN for Resident #37. The doctor's order expired on 12/27/19 and 13 pills remained in the cassette. The PRN was used twice in December and not in

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November at all.

A cassette of Ativan 0.5 mg every day (QD) PRN for Resident #34. The doctor's order expired on 1/10/20 and 7 pills remained in the cassette. A review of the medication administration records (MAR) revealed the resident did not use the as needed medication in December, January or so far in February.

In a review of the other two medication carts with Staff J, RN at 12:05 it was discovered that Resident #42 had a cassette of 0.5 mg Ativan 1-2 tabs every 30 minutes. A review of the electronic chart revealed that the doctor's order expired on 2/18/20. There were 29 pills remaining in the two cassettes and the MAR identified the medication used 9 times in the month of February.

On 2/19/20 at 2:57 PM a report from the pharmacy was generated to help determine if any tablets were unaccounted for. The report was generated for three of the five residents with lapsed orders.

Resident #37 had 16 tabs send to the facility on 10/30/19. The MAR indicated that three had been given to the resident and 13 remained in the cassette.

Resident #34 had 14 tabs send to the facility on 8/6/19. The MAR showed that 7 had been given to the resident in August and September, and 7 remained in the cassette.

Resident #13 had 16 tabs sent to the facility on 11/22/19. Two of the pills were sent to the emergency kit on 11/21/19 and 14 put in a cassette to be kept in the medication cart. Over

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F 761	Continued From page 15 November and December three doses had been given to the resident and 11 tabs remained in the cassette. In an interview with the DON on 2/19/20 at 3:06 she said the cassettes with PRN medications should have been sent back to the pharmacy once the doctor's order expired. She stated that she understood the potential for abuse when antianxiety medication are not counted or used on a regular basis. On 2/20/20 at 8:30 AM the DON stated she placed the PRN benzodiazepine medications under a second lock and staff would count them on a regular basis in the future. She acknowledged that this may be a safer process.	F 761		
F 803 SS=E	Menus Meet Resident Nds/Prep in Adv/Followed CFR(s): 483.60(c)(1)-(7) §483.60(c) Menus and nutritional adequacy. Menus must- §483.60(c)(1) Meet the nutritional needs of residents in accordance with established national guidelines.; §483.60(c)(2) Be prepared in advance; §483.60(c)(3) Be followed; §483.60(c)(4) Reflect, based on a facility's reasonable efforts, the religious, cultural and ethnic needs of the resident population, as well as input received from residents and resident groups; §483.60(c)(5) Be updated periodically;	F 803		

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§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, record review and staff interview, the facility failed to assure residents on a mechanical soft diet received an appropriate portion of meat for 1 meal. The facility reported a census of 43 residents and identified 9 residents on a mechanical soft diet.

Findings include.

The Menu for Tuesday 2/18/20 showed mechanical soft diets would receive 3 ounces of ground roast turkey or 3 ounces of ground baked ham.

A Diets Prescribed Physician report dated 2/17/10 showed the following Residents on mechanical soft diets: #9, #12, #18, #19, #30, #32, #35, and #196.

A Physician's Telephone Order dated 2/17/20 at 9:40 a.m. showed Resident #6 on a mechanical soft diet.

During an observation on 2/18/20 10:37 am Staff H (Cook) ground 6 servings of turkey and 5 servings of ham. She put them in a pan without any kind of measurement.
At 11:18 Staff H started plating food for the assisted dining room. During the meal service

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F 803	Continued From page 17 Staff H served 4 residents each a #10 scoop of ground ham (Resident # 9, Resident # 12, Resident # 30, and Resident #35) and 5 residents each a #10 scoop of ground turkey (Resident # 196, Resident #6, Resident #32, Resident #19, and Resident #18). At 12:20 p.m. Staff H measured the remaining ground meats and had 3 #10 scoops of the turkey remaining, and 3 #10 scoops of the ground ham remaining. She confirmed if the residents received a full portion there should only be 1 serving remaining of each ground meat. During an interview on 2/18/20 at 12:25 p.m. the Dietary Supervisor stated they should weigh a scoop of the ground meat to assure they were getting the right serving. She stated they should not have that much left over.	F 803		
F 812 SS=F	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	F 812		

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serve food in accordance with professional standards for food service safety.
This REQUIREMENT is not met as evidenced by:
Based on observation and staff interview, the facility failed to prepare, and serve food in accordance with professional standards for food safety. The facility reported a census of 43 residents.

Findings include:

1. During an observation on 2/17/20 at 9:30 a.m. initial tour of the kitchen revealed the low water temperature (temp) dishwasher ran with a wash temp of 115 degrees and rinse of 118 degrees. A review of the temp record showed multiple temps under 120. The facility had no record of the chemical checks. The Dietary Supervisor (DS) stated they did the checks daily, but did not record them. A check at the time revealed 50 parts per million (ppm) of chemical. She would check with their supplier regarding the dishwasher temps.

The Dishwasher Temp record showed the temp recorded 3 times a day. The February 2020 record through 2/17/20 recorded rinse temps were below 120 degrees 29 of 51 times.

A manual for Low Temp, Low Energy Dishwashers technical data included a minimum wash temp of 120 degrees.

2. During an observation on 2/18/20 at 10:41 a.m. Staff H (Cook) washed her hands, reached around the wall and obtained a paper towel, turned the faucet off then dried her hands with the same paper towel.

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F 812	Continued From page 19 During the meal service Staff H washed her hands in the manner stated above 6 times During an observation on 2/18/20 at 11:18 a.m. Staff I (dietary aide) washed her hands and turned the faucet off with her bare hand and then got a paper towel and dried her hands. During the meal service Staff I washed her hands in the manner described 3 times. During an interview on 2/18/20 at 12:25 p.m. the DS stated after washing hands, staff should dry their hands then turn the faucet off with a paper towel. A facility Food Safety Handwashing Techniques sheet including after washing hands, dry with a single use towel, then use towel to turn the faucet off.	F 812		
F 880 SS=D	Infection Prevention & Control CFR(s): 483.80(a)(1)(2)(4)(e)(f) §483.80 Infection Control The facility must establish and maintain an infection prevention and control program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of communicable 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:	F 880		

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§483.80(a)(1) A system for preventing, identifying, reporting, investigating, and controlling infections and communicable diseases for all residents, staff, volunteers, visitors, and other individuals providing services under a contractual arrangement based upon the facility assessment conducted according to §483.70(e) and following accepted national standards;

§483.80(a)(2) Written standards, policies, and procedures for the program, which must include, but are not limited to:
(i) A system of surveillance designed to identify possible communicable diseases or infections before they can spread to other persons in the facility;
(ii) When and to whom possible incidents of communicable disease or infections should be reported;
(iii) Standard and transmission-based precautions to be followed to prevent spread of infections;
(iv)When and how isolation should be used for a resident; including but not limited to:
(A) The type and duration of the isolation, depending upon the infectious agent or organism involved, and
(B) A requirement that the isolation should be the least restrictive possible for the resident under the circumstances.
(v) The circumstances under which the facility 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

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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 observation, chart review and interview the facility failed to maintain sanitary environment to help prevent the development and transmission of communicable diseases for 1 of 14 residents reviewed. (Resident #33) The facility reported a census of 43 residents.

Findings include:

According to the electronic record, Resident #33 admitted to the facility on 10/25/17 with diagnosis including hypertension, dysthymic disorder, and sebaceous cyst. A review of the chart revealed a medication order initiated on 12/13/17 for Tramadol HCL (narcotic) 50 milligrams (mg) 2 tablets by mouth three times a day.

In an observation on 2/18/19 at 7:19 AM, RN (registered nurse) Staff J opened a locked container of scheduled medications and placed two Tramadol in the medication cup for Resident #33. She then went on to prepare other medication from prepackaged cassettes. As she gathered the cassettes, the medication cup tipped over and one of the Tramadol tabs landed on the surface of the medication cart. The RN took a

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F 880	Continued From page 22 plastic spoon to gather it up, put it back into the cup and gave it to the resident with the other medications. In an interview on 2/20/20 at 8:00 AM with the Director of Nursing (DON), she stated if the surface where the tablet landed did not contain a barrier, she would expected the nurse to dispose of the tablet and get another pill to give to the resident.	F 880		

The preparation of the following plan of correction for this deficiency does not constitute and should not be interpreted as an admission nor an agreement by the facility of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction prepared for these deficiencies were executed solely because provisions of State and Federal law require it.

F689 Completion Date: 2/26/2020

1. Resident #13 a new (different manufacturer) Motion Alarm was purchased and is in place
2. All other residents care planned for Motion Alarms have had the New Motion Alarms implemented
3. Staff have been educated on use and placement of new Motion Alarms
4. As part of Maple Heights ongoing commitment to quality care, the DON / QA Nurse will investigate and determine causal factors (such as any non-functioning alarm) of falls to aid in implementing new interventions.

The preparation of the following plan of correction for this deficiency does not constitute and should not be interpreted as an admission nor an agreement by the facility of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction prepared for these deficiencies were executed solely because provisions of State and Federal law require it.

F690 Bowel/Bladder Incontinence, Catheter, UTI: Completion Date: 3/4/2020

1. Hand Hygiene, Glove use, and Catheter Care education was provided and completed with staff on 3/4/2020
2. As part of Maple Heights ongoing commitment to quality care, the DON / QA Nurse will perform random audits monthly x 3. Findings will be brought to department head committee and will be reviewed and determine to continue or discontinue audit.

F761 Labeling of Drugs and Biologicals: Completion Date: 3/4/2020

1. Training with nursing staff on the removal of outdated medication on 3/4/2020.
2. The new processes to double lock and count PRN antianxiety drugs with potential for abuse was implemented on 2/19/2020.
3. Training with nursing staff to remove medications without an order was completed on 3/4/2020.
4. As part of Maple Heights ongoing commitment to quality care, the DON / QA Nurse will perform random audits monthly x 3. Findings will be brought to department head committee and will be reviewed and determine to continue or discontinue audit.

F880 Infection prevention and Control: Completion Date: 3/4/2020

1. Training with all staff and nursing staff J on proper medication administration was completed on 3/4/2020.
2. As part of Maple Heights ongoing commitment to quality care, the DON / QA Nurse will perform random audits monthly x 3. Findings will be brought to department head committee and will be reviewed and determine to continue or discontinue audit.

F812 Food Procurement, Store/ Prepare/Serve-Sanitary

The dish machine policy has been changed to include; At each meal check the temperature and injector system (PPM strip) to assure the soap, rinse and sanitizer are being properly dispensed. The temperature on the dish machine has to be 120 degrees or above during the wash and rinse cycles. If not the dishes need to be rewashed until the temperature is above 120 degrees. (see policy)

A sign is now posted on the dish machine that says the temperature must reach 120 degrees during both the wash and rinse cycles. If not the dishes need to be rewashed until the temperature is above 120 degrees.

Staff H and Staff I have been given education and instructed on the proper way to wash hands.

All Dietary Staff was given education on the proper dish washing temperatures. The staff at this time reviewed the correct procedure to wash hands. **In-serviced 03-04-2020**

Random audits will be conducted weekly x12 by the F.S.S.. Findings will be brought and reviewed to Department Head Committee to determine to continue or discontinue audits.

F803 Menus and Nutritional Adequacy

Cook H has been instructed how to measure servings of ground protein by weight not volume during meal service. All cooks reviewed how/when to calculate servings of ground protein by volume and weight at the inservice. **In-serviced 03-04-2020**

Random audits will be conducted weekly x12 by the F.S.S.. Findings will be brought to department Head Committee and will be reviewed and determine to continue or discontinue audits.

ON 2/26/2020 AliMed Alarm PIR that facility had in stock from order placed on 5/14/2019 replaced all gray motion alarms in use. New order was placed on 2/27/2020 in order to have additional alarms on hand as shown on Invoices.

On 2/26/2020 nursing staff received education on new alarms and how to work them. Instructions posted in communication books and reviewed with nursing staff.

On 3/4/2020 In person Inservice held with Nursing staff to review survey findings and plan of corrections.