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
	165293	A. BUILDING _____ B. WING _____	05/13/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SOUTHERN HILLS SPECIALTY CARE	444 NORTH WEST VIEW DRIVE OSCEOLA, IA 50213

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 000	INITIAL COMMENTS Correction date 6/13/21 The following deficiencies relate to the annual recertification and State Licensure Survey conducted on 5/5/21 -5/13/21 See Code of Federal Regulations (42CFR) Part 482, Subpart B-C.	F 000	"This Plan of Correction is prepared and submitted as required by law. By submitting this Plan of Correction, Southern Hills Specialty Care does not admit that the deficiency listed on this form exist, nor does the facility admit to any statements, findings, facts, or conclusions that form the basis for the alleged deficiency. The facility reserves the right to challenge in legal and/or regulatory or administrative proceedings the deficiency, statements, facts, and conclusions that form the basis for the deficiency."	
F 684 SS=D	Quality of Care CFR(s): 483.25 § 483.25 Quality of care Quality of care is a fundamental principle that applies to all treatment and care provided to facility residents. Based on the comprehensive assessment of a resident, the facility must ensure that residents receive treatment and care in accordance with professional standards of practice, the comprehensive person-centered care plan, and the residents' choices. This REQUIREMENT is not met as evidenced by: Based on clinical record review and resident and staff interviews, the facility failed to assess and monitor the weight of a resident with a history of congestive heart failure and implement interventions to prevent them from experiencing a significant decline in condition which required a transfer and admission to the hospital for 1 of 20 residents reviewed (Resident #48). The facility reported a census of 85 residents. Findings include: The MDS (Minimum Data Set) assessment dated 2/6/21 revealed Resident #48 had diagnoses of heart failure and hypertension. The MDS	F 684	F684 Residents who have a diagnosis of CHF will have the following put into place for monitoring and reporting: Weekly weights with notification to physician of greater than 5 pounds in 1 week, Care plan and Physician Orders to reflect monitoring of labs, unless otherwise specified by physician. Nursing will implement the intervention of daily weights if resident is noted to have a gain of 5 pounds or greater in 1 week. How residents affected & residents with potential of being affected were identified: Audit performed by DON to identify residents with a diagnosis of CHF, chart review performed to evaluate resident risk, after review of residents it was determined that the plan of correction will be applied to residents with a diagnosis of CHF. Measures or systemic changes made to ensure this will not recur and affect others: Weekly review performed by unit managers to ensure weight monitoring and physician notification is being completed if a 5lbs gain as occurred. Planned monitoring of corrective actions to ensure practice is corrected and will not occur: Administrator and DON to review completion of tasks weekly in stand up meeting.	6/11/21

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE — TITLE: Administrator — (X6) DATE: 6/13/21

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 684	Continued From page 1 documented the resident had a brief interview for mental status (BIMS) test score of 15 which indicated the resident demonstrated intact cognition. The MDS reveled the resident took a diuretic on 7 of 7 days during the look-back period. The MDS dated 3/27/21 revealed resident #48 readmitted to the facility from the hospital on 3/5/21. The care plan revised 7/20/20, revealed the resident took Lasix and metoprolol related to hypertensive heart failure. Staff directives included to administer medication as ordered, monitor for side effects and effectiveness of the medication, monitor per protocol for signs and symptoms of ineffective cardiac output such as edema, abnormal pulse/blood pressure, dizziness, tiredness, headache, and fluid volume disturbances related to heart failure diagnosis, and notify the physician of any symptoms. Interventions added to the care plan after the resident readmitted from the hospital on 3/5/21 included: check breath sounds and monitor for labored breathing and use of accessory muscles (added 3/5/21), evaluate for excessive fluid retention (added 3/5/21), monitor lab work (3/5/21), monitor and document edema of legs and feet, shortness of breath upon exertion, dry cough, weight gain unrelated to intakes, crackles or wheezes in the lungs, increased heart rate, or lethargy. (added 3/5/21) An eINTERACT SBAR communication form dated 2/28/21 revealed the resident had abnormal vital signs, edema, and shortness of breath. The resident had a history of CHF	F 684		

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F 684	Continued From page 2	F 684		

(congestive heart failure). Blood pressure 113/65, Pulse 126, Respirations 20, oxygen saturation 96 %, and weight 260.2 lbs (on 3/12/21). Primary care physician notified and resident sent to the ER (Emergency Room).

An e-INTERACT Transfer Form dated 2/28/21 revealed the resident had increased edema to her bilateral lower extremities (BLE's), blood pressure 113/65, heart rate 126, respiratory rate 20, and oxygen saturation 90 %.

The EHR weight summary documented the following weights for Resident #48:

8/27/2019	245.5 Lbs	Wheelchair
9/1/2019	241.1 Lbs	Wheelchair
9/10/2019	227.6 Lbs	Wheelchair
9/24/2019	229.4 Lbs	Wheelchair
10/12/2019	245.0 Lbs.	Wheelchair
11/2/2019	234.1 Lbs	Wheelchair
12/1/2019	244.0 Lbs	Wheelchair
2/3/2020	256.6 Lbs	Wheelchair
4/5/2020	252.1 Lbs	Wheelchair
6/2/2020	257.4 Lbs	Wheelchair
8/2/2020	265.1 Lbs	Wheelchair
10/28/2020	259.6 Lbs	Wheelchair
12/6/2020	265.4 Lbs	Wheelchair
1/16/2021	267.0 Lbs	Wheelchair
2/1/2021	271.4 Lbs	Wheelchair
3/5/2021	284.8 Lbs	Wheelchair

The MAR dated 2/1- 2/28/21 revealed staff initiated Lasix 40 mg daily (qd) for edema on 2/15/21 and initiated Lasix 80 mg daily for increased edema on 2/27/21.

The Order Summary report dated 1/1/21 and 2/1/21 revealed an order for Furosemide 80 mg

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F 684	Continued From page 3 daily for edema related to heart failure initiated on 8/27/19. Review of the summary revealed it did not direct staff to check the resident's weight and monitor for symptoms of heart failure, or contain parameters that ordered staff when to notify the physician for weight changes. The dietary progress notes revealed the following: a. On 1/20/2021 at 1:32 PM, On Resident #48 n 1/16, the resident weighed 267 lbs. The resident's weights are up 0.6% x 30 days and up 2.9% in 180 days and the resident continues on 80 mg Furosemide daily for fluid management related to heart failure. Staff documented no new recommendations at this time. b. On 2/8/2021 at 3:30 PM, staff documented resident had history of heart failure and COVID-19 and resident's weight on 2/1 = 271.4 lbs. This meant a weight increase of 1.6% in two weeks, 2.7% in three months, and 2.4% in six months; although this triggered no significant weight changes, the resident was at her heaviest since admission. Her weight has been 260#-271# with edema to her BLEs and she had an order for 80 mg Furosemide daily for heart failure. Her diuretic use and edema can cause significant weight fluctuations and staff discussed limiting sodium related to fluid retention with the resident and she verbalized understanding. In addition, the facility obtained a new order 2/8 to discontinue tubi-grips and start ACE wraps to BLEs. c. On 3/10/2021 at 1:12 PM, staff documented Resident recently hospitalized related to diagnoses of pneumonia and CHF. Resident aware of need to limit sodium related to heart health and fluid retention. Her weight as of 3/10 was 269.8 lbs.	F 684		

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F 684	Continued From page 4 The progress notes revealed the following: a. On 2/8/21 at 11:02 AM, resident refused to wear tubi grips because they cut into her legs. Waiting for response from physician for ace wraps. Resident continues to have 3+ edema to BLE and does not elevate her legs after she was up for the day. b. On 2/8/21 at 1:24 PM, tubigrips discontinued and order for ace wraps. c. On 2/14/21 at 1:00 PM, resident has 3+ BLE edema, redness, and increased warmth. Left lower extremity has seepage from the shin area. Ace wraps on as ordered. Resident complained her legs very painful and keeping her awake at night. Resident refuses to elevate throughout the day. d. On 2/16/21 at 3:04 PM, fax received from physician related to edema on 2/14. No new orders. Ceftin (antibiotic) 500 mg twice a day for 7 days, Lasix 40 mg at noon added, and culture and sensitivity of leg drainage already addressed. Resident encouraged to elevate her lower extremities through-out the shift but resident states "I have to go to the bathroom all the time due to that fluid pill". e. On 2/18/21 at 2:09 PM, oxygen saturation 94,0 %. BLE remain edematous, red with increased warmth. Resident refusing ace wraps to legs. f. On 2/22/21 at 11:55 AM physician updated on condition to BLE's with request for lab orders and Doppler scan. g. On 2/24/21 at 06:23 AM, order for Furosemide 80 mg by mouth one time a day for edema related to heart failure. BLE remain 3+ edema. LLE remains red and with increased warmth. No weeping noted. Resident does not elevate legs throughout day despite encouragement from staff.	F 684		

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F 684	Continued From page 5 h. On 2/26/21 at 12:59 PM, fax received regarding Doppler with no evidence of deep venous thrombosis. No new orders. i. On 2/26/21 at 2:03 PM, resident continues to have 3+ edema to BLE. Left lower extremity weeping and red with increased warmth. BLE painful to touch. Resident noted to be more short of breath, falling asleep while sitting in the wheelchair and also during conversation. Fax sent to physician. Lungs clear to auscultation, heart beat irregular at times, blood pressure lower than normal for resident. Oxygen saturation 93.0 %, blood pressure 90/48, pulse 92, respirations 18. j. On 2/28/21 at 7:45 AM, resident with increased edema to BLE's. Resident with increased heart rate and decreased pulse oximetry, cough noted, lung sounds with wheezes noted. Resident had shortness of breath. New order noted to send resident to the ER for evaluation and treatment. k. On 2/28/21 at 11:50 AM, resident admitted to the hospital for increased edema to BLE's. In an interview 05/05/21 at 01:28 PM, Resident #48 reported she took a fluid pill. The resident reported she had been hospitalized within the past few months because she had fluid build-up in her legs. The resident reported she had ace wraps on her legs because of the edema and had to watch her fluid intake. In an interview 05/12/21 at 02:40 PM, Staff G, Licensed Practical Nurse, reported if a resident had a history of CHF, she would listen to the resident's lung sounds, monitor the resident for edema, monitor for weight changes, and symptoms of shortness of breath. Staff G reported the residents' weights documented in the EHR under the weight and vitals tab. The	F 684		

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F 684	Continued From page 6 CNA's usually obtained resident weights, and reported to the nurse if any weight changes or changes in the residents' condition. Staff G stated she notified the physician if a resident had changes in weight, shortness of breath, or changes in lung sounds. She would have staff complete daily weights if the resident had any edema or weight trends on a resident. Staff G reported they did not need a physician order for staff to obtain weights, it was nursing judgement. Staff G reported Resident #48 went to the hospital in 2/2021 because she had swelling in her legs, shortness of breath, changes in her vital signs, and had increased drowsiness. In an interview 05/12/21 at 02:42 PM, the Director of Nursing (DON) reported the facility obtained resident weights upon admission and weekly for four weeks, then it depended upon the resident how often they needed staff to weigh them. The DON reported if a resident had a history of CHF, she would expect staff monitored the residents lung sounds, monitor for symptoms of shortness of breath, edema, medication changes, and labs. The DON reported Resident #48 had ace wraps and had been on a diuretic. Staff had talked to the physician before the resident went to the hospital. The resident had a lot of swelling and dependent edema in her legs, and slept in her recliner or sat in her wheelchair most of the day. The resident needed to get her legs above her heart level but she would not sleep in the bed.	F 684		
F 686 SS=G	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	F 686		

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F 686	Continued From page 7 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, clinical record review and staff and resident interviews, the facility failed to provide necessary treatment and services, consistent with professional standards of practice, to promote healing, prevent infection and prevent new ulcers from developing for 1 of 1 residents reviewed (Resident #14). The facility reported a census of 85 residents. Findings include: The Minimum Data Set (MDS) assessment tool defines pressure ulcer stages as follows: Stage I is an intact skin with non-blanchable redness of a localized area usually over a bony prominence. Darkly pigmented skin may not have a visible blanching; in dark skin tones only it may appear with persistent blue or purple hues. Stage II is partial thickness loss of dermis presenting as a shallow open ulcer with a red or pink wound bed, without slough (dead tissue, usually cream or yellow in color). May also present as an intact or open/ruptured blister.	F 686	F686 Plan of Correction: Requested software changes be made to PCC algorithm to facilitate nursing staffs awareness of new skin areas. Audit of mattresses and cushion in place, comparison made with resident Braden and MNA to assess appropriateness of current interventions, modifications implemented as indicated based on findings. Audit implemented to assess nursing completion and documentation of treatments, nurse managers to perform daily. Audit performed to skin care plans of residents with Braden score of less than 18 to determine if appropriate interventions are in place and effective based on resident need. Nursing staff will be educated on the purpose and correct placement of pressure reducing devices. Education provided to nursing staff regarding the expectation of weekly full body skin assessment. In-Depth Analysis: Braden report reviewed for facility, residents identified with Braden of less than 18 received in depth review of care plan to assure interventions are appropriate. How residents affected & residents with potential of being affected were identified: Braden report reviewed for facility, residents identified with Braden of less than 18 identified as at risk. Corrective action taken for resident(s) affected: Based on findings of at risk residents and review of interventions currently in place, new pressure relieving devices have been ordered and implemented as appropriate. Education has been provided to staff regarding correct placement and significance of pressure relieving devices. Education provided to C.N.A. staff to report skin issues to the nurse on duty until further notice while we await software changes to PCC algorithm. Education provided to facility nurses that the expectation of weekly full body skin checks includes areas of resident body.	

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F 686	Continued From page 8 Stage III Full thickness tissue loss. Subcutaneous fat may be visible but bone, tendon or muscle is not exposed. Slough may be present but does not obscure the depth of tissue loss. May include undermining and tunneling. Stage IV is full thickness tissue loss with exposed bone, tendon or muscle. Slough or eschar (dry, black, hard necrotic tissue). May be present on some parts of the wound bed. Often includes undermining and tunneling or eschar. Unstageable Ulcer: inability to see the wound bed. Other staging considerations include: Deep Tissue Pressure Injury (DTPI): Persistent non-blanchable deep red, maroon or purple discoloration. Intact skin with localized area of persistent non-blanchable deep red, maroon, purple discoloration due to damage of underlying soft tissue. This area may be preceded by tissue that is painful, firm, mushy, boggy, warmer or cooler as compared to adjacent tissue. These changes often precede skin color changes and discoloration may appear differently in darkly pigmented skin. This injury results from intense and/or prolonged pressure and shear forces at the bone-muscle interface. According to MDS dated 2/18/21, Resident #14 had diagnoses that included: multiple sclerosis, non-Alzheimer's dementia, diabetes mellitus, neurogenic bladder (urinary catheter dependent), peripheral vascular disease, malnutrition, dependence on wheelchair, and weakness. The	F 686	F686 Measures or systemic changes made to ensure this will not recur and affect others: Ongoing weekly review of resident braden score in weekly weight meeting to identify risk. Nursing managers will perform audit with hot chart review to assess nursing completion and documentation of treatments. DON will review skin care plans with MDS coordinator on admit and with weekly care plans to assure appropriate interventions are in place. Planned monitoring of corrective actions to ensure practice is corrected and will not occur: Administrator and DON to review completion of tasks weekly in stand up meeting.	6/11/21

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F 686	Continued From page 9 MDS documented the resident had the ability to understand others and scored 10 of 15 possible points on the Brief Interview for Mental Status (BIMS) test, which meant the resident demonstrated mild cognitive impairment. The MDS also documented Resident #14 required assist of 2 staff with bed mobility, surface-to-surface transfers, and dressing and required set up assist with eating. The MDS revealed the resident depended on a wheelchair for locomotion, showed impairment on one side of her upper extremities and both sides of her lower extremities, utilized an indwelling, suprapubic urinary catheter for bladder elimination and experienced bowel incontinence. The MDS indicated the resident's weight had remained stable, she had 1 unstageable pressure injury presenting deep tissue injury during the lookback period and the facility had preventative treatments in place. The MDS documented the resident as at a high risk for falls. The Braden Scale (an evidence-based too that predicts the risk for developing a hospital- or facility-acquired pressure ulcer or injury) dated 2/18/21 deemed the resident as at risk for pressure sores. The Care Plan dated 9/16/20 documented Resident #14 had actual skin impairment (an unstable pressure injury to the left heel). An addendum dated 5/7/21 revealed Resident #14 had a Stage 4 pressure injury to the left heel and directed staff to implement interventions that included: a. Prove a new recliner with more padding to the foot rest until Resident #14's daughter can provide more padding to the resident's previous	F 686		

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F 686	Continued From page 10 recliner's footrest. b. Apply Alternating Pressure Mattress (APP) mattress to bed (completed 2/16/21) c. Provide a body pillow for positioning in bed d. Educate Resident #14, their caregivers, and family of causative factors and measures to prevent skin injury e. Encourage the resident to maintain good nutrition and hydration to promote healthier skin f. Apply Equagel cushion to wheelchair (completed 2/16/21) g. Float the resident's heels elevate the heels to position them in such a way as to remove all contact between the heel and the bed or recliner) with a pillow when they rest in the recliner and in the bed (added 11/9/20). h. Follow E-TAR (Electronic Treatment Administration Record) for blister to right thigh (added 6/8/20) and treatment (added 12/1/2020). i. Apply a foot cradle (a frame that is installed at the foot of the bed to keep sheets/blankets off legs/feet to help with air circulation, sensitive skin, and keeping skin dry, especially if for a resident lying in bed for long periods of time.) to the bed. j. Apply heel cushion to wheelchair pedals. k. Provide the blue pillow under the resident's heels when in wheelchair The Braden Scale for Predicting Pressure Sore Risk dated 2/18/21 revealed Resident #14 scored 16 points which indicated a risk of pressure sore development. A Pressure Injury Evaluation dated 2/22/21 documented a Stage II wound to Resident #14's left heel. A Pressure Injury Evaluation dated 5/7/21 documented a Stage IV wound to Resident #14's	F 686		

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F 686	Continued From page 11 left heel that measured 3 centimeters (cm) in length; 3 cm in width; 2.5 cm in depth with tunneling present and large amounts of odorous purulent drainage. The Treatment Administration Record (TAR) dated 2/1/21-2/28/21 directed staff to complete a pressure skin evaluation for the resident's her left heel every Monday The TAR dated 3/1/21-3/31/21 directed staff to complete a pressure skin evaluation with regard to the resident's left heel every Monday starting 9/21/20 and ending 3/1/21. Review of the documentation on the TAR revealed no assessments documented regarding the left after 3/1/21. The TAR dated 3/1/21-3/31/21 directed staff to apply Cavilon to bilateral heels to prevent breakdown twice daily starting 11/11/20. Review of the documentation from 3/1/21 to 3/31/21 revealed 9 instances when the TAR failed to contain documentation to show that staff completed the treatment as ordered. Observation on 5/5/21 at 12:57 p.m. revealed Resident #14 sat in a recliner with her eyes closed with her feet resting on pillows rather than arranged in a manner to float heels as directed on the Care Plan. An observation on 5/10/21 at 10:30 a.m. revealed the foot cradle placed in an incorrect manner below Resident #14 legs while her heels touched the bed. The wound on her left did not contain the dressing the physician had ordered and the wound drainage had had saturated the bed sheets.	F 686		

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F 686	Continued From page 12 An observation on 5/11/21 at 9:04 a.m. revealed Resident #14 sat in a wheelchair and ate breakfast. Closer observation showed her heels rested on the properly positioned heel cushion, but the blue pillow sat in a chair next to her bed rather than under her heels as directed by the Care Plan. Observation on 5/12/21 at 11:00 a.m. revealed Resident #14 sat in a wheelchair, with the foot cushion in place on foot rests and the blue pillow in a chair next to the bed. During an interview on 5/10/21 at 10:45 a.m. with DON reported she discovered Resident #14 had a Stage IV pressure ulcer on her left heel and notified the physician who ordered lab work, a wound culture, oral antibiotics, wet to dry dressing changes to the left heel twice daily and directed staff to float the resident's heels. The DON added the resident had a history of a pressure ulcer in the same location in September of 2020. During an interview on 5/11/21 at 9:04 a.m., Resident #14 denied staff applied the daily lower extremity lotions or ointment to her legs or heels. The resident commented the only person that had applied any type of lotion was her daughter, but she had not seen her since prior to the COVID-19 lockdown. During an interview on 5/12/21 at 10:12 a.m., the DON reported staff routinely completed skin assessments, but could not verify whether or not staff included the heels in their assessments . The DON stated the resident's mattress was based on weight but did not know what a setting of 2 meant. During the interview, she reviewed the	F 686		

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F 686	Continued From page 13	F 686		

interventions on the care plan and stated she did not routinely complete audits to check if staff followed all of the interventions and had not been aware they weren't using the blue pillow. She stated the education to staff regarding the interventions was verbal and she did not have documentation that verified when or to whom it had been provided.

During an interview on 5/12/21 at 10:45 a.m., the DON reported the mattress in use for Resident #14 was a PressureGuard Easy Air XL mattress rather than an APP mattress. She stated staff placed the mattress on the most comfortable setting for the resident and confirmed the PressureGuard Easy Air XL was not a mattress that alternated pressure as the Care Plan specifically directed.

During an interview on 5/12/21 at 11:45 a.m. with Staff F, Certified Med Aide (CMA) revealed she often showered Resident #14 and she had notified nursing staff approximately a month ago that Resident #14 had a red spot on her left heel. She demonstrated the use of the shower chair used and showed how she could easily view a resident's heels. Staff F said she was "not surprised to learn Resident #14 developed another pressure ulcer. I have found her without her heels floated multiple times" and opined, "with the facility as short staffed as we have been , staff does not slow down and provide cares like they should."

A facility policy titled, "Assessments-Residents at Risk" dated January 2015 documented its purpose as follows: to identify at-risk individuals needing preventative interventions and the specific factors placing them at risk, to provide a

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F 686	Continued From page 14 supportive care prior to need, and to minimize skin problems. The policy directed staff to: a. Complete the Braden Scale quarterly and with a change in the resident's condition. b. Utilize and complete the MDS Assessment according to guidelines to identify residents at risk c. Establish a plan of care to minimize risks and initiate interventions. d. Keep the resident's family/physician informed of findings and status of skin. e. Reevaluate the resident periodically for effectiveness and alter plan of care according to need. f. Document the use of protective measures according to facility policy The policy directed staff to include the following information and activities in the Care Planning Process: a. Identify the problem and include the diagnosis, pre-existing conditions, nutrition, and past history of ulcers. b. Establish goals with resident input. c. Develop approaches and identify disciplines responsible for completion d. Review the problem daily at the QA meeting e. Provide information to assure staff are aware of preventative measures. An undated guide PressureGuard Easy Air XL documented the design of the mattress was intended to provide a high level of comfort, but did not contain any information to indicate the mattress had the alternating pressure ability as directed on Resident #14's care plan. The Director of Nursing (DON) verified Resident #14's room contained this bed for her to sleep in rather	F 686		

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F 686	Continued From page 15 than the alternating pressure mattress.	F 686		
F 688 SS=D	Increase/Prevent Decrease in ROM/Mobility CFR(s): 483.25(c)(1)-(3) §483.25(c) Mobility. §483.25(c)(1) The facility must ensure that a resident who enters the facility without limited range of motion does not experience reduction in range of motion unless the resident's clinical condition demonstrates that a reduction in range of motion is unavoidable; and §483.25(c)(2) A resident with limited range of motion receives appropriate treatment and services to increase range of motion and/or to prevent further decrease in range of motion. §483.25(c)(3) A resident with limited mobility receives appropriate services, equipment, and assistance to maintain or improve mobility with the maximum practicable independence unless a reduction in mobility is demonstrably unavoidable. This REQUIREMENT is not met as evidenced by: Based on clinical record review, observation, and resident and staff interview, and policy review, the facility failed to provide a restorative maintenance program for range of motion for three of six residents reviewed who displayed a limitation in range of motion and decline in activities of daily living (Resident #48, #82, and #34). The facility reported a census of 85 residents. Findings include: 1. The MDS (Minimum Data Set) assessment dated 12/23/20 revealed Resident #48 had diagnoses of heart failure, COVID-19, chronic	F 688	F688 Restorative Care Plans Re-written for resident's specific needs-Restorative Aide, Certified Nurses Aids, and Activity Personnel Educated on current restorative plans and signing off each day they are completed and turned into the Restorative Nurse. In the event that restorative aide is needed to perform daily care and is unable to perform restorative, activity staff will complete scheduled restorative activities. How residents affected & residents with potential of being affected were identified: DOR of facility performed audit to determine recommended Restorative programs for residents. DON initiated programs for specified residents. Corrective action taken for resident(s) affected: Residents evaluated by nursing and by therapy on who needs a restorative program. Care plans updated and Staff educated. Restorative Alde, Restorative Nurse, and Activity personnel who assisted in having their programs completed will sign off each day and document in the residents chart that it was completed. Measures or systemic changes made to ensure this will not recur and affect others: Staff will follow and perform current restorative care plans and document when completed on each resident. Planned monitoring of corrective actions to ensure practice is corrected and will not occur: Restorative nurse to monitor daily documentation to ensure completion and have the restorative aid and activity personnel sign off that is was completed. Check list for Restorative programs to be completed by appropriate staff and returned to DON each day for review.	6/11/21

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F 688	Continued From page 16 deep vein thrombosis, history of pulmonary embolism, and muscle weakness. The MDS documented the resident had a brief interview for mental status (BIMS) score of 15 which indicated intact cognition. The MDS identified the resident had experienced impaired range of motion (ROM) to bilateral lower extremities (BLE's). The resident required extensive assistance of two staff for bed mobility, transfers, dressing, and toileting, and limited assistance of one for personal hygiene. The MDS recorded the resident had occupational therapy 11/4/20 - 12/9/20 and physical therapy 3/30/20-5/14/20. The MDS recorded the resident had no Restorative Nursing Program (RNP) performed during seven of seven days during the assessment reference period. The quarterly MDS dated 3/27/21 documented the resident required extensive assistance of two staff for bed mobility, had total dependence on two staff for transfers, and extensive assistance of two staff for toileting. The MDS recorded the resident had no RNP performed during seven of seven days during the assessment reference period. The care plan revised 3/10//21 revealed the resident required staff assistance for activities of daily living (ADL's) related to weakness and immobility. The staff directives included a mechanical lift and two staff for transfers and toileting. The care plan focus area for restorative active range of motion and an intervention to perform ROM exercises to the upper extremities (BUE's) using pulleys for 2 minutes and use of omni cycle for upper and lower extremities up to 6 days a week for 15 minutes resolved on 3/10/21	F 688		

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F 688	Continued From page 17 The Documentation Survey Report dated 3/2021 - 5/2021 revealed the ADL's and the level of support required for dressing, hygiene, transfers, and locomotion on and off the unit. The report lacked any restorative nursing program exercises documented. Review of the PT discharge summary dated 3/26/21 revealed Resident #48 had CHF, muscle wasting and atrophy, and difficulty walking. The therapist documented the resident had met her maximum potential for therapy services and referred to a RNP for strengthening the BLE. The progress notes on 2/5/21 at 2:42 PM, therapy communication received for resident to start BUE pulley's and omnicycle to BUE and BLE. During an interview 05/05/21 at 12:59 PM, Resident #48 sat in a wheelchair in her room. The resident reported the facility sometimes had one aide working in the 400 hall. The resident reported staff used an EZ stand (a mechanical lift) whenever they transferred her, and she had to have staff assistance for toileting. The resident reported she had not done restorative activity for quite a while since the facility had been shorthanded. The person who did the restorative program had been pulled to do other things and she had not had restorative exercises for awhile. The resident voiced concerns that she preferred not to have to end up using a hoyer when staff transferred her. In an interview 05/12/21 at 10:16 AM, Staff F, CMA and restorative aide reported she looked at the kardex for information on the cares needed for each resident. The resident's restorative program listed on the computer under point of	F 688		

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F 688	Continued From page 18 care. Staff F reported she had worked at the facility for five years as a CNA, CMA, and restorative aide. Staff F reported Staff H, LPN, is the restorative nurse that helped develop an RA program for a resident. Staff F reported she was the only restorative aide that worked at the facility. Staff F reported over the past 9 months, the restorative activities with residents had been "hit and miss" due to COVID-19 and being short-staffed, and she had been assigned to work in other roles besides restorative activities. Staff F reported Resident #82 had been on restorative program but when she got her prosthesis, she had therapy services for awhile. Staff F stated she documented in POC whenever restorative exercises completed with the residents. Staff F reported if a resident refused restorative activity, she reattempted three times, and documented the reason for the refusal. Staff F reported she had seen a decline in resident ADL function since RA not done regularly. Staff F reported the last day she worked with residents for restorative exercises was a half day on 4/21/21. In an interview 05/12/21 at 12:01 PM, Staff H, LPN, reported she had not been the restorative nurse since 2/2020. Staff H stated the DON took over the restorative nurse program role at that time. In an interview 05/11/21 at 02:53 PM, Staff PT, reported resident not on case load at this time. Staff F does restorative with residents on a restorative program, but also worked as a CNA. Whenever a resident ended therapy services, the therapist wrote recommendations for restorative program or based on activity to meet a resident's needs. Staff F reported she gave the communication to nursing and the restorative	F 688		

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F 688	Continued From page 19 aide to follow the recommendations. In an interview 05/12/21 at 12:57 PM, the DON reported she received communication from therapy whenever a resident completed therapy and the therapy recommendations such as a restorative program. The DON reported she then added the restorative program to the care plan and Staff F, Restorative Aide, documented restorative activity performed in the EHR. The DON checked the EHR under the care plan tab for Resident # 48, and reported the resident had no restorative program listed. In an interview 05/12/21 at 02:40 PM, Staff G, LPN, reported no restorative aide working routinely due to the restorative aide working the floor as a cna for quite some time. Staff G reported she had not noticed any resident who had an ADL decline yet. Staff G reported some staff CNA's tried to have the resident do ROM exercise as dressed the resident or walked to dine with the residents that could walk. In an interview 05/12/21 at 02:42 the DON reported no restorative activity regularly done with the residents due to need for the restorative aide to work as a cna. The DON stated staffing needed due to COVID. A facility policy titled Restorative Nursing Program dated 11/2011, revealed the restorative nursing focuses on achieving and maintaining optimal physical, mental, and psychological functioning of the resident. Restorative nursing services provided by restorative nursing assistant, CNA's, or nurse trained in restorative techniques. Each resident who received restorative nursing had individualized goals and interventions listed on	F 688		

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F 688	Continued From page 20 the care plan. Components of the restorative nursing program included passive and active range of motion, splint/brace assistance, training and skills practice in transfers, bed mobility, ambulation, dressing, grooming, amputation/prosthesis, and communication. 2. The MDS assessment dated 11/12/20 revealed Resident #82 had diagnoses of of right below the knee amputation (BKA), muscle wasting and atrophy, and difficulty walking. The MDS documented the resident had a brief interview for mental status (BIMS) score of 15 which indicated intact cognition. The MDS identified the resident had experienced impaired range of motion to bilateral lower extremities. The resident required supervision for bed mobility, dressing, and personal hygiene, limited assistance of one staff for toileting, and had total dependence of two staff for transfers. The MDS recorded the resident had no RNP performed during seven of seven days during the assessment reference period. The MDS dated 4/29/21 revealed the resident required limited assistance of one staff for bed mobility, dressing, and personal hygiene, and extensive assistance of one staff for toileting . The MDS revealed the resident had OT services 11/11- 12/10/20 and PT services 1/27- 2/26/21. The MDS recorded the resident had not participated in a RNP during seven of seven days during the assessment reference period. The care plan updated 2/25/21 revealed the resident had a right below the knee amputation and had a risk for falls. The care plan documented the resident needed assistance with activities of daily living (ADL's) at times due to the	F 688		

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F 688	Continued From page 21 right BKA, and wore a prosthesis to her right leg. The care plan noted on 2/25/20 the resident chose not to ambulate due to weakness in her left leg and didn't feel stable enough for ambulation. The care plan focus area for restorative active range of motion and an intervention to perform restorative plan as written had been resolved on 5/28/20. Review of the Physical Therapy (PT) discharge summary dated 2/26/21 revealed the resident had a diagnoses of muscle wasting and atrophy. The resident discharged from PT on 2/26/21 after the resident had reached maximum potential with skilled services. The PT discharge recommendations included provision in assistance with IADL's and a referral for RNP for continuation of ROM (range of motion) for strengthening the bilateral lower extremities. Review of the Documentation Survey Report dated 3/2021 - 5/2021, revealed ADL's and the level of support required for dressing, hygiene, transfers, and locomotion on and off the unit. The report lacked any restorative nursing program exercises documented. During an interview 05/05/21 at 03:11 PM, Resident #82 reported she had not had any restorative activity for about a year. The resident reported the staff person who did restorative worked the floor. Observations at that time revealed the resident had a right BKA, and had a RLE prosthesis which sat on the bathroom floor. In an interview 05/12/21 at 10:16 AM, Staff F, CMA and restorative aide reported she looked at the kardex for information on the cares needed for each resident. The resident's restorative	F 688		

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F 688	Continued From page 22 program listed on the computer under point of care. Staff F reported she had worked at the facility for five years as a CNA, CMA, and restorative aide. Staff F reported Staff H, LPN, is the restorative nurse that helped develop an RA program for a resident. Staff F reported she was the only restorative aide that worked at the facility. Staff F reported over the past 9 months, the restorative activities with residents had been "hit and miss" due to COVID-19 and being short-staffed, and she had been assigned to work in other roles besides restorative activities. Staff F reported Resident #82 had been on restorative program but when she got her prosthesis, she had therapy services for awhile. Staff F stated she documented in POC whenever restorative exercises completed with the residents. Staff F reported if a resident refused restorative activity, she reattempted three times, and documented the reason for the refusal. Staff F reported she had seen a decline in resident ADL function since RA not done regularly. Staff F reported the last day she worked with residents for restorative exercises was a half day on 4/21/21. In an interview 05/12/21 at 12:01 PM, Staff H, LPN, reported she had not been the restorative nurse since 2/2020. Staff H stated the DON took over the restorative nurse program role at that time. In an interview 05/12/21 at 12:57 PM, the DON reported she received communication from therapy whenever a resident completed therapy and the therapy recommendations such as a restorative program. The DON reported she then added the restorative program to the care plan and Staff F, Restorative Aide, documented restorative activity performed in POC. The DON	F 688		

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F 688	Continued From page 23 checked the EHR under the care plan tab for Resident # 82, and reported the resident had no restorative program listed. 3. The MDS for Resident #34 with an Assessment Reference Date (ARD) of 03/04/21 included diagnoses of need for assistance with personal care, osteoarthritis, spinal stenosis, and muscle weakness. The MDS documented the resident had a BIMS score of 15 indicating cognition intact. The MDS documented the resident required extensive assistance of two staff for bed mobility, toileting, and dressing, total dependence and assistance of two staff for transfers, and required limited assistance of one staff for personal hygiene. The MDS documented the resident did not walk in the seven day look-back period. The MDS revealed the resident had impairment range of motion to her bilateral lower extremity, and used a wheelchair. The care plan initiated on 03/09/2015 revealed Resident #34 needed assistance with activities of daily living (ADL ' s) due to spinal stenosis. The care plan revealed a restorative range of motion plan was initiated on 11/06/2019. The interventions revealed active range of motion with Omnicycle for bilateral upper extremities a minimum of 15 minutes up to six days per week and restorative passive range of motion with Omnicycle for bilateral lower extremities a minimum of 15 minutes up to six days per week. The chart lacked documentation of any current restorative services for Resident #34. The Documentation Survey Report revealed Resident did not receive restorative services for	F 688		

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F 688	Continued From page 24 the months of 02/2021, 03/2021, 04/2021, and did not receive services 05/01/21-05/12/21. In an interview on 05/05/21 at 02:55 PM, Resident #34 revealed the facility was short handed and hadn't had restorative activity for at least a year, since the Covid-19 virus started. The resident reported the person who did restorative work had been pulled to work as a Certified Nursing Assistant (CNA). The resident hadn't noticed any decline in ADL's. She wasn't able to walk before and still can't walk, but just liked doing restorative care and felt like it helped her. In an interview on 05/12/21 at 12:57 PM the DON reported she received communication from therapy when resident #34 completed therapy and therapy had recommendations for a restorative program. The DON reported she then added the restorative program to the care plan and Staff F documented restorative care in Point Click Care. In an interview on 05/12/21 at 01:46 PM Staff F revealed she is the restorative aide, but said she hardly had any time to do restorative programs since Covid-19 and is usually working as a CNA. Per Iowa Administrative code (https://www.legis.iowa.gov/docs/iac/chapter/09-09-2020.481.58.pdf) accessed on 5/13/21 at 01:10 PM: 58.20(135C) Duties of health service supervisor. Every nursing facility shall have a health service supervisor who shall: 58.20(5) Initiate preventative and restorative nursing procedures for each resident so as to achieve and maintain the highest possible degree	F 688		

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F 688	Continued From page 25 of function, self-care, and independence based on resident choice, where practicable.	F 688		
F 725 SS=D	Sufficient Nursing Staff CFR(s): 483.35(a)(1)(2) §483.35(a) Sufficient Staff. The facility must have sufficient nursing staff with the appropriate competencies and skills sets to provide nursing and related services to assure resident safety and attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident, as determined by resident assessments and individual plans of care and considering the number, acuity and diagnoses of the facility's resident population in accordance with the facility assessment required at §483.70(e). §483.35(a)(1) The facility must provide services by sufficient numbers of each of the following types of personnel on a 24-hour basis to provide nursing care to all residents in accordance with resident care plans: (i) Except when waived under paragraph (e) of this section, licensed nurses; and (ii) Other nursing personnel, including but not limited to nurse aides. §483.35(a)(2) Except when waived under paragraph (e) of this section, the facility must designate a licensed nurse to serve as a charge nurse on each tour of duty. This REQUIREMENT is not met as evidenced by: Based on observation, clinical record review, and resident and staff interviews, the facility failed to ensure a resident had access to their call light (Resident #75). The facility also failed to ensure	F 725	F725 Sufficient Nursing staff, Plan of Correction: Call light audit to be performed by nurse each shift to assess if call lights are being answered promptly. Call light audit form will be audited by nursing managers daily for completion. Administrative staff will perform random audit of 5 alert and oriented residents daily throughout the facility to assess if call lights are being responded to in a timely manner, and will record the names of residents they speak with. Administrative staff will perform random audit of 5 residents who have been determined to be unable to utilize call light appropriately to assess for safety and needs fulfilled. How residents affected & residents with potential of being affected were identified: Review of resident history and staff questionnaire performed to determine residents who are at risk of being unable to utilize call light to call for assist. IDT team has determined interview of alert and oriented residents to be best practice of assessing timely staff responsiveness to call lights. Corrective action taken for resident(s) affected: Audits to be performed as listed in plan of correction. Staff education provided to nursing staff regarding importance of rounding the halls throughout their shift to assess for safety and needs fulfilled of residents who have been determined to be unable to utilize call light appropriately. Measures or systemic changes made to ensure this will not recur and affect others: Auditing and staff education. Planned monitoring of corrective actions to ensure practice is corrected and will not occur: Administrator and DON to review completion of audits weekly in stand up meeting.	6/11/21

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F 725	Continued From page 26 staff answered call lights in a timely manner (within 15 minutes) for 2 of 5 resident council members interviewed. The facility reported a census of 85 residents. 1. According to the Minimum Data Set (MDS) assessment tool dated 04/22/21, Resident #75 had diagnoses that included dementia with behavioral disturbance, hypertension, neurogenic bladder, arthritis, anxiety, depression, and psychotic disorder. The MDS documented Resident #75 scored 0 out of 15 points possible on the Brief Interview for Mental Status (BIMS) test, which meant the resident demonstrated severe cognitive impairment. The MDS revealed the resident required assist of 2 staff for bed mobility, surface-to-surface transfers, and dressing, and set-up assistance for eating. The MDS also documented the resident utilized an indwelling urinary catheter for elimination and experienced bowel incontinence, and revealed the resident was at a high risk for falls. An observation on 5/5/21 at 2:30 p.m. revealed Resident #75 sat in a wheelchair in her room with her call light out of her reach. At 2:50 p.m. she yelled, "I don't know what to do, I am supposed to have a call button to push for help!" At 3:02 p.m. the Dietary Manager stopped into the resident's room and offered her a snack. At 3:04 p.m. the resident yelled, "I don't have a call button to push, where the hell is everybody!" At 3:14 p.m. a Certified Nurse Assistant entered the resident's room to assist her. During an interview at Resident Council on 5/6/21 at 1:03 p.m. two of five members reported it took too long for staff to answer the call lights and added that staff often asked residents to turn off	F 725		

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F 725	Continued From page 27 their light and claim they will return to assist them and often do not return. During an interview with the Director of Nursing (DON) on 5/12/21 at 11:00 a.m., she reported their corporate office no longer allow them to provide a call light log and then stated the staff are to round on residents every 15 minutes.	F 725		
F 755 SS=D	Pharmacy Srvcs/Procedures/Pharmacist/Records CFR(s): 483.45(a)(b)(1)-(3) §483.45 Pharmacy Services The facility must provide routine and emergency drugs and biologicals to its residents, or obtain them under an agreement described in §483.70(g). The facility may permit unlicensed personnel to administer drugs if State law permits, but only under the general supervision of a licensed nurse. §483.45(a) Procedures. A facility must provide pharmaceutical services (including procedures that assure the accurate acquiring, receiving, dispensing, and administering of all drugs and biologicals) to meet the needs of each resident. §483.45(b) Service Consultation. The facility must employ or obtain the services of a licensed pharmacist who- §483.45(b)(1) Provides consultation on all aspects of the provision of pharmacy services in the facility. §483.45(b)(2) Establishes a system of records of receipt and disposition of all controlled drugs in sufficient detail to enable an accurate reconciliation; and	F 755	Description: F755 Pharmacy Services/ Procedures/Pharmacist/ Records. Plan of Correction: Daily Monitoring of Narcotic Counts to be performed by nurses at shift change and check off list with each hall to be completed daily. In-Depth Analysis: Identified the following: Fentanyl patch missing on controlled narcotic count with discrepancy noted in the narcotic count that was signed off. How residents affected & residents with potential of being affected were identified: Residents receiving narcotics have been identified as potential to be affected. Corrective action taken for resident(s) affected: Narcotic count corrected for fentanyl patch and nurse on prior shift signed off narcotic given. Measures or systemic changes made to ensure this will not recur and affect others: Nurse education provided regarding expectation of completing narcotic count with two nurses present to assure number of medications in narcotic box coincide correctly with the narcotic count sheet. Planned monitoring of corrective actions to ensure practice is corrected and will not occur: Nurse Manager to review narcotic counts daily and sign off completion.	6/11/21

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F 755	Continued From page 28 §483.45(b)(3) Determines that drug records are in order and that an account of all controlled drugs is maintained and periodically reconciled. This REQUIREMENT is not met as evidenced by: Based on observation, staff interview, and facility document and policy review, the facility failed to ensure staff kept an accurate count of a controlled substance for 1 of 2 medication carts reviewed. The facility reported a census of 85 residents. Findings include: During an observation of the medication cart on the 400 hall on 05/10/21 at 01:25 PM with Staff G, Licensed Practical Nurse (LPN), Resident #26's Counting of Controlled Substances document revealed one missing Fentanyl 50 microgram (mcg) patch. The undated controlled medication utilization record form documented two remaining patches, but the Fentanyl box contained only one patch.. The undated Fentanyl Patch Checks to verify placement and removal form for Resident #26 revealed one nurse signed 05/06/2021 for application/removal of a Fentanyl 50 mcg patch, but had not made an entry for 05/9/21. The Electronic Medical Record (EMR) medication administration record revealed Staff J documented they administered a Fentanyl patch to Resident #26 on 5/9/21. In an interview at the time the discrepancy was discovered, Staff G verified the discrepancy and	F 755		

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F 755	Continued From page 29 said she was not sure what had happened as she had thought two patches remained when she completed the controlled medication count with Staff J at shift change the morning of 05/10/21. On 05/10/21 at 02:18 PM, the DON reported she contacted the nurse that worked the evening shift on 05/09/21 and confirmed Staff J had administered a Fentanyl patch for Resident # 26. The DON stated Staff J planned to reconcile the narcotic record for the Fentanyl patch removed for Resident #26. Staff J had documented on the MAR she applied the Fentanyl patch on 5/9/21. The policy for Receiving and Administering Controlled Medications dated 02/20 revealed controlled substances are subject to special ordering, receipt, and record keeping requirements in the facility in accordance with federal and state laws and regulations. The policy directed the nurse entered the date, time of administration, dose, and signature on the drug control record immediately whenever they administered a controlled medication. The policy also directed the nurse coming on duty and the nurse going off duty must count at the end of each shift.	F 755		
F 761 SS=D	Label/Store Drugs and Biologicals CFR(s): 483.45(g)(h)(1)(2) §483.45(g) Labeling of Drugs and Biologicals Drugs and biologicals used in the facility must be labeled in accordance with currently accepted professional principles, and include the appropriate accessory and cautionary instructions, and the expiration date when applicable.	F 761	F761 Label/ Store Drugs Audit Med Carts and Med Room for expired medications and label. Plan of Correction: Nurse management to audit med room medications daily for labeling of name, expiration, and open date. Nurse management will sign off completion. Nurse Management will complete bi-weekly audit of medication and treatment cart audits to ensure labeling of name, expiration, and open date occur with medications and treatments and sign off bi-weekly. Monthly sign off sheet of medication room freezers to occur.	

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F 761	Continued From page 30 §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 observations, staff interviews, and facility policy review, facility staff failed to store drugs in accordance with currently accepted professional principles in two of two medication carts (400 hall, and 100 hall) and also failed to properly store a controlled substance to prevent potential drug diversion for one of one medication rooms (400 hall) reviewed. The facility reported a census of 85 residents. Findings include: Observation on 05/10/21 at 01:25 PM with Staff G, Licensed Practical Nurse (LPN) revealed the following: a. The 400 hall medication cart contained ten prefilled 0.9% sodium chloride 10 milliliter syringes. Four of the syringes had an expiration date of 12/2020.	F 761	F761 How residents affected & residents with potential of being affected were identified: Affected residents medication had label present identifying name. IDT team determined residents with medication stored in medication refrigerator could be potentially be affected. Corrective action taken for resident(s) affected: Nurse Management to audit med room medications daily for labeling of name, expiration, and open date. Nurse Management will complete bi-weekly audit of medication and treatment cart audits to ensure labeling of name, expiration, and open date occur with medications and treatments and sign off bi-weekly. Monthly sign off sheet of medication room freezers to occur. Nursing staff have been provided education regarding labeling of name, expiration, and open date expectations related to medications. Measures or systemic changes made to ensure this will not recur and affect others: Nurse management to audit med room medications daily for labeling of name, expiration, and open date. Nurse management will sign off completion. Nurse Management will complete bi-weekly audit of medication and treatment cart audits to ensure labeling of name, expiration, and open date occur with medications and treatments and sign off bi-weekly. Monthly sign off sheet of medication room freezers to occur. Planned monitoring of corrective actions to ensure practice is corrected and will not occur: Administrator and DON to review completion of tasks weekly in stand up meeting.	6/11/21

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F 761	Continued From page 31 2. A medication room located near the 400 hall contained a locked medication refrigerator with a three inch build-up of ice. 3. The same medication room contained an unlabeled, opened bottle of lorazepam (controlled substance) concentrate 2 milligram (mg)/milliliter (ml) with the expiration date worn off and not visible. The controlled medication record documented 4 ml remained in the bottle (during an additional observation on 05/12/21 at 11:30 AM with Staff E, nurse manager, the bottle and the documentation remained unchanged). An observation on 05/10/21 01:55 PM with Staff I, CMA revealed the medication cart for 100 hall and beginning of 200 hall contained an unlabeled box of Benadryl 25 mg tablets with 22 pills remaining and an expiration date of 3/21. Staff I then disposed of the expired Benadryl and said none of the residents currently utilized that medication. In an interview on 05/10/21 at 01:25 PM Staff G, LPN, reported the facility used the prefilled 0.9% sodium chloride 10 milliliter syringes for residents with intravenous fluids (IV), although they did not currently have anyone that required IV's. Staff G added a resident returning to the facility later in the week would have an IV. Staff G then disposed of the expired syringes. In an interview on 05/12/21 at 11:30 AM, Staff E, nurse manager, stated the expectation that staff label Lorazepam with name, opened date, and expiration date. Staff E reported the medication was for Resident # 84 and added all the staff knew this because she is the only resident that used liquid lorazepam. She said that normally maintenance defrosts the freezer, but she did not	F 761		

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F 761	Continued From page 32 know the last time that had occurred. The Policy for Medication Storage dated 02/20 directed staff to store medications in bins, containers, drawers or compartments that are clearly labeled with the resident's name.	F 761		
F 812 SS=D	Food Procurement,Store/Prepare/Serve-Sanitary CFR(s): 483.60(i)(1)(2) §483.60(i) Food safety requirements. The facility must - §483.60(i)(1) - Procure food from sources approved or considered satisfactory by federal, state or local authorities. (i) This may include food items obtained directly from local producers, subject to applicable State and local laws or regulations. (ii) This provision does not prohibit or prevent facilities from using produce grown in facility gardens, subject to compliance with applicable safe growing and food-handling practices. (iii) This provision does not preclude residents from consuming foods not procured by the facility. §483.60(i)(2) - Store, prepare, distribute and serve food in accordance with professional standards for food service safety. This REQUIREMENT is not met as evidenced by: Based on observation, clinical record review, and resident and staff interviews, the facility failed to store food properly in accordance with professional standards for food service safety. The facility reported a census of 85 residents. Findings include:	F 812	F812 Food Procurement. Store/Prepare/ Serve-Sanitary Plan of Correction: Dietary staff have been trained on the facility policy and the importance of labeling and dating opened food items on 6/8/21 by the facility ADM and CDM. Dietary staff have been trained on the facility protocol related to proper hand washing, wearing of hair restraints and wearing of PPE on 6/8/21 by the facility ADM and CDM. The plastic domes were removed from use on 6/8/21 and dietary staff were trained on this standard of practice for meal service to the main and activity dining rooms. Monitoring of dietary staff practices will be completed by the Certified Dietary Manager thru routine audits. The facility management team will also monitor during the kitchen rounds as part of the facility rounding. In-Depth Analysis: There is no need for plastic dome covers at meals served in the main dining room areas. How residents affected & residents with potential of being affected were identified: Residents served meals with the plastic covers and hand washing could be "at risk" of cross contamination.	

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F 812	Continued From page 33 Observations during the initial kitchen tour on 5/5/21 from 11:40 a.m. to 12:05 p.m. revealed the following: a. An undated zip closure bag held an opened bag of bread crumbs not dated b. The Victory fridge contained an opened container of beef bouillon without an opened date. d. On the counter sat an uncovered container of butter without an opened date. A subsequent observations of the kitchen on 5/10/21 from 9:07 a.m. to 12:11 p.m. revealed the following: a. Staff A, Dietary Staff, had 1 inch of hair exposed in the front and back of her hairline not covered by the hairnet. b. Staff B, Dietary Staff prepared food for residents with her face mask on her chin. c. Staff C, Cook prepared food for residents with her face mask unfastened, the loop attached to her ear, and the mask hanging free. d. Staff placed clear colored plastic plate covers with a small hole in the center over prepared resident meals and took them to the resident's dining room to be served. Various staff members removed the plastic cover and return the cover to the kitchen where staff re-used them on another resident's plate of food without washing or sanitizing them. e. Staff C, Cook, did not wash her hands prior to serving lunch meal. f. Staff C, Cook retrieved a piece of paper from the floor, placed it into the trash, and then did not wash her hands before returning to serve residents' lunch trays. During subsequent observations of the kitchen on	F 812	F812 Corrective action taken for resident(s) affected: Measures or systemic changes made to ensure this will not recur and affect others: The plastic domes used to cover plates at meals in the dining room were removed from the meal delivery process. Cooks were trained on proper hand washing. Planned monitoring of corrective actions to ensure practice is corrected and will not occur: Food temperature logs will be reviewed daily by cook. Hand washing audits will be completed routinely on dietary staff by DSM	6/11/21

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F 812	Continued From page 34 5/12/21 at 12:00 p.m., the Dietary Manager removed dietary carts filled with trays of food and drinks from the kitchen and distributed them to the residents in the dining room at the end of 300 hall. She inserted her finger into the center hole of the clear plastic plate cover to lift it, then returned the cart and plastic covers to the kitchen to be reused without washing or sanitizing them prior to other staff re-using the covers. Several other staff members assisted her with the distribution of meals to the residents and removal of covers. Observations revealed staff performed no hand hygiene at that time. A facility Storage policy dated 2/16 directed: a. All foods and non-food items will be received, dated and placed in designated storage areas by dietary services personnel. b. Food shall be arranged in storage areas by food group to make it easier to store, locate, and inventory. Food should be dated as it is placed on the shelves. A facility Handwashing policy revised on 3/9/20 directed staff to wash their hands after the following activities: a. After hand contact with unclean equipment and work surfaces, soiled clothing, and rags. b. After taking out garbage c. After leaving and returning to kitchen/prep area An undated facility Personnel Health Standards and Conduct policy directed: a. Hair will be properly covered by a hair restraint An undated corporate Visitation Policy	F 812		

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	165293	A. BUILDING _____ B. WING _____	05/13/2021

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F 812	Continued From page 35 documented, directed, and revealed Core Principles of COVID-19 Infection Prevention: a. Hand hygiene b. Face covering or mask covering the mouth and nose c. Cleaning and disinfecting high frequency touched surfaces in the facility often, and designated visitation areas after each visit d. Appropriate staff use of Personal Protective Equipment In an interview on 5/12/21 at 12:29 p.m., the Dietary Manager reported the kitchen had 12 clear plastic plate covers and approximately 17 residents that eat their meals in the dining rooms. She stated it would take too long to wash the covers before using them again while residents wait for their meals. She stated all staff should wash their hands after touching their face masks or items they retrieve from the floor before returning to food preparation.	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	Description: F880-Infection Control. Plan of Correction: Daily Monitoring to ensure residents with catheters, that catheter bags are off the floor and placed in privacy bag. How residents affected & residents with potential of being affected were identified: Residents with catheters identified as potential to be affected. Corrective action taken for resident(s) affected: Resident with catheters to have catheter bags securely fastened and placed in privacy bag off floor. Measures or systemic changes made to ensure this will not recur and affect others: CNA and Nurse education provided that resident catheter bags are to be securely fastened and placed in privacy bag off floor	

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

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F 880	Continued From page 36 §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 .	F 880	F880 Planned monitoring of corrective actions to ensure practice is corrected and will not occur: Team management member to perform daily audit to ensure catheter bags are securely fastened and placed in a privacy bag off floor. Director of Nursing will Contact Gina Anderson @ ganderson@telligen.com, to schedule root cause analysis of infection control practice, and will submit evidence of completing the training to program coordinator. Staff will view the following videos: PPE lessons: https://www.youtube.com/watch?v=YYTATw9yav4&feature=youtu.be Sparkling Surfaces:https://www.youtube.com/watch?v=t7OH8ORr5Ig&feature=youtu.be Clean Hands: https://www.youtube.com/watch?v=xmYMUly7qiE&feature=youtu.be Keep COVID OUT: https://www.youtube.com/watch?v=7srwrF9MGdw&feature=youtu.be	6/11/21

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F 880	Continued From page 37 §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 record review, observations, staff interview, and policy review, the facility failed to ensure a resident's catheter bag had been securely fastened in a manner to prevent the catheter bag from coming in contact with the floor and in order to prevent cross-contamination and spread of infection for one of three residents reviewed who had a catheter (Resident #76). The facility reported a census of 85 residents. The Minimum Data Set (MDS) assessment dated 4/22/21 revealed Resident #76 had diagnoses of neurogenic bladder, renal insufficiency, multiple sclerosis, methicillin susceptible staphylococcus aureus (MSSA) (a bacterial infection), and COVID-19. The MDS documented the resident had severely impaired cognition, and required extensive assistance of one staff for bed mobility and hygiene, and total dependence on one staff for toileting. The MDS indicated the resident had an indwelling catheter. The care plan updated on 4/4/21 revealed Resident #76 had a diagnosis of multiple sclerosis, had a suprapubic catheter, and a	F 880		

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F 880	Continued From page 38 history of MSSA and proteus mirabilis (a bacteria) in his urine. The staff directives included to perform catheter cares every shift, monitor for signs and symptoms of an acute infection, and report to the doctor as needed. Observations revealed the following: a. On 05/05/21 at 02:15 PM, Resident #76 sat in a recliner with his feet elevated. The resident's catheter bag was lying on the tile floor by the resident's chair. Light yellow urine drained into the catheter bag. A dignity bag hung on the bed frame at the end of the bed across from where the resident sat. b. On 05/05/21 at 02:23 PM, Staff D, Certified Nursing Assistant (CNA) entered the resident's room and spoke with the resident. c. On 05/05/21 at 03:35 PM, Resident #76 sat in a recliner. The catheter bag remained lying on the tile floor by the resident's chair. d. On 05/12/21 at 08:40 AM, Resident #76 propelled his wheelchair from the dining room to his room. The resident's catheter bag hung under the wheelchair and the bag drug on the floor under the wheelchair. In a nursing guidance and procedure manual (section 23-8) titled Catheter Care dated 1/2015 revealed the catheter needed secured to prevent trauma to the meatus. In an interview 05/12/21 at 02:34 PM, Staff E, Licensed Practical Nurse and Nurse Manager reported a resident's catheter bag should not touch or drag on the floor.	F 880		