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| TOUCHSTONE HEALTHCARE COMMUNITY | 1800 INDIAN HILLS DRIVE SIOUX CITY, IA 51104 |

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| F 000 | INITIAL COMMENTS<br><br>Correction date 9/14/17<br><br>The following deficiencies result from the facility's annual health survey and investigation of complaints #67941-C, #68377-C, #68396-C, #68424-C, #68714-C, #69644-C and #69658-C.<br><br>Complaint #68510-C was not substantiated.<br><br>See the Code of Federal Regulations (42CFR) Part 483, Subpart B-C. | F 000 | | |
| F 166 SS=E | 483.10(j)(2)-(4) RIGHT TO PROMPT EFFORTS TO RESOLVE GRIEVANCES<br><br>(j)(2) The resident has the right to and the facility must make prompt efforts by the facility to resolve grievances the resident may have, in accordance with this paragraph.<br><br>(j)(3) The facility must make information on how to file a grievance or complaint available to the resident.<br><br>(j)(4) The facility must establish a grievance policy to ensure the prompt resolution of all grievances regarding the residents' rights contained in this paragraph. Upon request, the provider must give a copy of the grievance policy to the resident. The grievance policy must include:<br><br>(i) Notifying resident individually or through postings in prominent locations throughout the facility of the right to file grievances orally (meaning spoken) or in writing; the right to file grievances anonymously; the contact information of the grievance official with whom a grievance | F 166 | | |

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

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| F 166 | Continued From page 1 | F 166 | | |

can be filed, that is, his or her name, business address (mailing and email) and business phone number; a reasonable expected time frame for completing the review of the grievance; the right to obtain a written decision regarding his or her grievance; and the contact information of independent entities with whom grievances may be filed, that is, the pertinent State agency, Quality Improvement Organization, State Survey Agency and State Long-Term Care Ombudsman program or protection and advocacy system;

(ii) Identifying a Grievance Official who is responsible for overseeing the grievance process, receiving and tracking grievances through to their conclusions; leading any necessary investigations by the facility; maintaining the confidentiality of all information associated with grievances, for example, the identity of the resident for those grievances submitted anonymously, issuing written grievance decisions to the resident; and coordinating with state and federal agencies as necessary in light of specific allegations;

(iii) As necessary, taking immediate action to prevent further potential violations of any resident right while the alleged violation is being investigated;

(iv) Consistent with §483.12(c)(1), immediately reporting all alleged violations involving neglect, abuse, including injuries of unknown source, and/or misappropriation of resident property, by anyone furnishing services on behalf of the provider, to the administrator of the provider; and as required by State law;

(v) Ensuring that all written grievance decisions

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| F 166 | Continued From page 2<br>include the date the grievance was received, a summary statement of the resident's grievance, the steps taken to investigate the grievance, a summary of the pertinent findings or conclusions regarding the resident's concerns(s), a statement as to whether the grievance was confirmed or not confirmed, any corrective action taken or to be taken by the facility as a result of the grievance, and the date the written decision was issued;<br><br>(vi) Taking appropriate corrective action in accordance with State law if the alleged violation of the residents' rights is confirmed by the facility or if an outside entity having jurisdiction, such as the State Survey Agency, Quality Improvement Organization, or local law enforcement agency confirms a violation for any of these residents' rights within its area of responsibility; and<br><br>(vii) Maintaining evidence demonstrating the result of all grievances for a period of no less than 3 years from the issuance of the grievance decision.<br>This REQUIREMENT is not met as evidenced by:<br>Based on review of Resident Council minutes, staff interview, group resident interview and family member interview, the facility failed to address resident concerns in a timely manner and failed to follow up to ensure resolution of the grievance with the person who filed the concern for 7 out of 7 group residents and 1 of 20 total residents sampled (Resident #3). The facility reported a census of 90 residents.<br><br>Findings include:<br><br>1. The Resident Council minutes from 2/17/17 documented under the Dietary section: the food | F 166 | | |

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| F 166 | Continued From page 3<br>did not taste good, a suggestion that a cook/dietitian make the menu on the corporate level and the comment for the facility to get away from canned fruit as the desert. Under the Nursing section the minutes, the minutes documented an agency staff person tried to give the wrong meds/double doses of medication at bedtime for 2 residents, the changes on Cherry Blossom Hall were not working and stretched the staff too thin, call lights still took a while to answer and staff shut off the call light without residents' needs being addressed.<br><br>The Resident Council minutes from 3/17/17 documented under the Nursing section: residents were getting sick of everyone being over stretched due to Cherry Blossom hall and they tried to be patient, staff stated they would get the resident if they remembered and had time and staff did not take out dirty laundry in a timely manner on all shifts.<br><br>The Resident Council minutes from 4/21/17 documented under the Nursing section: call lights took 45 minutes to be answered and staff unhooked a resident from the EZ stand (mechanical lift) and left them to wait there.<br><br>The Resident Council minutes from 5/20/17 documented under the Dietary section that facility food was cold with long wait times for meals specifically in the evening. Under the Nursing section the minutes documented that staff did not answer call lights in a timely manner, a resident sat for 30 to 40 minutes on the toilet hooked up to the EZ stand, baths were not getting done and a resident went 2 weeks without a bath. Under the Activities section the minutes documented a resident felt upset over activities being canceled | F 166 | | |

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| F 166 | Continued From page 4<br>because the facility had no staff available to do them.<br><br>The Resident Council minutes from June (2017) documented under the Dietary section, residents received cold food sometimes and waited long time for meals especially in the evenings. Under the Housekeeping/Laundry section, the minutes documented that staff didn't use cleaning supplies in the bathroom and did not clean thoroughly. Under the Nursing section, the minutes documented it sometimes took 30 minutes to find an EZ stand and it took forever to have lights answered. Under the Administration section, the minutes documented the council did not see administrative staff and did not know who the Administrator was.<br><br>The Resident Council minutes from July 2017 documented under the Minutes section: the residents discussed with the Administrator issues in the kitchen without a kitchen manager such as the food not being as good and the use of pre-packaged food, housekeeping staff not properly cleaning rooms and the Administrator explained she would be helping with food ordering and making sure things ran smoothly in the kitchen. Under the Housekeeping/Laundry section the minutes documented: staff were not cleaning corners in the rooms, not cleaning under the bed, not emptying trash cans, housekeeping did the bare minimum and the staff did not move stuff when cleaning. Under the Dietary section the minutes documented: dietary stinks, the food was lousy and served cold, portions were getting smaller, especially on room trays and residents were not always being served when requesting room trays. Under the Nursing section the minutes documented that residents want a bath | F 166 | | |

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| F 166 | Continued From page 5<br>at a set time so they know when going to get the bath, residents were still not getting a bath 2 times per week, it took 45 minutes to an hour to get call lights answered, especially when they are short, ice water not being passed and staff did not offer snack carts at all.<br><br>2. In an interview on 8/1/17 at 7:25 a.m., the Administrator reported she had received grievances from care conferences about food quality, pre-made foods like meatloaf and not attempting to follow the menus. The Administrator stated she reviewed these in QA (Quality Assurance meeting) monthly.<br><br>During a group interview conducted 8/2/17 at 1:15 p.m., 7 out of 7 residents stated the Administrator did not follow up on the Resident Council concerns. The group commented they do not feel they can complain to the facility because the Administrator didn't do anything. The group stated their concerns go in one ear and out the other.<br><br>3. In a family interview on 8/7/17 at 3:25 p.m., a family member of Resident #3 stated he/she spoke to the Administrator regarding concerns of no food in the building, but the Administrator did not resolve his/her concerns. | F 166 | | |
| F 167 SS=C | 483.10(g)(10)(i)(11) RIGHT TO SURVEY RESULTS - READILY ACCESSIBLE<br><br>(g)(10) The resident has the right to-<br><br>(i) Examine the results of the most recent survey of the facility conducted by Federal or State surveyors and any plan of correction in effect with respect to the facility; and | F 167 | | |

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| F 167 | Continued From page 6<br><br>(g)(11) The facility must--<br><br>(i) Post in a place readily accessible to residents, and family members and legal representatives of residents, the results of the most recent survey of the facility.<br><br>(ii) Have reports with respect to any surveys, certifications, and complaint investigations made respecting the facility during the 3 preceding years, and any plan of correction in effect with respect to the facility, available for any individual to review upon request; and<br><br>(iii) Post notice of the availability of such reports in areas of the facility that are prominent and accessible to the public.<br><br>(iv) The facility shall not make available identifying information about complainants or residents.<br>This REQUIREMENT is not met as evidenced by:<br>Based on observation, the facility failed to display the results of all survey activities conducted from the previous survey and failed to post a notice regarding the availability of the previous 3 years of survey results. The facility reported a census of 90 residents.<br><br>Findings include:<br><br>Observation on 8/8/17 at 9:05 a.m., revealed a notice regarding the location of the facility's most recent survey results and a binder labeled "Federal/State Survey Report" in an accessible location next to the front entrance. Upon review, the notebook lacked the results and plan of correction from a recertification revisit from | F 167 | | |

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| F 167 | Continued From page 7<br>3/1/17, which resulted in 2 deficiencies and the results of the Life Safety Code survey from the annual recertification survey on 1/26/17. Observation in the same area and throughout the building revealed the facility failed to post a notice of the availability upon request of any survey results completed in the past 3 years.<br><br>Observation on 8/10/17 at 8:00 a.m., revealed the notebook failed to include the previously identified survey results in the binder labeled "Federal/State Survey Report" and additional observations throughout the building verified the lack of a posting regarding the availability of survey results completed in the past 3 years. | F 167 | | |
| F 226 SS=D | 483.12(b)(1)-(3), 483.95(c)(1)-(3) DEVELOP/IMPLMENT ABUSE/NEGLECT, ETC POLICIES<br><br>483.12<br>(b) The facility must develop and implement written policies and procedures that:<br><br>(1) Prohibit and prevent abuse, neglect, and exploitation of residents and misappropriation of resident property,<br><br>(2) Establish policies and procedures to investigate any such allegations, and<br><br>(3) Include training as required at paragraph §483.95,<br><br>483.95<br>(c) Abuse, neglect, and exploitation. In addition to the freedom from abuse, neglect, and exploitation requirements in § 483.12, facilities must also provide training to their staff that at a minimum | F 226 | | |

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| F 226 | Continued From page 8<br>educates staff on-<br><br>(c)(1) Activities that constitute abuse, neglect, exploitation, and misappropriation of resident property as set forth at § 483.12.<br><br>(c)(2) Procedures for reporting incidents of abuse, neglect, exploitation, or the misappropriation of resident property<br><br>(c)(3) Dementia management and resident abuse prevention.<br>This REQUIREMENT is not met as evidenced by:<br>Based on personnel file review, policy review and staff interview, the facility failed to obtain timely criminal and abuse background checks prior to hire; and failed to secure an evaluation by the Department of Human Services (DHS) to determine whether or not the individual could work at the facility prior to hire. A concern was identified for 2 of 5 employee records selected for review (Staff F and Staff I). The facility identified a census of 90 residents.<br><br>Findings include:<br><br>1. Review of the personnel file for Staff F, Certified Nurse Aide (CNA), identified a hire date of 5/10/17. The file contained a document titled "Single Contact License & Background Check (SING), dated 5/3/17, which identified the need for further research on criminal history. Review of a document titled "Iowa Record Check Request Form", dated 5/8/17, revealed a criminal offense. The file lacked the required clearance from the Department of Human Services (DHS) to work at the facility. | F 226 | | |

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| F 226 | Continued From page 9<br>During an interview on 8/9/17, at 9:30 a.m., the Human Resources Coordinator confirmed the results of Staff F's criminal background check required a DHS clearance to work in the facility and her personnel file lacked documented evidence of the clearance. During a follow-up interview on 8/9/17, at 10:15 a.m., reported she had faxed the required form to obtain the DHS clearance.<br><br>Staff F's Timecard showed she worked from 5/10/17 to 7/7/17, including on 5/10/17, 5/11/17, 5/15/17.<br><br>2. Review of the personnel file for Staff I, Dietary Aide, identified a hire date of 6/15/17. The file lacked a copy of a SING check and failed to include any other documented evidence of dependent adult abuse registry verification.<br><br>During an interview on 8/9/17, at 9:30 a.m., the Human Resources Coordinator confirmed the file lacked a SING check and reported she always does one and could look to see if it had been misfiled. During a follow-up interview on 8/9/17, at 10:15 a.m., the Human Resources Coordinator provided a copy of a SING check which identified a dependent adult abuse registry check but confirmed she had just completed the check earlier today.<br><br>Staff I's Timecard showed she worked from 6/15/17 to 7/7/17, including on 6/15/17, 6/16/17, 6/19/17.<br><br>Review of a facility policy titled "Abuse Prevention Plan", revised in June 2017, identified the facility will attempt to obtain information regarding a | F 226 | | |

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| F 226 | Continued From page 10<br>history of abuse, neglect or mistreatment of residents from appropriate licensing boards and registries, prior to a conditional offer of employment. In addition, the policy identified, after a conditional offer, but before an employee starts working, the facility must obtain criminal background checks from the Department of Public Safety and abuse checks from the Department of Human Services. | F 226 | | |
| F 241 SS=E | 483.10(a)(1) DIGNITY AND RESPECT OF INDIVIDUALITY<br><br>(a)(1) A facility must treat and care for each resident in a manner and in an environment that promotes maintenance or enhancement of his or her quality of life recognizing each resident's individuality. The facility must protect and promote the rights of the resident.<br>This REQUIREMENT is not met as evidenced by:<br>Based on group resident interview, facility policy review, observation and resident interviews, the facility failed to treat and care for residents in a dignified manner when the staff utilized headphones while on duty and ignored requests for assistance for 7 out of 7 residents present during the group interview and 3 of 15 current residents reviewed (Residents #14, #7 and #20). The facility reported a census of 90.<br><br>Findings include:<br><br>1. During a group resident interview conducted on 8/2/17 at 1:15 p.m., 7 out of 7 residents reported nurses and aides listen to headphones while working. The group commented the staff did not socialize with them and the group would prefer for staff to socialize instead of listening to | F 241 | | |

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| F 241 | Continued From page 11<br>the headphones. The group voiced concerns the staff could not hear call lights sounding if they wore headphones.<br><br>The facility policy titled Cell Phone, Camera and Other Recording Devices, effective 7/1/14, documented the intent of the facility is to assure all associates may be reached in case of an emergency while they are at work and facility intent to provide care and services for residents in a polite, timely and dignified manner. The policy instructed that personal cell phones are to be kept in the associate's locker or associate designated area and are to be used only on break or meal times.<br><br>2. The Minimum Data Set (MDS) assessment dated 6/23/17 for Resident #14 identified a Brief Interview for Mental Status (BIMS) score of 9, indicating moderate cognitive impairment.<br><br>Observation on 8/8/17 at 7:58 a.m., revealed Resident #14 standing at a medication cart. Resident #14 stated he/she had been waiting for 15 minutes to get his/her pills. Staff A, Licensed Practical Nurse (LPN), exited a room and Resident #14 asked for his/her medications. Staff A asked the resident if he/she could wait as she was going to be busy. Resident #14 appeared upset, walked off and said 'you said one minute'! Staff A ignored the resident and looked at a computer screen as the resident s/he was going to eat. The surveyor attempted to speak to Staff A. Staff A then removed headphones from both ears and music could be heard.<br><br>In an interview on 8/8/17 at 8:15 a.m., Resident #14 sat in the dining room nearly finished with | F 241 | | |

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breakfast. Resident #14 reported Staff A still had not given him/her medication. Resident #14 stated that's what happens when he/she complained, he/she got moved to the bottom of the list and staff won't give medications and they won't help.

3. Observation on 8/7/17 at 4:20 p.m. revealed Resident #7 stopped the surveyor to request coffee, who then informed Staff U, LPN, who sat at the nurses station. While looking at the computer screen, Staff U responded that she heard the resident and she would take care of the request.

Observation on 8/7/17 at 4:35 p.m. revealed Staff U remained at the nurses station desk and Resident #7 had no coffee.

4. The MDS assessment dated 5/18/17 for Resident #20 identified a BIMS score of 15, indicating intact cognition. The MDS revealed the resident required the assistance of one person for toilet use.

The care plan focus area revised on 12/8/16 identified the resident as at a risk for falls due to history of CVA (cerebrovascular accident) and the medications he/she takes. The care plan intervention dated 11/29/16 informed staff the resident could dress, groom and toilet him/herself and will occasionally ask for assistance.

The Progress Notes dated 7/30/17 at 7:45 a.m. documented the resident reported he/she fell at 6:37 a.m., the resident activated the call bell at the time of the fall, and waited on the floor until 7:10 a.m. The note recorded the resident maneuvered themselves up with the commode

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| F 241 | Continued From page 13<br>side rails and once up into a wheelchair went out to the hallway to approach a CNA (Certified Nurse Aide). The note documented a witness confirmed the CNA responded to the resident that 'I have residents to get up and getting you water is not important'. The note recorded the resident stated he/she didn't feel safe when the CNA worked because they did not treat him/her with respect and did not answer his/her call bell. The note documented the resident felt it was not fair to be ignored in a priority situation such as a fall.<br><br>In an interview on 8/14/17 at 2:25 p.m., Resident #20 reported staff used headphones while working. Resident #20 asked how can the staff hear call lights if they wear headphones? Resident #20 reported he/she fell about 2 weeks prior and a staff member (who no longer worked at the facility) ignored his/her call light and stated she did not care about the resident's need for tea as she had others that needed assistance. | F 241 | | |
| F 252 SS=E | 483.10(e)(2)(i)(1)(I)(II)<br>SAFE/CLEAN/COMFORTABLE/HOMELIKE ENVIRONMENT<br><br>(e)(2) The right to retain and use personal possessions, including furnishings, and clothing, as space permits, unless to do so would infringe upon the rights or health and safety of other residents.<br><br>§483.10(l) Safe environment. The resident has a right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely. The facility must provide-<br><br>(l)(1) A safe, clean, comfortable, and homelike | F 252 | | |

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| F 252 | Continued From page 14<br>environment, allowing the resident to use his or her personal belongings to the extent possible.<br><br>(i) This includes ensuring that the resident can receive care and services safely and that the physical layout of the facility maximizes resident independence and does not pose a safety risk.<br><br>(ii) The facility shall exercise reasonable care for the protection of the resident's property from loss or theft.<br>This REQUIREMENT is not met as evidenced by:<br>Based on Resident Council minutes, observation, staff interview, and group interview, the facility failed to maintain a safe, sanitary, comfortable environment for their residents. The facility reported a census of 90 residents.<br><br>Findings include:<br><br>1. The Resident Council minutes from 3/17/17 documented under the Nursing section that staff do not take laundry in a timely manner on all shifts.<br><br>The Resident Council minutes from June (2017) documented under the Housekeeping/Laundry section that staff didn't use cleaning supplies in the bathroom and did not clean thoroughly.<br><br>The Resident Council minutes from July 2017 documented under the Minutes section that residents discussed with the Administrator issues of housekeeping not properly cleaning rooms. Under the Housekeeping/Laundry section the minutes documented staff did not clean the corners in the rooms, did not clean under the bed, did not empty trash cans, did the bare minimum | F 252 | | |

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| F 252 | Continued From page 15<br>and did not move stuff when cleaning.<br><br>2. Observation on 7/31/17 at 7:20 p.m. revealed a strong ammonia -like urine odor and the linen container at the top of the Aspenwood Hall overflowed with dirty linens.<br><br>Observation on 7/31/17 at 7:35 p.m. revealed the Northside commons area contained a lizard tank and a wire bird cage. The lizard tank had feces in piles all over the tank. The bird cage contained large amounts of buildup debris, mold, dirt and bird feces. The bottom of the cage had 2 layers of newspaper lining separated by a couple inches, both layers were completely covered with dried food remains and piles of feces.<br><br>In an interview on 8/1/17 at 8:07 a.m., Staff SS, Housekeeper, stated the facility had 3 day shift housekeepers scheduled. Staff SS said 3 needed, but on weekends not have enough housekeepers because only 2 scheduled.<br><br>Observation on 8/15/17 at 10:50 a.m. revealed the bird cage remained unclean and the Maintenance Director cleaning the lizard tank.<br><br>3. Observation on 8/1/17 at 6:30 p.m. revealed the ceiling tiles in the main dining room above the ice machine leaked. The 2 tiles were stained a brownish color and measured approximately 48 inches by 30 inches.<br><br>Observation on 8/1/17 at 6:42 p.m. revealed the Southside Nook with a sticky floor due to dried spills.<br><br>4. Observation on 8/15/17 at 9:33 a.m. revealed a spa room at the top of the Daisy Lane Hallway | F 252 | | |

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| F 252 | Continued From page 16<br>with broken floor tiles. In front of the whirlpool tub 2, approximate 1 inch by 1 inch, tiles were broken and missing where the wheels of tub or shower chair could catch in the holes. Observation revealed the partitioned wall divider with 6 inch by 6 inch broken tiles with the 2 by 4 studs of the interior exposed.<br><br>5. Observation on 8/8/17 at 8:21 a.m. revealed several marred areas on the wall on both sides of D Hall and several areas with drywall showing. A desk at end of D Hall had gouges in the trim and exposed wood.<br><br>6. Observation on 8/8/17 at 10:02 a.m. during medication administration revealed Resident #21's room floor to be dirty with dried circle spots on the floor and sticky when walking across floor.<br><br>7. Observation on 8/9/17 at 10:50 a.m. revealed upon entering G hall on the wall to the left had 3 marred areas with drywall exposed.<br><br>8. During the group interview on 8/2/17 at 1:15 p.m., a resident complained his/her air conditioner broke down on Saturday 7/29/17. The Maintenance Man had been out of town and the air conditioner did not get fixed until today 8/2/17, 4 days later. | F 252 | | |
| F 279 SS=D | 483.20(d);483.21(b)(1) DEVELOP COMPREHENSIVE CARE PLANS<br><br>483.20<br>(d) Use. A facility must maintain all resident assessments completed within the previous 15 months in the resident's active record and use the results of the assessments to develop, review and revise the resident's comprehensive care | F 279 | | |

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| F 279 | Continued From page 17<br>plan.<br><br>483.21<br>(b) Comprehensive Care Plans<br><br>(1) The facility must develop and implement a comprehensive person-centered care plan for each resident, consistent with the resident rights set forth at §483.10(c)(2) and §483.10(c)(3), that includes measurable objectives and timeframes to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment. The comprehensive care plan must describe the following -<br><br>(i) The services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §483.24, §483.25 or §483.40; and<br><br>(ii) Any services that would otherwise be required under §483.24, §483.25 or §483.40 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(c)(6).<br><br>(iii) Any specialized services or specialized rehabilitative services the nursing facility will provide as a result of PASARR recommendations. If a facility disagrees with the findings of the PASARR, it must indicate its rationale in the resident's medical record.<br><br>(iv)In consultation with the resident and the resident's representative (s)-<br><br>(A) The resident's goals for admission and | F 279 | | |

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| F 279 | Continued From page 18<br>desired outcomes.<br><br>(B) The resident's preference and potential for future discharge. Facilities must document whether the resident's desire to return to the community was assessed and any referrals to local contact agencies and/or other appropriate entities, for this purpose.<br><br>(C) Discharge plans in the comprehensive care plan, as appropriate, in accordance with the requirements set forth in paragraph (c) of this section.<br>This REQUIREMENT is not met as evidenced by:<br>Based on clinical record review and staff interview, the facility failed to update resident care plans in regards to bed mobility and transfer assistance for 3 of 15 current residents reviewed (Residents #12, #4 and #5). The facility reported a census of 90 residents.<br><br>Findings included:<br><br>1. According to the Minimum Data Set (MDS) assessment dated 7/7/17, Resident #12's diagnoses included hypertension, diabetes mellitus, depression, pressure sore of sacral region Stage 3, open wound of unspecified buttock, candidiases of skin and nails and morbid obesity. The MDS documented a Brief Interview for Mental Status (BIMS) of 15 indicating intact memory and cognition. The assessment documented the resident required extensive assistance of 2 or more staff with bed mobility, transfers and ambulation in the room.<br><br>Review of the care plan updated 6/30/17 revealed a focus on transfers, bed mobility and ambulation. | F 279 | | |

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| F 279 | Continued From page 19<br>The care plan documented the resident as independent with bed mobility. Another entry on the same care plan documented the resident required assistance of 2 staff with bed mobility, grooming and bathing.<br><br>2. The 6/29/17 MDS assessment recorded Resident #4 had memory problems and severely impaired cognition for daily decision making; the resident never or rarely made decisions. Resident #4 required the assistance of two with bed mobility, transfers, dressing, toilet use and personal hygiene and the assistance of one with eating. The MDS also recorded Resident #4 had the diagnosis of Non-Alzheimer's dementia.<br><br>The 12/26/16 revised care plan recorded Resident #4 needed assistance activates of daily living (ADL's). The care plan also recorded the need for EZ stand (a mechanical lift to help a resident stand) lift and to use a Hoyer (mechanical lift) as needed.<br><br>The resident's Transfer Assessment dated 6/29/17 recorded a Registered Nurse (RN) analysis recorded the resident required a Hoyer lift to transfer.<br><br>An observation on 8/8/17 at 9:14 a.m. revealed Staff S Certified Nursing Aide (CNA) took the Hoyer lift in to Resident # 4's room. Staff K CNA and Staff S performed morning cares and placed the Hoyer sling under the resident. The Staff K and S transferred the resident to the wheelchair and removed the Hoyer sling from under the resident.<br><br>During an interview on 8/14/17 at 3:10 p.m., the MDS coordinator acknowledged the transfer | F 279 | | |

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| F 279 | Continued From page 21<br><br>Observation on 8/8/17 at 8:41 a.m. revealed Staff D CNA brought the EZ stand into Resident #5's room. Staff D and Staff K CNA's transferred Resident #5 using the EZ stand to his/her wheelchair.<br><br>During an interview on 8/8/17 at 10:10 a.m. Staff K stated in the computer, the Kardex told staff everything needed to take care of each resident. | F 279 | | |
| F 281 SS=E | 483.21(b)(3)(i) SERVICES PROVIDED MEET PROFESSIONAL STANDARDS<br><br>(b)(3) Comprehensive Care Plans<br><br>The services provided or arranged by the facility, as outlined by the comprehensive care plan, must-<br><br>(i) Meet professional standards of quality.<br>This REQUIREMENT is not met as evidenced by:<br>Based on clinical record review, observation, resident interview and staff interview, the facility failed to administer medications and treatments as ordered and according to professional standards for 4 of 15 current residents reviewed (Residents #14, #5, #24 and #20). The facility reported a census of 90 residents.<br><br>Findings include:<br><br>1. The Minimum Data Set (MDS) assessment dated 6/23/17 for Resident #14 identified a BIMS (brief interview for mental status) score of 9, indicating moderate cognitive and memory impairment. The assessment documented Resident #14 had diagnoses that included | F 281 | | |

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| F 279 | Continued From page 20<br>assessment did not match the care plan. He stated he uses the Transfer Assessment tool to help create the resident care plans and staff would use the care plan to complete the care for the residents.<br><br>During an interview on 8/14/17 at 3:15 p.m. with Staff O Certified Nursing Assistant (CNA) stated they would transfer Resident #4 with an EZ stand if he/she would let them use the EZ stand or a 2 person pivot transfer.<br><br>3. The 6/29/17 MDS assessment recorded Resident #5 had memory problems and severely impaired cognition for daily decision making. The resident required the assistance of two with bed mobility, transfers and toilet use and the assistance of one with dressing and personal hygiene. The resident's diagnoses included Non-Alzheimer's dementia, Alzheimer's disease and an old myocardial infarction (heart attack).<br><br>Resident #5's Care plan dated 4/2/17 included a focus area of the risk for falls related to cognition. The care plan directed that Resident #5 needed the assistance of two staff for transfers and ambulation. The Care Plan also documented another focus area that Resident #5 needed assistance in all mobility including toileting, transfers and ambulation and direction to proved the assistance of one with ambulation, transfers and toileting.<br><br>Resident #5's Kardex (a shortened version of the care plan) listed under safety to assist the resident using two staff with transfers and ambulation and a few lines down listed to provide the assistance of one staff for ambulation, transfers and toileting. | F 279 | | |

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| F 281 | Continued From page 22<br>diabetes mellitus (DM), Vitamin D deficiency and hypothyroidism.<br><br>Review of the resident's Medication Administration Record for August 2017 revealed the resident had orders for the medications that included:<br>a. Insulin Aspart solution 8 units via injection before meals;<br>b. Vitamin D3 2000 units once a day (for vitamin D deficiency);<br>c. Levothyroxine 100 micrograms every day (for hypothyroidism).<br><br>Observation on 8/8/17 at 7:58 a.m. revealed Resident #14 standing at a medication cart. Resident #14 stated he/she had been waiting for 15 minutes to get his/her pills. Staff A, LPN (Licensed Practical Nurse) exited a room and Resident #14 asked Staff A for his/her medications. Staff A asked the resident if he/she could wait as she was going to be busy.<br><br>In an interview on 8/8/17 at 8:15 a.m., Resident #14 reported he/she still had not received his/her pills and the resident had almost finished eating breakfast.<br><br>In an interview on 8/14/17 at 2:55 p.m., the Administrator stated the facility had no way to see what time staff actually gave medications, so the clinical record reflected the resident received the meds according to the Medication Administration Record at the scheduled time of 8:00 a.m.<br><br>The Medication Administration Audit Report dated 8/15/17 at 9:51 a.m. recorded the scheduled and actual times Resident #14 received his/her medications on 8/1/17. The report documented | F 281 | | |

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| F 281 | Continued From page 23<br>the resident as scheduled to receive 1 medication at 6:00 a.m., 3 medications at 7:00 a.m., and 7 medications at 8:00 a.m. The report revealed the resident received all 11 medications from 8:47 a.m. to 9:00 a.m. The report also revealed the resident's blood sugar level to be monitored fasting (upon waking) and 2 hours after meals. The report documented staff measured the fasting blood sugar at 8:47 a.m. and the 10:00 scheduled blood sugar check for after breakfast at 9:02 a.m. In addition, staff documented administration of the resident's Insulin Aspart as given at 8:45 a.m.<br><br>2. The 6/29/17 MDS assessment recorded Resident #5 had memory problems and severely impaired cognition for daily decision making. The resident required the assistance of two with bed mobility, transfers and toilet use and the assistance of one with dressing and personal hygiene. The resident's diagnoses included Non-Alzheimer's dementia, Alzheimer's disease and an old myocardial infarction (heart attack).<br><br>Resident #5's care plan dated 4/2/17 included a focus area of cognition related to dementia and Alzheimer's disease and listed an intervention to calmly redirect if disruptive toward other or exit seeking. The care plan listed the confusion and sundowners started around 4 p.m. An additional focus area that Resident #5 needed assistance with ADL's and experienced incontinence at times. The interventions included to make sure to shave the resident daily, to wear Tubigrips to arms during hours of wake for protection and to wear only pull up style incontinent brief.<br><br>A Physician Communication to the facility for Resident #5 dated 5/3/17 included the following | F 281 | | |

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| F 281 | Continued From page 24<br>care orders:<br>a. Apply Tubigrips daily to bilateral (both) arms while awake.<br>b. Use pull -up brief only for incontinence<br><br>During observation on 8/8/17 at 8:41 a.m. Staff D and Staff K CNA's assisted Resident #5 with morning cares. During the cares the staff removed a urine soaked tabbed style incontinent brief placed a tabbed style incontinent brief back on to the resident. Staff D and K transferred Resident #5 to the wheelchair using the EZ stand (a mechanical lift to assist with standing) and they failed to place Tubigrips on the resident's arms.<br><br>During observations on 8/8/17 at 10:50 a.m., 11:15 a.m. and 11:43 a.m., Resident #5 sat in his/her wheelchair without Tubigrips on his/her arms.<br><br>During observation on 8/9/17 at 10:10 a.m., Resident #5 sat in his/her wheelchair in the Southside lounge without Tubigrips on his/her arms.<br><br>During an observation on 8/9/17 at 11:44 a.m. Resident #5 sat in his/her wheelchair without Tubigrips on his/her arms<br><br>During an observation on 8/9/17 at noon Resident #5 sat in his/her wheelchair at the medication cart with Staff J LPN without Tubigrips on his/her arms.<br><br>A facility fax to the physician dated 6/28/17 reported that Resident #5 consumed another resident's medication during the shift. The medication included Keppra (an anticonvulsant) 500 mg, lorazepam (an antianxiety) 0.5 mg and | F 281 | | |

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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 |
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| F 281 | Continued From page 25 | F 281 | | |

Midodrine (for blood pressure support) 10 mg. with orders to check blood pressure every hour for 3 hours signed by Staff P RN. The new orders included direction to make sure all residents have taken their medication prior to leaving them, so no one else can take other resident's medication.

During an interview on 8/14/17 at 4:06 p.m. with Staff P stated she notified the doctor, family and the on call supervisor of the incident. Staff P further explained she did not see Resident #5 take the other resident's medication it had been reported to her by Staff Q CMA. Staff P acknowledged Staff R CNA reported to Staff Q that Resident #5 took someone else's medication.

During an interview on 8/14/17 at 7:30 p.m., Staff R stated she reported the incident to Staff Q. Staff R had been feeding a different resident when Staff T CMA tried to give them medication and did not take well. Staff R stated Staff T CMA placed the medication in to a supplement drink and Staff R gave the supplement drink with the medications included in it. Staff R used a larger syringe (used for giving fluids) to give the resident the supplement. Staff R then took the tray out to the Southside nook area with a small amount of medication left, and later found Resident #5 drinking the rest of the supplement. Staff R reported it to Staff Q the new CMA that came on duty.

During an interview on 8/14/17 at 8:35 p.m. Staff Q stated she came on duty at 6 p.m. that night and relieved Staff T. Staff Q stated Staff R reported to her that Resident #5 took the rest the medication that had been left on a tray in the nook area. Staff Q stated she looked up the

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| F 281 | Continued From page 26<br>medications and reported to the nurse on duty, Staff P.<br><br>3. According to the quarterly MDS assessment dated 7/6/17 Resident #24 had diagnoses that included manic depression and metabolic encephalopathy. The MDS recorded Resident #24 had moderately impaired cognitive skills with poor decision making and needed cueing and/or supervision.<br><br>Resident #24's Care Plan included a problem (revised 2/17/17) for long term psychotropic medications due to disease process and has been refusing medication an intervention directed staff to have the medications added to food or drink since the resident will not take them otherwise.<br><br>Resident #24's Medication Administration Record included Duloxetine (an antidepressant) capsule delayed releases 30 mg to give on capsule by mouth one time a day related to bipolar disorder with a start date 7/25/17 at 7:00 a.m. and signed off as given on 8/8/17.<br><br>An observation on 8/8/17 at 8:09 a.m. revealed Staff J, LPN, had opened capsules in her hand and stirred Resident 24's orange juice while Staff M dietary aide held the tray. Staff M took the tray into Resident# 24's room while Staff J returned to the medication cart and discarded the empty capsules. Another surveyor (present in Resident #24's room) reported when Staff M took the meal tray into his/her room that that Staff J did not enter the room during the time the resident drank the orange juice.<br><br>During an interview on 8/8/17 at 8:11 a.m. with | F 281 | | |

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Staff M reported the nurse put Resident #24's medication in his/her orange juice.

During an interview on 8/9/10 at 10:30 a.m., Staff J acknowledged she put duloxetine 30 mg capsule into Resident #24's orange juice on 8/8/17 morning. Staff J stated the facility had an order to put medication into the resident's food or drink.

During an interview on 8/15/17 at 8:18 a.m. with the Director of Nursing (DON) acknowledged she would expect a licensed personnel to administer medication and that only someone in that scope of practice should administer medication.

The facility's policy entitled Medication Pass, revised 3/15, instructed that only persons licensed or permitted by this state may prepare, administer, or record administration of medication. The policy further listed to witness the resident swallow/ingest administered medication.

4. According to the MDS assessment dated 7/6/17, Resident #20 had diagnoses that included heart failure, high blood pressure, diabetes mellitus, manic depression chronic pulmonary edema (fluid in the lungs). The assessment documented Resident #20 possessed moderately impaired cognitive skills for daily decision making.

Observation during a medication pass performed by Staff A, LPN, on 8/8/17 at 8:16 AM, revealed she set up and provided the following medications to Resident #20:

Aspirin Enteric coated 81 milligrams (mg) one tablet (anticoagulant/anti-inflammatory)

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| F 281 | Continued From page 28<br>Vitamin B complex one tablet (nutritional supplement)<br>Escitalopram 20 mg one tablet (anti-depressant)<br>Ferrous sulfate 325 mg one tablet (nutritional supplement)<br>Furosemide 40 mg one tablet (diuretic)<br>Gabapentin 300 mg one tablet (anti-seizure and neuralgia)<br>Hydrazaline 50 mg one tablet (anti-hypertensive)<br>Lisinopril 40 mg one tablet (anti-hypertensive)<br>Metoprolol tartrate 100 mg one tablet (antihypertensive)<br>Multi-therapeutic vitamin with minerals one tablet (nutritional supplement)<br>Nitrofurantoin 100 mg one tablet (antibiotic)<br><br>During this observation, Staff A brought the above-listed medications in a cup to the resident's room. The resident stated she/he needed a pain pill and a laxative. Staff A left the cup of medications on the bedside table with water and left the room to return to the medication cart in the hall. Observation revealed that at 8:25 AM, Staff A returned to the resident's room with the pain pill and laxative. Observation revealed the cup of medications left in the room were missing when the Staff A and surveyor returned at 8:25 AM. | F 281 | | |
| F 282 SS=D | 483.21(b)(3)(ii) SERVICES BY QUALIFIED PERSONS/PER CARE PLAN<br><br>(b)(3) Comprehensive Care Plans<br>The services provided or arranged by the facility, as outlined by the comprehensive care plan, must-<br><br>(ii) Be provided by qualified persons in accordance with each resident's written plan of | F 282 | | |

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| F 282 | Continued From page 29<br>care.<br>This REQUIREMENT is not met as evidenced by:<br>Based on clinical record review, observations and staff interview, the facility failed to follow interventions on the care plans for 2 of 15 current residents reviewed (Resident #2 and #4). The facility reported a census of 90 residents.<br><br>Findings include:<br><br>1. The Minimum Data Set (MDS) assessment dated 5/25/17 identified diagnoses for Resident #2 that included arthritis, Parkinson's disease, depression and Non-Alzheimer's dementia (a deteriorating condition). According to the MDS, the resident required the assistance of 2 staff for bed mobility, transfers dressing and toilet use and the assistance of one staff with eating and personal hygiene. The MDS indicated the resident experienced severely impaired cognitive skills for daily decision-making<br><br>Review of Resident #2's care plan revealed a focus on the risk for skin breakdown, initiated on 5/31/17, with interventions to have pressure reduction boots on at all times and heels elevated on a pillow when laying down.<br><br>An observation on 8/8/17 at 2:15 p.m. revealed Resident #2 going to lay in bed when Staff C took their pressure reduction boots from the bed and laid them on the floor. Resident #2 did not have boots on while up in the wheelchair. Staff transferred the resident to bed and applied pressure reduction boots to the resident's feet, but did not elevate the resident's heels on a pillow in bed. | F 282 | | |

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| F 282 | Continued From page 30<br>An observation on 8/8/17 at 11:42 a.m. revealed Resident #2 sat in the Bay area by the television without pressure reduction boots on their feet. Further observation revealed the pressure reduction boots sat on the couch in the resident's room.<br><br>An observation on 8/9/17 at 12:00 p.m. revealed Resident #2 in the dining area with their spouse and resident did not have pressure reduction boots on their feet.<br><br>2. The 6/29/17 MDS assessment recorded Resident #4 had severely impaired cognitive skills for daily decision making; s/he never or rarely made decisions. Resident #4 required the assistance of 2 staff with bed mobility, transfers, dressing, toilet use, personal hygiene and bathing and the assistance of one with eating. The MDS also recorded Resident #4 had Non- Alzheimer's dementia.<br><br>The Care plan, revised on 12/26/16, recorded that Resident #4 needed assistance with activities of daily living (ADL's) and ate poorly. The 5/26/15 revision recorded that Resident # 4 sometimes had behaviors during meal times and to have the charge nurse or designee supervise during meal times outside of the dining room (such as nook or nurses station). The Care plan also documented the need for encouragement and supervision while eating in the Southside nook.<br><br>The bedside Kardex Report (a shortened version of the care plan) listed under Eating/Nutrition that Resident #4 ate in the Southside nook, with encouragement and supervision.<br><br>Observation on 8/7/17 at 12:53 p.m. revealed | F 282 | | |

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| F 282 | Continued From page 31<br>Resident #4 sat in the Southside lounge area alone with a food tray in front of him/her. The tray had ½ cup of liquid supplement left and no food eaten with flies on the food.<br><br>Observation on 8/8/17 at 1:41 p.m. revealed Resident #4 sat in the Southside lounge area alone pounding on a food tray in front of him/her and yelling 'help, help' with no staff in the area.<br><br>Observation on 8/15/17 at 8:53 a.m. revealed Resident #4 sat in the Southside lounge area alone with his/her eyes closed with a covered food tray, the milk and the juice on had been unopened and no staff worked in the area. | F 282 | | |
| F 283 SS=E | 483.21(c)(2)(i)-(iii) ANTICIPATE DISCHARGE: RECAP STAY/FINAL STATUS<br><br>(c)(2) Discharge Summary<br><br>When the facility anticipates discharge, a resident must have a discharge summary that includes, but is not limited to, the following:<br><br>(i) A recapitulation of the resident's stay that includes, but is not limited to, diagnoses, course of illness/treatment or therapy, and pertinent lab, radiology, and consultation results.<br><br>(ii) A final summary of the resident's status to include items in paragraph (b)(1) of §483.20, at the time of the discharge that is available for release to authorized persons and agencies, with the consent of the resident or resident's representative.<br><br>(iii) Reconciliation of all pre-discharge medications with the resident's post-discharge | F 283 | | |

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| F 283 | Continued From page 32<br>medications (both prescribed and over-the-counter).<br>This REQUIREMENT is not met as evidenced by:<br>Based on clinical record review and staff interview, the facility failed to document a final discharge note for disposition of medications for 2 residents (Residents #17 and #18), and failed to complete discharge summaries with recapitulations of the residents' stays for 2 residents (Resident #3, #19) out of 5 residents reviewed for discharge. The facility reported a census 90 residents.<br><br>Findings include:<br><br>1. Review of the Progress Note dated 6/23/17 at 9 a.m. documented Resident #17 expired at the facility on that date. During a clinical record review of Resident #17 the record lacked documentation of the whereabouts of the resident's medications after discharge; staff only accounted for the resident's narcotics.<br><br>2. Review of the Admission record revealed Resident #18 discharged from the facility on 5/20/17 to an acute care hospital. The resident's clinical record lacked documentation of the whereabouts of the resident's medications after discharge; staff only accounted for the resident's narcotics.<br><br>During an interview on 8/15/17 at 8:15 a.m. the Administrator stated she did not have any documentation of where the medications went.<br><br>3. The Minimum Data Set MDS assessment dated 7/20/17 for Resident #3 recorded an admission date of 7/13/17. | F 283 | | |

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| F 283 | Continued From page 33<br><br>The care plan focus area revised 7/13/17 identified the resident anticipated a short stay at the facility for strengthening with therapy, wound cares, and IV (intravenous) antibiotics. The care plan intervention revised on 7/13/17 directed staff to provide written and verbal instructions to the resident for his/her aftercare to include activity level, medications, follow-up appointments, and have the resident return demonstration he/she understood the plan.<br><br>Review of the clinical record revealed an incomplete Discharge Summary dated 7/31/17 at 8:55 a.m. The summary lacked documentation in the following sections: Recapitulation of Resident's Stay; Vital Signs at Time of Discharge; Physical Functioning Status; Special Treatments or Procedures planned for Discharge; Dental Condition; Dietary; Activities; and Therapy. Only the Social Worker signed and completed a section; Psychosocial section.<br><br>The Progress Notes dated 8/1/17 at 3:18 p.m. documented a discharge note. The note recorded the resident left with a family member at 11:30 a.m. to home. The note did not contain a recapitulation of the resident's stay.<br><br>4. The MDS assessment dated 3/9/17 for Resident #19 recorded an admission date of 7/13/16.<br><br>The care plan focus area revised 12/8/16 identified the resident anticipated a short stay at the facility. The care plan informed staff the resident's case manager had assisted the resident to find placement once discharged. The care plan intervention revised on 11/4/16 directed | F 283 | | |

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| F 283 | Continued From page 34<br>staff to provide written and verbal instructions to the resident for his/her aftercare to include activity level, medications, follow-up appointments, and have the resident return demonstration he/she understood the plan.<br><br>Review of the clinical record revealed an incomplete Discharge Summary dated 5/1/17 at 8:03 a.m. The summary lacked documentation in the following sections: Recapitulation of Resident's Stay; Vital Signs at Time of Discharge; Physical Functioning Status; Special Treatments or Procedures planned for Discharge; Dental Condition; Dietary; Activities; and Therapy. Only the Social Worker signed and completed a section; Psychosocial section. | F 283 | | |
| F 309 SS=G | 483.24, 483.25(k)(l) PROVIDE CARE/SERVICES FOR HIGHEST WELL BEING<br><br>483.24 Quality of life<br>Quality of life is a fundamental principle that applies to all care and services provided to facility residents. Each resident must receive and the facility must provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being, consistent with the resident's comprehensive assessment and plan of care.<br><br>483.25 Quality of care<br>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, including | F 309 | | |

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| F 309 | Continued From page 35<br>but not limited to the following:<br><br>(k) Pain Management.<br>The facility must ensure that pain management is provided to residents who require such services, consistent with professional standards of practice, the comprehensive person-centered care plan, and the residents' goals and preferences.<br><br>(l) Dialysis. The facility must ensure that residents who require dialysis receive such services, consistent with professional standards of practice, the comprehensive person-centered care plan, and the residents' goals and preferences.<br>This REQUIREMENT is not met as evidenced by:<br>Based on clinical record review, hospital record review, family interview, and staff interview, the facility failed to complete ongoing assessments of a resident's pain by a qualified nurse and failed to provide pain medications after indicators of pain presented for 1 out of 15 current residents reviewed (Resident #3). The facility continually ignored the resident's request for pain medication over a minimum period of 8 hours who had a recent amputation of the forefoot and failed to provide a daily dressing change to the surgical site. The facility failures lead to Resident #3 seeking treatment at the hospital. Based on record review, staff interview and facility policy, the facility failed to assess and intervene for 1 of 15 current residents reviewed (Resident#7). The facility reported a census of 90 residents.<br><br>1. The Minimum Data Set (MDS) dated 7/20/17 for Resident #3 identified the resident admitted on 7/13/17 with a Brief Interview for Mental Status | F 309 | | |

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| F 309 | Continued From page 36<br>(BIMS) score of 15. A score of 15 indicated intact cognition. The MDS revealed the resident required the extensive physical assistance of 1 person for bed mobility, transfers, dressing, and toilet use. The MDS revealed the resident independent with locomotion on/off the unit and the resident utilized the use of a walker and wheelchair. The MDS documented diagnoses that included diabetes, traumatic amputation of right great toe, history of diabetic foot ulcer, and cellulitis (inflammation of cells). The MDS recorded the resident received scheduled and PRN (as needed) pain medications for pain management. The MDS documented the resident experienced pain frequently rating the worst pain in the previous 5 days a 6 on a scale of 10 (with 0 indicating no pain and 10 the worst pain imaginable). The MDS recorded the presence of surgical wounds with the surgical wound care. The MDS documented the resident received IV (intravenous) medications.<br><br>The care plan focus areas revised on 7/13/17 identified the resident with a wound and infection in his/her right lower extremity post amputation and at risk for skin impairment related to decreased mobility and medical diagnosis. The care plan directed staff to: educate the resident/family/staff regarding preventative measures to contain the infection; give all meds and IV therapy as ordered; and assess the resident's skin with any dressing changes, bathing, dressing/undressing, and update the resident's physician as needed.<br><br>The Dismissal/Interagency Instruction Sheet dated 7/13/17 at 12:00 p.m. directed the following Discharge Instructions Medication Orders for Resident #3: | F 309 | | |

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| F 309 | Continued From page 37<br>a. Norco 5/325 (narcotic pain pill with 5 milligrams (mg) hydrocodone and 325 mg of Tylenol); take 1 tab by mouth every 4 hours as needed for pain<br>b. Change dressing to right lower extremity (RLE) daily with adaptic (non-adhering gauze), gauze, Kling (absorbent gauze roll), and lightly wrap ACE bandage<br><br>The Progress Notes dated 7/13/17 at 6:20 p.m., written by Staff E, Unit Manager/Registered Nurse (RN), documented a general note. Staff E wrote she pulled 2 tabs of Norco 5/325 from the e-box per pharmacy Code #WC02IA15Y. The note did not indicate what Staff E did with the narcotic pain pills.<br><br>The Progress Notes dated 7/13/17 at 7:43 p.m. documented the resident admitted at 4:10 p.m. with pain in the right foot. The note recorded an incision at the amputation site of the toes of right foot with sutures intact, top of foot sore area, and boot on right foot. The entry did not indicate that any pain medication given to the resident.<br><br>The Initial Nursing Evaluation and Vitals dated 7/13/17 at 7:47 p.m., documented a resident assessment. The assessment did not assess pain and did not indicate that any pain medication given to the resident.<br><br>The Pain Assessment dated 7/13/17 at 8:07 p.m. documented:<br>A. Pain Presence - pain or hurting at any time in the last 5 days<br>Answer: Yes<br>B. Pain Frequency - how much time experienced pain or hurting over the last 5 days<br>Answer: Almost constantly<br>D. Pain Intensity - numeric rating scale 00-10 | F 309 | | |

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| TOUCHSTONE HEALTHCARE COMMUNITY | 1800 INDIAN HILLS DRIVE SIOUX CITY, IA 51104 |

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| F 309 | Continued From page 38<br>Answer: 8<br>E. Indicators of Pain or Possible Pain<br>Answer: vocal complaints of pain<br>F. Frequency of Indicator of Pain or Possible Pain<br>Answer: Indicators of pain for 3 to 4 days<br>G. Pain Management<br>1a. Describe treatment, any side effects and effectiveness<br>Answer: Hospitalized<br>2a. Describe administration patterns, any side effects and effectiveness<br>Answer: Effective, brings pain to a 5 -6 which is tolerable<br>RN Analysis of Pain and Plan<br>Answer: Patient has pain that is controlled.<br>The assessment did not indicate that any pain medication given to the resident.<br><br>The Comprehensive Evaluation of Skin Inspection and Risk Factors, dated 7/13/17 at 7:57 p.m., documented a skin assessment. The assessment recorded a surgical incision on the right toes measured 15.2 centimeters (cm) length by 0.1 cm width by 0.1 cm depth. The assessment did not assess pain and did not indicate that any pain medication given to the resident or that a dressing change completed.<br><br>The Skilled Status Assessment dated 7/13/17 at 10:00 p.m. documented:<br>A. Neuro Checks<br>Question 6 - Please enter pain level, pain interventions used and if effective Describe treatment, any side effects and effectiveness<br>Answer: Resident rates pain 6 out of 10<br>Question 8 - Does patient have any surgical wounds?<br>Answer: No | F 309 | | |

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| F 309 | Continued From page 39<br>The assessment did not indicate that any pain medication given to the resident or that a dressing change completed.<br><br>The Progress Notes dated 7/13/17 at 10:00 p.m. documented a skilled status note. The entry documented the resident skilled for PT/OT (physical & occupational therapy) related to transmetatarsal amputation, (surgical procedure to remove the forefoot in cases where the tissues in a patient's foot injured beyond repair, more extreme than a toe amputation), and RLE osteomyelitis (infection of the bone). The entry recorded the resident rated his/her pain a 6 out of 10. The entry did not indicate that any pain medication given to the resident.<br><br>The Skilled Status Assessment dated 7/14/17 at 4:20 p.m. documented by Staff A, Licensed Practical Nurse (LPN):<br>A. Neuro Checks<br>Question 6 - Please enter pain level, pain interventions used and if effective Describe treatment, any side effects and effectiveness<br>Answer: 10 prn given with relief obtained<br>Question 8 - Does patient have any surgical wounds?<br>Answer: yes<br>Question 8a - if yes, describe what type, and treatment, any redness, drainage, or pain<br>Answer: Right transmetatarsal amputation, change dressing to RLE daily with adaptic, gauze, Kling, and lightly wrapped ACE bandage.<br>The assessment did not indicate that a dressing change actually completed just listed type.<br><br>The Progress Notes dated 7/14/17 at 4:20 p.m., written by Staff A documented a skilled status note. The entry documented a 10 prn given with | F 309 | | |

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| F 309 | Continued From page 40<br>relief obtained. The note recorded the resident oriented to person, place, and time. The note documented a surgical wound present with right transmetatarsal amputation, change dressing to RLE daily with adaptic, gauze, Kling, and lightly wrap with ACE bandage.<br><br>The Controlled Medication Utilization Records for Resident #3 documented no Norco signed out on 7/13/17. The record documented 1 Norco signed out on 7/14/17 at AM.<br><br>The July 2017 Medication Administration Record (MAR) documented Norco not given on 7/13/17 and only given once on 7/14/17 at 10:26 a.m. by Staff Cc, Certified Medication Aide (CMA).<br><br>The July 2017 Treatment Administration Record (TAR) documented the dressing change scheduled to be completed on the 6 to 2 shift. The TAR reflected a blank space on 7/14/17 which indicated the treatment not completed.<br><br>The July 2017 MAR reflected Staff H initialed a check for monitoring the resident's pain and the resident rated pain at a 10 level on 7/14/17.<br><br>The Medication Admin Audit Report dated 8/10/17 at 12:59 p.m. recorded Staff H signed off the pain monitoring on 7/14/17 at 5:29 p.m.<br><br>The Transfer/Discharge Report, signed by Resident #3's family member on 7/15/17 at 12:10 a.m., recorded the family member took the resident on 7/14/17 at 9:00 p.m. to the hospital, took stuff, and would be back for the rest. The report reflected a print date in the top right hand corner of 7/15/17. | F 309 | | |

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| F 309 | Continued From page 41<br>The next Progress Note occurred at 7/15/17 at 2:09 a.m., written by Staff AA, RN. Staff AA wrote the resident's family member approached her at approximately midnight and stated he/she picking up the resident's belongings. Staff AA wrote the family member stated at 9:00 p.m. he/she took the resident to the hospital without informing staff because concerned about the resident's dressing changes and not getting pain medication routinely. Staff AA documented the family member requested the names of staff who worked the evening shift. Staff AA wrote the family member reported the ER (emergency room) said they would probably admit the resident and he/she wouldn't be back. Staff AA recorded she had the family member sign for taking personal belongings. Staff AA wrote she received call from the ER doctor stating they had changed the resident's dressing and everything looked fine. Staff AA recorded the doctor reported they gave the resident pain medication and would be sending him/her back. Staff AA documented she told the doctor the family member had just picked up personal belongings and stated hospital admitting the resident and he/she wouldn't be back. Staff AA recorded the doctor stated there wasn't a need to admit and he would attempt to get the family member to bring the resident back to facility. Staff AA documented the doctor asked if the resident on the skilled unit and she told him yes. The entry documented at approximately 1:30 a.m. the resident returned to the facility accompanied by the family member. Staff AA recorded the family member reported the dressing changed and the resident had received pain medication. Staff AA documented she gave the resident medication at 1:50 a.m., the resident went outdoors for cigarette, and the resident returned inside at 2:30 a.m. going to bed. Staff | F 309 | | |

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| F 309 | Continued From page 42<br>AA documented she contacted the DON (Director of Nursing) and informed her of the situation.<br><br>The Emergency Department (ED) Discharge Summary, documented on 7/15/17 at 1:06 a.m., recorded a DOS (Date of Service) of 7/14/17 at 9:25 p.m. for Resident #3. The Summary documented the following pain medications given at the hospital by IV Push (a syringe a medicine pushed into the IV line):<br>a. ondansetron (anti-nausea medication) 4 mg at 10:27 p.m.<br>b. hydromorphone (used to treat severe pain) 1 mg at 10:27 p.m.<br>c. hydromorphone (also known as Dilaudid) 0.5 mg at 11:31 p.m.<br>The Summary recorded the resident departed the ER on 7/15/17 at 1:06 a.m.<br><br>The ED Adult Triage Form, documented on 7/14/17 at 9:59 p.m., recorded at 9:54 p.m. Resident #3 complained of a pain score of 10 in the left leg described as constant, throbbing.<br><br>The ER Progress Note Form, documented on 7/15/17 at 1:03 a.m., recorded at 1:00 a.m. Resident #3 foot rewrapped with emulsion, 4 by 4's, Kling/ACE after additional dose of IV pain medication given.<br><br>The ED Physician Notes Final Report, documented on 7/15/17 at 1:23 a.m., included the following documentation recorded for Resident #3:<br>History of Present Illness: Patient presented with right, foot pain; complained of sever right foot pain; family member upset because stated the dressing to the right foot not changed since arriving at the facility; also stated upset because | F 309 | | |

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| F 309 | Continued From page 43<br>facility not giving pain medication; the last dose of Norco sometime in the early morning; and Resident #3 stated the nurse told him/her his/her pain pills had run out.<br>Reexamination/Reevaluation: After 2 doses of Dilaudid patient's pain now under adequate control. Called the facility and had a conversation with a nurse named (Staff AA). She does tell me that they have orders for dressing changes to the right foot daily. She cannot tell me when they have not yet been done. They also have a prescription for Norco to be given to the patient scheduled for pain. She cannot tell me why the patient not provided with this earlier. She does however have a prescription and does not need any further orders. The doctor discussed the importance of following physician orders as directed. The doctor noted the dressing to right foot reapplied by RN.<br>Impression and Plan:<br>Diagnosis acute postoperative pain of right foot.<br><br>In a family interview on 8/7/17 at 3:25 p.m., Resident #3's family member expressed concern the resident did not receive pain medications the day of and after admit. The family member confirmed the resident admitted on 7/13/17. The family member stated on 7/14/17 he/she asked 3 staff if the resident received pain medication but told the computer showed it had not been given. The family member said staff informed him/her the pain medication not scheduled to be given, only ordered as needed every 4 hours. The family member reported the 3 staff to be: Staff H, LPN; Staff CC, CNA (Certified Nurse Aide); and Staff G, CNA. The family member stated he/she did not believe any staff took pain medication from an EKIT (emergency medicine box | F 309 | | |

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| F 309 | Continued From page 44<br>containing certain backup medications in a facility) to give to the resident. The family member reported the day of admit, a staff nurse removed the resident's dressing and put it on the floor. The family member stated after the nurse did an assessment, she put the same dirty dressing back on the resident. The family member stated the nurse informed him/her the facility had not ordered new dressings yet. The family member commented the facility had been aware the resident would be admitting and they should have had the dressings ready. The family member stated on 7/14/17 the resident told him/her he/she had asked for quite some time for pain pills. The family member reported the resident requested he/she bring the resident's pain pills from home. The family member stated the nurse offered the resident a Tylenol. The family member reported when he/she came into the facility no one at the nursing station so he/she grabbed the resident from the smoking area to take him/her to the ER (Emergency Room). The family member stated at that time the resident's dressing bleeding through the ace wrap and into the boot. The family member said he/she concerned about infection as the resident already had infection in the bone, the resident diabetic, and he/she did not want the resident to have their foot amputated. The family member stated he/she left with the resident around 9:00 p.m. to 9:30 p.m. The family member reported the facility gave the resident a pain pill around 10:00 a.m. only on 7/14/17.<br><br>In an interview on 8/8/17 at 11:00 a.m., Staff A, LPN, reported familiar with Resident #3's care. Staff A recalled the day of 7/14/17 she stayed over to get charting done. Staff A commented she did not like to do charting till the end of a | F 309 | | |

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| F 309 | Continued From page 45<br>shift. Staff A said med aides assist the nurses to administer pills and the med aides must let the nurses know if they give a pain pill because the nurse needed to do an assessment. Staff A reviewed her charting from that day and stated she wrote an end of day summary. Staff A said at the end of the shift she looked back at what the CNA's and med aides told her. Staff A stated the resident reported a pain level of 10 and a pain pill given at 10:26 a.m. by Staff Cc. Staff A stated she never gave the resident any pills and the pain rating of a 10 reflected the pain assessed at 10:26 a.m., not at 4:20 p.m. when she actually completed charting.<br><br>In an interview on 8/8/17 at 11:30 a.m., Staff H stated she worked for the facility for 6 weeks. Staff H acknowledged slightly familiar with Resident #3's cares. Staff H reported she recalled 1 instance when the resident's PRN hydrocodone (narcotic pain medication) did not come in from the pharmacy. Staff H stated the resident's pain pill PRN, but the resident expected the pills every 4 hours. Staff H commented the resident did not get pills automatically, only if he/she showed signs/symptoms of pain. Staff H stated she did not want to give the resident pain pills because she did not want to make the resident dependent on pills or drug the resident up. Staff H stated honestly, the med aide assesses for pain and gives pain pills. Staff H said residents need to go to the person on the medication cart if they want pain pills because nurses are for phone calls and skilled assessments. Staff H reported skilled nursing assessments done once a shift on the 1st and 2nd shifts but not on 3rd shift, that would be redundant. Staff H responded if she did not make a skilled status note that day she probably | F 309 | | |

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| F 309 | Continued From page 46<br>worked short staffed. Staff H reported on 7/14/17 she worked on the Northside for the 1st time and recalled having 3 extra hours of charting. Staff H stated Northside fast paced, a lot to take on, and it took adjustment to work that side. Staff H said Southside not as critical as the Northside which had more frequent specific needs. Staff H reported at that time she did not prioritize when pills due but she did now. Staff H commented she had been a little overwhelmed. Staff H stated, honestly, the resident very angry when he/she arrived to the facility. Staff H said the resident felt he/she did not get things promised before admission and the resident wanted a pain pill whenever he/she wanted it. Staff H recalled the resident called for her because he/she did not want the med aide. Staff H stated she informed the resident his/her order for PRN only and the resident got upset saying he/she would bring their pills from home. Staff H stated she then told the resident he/she could have Tylenol but unfortunately, the resident adamant he/she wanted a pain pill. Staff H said she did not know why the resident didn't get a pain pill. Staff H stated she did not recall the resident's dressing changes except that the resident hard to find at times. Staff H said the resident spent time roaming with family and outside smoking. Staff H stated the resident hard to track down, so if she did not sign the treatment then it was because the resident not available. When told the resident went to the ER on 7/14/17, Staff H responded she wondered if the resident just tried to get more pain pills. Staff H stated the more she talked in the interview the clearer the issue became to her. Staff H said she recalled the resident arrived with an abnormal number of pills; 3 of each med. Staff H recalled the last hydrocodone pill used and she had to await authorization from the | F 309 | | |

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| F 309 | Continued From page 47<br>pharmacy to open the EKIT for narcotics. Staff H commented pharmacy readily available at all hours, however, when she had 30 residents who all needed something from her, calls from doctors, a resident already angry about not getting pain meds; it was not her problem the medication not scheduled to give routinely. Staff H stated she couldn't do everything simultaneously and she had to prioritize a resident's chest pain that needed to go to the hospital. Staff H stated the pain pill important also and she did the best she could, but the resident well enough to go out to smoke. Staff H said the priority of the resident with chest pain took a chunk of time and working on Northside there's no time for anything to go wrong. Staff H stated up until a little bit ago, they staffed just 1 nurse and 1 med aide on Northside; now they staff 2 nurses. Staff H reported she asked the resident to exercise patience because he/she did not show any signs of non-verbal pain. Staff H stated again, she offered the resident Tylenol but he/she said no, they wanted a narcotic. Staff H said she did tell the resident he/she could not take the medicine from home. Staff H commented she felt the resident easily not pleased that day, bitter about meds not being in, and she was in a terrible situation with not enough staff.<br><br>In an interview on 8/8/17 at 12:28 p.m., Staff AA, RN (Registered Nurse), stated she worked overnights 1 day a week on Fridays and acknowledged familiar with Resident #3's cares. Staff AA recalled working on the overnight of 7/14/17 going into the morning of 7/15/17. Staff AA reported she did not know the resident not there. Staff AA stated the nurse before her did not tell her the resident gone. Staff AA said | F 309 | | |

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| F 309 | Continued From page 48<br>Resident #3's family member came after midnight sometime taking all belongings out; something to do with upset about a dressing change. Staff AA stated the family member left then she received a call from the ER saying the resident ready to return to the facility; the dressing off and they redressed the wound. Staff AA said she gave the resident a pain pill upon return to the facility. Staff AA clarified she did not know if the shift before her knew the resident went to the ER but she did not know. Staff AA stated the family member told her he/she did not tell anyone; he/she so mad the dressing change not done and no pain pill given, he/she just took the resident. Staff AA recalled pain pills available for the resident. Staff AA remembered 3 pain pills in an envelope from the EKIT. Staff AA said the pharmacy needed to hear an Iowa approval number to give the okay to take so may out of stock. Staff AA stated she called the pharmacy and they reported a whole card, (contains pills packed to punch out of a bubble pack - usually a month's worth at a time), of medicine should be at the facility. Staff AA said, sure enough, she found 3 pills in an envelope and a whole card. Staff AA concluded, so we had the pain pills available to give.<br><br>In an interview on 8/9/17 at 10:08 a.m., the DON, stated she addressed that CMA's could not assess for pain or effectiveness of pain pills in meetings the last 3 months. The DON stated the CMA's could give a pain pill after a nurse assessed the pain. The DON stated it would be out of the scope of practice for a CMA to assess pain.<br><br>On 8/9/17 at 11:23 a.m. a follow-up phone interview conducted with Staff H to ask why she | F 309 | | |

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| TOUCHSTONE HEALTHCARE COMMUNITY | 1800 INDIAN HILLS DRIVE SIOUX CITY, IA 51104 |

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| F 309 | Continued From page 49 | F 309 | | |

signed out a narcotic on 7/19/17 at 1:00 a.m. but failed to document anywhere else that she gave the pain pill to the resident. Staff H stated she had no idea why she signed out a pill on the narcotic count sheet and said not going to own up to it. Staff H commented she guaranteed though, if she signed out a pill she gave it. Staff H stated she did not know why she did not document on the MAR or in the nurses notes, but she guaranteed she gave the pain pill to the resident if she signed it out.

On 8/9/17 at 2:10 p.m., Staff H arrived at the facility for an in-person interview. Staff H stated she did not take the narcotic pain pill signed out on 7/19/17 at 1:00 a.m. Staff H verified her signature on that date and time. Staff H stated she did not document on non-verbal signs of pain if not displayed. Staff H acknowledged her nurse training taught her to assess a resident before giving a pain pill. Staff H stated the facility only required her to rate the resident's pain for pain assessments.

2. According to the MDS assessment dated 7/13/17, Resident #7's diagnoses included hypertension, fracture, hemiplegia or hemiparesis, traumatic subdural hematoma with loss of consciousness of unspecified duration. The MDS documented long and short term memory problems with severely impaired cognitive skills for daily decision making. The assessment documented the resident the assistance of one staff with toileting.

Review of the resident's Care Plan updated 5/22/17 revealed a focus on being incontinent of bowel and bladder at times. The care plan directed the staff to assist with pericare and

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| F 309 | Continued From page 50<br>incontinence care as needed, that the resident used a toilet and wore incontinent products.<br><br>Review of a facsimile to the Medical Director dated 2/14/17 (identified by the Director of Nursing (DON) as a copy of the bowel policy) revealed a request for a bowel protocol and standing orders for all current residents and all new admissions as long as there are no allergies/adverse reactions.<br>The protocol instructed:<br><br>On day 3, if no bowel movement (BM), administer Milk of Magnesia (oral laxative) 30 cubic centimeter (cc) orally daily as needed or Bisacodyl (oral laxative) 5 milligrams (mg) tablets 1 or 2 tablets daily as needed.<br><br>On day 4, if no BM, insert Dulcolax (stool softener)10 mg suppository rectally daily as needed.<br><br>On day 5, if no BM, notify the primary care provider.<br><br>Review of the electronic bowel movement history form revealed the staff recorded bowel movements (BM) for the resident on:<br><br>7/7/17<br>7/12/17<br>7/14/17<br>7/18/17<br>7/19/17<br>7/20/17<br>7/25/17<br>7/28/17<br>7/31/17 | F 309 | | |

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| F 309 | Continued From page 51<br>8/3/17<br>8/4/17<br><br>Review of a progress note dated 7/12/17 at 5:09 AM revealed that the resident had no BM for 5 days.<br><br>Review of another progress note dated 7/25/17 at 5:25 AM revealed that Resident #7 had no documented BM for 5 days.<br><br>Review of the medication administration record (MAR) dated 7/1/17 - 7/31/17 revealed the facility documented the administration of Bisac-Evac Suppository (rectal stimulant) one as needed on 7/12/17 at 5:09 AM and 7/25/17 at 5:25 AM.<br><br>Review of the MAR dated 7/1/17-7/31/17 revealed the facility documented the administration of Milk of Magnesia oral suspension (oral laxative) 30 milliliters (ml) on 7/28/17 at 8:08 AM only. | F 309 | | |
| F 312 SS=E | 483.24(a)(2) ADL CARE PROVIDED FOR DEPENDENT RESIDENTS<br><br>(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.<br>This REQUIREMENT is not met as evidenced by:<br>Based on clinical record review, resident interview, facility policy review, observation, family interview, Resident Council minutes and group interview, the facility failed to provide toileting assistance for 2 residents (#1 and #9), failed to provide bathing assistance for 6 residents (#7, | F 312 | | |

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| F 312 | Continued From page 52<br>#11, #12, #2, #9, #3) and 7 out of 7 residents present for the Group resident interview and failed to provide eating assistance for one resident (#4) of 15 current residents reviewed. The facility reported a census of 90 residents.<br><br>Findings include:<br><br>1. According to the Minimum Data Set (MDS) assessment dated 7/13/17, Resident #7's diagnoses included hypertension, other fracture, hemiplegia or hemiparesis, traumatic subdural hematoma with loss of consciousness of unspecified duration. The MDS documented long and short term memory problems with severely impaired cognitive skills for daily decision making. The assessment documented the resident required the assistance from 2 or more staff with bathing and utilized a wheelchair for mobility.<br><br>Review of the Care plan updated 5/22/17 revealed a focus on dressing, grooming and bathing. The care plan documented the the resident required assistance of one staff with bathing, dressing and grooming and may take a shower or bed bath. The care plan also focused on the resident's risk for skin impairment The care plan directed the staff to observe the resident's skin during the bathing process at least weekly and report any changes to the charge nurse.<br><br>Review of a follow up questioning report regarding bathing revealed the resident received a bath on the following days between 6/1/17-8/9/17:<br>7/10/17<br>7/18/17<br>7/29/17 | F 312 | | |

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| F 312 | Continued From page 53<br><br>2. According to the MDS assessment dated 5/17/17, Resident #11's diagnoses included heart failure, gastrointestinal esophageal reflux disease, renal insufficiency, urinary tract infection, depression, alcohol abuse, hypokalemia, fatty liver, acute pancreatitis, underweight, enterocolitis due to clostridium difficile and acute cystitis with hematuria (blood in the urine). The MDS documented a BIMS of 14 indicating intact memory and cognition. The assessment documented the resident required the assistance from 2 or more staff with personal hygiene and utilized a walker and wheelchair for mobility.<br><br>Review of the Care plan updated 6/2/17 revealed a focus on assistance with dressing, grooming and bathing due to weakness from a recent hospitalization. The care plan documented the the resident required minimal assistance from staff with dressing, grooming and bathing. The care plan also focused on wounds present upon admission and a nephrostomy (urine drainage) tube. The care plan directed nurses to assess the resident's skin weekly.<br><br>Review of a follow up questioning report regarding bathing revealed the resident received a bath on the following days between 6/1/17 and 8/9/17:<br>6/1/17-resident refused<br>6/5/17-resident refused<br>6/12/17-resident refused<br>6/15/17-resident refused<br>6/19/17-resident refused<br>6/22/17-resident refused<br>6/26/17-resident refused<br>6/27/17-resident refused<br>6/29/17-resident refused | F 312 | | |

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| F 312 | Continued From page 54<br>7/10/17-resident refused<br>7/18/17<br><br>During an interview with Resident #11 on 8/10/17 at 9:57 AM, the resident stated that he/she has refused to bathe at times but staff did not offer the resident 2 baths per week.<br><br>3. According to the MDS assessment dated 7/7/17, Resident #12's diagnoses included hypertension, diabetes mellitus, depression, a pressure sore of sacral region (Stage 3), an open wound of unspecified buttock, candidiasis (yeast infection) of the skin and nails and morbid obesity. The assessment documented Resident #12 entered the facility on 6/30/17 and that bathing at not yet occurred at the time of the assessment. The MDS documented a BIMS of 15 indicating intact memory and cognition. The assessment documented Resident #12 required the assistance of 2 or more staff with bed mobility, transfers and walking in their room.<br><br>Review of the Care plan updated 6/30/17 revealed a focus on skin documenting the resident has a skin issue. The care plan instructed the nurse to observe the skin at least weekly during the bathing process.<br><br>The follow up questioning report regarding bathing documented the resident refused a bath on 7/18/17 and received a bath on 7/29/17 only.<br><br>Review of a facility policy entitled Bathing, dated June 2017, revealed that a minimum of a complete tub bath or shower once a week shall be provided for all residents or more often if desired or necessary. At times, a complete bed bath will be substituted for a tub bath or shower. A | F 312 | | |

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| F 312 | Continued From page 55<br>minimum of weekly shampoos and assistance with daily hair grooming as needed.<br><br>4. The MDS assessment dated 7/10/17 identified diagnoses for Resident #1 that included hemiplegia (paralysis on one side) and postprocedural cerebrovascular infarction following other surgery (stroke following surgery). According to the MDS, the resident required the extensive assistance for bed mobility, transfer, dressing and toileting. The MDS indicated the resident had a BIMS score of 15, indicating no cognitive impairment.<br><br>The Care plan dated 7/7/17 revealed a focus of the need for assistance with toileting with an intervention for need of assist times 1 for toileting needs.<br><br>An interview with Resident #1 on 8/9/17 at 1:45 p.m. revealed she/he is not getting to the bathroom when they need to go. The resident stated there is only one staff working down their hall, the aide has come to answer the light and tells the resident to hold for a while and then the aide never returns. Resident #1 stated s/he has waited up to 3 hours for the call light to be answered.<br><br>5. The MDS assessment dated 5/25/17, identified diagnoses for Resident #2 which included Parkinson's disease, depression and Non-Alzheimer's dementia (deteriorating condition). According to the MDS, the resident required extensive assistance for bed mobility, locomotion and dressing and dependent with transfers, toileting and bathing. The MDS indicated the resident experienced severely impaired cognitive skills for daily decision making. | F 312 | | |

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| F 312 | Continued From page 56<br><br>Review of Schedule for May 2017 for resident #2 revealed staff did not provide the resident a bath from 5/23/17 to 5/30/17.<br><br>6. The MDS assessment dated 7/13/17 identified diagnoses for Resident #9 that included cerebrovascular accident (CVA), neurogenic bladder, anxiety disorder and depression. The assessment documented the resident needed the assistance of 2 staff with toilet use and personal hygiene and s/he experienced frequent urinary and bowel incontinence. The MDS indicated the resident has a BIMS of 15.<br><br>Review of the Care plan dated 1/10/17 for Resident #9 revealed a toileting focus with an intervention for extensive assistance of 2 staff in toileting.<br><br>An observation on 8/8/17 at 9:58 a.m. call light turned on in Resident #9's room 3. An interview with Resident #9 on 8/8/17 at 10:06 a.m. revealed that the resident needed to go to the bathroom.<br><br>An observation on 8/8/17 at 10:19 a.m. revealed call light on until this time when Staff D, CNA entered the room, turned off the call light and then left.<br><br>An interview with Resident #9 on 8/8/17 at 10:19 a.m. revealed the aide (Staff D) said he/she would have to wait awhile. Resident #9 stated s/he also had to wait in the morning to get out of bed because of the lack of staff. Sometimes, staff did not assist the resident to get up until 10 a.m.<br><br>Observation on 8/8/17 at 10:29 a.m. revealed | F 312 | | |

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| F 312 | Continued From page 57<br>Staff D took a stand up lift into another resident room.<br><br>An interview on 8/8/17 at 10:30 a.m. with Staff E, Unit Manager/Registered Nurse (RN), revealed she spoke to Resident #9 and knew of the resident's need to use the bathroom. At 10:34 a.m. Staff E and an LPN entered Resident #9's room with a mechanical lift and shut the door.<br><br>An interview on 8/9/17 at 12:08 p.m. with Resident #9 revealed s/he had trouble with the call light again last night. Resident #9 stated the call light was on from 9 p.m. to 9:45 p.m. before anyone answered it.<br><br>An interview on 8/15/17 at 8:30 a.m. with the Director of Nursing (DON) revealed her expectations with bathing would be the residents would get 2 baths a week.<br><br>In an interview on 8/10/17 at 9:45 a.m., Resident #9 confirmed he/she had not received a bath. Resident #9 stated supposed to get a bath the previous Friday but staff did not offer it. Resident #9 said he/she had only 3 baths in the past month and stated s/he felt glad bathing was reviewed. Observation revealed Resident #9's hair appeared greasy and stringy at the time of the interview. Resident #9 stated staff had not washed his/her hair.<br><br>7. The MDS assessment dated 7/20/17 for Resident #3 revealed the resident required the physical assistance of one with bathing. The MDS documented the resident's diagnoses included diabetes, traumatic amputation of right great toe, history of diabetic foot ulcer and cellulitis (inflammation of cells). | F 312 | | |

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| F 312 | Continued From page 58<br><br>The Care plan focus areas revised on 7/13/17 identified the resident needed assistance with ADLs (Activities of Daily Living) related to weight bearing status, deconditioning, safety and health decline. The Care plan directed staff to assist the resident with dressing with 1 to 2 staff and s/he transfers with 2 staff, gait belt and walker.<br><br>The Dismissal/Interagency Instruction Sheet dated 7/13/17 at 12:00 p.m. directed the following Discharge Orders under Discharge Activities for Resident #3:<br>a. May shower; non-weight bearing to right lower leg<br><br>The Follow-up Question Report for 7/1/17 through 7/31/17 reflected bathing support provided for the resident on 7/18/17 and 7/29/17 only. The report lacked any documentation of resident refusals to bathe.<br><br>8. The Resident Council minutes dated 5/20/17 documented under the Nursing section that baths were not getting done and one resident went 2 weeks without a bath.<br><br>The Resident Council minutes dated July 2017 documented under the Nursing section that residents want a bath at a set time so they know when going to get the bath and they till not getting a bath 2 times per week.<br>9. The 6/29/17 MDS assessment recorded Resident #4 had severely impaired memory and cognition; s/he never or rarely made decisions. Resident #4 required the assistance of 2 staff for bed mobility and transfers and the assistance of one staff in order to eat. The MDS also recorded Resident #4 had Non-Alzheimer's dementia. | F 312 | | |

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| F 312 | Continued From page 59<br><br>The 12/26/16 revised Care plan recorded Resident #4 needed assistance activates of daily living (ADL's) and ate poorly. The 5/26/15 revision recorded the Resident # 4 sometimes had behaviors during meal times and to have the charge nurse or designee supervise during meal times outside of the dining room (such as Nook or Nurses station). The care plan also instructed the resident needed encouragement and supervision while eating in the Southside nook.<br><br>The bedside Kardex Report (a short version of the Care plan) listed under Eating/Nutrition that Resident #4 ate in the Southside nook, with encouragement and supervision.<br><br>Observation on 8/7/17 at 12:53 p.m. revealed Resident #4 sat in the Southside lounge area alone with a food tray in front of him/her. The tray had ½ cup of liquid supplement left and no food eaten with flies on the resident's food.<br><br>Observation on 8/8/17 at 1:41 p.m. revealed Resident #4 sat alone in the Southside lounge area, pounding on a food tray in front of him/her and yelling 'help, help' with no staff in the area.<br><br>Observation on 8/15/17 at 8:53 a.m. revealed Resident #4 sat alone in the Southside lounge area with his/her eyes closed with a covered food tray. The milk and the juice on the tray had not been opened and no staff worked in the area.<br><br>During an interview on 8/8/17 at 10:10 a.m. with Staff K CNA stated the Kardex in the computer tells staff everything they need to know on how to take care of each resident. | F 312 | | |

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| F 312 | Continued From page 60<br>10. During a Group resident interview on 8/2/17 at 1:15 p.m., 7 out of the 7 residents in attendance stated that 55 residents have baths scheduled on Monday and many of the baths do not get done. One resident stated he/she had therapy scheduled at the time staff wanted to give him/her a bath and staff did not come back either that day or the next day to offer it. | F 312 | | |
| F 314 SS=D | 483.25(b)(1) TREATMENT/SVCS TO PREVENT/HEAL PRESSURE SORES<br><br>(b) Skin Integrity -<br><br>(1) Pressure ulcers. Based on the comprehensive assessment of a resident, the facility must ensure that-<br><br>(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<br><br>(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.<br>This REQUIREMENT is not met as evidenced by:<br>Based on clinical record review, observation, staff interview and facility policy review, the facility failed to prevent the development of a pressure sore for 1 of 4 residents reviewed who had pressure sores (Resident #13). The facility reported a census of 90 residents.<br><br>Findings include: | F 314 | | |

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| F 314 | Continued From page 61<br><br>The Minimum Data Set (MDS) assessment dated 6/15/17 documented Resident #13 had diagnoses of neurogenic bladder, quadriplegia, chronic lung disease, methicillin susceptible staphylococcus infection and other disorders of the peripheral nervous system. The resident scored 15 on the Brief Interview for Mental Status (BIMS), indicating intact memory and cognitive functioning. The MDS revealed the resident required the assistance of 2 staff with bed mobility , transfers, dressing toilet use and personal hygiene activities. The assessment identified Resident #13 as at risk for the development of pressure ulcers and s/he had two Stage 2 pressure ulcers at the time of the assessment. The resident's admission MDS assessment dated 3/16/17 revealed s/he had no pressure ulcers present during the assessment period.<br><br>A Braden Scale For Predicting Pressure Sore Risk form dated 3/10/17 revealed the resident scored 14 and represented at moderate risk for pressure sore development.<br><br>Review of the care plan dated 3/10/17 revealed a focus on skin issues related to redness on the resident's bottom and pressure areas on bilateral (both) heels. The care plan included interventions to:<br><br>Assist with position changes as needed;<br>Complete treatments as ordered;<br>The resident chooses to wear only socks and s/he did not wish to use padded wheelchair pedals (initiated 7/7/17);<br>Wear Prafo (off-loading) boots when in bed;<br>A pressure redistribution mattress on the bed; | F 314 | | |

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| F 314 | Continued From page 62<br>A nurse would observe skin at least weekly during the bathing process.<br><br>Review of a facsimile (fax) dated 5/20/17 at 1524 (3:24 PM) to the physician revealed the resident had open areas to both Achilles tendon areas with the left measuring 0.5 centimeters (cm) by 0.5 cm with yellowish scab. The right measured unknown (documentation blanked out) by 0.5 cm with a yellowish scab. The fax documented the areas were cleansed, patted dry and covered with Mepilex (a dressing). The physician inquired if this was due to footwear and ordered an occupational therapy (OT) evaluation.<br><br>Review of the resident's record revealed staff completed the Initial Weekly Wound Documentation on 6/7/17 on the right heel. The form documented staff notified the physician on 6/2/17. This assessment documented the right posterior heel measured 1.1 cm by 1.6 cm at a Stage 1.<br><br>Review of the resident's record revealed staff completed the Initial Weekly Wound Documentation on 6/7/17 on the left heel The form documented staff notified the physician on 6/2/17. This assessment documented the left posterior heel measured 3.2 cm by 1.6 cm by 0.1 at a Stage 2.<br><br>The Initial Weekly Wound Documentation form also instructed the initial wound sheet should be completed when a wound is first discovered.<br><br>Review of a Progress note dated 5/31/17 at 11:42 AM, revealed that the wound to the back of the left Achilles area appeared to be worse. Staff placed a call to the physician to get an order for | F 314 | | |

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| F 314 | Continued From page 63<br>the wound clinic or to be seen in the office.<br><br>Review of a Progress note dated 6/2/17 at 2:06 PM documented the Nurse Practitioner came to the facility to see the wound on the resident's left heel. The physician ordered an oral antibiotic for 10 days for wound care.<br><br>During an interview with Resident on 8/10/17 at 11:30 AM, the resident stated that he/she bought a new pair of shoes that were about a 1/2 size too big. The resident wore them to appointments during one week. The resident stated that he/she cannot feel pain, but is able to feel pressure. The resident stated that he/she developed an open area on the right heel during a rehab admission elsewhere. The resident stated he/she had their own air mattress that he/she brought with him/her as well as Prafo boots. The resident stated that he/she wore Prafo boots anytime he/she was in bed and he/she had no skin issues upon admission to the facility. During additional interview on 8/14/17 at 11: 14 AM, Resident #13 stated at the time the blister (pressure ulcer) formed on the heel, he/she wore socks in the tennis shoes. The resident stated at now he/she wears only socks and has discarded the tennis shoes.<br><br>During an interview with the Wound Clinic Nurse on 8/14/17 at 1:18 PM, he stated the left heel was a pressure ulcer. He stated the wound may or may not have been preventable due to the resident's noncompliance with treatment. The nurse stated he had recommended the resident wear Heelmedix (off-loading) boots at all times but the resident refused. He also suggested the resident wear Rook (offloading) boots but the resident refused. The nurse stated if Resident | F 314 | | |

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| F 314 | Continued From page 64<br>#13 had been wearing an offloading boot, the resident wouldn't have had the heel issue.<br><br>Review of the facility's Skin Program policy, revised 4/16, revealed that on admission a baseline assessment of of the resident's skin status will be completed within 2 hours of admission. When a skin ulcer is identified, a comprehensive wound assessment will be completed. Reassess the wound at least weekly. | F 314 | | |
| F 323 SS=J | 483.25(d)(1)(2)(n)(1)-(3) FREE OF ACCIDENT HAZARDS/SUPERVISION/DEVICES<br><br>(d) Accidents.<br>The facility must ensure that -<br><br>(1) The resident environment remains as free from accident hazards as is possible; and<br><br>(2) Each resident receives adequate supervision and assistance devices to prevent accidents.<br><br>(n) - Bed Rails. The facility must attempt to use appropriate alternatives prior to installing a side or bed rail. If a bed or side rail is used, the facility must ensure correct installation, use, and maintenance of bed rails, including but not limited to the following elements.<br><br>(1) Assess the resident for risk of entrapment from bed rails prior to installation.<br><br>(2) Review the risks and benefits of bed rails with the resident or resident representative and obtain informed consent prior to installation.<br><br>(3) Ensure that the bed's dimensions are appropriate for the resident's size and weight. | F 323 | | |

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| F 323 | Continued From page 65<br>This REQUIREMENT is not met as evidenced by:<br>Based on clinical record review, family interview, staff interview, and facility policy review, the facility failed to provide adequate supervision during rounds and shift change leading to a resident being unaccounted for 1 resident out of 20 total residents reviewed for adequate nursing supervision (Resident #3). The facility failed to complete rounds in a manner to check on all residents whereabouts on 7/14/17 when Resident #3 not in the building or on the premises when shift change occurred at 10:00 p.m. The facility remained unaware until the resident's family member reported to the facility at 12:10 a.m. on 7/15/17 the resident being treated at the hospital Emergency Room. The findings constitute an Immediate Jeopardy situation to residents. Additionally, the facility failed to provide supervision of an unlocked medication cart so that residents would not have access to medications not prescribed to them. The facility reported a census of 90 residents.<br><br>Findings include:<br><br>1. The Minimum Data Set (MDS) assessment dated 7/20/17 for Resident #3 identified the resident admitted on 7/13/17 with a Brief Interview for Mental Status (BIMS) score of 15. A score of 15 indicated intact cognition. The MDS revealed the resident required the extensive physical assistance of 1 person for bed mobility, transfers, dressing, and toilet use. The MDS revealed the resident independent with locomotion on/off the unit and the resident utilized the use of a walker and wheelchair. The MDS documented diagnoses that included diabetes, traumatic amputation of right great toe, history of | F 323 | | |

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| F 323 | Continued From page 66<br>diabetic foot ulcer, and cellulitis (inflammation of cells).<br><br>The care plan focus areas revised on 7/13/17 identified the resident: with a wound and infection in his/her right lower extremity post amputation; at risk for skin impairment related to decreased mobility and medical diagnosis; needed assistance with ADLs (Activities of Daily Living) related to weight bearing status, de-conditioning, safety and decline in health; and at risk for falls due to need for ADL assistance. The care plan directed staff to: use a wheelchair for mobility as the resident not ambulatory; assist bed mobility with 1 staff, dressing 1 to 2 staff, toileting 2 staff with use of a gaitbelt; and encourage the resident to use the call light and request assistance for any needs that required transfer or to reach unsafely.<br><br>The Progress Notes dated 7/13/17 at 7:43 p.m. documented the resident admitted at 4:10 p.m. with pain in the right foot.<br><br>The Progress Notes dated 7/13/17 at 10:00 p.m. documented a skilled status note. The entry documented the resident skilled for PT/OT (physical & occupational therapy) related to transmetatarsal amputation, (surgical procedure to remove the forefoot in cases where the tissues in a patient's foot injured beyond repair, more extreme than a toe amputation), and RLE (right lower extremity) osteomyelitis (infection of the bone). The entry recorded the resident rated his/her pain a 6 out of 10.<br><br>The Progress Notes dated 7/14/17 at 4:20 p.m., written by Staff A, Licensed Practical Nurse (LPN), documented a skilled status note. | F 323 | | |

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| F 323 | Continued From page 67<br><br>The Progress Notes lacked any documentation by Staff H, LPN, on 7/14/17, who worked the 2nd shift as Resident #3's charge nurse.<br><br>The Medication Admin Audit Report, dated 8/10/17 at 12:59 p.m., reflected Staff H signed off the pain monitoring on the MAR at 5:29 p.m. The audit recorded Staff H documented she administered medications to the resident on 7/14/17 at the following times:<br>a. 2 medications signed off at 5:30 p.m.<br>b. 1 medication signed off at 5:31 p.m.<br>c. 4 medications signed off at 9:15 p.m.<br>d. 2 medications signed off at 9:16 p.m.<br>e. 1 medication signed off at 9:17 p.m.<br>f. 1 medication signed off at 9:19 p.m.<br><br>The Transfer/Discharge Report, signed by Resident #3's family member on 7/15/17 at 12:10 a.m., recorded the family member took the resident on 7/14/17 at 9:00 p.m. to the hospital, took stuff, and would be back for the rest. The report reflected a print date in the top right hand corner of 7/15/17.<br><br>The Progress Notes dated 7/15/17 at 2:09 a.m., written by Staff AA, Registered Nurse (RN). Staff AA wrote the resident's family member approached her at approximately midnight and stated he/she picking up the resident's belongings. Staff AA wrote the family member stated at 9:00 p.m. he/she took the resident to the hospital without informing staff because concerned about the resident's dressing changes and not getting pain medication routinely. Staff AA wrote the family member reported the ER (emergency room) said they would probably admit the resident and he/she wouldn't be back. | F 323 | | |

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| F 323 | Continued From page 68<br>Staff AA recorded she had the family member sign for taking personal belongings. Staff AA wrote she received call from the ER doctor stating they had changed the resident's dressing and everything looked fine. Staff AA recorded the doctor reported they gave the resident pain medication and would be sending him/her back. Staff AA documented she told the doctor the family member had just picked up personal belongings and stated hospital admitting the resident and he/she wouldn't be back. Staff AA recorded the doctor stated there wasn't a need to admit and he would attempt to get the family member to bring the resident back to facility. Staff AA documented the doctor asked if the resident on the skilled unit and she told him yes. The entry documented at approximately 1:30 a.m. the resident returned to the facility accompanied by the family member. Staff AA documented she contacted the DON (Director of Nursing) and informed her of the situation.<br><br>The Emergency Department (ED) Discharge Summary, documented on 7/15/17 at 1:06 a.m., recorded a DOS (Date of Service) of 7/14/17 at 9:25 p.m. for Resident #3. The Summary recorded the resident departed the ER on 7/15/17 at 1:06 a.m.<br><br>In a family interview on 8/7/17 at 3:25 p.m., Resident #3's family member confirmed the resident admitted on 7/13/17. The family member stated on 7/14/17 the resident told him/her he/she had asked for quite some time for pain pills. The family member reported when he/she came into the facility no one at the nursing station so he/she grabbed the resident from the smoking area to take him/her to the ER. The family member said he/she concerned about | F 323 | | |

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| F 323 | Continued From page 69 | F 323 | | |

infection as the resident already had infection in the bone, the resident diabetic, and he/she did not want the resident to have their foot amputated. The family member reported the smoking area had no supervision while the resident smoked. The family member reported the overnight shift did not know the resident gone. The family member reported the overnight shift nurse said the evening shift nurse, Staff H, reported to her everyone in the building. The family member stated he/she left with the resident around 9:00 p.m. to 9:30 p.m. The family member reported the resident had been allowed to smoke alone. The family member stated no one called while they were gone.

In a follow-up family interview on 8/9/17 at 3:45 p.m., Resident #3's family member recalled he/she returned to the facility from the ER on 7/14/17 to get Resident #3's clothing. The family member stated he/she didn't take everything but thought the resident would be admitted to the hospital. The family member reported he/she returned to the facility for clothes after 3rd shift on duty, around midnight to 12:30 a.m. The family member did not think or recall signing anything for the belongings. The family member clarified that at 9:00 p.m. he/she looked for staff on the Northside, the nurses' desk, no one in the office, and he/she assumed staff with other residents. The family member stated she looked around for about 5 minutes then left with the resident. The family member reported the resident could stand, pivot, and transfer by his/herself, but did need help in the bathroom. The family member stated he/she did not sign out in a book.

In an interview on 8/7/17 at 4:15 p.m., the Administrator stated she was aware of a night

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| F 323 | Continued From page 70<br>when Resident #3 out of the building without staff knowledge. The Administrator said she looked into the fact the resident's family member worked for the facility in the past but she could find no record of the employment. The Administrator stated the family member must have worked for agency staffing. The Administrator stated she believed the family member must have separated employment on bad terms because she talked to the family member at length before about many concerns.<br><br>In an interview on 8/8/17 at 11:30 a.m., Staff H stated she worked for the facility for 6 weeks. Staff H acknowledged slightly familiar with Resident #3's cares. Staff H reported skilled nursing assessments done once a shift on the 1st and 2nd shifts but not on 3rd shift, that would be redundant. Staff H responded if she did not make a skilled status note that day she probably worked short staffed.<br>Staff H reported on 7/14/17 she worked on the Northside for the 1st time and recalled having 3 extra hours of charting. Staff H stated Northside fast paced, a lot to take on, and it took adjustment to work that side. Staff H said Southside not as critical as the Northside which had more frequent specific needs.<br>Staff H commented she had been a little overwhelmed. Staff H said the resident spent time roaming with family and outside smoking. Staff H stated the resident could be hard to track down. Staff H responded she did not know the resident went out to the ER on 7/14/17, but unsure if she knew that or not, because it happened 3 weeks prior. Staff H continued stating she worked with the resident 3 times, did not recall that night, and did not understand how the mix up happened because the resident had to | F 323 | | |

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| F 323 | Continued From page 71<br>sign out at the front. Staff H then asked if the surveyor saying the resident left that night without her knowing. When told yes, Staff H responded the resident's family member quite an advocate when wants to be. Staff H stated she guaranteed the family member didn't tell her then stated a 2nd time she knew the family member didn't tell her. Staff H commented, "see this is what I mean about the resident being hard to find." Staff H reported residents who smoked tended to wander and she could not see someone if they smoked out front. Staff H stated, unfortunately, the family member didn't say anything to anyone. Staff H stated the more she talked the clearer the issue became to her. Staff H stated up until a little bit ago, they staffed just 1 nurse and 1 med aide on Northside; now they staff 2 nurses.<br><br>In an interview on 8/8/17 at 12:28 p.m., Staff AA stated she worked overnights 1 day a week on Fridays and acknowledged familiar with Resident #3's cares.<br>Staff AA recalled working on the overnight of 7/14/17 going into the morning of 7/15/17. Staff AA reported she did not know the resident was not there. Staff AA stated the nurse before her did not tell her the resident was gone.<br>Staff AA said Resident #3's family member came after midnight sometime taking all belongings out. Staff AA stated the family member left then she received a call from the ER saying the resident ready to return to the facility. Staff AA said she informed the doctor the family member picked up all stuff and the doctor told her then maybe you'll see him/her maybe you won't.<br>Staff AA reported the family member then came back to the building to say the resident couldn't stay at the hospital and asked permission to bring the resident back. Staff AA stated she told the | F 323 | | |

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| F 323 | Continued From page 72<br>family member sure. Staff AA commented the family member only stayed approximately 10 minutes once the resident back, but he/she said they wanted to speak to the Administrator about the situation. Staff AA stated she called the DON to report the event. Staff AA clarified she did not know if the shift before her knew the resident went to the ER but she did not know either. Staff AA stated the family member told her he/she did not tell anyone; he/she so mad the dressing change did not get done and the resident did not get pain pills, he/she just took the resident.<br><br>In an interview on 8/8/17 at 2:30 p.m., Staff CC, CNA (Certified Nurse Aide), stated he did not recall Resident #3. Staff CC said he did not recall working on 7/14/17 or recall knowing about the resident leaving to the hospital.<br><br>In an interview on 8/8/17 at 2:45 p.m., Staff DD, CNA, stated she worked overnights on both sides of the building. Staff DD recalled she worked 1 night at 10:00 p.m. and someone said throughout the shift, Resident #3 not there. Staff DD stated no one said the resident gone. Staff DD said she knew the resident's family member spoke to the nurse that night. Staff DD reported she did not know the resident gone until the family member brought him/her back.<br><br>In an interview on 8/8/17 at 2:52 p.m., Staff G, CNA, stated she worked the 2:00 p.m. to 10:00 p.m. shift for 2 months. Staff G responded familiar with Resident #3 only after a description of the resident given to Staff G. Staff G stated she remembered the resident always seem to go smoke. Staff G reported not aware the resident left the facility to the hospital ever. Staff G stated she did not recall the night of 7/14/17. | F 323 | | |

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| F 323 | Continued From page 73<br><br>In an interview on 8/8/17 at 3:05 p.m., Staff EE, CNA, stated she worked at the facility since December and usually picked up in activities. Staff EE responded a little bit familiar with Resident #3. Staff EE reported she had no knowledge of the resident going to the hospital on 7/14/17.<br><br>In an interview on 8/8/17 at 3:10 p.m., Staff K, CNA, stated she did not usually work on Northside. Staff K reported not aware of anytime Resident #3 went to the ER or of being told the resident gone 7/14/17.<br><br>In an interview on 8/8/17 at 3:35 p.m., Staff O, CNA, stated she did not work Northside and not familiar with Resident #3. Staff O reported not aware the resident gone on 7/14/17.<br><br>In an interview on 8/8/17 at 3:45 p.m., Staff W, CNA, responded not familiar with Resident #3. Staff W reported not aware the resident left the building on 7/14/17.<br><br>In an interview on 8/8/17 at 3:48 p.m., Staff FF, CNA, stated she did not work Northside and not familiar with Resident #3. Staff FF reported not aware the resident left the building 7/14/17.<br><br>In an interview on 8/8/17 at 4:00 p.m., Staff GG, CNA, stated she worked the 2nd shift, always on the Southside, and not familiar with Resident #3. Staff GG reported not aware the resident left the building 7/14/17 and no one told her either.<br><br>In an interview on 8/8/17 at 4:15 p.m., Staff Q, CMA (Certified Medication Aide), stated she worked all shifts on Southside. Staff Q reported | F 323 | | |

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| F 323 | Continued From page 74<br>not familiar with Resident #3 and not aware the resident left the facility on 7/14/17.<br><br>In an interview on 8/8/17 at 4:45 p.m., Staff F, CNA, responded familiar with Resident #3. Staff F reported not aware the resident left the building on 7/14/17 and no one told her.<br><br>In an interview on 8/81/7 at 4:55 p.m., Staff X, LPN, responded not familiar with Resident #3. Staff X reported not aware the resident left the building 7/14/17 and stated she did not work that side.<br><br>In an interview on 8/8/17 at 5:05 p.m., Staff HH, LPN, responded took care of Resident #3 a couple of times. Staff HH reported not aware the resident left the building 7/14/17.<br><br>In an interview on 8/9/17 at 10:00 a.m., Staff II, CNA and Staff C, CNA, stated they did report at the end of the shift by doing rounds going room to room to look at residents. Both Staff II and Staff C worked the Northside at the time of the interview.<br><br>In an interview on 8/9/17 at 10:05 a.m., Staff X stated nurses did not go down the halls for reports at the end of shift. Staff X said nurses have paper but the aides should go room to room. Staff X worked the Northside at the time of the interview.<br><br>In an interview on 8/9/17 at 10:08 a.m., the DON stated she expected residents to be checked on by the CNA's every 2 hours with eyes on the residents. The DON stated the CNA's complete physical rounds at the end of the shifts by making sure they know where the residents are at. The | F 323 | | |

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| F 323 | Continued From page 75<br>DON stated the nurses sit to do verbal report nurse to nurse. The Administrator commented she expected residents who were alert and orientated to sign out and let the nurse know if leaving. The Administrator stated Resident #3 and their family member did not do that. The DON stated she staffed Northside 6:00 a.m. to 2:00 p.m. shift with 1 nurse, 1 CMA, 2 CNA's, and a float depending on census on.<br>The DON stated she staffed Northside 2:00 p.m. to 10:00 p.m. shift with 1 nurse, may not get a CMA, and 2 CNA's. The DON stated she staffed Northside 10:00 p.m. to 6:00 a.m. shift with 1 nurse and 1 CNA.<br><br>On 8/9/17 at 11:23 a.m. a follow-up interview conducted with Staff H via phone to ask about the location of staff on the night of 7/14/17, when the family member could not find staff. Staff H responded staff everywhere. Staff H stated the family member did not tell anyone he/she took the resident. Staff H said the residents go out the front door to the front area to smoke. Staff H stated she would have no way of knowing if the resident left. Staff H commented she guaranteed the resident's family member didn't look for staff on purpose.<br><br>In an interview on 8/9/17 at 11:45 a.m., Staff JJ, Receptionist/Administrative Assistant, responded the residents who smoked out front had no way to call for help. Staff JJ said the person that takes the resident out to smoke should stay with them or check back on them. Staff JJ stated she would need to verify, maybe there was a call button. Observation after the interview revealed no call button accessible in the area where the residents sat. | F 323 | | |

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| F 323 | Continued From page 76<br>On 8/9/17 at 3:40 p.m., an interview conducted with Staff KK, Director of Clinical Services (nurse consultant), and the DON to ask how the staff learn about new admissions. They stated the nurses find out through verbal report and CNA's talked about admissions on the white board used for admits and discharges. The DON stated the CNA end of shift rounds were not documented.<br><br>In an interview on 8/9/17 at 3:56 p.m., the DON stated the nurse to nurse reports were not documented.<br><br>In an interview on 8/9/17 at 4:30 p.m., the DON stated the sign out book usually accessible to resident by the nursing station, but she could only find an old book.<br><br>On 8/10/17 at 9:55 a.m., a follow-up interview conducted with Staff AA to ask if she had been aware Resident #3 admitted Thursday 7/13/17 as she only worked on Fridays. Staff AA stated she did not think she knew. Staff AA reported when Resident #3's family member approached her that night she told the family member she did not know who Resident #3 was. Staff AA stated she knew Staff H her did not know the resident out of the building because the family member told her he/she did not tell Staff H. Staff AA responded if Staff H had told her the resident had untreated pain, she would have assessed the resident right away. Staff AA concluded the interview by stating again she did not know Resident #3 had been admitted.<br><br>On 8/10/17 at 10:00 a.m., Staff KK approached the surveyor and stated "if the thing with Resident #3 being out of the facility going to be a big issue then, the facility wanted to submit additional | F 323 | | |

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| F 323 | Continued From page 77<br>information and do their own investigation." Staff KK stated the facility had a different timeframe of the resident being gone without staff knowledge 2 ½ hours rather than 3 hours the surveyor portrayed; 9:00 p.m. to 12:00 p.m. Staff KK refused a meeting with the surveyor to discuss her information/investigation and stated the facility wasn't ready to present any information.<br><br>The Resident/Patient Rounding policy & procedure effective June 2014, documented the following:<br>Policy<br>Rounding will be completed at the beginning and end of each shift, and more often as needed, to observe and discuss direct care and services of the residents/patients provided.<br>Purpose<br>Nursing staff will complete walking rounds to ensure a safe and comfortable environment for the residents/patients who reside at the facility. These rounds should review/note the following (not all inclusive):<br>Safety: environment is safe<br>a. no fall risks (liquid on floor, cord not in hazardous positions, etc.)<br>b. individual fall interventions are in place, if needed<br>c. adequate lighting and room uncluttered<br>Adaptive equipment and support items present, if ordered/needed per care plan<br>Call light in place - personal items within reach for resident<br>Appearance of resident (e.g. clean and comfortable)<br>Privacy and dignity<br>Change in resident condition<br>Ensure resident's care needs met<br>Note and correct any issues and report to the | F 323 | | |

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| F 323 | Continued From page 78<br>charge nurse/supervisor.<br><br>The facility abated the IJ on 8/10/17 when they completed the following:<br>In-serviced staff on Resident/Patient Rounding policy every 2 hours and round per facility practice; and explained the expectation at shift change for verbal report using the communication sheets; this education was started on 8/10/17 and was completed 8/11/17.<br>The communication sheet was revised to Educated staff on rounding policy to assure staff are in full understanding of current practice which included walking rounds at shift to shift report and every two hours rounding during shift.<br>The education included the quality conference process which is held 2 time a day at all Events, discharges/admissions are reviewed and will continue. The facility revealed on 8/10/17, audits on the prior would be done via observations of rounding for 30 days; and shift to shift communication forms will be audited weekly for 30 days and reviewed for further evulation.<br>On 8/11/17, the facility updated the Communication Sheets with Resident information for nursing staff and non-nursing staff (the communication sheet provided on 8/10/17 did not show any different expectation between nursing staff and non-nursing staff). The communication sheet audits would be done by the DON or designee to ensure 2 hour rounding was being done.<br>On 8/11/17, the facility updated the shift to shift communication sheets would be audited by the DON or designee (to ensure a similar situation did not re-occur); with weekly for 30 days then forward to the QAPI team for evaluation.<br><br>2. Observation on 8/7/17 at 8:18 p.m. revealed a | F 323 | | |

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| F 323 | Continued From page 79<br>treatment cart on Bayberry Hall unlocked. The treatment cart contained scissors, powders, lotions, and medicated treatments that listed keep out of reach of children on the labels. The medication cart contained a medication cup with 15 ml (milliliters) of applesauce and a white substance; no staff present on the hallway.<br><br>In an interview on 8/7/17 at 8:28 p.m., Staff X, LPN, stated the applesauce contained Tylenol and she just didn't throw it away after giving it to a resident. Staff X said she should have thrown it away.<br><br>Observation on 8/7/17 at 8:34 p.m. revealed a treatment cart unlocked at the North side nurses station. The cart contained: 3 full 16 ounce bottles and 1 half bottle of sodium hypochlorite 0.50% solution that read keep out of reach of children on the labels; 6 wound cleanser bottles; and 2 heparin (blood thinner medication) 500 unit/5 ml syringes. At 8:38 p.m., Staff U, LPN, approached and stated she normally locked the cart but she had to take care of a resident that received a ride home.<br><br>Observation on 8/8/17 at 7:58 a.m., revealed Staff A, LPN, entered a room leaving an inhaler on top of the med cart that had 60 actuations left and a 10 ml syringe of saline. A resident approached the medication cart and asked the surveyor for a breathing treatment. When Staff A returned to the medication cart at 8:00 a.m. she stated she messed up by leaving meds out.<br><br>3. The MDS assessment dated 5/18/17 for Resident #20 identified a BIMS score of 15, indicating intact memory and cognition. | F 323 | | |

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| F 323 | Continued From page 80<br>In an interview on 8/14/17 at 2:25 p.m., Resident #20 reported about 2 months prior he/she given the wrong medications to take. Resident #20 stated he/she did not take the medication because he/she familiar with own medications but he/she did report it to a physician. Resident #20 stated the medication aides not good and need trained. Resident #20 reported the other night he/she sent the medication aide back 3 times until she got it right.<br><br>The Resident Council minutes from 2/17/17 documented under the Nursing section: an agency staff person tried to give the wrong meds/double doses of medication at bedtime for 2 residents.<br><br>These actions lowered the severity of the IJ to a "D" severity with the need for ongoing monitoring for supervision of residents (including residents outside for smoking and for monitoring the medication cart for hazards). | F 323 | | |
| F 329 SS=D | 483.45(d)(e)(1)-(2) DRUG REGIMEN IS FREE FROM UNNECESSARY DRUGS<br><br>483.45(d) Unnecessary Drugs-General.<br>Each resident's drug regimen must be free from unnecessary drugs. An unnecessary drug is any drug when used--<br><br>(1) In excessive dose (including duplicate drug therapy); or<br><br>(2) For excessive duration; or<br><br>(3) Without adequate monitoring; or | F 329 | | |

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| F 329 | Continued From page 81<br>(4) Without adequate indications for its use; or<br><br>(5) In the presence of adverse consequences which indicate the dose should be reduced or discontinued; or<br><br>(6) Any combinations of the reasons stated in paragraphs (d)(1) through (5) of this section.<br><br>483.45(e) Psychotropic Drugs.<br>Based on a comprehensive assessment of a resident, the facility must ensure that--<br><br>(1) Residents who have not used psychotropic drugs are not given these drugs unless the medication is necessary to treat a specific condition as diagnosed and documented in the clinical record;<br><br>(2) Residents who use psychotropic drugs receive gradual dose reductions, and behavioral interventions, unless clinically contraindicated, in an effort to discontinue these drugs;<br>This REQUIREMENT is not met as evidenced by:<br>Based on clinical record review, facility policy review and staff interview, the facility failed to document non-pharmacological interventions attempted prior to administration of as needed antianxiety and antipsychotic medications for 2 residents (Residents #7 and #16) out of 9 residents reviewed for psychotropic medications. The facility reported a census of 90 residents.<br><br>Findings included:<br><br>1. According to the MDS (Minimum Data Set) | F 329 | | |

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| F 329 | Continued From page 82<br>assessment dated 7/13/17, Resident #7's diagnoses included hypertension, other fracture, hemiplegia or hemiparesis, traumatic subdural hematoma with loss of consciousness of unspecified duration. The MDS documented long and short term memory problems with severely impaired cognitive skills for daily decision making. The assessment documented the resident displayed physical, verbal, and other physical symptoms 4-6 days during the 7 day assessment period.<br><br>Review of the Care plan updated 5/22/17 revealed a focus that Resident #7 could be easily agitated and known to holler and strike out at others, be demanding and impatient, and use foul language. The focus documented that the resident had an as needed order for an anti-anxiety. The care plan directed the staff to divert behaviors by reminiscing with me about past life events, provide with reassurance and support when upset or being impatient or demanding. The care plan instructed to meet the resident's needs in a timely manner, provide the resident with 1:1 conversations to allow him/her to express their feelings and remove the resident from situations and environments if the resident is being disruptive or physically agitated toward others.<br><br>Review of the 7/1/17-7/31/17 medication administration record (MAR) revealed Ativan (antianxiety medication) 0.5 milligrams (mg) administered as needed on:<br><br>7/4/17 at 9:12 AM;<br>7/4/17 at 4:19 PM;<br>7/8/17 at 8:00 AM;<br>7/10/17 at 6:57 PM. | F 329 | | |

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| F 329 | Continued From page 83<br><br>Review of a Progress note dated 7/4/17 at 9:12 AM revealed staff administered Ativan 0.5 mg as needed to the resident. The progress note failed to document any non-pharmacological or initiate care plan interventions prior to administration of the Ativan.<br><br>Review of a Progress note dated 7/4/2017 at 4:19 PM revealed staff administered Ativan 0.5 mg. The resident screamed out at staff and other residents, was aggressive earlier today and was given as needed Ativan without effective results and given again this shift to attempt relief of agitation. The progress note failed to document any non-pharmacological or initiate care plan interventions prior to administration of the Ativan.<br><br>Review of a Progress note dated 7/8/2017 at 08:00 AM revealed staff administered Ativan 0.5 MG. The note documented the resident was hitting staff and using foul language. The progress note failed to document any non-pharmacological or initiate care plan interventions prior to administration of the Ativan.<br><br>Review of a Progress note dated 7/10/2017 revealed staff administered Ativan 0.5 mg at 6:57 PM. The note documented behaviors and agitation observed. The progress note failed to document any non-pharmacological or initiate care plan interventions prior to administration of the Ativan.<br><br>2. The MDS assessment dated 3/17/17 documented Resident # 16's diagnoses as anemia, coronary artery disease, heart failure, gastroesophageal reflux disease, end-stage renal disease, pneumonia, history of urinary tract | F 329 | | |

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| F 329 | Continued From page 84<br>infection, non-Alzheimer's disease, transient cerebral ischemic attack and constipation. The MDS documented the resident displayed physical symptoms directed toward others 1-3 days during the assessment period. The assessment document the resident with long and short memory problems and severely impaired cognitive skills for daily decision making. The MDS also documented the resident required assistance of two or more persons with bed mobility and transfer as well as being totally dependent for dressing, toilet use, personal hygiene and bathing.<br><br>Review of the Care plan updated on 3/17/17 revealed a focus on physical aggression with the staff at times during cares. The care plan directed the staff to monitor and intervene when the behaviors occurred. The care plan directed the staff to attempt redirection, attempt to recognize needs through non-verbal signs, offering toileting, hydration, food, contact the support system such as family and friends to spend additional time with the resident.<br><br>Review of the 4/1/17-4/30/17 MAR revealed Haldol (antipsychotic medication) 0.5 mg administered on:<br><br>4/21/17 at 7:10 AM and 7:43 PM;<br>4/26/17 at 8:00 AM;<br>4/29/17 at 7:35 AM and 3:47 PM.<br><br>Review of a Progress note dated 4/21/17 at 7:10 AM revealed staff administered Haldol 0.5 mg as needed to the resident. The progress note failed to document any behaviors, non-pharmacological interventions or initiate care plan interventions prior to administration of the Haldol. | F 329 | | |

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| F 329 | Continued From page 85<br><br>Review of a Progress note dated 4/21/17 at 7:43 PM revealed staff administered Haldol 0.5 mg as needed to the resident. The progress note failed to document non-pharmacological interventions or initiate care plan interventions prior to administration of the Haldol. The Progress note documented the resident as agitated and s/he wanted to go home.<br><br>Review of a Progress note dated 4/26/17 at 8:08 AM revealed staff administered Haldol 0.5 mg as needed to the resident. The Progress note failed to document any behaviors, non-pharmacological interventions or initiate care plan interventions prior to administration of the Haldol.<br><br>Review of a Progress note dated 4/29/17 at 7:35 AM revealed staff administered Haldol 0.5 mg as needed to the resident. The Progress note failed to document non-pharmacological interventions or initiate care plan interventions prior to administration of the Haldol. The Progress note documented the resident as fighting everyone, hitting and yelling.<br><br>Review of a Progress note dated 4/29/17 at 3:47 PM revealed staff administered Haldol 0.5 mg as needed to the resident. The Progress note failed to document non-pharmacological interventions or initiate care plan interventions prior to administration of the Haldol. The Progress note documented the first administration in the morning was ineffective.<br><br>Review of the resident's record between the dates of 4/29/17 at 7:35 AM and 4/29/17 at 3:47 PM failed to reveal any documented behaviors during this period. | F 329 | | |

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| TOUCHSTONE HEALTHCARE COMMUNITY | 1800 INDIAN HILLS DRIVE SIOUX CITY, IA 51104 |

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| F 329 | Continued From page 86<br><br>Review of a facility policy entitled Antipsychotic Use with a revision date of March 2016 revealed the intent of the policy was to assure all non-medication interventions have been attempted to assist with resident's displaying mood, behavior or sleep concerns. This policy referred to all neuroleptics, hypnotics, sedatives, antidepressants and anxiolytics. Antipsychotic medications will be used only when it is necessary to treat a specific condition. Prior to requesting a medication for the purpose of mood, behavior or sleep concerns, the Interdisciplinary Team (IDT) will meet to review all non-medical alternatives which have been/need to be attempted. All residents receiving an antipsychotic will have target behaviors monitored daily, recorded and summarized each quarter. Areas assessed will include resident specific behaviors, non-pharmacological interventions attempted and the resident's response to the intervention. | F 329 | | |
| F 353 SS=E | 483.35(a)(1)-(4) SUFFICIENT 24-HR NURSING STAFF PER CARE PLANS<br><br>483.35 Nursing Services<br><br>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). | F 353 | | |

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| F 353 | Continued From page 87<br>[As linked to Facility Assessment, §483.70(e), will be implemented beginning November 28, 2017 (Phase 2)]<br><br>(a) Sufficient Staff.<br>(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:<br><br>(i) Except when waived under paragraph (e) of this section, licensed nurses; and<br><br>(ii) Other nursing personnel, including but not limited to nurse aides.<br><br>(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.<br><br>(a)(3) The facility must ensure that licensed nurses have the specific competencies and skill sets necessary to care for residents' needs, as identified through resident assessments, and described in the plan of care.<br><br>(a)(4) Providing care includes but is not limited to assessing, evaluating, planning and implementing resident care plans and responding to resident's needs.<br>This REQUIREMENT is not met as evidenced by:<br>Based on resident group interview, observation, clinical record review, resident interviews, staff interview, and Resident Council minutes, the facility failed to answer call lights or requests for assistance in a timely manner to meet the needs | F 353 | | |

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| F 353 | Continued From page 88<br>of residents for 7 out of 7 group residents and 4 of 15 current residents reviewed (Residents #9, #1, #15 and #20). The facility reported a census of 90 residents.<br><br>Findings included;<br><br>1. During the group interview on 8/2/17 at 1:15 p.m., 7 out of the 7 residents complained of issues with the call lights getting answered. The group reported not uncommon to take up to an hour to answer the light during the day and 1 resident stated once it took 4 to 5 hours to answer the call light at night. The group reported they have clocks on the wall, so they are able to keep track of how long it takes to get help. They even explained that some do not always have the call light available to reach, they have to go up the hall to yell for help. The group felt as if the facility did not have enough staff to assist them with their needs. The group reported they have 1 aide staffed on Daisy Lane Hall, 1 aide Cherry Blossom Hall, 1 aide Bayberry Hall, and 2 on Aspenwood Hall. The group stated they needed to have 2 aides on each hall.<br><br>2. The Minimum Data Set (MDS) assessment dated 7/13/17 identified diagnoses for Resident #9 included cerebrovascular accident (CVA), anxiety disorder and depression. According to the MDS, the resident is dependent on staff for bed mobility, transfers, dressing, bathing and toilet use. The MDS indicated the resident has a Brief Interview for Mental Status (BIMS) score of 15, which indicates no cognitive impairment.<br><br>Review of the care plan dated 1/10/17 for Resident #9 revealed a toileting focus with an intervention for extensive assistance of 2 staff in | F 353 | | |

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| F 353 | Continued From page 89<br>toileting. The resident's care plan revealed he/she could use the bed pan at time and used incontinent pads.<br><br>An observation on 8/8/17 at 9:58 a.m. call light turned on in Resident #9's room.<br>An interview with Resident #9 on 8/8/17 at 10:06 a.m. revealed the resident needed to use the bathroom.<br>An observation on 8/8/17 at 10:19 a.m. revealed call light on until this time. Staff D, CNA entered Resident #9's room and turned off the call light and then left.<br>An interview with Resident #9 on 8/8/17 at 10:19 a.m. revealed resident stated the aide (Staff D, CNA) said he/she would have to wait awhile. Resident also talked about having to wait in the morning to get out of bed because the lack of staff and sometimes not assisted up until 10 a.m. Resident talked about waiting too long sometimes that he/she wets self before the staff return.<br>An observation on 8/8/17 at 10:29 a.m. showed Staff D taking stand up lift into room 8.<br><br>An interview on 8/8/17 at 10:30 a.m. with Staff E, Unit Manager/Registered Nurse (RN), revealed acknowledged she had spoken to Resident #9 and is aware of the need to use bathroom.<br><br>An observation on 8/8/17 at 10:34 a.m. revealed Staff E and a Licensed Practical Nurse (LPN) entered Resident #9's room with a mechanical lift and shut the door.<br><br>An interview on 8/9/17 at 12:08 p.m. with Resident #9 revealed he/she had trouble with the call light again last night; and stated his/her call light had been on from 9 p.m. to 9:45 p.m. before anyone answered. Resident asked how this made | F 353 | | |

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| F 353 | Continued From page 90<br>him/her feel as he/she reported being incontinent of urine and he/she replied being mad.<br><br>3. The MDS assessment dated 7/10/17 identified diagnoses for Resident #1 included hemiplegia (paralysis on one side) and postprocedural cerebrovascular infarction following other surgery (stroke following surgery). According to the MDS, the resident required the extensive assistance for bed mobility, transfer, dressing and toileting. The MDS indicated the resident had a BIMS score of 15, indicating no cognitive impairment.<br><br>The care plan dated 7/7/17 revealed a goal for the resident to be clean and odor free. The care plan revealed Resident #1 needed assistance of one staff for toileting. Resident #1 used the toilet and occasionally the urinal.<br><br>An interview with Resident #1 on 8/9/17 at 1:45 p.m. revealed resident stating that she/he is not getting to the bathroom when needs to go. Also stated there is only 1 staff working down this hall D, the aide had come to answer the call light and she/he was told to hold for a while, then the aide never returned. Resident indicated she/he had waited up to 3 hours for staff to answer the call light.<br>4. The MDS assessment dated 2/3/17 recorded a discharge assessment for Resident #15. The MDS identified a BIMS score of 15. A score of 15 indicated intact cognition.<br>The MDS assessment dated 8/2/17 identified the resident admitted again on 8/2/17.<br><br>The care plan printed 8/14/17 identified the resident anticipated a short stay. The care plan did not contain any focus areas identifying cognition issues. The care plan listed diagnoses | F 353 | | |

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| F 353 | Continued From page 91<br>that included obstructive sleep apnea and chronic respiratory failure with hypoxia (low oxygen levels). The care plan fall prevention focus area initiated 8/7/17 directed staff to keep a floor mat beside the resident's bed. The care plan directed staff to assist the resident with transfers, bed mobility, and ambulation with 1 person.<br><br>The Progress Notes dated 8/7/17 at 12:55 a.m. documented the resident heard yelling and found lying on the floor beside his/her bed. The note recorded the resident stated he/she sat on the edge of his/her bed and must have fallen asleep. The entry documented the staff used a Hoyer (mechanical lift) and 2 people to assist the resident back to bed.<br><br>The Progress Notes dated 8/7/17 at 3:15 a.m., written by Staff Y, RN, documented staff discovered the resident lying on the floor beside his/her bed. Staff Y documented the resident assisted back to bed with the use of a Hoyer and 2 person assist. Staff Y wrote a mattress placed on the floor beside the resident's bed and the resident assisted to lay down on it.<br><br>The next Progress Notes dated 8/7/17 at 7:30 a.m., written by the MDS Coordinator, documented communication done with the resident. The note recorded a visit with the resident related to falls overnight. The MDS Coordinator wrote he discussed the possibility of the resident moving to a room closer to the building center, the resident agreed.<br><br>The Weekly ID (Interdisciplinary) Team Fall Review Committee report dated 8/7/17 at 8:16 a.m. recorded the resident fell 8/7/17 at 12:55 a.m. and 3:15 a.m. The report documented both | F 353 | | |

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| F 353 | Continued From page 92<br>falls the resident fell beside the bed with the resident stating he/she sat on the edge of the bed and fell asleep. The report recorded under category Dementia - no diagnosis. The New Interventions section listed floor mat beside bed after first incident, then mattress on floor temporarily, changed rooms.<br><br>In an interview on 8/7/17 at 8:52 p.m., Resident #15 reported he/she fell two times the previous night. Resident #15 stated his/her legs hurt when he/she laid down so he/she sat on the edge of the bed. Resident #15 said he/she fell out of bed to the floor. Resident #15 stated the staff helped him/her back to bed. Resident #15 reported he/she then fell out of bed a second time. Resident #15 stated the staff assessed him/her but then told him/her they would be back as they had another resident to assist; but they did not come back. Resident #15 reported the second fall occurred at approximately 3:45 a.m. and he/she had a clock on the wall. Resident #15 stated the staff did not come back until the 6:00 a.m. to 2:00 p.m. shift arrived and helped him/her up at 7:00 a.m.<br><br>In an interview on 8/8/17 at 7:45 a.m., Resident #15 reported Staff E, Unit Manager/RN, asked him/her a lot of questions about his/her conversation with the surveyor the night before. Resident #15 stated Staff E made him/her confused about how long he/she remained on the floor the other night. Resident #15 said the thing he/she couldn't figure out though, staff brought him/her something like a blanket to lay on and staff would not have done that if he hadn't been on the floor.<br><br>In an interview on 8/14/17 at 4:13 p.m., Staff Y | F 353 | | |

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| F 353 | Continued From page 93<br>stated Resident #15 did have 2 falls out of bed on the overnight of Sunday 8/6/17 going into the morning of 8/7/17. Staff Y stated after the first fall from bed it took 2 staff to assist the resident back to bed and then she placed a fall mat beside the bed as an intervention. Staff Y reported the resident fell a second time around 3:30 a.m. and it took 3 staff to assist the resident up. Staff Y said she retrieved a mattress from the storage room and put it on the resident's floor for his/her safety. Staff Y stated she directed the resident to get onto the mattress, sitting on the edge of the bed and rolling him/herself onto the mattress. Staff Y stated she did not recall the resident saying he/she did not want to get on the mattress. Staff Y stated the resident on the mattress from 4:00 a.m. until 7:00 a.m. Staff Y stated she passed on during report the resident requested at 5:30 a.m. to get up and the resident upset that he/she not helped up yet.<br><br>5. The MDS assessment dated 5/18/17 for Resident #20 identified a BIMS score of 15. A score of 15 indicated intact cognition. The MDS revealed the resident required the extensive physical assistance of 1 person for toilet use.<br><br>The care plan focus area revised on 12/8/16 identified the resident at a risk for falls due to history of CVA and the medications he/she took. The care plan intervention dated 11/29/16 informed staff the resident able to dress, groom, toilet self, and will occasionally ask for assistance.<br><br>The Progress Notes dated 7/30/17 at 7:45 a.m. documented the resident reported he/she experienced a fall off the commode at 6:37 a.m., the resident activated the call bell at the time of | F 353 | | |

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| F 353 | Continued From page 94<br>the fall, and waited on the floor until 7:10 a.m. because no one answered the call bell.<br><br>In an interview on 8/14/17 at 2:25 p.m., Resident #20 reported the facility did not have enough staff. Resident #20 stated he/she fell about 2 weeks prior. Resident #20 said he/she had to get self up because no one came. Resident #20 stated he/she scraped his/her knuckles getting self up and scabs observed on the resident's right hand. Resident #20 said he/she spent a half hour on the floor and it took a total of 1 hour and 7 minutes for him/her to get help.<br><br>6. The Resident Council minutes from 2/17/17 documented under the Nursing section: the changes on Cherry Blossom Hall not working and stretched the staff too thin; call lights still took a while to answer; and staff shut off the call light without the needs being addressed.<br><br>The Resident Council minutes from 3/17/17 documented under the Nursing section: resident getting sick of everyone being over stretched due to Cherry Blossom hall, tried to be patient; staff state they would get the resident if they remembered and had time.<br><br>The Resident Council minutes from 4/21/17 documented under the Nursing section: call lights took 45 minutes to answer and a resident unhooked from the EZ stand (mechanical lift) and left there to wait.<br><br>The Resident Council minutes from 5/20/17 documented under the Nursing section: call lights not answered in a timely manner; a resident sat for 30 to 40 minutes on the toilet hooked up to the EZ stand; and baths not getting done. Under | F 353 | | |

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| F 353 | Continued From page 95<br>the Activities section the minutes documented: upset over activities being canceled because no staff available to do them.<br><br>The Resident Council minutes from June (2017) documented under the Nursing section it sometimes took 30 minutes to find an EZ stand and it took forever to have lights answered.<br><br>The Resident Council minutes from July 2017 documented under the Nursing section it took 45 minutes to an hour to get call lights answered, especially when they are short [staff].<br><br>7. Additional Staff Interviews revealed:<br><br>In an interview on 8/1/17 at 9:07 a.m., Staff D, CNA, stated she was the only aide for 2 halls. Staff D said she could not keep up with the call lights.<br><br>In an interview on 8/1/17 at 9:10 a.m., Staff K, CNA, stated she did not feel there was enough staff. Staff K said the previous week she was the only aide for Aspenwood Hall which required 2 aides. Staff K reported Aspenwood Hall the heaviest because 4 residents used the Hoyer (a full mechanical lift) and 7 residents used the EZ stand (a stand up lift).<br><br>In an interview on 8/7/17 at 8:23 p.m., Staff W, CNA, stated sometimes she felt there was not enough staff on the 2:00 p.m. to 10:00 p.m. shift to meet residents' needs.<br><br>In an interview on 8/7/17 at 8:25 p.m., Staff Z, CNA, stated sometimes the weekends did not have enough staff on the 2:00 p.m. to 10:00 p.m. shift. | F 353 | | |

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| F 353 | Continued From page 96<br><br>In an interview on 8/7/17 at 8:28 p.m., Staff X, LPN, stated residents have complained at times about not having enough staff. Staff X commented they needed 2 aides on each hall, Aspenwood, Bayberry, and Daisy Lane which also covers Cherry Blossom. Staff X stated that night they only had 1 aide each hall so could be a challenge to meet the residents' needs.<br><br>In an interview on 8/8/17 at 12:28 p.m., Staff AA, RN, stated she worked overnights one day a week on Fridays. Staff AA responded she did not feel they had enough staff. Staff AA said the census ranged from 28 to 36 residents and the facility staffed with 1 nurse and 1 med aide. Staff AA commented between completing treatments, managing IV's (intravenous fluids) and assisting residents who required 2 people, it left the floor uncovered for supervision because there were residents who required 1:1 (one to one) supervision and others on 15 minute observation checks. Staff AA stated she reported concern to the DON. Staff AA said the DON responded they would staff 1 nurse and 2 CNAs, but not staffed with 2 CNAs. Staff AA stated times 1 nurse in the building and she told the DON not safe. Staff A reported the DON responded she trusted Staff AA's judgement but felt Staff AA could do it as there weren't many pills (to pass) on the Southside. Staff AA stated this occurred in the springtime but an ongoing staffing issue since then. Staff AA commented the facility had a lot of residents with heavy care due to mental and physical issues. Staff AA reported they used to staff with agency (temporary help) but no longer did. Staff AA stated she did not feel the staffing getting any better. Staff AA commented she could talk to management till she's blue in the | F 353 | | |

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| F 353 | Continued From page 97<br>face but it wouldn't matter. Staff AA reported she had so many residents requesting pain pills and the call lights super busy, she forgot to give a resident a pain pill.<br><br>In an interview on 8/8/17 at 2:45 p.m., Staff DD, CNA, stated she worked overnights on both sides of the building. Staff DD responded she did not feel there was enough staff as it could be overwhelming at times. Staff DD stated some residents needed 1:1 and other residents used their call lights constantly. Staff DD said it took time to get to the residents when only one nurse and one aide; but when the facility staff 2 aides, she could do it. Staff DD stated management is aware yet they cut out agency staffing.<br><br>In an interview on 8/8/17 at 3:35 p.m., Staff O, CNA, stated worked 2:00 p.m. to 10:00 p.m. Staff O reported if everyone showed up, they staffed 2 aides per hall. Staff O stated Aspenwood Hall took longer because 4 residents used a Hoyer and 7 residents used the EZ stand. Staff O reported there were times they couldn't get call lights answered in 2 hours because they only had 1 aide on each hall. Staff O commented she didn't think management cared. Staff O reported when she worked overnights, times the on-call nurse did not answer the phone. Staff O reported the week before the overnight shift staffed with just a med aide on the Southside and nurses had a hard time.<br><br>In an interview on 8/8/17 at 3:48 p.m., Staff FF, CNA, stated they needed to staff 2 aides on each hall at all times.<br><br>In an interview on 8/8/17 at 4:45 p.m., Staff F, CNA, responded she did not feel there was | F 353 | | |

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| F 353 | Continued From page 98<br>enough staff. Staff F stated the Northside 2nd shift needed 3 aides but staffed with 2 aides. Staff F commented management aware they need 3 aides.<br><br>In an interview on 8/9/17 at 10:08 a.m., the DON stated she staffed Northside 6:00 a.m. to 2:00 p.m. shift with 1 nurse, 1 CMA, 2 CNA's, and a float depending on census on. The DON stated she staffed Northside 2:00 p.m. to 10:00 p.m. shift with 1 nurse, may not get a CMA, and 2 CNA's. The DON stated she staffed Northside 10:00 p.m. to 6:00 a.m. shift with 1 nurse and 1 CNA.<br><br>In an interview on 8/15/17 at 9:30 a.m., Staff S, CNA, stated sometimes not enough staff to complete baths. Staff S commented at times she stayed over by herself just to complete baths because couldn't get them done due to staffing issues. | F 353 | | |
| F 361 SS=F | 483.60(a)(1)(2) QUALIFIED DIETITIAN - DIRECTOR OF FOOD SVCS<br><br>(a) Staffing<br><br>The facility must employ sufficient staff with the appropriate competencies and skills sets to carry out the functions of the food and nutrition service, taking into consideration resident assessments, individual plans of care and the number, acuity and diagnoses of the facility's resident population in accordance with the facility assessment required at §483.70(e).[As linked to Facility Assessment, §483.70(e), will be implemented beginning November 28, 2017 (Phase 2)] | F 361 | | |

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| F 361 | Continued From page 99<br>This includes:<br><br>(a)(1) A qualified dietitian or other clinically qualified nutrition professional either full-time, part-time, or on a consultant basis. A qualified dietitian or other clinically qualified nutrition professional is one who--<br><br>(i) Holds a bachelor's or higher degree granted by a regionally accredited college or university in the United States (or an equivalent foreign degree) with completion of the academic requirements of a program in nutrition or dietetics accredited by an appropriate national accreditation organization recognized for this purpose.<br><br>(ii) Has completed at least 900 hours of supervised dietetics practice under the supervision of a registered dietitian or nutrition professional.<br><br>(iii) Is licensed or certified as a dietitian or nutrition professional by the State in which the services are performed. In a State that does not provide for licensure or certification, the individual will be deemed to have met this requirement if he or she is recognized as a "registered dietitian" by the Commission on Dietetic Registration or its successor organization, or meets the requirements of paragraphs (a)(1)(i) and (ii) of this section.<br><br>(iv) For dietitians hired or contracted with prior to November 28, 2016, meets these requirements no later than 5 years after November 28, 2016 or as required by state law.<br><br>(a)(2) If a qualified dietitian or other clinically | F 361 | | |

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| F 361 | Continued From page 100<br>qualified nutrition professional is not employed full-time, the facility must designate a person to serve as the director of food and nutrition services who--<br><br>(i) For designations prior to November 28, 2016, meets the following requirements no later than 5 years after November 28, 2016, or no later than 1 year after November 28, 2016 for designations after November 28, 2016, is:<br><br>(A) A certified dietary manager; or<br><br>(B) A certified food service manager; or<br><br>(C) Has similar national certification for food service management and safety from a national certifying body; or<br><br>(D) Has an associate's or higher degree in food service management or in hospitality, if the course study includes food service or restaurant management, from an accredited institution of higher learning; and<br><br>(ii) In States that have established standards for food service managers or dietary managers, meets State requirements for food service managers or dietary managers, and<br><br>(iii) Receives frequently scheduled consultations from a qualified dietitian or other clinically qualified nutrition professional.<br>This REQUIREMENT is not met as evidenced by:<br>Based on Resident Council minutes review and staff interview, the facility failed to employ a competent, certified dietary manager. The facility reported a census of 90 residents. | F 361 | | |

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| F 361 | Continued From page 101<br><br>Findings include:<br><br>1. The Resident Council minutes from 2/17/17 documented under the Dietary section: the food did not taste good and the residents suggested a cook/dietitian make the menu on the corporate level.<br><br>The Resident Council minutes from July 2017 documented under the Minutes section: the residents discussed with the Administrator issues in the kitchen without a kitchen manager such as the food not being as good and the use of pre-packaged food, housekeeping staff not properly cleaning rooms and the Administrator explained she would be helping with food ordering and making sure things ran smoothly in the kitchen. Under the Dietary section the minutes documented: dietary stinks, the food was lousy and served cold, portions were getting smaller, especially on room trays and residents were not always being served when requesting room trays.<br><br>2. In an interview on 7/31/17 at 7:05 p.m., the Administrator reported the facility had no dietary manager at the time. The Administrator stated the facilty had a consultant dietician that came weekly on Fridays.<br><br>In an interview on 8/1/17 at 7:25 a.m., the Administrator stated Staff AA, (previous Dietary Manager) was on a 60 day PIP (Performance Improvement Plan) for recurring issues. The Administrator reported she fired Staff AA on 7/8/17 and actively sought a manager. The Administrator stated she changed the position to a senior, salaried position and had awarded Staff | F 361 | | |

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| F 361 | Continued From page 102<br>PP, cook, a step-up with responsibility for ordering. The Administrator clarified Staff PP was not the manager as she did not know much about dietary. The Administrator stated the kitchen needed solid leadership.<br><br>In an interview on 8/2/17 at 3:05 p.m., the Director of Operations (DOO) reported the facility's contractor for housekeeping would be supplying the facility with a Certified Dietary Manager (CDM) on 8/7/17. The DOO stated the plan going forward would include Staff UU, Dietary Manager (from a sister facility) would be in the facility on 8/7/17 and 8/9/17 and the consultant Registered Dietician (RD) would be in the facility on 8/8/17 to assist with orientation/training of the contract CDM. | F 361 | | |
| F 362 SS=F | 483.60(a)(3)(b) SUFFICIENT DIETARY SUPPORT PERSONNEL<br><br>(a)(3) Support staff. The facility must provide sufficient support personnel to safely and effectively carry out the functions of the food and nutrition service.<br><br>(b) A member of the Food and Nutrition Services staff must participate on the Interdisciplinary team as required in § 483.21(b)(2)(ii).<br>This REQUIREMENT is not met as evidenced by:<br>Based on review Resident Council minutes, staff interview, observation, clinical record review, and resident interview, the facility failed to provide sufficient, competent, dietary staff to provide residents organized, timely meal services prepared with proper sanitary techniques. The facility reported a census of 90 residents. | F 362 | | |

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| F 362 | Continued From page 103<br>Findings include:<br><br>1. The Resident Council minutes from 2/17/17 documented under the Dietary section: the food did not taste good and the residents suggested a cook/dietitian make the menu on the corporate level.<br><br>The Resident Council minutes from 5/20/17 documented under the Dietary section that facility food was cold with long wait times for meals specifically in the evening<br><br>The Resident Council minutes from June (2017) documented under the Dietary section the food sometimes cold and waited long time for meals especially in the evenings.<br><br>The Resident Council minutes from July 2017 documented under the Minutes section: the residents discussed with the Administrator issues in the kitchen without a kitchen manager such as the food not being as good and the use of pre-packaged food, housekeeping staff not properly cleaning rooms and the Administrator explained she would be helping with food ordering and making sure things ran smoothly in the kitchen. Under the Dietary section the minutes documented: dietary stinks, the food was lousy and served cold, portions were getting smaller, especially on room trays and residents were not always being served when requesting room trays.<br><br>2. In an interview on 7/31/17 at 7:05 p.m., the Administrator reported Staff PP, Dietary Cook, called in on Saturday 7/29/17, but Staff NN, Dietary Aide did not get the message in the kitchen. The Administrator stated Staff JJ, | F 362 | | |

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| F 362 | Continued From page 104<br>Receptionist/Administrative Assistant, came in later in the morning, at approximately 8:00 a.m., and Staff OO, Dietary Cook, came in at 11:00 a.m. The Administrator stated 4 dietary aides also worked in the kitchen on 7/29/17. The Administrator said breakfast went okay but the menu items for lunch were not prepped.<br><br>Observation on 8/1/17 at 6:47 a.m. revealed Staff QQ, Director of Housekeeping, worked in the kitchen cooking bacon and sausage. Staff QQ stated the cook did not answer her phone and did not come that day. Staff QQ stated she had not cross trained in dietary department.<br><br>In an interview on 8/1/17 at 9:10 a.m., Staff K, Certified Nurse Aide (CNA), stated the previous weekend the facility ran out of lunch food because they had no cook. Staff K said management came to cook and bought food.<br><br>Observation on 8/2/17 at 12:18 p.m. revealed the first plate served in the main dining room. At 12:35 p.m. Staff L, Dietary Cook, commented the steam cart should leave the kitchen at 12:15 p.m. but they had to wait on meatballs. At 12:50 p.m. staff delivered the first room trays on Northside. At 1:05 p.m. staff plated the last room tray on Northside. At 1:19 p.m., Staff OO asked where everyone was at as normally he had 3 dietary aides to help but said 2 went home early that day. At 1:40 p.m. Staff OO stated he finished service.<br><br>In an interview on 8/14/17 at 2:15 p.m., the Administrator stated she could not locate any dietary inservices or dietary training since the previous survey.<br><br>3. The MDS assessment dated 5/18/17 for | F 362 | | |

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| F 362 | Continued From page 105<br>Resident #20 identified a BIMS score of 15, indicating intact memory and cognition.<br><br>In an interview on 8/14/17 at 2:25 p.m., Resident #20 reported the facility did not have enough kitchen staff. | F 362 | | |
| F 363 SS=L | 483.60(c)(1)-(7) MENUS MEET RES NEEDS/PREP IN ADVANCE/FOLLOWED<br><br>(c) Menus and nutritional adequacy.<br><br>Menus must-<br><br>(c)(1) Meet the nutritional needs of residents in accordance with established national guidelines.;<br><br>(c)(2) Be prepared in advance;<br><br>(c)(3) Be followed;<br><br>(c)(4) Reflect, based on a facility's reasonable efforts, the religious, cultural and ethnic needs of the resident population, as well as input received from residents and resident groups;<br><br>(c)(5) Be updated periodically;<br><br>(c)(6) Be reviewed by the facility's dietitian or other clinically qualified nutrition professional for nutritional adequacy; and<br><br>(c)(7) Nothing in this paragraph should be construed to limit the resident's right to make personal dietary choices.<br>This REQUIREMENT is not met as evidenced by:<br>Based on observation, dietary menu review, resident council minute review, resident, staff , | F 363 | | |

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| F 363 | Continued From page 106<br>dietitian and family interview, the facility failed to: meet the nutritional needs of residents and failed to provide enough planned food items for 7 of 7 group residents interviewed; and 3 of 20 total residents reviewed for meeting nutritional needs ( Residents #3, #14 and #20).<br>Observation revealed residents nutritional needs according to menu planning and puree therapeutic diets was inadequate during one meal observation with 6 of 6 residents on a pureed diet not receiving bread as planned.<br>Onsite observation revealed no bread or snacks available for residents. Several staff reported the facility was running out of food the last few weeks; and similarly residents and family members reported the facility was running out of food. Onsite observation showed the Director of Housekeeping (with no dietary training) preparing meal service.<br>Staff interviews revealed the facility failed to order and receive food and according to the planned dietary menu; the facility failed to procure menu items in advance and failed to have a dietitian approve substitutions for the planned menu. The findings constitute an Immediate Jeopardy situation for residents. The facility identified a census of 90 residents.<br><br>Findings include:<br><br>1. During the group interview on 8/2/17 at 1:15 p.m., 7 out of the 7 residents in attendance complained this month the facility had cook and management troubles. The group reported times in the month they did not have food because the food not ordered. The group explained on Saturday 7/29/17 the facility had Pizza Ranch deliver pizza and chicken since the facility did not have the food for lunch. | F 363 | | |

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| F 363 | Continued From page 107<br><br>2. During an observation of meal service on 8/1/17 at 12:40 p.m., the facility ran out of carrots during the meal service with 20 residents still left to have lunch served.<br><br>3. During an observation on 8/1/17 at 1:10 p.m. the Dietician checked the freezer to see if the facility had the food for the next day's meal. The facility did not have the meat balls listed on the menu for 8/2/17.<br><br>4. The Resident Council minutes from 2/17/17 documented under the Dietary section: the food did not taste good; suggested a cook/dietitian make the menu on the corporate level; and wanted the facility to get away from canned fruit as the desert.<br><br>The Resident Council minutes from July 2017 documented under the Minutes section: residents discussed with the Administrator issues in the kitchen without a kitchen manager such as the food not being as good; use of pre-packaged food; and the Administrator explained she would be helping with food ordering and making sure things ran smoothly in the kitchen. Under the Dietary section the minutes documented: dietary stinks; the food lousy, not taste good; food is cold; portions getting smaller, especially on room trays; and [residents] not always being served when requests room trays.<br><br>5. The consultant Registered Dietician (RD) review for 5/2/17 included the following documentation:<br>Meal Observation:<br>Point 2. Menu not posted on white board in the | F 363 | | |

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| F 363 | Continued From page 108<br>dining room.<br>Point 3. Please do not order the fish served today. The fish needed to be fried to look appealing; it did not look appealing and it did not taste very good.<br>Point 4. Chicken fried steak overcooked and very tuff.<br>Point 6. Use correct scoop sizes - reviewed with the cook proper scoop sizes and how to check the menu to ensure proper scoop sizes are used.<br><br>The RD review for 5/11/17 documented please check into when going to get the spring/summer menus as they need to be started ASAP (as soon as possible).<br><br>The RD review for 6/22/17 included the following documentation:<br>a. Use correct scoop sizes at meals. Steam cart did not use correct scoop sizes for the mashed potatoes. They used a #12 scoop (1/3 cup) instead of a #8 (1/2 cup)<br>b. Make sure all diet orders match diet cards. There are a few residents with diabetic and low fat/low cholesterol diet orders that need to followed; the MD (doctor) did not want them on a general diet.<br>c. Small portion diet orders needed to be followed.<br>d. A resident complained of waiting too long in the ding room for staff to wait on him/her even to get drinks.<br>e. A resident complained of his/her meals usually cold.<br><br>The RD review for 7/25/17 included the following documentation:<br>a. The eggs at breakfast looked horrible, they were gray. Staff needed to cook scrambled eggs | F 363 | | |

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| F 363 | Continued From page 109<br>on the stove top and stop using the steamer to cook eggs.<br>b. No dessert served at lunch. The RD asked the dietary aid to get the residents a brownie left from the cook out and pudding for pureed diets.<br>c. The RD asked the staff what week of the menu cycle they were "ON" and the cook could not even tell her. The RD asked the cook how he knew what to cook and she [RD] got just excuses that they didn't have everything on hand to follow the menus.<br>d. Follow the menu as written!!<br><br>6. In an interview on 7/31/17 at 6:00 p.m., Staff I, Dietary Aide, stated the facility ran out of food for the last 2 weeks. Staff I commented they did not have dry foods. Staff I showed the dry storage racks barren and the snack rack empty. Staff I stated waiting on the truck for deliveries and she did not think there was a set delivery date. Staff I said the truck comes whenever the main person orders. Staff I showed the freezer and stated the freezer should be filled up but appeared empty.<br><br>Observation on 7/31/17 at 6:01 p.m. revealed the food contents of the kitchen inventoried by 2 surveyors in the dry storage, walk-in cooler, and walk-in freezer, with no bread or snacks found on the shelves.<br><br>In an interview on 7/31/17 at 6:40 p.m., Staff L, Cook, stated he worked for the facility previously for 2 years, took about a month off, and that day he's second day back. Staff L reported he did not have enough of the correct food for the meal the day before; and he ran out of the food he made. Staff L stated he was not able to serve the menu items, they ran out of bread, and toast to be served everyday. Staff L reported staff went to | F 363 | | |

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| TOUCHSTONE HEALTHCARE COMMUNITY | 1800 INDIAN HILLS DRIVE SIOUX CITY, IA 51104 |

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| F 363 | Continued From page 110 | F 363 | | |

the store the day before to buy bread. Staff I. stated he heard Saturday 7/29/17 staff ordered pizza because there was no Cook on Saturday and he had no idea how they got things served.

In an interview on 7/31/17 at 6:50 p.m., Staff MM, Dietary Aide, stated she had worked for the facility for 5 months. Staff MM said they had been running out of food like bread, snacks, and juices. Staff MM reported the Administrator had told them not to order snacks anymore but she did not know the reason why. Staff MM stated the residents were not happy for about 2 to 3 weeks; since Staff Aa, previous Dietary Manager, left. Staff MM reported Staff PP, Dietary Cook, did not show 7/31/17 so they called in Staff L. Staff MM stated substitutes not getting made for lunch or suppers. Staff MM reported tater tots not available for that night's meal so they substituted Spanish rice. Observation revealed the meal board in the dining room listed dinner as tilapia, yellow squash, Spanish rice, strawberry cake, and substitute chicken salad croissant.

The facility's Spring/Summer Week 2 Day 2 menu, signed by the Consultant Dietitian on 7/11/17, identified the following items to be served for dinner on Monday 7/31/17:
a. cornflake fish
b. tater tots
c. yellow squash with red peppers
d. dinner roll or bread, margarine
e. fresh fruit
f. milk
g. alternative - egg salad on a croissant
h. alternative - marinated cucumber & onion salad

In an interview on 7/31/17 at 7:05 p.m., the

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| F 363 | Continued From page 111<br>Administrator reported Staff PP called in on Saturday 7/29/17, but Staff NN, Dietary Aide (although the Administrator referred to as a cook), did not get the message in the kitchen. The Administrator stated Staff JJ, Receptionist/Administrative Assistant, came in later in the morning at approximately 8:00 a.m., and Staff OO, Dietary Cook, came in at 11:00 a.m. The Administrator stated 4 dietary aides also in the kitchen on 7/29/17. The Administrator said breakfast went okay but the menu items for lunch were not prepped. The Administrator reported they made mash potatoes and gravy for the puree at lunch and the staff ordered pizza for the other residents. The Administrator reported the facility had no dietary manager employed at the time. The Administrator stated the facility ordered food 2 times per week; order Mondays for delivery Tuesdays and order Thursday for delivery Fridays from US Foods. The Administrator stated bread and milk separately ordered and not certain on the vendors or when the bread and milk delivered. The Administrator commented she thought the vendor for bread might be Earthgrains. The Administrator stated 2 cooks, Staff OO and Staff PP, came in to assist her with ordering the food items.<br><br>The facility's Spring/Summer Week 1 menu identified the following items to be served for lunch on Saturday 7/29/17:<br>a. herbed turkey<br>b. poultry gravy<br>c. sage bread dressing<br>d. squash medley<br>e. dinner roll or bread, margarine<br>f. chocolate brownie<br>g. milk/beverage of choice<br>h. alternative - tilapia with lemon butter | F 363 | | |

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| F 363 | Continued From page 112<br>i. alternative - wild blend rice<br>j. alternative - creamy coleslaw<br><br>In an interview on 8/1/17 at 6:45 a.m., Staff N, Dietary Aide, stated she worked for the facility for 3 weeks. Staff N reported they had bread and eggs the past couple of days only but not able to serve other stuff. Staff N stated she thought food deliveries came on Tuesdays and Fridays but no groceries had arrived yet that day (which was a Tuesday). Staff N stated she did not think the groceries would come.<br><br>Observation on 8/1/17 at 6:47 a.m. revealed Staff QQ, Director of Housekeeping, worked in the kitchen cooking bacon and sausage. Staff QQ stated the cook did not answer her phone and did not come. Staff QQ stated she was not cross trained in dietary department. Staff QQ reported she started breakfast and bread available because management bought it last night. Staff QQ stated the kitchen had issues since December 2016. At 6:50 a.m., Staff M, Dietary Aide, arrived. Staff QQ left the kitchen stating left because surveyor on site and Staff JJ, Receptionist/Administrative Assistant was coming. Staff M responded Staff JJ can't cook. Staff RR, Dietary Cook, arrived at 7:15 a.m. Staff RR stated the facility fired the previous Dietary Manager (Staff Aa) about a month ago and they had no food the last 3 weeks. Staff RR reported no manager came to the kitchen and that included the Administrator. Staff RR stated the last Saturday (7/29/17) she had been the one there. Staff RR stated the facility ordered pizza. Staff RR said she prepared cheese pizza, mashed potatoes, and vegetables for residents on puree diets. | F 363 | | |

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| F 363 | Continued From page 113<br>In an interview on 8/1/17 at 7:20 a.m., Staff JJ stated she was trained in dietary and worked in dietary a couple times a month. Staff JJ entered the dry storage to put on a hairnet. Staff JJ stated the empty shelves should contain snacks and pop. Staff JJ said she thought food delivered Tuesdays around 9:00 a.m. and Friday around 1:00 p.m. Staff JJ commented she did not think the food getting ordered and she made a huge list which she gave to the dietician. At the time of the interview, the bread rack contained 6 loaves of white bread and 5 loaves of wheat bread [with a census of 90 residents].<br><br>In an interview on 8/1/17 at 7:25 a.m., the Administrator stated Staff Aa on a 60 day PIP (Performance Improvement Plan) for recurring issues. The Administrator reported she fired Staff Aa on 7/8/17 and actively sought a manager. The Administrator stated she changed the position to a senior, salaried position and had awarded Staff PP a step up with responsibility for ordering. The Administrator clarified Staff PP not the manager as she did not know much about dietary. The Administrator stated she did the ordering with Staff PP but there were times not enough food ordered. The Administrator reported the previous night she bought bread and sausage because Staff L did not think they had enough sausage. The Administrator stated Staff PP did not come today to do the order. The Administrator stated the kitchen needed solid leadership. The Administrator stated she planned on Staff JJ for breakfast today. The Administrator stated normally, the facility did not get a delivery on Tuesday so food would come on Wednesday. The Administrator reported the consultant RD would be coming to see what food the facility had on hand and what to make. The Administrator | F 363 | | |

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| F 363 | Continued From page 114<br>stated the kitchen staff made a lot of drama in the kitchen that past 2 weeks. The Administrator commented the issue on 7/29/17 that staff did not take items out of the freezer versus not having items. The Administrator stated Staff JJ trained for the pureed process so she pureed pizza that day. The Administrator reported the weekend circumstances beyond her control. The Administrator reported she had received grievances from care conferences about food quality, pre-made foods like meatloaf, and not attempting to follow the menus. The Administrator stated she reviewed in QA (Quality Assurance meeting) monthly. The Administrator commented she wanted to clarify Staff Aa's PIP about sanitation, food quality, attendance, ordering issues, but not for lack of food. The Administrator stated she had gone into the kitchen. The Administrator stated she initiated a pre-production meeting with Staff JJ to ensure each day food there. The Administrator said yesterday a late morning so she started the meetings after breakfast on 7/31/17 to ensure the lunch and dinner items available for that day. The Administrator reported she had access to a sister facility but she did not know if they had the same order schedule. The Administrator stated she may be able to get food delivered from the sister facility.<br><br>In an interview on 8/1/17 at 8:30 a.m., the consultant RD stated sometimes the facility had food but not have the food on the menu.<br><br>In an interview on 8/1/17 at 9:07 a.m., Staff D, Certified Nurse Aide (CNA), stated lately the residents complained of running out of food and snacks. | F 363 | | |

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| F 363 | Continued From page 115<br>In an interview on 8/1/17 at 9:10 a.m., Staff K, CNA, stated she heard residents complained of no bread or eggs; Staff K said it had been like that for a week.<br><br>In an interview on 8/1/17 at 10:20 a.m., Staff OO stated he was starting to cook lunch at that time. Staff OO said he should unthaw the beef patties but due to time constraints, he would cook from frozen.<br><br>The facility's Spring/Summer Week 2 Day 3 menu identified the following items to be served for lunch on Tuesday 8/1/17:<br>a. beef pepper steak with gravy<br>b. rice<br>c. parslied carrots<br>d. dinner roll or bread, margarine<br>e. banana pudding<br>f. milk/beverage of choice<br>g. alternative - baked thyme chicken<br>h. alternative - roasted red skin potatoes<br>i. alternative - greens<br><br>The facility's Spring/Summer Week 2 Day 3 menu identified the following items to be served for dinner on Tuesday 8/1/17:<br>a. BBQ pork rib patty on a bun<br>b. crinkle cut fries<br>c. red supreme cabbage<br>d. chilled peaches<br>e. milk/beverage of choice<br>f. alternative - hamburger on a bun<br>g. alternative - battered corn nuggets<br>h. alternative - lettuce tomato onion & pickle<br><br>In an interview on 8/1/17 at 11:35 a.m., the RD stated she listed the substitutes on the menu for the evening meal. The RD reported the | F 363 | | |

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| F 363 | Continued From page 116<br>Administrator would need to go to the store to buy hamburger buns.<br><br>Observation on 8/1/17 at 11:53 a.m. revealed Staff OO said he needed to get the pureed going as it should have been done a long time ago since meal should be at 11:45 a.m. Staff N reported she ran out of peaches and would make chocolate pudding.<br><br>On 8/1/17 at 12:00 p.m. the RD stated she had not been told daily about the menu changes nor had she approved the substitutes.<br><br>Observation on 8/1/17 at 12:40 p.m. revealed the RD prepared pureed green beans as the facility ran out of carrots. At 12:47 p.m. the North side staff asked the kitchen for 2 room trays because they did not get served. Staff RR responded because those residents needed mechanical soft and they did not have it. The RD responded she had some mechanical soft ready to go now for them.<br><br>In an interview on 8/1/17 at 1:45 p.m., the RD confirmed after observation with the surveyor, the meals for that evening not going as planned due to not having food. The RD stated the items they did not have were: BBQ pork rib patty, hamburger buns, red cabbage, or hamburger. The RD said she would have the facility substitute fish sandwich, broccoli, and the facility would go buy hamburger buns for the fish sandwich. The RD reported they also did not have all the food items needed for Wednesday, 8/2/17. The RD stated they were missing the Swedish meatballs and 1 bag of soup. The RD stated she would take a look at what had been ordered to come on 8/2/17, compare it to the menu, and go from | F 363 | | |

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| F 363 | Continued From page 117<br>there.<br><br>The delivery invoice dated 8/1/17, for the order date of 7/31/17, failed to contain orders/deliveries for bread, peaches, BBQ pork rib patty, red cabbage, hamburger buns, asparagus cuts, Swedish meatballs, Italian soup, or mandarin oranges. The delivery invoice documented receipt of 13 foods on 8/1/17:<br>a. banana pudding mix<br>b. snack chips<br>c. mild cheddar cheese<br>d. ground beef<br>e. coleslaw mix<br>f. beef chuck ground<br>g. red potatoes<br>h. eggs<br>i. frozen beef patty<br>j. chicken breast<br>k. sausage, pork links<br>l. loin pork chops<br>m. potato, french fries<br><br>Observation on 8/1/17 at 5:40 p.m. revealed Staff OO finishing cooking hamburgers for the supper meal; some of the hamburger fresh and some made from frozen beef patty, (the same patty served at lunch). At 6:00 p.m. the steam cart held a small pan of fish, corn nuggets, green bean mix, fries, and spinach. The main kitchen cart did not contain fish or broccoli as substituted by the RD but rather all hamburger patties and spinach. At 6:10 p.m. meal service started and Staff OO stated he cooked spinach instead of broccoli because quicker to cook and he had short notice.<br><br>The facility's Spring/Summer Week 2 Day 4 menu identified the following items to be served for lunch on Wednesday 8/2/17: | F 363 | | |

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| F 363 | Continued From page 118<br>a. crispy baked chicken<br>b. baked sweet potato<br>c. asparagus cuts<br>d. dinner roll or bread, margarine<br>e. pineapple upside down cake<br>f. milk/beverage of choice<br>g. alternative - Swedish meatballs<br>h. alternative - noodles<br>i. alternative - roasted zucchini<br><br>The facility's Spring/Summer Week 2 Day 4 menu identified the following items to be served for dinner on Wednesday 8/2/17:<br>a. Italian wedding soup<br>b. saltine crackers<br>c. ham salad sandwich<br>d. broccoli salad<br>e. mandarin orange gelatin<br>f. milk/beverage of choice<br>g. alternative - egg and hashbrown casserole<br>h. alternative - sausage links<br>i. alternative - tomato wedges<br>j. alternative - muffin/margarine<br><br>Observation on 8/2/17 at 8:37 a.m. revealed the dry storage room contained items obtained from a delivery or the store:<br>a. 1 box of Cheetos with 90 - 1 oz bags of Cheetos<br>b. 14 cans of 15 oz mandarin oranges - Hy-Vee brand<br>c. 2 - 6 lb 5 oz cans of asparagus cuts (previously inventoried on 7/31/17)<br><br>In an interview on 8/2/17 at 9:00 a.m. Staff L reported he needed 3 to 4 cans of asparagus cuts for lunch. Staff L stated Staff UU, Dietary Manager (from a sister facility), brought a 3rd can that day. The RD stated she had been unaware | F 363 | | |

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| F 363 | Continued From page 119<br>the Cheetos and banana pudding delivered on 8/1/17. The RD reported the main delivery truck should arrive sometime between 9:00 a.m. and 11:00 a.m. that day.<br><br>In an interview on 8/2/17 at 10:00 a.m. the Administrator reported Monday's order for Tuesday delivery not entered in time. The Administrator stated she did a late bulk order and told US Foods told her it did not come; but they did send 10 warehouse items available on another truck received 8/1/17. The Administrator again stated the facilities normal delivery days Tuesdays and Fridays. The Administrator stated she would have Staff UU's help that week and the next. The Administrator commented she had been afraid they did not have enough meatballs for that day's lunch so she went to the store the day before to purchase foods after the RD left for the day. The Administrator stated she would need to clarify which day the next truck would come for delivery as they were ordering food at that time. The Administrator unclear if truck would come Thursday or Friday and unclear when the next deadline for ordering food was; either 3:00 p.m. 8/2/17 or 8/3/17. The Administrator acknowledged not aware about only having 3 cans of asparagus cuts available for that day's lunch or the cook saying it took 3 to 4 cans for a meal. The Administrator stated she would have to check if the asparagus ordered Monday and coming on the truck that day; she commented but there's enough viable substitutions.<br><br>Observation on 8/2/17 at 12:18 p.m. revealed the first plate served in the main dining room. At 12:25 p.m., all menu items available per the menu. The chicken baked but not crusted. At | F 363 | | |

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| F 363 | Continued From page 120<br>12:35 p.m. Staff L commented the steam cart should leave the kitchen at 12:15 p.m. but they had to wait on meatballs. Staff L stated the residents used to fill out menus but don't now and he believed it lead to a lot more food waste because staff did not know how much to prepare. At 12:50 p.m. staff delivered the first room trays on Northside. At 12:55 p.m. Staff OO informed staff out of milk cartons as waiting on the milk truck but residents could get a glass of milk. At 1:19 p.m., a resident approached Staff OO asking what was available for lunch. The resident stated he/she asked Staff L for pancakes but Staff L looked around and no pancake mix available. At 1:40 p.m. Staff OO stated he finished service as the last 3 trays were residents attending Resident Council who he would serve them when they got done with their meeting.<br><br>In an interview on 8/2/17 at 2:30 p.m., the Administrator stated no delivery truck would be coming that day. The Administrator stated US Foods arranged a special truck to come Thursday 8/3/17 which would have all items ordered Monday 7/31/17 plus food items ordering that day. The Administrator acknowledged the facility needed to get the order finished because it was due by 3:00 p.m. The Administrator said not aware out of pancakes and surveyor informed her pancakes on the menu for Friday morning. The Administrator confirmed no truck coming Friday 8/4/17 now so she needed to order food all the way thru Tuesday 8/8/17 of the next week.<br><br>In an interview on 8/2/17 at 3:05 p.m., the Director of Operations (DOO) reported the facilities contractor for housekeeping would be supplying the facility with a Certified Dietary Manager (CDM) on 8/7/17. The DOO stated the | F 363 | | |

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| | 165161 | A. BUILDING _____ B. WING _____ | 08/15/2017 |

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| TOUCHSTONE HEALTHCARE COMMUNITY | 1800 INDIAN HILLS DRIVE SIOUX CITY, IA 51104 |

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| F 363 | Continued From page 121<br>plan going forward would include Staff UU continuing to do the facilities ordering. The DOO said the facility had his approval to go to the store for any items not received on an order. The DOO stated they needed to make sure staff utilized the right portion sizes. The DOO said Staff UU put together inservices for the dietary staff. The DOO reported the facility realized the last Director of Dietary (Staff Aa) worked with HR (human resources) with a PIP but had to let her go. The DOO stated the internal person planned for the position not available so some transitions being worked thru. The DOO said the facility between a rock and hard place. The DOO stated they talked about going thru the menu on a daily basis, line by line, to ensure they had the food items.<br><br>In an interview on 8/3/17 at 8:30 a.m., the DOO reported bread and milk ordered and received from US Foods. The DOO stated the corporate policy to use US Foods for all food and US Foods procures the food from all the vendors for delivery thru US Foods truck. At 8:45 a.m., the Administrator informed the DOO and surveyor Staff Aa got off track from corporate policy and ordered milk from Dean Foods. The Administrator stated since Staff Aa left on 7/8/17, Staff PP and Staff OO would have ordered the milk. The Administrator said the last milk ordered on 7/27/17 from Dean Foods. When questioned if she personally looked at milk for orders prior to Staff UU assisting, the Administrator responded no, Staff PP and Staff OO would have been responsible to ensure milk ordered. The Administrator, the DOO, and surveyor went to Staff UU in the kitchen to confirm if she ordered milk. Staff UU stated she did not order milk because staff told her a truck comes with it. The Administrator stated she would have to verify if | F 363 | | |

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| F 363 | Continued From page 122<br>they needed to order milk. At that time, Staff Bb, Dietary Manager (from a different sister facility), observed bringing in food for the facility.<br><br>Observation of the cooler on 8/3/17 at 9:00 a.m. revealed 9 - one gallon 2% milks, no cartons (pints) of milk, no chocolate milk, and no skim milk.<br><br>In an interview on 8/3/17 at 9:30 a.m., the Administrator verified the US Food truck expected to deliver between 1:00 p.m. to 2:00 p.m. that day. The Administrator confirmed the milk truck from Dean Foods came every Thursday. The Administrator stated she learned the milk guy checks their stock and automatically brings them back up to a certain level each week; 200 - 1/2 pints chocolate milk, 36 gallons 2% milk, and 600 half pints of skim milk. The Administrator stated the milk truck en route making deliveries on the south side of the city and should be at the facility around lunch time. The Administrator confirmed she had not been aware the facility had a recurring order every Thursday.<br><br>In an interview on 8/10/17, the contracted Dietary Manager confirmed he served all menu items as written on the menu from 8/7/17 thru 8/10/17. The Dietary Manager stated the facility had all the food items except the ravioli with cheese on the menu for 8/7/17 dinner. The Dietary Manager reported the facility went to the store on the morning of 8/7/17 to purchase the ravioli.<br><br>The facility's Spring/Summer Week 3 Day 2 menu identified cheese ravioli casserole to be served for dinner on Monday 8/7/17. | F 363 | | |

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| F 363 | Continued From page 123<br>7. The Minimum Data Set (MDS) assessment dated 6/23/17 for Resident #14 identified a Brief Interview for Mental Status (BIMS) score of 09. A score of 9 indicated moderate cognitive impairment.<br><br>In an interview on 8/8/17 at 8:15 a.m., Resident #14 sat in the dining room almost finished with breakfast. Resident #14 reported the food did not taste good. Resident #14 said the facility had been running out of food and they did not have snacks. Resident #14 stated the previous week awful even waiting for butter. Resident #14 commented the facility serves things for breakfast that were not normal breakfast items like sandwiches.<br><br>8. In a family interview on 8/7/17 at 3:25 p.m., a family member for Resident #3 stated the facility had issues with running out of food. The family member reported the resident ate in his/her room. The family member reported the resident once received a pureed diet tray and he/she had to correct staff to give a regular food tray.<br><br>9. The MDS assessment dated 5/18/17 for Resident #20 identified a BIMS score of 15. A score of 15 indicated intact cognition.<br><br>In an interview on 8/14/17 at 2:25 p.m., Resident #20 reported the facility had plenty of food that day and week, but the facility had been running out of food. Resident #20 stated 1 day he/she received lima beans and spinach 2 times. Resident #20 commented he/she could not have pork and the facility did not always have an alternative for him/her. | F 363 | | |

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| F 363 | Continued From page 124<br>10. The facility's Week 3 menu, signed by the Consultant Dietitian on 7/11/17, identified a pureed serving of dinner roll, as part of the planned menu for the pureed texture diet, at the noon meal on 8/8/17.<br><br>Observation on 8/8/17, from 10:10 a.m. to 1:00 p.m., revealed Staff L, Cook, assigned to puree the food items needed for the noon meal. Staff L pureed the meat, potato and vegetable, but did prepare pureed dinner rolls nor did Staff L add dinner rolls/bread to the items pureed.<br><br>Review of a document titled "Diet Listing", dated 7/31/17, revealed the 6 observed residents identified to be on a pureed texture diet.<br><br>Observation on 8/8/17, from 12:05 p.m. to 1:00 p.m., during noon meal service revealed a pureed bread item not served to the 6 of 6 observed residents on a pureed diet.<br><br>During an interview on 8/8/17, at 1:05 p.m., Staff L acknowledged he did not puree a bread item or add bread to pureed meat and/or vegetables at the noon meal . He reported he did not routinely puree bread and only added it to products that needed it to help with improved texture.<br><br>During an interview on 8/8/17, at 1:35 p.m., the Consultant Dietitian confirmed the expectation for the bread items, identified on the menu, to be pureed and prefers the addition to meat/vegetable to help with a cohesive texture, rather than pureeing by itself.<br><br>Review of a policy titled "Pureed Foods", revealed residents will receive pureed foods in accordance with the prescribed diet order ... all food is pureed | F 363 | | |

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| F 363 | Continued From page 125<br>per the procedure attached/posted ... "<br><br>Review of documents titled "Pureed Vegetable/Starch Procedure" and "Pureed Meat Procedure", posted in the kitchen, identified the addition of 1/2 piece of buttered bread or 1/2 dinner roll for each portion of vegetable and meat pureed.<br><br>The IJ was abated on 8/2/17 when the facility completed the following:<br>Ensured the breakfast serve on 8/2/17 and all menu items were avialbe and being severed.<br>Confirmed with the registered dietician and interim dietary manage that all [food] items are avilalbe for the meal 8/2/17.<br>On 8/2/17 the interim dietary manager worked with a team overseeing each meal to ensure meals are prepped and served timely; and dietary staff were re-educated on the overall dietary meal service.<br>The facility identified on 8/1/17/ the RD complied a list of residents who were at risk for weight loss, and will review menus to ensure adequate nutritional will be maintained. The Administrator would ensure ongoing communication with dietary staff on ordering needs witll continue, hire a dietary manager, interview residents and families starting 8/1/17 to ensure food was being offered; and evaluate dietary sanitation. The Administrator reported audits of menu items will be conducted weekly for 30 days.<br>These actions lowered the IJ from "L" severity to "E" with the need for ongoing monitoring to ensure future orders and deliveries would be served to meet residents nutritional needs. | F 363 | | |
| F 368 SS=F | 483.60(f)(1)-(3) FREQUENCY OF MEALS/SNACKS AT BEDTIME | F 368 | | |

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| F 368 | Continued From page 126<br><br>(f) Frequency of Meals<br><br>(f)(1) Each resident must receive and the facility must provide at least three meals daily, at regular times comparable to normal mealtimes in the community or in accordance with resident needs, preferences, requests, and plan of care.<br><br>(f)(2)There must be no more than 14 hours between a substantial evening meal and breakfast the following day, except when a nourishing snack is served at bedtime, up to 16 hours may elapse between a substantial evening meal and breakfast the following day if a resident group agrees to this meal span.<br><br>(f)(3) Suitable, nourishing alternative meals and snacks must be provided to residents who want to eat at non-traditional times or outside of scheduled meal service times, consistent with the resident plan of care.<br>This REQUIREMENT is not met as evidenced by:<br>Based on group resident interview, observation, staff interview, review Resident Council minutes, facility record review and resident interview, the facility failed to serve meals at regular times and failed to offer a variety of satisfying snacks for 7 of 7 residents present for the group interview and 3 of 15 current residents reviewed (Resident #14, #20, #11). The facility reported a census of 90.<br><br>Findings include:<br><br>1. During the Group resident interview on 8/2/17 at 1:15 p.m., 7 out of the 7 residents complained that facility staff general served meals late. The group stated they wished there were more variety | F 368 | | |

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| F 368 | Continued From page 127<br>with snacks as residents without teeth could not eat the apples or pears. The group voiced staff did not offer bedtime snacks and the residents with a pureed diet did not have anything prepared or offered.<br><br>2. During a meal observation on 8/2/17 at 12:31 p.m. staff added meat balls to the steam table. At 12:39 p.m. the steam cart and room trays left the kitchen.<br><br>In an interview on 8/2/17 at 12:34 p.m., Staff L, cook, stated the steam cart should leave the kitchen by 12:15 p.m. He acknowledged they were waiting on the meat balls before they could leave the kitchen.<br><br>3. The Resident Council minutes from 5/20/17 documented under the Dietary section: the food tasted cold with long wait times for meals, specifically in the evening.<br><br>The Resident Council minutes from June (2017) documented under the Dietary section that food is sometimes served cold and residents waited a long time for meals, especially in the evenings.<br><br>The Resident Council minutes from July 2017 documented under the Dietary section not always being served when requests room trays. Under the Nursing section the minutes documented staff did not pass ice water or offer snack carts at all.<br><br>4. The Meal Times list provided by the facility listed the following meal times:<br>Breakfast<br>7:00 a.m. - 9:15 a.m. - Main Dining Room<br>7:30 a.m. - Assisted Residents in the Main Dining Room | F 368 | | |

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| F 368 | Continued From page 128<br>7:30 a.m. - North Nook then South Side<br>The steam cart will go to the North Side Nook first the South Side Nook area for room trays<br>Lunch<br>11:45 a.m. - 12:30 p.m. Main Dining Room<br>12:15 p.m. - Assisted Residents in the Main Dining Room<br>12:15 p.m. - North Nook then South Side<br>The steam cart will go to the North Side Nook first the South Side Nook area for room trays<br>Supper<br>5:00 p.m. - 5:45 p.m. Main Dining Room<br>5:30 p.m. - Assisted Residents in the Main Dining Room<br>5:30 p.m. - North Nook then South Side<br>The steam cart will go to the North Side Nook first the South Side Nook area for room trays<br><br>5. In an interview on 7/31/17 at 6:00 p.m., Staff I, Dietary Aide, showed the dry storage racks barren and the snack rack to be empty.<br><br>Observation on 7/31/17 at 6:01 p.m. revealed the food contents of the kitchen inventoried by 2 surveyors in the dry storage with no snacks found on the shelves.<br><br>In an interview on 7/31/17 at 6:50 p.m., Staff MM, Dietary Aide, stated she had worked for the facility for 5 months. Staff MM said they had been running out of food like bread, snacks, and juices. Staff MM reported the Administrator had told them not to order snacks anymore but she did not know the reason why.<br><br>In an interview on 8/1/17 at 8:50 a.m., Staff OO, Dietary Cook, stated breakfast is served and cleaned up to switch over to lunch. Staff OO said lunch supposed to start at 11:45 a.m. | F 368 | | |

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| F 368 | Continued From page 129<br><br>In an interview on 8/1/17 at 9:07 a.m., Staff D, Certified Nurse Aide (CNA), stated the meals are not starting on time.<br><br>In an interview on 8/1/17 at 10:20 a.m., Staff OO stated he was starting to cook lunch at that time. Staff OO said he should unthaw the beef patties but due to time constraints, he would cook from frozen.<br><br>Observation on 8/1/17 at 11:53 a.m. revealed Staff OO said he needed to get the pureed going as it should have been done a long time ago since meal should be at 11:45 a.m. At 12:30 p.m., the food began going out to the main dining room. The lunch meal service ended at 1:20 p.m.<br><br>Observation on 8/1/17 at 5:40 p.m. revealed 35 residents in the dining room waiting for food and random residents yelled out for food. At that time, no residents had food. At 6:10 p.m., staff started the meal service in the main dining room and ended it at 7:00 p.m. in the main dining room.<br><br>Observation on 8/2/17 at 11:50 a.m. revealed prep started for the pureed foods by the Registered Dietician (RD) and staff were not ready to serve yet. At 12:15 p.m., the RD asked staff if they were ready to go and Staff L responded no, he needed to puree the starch yet. The RD directed staff to get going with serving regular plates and she began to puree noodles. At 12:18 p.m. staff served the first plate in the main dining room. At 12:35 p.m. Staff L commented the steam cart should leave the kitchen at 12:15 p.m. but they had to wait on meatballs. At 12:40 p.m. the steam cart left the kitchen. At 12:50 p.m. staff delivered the first | F 368 | | |

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| F 368 | Continued From page 130<br>room trays on Northside. At 1:05 p.m. staff plated the last room tray on Northside. At 1:15 p.m., the RD and Administrator asked Staff OO why it took so long to go to the Southside and Staff OO responded he waited on 2 more residents that were new. Staff N, Dietary Aide responded he could go and she would bring trays back. Staff served the first tray for Southside at 1:22 p.m. then Staff OO waited for plates to arrive. At 1:28 p.m. 8 residents still needed to be served. At 1:40 p.m. Staff OO stated he finished service as the last 3 trays were residents attending Resident Council who he would serve when they got done with their meeting.<br><br>In an interview on 8/8/17 at 3:35 p.m., Staff O, CNA (Certified Nursing Assistant) stated the staff are supposed to have a snack cart. Staff O reported the dry storage drawers as empty and no snacks available in the nooks. Staff O stated she could not pass HS (bedtime) snacks. Staff O said the residents on a pureed diet did not get snacks.<br><br>5. The MDS (Minimum Data Set) assessment dated 6/23/17 for Resident #14 identified a BIMS score of 9, indicating moderate cognitive and memory impairment.<br><br>In an interview on 8/8/17 at 8:15 a.m., Resident #14 reported they did not have snacks.<br><br>6. The MDS assessment dated 5/18/17 for Resident #20 identified a BIMS score of 15, indicating intact memory and T cognition.<br><br>In an interview on 8/14/17 at 2:25 p.m., Resident #20 reported the facility did not always remember to serve everyone. Resident #20 stated he/she | F 368 | | |

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| F 368 | Continued From page 131<br>ate in his/her room and received supper anywhere from 6:00 p.m. to 6:45 p.m. Resident #20 reported sometimes he/she would have to send staff to get food or else heat up his/her own food in microwave in room.<br><br>7. The MDS assessment dated 5/17/17 documented Resident #11 had a BIMS score of 14, indicating intact memory and cognition.<br><br>During an interview with Resident #11 on 8/8/17 at 2:38 PM, he/she stated that he/she usually ate in her room and the facility usually served meals late. | F 368 | | |
| F 371 SS=F | 483.60(i)(1)-(3) FOOD PROCURE, STORE/PREPARE/SERVE - SANITARY<br><br>(i)(1) - Procure food from sources approved or considered satisfactory by federal, state or local authorities.<br><br>(i) This may include food items obtained directly from local producers, subject to applicable State and local laws or regulations.<br><br>(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.<br><br>(iii) This provision does not preclude residents from consuming foods not procured by the facility.<br><br>(i)(2) - Store, prepare, distribute and serve food in accordance with professional standards for food service safety.<br><br>(i)(3) Have a policy regarding use and storage of | F 371 | | |

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| F 371 | Continued From page 132<br>foods brought to residents by family and other visitors to ensure safe and sanitary storage, handling, and consumption.<br>This REQUIREMENT is not met as evidenced by:<br>Based on Registered Dietician reports, observation, staff interview, facility record review, facility policy review, and the Food and Drug Administration code, the facility failed to store, handle and serve food and equipment under sanitary conditions in order to reduce the risk of contamination and food-borne illness. The facility identified a census of 90 residents.<br><br>Findings include:<br><br>1. The consultant Registered Dietician (RD) review for 5/2/17 included the following documentation:<br>Kitchen inspection completed:<br>Point 1. Clean the top of knife rack, very dusty.<br>Point 2. Clean the toaster after every breakfast.<br>Point 3. Clean the microwave.<br>Point 4. Clean the ceiling and vents.<br>Point 5. Fix freezer door.<br>Point 6. Clean the oven.<br>Point 7. Clean the hood.<br><br>The RD review for 5/11/17 included the following documentation:<br>Kitchen inspection completed:<br>Point 1. Scoops CANNOT be left in the sugar container.<br>Point 2. Clean the microwave.<br>Point 3. Clean the hood.<br>Point 5. Clean the ceiling vents.<br>Point 6. Wipe down the shelves in the walk-in fridge.<br>Point 7. Keep food off the store room floor. | F 371 | | |

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| F 371 | Continued From page 133<br>Point 8. Staff need to use tongs when serving dinner rolls-staff using steam cart used their hands.<br>Point 10. Temperatures need to be recorded on the milk refrigerator in the dining room, being done only randomly.<br><br>The RD review for 6/6/17 included the following documentation:<br>Kitchen inspection completed:<br>Point 1. Clean the knife rack.<br>Point 2. Clean ceiling vent by the walk-in.<br>Point 3. Clean hood - This should have been done at least every 6 months professionally. Staff are working on it today.<br>Point 4. Fix the freezer door!!!<br>Point 5. Keep food off the store room floor - a bag of onions sat on the floor.<br>Point 6. Everything in the walk-in needs a label and date - 2 containers of fruit had no label or date.<br><br>The RD review for 6/22/17 included the following documentation:<br>Kitchen inspection completed:<br>Point 1. Glasses still wet when set out in the dining room after breakfast. Everything needs to be dry before put away!!<br>Point 2. Keep food off the store room floor.<br>Point 4. Fix the freezer door!!!<br><br>The RD review for 7/11/17 included the following documentation:<br>a. The kitchen is filthy!! Cereal left on counter spilled from lunch.<br>b. Microwave needs to be cleaned.<br>c. Scoop in the sugar bag.<br>d. Containers of cereal need a label and date.<br>e. The RD threw away 3 expired containers of | F 371 | | |

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| F 371 | Continued From page 134<br>sour cream.<br>f. The RD threw away 4 expired containers of cottage cheese.<br>g. Kitchen staff will need dish soap from Ecolab.<br><br>The RD review for 7/18/17 included the following documentation:<br>Kitchen Inspection completed - Areas that need to be addressed:<br>Point 1. Temperatures of the walk-in fridge and freezer are not being done.<br>Point 2. Missing temperature and sanitizer on the dishwasher.<br>Point 3. Scoops left in the sugar and flour bags. NO scoops left in there!!!<br>Point 4. Clean the microwave.<br>Point 5. Keep food off the freezer, fridge and store room floor.<br>Point 6. Cleaning list need to be completed.<br><br>The RD review for 7/25/17 included the following documentation:<br>Kitchen inspection completed:<br>Point 1. Clean microwave. It did not look like done from last week when RD asked staff to clean it.<br>Point 2. All cereal containers need to be labeled.<br>Point 3. All juices/milk need to be kept off the floor in the walk-in<br>Point 4. Keep boxes of food off the freezer floor.<br>Point 5. Keep food off the store room floor - a bag of onions sat on the floor.<br>Point 6. Throw broken-down boxes away instead of laying them all over the kitchen.<br>Point 7. The RD asked if the hood could be professionally cleaned semi-annually???<br>Point 8. Sweep and mop behind/under counters. Floors need to be moped each night.<br>Point 9. Countertops need kept cleaned and | F 371 | | |

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| F 371 | Continued From page 135<br>wiped down during the day.<br>General notes:<br>a. Staff asked the RD if they could have a cleaning party, told to set up for next week and staff need to complete cleaning task on a daily routine and some items weekly so cleaning parties not needed.<br>b. Staff should not be eating in the kitchen or talking on cell phones in the kitchen.<br>c. The RD posted a list of a few cleaning items that she wanted staff to complete ASAP (as soon as possible).<br><br>2. Observation on 7/31/17 at 6:01 p.m. revealed the food contents of the kitchen inventoried in the dry storage, walk-in cooler and walk-in freezer. The following items observed:<br>a. 2 large packages of meat unthawed (approximately 5 pound (lbs) of possible pork loin, unlabeled and undated.<br>b. A 5 lb tub of deviled egg potato salad, opened with no open date.<br>c. Staff LL, Dietary Aide, entered the dry storage room eating a cookie.<br>d. 3 and 1/4 bags of Rice Krispies with no labels, no dates.<br>e. 4 one gallon Cole slaw dressings, expired 6/8/17.<br>f. 3 six lb 5 ounces (oz) jellied cranberry sauce, expired 11/7/16.<br>g. 2 one gallon containers of Italian salad dressing, expired 11/15/16.<br>h. 2 one gallon of Caesar salad dressing, expired 3/2/17.<br>i. 22 oz of strawberry syrup on top shelf dripping onto all 4 shelves, floor and thawed meat.<br>j. Two of two hand washing stations had no paper towels in the dispenser. | F 371 | | |

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| F 371 | Continued From page 136<br>Observation on 7/31/17 at 7:10 p.m. of the North Nook assisted dining room revealed:<br>a. The General Electric (GE) refrigerator contained a large amount of debris, dried food on the shelves and sticky shelves and foods undated and unlabeled.<br>b. The ice chest contained just pink discolored water with 1 bobbing apple, one 2 quart pitcher of lemonade (1/2 full) dated 7/20/17 and one 2 quart pitcher of fruit punch (1/3 full) dated 7/20/17. The ice chest had a foul odor when opened.<br><br>Observation on 7/31/17 at 7:20 p.m. of the Southside Nook assisted dining room revealed:<br>a. The GE refrigerator revealed debris and dirty shelves. The refrigerator stored one room tray which contained unlabeled and undated rice, meat, potatoes and beans.<br>b. A 48 oz container of thickener, opened and undated.<br>c. Orange juice and apple juice, 48 oz containers, also opened and undated.<br>c. An ice chest with 2 bobbing apples in melted water.<br>d. Another ice chest with a scoop on a dirty white towel completely discolored orange. A pan had been placed below the leaking chest on the second shelf to catch drips and the chest was 1/4 full of water. The interior of the chest showed a 50-cent sized piece of cracked and missing plastic and rusty hinges, brown debris with an orange mold-like substance grew inside the container with a black mold-like substance could be seen all exterior sides. The ice chest had been 1/2 filled with fresh ice.<br><br>Observation on 7/31/17 at 7:25 p.m. of the North Nook revealed:<br>a. An ice chest that contained black and orange | F 371 | | |

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| F 371 | Continued From page 137<br>mold-like substances on all sides and a dirty towel soaked and discolored orange. A drip pan 3/4 full from a constant drip from the cooler sat under it. The ice scoop was placed on a dirty towel, not covered, and the scoop tray had cracks. The ice chest had been 1/2 filled with fresh ice.<br><br>Observation on 8/1/17 at 8:20 a..m. revealed a trash can full by the dish sink, not covered and flies around it.<br><br>In an interview on 8/1/17 at 8:30 a.m., the consultant RD stated she would expect all dented cans of food to be thrown away and she threw away 4 cans of peanut butter and 3 expired cranberry sauces. The RD stated there should be no eating in the storage room, meat should be in pans to thaw and be dated and shelves needed to be cleaned. The RD stated she would contact maintenance to fix the paper towel dispensers. The RD acknowledged the 2 ice chests needed to be replaced, they appeared gross and she would have the Administrator order 2 coolers.<br><br>Observation on 8/1/17 at 10:20 a.m. revealed the garbage remained uncovered.<br><br>In an interview on 8/1/17 at 10:20 a.m., Staff OO, Dietary Cook, stated he was starting to cook lunch at that time. Staff OO said he should unthaw the beef patties but due to time constraints, he would cook from frozen. Observation at the time revealed not all breakfast items cleaned up yet with a pan of sausage links remaining, approximately 30 to 50 links, and a Ziploc bag of about 10 pieces of bacon on the counter. The counter appeared soiled from the breakfast prep. Further observation revealed | F 371 | | |

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| F 371 | Continued From page 138<br>Staff JJ, Receptionist/Administrative Assistant, washed dishes in the 3 compartment sink with no water present in the 3rd compartment that should contain sanitizer. Staff JJ stated she did not know how to check the sanitization level. Staff OO gave her some testing strips and the test strip measured 0 ppm (parts per million) of sanitizer. Staff OO stated the sanitizer is so low, he just adds some other kind of sanitizer to the 2 sink. He knew that was not right, but that's the best he could do. Staff OO said the first sink contained soapy water and the second plain rinse water. Observation revealed the sanitizer container under the sink as completely empty. Staff JJ continued to wash 5 pans and lids with the 2 sink method and no sanitizer.<br><br>In an interview with the Administrator on 8/1/17 at 11:20 a.m., the Administrator stated Ecolab comes to the facility monthly and handles the sanitizers and they should be at the facility in 20 minutes. The Administrator could not say where additional supply of sanitizers would be stored in the facility and stated she did not know if they had any on hand in the facility.<br><br>Observation on 8/1/17 at 11:25 a.m. revealed the dish machine tested at 10 ppm; according to the machine's data plate it should be a minimum of 50 ppm. The facility then switched to the use of all paper products.<br><br>Observation on 8/1/17 at 11:30 a.m. revealed 18 eggs left on the shelf above the stove which Staff OO actively cooked on. The surveyor informed the RD the eggs felt hot to the touch and the RD threw the eggs away.<br><br>In an interview on 8/1/17 at 12:10 p.m., the | F 371 | | |

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| F 371 | Continued From page 139<br>representative from Ecolab stated the facility's representative from paper supplies orders chemicals. The Ecolab representative said he knew that Staff AA, previous Dietary Manager, dropped the ball with ordering. He stated he had inserviced staff just 2 weeks before on changing out the sanitizers. The Ecolab representative called the papers representative and informed him the facility ran out of Quat (quaternary) sanitizer. The Ecolab representative stated the facility ran out of sanitizer for the dish machine also. The Ecolab representative reported he previously trained staff on 7/18/17 but the facility had a large turnover in staff. He asked the Administrator at that time for permission to tell staff he would shut down the machine if they could not demonstrate how to properly clean and maintain the dish machine and the Administrator gave him the okay.<br><br>Observation on 8/1/17 at 12:40 p.m. revealed the can opener mounted to a table in a black holder which contained an extra large amount of a black, sticky substance on it, the holder and the floor beneath that covered an approximately 6-inch square floor tile. The RD cleaned it immediately with steel wool and observation revealed the holder as actually lighter blue in color.<br><br>On 8/1/17 at 1:10 p.m. the Ecolab representative returned with sanitizer for the facility's dish machine. He reported the facility would be receiving more sanitizer in 2 days.<br><br>Observation on 8/1/17 at 5:50 p.m. revealed Staff LL, Dietary Aide, placed 5 fresh tomatoes into the garbage disposal sink in the dishroom and washed them with the sprayer hose. Staff LL | F 371 | | |

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| F 371 | Continued From page 140<br>then placed the tomatoes on a cutting board and the surveyor informed Staff UU, Dietary Manager from a sister facility and Staff UU instructed Staff LL to throw the tomatoes away. At 5:55 p.m. Staff UU determined they had no sink for preparing food and staff tried to find out how to clean the sinks for food prep. Staff LL stated she did not know why she couldn't use the dishroom for food prep. At 6:05 p.m., while Staff UU attempted to clean the sinks, Staff LL tried to set the tomatoes down on the sink with cleaner on it. Staff UU intervened and educated Staff LL she could not set the tomatoes in the cleaner. Staff UU further educated Staff LL as she held the tomatoes with bare hands and she needed to wash hands and don gloves prior to handling the tomatoes. At 6:10 p.m. Staff OO started the meal service and used the same pair of gloves throughout the meal service to touch all hamburger buns and slices of cheese. Observation of the range hood and oven doors revealed them as covered with a large amount grease buildup, the steamer bottom with buildup of standing water and a blackish- orange substance.<br><br>3. Observation of the kitchen on 8/8/17, beginning at 7:20 a.m. to 9:00 a.m. and 9:20 to 1:00 p.m., revealed the following concerns:<br><br>a. An 8 ounce (oz.) can of Hormel Thick & Easy (powdered food thickener) held a scoop stored inside the can with the handle in contact with the product. During an additional observation on 8/9/17 at 10:50 a.m., the scoop remained inside the can and handle in contact with the product.<br><br>b. The Contracted Dietary Manager stationed at the steam table assisted with dishing breakfast | F 371 | | |

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| F 371 | Continued From page 141<br>meals. He donned gloves and touched multiple surfaces, including but not limited to the countertop, serving utensils and cart handles. He opened a package of bread and obtained 2 slices for service to a resident, with the potentially contaminated gloves, which had touched several different surfaces.<br><br>c. During these observation periods a large, garbage can located near the hand sink, paper storage shelf and steam table and a large garbage can near the end of the cooks table remained uncovered. An additional observation on 8/9/17 at 10:50 a.m. and 8/10/17, at 4:50 p.m., continued to show the garbage cans continued uncovered.<br><br>d. The walk-in cooler contained 2 fully thawed 5-lb packages of ground beef and did not have a date the product was stored to thaw. During an interview on 8/8/17 at 9:20 a.m., the Dietary Manager acknowledged it should be dated when placed in there to thaw and reported it would be discarded, since he did not know how long it had been there.<br><br>e. A utensil storage drawer in the cooks table stored several food portioning scoops, ladles and spoon and had an area in the front left corner that appeared soiled with a liquid and food debris. During an interview at the time, the Dietary Manager acknowledged the drawer needed to be cleaned, pulled the entire drawer out and placed it, along with all the utensils, near the 3 compartment sink for cleaning.<br><br>f. Two skillets, observed in use for food preparation, showed a heavy build up of black carbon build up on the outside and food contact | F 371 | | |

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| F 371 | Continued From page 142<br>portions. During an interview at the time, the Dietary Manager acknowledged the build up of grime on the skillets.<br><br>g. A large red cutting board, stored for use, revealed heavy wear and scoring on both sides with scattered dark stains. An additional observation on 8/9/17 at 10:50 a.m. showed the cutting board continued to be stored for use.<br><br>h. Staff N, Dietary Aide, assisted with noon meal service, washer her hands, donned gloves, opened the walk-in cooler and obtained sliced turkey and cheese. She used the gloved hands to unwrap the turkey and cheese and handled the slices and a hot dog bun to assemble a sandwich for service to a resident, after she had touched other surfaces with the gloves.<br><br>i. The Dietary Manager assisted with portioning food at the steam table for noon meal service. He donned gloves at the beginning of the meal service and touched multiple surfaces, including but not limited to, counter tops, serving utensils and cart handles. Toward the end of meal service he obtained a package of bread and handled 2 slices of bread for service to a resident, with the potentially contaminated gloves, which had touched multiple surfaces.<br><br>Review of an undated policy titled "Use of Plastic Gloves", identified gloves are like hands and must be changed anytime a contaminated surface is touched.<br><br>Review of a undated policy titled "Sanitization", provided as education to dietary staff, revealed in part "... all utensils, counters, shelves and equipment shall be kept clean, maintained in | F 371 | | |

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| F 371 | Continued From page 143<br>good repair and shall be free from breaks, corrosions, open seams, cracks and chipped ... kitchen wastes that are not disposed of by mechanical means shall be kept in ... tightly closed containers ... "<br><br>Review of a undated policy titled "Sanitization", provided as education to dietary staff, revealed in part "... Food preparation staff will adhere to proper hygiene and sanitary practices to prevent the spread of foodborne illness ... gloves can also become contaminated and/or soiled and must be changed between tasks ... Disposable gloves are single-use items and shall be discarded after each use ... "<br><br>The 2013 Food Code, published by the Food and Drug Administration and considered a standard of practice for the food service industry requires the following:<br><br>Food employees must wash their hands immediately before engaging in food preparation, including before donning gloves for working with food in order to prevent cross contamination when changing tasks. Single-use gloves are to be used for only one task, such as working with ready-to-eat food or with raw animal food, and used for no other purpose, and discarded when damaged or soiled, or when interruptions occur in the operation.<br><br>Garbage receptacles, containing food residue, must be kept covered inside food service establishment when not in continuous use.<br><br>If scoops are held in food that is not potentially hazardous, they must be stored with their handles above the top of the food within containers that | F 371 | | |

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| F 371 | Continued From page 144<br>can be closed, such as bins of sugar or flour.<br><br>Surfaces such as cutting boards, that are subject to scratching and scoring, need to be resurfaced if they can no longer be effectively cleaned and sanitized, or discarded if they are not capable of being resurfaced.<br><br>The food-contact surfaces of cooking equipment and pans shall be kept free of encrusted grease deposits and other soil accumulations. | F 371 | | |
| F 441 SS=D | 483.80(a)(1)(2)(4)(e)(f) INFECTION CONTROL, PREVENT SPREAD, LINENS<br><br>(a) Infection prevention and control program.<br><br>The facility must establish an infection prevention and control program (IPCP) that must include, at a minimum, the following elements:<br><br>(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 (facility assessment implementation is Phase 2);<br><br>(2) Written standards, policies, and procedures for the program, which must include, but are not limited to:<br><br>(i) A system of surveillance designed to identify possible communicable diseases or infections before they can spread to other persons in the facility; | F 441 | | |

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| F 441 | Continued From page 145<br><br>(ii) When and to whom possible incidents of communicable disease or infections should be reported;<br><br>(iii) Standard and transmission-based precautions to be followed to prevent spread of infections;<br><br>(iv) When and how isolation should be used for a resident; including but not limited to:<br><br>(A) The type and duration of the isolation, depending upon the infectious agent or organism involved, and<br>(B) A requirement that the isolation should be the least restrictive possible for the resident under the circumstances.<br><br>(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<br><br>(vi) The hand hygiene procedures to be followed by staff involved in direct resident contact.<br><br>(4) A system for recording incidents identified under the facility's IPCP and the corrective actions taken by the facility.<br><br>(e) Linens. Personnel must handle, store, process, and transport linens so as to prevent the spread of infection.<br><br>(f) Annual review. The facility will conduct an annual review of its IPCP and update their program, as necessary. | F 441 | | |

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| F 441 | Continued From page 146<br>This REQUIREMENT is not met as evidenced by:<br>Based on observations, facility procedure review and staff interviews, the facility failed to maintain an infection control program to prevent and control, to the extent possible, the onset and spread of infection within the facility by not following proper disinfecting procedures of a glucometer for 2 residents (Residents # 22 and #23). At the time of the survey, the facility reported a census of 90 residents and 15 current residents were selected for review.<br><br>Findings Included;<br><br>1. During observation on 8/8/17 at 7:55 a.m. Staff B Licensed Practical Nurse (LPN) entered Resident #22's room with a glucometer (to measure blood sugar), tissue, lancet, Humalog kwik pen (an insulin administration device) and alcohol prep pads. Staff B sat the items down on the resident's table on top of the tissue. Staff B then washed her hands, donned gloves, wiped the resident's finger with an alcohol swab, obtained a blood sample, wiped the first drop of blood away and placed the next on the test strip of the glucometer. Staff B dialed up the insulin dose and administered the insulin. Staff B then removed her gloves and took the glucometer, with the used test strip and lancet, back out to the medication cart and disposed of the lancet, test strip and needle and placed the resident's glucometer back into the medication stacking it next to other glucometers without cleaning the glucometer before storage.<br><br>During observation on 8/8/17 at 11:35 a.m. Staff B entered Resident #23's room with a glucometer, tissue, lancets, and alcohol prep | F 441 | | |

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| F 441 | Continued From page 147<br>pads. Staff B sat the items down on the resident's table on top of the tissue. Staff B washed her hands, donned gloves, cleansed the resident's finger with an alcohol swab, used a lancet to obtain blood sample, wiped the first drop of blood away and placed the next on the test strip of the glucometer. Staff B removed her gloves and took the glucometer, with the used test strip and lancet, back out to the medication cart and disposed of the lancet, test strip and needle and cleaned the glucometer with Micro-Kill One for 1 minute, placed the glucometer on top of a barrier to dry and returned the glucometer to the medication cart.<br><br>During an interview on 8/8/17 at 8:02 a.m. with Staff B stated she does not ever clean the glucometer since each resident had their own glucometers.<br><br>During an interview on 8/8/17 at 11:40 a.m. with Staff B stated she had questions about cleaning the glucometers and asked her supervisor. Staff B learned the glucometers needed to be cleaned with the Micro-Kill One and wiped for one minutes and let air dry.<br><br>During an interview on 8/9/17 at 9:10 a.m. the Director of Nursing stated staff need to clean the glucometers after each use even when the residents have their own glucometers since they are stored next to each other.<br><br>During an interview on 8/9/17 at 1:44 p.m. with Staff KK, Director of Clinical Services stated that when the glucometer are stored next to each other they would need to clean the glucometers just as it had been used as a multi-use glucometer. | F 441 | | |

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| F 441 | Continued From page 148<br><br>The facility procedure entitled Glucose Monitoring Disinfection, revised on 9/2016, provided general instructions as follows:<br>1. Gather equipment<br>2. Place equipment on bedside table/overbed table. Use paper towels as barrier between table and equipment prior to placing equipment on table.<br>3. Wash hands and put on a pair of gloves.<br>4. After performing the glucose test, throw used lancet and strip in sharps container.<br>5. Clean all external parts of the monitor with a Micro-Kill One wipe. Discard wipe.<br>6. Disinfect monitor be continually wiping or wrapping monitor with a second wipe to ensure contact time of 1 minute.<br>7. The disinfected monitor will be placed on a towel/ paper towel.<br>8. Gloves will be removed and hand wash performed.<br>9. The monitor will be placed in the medication cart or other clean storage area until needed.<br>2. The Minimum Data Set (MDS) assessment dated 5/25/17 identified diagnoses for Resident #2 that included arthritis, Parkinson's disease, depression and Non-Alzheimer's dementia (a deteriorating condition). According to the MDS, the resident required the assistance of 2 staff for bed mobility, transfers dressing and toilet use and the assistance of one staff with eating and personal hygiene. The MDS indicated the resident experienced severely impaired cognitive skills for daily decision-making<br><br>An observation on 8/8/17 at 2:15 p.m. revealed Staff C, CNA (certified nursing assistant) placed Resident #2's blanket and pressure reduction boots on the floor in the resident's room. Without | F 441 | | |

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| F 441 | Continued From page 149<br>gloves, Staff C removed dirty linen from the bed and placed the linen on the carpeted floor. Staff C then re-make the resident's bed with clean linen and did not wash hands between dirty and clean tasks. After Resident #2 transferred into bed, Staff C picked up blanket off the floor and pressure reduction boots and placed them on the resident to use. The boots and blanket were not cleaned after being on the floor prior to use on the resident.<br><br>An interview on 8/15/17 at 8:30 a.m. with the Director of Nursing (DON) revealed her expectations of bed making is hand hygiene when going from dirty to clean. During discussion of placing a blanket and pressure reduction boots on the floor, she stated would expect that nothing be placed on the floor especially those items to be reused on the resident. | F 441 | | |
| F 465 SS=F | 483.90(l)(5) SAFE/FUNCTIONAL/SANITARY/COMFORTABLE ENVIRON<br><br>(l) Other Environmental Conditions<br><br>The facility must provide a safe, functional, sanitary, and comfortable environment for residents, staff and the public.<br><br>(5) Establish policies, in accordance with applicable Federal, State, and local laws and regulations, regarding smoking, smoking areas, and smoking safety that also take into account non-smoking residents.<br>This REQUIREMENT is not met as evidenced by:<br>Based on observations and staff interview, the facility failed to maintain the kitchen environment | F 465 | | |

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| F 465 | Continued From page 150<br>in a safe, clean and sanitary manner. The facility identified a census of 90 residents.<br><br>Findings include:<br><br>1. Observation during the kitchen environment tour with the Dietary Manager on 8/8/17 beginning at 9:20 a.m., revealed the following concerns:<br><br>a. An area of the kitchen floor, to the side and under the convection oven revealed scattered food debris, dark brown grimy areas and a greasy feel underfoot.<br><br>b. The doors of the Southbend double convection oven had heavy grime build-up, especially at the lower portions of the doors, which felt greasy/sticky to the touch and had dark brown streaks coming from the bottom set of doors.<br><br>c. The Imperial gas stove had a build-up of grime on the doors, around the handles and below the doors with dark brown areas of grime extending below the doors and onto the floor.<br><br>d. The walk-in freezer floor appeared soiled and revealed a very sticky surface just inside the door, to the left side, extending to the shelving.<br><br>e. The dry storage room floor showed scattered food debris and heavily soiled areas around the perimeter of the room with the heaviest soil along the side of the walk-in cooler. The surface of the floor had a black substance in several areas by the walk-in side, which wiped off to the touch.<br><br>Additional observations on 8/9/17 at 10:50 a.m., revealed the condition of the identified concerns | F 465 | | |

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| F 465 | Continued From page 151<br>remained the same.<br><br>During an interview at the time, the Dietary Manager (DM) confirmed the soiled condition of the identified areas and acknowledged the department lacked and effective system to ensure cleaning activities are routinely completed.<br><br>During an interview on 8/8/17 at 1:05 p.m., Staff L, Cook, reported the previous DM had assigned cleaning duties to the staff position but acknowledged dietary staff were not required to sign off on them as completed and the DM did not ensure the duties were completed. Staff L acknowledged cleaning issues existed within the kitchen environment and attributed this partially to ineffective management and lack of time to complete the tasks.<br><br>During an interview on 8/8/17 at 1:35 p.m., the Consultant Dietitian reported she does a walk-through of the kitchen on each of her weekly visits, a portion of which addressed sanitation/cleaning issues. She acknowledged the department has ongoing problems with cleanliness in the kitchen and she's identified some of the same issues each week.<br><br>The 2013 Food Code, published by the Food and Drug Administration and considered a standard of practice for the food service industry requires the foodservice environment shall be cleaned as often as necessary to keep them clean.<br><br>2. A kitchen observation on 8/8/17 at 12:00 p.m., revealed the fire suppression system, under the stove hood, above the gas stove, showed the pipe extending the length of the stove, had 4 nozzles (to dispense the fire extinguishing | F 465 | | |

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| F 465 | Continued From page 152<br>material in the event the system was activated). The 4 nozzles angled outward at approximately a 45 degree angle away from the stove, and failed to be positioned in the downward position to extinguish a fire. During an additional observation on 8/9/17 at 10:50 a.m., the nozzles remained in the same position.<br><br>During an interview on 8/8/17 at 3:50 p.m., the Administrator and DM confirmed the position of the nozzles did not appear to be such that it would dispense the fire extinguishing material on the stove. This surveyor informed the Administrator contact had been made with the State Fire Marshal and he relayed to instruct the facility to contact their fire suppression system technician to remedy the situation.<br><br>During an interview on 8/9/17 at 3:05 p.m., the Administrator reported she had not contacted the suppression inspection company to inform them of the issue, but the Maintenance Director had returned to work that day and she would have him address it.<br><br>During an interview on 8/9/17 at 3:20 p.m., the Administrator and Maintenance Director reported the fire suppression system nozzles had been adjusted back to the downward position. The Maintenance Director believed the pipe had likely been moved inadvertently when a company came in and cleaned the stove hood last week.<br><br>Observation on 8/9/17 at 4:50 p.m. confirmed the fire suppression system nozzles had been angled back toward the stovetop. A sticker on the side of the stove hood identified A-1 Preferred cleaned the stove hood on 8/7/17. | F 465 | | |

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| F 465 | Continued From page 153<br>Observation of the stove hood fire suppression system, on 8/10/17 at 10:00 a.m., with the State Fire Marshall, Administrator and Maintenance Director, revealed the nozzles angled toward the stove top but failed to be at the required angle and a missing cap on one of the nozzles needed to be replaced. He informed the Administrator and Maintenance Director the fire suppression system technician should have been called to correct the situation, since the Maintenance Director is not certified to service the system. The State Fire Marshall instructed them to contact the technician and request service to have the cap replaced.<br><br>3. During a dietary observation on 8/1/17 at 1:05 p.m. the floor in the freezer showed multiple areas of dirt and felt sticky.<br><br>4. During a dietary observation on 8/1/17 at 5:55 p.m. Staff ZZ Maintenance man from another facility put on a lockout on the plug for the steamer. He stated he had been asked to come over and place the lockout since the steamer did not have an accurate temperature and was not safe to use. Staff ZZ had no idea on how long it did not work. | F 465 | | |
| F 469 SS=C | 483.90(i)(4) MAINTAINS EFFECTIVE PEST CONTROL PROGRAM<br><br>(i)(4) Maintain an effective pest control program so that the facility is free of pests and rodents. This REQUIREMENT is not met as evidenced by:<br>Based on group interview and observation, the facility failed to maintain effective control of flies in the building. The total sample size 15 current residents and the facility reported a census of 90. | F 469 | | |

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| F 469 | Continued From page 154<br><br>Findings include:<br><br>1. During the group interview on 8/2/17 at 1:15 p.m., 7 of 7 residents in attendance stated that flies were a recent problem and the flies bothered them.<br><br>2. Observation on 8/1/17 at 1:16 p.m. revealed numerous flies in the kitchen.<br><br>3. Observation on 7/31/17 at 5:55 p.m. revealed the dining room tables with plates of uneaten food on all tables and many flies everywhere.<br><br>Observation on 8/1/17 at 8:20 a..m. revealed an uncovered, full trash can by the dish sink in the kitchen and flies around. At 1:00 p.m., the trash remained uncovered in the kitchen with flies present.<br><br>Observation on 8/1/17 at 6:25 p.m. revealed a tall laundry basket present in the main dining room, without a liner or lid to cover, full of empty pop can and flies everywhere.<br><br>Observation on 8/2/17 at 12:05 p.m. flies remained flying around the full, uncovered garbage can with no lid in sight.<br><br>Observation on 8/7/17 at 9:00 p.m. revealed the North Nook dining room contained an uncovered basket full of empty pop cans, an uncovered full trash can and numerous flies flying. | F 469 | | |
| F 496 SS=D | 483.35(d)(4)-(6) NURSE AIDE REGISTRY VERIFICATION, RETRAINING<br><br>d)(4) Registry verification | F 496 | | |

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| F 496 | Continued From page 155<br><br>Before allowing an individual to serve as a nurse aide, a facility must receive registry verification that the individual has met competency evaluation requirements unless-<br><br>(i) The individual is a full-time employee in a training and competency evaluation program approved by the State; or<br><br>(ii)The individual can prove that he or she has recently successfully completed a training and competency evaluation program or competency evaluation program approved by the State and has not yet been included in the registry. Facilities must follow up to ensure that such an individual actually becomes registered.<br><br>(d)(5) Multi-State registry verification<br>Before allowing an individual to serve as a nurse aide, a facility must seek information from every State registry established under sections 1819(e)(2)(A) or 1919(e)(2)(A) of the Act the facility believes will include information on the individual.<br><br>(d)(6) Required retraining<br>If, since an individual's most recent completion of a training and competency evaluation program, there has been a continuous period of 24 consecutive months during none of which the individual provided nursing or nursing-related services for monetary compensation, the individual must complete a new training and competency evaluation program or a new competency evaluation program.<br>This REQUIREMENT is not met as evidenced by:<br>Based on personnel record review, policy review and staff interview, the facility failed to document | F 496 | | |

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| F 496 | Continued From page 156<br>registry verification for Certified Nurse's Aides (CNA) prior to the employment for 2 of 3 CNAs selected for review (Staff F and G). The facility identified a census 90 of residents.<br><br>Findings include:<br><br>Review of the personnel file for Staff F, CNA, showed a hire date of 5/10/17 for employment as a CNA. The personnel file contained a document titled Single Contact License & Background Check (SING), dated 5/3/17, which did not include the verification of eligibility to work as a CNA in Iowa. The file contained a document from the Direct Care Worker Registry Site search which identified Staff F eligible as a CNA but the document failed to identify the date it was done.<br><br>Review of the personnel file for Staff G, CNA , showed a hire date of 6/7/17 for employment as a CNA. Staff G's SING check dated 5/16/17 did not include the verification of eligibility to work as a CNA in Iowa. The file contained a document from the Direct Care Worker Registry Site search which identified Staff G eligible as a CNA but the document failed to identify the date it was done.<br><br>During an interview on 8/9/17 at 9:30 p.m., the Human Resources Coordinator confirmed she checked the Direct Care Worker Registry to verify Staff F and G's eligibility as CNAs prior to employment, but only knew how to print verification of eligibility in the view contained in the files which did not include the date. She acknowledged the documents failed to confirm the completion of registry checks prior to employment.<br><br>Review of a facility policy titled Abuse Prevention | F 496 | | |

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| F 496 | Continued From page 157<br>Plan, revised in June 2017, identified the facility will attempt to obtain information regarding a history of abuse, neglect or mistreatment of residents from appropriate licensing boards and registries, prior to a conditional offer of employment. | F 496 | | |
| F 497 SS=D | 483.35(d)(7) NURSE AIDE PERFORM REVIEW-12 HR/YR INSERVICE<br><br>(d)(7) Regular In-Service Education<br><br>The facility must complete a performance review of every nurse aide at least once every 12 months, and must provide regular in-service education based on the outcome of these reviews. In-service training must comply with the requirements of §483.95(g).<br>This REQUIREMENT is not met as evidenced by:<br>Based on personnel record review and staff interview, the facility failed to complete written employee performance evaluations for each individual nurse aide on at least an annual basis and failed to ensure nurse aides received education and training for 2 of 11 employees reviewed (Staff WW, Staff YY). The facility reported a census of 90 residents.<br><br>Findings include:<br><br>1. The untitled staff roster listed the following hire dates:<br>a. Staff WW, CMA (Certified Medication Aide) - 6/27/16<br>b. Staff YY, CNA (Certified Nurse Aide) - 3/28/16<br><br>Review of the employee files revealed no annual performance evaluations for Staff WW or Staff | F 497 | | |

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| F 497 | Continued From page 158<br>YY.<br><br>In an interview on 8/14/17 at 3:05 p.m., the Administrator confirmed the employee records lacked documentation of completion of annual performance evaluations. The Administrator stated the employee records lacked documentation of Staff WW or Staff YY receiving regular inservicing. The Administrator produced documentation that Staff WW attended one hour of inservicing. | F 497 | | |
| F 499 SS=D | 483.70(f)(1)(2) EMPLOY QUALIFIED FT/PT/CONSULT PROFESSIONALS<br><br>(f) Staff qualifications.<br><br>(1) The facility must employ on a full-time, part-time or consultant basis those professionals necessary to carry out the provisions of these requirements.<br><br>(2) Professional staff must be licensed, certified, or registered in accordance with applicable State laws.<br>This REQUIREMENT is not met as evidenced by:<br>Based on personnel record review, staff interviews and facility policy review, the facility failed to conduct nursing license verification before hiring 1 of 2 Licensed Practical Nurses (LPN) selected for review. The facility identified a census of 90 residents.<br><br>Findings include:<br><br>1. The personnel record for the Staff H, Licensed Practical Nurse (LPN), documented a hire date of 6/15/17. The personnel file contained a document | F 499 | | |

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| F 499 | Continued From page 159<br>titled Single Contact License & Background Check (SING), dated 6/13/17, which which did not include the verification of a valid nursing license.<br><br>During an interview on 8/9/17 at 9:30 a.m., the Human Resources Coordinator reported Staff F had a Pennsylvania LPN license upon hire and applied for an Iowa license on 6/15/17. The Human Resources Coordinator provided a document titled QuickConfirm License Verification Report, dated 8/8/17, which verified she had a valid Pennsylvania license and confirmed she just printed it yesterday.<br><br>Review of a facility policy titled Abuse Prevention Plan, revised in June 2017, identified the facility will attempt to obtain information regarding a history of abuse, neglect or mistreatment of residents from appropriate licensing boards and registries, prior to a conditional offer of employment. | F 499 | | |
| F 514 SS=D | 483.70(i)(1)(5) RES RECORDS-COMPLETE/ACCURATE/ACCESSIBLE<br><br>(i) Medical records.<br>(1) In accordance with accepted professional standards and practices, the facility must maintain medical records on each resident that are-<br><br>(i) Complete;<br><br>(ii) Accurately documented;<br><br>(iii) Readily accessible; and | F 514 | | |

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CENTERS FOR MEDICARE & MEDICAID SERVICES

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| F 514 | Continued From page 160<br>(iv) Systematically organized<br><br>(5) The medical record must contain-<br><br>(i) Sufficient information to identify the resident;<br><br>(ii) A record of the resident's assessments;<br><br>(iii) The comprehensive plan of care and services provided;<br><br>(iv) The results of any preadmission screening and resident review evaluations and determinations conducted by the State;<br><br>(v) Physician's, nurse's, and other licensed professional's progress notes; and<br><br>(vi) Laboratory, radiology and other diagnostic services reports as required under §483.50.<br>This REQUIREMENT is not met as evidenced by:<br>Based on clinical record review and staff interview, the facility failed to accurately document the disposition of narcotic medications after being signed out of the narcotic count for one resident (#3) and failed to document provision of treatments for another resident (#19) of 15 current residents reviewed. The facility reported a census of 90 residents.<br><br>Findings include:<br><br>1. The Minimum Data Set (MDS) assessment dated 7/20/17 for Resident #3 identified the resident entered the facility on 7/13/17. The MDS documented diagnoses that included diabetes, traumatic amputation of right great toe, history of diabetic foot ulcer and cellulitis (inflammation of | F 514 | | |

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| F 514 | Continued From page 161<br>cells). The MDS recorded the resident received scheduled and PRN (as needed) pain medications for pain management.<br><br>The Dismissal/Interagency Instruction Sheet dated 7/13/17 at 12:00 p.m. directed staff to administer Norco 5/325 (narcotic pain pill with 5 milligrams (mg) hydrocodone and 325 mg of Tylenol) one tab by mouth every 4 hours as needed for pain<br><br>The Progress Notes dated 7/13/17 at 6:20 p.m., written by Staff E, Unit Manager/Registered Nurse (RN), documented a general note. Staff E wrote she pulled 2 tabs of Norco 5/325 from the E-box per pharmacy Code #WC02IA15Y. The note did not indicate what Staff E did with the narcotic pain pills.<br><br>The Controlled Medication Utilization Records for Resident #3 documented 1 Norco 5 mg/325 mg tab signed out on the following dates and times in July 2017:<br>a. 7/15 at 1:50 a.m. by Staff AA, RN (Registered Nurse)<br>b. 7/15 at 8:20 a.m. by Staff Dd, CMA (Certified Medication Aide)<br>c. 7/16 at 4:00 p.m. by Staff U, LPN (Licensed Practical Nurse)<br>d. 7/16 at HS (bedtime) by Staff U, LPN<br>e. 7/19 at 1:00 a.m. by Staff H, LPN<br>f. 7/28 at 8:45 a.m. by Staff EE, CMA<br>g. 7/28 at 9:19 a.m. by Staff EE (documented the wrong date - should have been 7/29)<br>h. 7/29 at 11:55 p.m. by Staff Y, RN<br><br>The July 2017 Medication Administration Record (MAR) lacked documentation of Norco given on the correlating dates and times: | F 514 | | |

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| F 514 | Continued From page 162<br>a. 7/13 at anytime<br>b. 7/15 at 1:50 a.m. (Staff AA documented in the Progress Notes given a pain pill, but not what type)<br>c. 7/15 at 8:20 a.m. (nothing documented in the progress notes)<br>d. 7/16 at 4:23 p.m. (Staff U signed one dose on MAR but not 2nd HS dose)<br>e. 7/19 at 1:00 a.m. (nothing documented in the progress notes)<br>f. 7/28 at 9:19 a.m. (Staff EE signed out 2 pills this day, only documented one given on MAR)<br>g. 7/29 at 11:55 p.m. (but did Staff Y documented in the Progress Notes pain pill given)<br><br>On 8/9/17 at 11:23 a.m. a follow-up phone interview conducted with Staff H to ask why she signed out a narcotic on 7/19/17 at 1:00 a.m. but failed to document anywhere else that she gave the pain pill to the resident. Staff H stated she had no idea why she signed out a pill on the narcotic count sheet and said not going to own up to it. Staff H commented she guaranteed though, if she signed out a pill she gave it.<br><br>On 8/9/17 at 2:10 p.m., Staff H arrived at the facility for an in-person interview. Staff H stated she did not take the narcotic pain pill signed out on 7/19/17 at 1:00 a.m. Staff H verified her signature on that date and time. Staff H stated she did not know why she did not document on the MAR or in the nurses notes, but she guaranteed she gave the pain pill to the resident if she signed it out.<br><br>2. The MDS assessment dated 3/9/17 for Resident #19 identified diagnoses that included septicemia (blood infection), abscess of buttock and a non-pressure chronic ulcer of skin. | F 514 | | |

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| F 514 | Continued From page 163<br><br>The resident's Care Plan focus area dated 11/9/16 identified skin alterations on the resident's left and right buttocks. The care plan intervention dated 11/28/16 directed staff to complete treatments as ordered.<br><br>The Medication Review Report dated 4/14/17 documented active orders for the following treatments:<br>a. Anterior (genitalia): Cleanse wound base using normal saline and sterile gauze, pat dry; apply triple hydrophilic paste 3 mm (millimeter) thick with cotton swab applicator, twice daily<br>b. Bacitracin Zinc Ointment 500 unit/gm (gram); apply to (genital area) topically in the evening related to non-pressure chronic ulcer of skin<br>c. Change Foley (catheter) on the 23rd of every month<br>d. Left lower buttock, cleanse wound base with normal saline or saf-clens and sterile gauze and pat dry, apply 2 by 2 dakins quarter strength soaked gauze and cove with Mepilex border dressing; change dressing daily and as needed for looseness.<br>e. Neomy-Bacit-Polymyx-Pramoxine Ointment (antibiotic) 1%, apply to the left thigh topically every evening shift related to non-pressure chronic ulcer of skin.<br>f. Right lateral (genital area) and right posterior upper thigh wound care; cleanse wound base using NS (normal saline) and sterile gauze, pat dry, apply triad hydrophilic paste to wound bases on (genital area) and peri (around) wound 3 mm thick using cotton swab applicator in the evening for peri wounds.<br><br>The April 2017 Treatment Administration Record documented the above treatments, respectively | F 514 | | |

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| F 514 | Continued From page 164<br>listed a through f, were not completed as ordered on the following days:<br>a. 4/17, 4/20 and 4/23;<br>b. 4/17, 4/20 and 4/23;<br>c. 4/23;<br>d. 4/17, 4/20 and 4/23;<br>e. 4/20;<br>f. 4/17, 4/20 and 4/23.<br><br>The Progress Notes lacked documentation on any of the above dates regarding the treatments not being completed. | F 514 | | |
| F 520 SS=F | 483.75(g)(1)(i)-(iii)(2)(i)(ii)(h)(i) QAA COMMITTEE-MEMBERS/MEET QUARTERLY/PLANS<br><br>(g) Quality assessment and assurance.<br><br>(1) A facility must maintain a quality assessment and assurance committee consisting at a minimum of:<br><br>(i) The director of nursing services;<br><br>(ii) The Medical Director or his/her designee;<br><br>(iii) At least three other members of the facility's staff, at least one of who must be the administrator, owner, a board member or other individual in a leadership role; and<br><br>(g)(2) The quality assessment and assurance committee must :<br><br>(i) Meet at least quarterly and as needed to coordinate and evaluate activities such as identifying issues with respect to which quality assessment and assurance activities are | F 520 | | |

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| F 520 | Continued From page 165<br>necessary; and<br><br>(II) Develop and implement appropriate plans of action to correct identified quality deficiencies;<br><br>(h) Disclosure of information. A State or the Secretary may not require disclosure of the records of such committee except in so far as such disclosure is related to the compliance of such committee with the requirements of this section.<br><br>(I) Sanctions. Good faith attempts by the committee to identify and correct quality deficiencies will not be used as a basis for sanctions.<br>This REQUIREMENT is not met as evidenced by:<br>Based on survey history review, staff interview, and facility inservices record review, the facility failed to function effectively in their Quality Assurance (QA) program. The facility reported a current census of 90 residents.<br><br>Findings included:<br><br>1. Review of the survey results from 1/26/17 revealed the following deficiencies:<br><br>F156<br>F226<br>F241<br>F252<br>F279<br>F281<br>F282<br>F285<br>F309<br>F317 | F 520 | | |

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| F 520 | Continued From page 166<br>F323<br>F329<br>F353<br>F363<br>F371<br>F386<br>F496<br>F520<br><br>A complaint survey dated 4/4/17 revealed the following deficiencies:<br><br>F309<br>F364<br><br>During the present survey and complaint investigation the following repeat deficiencies re-occurred:<br><br>F241<br>F252<br>F309<br>F323<br>F329<br>F279<br>F281<br>F282<br>F353<br>F363<br>F371<br>F520<br><br>2. In an interview on 8/1/17 at 7:25 a.m., the Administrator reported she had received grievances from care conferences about food quality, pre-made foods like meatloaf and not attempting to follow the menus. The Administrator stated she reviewed in QA monthly. | F 520 | | |

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| F 520 | Continued From page 167<br>The Nursing Department Mandatory Meeting conducted 1/11/17 included documentation of the following concerns from a complaint survey:<br>III. F241 Dignity and Respect of Individuality<br>b. Cited for failing to knock on resident's door and gaining permission to enter<br>V. F279 Develop Comprehensive Care Pans<br>b. Cited for not updating care plans, not following care plans, not adding and implementing new interventions post falls<br>VI. F281 Services Provided Meet Professional Standards<br>VII. F312 ADL (Activities of Daily Living) Care Provided for Dependent Residents<br>b. Cited for not giving showers when scheduled<br>VIII. F314 Treatment/Services to Prevent/Heal Pressure Sores<br>b. Cited for not carrying out interventions to prevent pressure ulcers, not completing weekly skin assessments by a nurse and not documenting weekly skin assessments, not following Skin Program P&P (policy & procedure)<br>i. head to toe weekly skin checks by licensed nurse completed and documented findings.<br>ii daily observation by nurse aides checking especially pressure points (heels, ankles, knees, elbows, hips, coccyx, shoulder, etc.)<br>iii. Follow interventions on Kardex (elevating heels, turn and position)<br>IX. F323 Free of Accident Hazards/Supervision/Devices<br>b. cited for not assessing a wandering resident accurately, not following Elopement P&P<br>X. F363 Menus Meet Resident Needs/Prep In Advance/Followed<br>b. Cited for not following the menu/recipe and not giving residents all of their meal, omitting a pureed item. | F 520 | | |

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| F 520 | Continued From page 168<br>i. Must follow menus<br>ii. Must follow recipes<br>iii. Ensure all components of meal are on plate/tray<br>XI. F371 Food Procure, Store/Prepare/Sere-Sanitary<br>b. Cited for buildup on stove burners, grease build up on stove hood, deep fryer baskets dirty, debris on shelves, debris on scoop in drawer, spatulas with cracks in them. Dietary daily checklists with omissions, staff handling buns with bare hands and handled plates and ladle/scoop handles without washing hands.<br>XII. F425 Pharmaceutical Services - Accurate Procedures<br>b. Cited for a resident having pain scores of 6,7,8,9 and not administering prn (as needed) pain med<br>i. Managing pain<br>2. Use prns for breakthrough pain<br>ii. Notify supervisor if a med not available<br>1. Back up pharmacy<br>2. Emergency Kit<br>XIII. F465 Safe/Functional/Sanitary/Comfortable Environment<br>b. Cited for dust in window ledges, dirty coffee makers, plastic cup wedged into handrail with a dirty alcohol pad in it.<br><br>The All Staff Meeting conducted 2/7/17 included documentation of following concerns from the Annual Survey 2017:<br>I. Dignity/Resident Rights/Choices<br>II. Supervision/Falls<br>IV. GDR (Gradual Dose Reduction)<br>a. Document behaviors and non-pharmaceutical interventions so physicians can have reference to behavior issues and address the medication use appropriately. | F 520 | | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 165161 | A. BUILDING _____ B. WING _____ | 08/15/2017 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| TOUCHSTONE HEALTHCARE COMMUNITY | 1800 INDIAN HILLS DRIVE SIOUX CITY, IA 51104 |

| (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 520 | Continued From page 169<br>V. Call lights - not being answered timely.<br>a. NO ONE WALKS BY A CALL LIGHT!<br>b. leave call light on until need met<br>VI. Infection Control<br>VII. QA - medical director missed 1 meeting<br>IX. Sanitation - dirty microwave and temps low in the dishwasher in dietary<br>a. Housekeeping to clean daily<br>X. Care Plans - not up to date<br>XI. Physician's orders<br>XII. Assessment and Intervention - No bowel protocol, residents went several days with no BM (bowel movement) marked.<br>XIV. DHS (Department of Human Services) Criminal Background check - all steps not followed through the background check policy/regulation.<br>a. Staff may not work unless the entire process completed.<br>XV. CNA (Certified Nurse Aide) Registry - One staff member not checked upon hire.<br><br>The Mandatory Survey Education conducted 3/15/17 included training and documentation on the following:<br>I. F309 Provide Care/Services for Highest Well Being - did not assess and act on resident not eating, drinking, dehydrated.<br>a. Change of condition<br>ii. Listen to the families, they know when there is a change.<br>II. F323 Accidents and Supervision<br>III. F353 Sufficient 24 hour Nursing Staff per Care Plan<br>b. EVERYONE ANSWER CALL LIGHTS<br>c. Do not shut the call light off until needs are met<br>d. Managers completing audits daily to trend if longer wait times on specific shifts/times. | F 520 | | |

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 |
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|---|---|---|---|---|
| F 520 | Continued From page 170<br>e. Weekly Resident Council meeting to follow up with residents regarding call light wait times.<br>IV. F363 Menus Meet Resident Needs/Prep In Advance/Follow temps, recipes<br>V. F514 Records<br>Other:<br>a. Discharge Summary Recaps of stay must be completed on all patients that leave the facility even if deceased | F 520 | | |

F 166

**Immediate corrective action:**

Resident #3 discharge from facility 8/1/17.

**Action as it applies to others:**

The Grievance Policy and Procedure was reviewed and will be used to address resident concerns in a timely manner

Grievance Policy was reviewed with resident council 8/25/17.

Resident council agenda revised to ensure previous month's concerns are addressed.

All staff education on the Grievance Policy and Procedure was held on 9/13/17.

Staff members not in attendance at education sessions due to vacation, casual status, or FMLA will be educated upon their return, prior to their first shift worked.

**Date of completion: 9/14/17**

**Recurrence will be prevented by:**

Weekly resident interviews through the guardian angel program to address any concerns or grievances and their resolution x 30 days and brought to QAPI for review and recommendation.

**The correction will be monitored by:**

Administrator/Designee

F167 Survey results

**Immediate corrective action:**

Survey results from last 3 years are posted in facility.

Notice of availability of survey results is posted prominently in facility.

**Action as it applies to others:**

Surveys will be posted per requirement in an common area for residents and families to view.

Education was provided to the Administrator and DON on the survey posting requirements 8/24/17.

Staff members not in attendance at education sessions due to vacation, casual status, or FMLA will be educated upon their return, prior to their first shift worked.

**Date of completion: 9/14/17**

**Recurrence will be prevented by:**

Survey results posting will be audited weekly x 30 days. and brought to QAPI committee for review and recommendation.

**The correction will be monitored by:**

Administrator/Designee

F 226 Abuse Policies

**Immediate corrective action:**

Staff F DHS Clearance was obtained and placed in personnel file 8/22/17.

Staff I SING check was completed and placed in personnel file 8/9/17.

**Action as it applies to others:**

All personnel files were reviewed to ensure proper criminal & abuse background checks are documented.

HR Coordinator educated on importance of DHS clearance being obtained prior to start date and placing documentation in personnel file.

**Date of completion: 8/31/17**

**Recurrence will be prevented by:**

New hire personnel files will be audited weekly for proper DHS clearance x 30 days and brought to QAPI committee for review and recommendation.

**The correction will be monitored by:**

Administrator/Designee

F241 Dignity

**Immediate corrective action:**

Electronic device use policy will be reviewed with resident council 9/14/17.

Grievance form was utilized to address and resolve resident #14 concern.

Staff A was counseled regarding wearing headphones in resident care areas

Staff U was unable to be identified.

Resident # 20 concern was investigated internally; staff member was suspended pending investigation. Staff member no longer works at facility.

**Action as it applies to others:**

Staff educated on promptly attending to resident needs.

Education provided to all staff regarding providing dignity to residents, including not wearing headphones while working.

Staff members not in attendance at education sessions due to vacation, casual status, or FMLA will be educated upon their return, prior to their first shift worked.

**Date of completion: 9/14/17**

**Recurrence will be prevented by:**

Weekly observation audits of staff and resident interactions, to include during med pass will be completed x30 days and brought to QAPI committee for review and recommendation.

**The correction will be monitored by:**

DON/Designee

F252 Safe/Clean Environment

**Immediate corrective action:**

Aspenwood linen carts will be stored in soiled utility rooms until delivered to laundry.

Lizard Tank was cleaned 8/15/17.

Bird Cage was cleaned 9/2/17.

Ceiling Tiles above ice machine were replaced 8/28/17.

Southside nook floor will continue to be cleaned daily.

Daisy lane spa room wall and floor tiles were repaired 8/31/17.

Marred walls on Daisy lane were repaired 9/1/17.

Resident # 21 room floor continues to be cleaned daily.

Marred areas on walls were repaired in Ginger hall 9/1/17.

Grievance form was utilized to address and resolve resident concern regarding air conditioner.

**Action as it applies to others:**

Education Provided to Maintenance regarding regular rounding in facility for needed repairs.

Environmental rounds of facility were completed 8/28/17 to address any like issues.

**Date of completion: 9/14/17**

**Recurrence will be prevented by:**

Weekly environmental rounds will be completed x 30 days and brought to QAPI Committee for review and recommendation.

**The correction will be monitored by:**

Administrator/Designee

F 279 Comprehensive Care Plans

**Immediate corrective action:**

Bed mobility and transfer care plans were updated for residents #12, 4 and 5.

**Action as it applies to others:**

All residents transfer care plans reviewed for accuracy and consistency with transfer assessment and kardex.

Education provided to nursing staff regarding transfers and bed mobility per the care plan, kardex.

Staff members not in attendance at education sessions due to vacation, casual status, or FMLA will be educated upon their return, prior to their first shift worked.

**Date of completion: 9/14/17**

**Recurrence will be prevented by:**

Weekly observation audits of transfers will take place x30 days and brought to QAPI Committee for review and recommendation.

**The correction will be monitored by:**

DON/designee

F281 Professional Standards

**Immediate corrective action:**

All medications will be given to residents # 14 and 20 as ordered.

Resident 24 receives medications administered by qualified staff only.

Resident # 5 discharged from facility 8/31/17

**Action as it applies to others:**

Dietary staff have been educated not to deliver food or beverage containing medications.

All staff educated regarding Medications administered only by licensed nurses or certified medication aides.

Nursing staff have been educated to watch residents take medications and not leave them at the bedside.

Staff members not in attendance at education sessions due to vacation, casual status, or FMLA will be educated upon their return, prior to their first shift worked.

**Date of completion: 9/14/17**

**Recurrence will be prevented by:**

Weekly observation audits of med pass will be completed x 30 days and brought to QAPI committee for review and recommendation.

**The correction will be monitored by:**

**DON/Designee**

F282 Services per care plan

**Immediate corrective action:**

Resident #2 pressure relieving boots applied per care plan.

Resident #2 care plan reviewed and updated.

Resident #4 care plan reviewed and followed.

**Action as it applies to others:**

Nursing Staff educated regarding following care planned interventions.

Staff members not in attendance at education sessions due to vacation, casual status, or FMLA will be educated upon their return, prior to their first shift worked.

**Date of completion: 9/14/17**

**Recurrence will be prevented by:**

Weekly observation audits will be completed to ensure care planned interventions are in place x 30 days and brought to QAPI committee for review and recommendation.

**The correction will be monitored by:**

DON/Designee

F283 Discharge Summary

**Immediate corrective action:**

Resident #17 discharged from facility 5/20/2017.

Resident # 18 discharged from facility 6/23/2017.

Discharge summaries with recapitulation of stay were completed for residents # 3, 19.

**Action as it applies to others:**

All discharged resident records in the last 3 months were reviewed to ensure discharge summary and disposition of medications at discharge was completed.

Nursing staff responsible for completing discharges were re-educated on completing discharge summaries with recapitulation of stay and documenting disposition of medications.

Staff members not in attendance at education sessions due to vacation, casual status, or FMLA will be educated upon their return, prior to their first shift worked.

**Date of completion: 9/14/17**

**Recurrence will be prevented by:**

Discharged resident charts will be audited weekly for disposition of medications and completed discharge summaries x 30 days and brought to QAPI Committee for review and recommendation.

**The correction will be monitored by:**

DON/Designee

F309 Quality of Care

**Immediate corrective action:**

Resident #3 discharged 8/1/17.

Resident #7 bowel sounds and care plan assessed.

**Action as it applies to others:**

Nursing staff were re-educated regarding pain assessment and interventions.

Nursing staff were re-educated regarding bowel protocol.

Staff members not in attendance at education sessions due to vacation, casual status, or FMLA will be educated upon their return, prior to their first shift worked.

**Date of completion: 8/31/17**

**Recurrence will be prevented by:**

Weekly resident interview audits regarding pain will be completed x 30 days and brought to QAPI Committee for review and recommendation.

Weekly audits to ensure compliance with bowel protocol will be completed x 30 days and brought to QAPI committee for review and recommendation.

**The correction will be monitored by:**

DON/Designee

F 312 Bathing

**Immediate corrective action:**

Toileting care plans have been reviewed and are being followed for residents #1 & 9

Bathing assistance is being provided per resident preference for residents # 7, 11, 12, 2, & 9.

Resident # 3 discharged from facility 8/1/17

**Action as it applies to others:**

All residents interviewed and bathing schedules updated per their preferences.

Education was provided to nursing staff regarding Bathing schedule and process for documentation.

Education was provided to nursing staff regarding toileting residents per care plan.

Staff members not in attendance at education sessions due to vacation, casual status, or FMLA will be educated upon their return, prior to their first shift worked.

**Date of completion: 9/14/17**

**Recurrence will be prevented by:**

Weekly bathing audits will be completed x 30 days and brought to QAPI Committee for review and recommendation.

Weekly toileting audits will be completed x 30 days and brought to QAPI Committee for review and recommendation.

**The correction will be monitored by:**

DON/Designee

F 314 PU

**Immediate corrective action:**

Wound assessments are being completed for resident # 13 per policy

**Action as it applies to others:**

The facility Skin Program was reviewed and remains current.

All residents with Pressure Ulcers' Skin assessments have been reviewed to assure they are current and accurate and new assessments completed if indicated. All treatments were be reviewed to assure they are accurate and on Care Plan/kardex.

Nursing staff were re-educated regarding following care planned interventions.

Staff members not in attendance at education sessions due to vacation, casual status, or FMLA will be educated upon their return, prior to their first shift worked.

**Date of completion: 9/14/17**

**Recurrence will be prevented by:**

Weekly observations of care planned skin integrity interventions being in place will be completed x 30 days and brought to QAPI committee for review and recommendation.

**The correction will be monitored by:**

DON/Designee

F 323 Accident Hazards/Supervision

**Immediate corrective action:**

Resident #3 was with daughter who had taken her to the ER without alerting staff. Daughter brought resident back to facility after ER visit without incident.

Resident #3 discharged from facility 8/1/17.

Nurses X & U were not identified.

Resident #20 was interviewed to determine when and who offered resident wrong medications for further investigation.

**Action as it applies to others:**

The Policy and Procedure on Facility Rounding was reviewed and is used to ensure adequate supervision for residents.

All licensed nurses and trained medication aides were re-educated on the locking of medication and treatment carts.

Nursing staff were re-educated on the Resident Rounding policy and communication sheets.

Staff members not in attendance at education sessions due to vacation, casual status, or FMLA will be educated upon their return, prior to their first shift worked.

**Date of completion: 8/31/17**

**Recurrence will be prevented by:**

Weekly observation audits of Med & treatment carts being locked will be completed x 30 days

Weekly audits of shift to shift communication sheets and rounding will be completed x 30 days

The results of the audits will be brought to the QAPI Committee for review and recommendation

**The correction will be monitored by:**

DON/Designee

F 329 Unnecessary Medications

**Immediate corrective action:**

Non-pharmacological interventions added to care plan & MAR for Resident #7.

Resident # 16 discharged from facility 5/1/2017.

**Action as it applies to others:**

All residents utilizing antipsychotic medications PRN were reviewed for appropriateness of schedule and non-pharmacological interventions

Any PRN antipsychotic medications not administered in the past 30 days were requested to be discontinued.

Nursing staff will be re-educated on the Antipsychotic medication policy and the need for non-pharmacological interventions tried prior to use of the PRN Antipsychotic.

Staff members not in attendance at education sessions due to vacation, casual status, or FMLA will be educated upon their return, prior to their first shift worked.

**Date of completion: 9/14/17**

**Recurrence will be prevented by:**

Weekly audits of the MAR & nursing documentation to ensure non-pharmacological interventions tried prior to administering PRN antipsychotic medications.

**The correction will be monitored by:**

DON/Designee

F 353 Sufficient Staffing

**Immediate corrective action:**

Appropriate staffing levels are maintained.

**Action as it applies to others:**

Call Light Response times was added to resident council agenda on an ongoing basis for discussion.

Staffing Patterns are assessed regularly in Staffing Meeting. During this meeting, expected census changes on each unit as well as acuity are assessed for the upcoming days and staffing changes made as appropriate.

Additional Walkie Talkies were purchased for check out to staff to ensure that they are able to communicate about resident care needs and hear when they are summoned for assistance.

All Staff were educated regarding timely response to call lights. All Staff are expected to respond to call lights.

Staff members not in attendance at education sessions due to vacation, casual status, or FMLA will be educated upon their return, prior to their first shift worked.

**Date of completion: 8/31/17**

**Recurrence will be prevented by:**

Weekly call light response times audits will be completed x 30 days and brought to QAPI committee for review and recommendation.

**The correction will be monitored by:**

DON/Designee

F 361 Dietary Manager

**Immediate corrective action:**

The prior DM was removed from duty for failure to manage her duties satisfactorily 7/8/17.

An Interim Dietary Manager was contracted with for coverage on 8/7/17.

A permanent Dietary Manager was hired 9/6/17 and will begin employment & training 9/13/17.

**Action as it applies to others:**

The Dietician visits the facility weekly to provide consultation to the Dietary Manager.

The Dietician assists with menu planning, nutritional assessments, weight monitoring and interventions for skin concerns.

The Dietician will assist the Dietary Manager in assuring the duties of meal preparation, food ordering, menu planning, staffing and kitchen cleanliness are operating effectively.

**Date of completion: 9/14/17**

**Recurrence will be prevented by:**

Training and development of newly hired Dietary Manager.

Ongoing oversight of the dietary department by administrator and dietician.

**The correction will be monitored by:**

Administrator/Designee

F 362 Sufficient Staff in Dietary

**Immediate corrective action:**

A review of the staffing levels in kitchen along with assigned duties was completed on 8/18/17.

**Action as it applies to others:**

Based on the review of scheduled staff in kitchen and duties assigned it was determined there is a need to provide accountability for excessive absenteeism or tardiness.

Dietary staff were all in-serviced regarding attendance policy, sufficient staff to provide residents with organized, timely meal service.

**Date of completion: 9/14/17**

**Recurrence will be prevented by:**

Dietary schedule will be audited weekly for adequate staffing pattern

**The correction will be monitored by:**

Administrator/Designee

F 363 Menus

**Immediate corrective action:**

Menus will be followed as posted and if an item is not available for any reason a substitution will be made of same or higher nutritional value in same food group.

Grievances were completed to address and resolve food concerns for residents #14 & 20.

Dining Council instituted, first meeting held 9/6/17 to address resident dining and food concerns on an ongoing basis.

**Action as it applies to others:**

The Policy and Procedure for following posted menu and acceptable substitutions was reviewed and is used to ensure facility meets nutritional needs of residents.

Education was provided to dietary staff to assure menus are followed and what an acceptable substitute would be should an item not be available for whatever reason.

The Dietician will continue to work with the Dietary Manager on menu planning and food ordering.

**Date of completion: 8/31/17**

**Recurrence will be prevented by:**

Weekly audits of menu adherence and food item availability will be completed x 30 days and brought to the QAPI Committee for review and recommendation.

**The correction will be monitored by:**

Administrator/Designee

F 368 HS Snacks

**Immediate corrective action:**

HS snacks are available on all units.

Meals are served timely per scheduled meal times.

Grievance form used to address and resolve resident #20 concerns regarding snacks.

**Action as it applies to others:**

The Policy and Procedure for HS snacks was reviewed and ensures satisfying snacks for residents.

Pureed snacks are offered.

Education provided to dietary on HS snacks and timely meal service

**Date of completion: 9/14/17**

**Recurrence will be prevented by:**

Timeliness of meal service interview/audit will be completed weekly x 30 days and brought to QAPI committee for review and recommendation.

**The correction will be monitored by:**

DON/Dietary Manager

F 371 Kitchen Sanitation

**Immediate corrective action:**

Knife rack in kitchen was dusted 8/15/17.

Ceiling vents in kitchen were cleaned

Oven was cleaned 9/5/17.

Microwaves in nook areas and kitchen were cleaned 9/9/17.

Ice chests were replaced 8/4/17.

Can opener and floor beneath were cleaned 9/5/17.

Skillet Pans replaced 9/4/17.

Red Cutting board disposed of 9/4/17.

Garbage cans are covered when not being actively used for food preparation.

**Action as it applies to others:**

Education provided to dietary staff on glove use and hand hygiene

Education provided to dietary staff regarding not storing scoops in contents of container.

Education provided to dietary staff about proper sanitation.

**Date of completion: 9/14/17**

**Recurrence will be prevented by:**

Weekly sanitation audits of kitchen will be completed x 30 days and brought to QAPI committee for review and recommendation.

**The correction will be monitored by:**

Administrator/Designee

F441 Infection Control

**Immediate corrective action:**

Resident # 22 glucometer has been placed in an individual container

Resident #23 glucometer has been placed in an individual container

All resident glucometers have been placed in individual containers.

**Action as it applies to others:**

The Infection Control Policy which includes Glucometer cleaning and storage as well as prevention of contamination by not using items which have fallen onto floor was reviewed and remains current.

Nursing staff have been re-educated regarding infection control to include; linen handling, hand hygiene, individual glucometer policy and glucometer cleaning

**Date of completion: 9/14/17**

**Recurrence will be prevented by:**

Glucometer cleaning/infection control audits will be completed weekly

**The correction will be monitored by:**

DON/Designee

F 465 Safe/Functional Environment

**Immediate corrective action:**

Kitchen floor under and to the side of convection oven was cleaned 9/5/17.

Doors of the southbend double convection oven were cleaned 9/5/17.

Imperial gas stove doors and handles were cleaned 9/5/17.

Walk-in freezer floor was cleaned 9/5/17.

Dry storage room floor was cleaned 9/3/17.

stove hood fire suppression system was assessed by technician, nozzle cap replaced 8/15/17.

**Action as it applies to others:**

The checklists for assigned cleaning duties was reviewed by Dietary Manager and Dietician and is current and accurate.

Dietary Staff re-educated regarding scheduled cleaning of kitchen.

**Date of completion: 9/14/17**

**Recurrence will be prevented by:**

Weekly sanitation audits of kitchen will be completed weekly x 30 days and brought to QAPI Committee for review and recommendation.

**The correction will be monitored by:**

Administrator/Designee

F 469 Pest Control

**Immediate corrective action:**

Pest Control has been added to the agenda for monthly resident council meeting

Presto X was consulted and serviced facility 8/2 and 8/22.

Trash cans have been covered

Pop can baskets have been removed from dining room and northside nook area.

**Action as it applies to others:**

The facility is under contract for monthly visits by the Pest Control company which will continue.

Maintenance Director will assess the need of additional visits as indicated.

**Date of completion: 9/14/17**

**Recurrence will be prevented by:**

Weekly observation audits to ensure no pervasive pests will take place weekly x 30 days and brought to QAPI committee for review and recommendation

**The correction will be monitored by:**

Administrator/Designee

F 496 Certifications and Licenses

**Immediate corrective action:**

Staff F verification of eligibility to work as a C.N.A in Iowa was obtained and placed in personnel file.

Staff G verification of eligibility to work as a C.N.A in Iowa was obtained and placed in personnel file.

**Action as it applies to others:**

All CNA staff files were reviewed to assure all registry verifications are present and current.

HR Coordinator educated on importance of DHS clearance being obtained prior to start date, evidence in personnel file

**Date of completion: 9/14/17**

**Recurrence will be prevented by:**

Weekly audits of New Hire personnel files will be completed to ensure DHS clearance prior to start date x 30 days. The results of these audits will be brought to QAPI committee for review and recommendation.

**The correction will be monitored by:**

Adminstrator/Designee

F 497 Nurse Aide Performance Reviews

**Immediate corrective action:**

Staff WW performance Evaluation completed 8/31/17.

Staff YY was not identified.

**Action as it applies to others:**

All employee personnel files were audited to ensure annual performance evaluations were present

A system for providing and tracking annual in-service hours has been implemented.

**Date of completion: 9/14/17**

**Recurrence will be prevented by:**

Employee Anniversaries will be audited weekly to ensure compliance with annual performance reviews. The results of these audits will be brought to QAPI Committee for review and recommendation.

**The correction will be monitored by:**

Administrator/Designee

F499 Licenses

**Immediate corrective action:**

Staff H LPN License verified, placed in personnel file.

Staff F is identified earlier in 2567 as a C.N.A.

**Action as it applies to others:**

All personnel files audited to ensure appropriate license verifications present.

HR Coordinator educated on importance of obtaining license verification prior to start date for licensed professionals, and place the evidence in personnel files.

**Date of completion: 9/14/17**

**Recurrence will be prevented by:**

New Hire personnel files will be audited weekly to license verification prior to start date. The results of these audits will be brought to QAPI Committee for review and recommendation

**The correction will be monitored by:**

Administrator/Designee

F514 Maintaining accurate records

**Immediate corrective action:**

Narcotic count sheets and EMAR's were reviewed to assure they coincide.

Resident #3 discharged from facility 8/1/17.

Resident #19 discharged from facility 5/1/17.

**Action as it applies to others:**

The Policy and Procedure for Narcotic sign out and administration was reviewed and will accurately document disposition of narcotics.

Nursing Staff have been re-educated regarding accurate record keeping, proper documentation for disposition of narcotic medications and documentation of treatments.

**Date of completion: 9/14/17**

**Recurrence will be prevented by:**

Weekly audits of narcotic count sheets and treatment records will be completed x 30 days and brought to QAPI committee for review and recommendation.

**The correction will be monitored by:**

DON/Designee

F 520 QAPI

**Immediate corrective action:**

An Ad Hoc QAPI meeting was held to develop a plan of action for deficient practices 8/25/17.

**Action as it applies to others:**

Additional training on the QAPI process was provided for the QAPI Team members by the Director of Customer Service & Quality Management 9/7/17.

All areas found to be deficient in most recent State survey will be reviewed for Root Cause, Action Plans, and audits to ensure corrections are sustained.

**Date of completion: 9/14/17**

**Recurrence will be prevented by:**

Corporate staff will participate in monthly QAPI meeting x 3 months to ensure sustainability of plans.

Deficient areas will be audited x 30 days to review corrections are sustained.

**The correction will be monitored by:**

Administrator/Designee

DEPARTMENT OF INSPECTIONS AND APPEALS

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | IA0429 | A. BUILDING: _____ B. WING _____ | 08/15/2017 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| TOUCHSTONE HEALTHCARE COMMUNITY | 1800 INDIAN HILLS DRIVE SIOUX CITY, IA 51104 |

| (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) COMPLETE DATE |
|---|---|---|---|---|
| L 257 | 58.12(1) Admission, transfer, and discharge<br><br>481-58.12(135C) Admission, transfer, and discharge.<br>58.12(1) General admission policies.<br><br>This Statute is not met as evidenced by:<br>Based on facility record review and staff interview, the facility failed to report 3 of 3 resident admissions to the Iowa Department of Veteran Affairs (Residents #5, #25 and #26) within 30 days from admission. The facility reported a census of 90 residents.<br><br>Findings include:<br><br>During an interview on 8/8/17 at 4:40 p.m., the Administrator reported she did not have a log-in to the Veterans Affairs (VA) web site and had been trying to get one. She stated she did not know of anyone in the building with a log in to the VA web site or in charge of the process. She acknowledged the process may be an issue.<br><br>On 8/14/17 at 1:40 p.m., the Administrator stated the facility did not have anyone entering the resident information into the VA web site. She stated the Interim Administrator entered all the eligible residents into the system on 8/11/17 and he reviewed the admission questions or interviewed the residents.<br><br>Review of the facility's Iowa Department of Veterans Affairs Resident Eligibility Current Resident Status report dated 8/9/17 did not contain any VA status checks for residents admitted to the facility since 1/26/17. The report documented that Resident #5 entered the facility on 3/15/17, Resident # 25 entered the facility on | L 257 | | |

DEPARTMENT OF INSPECTIONS AND APPEALS

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | IA0429 | A. BUILDING: _____ B. WING _____ | 08/15/2017 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| TOUCHSTONE HEALTHCARE COMMUNITY | 1800 INDIAN HILLS DRIVE SIOUX CITY, IA 51104 |

| (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) COMPLETE DATE |
|---|---|---|---|---|
| L 257 | Continued From page 1<br>2/16/17 and Resident #26 entered the facility on 3/20/17. | L 257 | | |
| L 435 | 58.20(13) Duties of health service supervisor<br><br>481-58.20(135C) Duties of health service supervisor. Every nursing facility shall have a health service supervisor who shall:<br>58.20(13) Evaluate in writing the performance of each individual on the health care staff on at least an annual basis. This evaluation shall be available for review in the facility to the department; (III)<br><br>This Statute is not met as evidenced by:<br>Based on personnel record review and staff interview, the facility failed to complete written employee performance evaluations for each health care staff on an annual basis for 1 of 2 nurse employee files reviewed (Staff XX). The facility reported a census of 90 residents.<br><br>Findings include:<br><br>1. The untitled staff roster listed the following hire date:<br>a. Staff XX, LPN (Licensed Practical Nurse) - 3/21/16<br><br>Review of the employee files revealed no performance evaluations for Staff XX.<br><br>In an interview on 8/14/17 at 3:05 p.m., the Administrator confirmed Staff XX's employee file lacked documentation of completion of an annual performance evaluation. | L 435 | | |

L 257 Admission, Transfer and Discharge

**Immediate corrective action:**

Resident #5, 25 and 26's admissions have been reported to the Iowa Department of Veterans Affairs

**Action as it applies to others:**

All admitted residents where interviewed regarding their veteran status.

Those residents who identified as having a veteran status had their information entered into the electronic IDVA reporting system.

**Date of completion: 9/14/17**

**Recurrence will be prevented by:**

Weekly audits of new admissions will be completed x 30 days and brought to QAPI committee for review and recommendation.

**The correction will be monitored by:**

Administrator/Designee

L 435 Performance Evaluations

**Immediate corrective action:**

Staff XX was not identified.

**Action as it applies to others:**

All personnel files were audited to ensure annual performance evaluations were present.

**Date of completion: 9/14/17**

**Recurrence will be prevented by:**

Weekly audits of employee anniversaries will be completed x 30 days and brought to QAPI committee for review and recommendation.

**The correction will be monitored by:**

Administrator/Designee