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
	165575	A. BUILDING _____ B. WING _____	C 02/02/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MANORCARE HEALTH SERVICES-UTICA RIDGE	3800 COMMERCE BLVD DAVENPORT, IA 52807

(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 OK TAG Correction Date: See Attached 3/26/21 The investigation of Complaints #90999, #91789, #93295, #93986, #95123, #95124 and a Mandatory #91468 was conducted 1/11/21-2/2/21 and resulted in the following deficiencies. (See Code of Federal Regulations (42CFR) Part 483, 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.	F 580		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE (Clinical Nurse) | (X6) DATE 2/24/21

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 (iii) The facility must also promptly notify the 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 and physician interviews, the facility failed to notify the physician and the resident's family of a change in condition for 1 of 3 residents reviewed with a weight loss(Resident #2). The facility reported a census of 85 residents. Findings Include: 1. The Minimum Data Set (MDS) Assessment Tool, dated 12/7/20, listed diagnoses for Resident #2 included heart failure, cancer, and debility related to cardiorespiratory conditions. The MDS stated the resident required extensive assistance	F 580		

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F 580	Continued From page 2 of 1 staff for personal hygiene, walking, and bathing, and extensive assistance of 2 staff for bed mobility, transfers, dressing, and toilet use. The MDS listed the resident's Brief Interview for Mental Status (BIMS) score as 15 out of 15, indicating intact cognition. An 11/2/20 History and Physical report stated the resident presented to the Emergency Department with bilateral(pertaining to both sides of the body) hip fractures and listed the resident's weight as 122.98 lbs(pounds). The resident's facility Admission Record Report stated the resident had a hospital stay from 11/2/20-11/17/20 and initially admitted to the facility on 11/17/20. The Weights and Vitals Summary listed an 11/17/20 weight of 124.4 lbs. A Progress Note, dated 11/18/20, stated the resident admitted to the facility following a hip replacement and planned to discharge to home following her stay. The note stated the resident was in "good spirits". A facility Progress Note, dated 11/21/20, stated the resident discharged to the hospital due to vomiting and respiratory distress. A Hospital Dietician Report, dated 11/27/20, stated the resident had lost 4.2 lbs. from her stated weight and reported it was not significant but clinically relevant. The note stated the resident was receptive to trying Ensure Enlive chocolate(a dietary supplement) and stated the resident would return to the facility with dietary supplements 2-3 times per day. The note stated	F 580		

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F 580	Continued From page 3 the facility Dietician should follow. A facility Progress Note, dated 11/28/20, stated the resident readmitted to the facility after a hospitalization. The Weights and Vitals Summary listed an 11/29/20 weight of 115 lbs. This calculated as a 7.56% loss from the resident's weight of 124.4 lbs prior to the hospitalization on 11/17/20. A 12/2/20 Nutrition Assessment, completed by the facility dietician, listed the resident's weight as 112 lbs. It stated the resident was underweight for an older adult and consumed 25-100% of meals. The assessment stated the resident did not like the food choices offered and the lack of salt was affecting her food intake. The notes stated the resident's was on a No Added Salt (NAS) diet and requested a regular diet. The note stated the Dietician obtained an order for a regular diet per the resident's request. The resident agreed to a "magic cup" (a frozen high calorie supplement) three times per day and listed a recommendation for a multivitamin with minerals. An Order Audit Report listed a 12/7/20 order for a magic cup three times per day. The facility lacked documentation of a magic cup initiated on 12/2/20 when the Dietician stated the resident agreed to it. The resident's December 2020 Medication Administration Record (MAR) listed an order for a multivitamin which started on 12/9/20. The MAR lacked documentation the resident received the vitamin prior to 12/9/20.	F 580		

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F 580	Continued From page 4 A 12/10/20 the Nurse Practitioner report directed staff to continue the resident's NAS diet. The Order Summary Report with a list of active orders as of 12/27/20, listed an order for a NAS diet with an order date of 11/28/20. The orders did not list a change to a regular diet between the time the Dietician obtained an order for the change on 12/2/20 per the resident's request and the resident's death at the facility on 12/27/20. The Weights and Vitals Summary listed a 12/6/20 weight of 101.1 lbs, calculated as a 12.09% loss from the resident's readmission weight of 115 lbs on 12/29/20 and an 18.73% loss from the resident's original admission weight on 11/17/20. The Weights and Vitals Summary listed a 12/14/20 weight of 95.4 lbs, calculated as a 17.04% loss from the resident's readmission weight of 115 lbs on 12/29/20 and a 23.3% loss from the the resident's original admission weight on 11/17/20. An untitled Physician's Progress Note, dated 12/15/20, stated the resident's had lost 20 lbs since her initial admission. The note stated the resident reported she had a decline in her appetite since being at the facility but had not been taking her antidepressant. The note also stated the resident had chronic diarrhea several times per day and was usually on loperamide(an antidiarrheal). The note stated the physician would restart the resident's loperamide and antidepressant. The facility lacked documentation of physician and family notification of the resident's weight loss between the resident's readmission on	F 580		

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F 580	Continued From page 5 11/28/20 and 12/15/20 when the physician noted the weight loss. The facility lacked documentation of an additional intervention carried out aside from the magic cup initiated on 12/7/20 and the multivitamin on 12/9/20. The facility lacked documentation of whether or not the resident consumed the magic cup and lacked documentation of ongoing assessments of the resident's weight or an evaluation as to whether the magic cup was effective. The Weights and Vitals Summary included the following weights(in lbs): 11/17/20: 124.4 11/19/20: 114 Resident was in the hospital from 11/21/20-11/28/20 11/29/20: 115 11/30/20: 114.6 12/1/20: 110.6 12/2/20: 110.6 12/3/20: 103 12/4/20: 102.6 12/5/20: 100.8 12/6/20: 101.1 12/7/20: 98.6 12/9/20: 98.8 12/10/20: 99 12/11/20: 98.6 12/12/20: 98.9 12/13/20: 97.1 12/14/20: 95.4 12/15/20: 94.8 12/16/20: 94.2 12/17/20: 99 12/18/20: 94.8 12/19/20: 94.4 12/20/20: 94.2 12/21/20: 93.4	F 580		

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F 580	Continued From page 6 12/22/20: 93 12/24/20: 93.2 A 12/18/20 Progress Note stated the family requested to discharge the patient to home on 12/21/20. A 12/21/20 Progress Note stated the resident tested positive for COVID-19. A 12/24/20 Progress Note stated the family requested a Hospice evaluation. The resident's December 2020 Documentation Survey Report v2 lacked documentation staff offered the resident fluids on the following 6:00 a.m.-2:00 p.m. shifts: 12/4/20 and 12/19/20 and on the following 2:00 p.m.-10:00 p.m. shifts: 12/1/20, 12/9/20, 12/12/20, 12/15/20, 12/18/20, 12/21/20, 12/22/20, and 12/23/20. The report documented the resident did not consume any of her meals from from 12/20/20-12/27/20. The facility had documentation the resident's Advanced Registered Nurse Practitioner (ARNP) aware the resident was not eating according to the 12/21/20 ARNP Progress Note. The facility lacked further documentation of provider notification the resident was not eating from 12/21/20 until the time the resident was sent to the emergency room on 12/25/20. An Emergency Department Report, dated 12/25/20, stated the resident admitted to the ER due to hypoxia(inadequate oxygen in the blood) and hypotension(low blood pressure). The note stated the resident had dry, cracked oral mucous membranes and her labs were consistent with acute kidney injury likely secondary to	F 580		

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F 580	Continued From page 7 dehydration. A 12/25/20 Progress Note stated the resident returned from the hospital. A 12/27/20 Progress Note stated the resident expired at the facility at 6:10 p.m. Care Plan entries, dated 11/17/20, stated the resident would experience no significant weight change and included the following interventions: a. Vitamin and mineral supplements. b. Honor food preferences. c. Supplements(dietary). d. Report intolerance to current diet. e. Review weights and notify the physician and responsible party of significant weight change. f. Snacks per resident preference. The Care Plan lacked additional resident centered, specific interventions based on the residents likes and dislikes to assist the resident in maintaining or gaining weight. The facility policy "Weight Measurement", dated 03/2018, directed staff to compare weights to the previous weight and review discrepancies with the nurse. The policy stated discrepancies were considered to be 5 lbs if the patient was over 100 lbs. The policy directed staff to notify the physician and the responsible party of the weight loss and stated the dietician would evaluate and document in the nutrition progress notes. The untitled facility policy regarding Care Plans, dated 2013, stated the facility would create a Comprehensive Care Plan to include individualized interventions which focused on specific risk factors.	F 580		

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F 580	Continued From page 8	F 580		

The facility policy "Change in Condition", dated 11/2016, stated the facility must immediately inform the resident, the resident's physician, and the resident's representative when there was a significant change in the resident's physical, mental, or psychosocial status.

During an interview on 1/19/21 at 2:32 p.m., the Director of Nursing (DON) stated she could not locate any additional dietary interventions for Resident #2 other than a magic cup. She stated a weight loss would trigger if it occurred in a 30 day time period. She stated it would not trigger for a shorter period of time. When the surveyor asked if the facility could miss a weight loss due to this, she stated "potentially".

During an interview on 1/19/21 at 3:30 p.m., the Registered Dietician stated if a resident had an 8-10 pound weight loss in a week, it should trigger. She stated though that weight changes were triggered for the period of 1 month and 6 months and may not trigger for a shorter period of time. She stated she completed Resident #2's initial assessment but did not complete any follow up.

During an interview on 1/20/21 at 7:45 a.m., the Registered Dietician stated she completed the resident's assessment on 12/2/20 and liberalized the diet, started a magic cup, and recommended a multivitamin. On 12/7/20, she continued those interventions. She stated on 12/7/20, she already had interventions in place. She stated the unit managers would let her know of weight losses and stated unless someone told her of more of a weight loss, she would not have followed up. She stated the resident told her 110-115 lbs was her

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F 580	Continued From page 9	F 580		

usual weight. She stated they would notify the physician of a weight loss if it triggered for the period of 1 month or 6 months. She stated they may not inform the physician of a weight loss in a shorter period of time. She stated with Resident #2, the month period hadn't passed yet.

During an interview on 1/26/21 at 9:28 a.m., Staff P, Physician, stated if a resident's weight decreased from 115 lbs-101 lbs in a period of a week, she would want the facility to notify her. She stated with weight loss, they may start an appetite stimulant. If the facility tried a supplement and it wasn't working or the resident did not like it, she would expect them to try something different. If a magic cup was the intervention, she would want the facility to evaluate whether or not it was effective. She stated if a resident returned from the hospital with a weight loss, the facility should monitor the weight even more closely

During an interview on 1/26/21 at 9:52 a.m., the Food Service Director stated the facility Dietician assessed weight loss. She stated the Dietician discussed the resident's preferences of food. She stated she wasn't provided a list of weight losses in the facility.

During an interview on 1/26/21 at 10:30 a.m., Staff Q, Licensed Practical Nurse (LPN) stated she would want to know if a resident's weight decreased from 115 lbs to 101 lbs in 1 week. She stated if this happened, she would let the Dietician and the physician know and would start giving snacks and Ensure(a dietary supplement).

During an interview on 1/26/21 at 10:58 a.m., Staff F, Registered Nurse (RN) stated the facility

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F 580	Continued From page 10 Dietician flagged residents with weight loss. She stated if a resident's weight decreased from 115 lbs to 101 lbs in a period of a week, they should notify the physician. During a interview on 1/27/21 at 8:05 a.m., Staff D RN/Nurse Manager stated if a resident's weight decreased from 115 lbs to 101 lbs in a week and the weight was accurate, he would expect staff to notify the doctor and the Dietician for supplements. He stated they would notify the family and inquire if the resident had any comfort foods. He stated staff should evaluate the effectiveness of an intervention such as a magic cup. During an interview on 1/27/21 at 8:54 a.m., Staff M RN/Nurse Manager stated if a resident had a weight loss, she would let the Dietician and the physician know. She would want to figure out the reason, possibly the resident had food preferences and the family could bring in food. She stated the Certified Nursing Assistants (CNA's) weighed the resident and it was the nurses responsibility to look at the previous weight to see if there was a change and if so to notify the physician. She stated if a resident's weight decreased from 115 lbs to 110 lbs in 1 week, she would speak to the physician to determine the root cause. She stated she wasn't sure if staff monitored interventions such as a magic cup to see if residents consumed them. She stated if a resident had a weight loss during a hospital stay, this would be a trigger to keep an eye on the resident's weight. During an interview on 1/27/21 at 10:43 a.m., the DON stated the Dietician monitored weights on a 30 day basis and was not sure about weight	F 580		

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F 580	Continued From page 11 losses which occurred in a shorter period of time. When the surveyor asked whether the facility should notify the physician if a resident's weight decreased from 115 lbs to 101 lbs in the period of a week, she stated she was not sure how that worked outside of the 30 day time frame and stated she would check the facility policy and get back to the surveyor. During subsequent email correspondence on 1/27/21 at 1:49 p.m., the DON wrote that the facility followed the regulatory guidelines for a notification of a 5% weight loss in 30 days.	F 580		
F 610 SS=D	Investigate/Prevent/Correct Alleged Violation CFR(s): 483.12(c)(2)-(4) §483.12(c) In response to allegations of abuse, neglect, exploitation, or mistreatment, the facility must: §483.12(c)(2) Have evidence that all alleged violations are thoroughly investigated. §483.12(c)(3) Prevent further potential abuse, neglect, exploitation, or mistreatment while the investigation is in progress. §483.12(c)(4) Report the results of all investigations to the administrator or his or her designated representative and to other officials in accordance with State law, including to the State Survey Agency, within 5 working days of the incident, and if the alleged violation is verified appropriate corrective action must be taken. This REQUIREMENT is not met as evidenced by: Based on observation, clinical record review, staff interviews and facility policy review the	F 610		

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F 610	Continued From page 12 facility failed to separate an alleged perpetrator from the victims for three (3) residents reviewed and allowed the alleged perpetrator to continue to work and handle narcotic/schedule II medications. (Resident #7, #13 and #14). The facility identified a census of 85 residents. Findings Include: 1. A Patient Protection Abuse, Neglect, Exploitation, Mistreatment and Misappropriation Prevention form issued 11/2016 included the following directive: a. Patient protection actions included to have immediately removed the patient from contact with the alleged abuser during the investigation. If the incident involved a center employee, the employee would have been suspended immediately after the facility obtained their statement, pending the completion of the investigation. A Delivery Receipt dated 5/6/20 at 7:06 p.m. indicated the pharmacy courier delivered the following: a. Two (2) narcotic cards for Resident#7 which contained 30 Hydrocodone/Acetaminophen 10/325 milligram (mg) tablets per card. b. One (1) narcotic card for Resident #14 which contained 30 Hydrocodone/Acetaminophen 5/235 mg tablets. c. One medication card for Resident #13 which contained 15 Alprazolam/Xanax (anti-anxiety) tablets. 2. A Pharmacy Proof of Delivery form dated 5/6/20 at 8:20 p.m. indicated the medications as stated above for Resident #7, #13 and #14 received by Staff A, Licensed Practical Nurse	F 610		

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MANORCARE HEALTH SERVICES-UTICA RIDGE	3800 COMMERCE BLVD DAVENPORT, IA 52807

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F 610	Continued From page 13	F 610		

(LPN).

3. A Minimum Data Set (MDS) assessment form dated 12/23/20 documented Resident #7 with diagnosis that included Arthritis, Cerebrovascular Accident (CVA), Peripheral Vascular Disease, Idiopathic Peripheral Autonomic Neuropathy and muscle weakness. The assessment documented the resident suffered from occasional pain which made it hard for him to sleep at night with his worst pain rated at a 4 out of 10.

A Care Plan identified a focused area last revised 12/18/17 of generalized pain related to falls evidenced by verbalization of pain.

A Medication Administration Record (MAR) form dated 5/1/20 thru 5/31/20 documented the resident had a physician's order for Hydrocodone/Acetaminophen 10-325 mgs one (1) tablet by mouth (PO) four times a day (QID) and 1 tablet PO as needed (PRN).

4. A MDS assessment form dated 12/7/20 documented Resident #13 with diagnosis that included Hemiplegia, CVA, Seizure Disorder, Peripheral Vascular Disease, Depression, Aphasia and Type II Diabetes Mellitus.

A Controlled Medication Prescription (Schedule II-V Medications) form signed by the physician 5/6/20 documented an order for Xanax/Alprazolam 0.25 mg 1 tablet PO daily (QD) and 1 tablet at the hour of sleep (HS) PRN.

The MAR form failed to address/document the physician's order.

5. A MDS assessment form dated 10/18/20

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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F 610	Continued From page 14 indicated Resident #14 with diagnosis that included Coronary Artery Disease (CAD), Osteoporosis, Non-Alzheimer's Dementia, Respiratory Failure with hypoxia, Encephalopathy and muscle wasting and atrophy in multiple sites. The assessment documented the resident as not in pain. A Care Plan with a focus area created 11/17/19 documented the resident received pain medication therapy. A MAR form dated 5/1/20 thru 5/31/20 documented the resident had an physician's order for Hydrocodone/Acetaminophen 5/325 mg tablet 1 PO 2 times a day (BID) for pain and 1 tablet PO every 8 hours PRN for breakthrough pain. During an interview 1/14/21 at 2:44 p.m., Staff A, Licensed Practical Nurse (LPN) stated around 8:00 p.m. - 9:00 p.m. she received the above medications from a pharmacy courier. The staff member opened up the unlabeled gray sealed bag which contained the narcotics/controlled substances and identified the narcotics as ordered for downstairs residents. Staff A indicated when nurses received narcotics they delivered them to the nurse responsible for that resident right away so Staff A delivered the medications to Staff B, LPN as he sat at the nurse's desk charting with Staff C, LPN located on the other side of the nurse's station. Staff A indicated when she gave the medications to Staff B he placed the medication cards on the computer desk and failed to have taken them to his medication cart as expected. Staff A then left the floor and had no more contact with the medications and/or Staff B.	F 610		

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F 610	Continued From page 15 During an interview 1/14/21 at 3:54 p.m. Staff C, LPN stated she worked with Staff B, LPN on the evening of the situation but she could not remember which nurse brought the medications to Staff B. Staff C indicated the medications in question sat on the counter when she returned to the nurse's station with Staff B present. Staff C confirmed she observed Staff B as he tried to scan the medications into Point Click Care (PCC) (the facilities computer program) without success so Staff B asked for her assistance. Staff C attempted to scan the medications without success. Staff C then directed Staff B to place the medications into the medication cart and verify the narcotics with the nurse coming in on the 10:00 p.m. to 6:00 a.m. shift. Staff C stated at the time of the incident the nurses took the stickers off the narcotic controlled record attached to the medication card, placed them in the narcotic book, 2 nurses verified the number and type of medications and signed the form. Staff C stated the next day Staff B came into the facility and looked for the medications which had not been found. Staff B told her he placed the medications in the 2nd drawer of the medication cart which had not been the narcotic/schedule II locked drawer. During an interview 1/21/21 at 12:57 p.m., Staff B confirmed as he sat at the Nurse's Station in Garden South on the date of the incident Staff A arrived around 9:00 p.m. to 9:10 p.m. and gave him what he thought had been 3 medication cards for Residents #7, #13 and #14. Once Staff A gave him the medications he tried to scan them into the facilities computer system without success. Staff B asked Staff C for assistance however she had been unable to scan the medications as well. Staff B then placed the	F 610		

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F 610	Continued From page 16 medications in the bottom right drawer of the medication cart which had not been the narcotic/schedule II locked box. Staff B proceeded to conduct his nursing duties until Staff O, LPN arrived for the night shift. Staff B gave Staff O report and counted the narcotics but failed to tell her about the narcotics/schedule II medications he stored in bottom right hand drawer of the medication cart. When Staff B arrived the next day for his 2:00 p.m. to 10:00 p.m. shift he remembered about the narcotic/schedule II medications and went to Garden South to locate the medications which had been gone. He informed Staff D, RN/Nurse Manager of the situation which triggered a full investigation with a result of not locating the medications. During an interview 1/15/21 at 10:51 a.m. Staff O confirmed she arrived at work at 10:00 p.m. and Staff B gave her report and counted the narcotics in the narcotic/schedule II medication drawer. Staff B failed to inform her of the narcotic/schedule II medications he placed in the medication cart. Staff O indicated she had not known what drawer Staff B placed the medications into however she passed morning medications and had not observed the medications in any of the drawers she accessed in the medication cart. During an interview 1/13/21 at 4:03 p.m. Staff E, LPN confirmed she worked 5/7/20 on the 6:00 a.m. to 2:00 p.m. shift and knew nothing about the narcotic/schedule II medications stored in the bottom right drawer of the medication cart until Staff B came to Garden South all frantic. Staff E asked Staff B what he had been looking for and he said he took in some narcotic medications and	F 610		

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F 610	Continued From page 17 he thought he put them in a drawer of the medication cart which had not been the narcotic locked box. Staff E denied having observed the said narcotic/schedule II medications in the medication cart during her scheduled shift. Staff E stated all of the medications Staff B said he placed in the general area of the medication cart had not been located anywhere. During an interview 1/13/21 at 1:09 p.m. the Administrator confirmed the facility conducted an investigation and although the missing narcotic/schedule II medications were never found she had no reason to believe Staff B diverted the medications so he returned to work at the conclusion of the facilities investigation. Staff B had been working at the facility ever since and his job duties included handling resident narcotics/schedule II medications.	F 610		
F 658 SS=D	Services Provided Meet Professional Standards CFR(s): 483.21(b)(3)(i) §483.21(b)(3) Comprehensive Care Plans The services provided or arranged by the facility, as outlined by the comprehensive care plan, must- (i) Meet professional standards of quality. This REQUIREMENT is not met as evidenced by: Based on observation, record review, and interview, the facility failed to carry out professional standards of practice by: not observing the swallowing of medications for 1 of 5 residents observed receiving medications (Resident #17), by not ensuring a current physician's order was in place for 1 of 5 residents observed receiving medications (Resident #18), and by not following physician's orders in a timely	F 658		

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F 658	Continued From page 18 manner for 1 of 6 residents reviewed for physician's orders(Resident #5). The facility reported a census of 85. Findings: 1. During an observation on 1/12/21, Staff F, Registered Nurse (RN) brought a medication cup full of medications into Resident #17's room at 7:50 a.m. and sat them in front of the resident on an overbed table. Staff F left the medication cup with the resident and left the room without observing the resident take the medications. The resident's Order Summary Report listed current orders as of 1/27/21. The report did not include an order stating the resident may self administer medications. The resident's January 2021 Medication Administration Report (MAR) listed the following medications given by Staff F(as shown by her initials) for the 8:00 a.m. dose on 1/12/21: Acidophilus(a probiotic) 1 capsule Ascorbic acid(Vitamin C) 500 mg(milligrams) Aspirin 81 mg Furosemide(a diuretic-rids the body of fluid) 40 mg Guaifenesin(treats cough and congestion) 600 mg Multivitamin Potassium Chloride 10 mEq(milliequivalents) Protonix(used to treat heartburn) 40 mg Vitamin B-12 1000 mcg(micrograms) Acetaminophen 500 mg(2 tablets) Allopurinol(used to treat gout, a type of arthritis) 100 mg Augmentin(an antibiotic) 500-125 mg Eliquis(used to prevent blood clots) 5 mg	F 658		

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F 658	Continued From page 19 Metoprolol(used to treat high blood pressure) 25 mg Oxycodone (a narcotic pain reliever) 5 mg Topiramate(used to treat pain and seizures) 50 mg 2. During an medication pass observation on 1/13/21 at 7:30 a.m., Staff K, RN administered Afrin(a nasal decongestant) 1 spray in each nostril to Resident #18. Review of the resident's Order Summary for 1/13/21 revealed no order listed an for Afrin. 3. The Minimum Data Set (MDS) Assessment Tool, dated 7/7/20, listed a diagnosis for Resident #5 included fracture. An Order Summary Report listed a 7/2/20 order for TED Hose(compression hose, used to prevent blood clots) to the left leg, on in the morning and off at bedtime. An untitled Nurse Practitioner Note, dated 7/2/20, stated the resident had a history or DVT(Deep Vein Thrombosis-blood clots) and had TED hose to the left leg, on in the morning and off at bedtime and stated the resident was on Lovenox and Coumadin(medications used to prevent blood clots). The July 2020 Treatment Administration Report (TAR) stated the resident had TED hose starting on 7/3/20. The TAR lacked documentation the resident had TED hose prior to this. The facility policy "Medication Administration:	F 658		

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F 658	Continued From page 20	F 658		

Medication Pass", dated 3/2010, directed staff to remain with the resident until the administration of medication was complete.

The facility policy "Medication and Treatment Administration Guidelines" dated 2018, stated the facility would administer medication in accordance with standards of practice and state specified and federal guidelines. It stated the facility would retain medication orders in the clinical record.

During an interview on 1/20/21 at 12:37 p.m., the Director of Nursing (DON) stated she could not find an order for Resident #18's Afrin and did not know where it came from.

During an interview on 1/26/21 at 10:30 a.m., Staff Q, Licensed Practical Nurse (LPN) stated nurses should watch residents take their medications. She stated she had "sometimes" seen cups of medications left in resident rooms by other nurses.

During an interview on 1/26/21 at 1:49 p.m., Staff G, Certified Nursing Assistant (CNA) stated he had observed medication in medication cups in resident rooms without a nurse present.

During a interview on 1/27/21 at 8:05 a.m., Staff D RN/Nurse Manager stated staff should observe residents take their medications.

During an interview on 1/27/21 at 8:54 a.m., Staff M RN/Nurse Manager stated she had seen medications in cups where residents had not taken them. She stated this occurred most recently 3-4 weeks ago. She stated nurses couldn't leave the medications with residents and

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F 658	Continued From page 21 assume they would take them because this didn't always happen. She stated OTC medications required an order to administer. During an interview on 1/27/21 at 10:43 a.m., the DON stated nurses should sign out medications immediately after administration and stated nurses should watch residents take medications. She stated if a resident had a medication from home they desired, the facility would need an order to administer this. She stated the order dated for Resident # 5's TED hose was 7/2/20 but did not trigger on the TAR until the next day due to the time of day of the order.	F 658		
F 677 SS=D	ADL Care Provided for Dependent Residents CFR(s): 483.24(a)(2) §483.24(a)(2) A resident who is unable to carry out activities of daily living receives the necessary services to maintain good nutrition, grooming, and personal and oral hygiene; This REQUIREMENT is not met as evidenced by: Based on observation, record review, and interview, the facility failed to provide repositioning assistance for 1 of 5 residents reviewed for positioning(Resident #11), failed to provide adequate assistance with bathing for 1 of 16 residents reviewed(Resident #4), and failed to provide complete perineal cares for 1 of 2 resident's observed during incontinence cares(Resident #11). The facility reported a census of 85 residents. Findings Include: 1. The Minimum Data Set (MDS) Assessment	F 677		

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F 677	Continued From page 22 Tool, dated 12/30/20, listed diagnoses for Resident #11 included high blood pressure, cardiovascular accident(stroke), and non-Alzheimer's dementia. The MDS stated the resident required extensive assistance of 2 staff for transfers, bed mobility, and toilet use, and extensive assistance of 1 staff for dressing, eating, personal hygiene, and bathing. The MDS stated the resident was at risk for the development of pressure ulcers and listed the resident's cognition as severely impaired. During an observation 1/12/21 at 7:24 a.m., Resident #11 sat in the Assisted Dining Room (ADR) in a Broda chair(a type of reclining wheelchair). The resident remained in the ADR in her chair at 8:02 a.m. During an observation on 1/12/21 at 8:14 a.m., Staff G, Certified Nursing Assistant (CNA) pushed Resident #11 in her chair from the hallway near the ADR into her room next to her bed. He then left the room and returned at 8:32 a.m. and closed the door. He exited the room at 8:40 a.m. and Resident #11 was still in her chair next to her bed. The surveyor asked Staff G if he provided assistance to Resident #11 and he stated that he had not. He stated he had assisted Resident #11's roommate. Subsequent observations on 1/12/21 revealed the following: At 9:14 a.m., Staff G entered Resident #11's room to pass water. The resident remained in her chair. Observations at the following times revealed the resident remained in her chair in her room next to her bed. 9:40 a.m., 10:05 a.m., 10:52 a.m., and	F 677		

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F 677	Continued From page 23 11:13 a.m. During this time period, the surveyor remained in the vicinity and did not observe staff entering the resident's room to assist her. At 11:15 a.m., Staff H, CNA pushed the resident in her chair from her room to the ADR. The resident remained in her chair in the ADR at 11:24 a.m., 11:36 a.m., and 11:40 a.m. During this time period, the surveyor remained in the vicinity. During an observation at 12:00 p.m., the resident remained in the ADR in her room. Staff H assisted the resident to eat. At 12:09 p.m., Staff H wheeled the resident out of the ADR into the hallway. At 12:13 p.m., Staff G wheeled the resident from the hallway into her room. At 12:21 p.m., Staff G transferred the resident into bed and changed the resident's incontinent brief. The resident's buttocks appeared red and Staff G applied a cream. During an interview directly following cares, Staff G stated a Hospice aide assisted the resident to get up and in the shower this morning. He stated he had not provided cares for her since then. He stated the resident usually sat in her chair between breakfast and lunch. During an observation on 1/20/21 at 7:18 a.m., Resident #11 was in her Broda chair in the ADR, slumped a bit to the left side. Observations on 1/20/21 at 8:35 a.m., 10:03 a.m., and 10:52 a.m. revealed the resident in her Broda chair in her room. Subsequent observations revealed the resident in the ADR in her chair at 11:58 a.m. and in the hall near the nursing station in her chair at 12:45.	F 677		

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F 677	Continued From page 24 During an observation on 1/20/21 at 12:49 p.m., Staff L, CNA pushed the resident to her room. Staff L and Staff K Registered Nurse (RN) transferred the resident to bed. Staff L then unfastened the resident's incontinent brief and rolled the resident onto the left side. The resident's incontinent brief was soiled with fecal material and her left gluteal fold appeared red. Staff L cleansed the resident's buttocks and right hip while the resident was on the left side and placed a clean incontinent brief under the resident. Staff L rolled the resident briefly over to the right side to pull out the side of the new brief but did not cleanse the resident's left hip or the outer portion of the left buttock. After Staff L finished assisting the resident and covered her up in bed, the resident stated "that feels good". During an interview directly following cares, Staff L stated Resident #11 usually laid down between meals but stated a staff member left so they were short so she was unable to assist her into bed "today". The Braden Scale for Predicting Pressure Sore Risk, dated 12/30/20, stated the resident was at moderate risk for the development pressure ulcers. Care Plan entries on 9/25/19 and 9/26/19 stated the resident was at risk for impaired skin integrity and encouraged staff to encourage the resident to reposition frequently to a position of comfort. 2. Resident #4's Admission Record Report listed an admission date of 7/23/20 and the diagnosis of fracture. Review of Progress Notes revealed the resident	F 677		

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F 677	Continued From page 25	F 677		

discharged to home on 7/30/20.

Review of the resident's Documentation Survey Report v2 for July 2020 revealed the resident received a bed bath on 7/25/20 and refused a shower or bath on 7/27/20 and 7/29/20. The report lacked documentation of another bath offered or given during the period of his stay at the facility from 7/23/20-7/30/20.

Review of the resident's Progress Notes for his stay revealed no documentation of the resident refusing any cares or therapies. The notes lacked any documentation of staff follow up to the resident's refusals of his bath or shower and lacked documentation the facility attempted to find out the cause of the refusals.

Care Plan entries, dated 7/24/20, stated the resident had cognitive-communication deficits and directed staff to assist the resident to bathe/shower as needed.

The facility policy "Bed Positioning", revised 02/2019, directed staff regarding how to assist residents with positioning. The policy did not include direction on how frequently staff should reposition residents.

The facility policy, "Incontinence Care", revised 08/2014, stated when completing incontinence cares, staff should turn the resident from side to side to cleanse the entire affected area.

The facility policy "Bathing", dated 07/2016, stated the purpose of bathing was to cleanse skin and promote circulation. The policy directed staff regarding how to assist with bathing but did not include guidance on the procedure to carry out if

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MANORCARE HEALTH SERVICES-UTICA RIDGE	3800 COMMERCE BLVD DAVENPORT, IA 52807

(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 677	Continued From page 26 a resident refused a bath. During an interview on 1/26/21 at 10:30 a.m., Staff Q, Licensed Practical Nurse (LPN) stated if a resident refused a bath, she would want to know about this so she could speak with the resident about it. She stated some staff were "lazy" with regard to giving baths. During an interview on 1/26/21 at 10:45 a.m., Staff R, RN stated if a resident refused showers, she would like to know to ensure they were staying hygienic. During an interview on 1/26/21 at 10:58 a.m., Staff F, RN stated she would want to know if a resident refused a shower. She stated possibly another staff member would be able to encourage the resident to shower. She stated some staff were "lazy" with regard to giving baths. During an interview on 1/26/21 at 11:10 a.m., Staff S, CNA stated if a resident refused a bath, staff should ask them again. She stated there were aides at the facility who didn't try with regard to giving baths. During an interview on 1/26/21 at 1:49 p.m., Staff G, CNA stated sometimes staff did not complete showers because they were "lazy". He stated he made the showers up on his shift. During a interview on 1/27/21 at 8:05 a.m., Staff D, RN/Nurse Manager stated staff should reposition residents every two hours. He stated Resident #11 usually laid down between breakfast and lunch. He stated she was not someone who was able to verbally ask for things like food or a drink.	F 677		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	165575	A. BUILDING _____ B. WING _____	C 02/02/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MANORCARE HEALTH SERVICES-UTICA RIDGE	3800 COMMERCE BLVD DAVENPORT, IA 52807

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F 677	Continued From page 27 During an interview on 1/27/21 at 8:54 a.m., Staff M, RN/Nurse Manager stated she questioned if staff provided baths as often as they should depending on which staff was working that day. She stated if an aide documented the resident refused, she would want to speak to the resident to see if they could change days to accommodate the resident. During an interview on 1/27/21 at 10:43 a.m., the Director of Nursing (DON) stated if a resident refused a bath, CNAs should notify the nurse and they would go in and speak to the residents to encourage them. She stated sometimes it was how the staff person asked the resident and possibly they would agree to a bath another time.	F 677		
F 686 SS=D	Treatment/Svcs to Prevent/Heal Pressure Ulcer CFR(s): 483.25(b)(1)(i)(ii) §483.25(b) Skin Integrity §483.25(b)(1) Pressure ulcers. Based on the comprehensive assessment of a resident, the facility must ensure that- (i) A resident receives care, consistent with professional standards of practice, to prevent pressure ulcers and does not develop pressure ulcers unless the individual's clinical condition demonstrates that they were unavoidable; and (ii) A resident with pressure ulcers receives necessary treatment and services, consistent with professional standards of practice, to promote healing, prevent infection and prevent new ulcers from developing. This REQUIREMENT is not met as evidenced by: Based on observation, record review, and staff interviews, the facility failed to notify the physician	F 686		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	165575	A. BUILDING _____ B. WING _____	C 02/02/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MANORCARE HEALTH SERVICES-UTICA RIDGE	3800 COMMERCE BLVD DAVENPORT, IA 52807

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F 686	Continued From page 28	F 686		

a new area of skin impairment and initiate interventions for 1 of 3 residents with a pressure ulcer(Resident #1) and failed to carry out an adequate assessment of a new skin area for 1 of 3 residents with a pressure ulcer(Resident #7). The facility reported a census of 85 residents.

Findings Include:

1. The Minimum Data Set (MDS) assessment tool, dated 12/3/20, listed diagnoses for Resident #1 included cancer, kidney failure ,and diabetes. The MDS stated the resident required limited assistance of 1 staff for transfers, dressing, and personal hygiene, and required extensive assistance of 1 staff for bed mobility, toileting, and bathing. The MDS stated the resident was at risk for pressure ulcers but had no current pressure or non-pressure ulcers. The MDS indicated the resident was not on a turning and repositioning schedule and listed the resident's Brief Interview for Mental Status (BIMS) score as 14 out of 15, indicating intact cognition.

The resident's facility Admission/Re-admission Evaluation, dated 11/24/20, stated the resident's left buttock had a 1.5 centimeter (cm) x 1.5 cm calloused area with surrounding red tissue.

An untitled Nurse Practitioner note, dated 12/14/20, stated the resident complained of pain in the coccyx. The notes stated the resident had a pressure ulcer to the coccyx and the facility would start wound care to the area. The notes did not include a description/assessment of the area or measurements.

The facility lacked documentation of any additional assessments or follow-ups regarding

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	165575	A. BUILDING _____ B. WING _____	C 02/02/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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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 686	Continued From page 29	F 686		

the resident's coccyx area from 11/24/20 when staff identified the area to 12/14/20 when the Nurse Practitioner ordered the initiation of a treatment. The facility lacked any additional assessments or measurements of the coccyx other than the 11/24/20 and lacked documentation of physician notification of the skin area between 11/24/20 and 12/14/20.

An untitled Nurse Practitioner note, dated 12/16/20, stated she did not assess the coccyx wound on that visit.

The Braden Scale for Predicting Pressure Sore Risk, dated 12/15/20, stated the resident was at risk for the development of pressure ulcers.

Care Plan entries, dated 11/25/20, stated the resident was at risk for the alteration in skin integrity and directed staff to encourage the resident to reposition as needed. The Care Plan did not indicate the resident had any actual skin impairment on his coccyx.

The resident's clinical record lacked documentation of staff assisting the resident with frequent turning and repositioning and the resident's Documentation Survey Report v2 for December 2020, listing Activities of Daily Living (ADL's) did not include a cue for staff to assist the resident with frequent repositioning.

Progress Notes revealed the resident discharged from the facility on 12/16/20.

A Hospital Progress Note, dated 12/18/20, stated the resident had a pressure ulcer on the coccygeal area which measured 4 cm x 5 cm.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	165575	A. BUILDING _____ B. WING _____	C 02/02/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MANORCARE HEALTH SERVICES-UTICA RIDGE	3800 COMMERCE BLVD DAVENPORT, IA 52807

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F 686	Continued From page 30	F 686		

2. The MDS assessment tool, dated 12/23/20, listed diagnosis for Resident #7 included Peripheral Vascular Disease (PVD), Heart Failure, and Kidney Failure. The MDS stated the resident required limited assistance of 1 staff for personal hygiene, extensive assistance of 2 staff for bed mobility, transfers, dressing, and toilet use, and depended completely on 2 staff for bathing. The MDS listed the resident's Brief Interview for Mental Status (BIMS) score as 15 out of 15, indicating intact cognition and stated the resident was at risk for developing pressure ulcers and had 1 unhealed pressure ulcer.

During an observation on 1/20/21 at 10:30 a.m., Staff K, Registered Nurse (RN) measured an area on Resident #7's left heel as 2.5 centimeters (cms) x 1.2 cm (length x width). The area was a pink open area with white tissue visible in the center. The area appeared to have some depth. Staff K measured the depth as 0.2 cm when the surveyor requested. Staff K stated the area "looked almost like a Stage III (full thickness) pressure area. Staff K cleansed the area with saline and place a piece of Hydrofera Blue(a type of foam dressing) on the area and covered it with Vaseline gauze and roll gauze.

Progress Notes, dated 9/8/20, stated the resident had a Deep Tissue Injury (DTI) to the left heel which was healed.

An untitled Nurse Practitioner note, dated 12/14/20, stated wound care would begin for left heel.

The facility lacked further documentation of an assessment of the left heel (measurements,

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	165575	A. BUILDING _____ B. WING _____	C 02/02/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MANORCARE HEALTH SERVICES-UTICA RIDGE	3800 COMMERCE BLVD DAVENPORT, IA 52807

(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 686	Continued From page 31 description/characteristics of the wound) until 12/21/20. Progress Notes, dated 12/21/20, stated the resident had a DTI to the left heel which measured 0.5 cm x 0.5 cm x 0 cm (length x width x depth) with wound orders in place. The note listed the origin of the area as pressure and the duration of the wound as 12/21/20. A Wound Assessments report from the wound clinic, dated 1/18/21, stated the resident had a pressure ulcer to the left heel which measured 1.4 x 2.7 x 0.3. Care Plan entries, dated 12/16/17, stated the resident was at risk for alteration in skin integrity and directed staff to observe skin conditions daily and report abnormalities. The Braden Scale for Predicting Pressure Sore Risk, dated 12/23/20, stated the resident was at moderate risk for he development pressure ulcers. The untitled facility policy related to alterations in skin integrity directed staff to complete a "PUSH Tool" which noted measurements, drainage, and tissue type. The policy stated the tool allowed the facility to graph scores over time to give a visual indicator of healing. The policy directed staff to notify the physician of alterations in skin integrity. The untitled facility policy regarding care plans, dated 2013, stated the facility would create a comprehensive care plan to included individualized interventions which focused on the specific risk factors.	F 686		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	165575	A. BUILDING _____ B. WING _____	C 02/02/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MANORCARE HEALTH SERVICES-UTICA RIDGE	3800 COMMERCE BLVD DAVENPORT, IA 52807

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F 686	Continued From page 32 During an interview on 1/21/21 at 9:10 a.m. the Director of Nursing (DON) stated she had no additional skin sheets for Resident #1. During an interview on 1/26/21 at 1:00 p.m., Staff N, Advanced Registered Nurse Practitioner (ARNP) stated with all of the problems Resident #1 had going on, his coccyx wound was not significant. She stated she did not see any assessments or measurements of Resident #7's left heel prior to 12/21/20 and stated he had other wounds which were much more critical than those on his heel. During an interview on 1/27/21 at 8:05 a.m., Staff D, RN/Nurse Manager, stated he expected a baseline assessment completed for any newly opened area. During an interview on 1/27/21 at 8:54 a.m., Staff M, RN/Nurse Manager stated if staff discovered a new skin concern, they should conduct a baseline assessment of the area. During an interview on 1/27/21 at 10:43 a.m., the DON stated she expected a baseline assessment for any new skin area. During an interview on 1/26/21 at 9:28 a.m., Staff P, Physician stated if a resident had a calloused area with red areas on their buttocks, she would want the facility to inform her. She stated she would expect the facility to assess any wound at least once per day. During an interview on 1/26/21 at 10:58 a.m., Staff F, RN, stated if a resident had a red area on their buttocks, she would notify the wound nurse and the physician.	F 686		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	165575	A. BUILDING _____ B. WING _____	C 02/02/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MANORCARE HEALTH SERVICES-UTICA RIDGE	3800 COMMERCE BLVD DAVENPORT, IA 52807

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F 686	Continued From page 33 During an interview on 1/27/21 at 8:54 a.m., Staff M, RN/Nurse Manager stated if a resident admitted with a calloused reddened area on the buttocks, she expected the nurse to measure the area and get an order for a treatment. She stated whoever discovered the area should complete an assessment and stated she would want a baseline assessment of the wound. During an interview on 1/27/21 at 10:43 a.m., the DON stated if a resident came in with a red, calloused area on the buttocks, the wound nurse should evaluate to determine if there was a treatment. She stated she would want a baseline assessment wounds.	F 686		
F 692 SS=G	Nutrition/Hydration Status Maintenance CFR(s): 483.25(g)(1)-(3) §483.25(g) Assisted nutrition and hydration. (Includes naso-gastric and gastrostomy tubes, both percutaneous endoscopic gastrostomy and percutaneous endoscopic jejunostomy, and enteral fluids). Based on a resident's comprehensive assessment, the facility must ensure that a resident- §483.25(g)(1) Maintains acceptable parameters of nutritional status, such as usual body weight or desirable body weight range and electrolyte balance, unless the resident's clinical condition demonstrates that this is not possible or resident preferences indicate otherwise; §483.25(g)(2) Is offered sufficient fluid intake to maintain proper hydration and health; §483.25(g)(3) Is offered a therapeutic diet when	F 692		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	165575	A. BUILDING _____ B. WING _____	C 02/02/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MANORCARE HEALTH SERVICES-UTICA RIDGE	3800 COMMERCE BLVD DAVENPORT, IA 52807

(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 692	Continued From page 34 there is a nutritional problem and the health care provider orders a therapeutic diet. This REQUIREMENT is not met as evidenced by: Based on record review and interview, the facility failed to assess and evaluate a resident's significant weight loss and implement interventions to prevent further loss for 1 of 3 residents reviewed with a weight loss (Resident #2). The facility reported a census of 85 residents. Findings Include: 1. The Minimum Data Set (MDS) Assessment Tool, dated 12/7/20, listed diagnoses for Resident #2 included heart failure, cancer, and debility related to cardiorespiratory conditions. The MDS stated the resident required extensive assistance of 1 staff for personal hygiene, walking, and bathing, and extensive assistance of 2 staff for bed mobility, transfers, dressing, and toilet use. The MDS listed the resident's Brief Interview for Mental Status (BIMS) score as 15 out of 15, indicating intact cognition. An 11/2/20 History and Physical report stated the resident presented to the Emergency Department with bilateral (pertaining to both sides of the body) hip fractures and listed the resident's weight as 122.98 lbs (pounds). The resident's facility Admission Record Report stated the resident had a hospital stay from 11/2/20-11/17/20 and initially admitted to the facility on 11/17/20. The Weights and Vitals Summary listed an 11/17/20 weight of 124.4 lbs.	F 692		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	165575	A. BUILDING _____ B. WING _____	C 02/02/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MANORCARE HEALTH SERVICES-UTICA RIDGE	3800 COMMERCE BLVD DAVENPORT, IA 52807

(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 692	Continued From page 35	F 692		

A Progress Note, dated 11/18/20, stated the resident admitted to the facility following a hip replacement and planned to discharge to home following her stay. The note stated the resident was in "good spirits".

A facility Progress Note, dated 11/21/20, stated the resident discharged to the hospital due to vomiting and respiratory distress.

A Hospital Dietician Report, dated 11/27/20, stated the resident had lost 4.2 lbs. from her stated weight and reported it was not significant but clinically relevant. The note stated the resident was receptive to trying Ensure Enlive chocolate (a dietary supplement) and stated the resident would return to the facility with dietary supplements 2-3 times per day. The note stated the facility Dietician should follow.

A facility Progress Note, dated 11/28/20, stated the resident readmitted to the facility after a hospitalization.

The Weights and Vitals Summary listed an 11/29/20 weight of 115 lbs. This calculated as a 7.56% loss from the resident's weight of 124.4 lbs prior to the hospitalization on 11/17/20.

A 12/2/20 Nutrition Assessment, completed by the facility dietician, listed the resident's weight as 112 lbs. It stated the resident was underweight for an older adult and consumed 25-100% of meals. The assessment stated the resident did not like the food choices offered and the lack of salt was affecting her food intake. The notes stated the resident's was on a No Added Salt (NAS) diet and requested a regular diet. The

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	165575	A. BUILDING _____ B. WING _____	C 02/02/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MANORCARE HEALTH SERVICES-UTICA RIDGE	3800 COMMERCE BLVD DAVENPORT, IA 52807

(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 692	Continued From page 36	F 692		

note stated the Dietician obtained an order for a regular diet per the resident's request. The resident agreed to a "magic cup" (a frozen high calorie supplement) three times per day and listed a recommendation for a multivitamin with minerals.

An Order Audit Report listed a 12/7/20 order for a magic cup three times per day. The facility lacked documentation of a magic cup initiated on 12/2/20 when the Dietician stated the resident agreed to it.

The resident's December 2020 Medication Administration Record (MAR) listed an order for a multivitamin which started on 12/9/20. The MAR lacked documentation the resident received the vitamin prior to 12/9/20.

A 12/10/20 the Nurse Practitioner report directed staff to continue the resident's NAS diet.

The Order Summary Report with a list of active orders as of 12/27/20, listed an order for a NAS diet with an order date of 11/28/20. The orders did not list a change to a regular diet between the time the Dietician obtained an order for the change on 12/2/20 per the resident's request and the resident's death at the facility on 12/27/20.

The Weights and Vitals Summary listed a 12/6/20 weight of 101.1 lbs, calculated as a 12.09% loss from the resident's readmission weight of 115 lbs on 12/29/20 and an 18.73% loss from the resident's original admission weight on 11/17/20.

The Weights and Vitals Summary listed a 12/14/20 weight of 95.4 lbs, calculated as a 17.04% loss from the resident's readmission

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	165575	A. BUILDING _____ B. WING _____	C 02/02/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MANORCARE HEALTH SERVICES-UTICA RIDGE	3800 COMMERCE BLVD DAVENPORT, IA 52807

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F 692	Continued From page 37	F 692		

weight of 115 lbs on 12/29/20 and a 23.3% loss from the the resident's original admission weight on 11/17/20.

An untitled Physician's Progress Note, dated 12/15/20, stated the resident's had lost 20 lbs since her initial admission. The note stated the resident reported she had a decline in her appetite since being at the facility but had not been taking her antidepressant. The note also stated the resident had chronic diarrhea several times per day and was usually on loperamide (an antidiarrheal). The note stated the physician would restart the resident's loperamide and antidepressant.

The facility lacked documentation of physician and family notification of the resident's weight loss between the resident's readmission on 11/28/20 and 12/15/20 when the physician noted the weight loss. The facility lacked documentation of an additional intervention carried out aside from the magic cup initiated on 12/7/20 and the multivitamin on 12/9/20. The facility lacked documentation of whether or not the resident consumed the magic cup and lacked documentation of ongoing assessments of the resident's weight or an evaluation as to whether the magic cup was effective.

The Weights and Vitals Summary included the following weights (in lbs):
11/17/20: 124.4
11/19/20: 114
Resident was in the hospital from 11/21/20-11/28/20
11/29/20: 115
11/30/20: 114.6
12/1/20: 110.6

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	165575	A. BUILDING _____ B. WING _____	C 02/02/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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F 692	Continued From page 38	F 692		

12/2/20: 110.6
12/3/20: 103
12/4/20: 102.6
12/5/20: 100.8
12/6/20: 101.1
12/7/20: 98.6
12/9/20: 98.8
12/10/20: 99
12/11/20: 98.6
12/12/20: 98.9
12/13/20: 97.1
12/14/20: 95.4
12/15/20: 94.8
12/16/20: 94.2
12/17/20: 99
12/18/20: 94.8
12/19/20: 94.4
12/20/20: 94.2
12/21/20: 93.4
12/22/20: 93
12/24/20: 93.2

A 12/18/20 Progress Note stated the family requested to discharge the patient to home on 12/21/20.

A 12/21/20 Progress Note stated the resident tested positive for COVID-19.

A 12/24/20 Progress Note stated the family requested a Hospice evaluation.

The resident's December 2020 Documentation Survey Report v2 lacked documentation staff offered the resident fluids on the following 6:00 a.m.-2:00 p.m. shifts: 12/4/20 and 12/19/20 and on the following 2:00 p.m.-10:00 p.m. shifts: 12/1/20, 12/9/20, 12/12/20, 12/15/20, 12/18/20, 12/21/20, 12/22/20, and 12/23/20. The report

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	165575	A. BUILDING _____ B. WING _____	C 02/02/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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F 692	Continued From page 39	F 692		

documented the resident did not consume any of her meals from 12/20/20-12/27/20.

The facility had documentation the resident's Advanced Registered Nurse Practitioner (ARNP) aware the resident was not eating according to the 12/21/20 ARNP Progress Note. The facility lacked further documentation of provider notification the resident was not eating from 12/21/20 until the time the resident was sent to the emergency room on 12/25/20.

An Emergency Department Report, dated 12/25/20, stated the resident admitted to the ER due to hypoxia (inadequate oxygen in the blood) and hypotension(low blood pressure). The note stated the resident had dry, cracked oral mucous membranes and her labs were consistent with acute kidney injury likely secondary to dehydration.

A 12/25/20 Progress Note stated the resident returned from the hospital.

A 12/27/20 Progress Note stated the resident expired at the facility at 6:10 p.m.

Care Plan entries, dated 11/17/20, stated the resident would experience no significant weight change and included the following interventions:
a. Vitamin and mineral supplements.
b. Honor food preferences.
c. Supplements (dietary).
d. Report intolerance to current diet.
e. Review weights and notify the physician and responsible party of significant weight change.
f. Snacks per resident preference.

The Care Plan lacked additional resident

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	165575	A. BUILDING _____ B. WING _____	C 02/02/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MANORCARE HEALTH SERVICES-UTICA RIDGE	3800 COMMERCE BLVD DAVENPORT, IA 52807

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F 692	Continued From page 40	F 692		

centered, specific interventions based on the residents likes and dislikes to assist the resident in maintaining or gaining weight.

The facility policy "Weight Measurement", dated 03/2018, directed staff to compare weights to the previous weight and review discrepancies with the nurse. The policy stated discrepancies were considered to be 5 lbs if the patient was over 100 lbs. The policy directed staff to notify the physician and the responsible party of the weight loss and stated the dietician would evaluate and document in the nutrition progress notes.

The untitled facility policy regarding Care Plans, dated 2013, stated the facility would create a Comprehensive Care Plan to include individualized interventions which focused on specific risk factors.

The facility policy "Change in Condition", dated 11/2016, stated the facility must immediately inform the resident, the resident's physician, and the resident's representative when there was a significant change in the resident's physical, mental, or psychosocial status.

During an interview on 1/19/21 at 2:32 p.m., the Director of Nursing (DON) stated she could not locate any additional dietary interventions for Resident #2 other than a magic cup. She stated a weight loss would trigger if it occurred in a 30 day time period. She stated it would not trigger for a shorter period of time. When the surveyor asked if the facility could miss a weight loss due to this, she stated "potentially".

During an interview on 1/19/21 at 3:30 p.m., the Registered Dietician stated if a resident had an

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	165575	A. BUILDING _____ B. WING _____	C 02/02/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MANORCARE HEALTH SERVICES-UTICA RIDGE	3800 COMMERCE BLVD DAVENPORT, IA 52807

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F 692	Continued From page 41	F 692		

8-10 pound weight loss in a week, it should trigger. She stated though that weight changes were triggered for the period of 1 month and 6 months and may not trigger for a shorter period of time. She stated she completed Resident #2's initial assessment but did not complete any follow up.

During an interview on 1/20/21 at 7:45 a.m., the Registered Dietician stated she completed the resident's assessment on 12/2/20 and liberalized the diet, started a magic cup, and recommended a multivitamin. On 12/7/20, she continued those interventions. She stated on 12/7/20, she already had interventions in place. She stated the unit managers would let her know of weight losses and stated unless someone told her of more of a weight loss, she would not have followed up. She stated the resident told her 110-115 lbs was her usual weight. She stated they would notify the physician of a weight loss if it triggered for the period of 1 month or 6 months. She stated they may not inform the physician of a weight loss in a shorter period of time. She stated with Resident #2, the month period hadn't passed yet.

During an interview on 1/26/21 at 9:28 a.m., Staff P, Physician, stated if a resident's weight decreased from 115 lbs-101 lbs in a period of a week, she would want the facility to notify her. She stated with weight loss, they may start an appetite stimulant. If the facility tried a supplement and it wasn't working or the resident did not like it, she would expect them to try something different. If a magic cup was the intervention, she would want the facility to evaluate whether or not it was effective. She stated if a resident returned from the hospital with a weight loss, the facility should monitor the

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	165575	A. BUILDING _____ B. WING _____	C 02/02/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MANORCARE HEALTH SERVICES-UTICA RIDGE	3800 COMMERCE BLVD DAVENPORT, IA 52807

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F 692	Continued From page 42	F 692		

weight even more closely

During an interview on 1/26/21 at 9:52 a.m., the Food Service Director stated the facility Dietician assessed weight loss. She stated the Dietician discussed the resident's preferences of food. She stated she wasn't provided a list of weight losses in the facility.

During an interview on 1/26/21 at 10:30 a.m., Staff Q, Licensed Practical Nurse (LPN) stated she would want to know if a resident's weight decreased from 115 lbs to 101 lbs in 1 week. She stated if this happened, she would let the Dietician and the physician know and would start giving snacks and Ensure (a dietary supplement).

During an interview on 1/26/21 at 10:58 a.m., Staff F, Registered Nurse (RN) stated the facility Dietician flagged residents with weight loss. She stated if a resident's weight decreased from 115 lbs to 101 lbs in a period of a week, they should notify the physician.

During a interview on 1/27/21 at 8:05 a.m., Staff D RN/Nurse Manager stated if a resident's weight decreased from 115 lbs to 101 lbs in a week and the weight was accurate, he would expect staff to notify the doctor and the Dietician for supplements. He stated they would notify the family and inquire if the resident had any comfort foods. He stated staff should evaluate the effectiveness of an intervention such as a magic cup.

During an interview on 1/27/21 at 8:54 a.m., Staff M RN/Nurse Manager stated if a resident had a weight loss, she would let the Dietician and the physician know. She would want to figure out the

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	165575	A. BUILDING _____ B. WING _____	C 02/02/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MANORCARE HEALTH SERVICES-UTICA RIDGE	3800 COMMERCE BLVD DAVENPORT, IA 52807

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F 692	Continued From page 43 reason, possibly the resident had food preferences and the family could bring in food. She stated the Certified Nursing Assistants (CNA's) weighed the resident and it was the nurses' responsibility to look at the previous weight to see if there was a change and if so to notify the physician. She stated if a resident's weight decreased from 115 lbs to 110 lbs in 1 week, she would speak to the physician to determine the root cause. She stated she wasn't sure if staff monitored interventions such as a magic cup to see if residents consumed them. She stated if a resident had a weight loss during a hospital stay, this would be a trigger to keep an eye on the resident's weight. During an interview on 1/27/21 at 10:43 a.m., the DON stated the Dietician monitored weights on a 30 day basis and was not sure about weight losses which occurred in a shorter period of time. When the surveyor asked whether the facility should notify the physician if a resident's weight decreased from 115 lbs to 101 lbs in the period of a week, she stated she was not sure how that worked outside of the 30 day time frame and stated she would check the facility policy and get back to the surveyor. During subsequent email correspondence on 1/27/21 at 1:49 p.m., the DON wrote that the facility followed the regulatory guidelines for a notification of a 5% weight loss in 30 days.	F 692		
F 759 SS=D	Free of Medication Error Rts 5 Prcnt or More CFR(s): 483.45(f)(1) §483.45(f) Medication Errors. The facility must ensure that its-	F 759		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	165575	A. BUILDING _____ B. WING _____	C 02/02/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MANORCARE HEALTH SERVICES-UTICA RIDGE	3800 COMMERCE BLVD DAVENPORT, IA 52807

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F 759	Continued From page 44 §483.45(f)(1) Medication error rates are not 5 percent or greater; This REQUIREMENT is not met as evidenced by: Based on observation, record review, and interview, the facility failed to ensure the medication error rate did not reach 5 percent or greater. The Medication Pass Observation revealed 3 errors out of 38 opportunities for errors resulting in a medication error rate of 7.89% The facility reported a census of 85 residents. Findings Include: 1. During a morning Medication Pass Observation on 1/13/21 at 7:15 a.m., Staff K, Registered Nurse (RN) administered Resident #19's morning medications but did not administer the resident's Gabapentin(used to treat nerve pain) 300 mg(milligrams). Resident #19's Medication Administration Audit Report for 1/13/21 listed an order for Gabapentin 300 mg daily scheduled at 8:00 a.m. The report listed the administration time as 10:59 a.m. 2. During a morning Medication Pass Observation on 1/13/21 at 7:30 a.m., Staff K administered Resident #18's morning medications including Afrin (a nasal decongestant) 1 spray to each nostril. During the medication pass Staff K did not administer the resident's Cholecalciferol(Vitamin D). Resident #18's Medication Administration Audit	F 759		

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	165575	A. BUILDING _____ B. WING _____	C 02/02/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MANORCARE HEALTH SERVICES-UTICA RIDGE	3800 COMMERCE BLVD DAVENPORT, IA 52807

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F 759	Continued From page 45 Report for 1/13/21 listed an order for Cholecalciferol 5000 IU(International Units) daily scheduled at 8:00 a.m. The report listed the administration time as 11:56 a.m. The report revealed no order listed an order for Afrin. The facility policy "Medication and Treatment Administration Guidelines", dated 2018, stated the facility would administer medications in accordance with standards of practice and state specified and federal guidelines. It stated the facility would retain medication orders in the clinical record. The facility policy "Medication Administration: Medication Pass", dated 3/2010, directed staff to refer to the Medication Administration Report (MAR) when preparing medications and to document medications on the MAR. During an interview on 1/20/21 at 12:37 p.m., the Director of Nursing (DON) stated she could not find an order for the resident's Afrin and did not know where it came from. During an interview on 1/27/21 at 10:43 a.m., the DON stated nurses should sign out medications immediately after administration and stated if a resident had a medication from home they desired, the facility would need an order to administer this.	F 759		
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	F 761		

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	165575	A. BUILDING _____ B. WING _____	C 02/02/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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F 761	Continued From page 46 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 record review, staff interview and facility policy review the facility failed to store controlled/Schedule II medications in a separately locked and permanently affixed compartment in the medication cart for 3 of 3 residents reviewed. (Resident #7, #13 and #14). The facility identified a census of 85 residents. Findings Include: 1. Review of the facilities Medication and Treatment Administration Guidelines form updated 3/2018 included the following directive: a. Controlled substances stored securely in a double-lock system (medication cart, medication room, refrigerator, controlled substance lock box	F 761		

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	165575	A. BUILDING _____ B. WING _____	C 02/02/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MANORCARE HEALTH SERVICES-UTICA RIDGE	3800 COMMERCE BLVD DAVENPORT, IA 52807

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F 761	Continued From page 47 and/or separately keyed controlled substance drawer in the medication cart. 2. Review of a Medication Administration: Master Controlled Substance Log form dated 11/2017 documented the guideline as the Master Controlled Substance Log and Controlled Record to have been used to aid in ensuring controlled substance accountability on medication carts and refrigerators that contained controlled substances. The procedure included the following: a. The medication carts that contained controlled substances would have the Master Controlled Substance Log which included the following: 1. Dated received. 2. Two (2) nurse's signatures. 3. Prescription (RX) information for placement of pharmacy refill label or handwritten if label not available which contained the following information: a. Resident name. b. Prescription number. c. Controlled substance name. d. Number of doses. During an interview 1/21/21 at 12:57 p.m., Staff B, Licensed Practical Nurse (LPN) stated he worked on Garden South on the date of the alleged incident but could not recall the date. Staff B indicated as he sat at the Nurse's Station Staff A, LPN came downstairs at around 9:00 p.m. to 9:10 p.m. and gave him three (3) medication cards for residents #7, #13 and #14. Staff B confirmed when Staff A brought him the medications the staff members failed to count and sign for the receipt of the medications. Staff B indicated once Staff A gave him the medications he tried to scan the medications into	F 761		

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	165575	A. BUILDING _____ B. WING _____	C 02/02/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MANORCARE HEALTH SERVICES-UTICA RIDGE	3800 COMMERCE BLVD DAVENPORT, IA 52807

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F 761	Continued From page 48	F 761		

the computer system but had not been unable to do so. Staff B then asked Staff C, LPN for assistance however neither staff members had been able to scan the medications. Staff B then placed the medications into the bottom right drawer of the medication cart, not the locked narcotic drawer. When the night nurse arrived at the facility for her scheduled shift Staff A gave report and counted the medications in the narcotic drawer but he forgot to tell the nurse he stored other narcotic medications in the bottom right drawer of the medication cart. Staff B then went home.

Staff B, LPN confirmed he failed to properly store the narcotic medications in the locked narcotic drawer in the medication cart.

During an interview 1/13/21 at 3:15 p.m., Staff D, Registered Nurse (RN)/ Nurse Manager confirmed Staff B failed to have documented receipt of the narcotic medications with another nurse and to have properly stored the narcotic medications in the locked narcotic drawer in the medication cart per facility policy.

During an interview 1/14/21 at 2:44 p.m., Staff A, LPN stated the facilities policy/procedure directed the facility staff to have stored narcotics in a double locked area at all times.

During an interview 1/13/21 at 4:05 p.m., Staff E, LPN confirmed the facility policy/procedure directed facility staff to have stored narcotics in the narcotic drawer in the medication cart and it had never been acceptable for narcotics to have been placed in an area not double locked.

During an interview 1/14/21 at 3:54 p.m., Staff C,

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	165575	A. BUILDING _____ B. WING _____	C 02/02/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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F 761	Continued From page 49 LPN confirmed facility policy and procedure for storage of narcotics and anxiety medications as always double locked.	F 761		
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: §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	F 880		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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MANORCARE HEALTH SERVICES-UTICA RIDGE	3800 COMMERCE BLVD DAVENPORT, IA 52807

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F 880	Continued From page 50 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 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, record review, and staff interview, the facility failed to carry out infection control measures for 1 of 3 dressing changes observed (Resident #7), 1 of 5 residents observed receiving medications (Resident #19), and 1 of 2 residents observed in TBP	F 880		

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	165575	A. BUILDING _____ B. WING _____	C 02/02/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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F 880	Continued From page 51 (Transmission Based Precautions) (Resident #16). The facility reported a census of 85 residents. Findings Include: 1. During an observation on 1/12/20 at 9:40 a.m., Staff F, Registered Nurse (RN) took scissors out of her pocket. Without cleaning them, she cut off the dressing on Resident #7's right foot. She subsequently took Santyl cream (a medication used to treat wounds) out of a drawer in the resident's room and sat it directly on the floor. She then applied the cream to a gauze bandage and placed the bandage on the resident's foot. 2. During a Medication Pass Observation on 1/13/20 at 7:15 a.m., Staff K, Registered Nurse (RN) was in the process of pouring a multivitamin out of the bottle into a medication cup when the multivitamin fell onto the top of the medication cart. Staff K picked up the multivitamin with her ungloved hand, placed it into the medication cup, and subsequently gave it to Resident #19. 3. During an observation on 1/13/20 at 12:47 p.m., Staff I, Certified Nursing Assistant (CNA) entered Resident #16's room. The resident laid in bed on her back. Staff I unfastened the resident's incontinent brief and rolled the resident over. The brief was soiled with fecal material. Staff I cleansed the resident's buttocks and changed her incontinent brief. During cares, Staff I wore gloves but did not wear a gown. During the cares, Staff I noticed a dressing on the resident's buttocks needed changed so he informed Staff J, Licensed Practical Nurse (LPN).	F 880		

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	165575	A. BUILDING _____ B. WING _____	C 02/02/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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F 880	Continued From page 52 Subsequently, Staff J entered the room with the supplies and changed the resident's dressing. Staff J had a gown on and stated the resident was in contact precautions due to Clostridium Difficile (C-Diff) - a contagious bacteria which causes inflammation of the bowel and diarrhea). The facility policy "Medication Administration: Medication Pass", dated 3/2010, stated during the administration of medications, staff should not touch medications. The facility policy "Transmission Based Precautions", dated 5/2013, stated if a resident was in contact precautions, staff should wear a gown when they anticipated their clothing would come in contact with the resident, environmental surfaces, or items in the room contaminated with the organism. During an interview on 1/27/21 at 10:43 a.m., the Director of Nursing (DON) stated Resident # 16 was positive for C-Diff from 12/20/20 and staff should wear gowns, gloves, and universal Personal Protective Equipment (PPE) when caring for her. She stated nurses could carry scissors in their pockets but should clean them before using them. She stated staff should place ointments on a barrier and should not pick up a pill with their bare hands. She stated if a nurse dropped a pill, they should discard it and get a new one.	F 880		