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
	165249	A. BUILDING _____ B. WING _____	06/12/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOOD SAMARITAN SOCIETY - NEWELL	416 WEST HIGHWAY 7 NEWELL, IA 50568

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 000	INITIAL COMMENTS The following deficiencies are the result of the recertification survey completed June 9-12, 2019. See Code of Federal Regulations (42CFR) Part 483, Subpart B-C. Correction Date_____	F 000		
F 625 SS=D	Notice of Bed Hold Policy Before/Upon Tmsfr CFR(s): 483.15(d)(1)(2) §483.15(d) Notice of bed-hold policy and return- §483.15(d)(1) Notice before transfer. Before a nursing facility transfers a resident to a hospital or the resident goes on therapeutic leave, the nursing facility must provide written information to the resident or resident representative that specifies- (i) The duration of the state bed-hold policy, if any, during which the resident is permitted to return and resume residence in the nursing facility; (ii) The reserve bed payment policy in the state plan, under § 447.40 of this chapter, if any; (iii) The nursing facility's policies regarding bed-hold periods, which must be consistent with paragraph (e)(1) of this section, permitting a resident to return; and (iv) The information specified in paragraph (e)(1) of this section. §483.15(d)(2) Bed-hold notice upon transfer. At the time of transfer of a resident for hospitalization or therapeutic leave, a nursing facility must provide to the resident and the resident representative written notice which specifies the duration of the bed-hold policy described in paragraph (d)(1) of this section.	F 625		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE 7.1.19

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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F 625	Continued From page 1 This REQUIREMENT is not met as evidenced by: Based on record review and staff interview, the facility failed to provide written information to the resident's representative at the time of transfer for 1 of 4 residents reviewed (Resident #20). The facility reported a census of 28 residents. Findings include: According to the Minimum Data Set (MDS) assessment, dated 2/8/19, Resident #20 was rarely/never understood and had severely impaired skills for daily decision making. The resident's diagnoses included Cerebral Palsy and a Seizure Disorder. The Progress Notes dated 2/10/19 documented the facility received a call from the hospital to update the nurse about the resident's admission to the hospital. The resident's clinical record lacked documentation of giving the resident's representative notice of the facility bed hold policy. During an interview on 6/11/19 at 1:45 p.m. the Social Services designee stated she did not have a bed hold notice for the resident's transfer and admission to the hospital.	F 625		
F 637 SS=D	Comprehensive Assessment After Signifcant Chg CFR(s): 483.20(b)(2)(ii) §483.20(b)(2)(ii) Within 14 days after the facility determines, or should have determined, that there has been a significant change in the resident's physical or mental condition. (For	F 637		

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F 637	Continued From page 2 purpose of this section, a "significant change" means a major decline or improvement in the resident's status that will not normally resolve itself without further intervention by staff or by implementing standard disease-related clinical interventions, that has an impact on more than one area of the resident's health status, and requires interdisciplinary review or revision of the care plan, or both.) This REQUIREMENT is not met as evidenced by: Based on record review and staff interview the facility failed to complete a comprehensive assessment after a significant change for 1 of 14 resident's reviewed (Resident #2). The facility reported a census of 28. Findings include: According to the Minimum Data Set (MDS) with assessment reference date of 5/28/19 Resident #2 had a Brief Interview for Mental Status Score (BIMS) of 6, indicating severe cognitive impairment. The resident showed an improvement in transfers, personal hygiene, verbal behaviors, and bowel continence. The resident had diagnoses Dementia and Hypertension. The Assessment Validation included a warning that indicated the significant change. The warning had been acknowledged on 6/4/19 by the MDS Coordinator. During an interview on 6/11/19 at 11:58 a.m., the Director of Nursing reported that a significant change should be completed if a change occurred in two or more areas per the Resident Assessment Instrument (RAI) Manual.	F 637		
F 655	Baseline Care Plan	F 655		

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F 655 SS=D	Continued From page 3 CFR(s): 483.21(a)(1)-(3) §483.21 Comprehensive Person-Centered Care Planning §483.21(a) Baseline Care Plans §483.21(a)(1) The facility must develop and implement a baseline care plan for each resident that includes the instructions needed to provide effective and person-centered care of the resident that meet professional standards of quality care. The baseline care plan must- (i) Be developed within 48 hours of a resident's admission. (ii) Include the minimum healthcare information necessary to properly care for a resident including, but not limited to- (A) Initial goals based on admission orders. (B) Physician orders. (C) Dietary orders. (D) Therapy services. (E) Social services. (F) PASARR recommendation, if applicable. §483.21(a)(2) The facility may develop a comprehensive care plan in place of the baseline care plan if the comprehensive care plan- (i) Is developed within 48 hours of the resident's admission. (ii) Meets the requirements set forth in paragraph (b) of this section (excepting paragraph (b)(2)(i) of this section). §483.21(a)(3) The facility must provide the resident and their representative with a summary of the baseline care plan that includes but is not limited to: (i) The initial goals of the resident. (ii) A summary of the resident's medications and	F 655		

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F 655	Continued From page 4 dietary instructions. (iii) Any services and treatments to be administered by the facility and personnel acting on behalf of the facility. (iv) Any updated information based on the details of the comprehensive care plan, as necessary. This REQUIREMENT is not met as evidenced by: Based on record review, observation, and interviews the facility failed to develop and implement a baseline care plan within 48 hours of admission or provided a written summary to the resident or the resident representative for 3 of 14 residents reviewed (Resident #30, Resident #19, and Resident #12). The facility reported a census of 28. Findings include: 1. According to the Minimum Data Set (MDS) with an assessment reference date (ARD) of 5/20/19, Resident #30 had a Brief Interview for Mental Status (BIMS) score of 13, indicating intact cognition. The resident had diagnoses Renal Insufficiency and Diabetes Mellitus. The resident admitted to the facility on 5/13/19. During record review noted the resident's chart lacked documentation regarding a baseline care plan review attempted or completed with the resident or their family. During an interview on 6/11/19 at 1:53 p.m., the Director of Nursing (DON), Registered Nurse (RN), reported that there was no completed baseline care plan for the resident. The Care Plan Policy with a revision date of 11/16 indicated that a 24-hour care plan would be	F 655		

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F 655	Continued From page 5 developed upon admission. The resident or family or legal representative would have the opportunity to participate in the planning of his or her care to the extent practicable. 2. According to the MDS assessment, dated 4/1/19, Resident #12 was admitted 3/26/19 and scored 15 on the Brief Interview for Mental Status indicating no cognitive impairment. The resident's diagnoses included Coronary Artery Disease and High Blood Pressure. The clinical record contained a baseline care plan initiated 3/26/19, but lacked documentation of the resident or his representative received a written summary of the baseline care plan. During an interview on 6/11/19 at 1:10 p.m. the DON stated they did not have documentation of giving the resident or his representative a written summary of the baseline care plan. 3. According to the MDS assessment, dated 5/9/19, Resident #19 admitted 5/2/19. The resident was rarely/never understood and had severely impaired skills for daily decision making. The resident's diagnoses included a Stroke. The clinical record contained a baseline care plan initiated 5/2/19. A Progress Note dated 5/3/19 documented the initial care plan reviewed with the resident and his son, but lacked documentation of the resident or his son received a written summary of the	F 655		

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F 655	Continued From page 6 baseline care plan. During an interview on 6/11/19 at 10 a.m. the DON stated she had not provided the resident or his family a written summary of the baseline care plan.	F 655		
F 657 SS=D	Care Plan Timing and Revision CFR(s): 483.21(b)(2)(i)-(iii) §483.21(b) Comprehensive Care Plans §483.21(b)(2) A comprehensive care plan must be- (i) Developed within 7 days after completion of the comprehensive assessment. (ii) Prepared by an interdisciplinary team, that includes but is not limited to— (A) The attending physician. (B) A registered nurse with responsibility for the resident. (C) A nurse aide with responsibility for the resident. (D) A member of food and nutrition services staff. (E) To the extent practicable, the participation of the resident and the resident's representative(s). An explanation must be included in a resident's medical record if the participation of the resident and their resident representative is determined not practicable for the development of the resident's care plan. (F) Other appropriate staff or professionals in disciplines as determined by the resident's needs or as requested by the resident. (iii)Reviewed and revised by the interdisciplinary team after each assessment, including both the comprehensive and quarterly review assessments. This REQUIREMENT is not met as evidenced by:	F 657		

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F 657	Continued From page 7 Based on interview, observations and record review the facility failed to review and revise the resident's care plan to meet the resident's needs for 2 of 14 resident's reviewed (Resident #14 and Resident #24). The facility reported a census of 28. Findings include: 1. The Minimum Data Set completed for Resident #14 with an Assessment Reference Date (ARD) of 4/12/19 showed a Brief Interview for Mental Status score of 10, indicating moderate cognitive impairment. The resident had the diagnoses Methicillin-Resistant Staphylococcus Aureus (MRSA) and arthritis. A Care Plan problem with a revision date of 3/21/19 indicated the resident had a pressure ulcer to the right buttock. During observation on 6/10/19 at 1:24 p.m., Resident #14 had no pressure ulcer to the right buttock. The Wound Registered Nurse (RN) Assessment, dated 5/1/19 indicated the pressure ulcer to the resident's right buttock healed. During an interview on 6/11/19 at 1:53 p.m., the Director of Nursing (DON), Registered Nurse, reported the pressure ulcer to the buttock healed and she would remove it from the Care Plan. 2. The MDS completed for Resident #24 with an ARD of 5/8/19 showed a BIMS score of 11, indicating moderate cognitive impairment. The resident had diagnoses Dementia and Diabetes	F 657		

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F 657	Continued From page 8 Mellitus Type II. The Incident Progress Note dated 3/28/19 indicated the resident had fallen. During an interview on 6/11/19 at 10:03 a.m., the DON stated the intervention for the fall on 3/38/19 was non-skid strips on the floor by the bed. The Incident Progress Note dated 1/31/19 indicated the resident had fallen. The resident was to have 30-minute checks when agitated or restless as the intervention for the fall. The Incident Progress Note dated 1/24/2019 indicated the resident had fallen. The Care Plan lacked interventions related to the falls on the dates 3/28/19, 1/31/19, and 1/24/19. During an interview on 6/11/19 at 11:59 a.m., the DON stated the fall in March occurred while she was on maternity leave. The DON said she expected the interventions updated on the care plan as they happened. The Care Plan policy with a revision date of 11/16 indicated a qualified team of persons would review Care Plans at least quarterly. Care Plans also would be reviewed, evaluated and updated when there was a significant change in the resident's condition. The plan of care would be modified to reflect the care currently required/provided for the resident.	F 657		
F 727 SS=D	RN 8 Hrs/7 days/Wk, Full Time DON CFR(s): 483.35(b)(1)-(3) §483.35(b) Registered nurse	F 727		

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F 727	Continued From page 9 §483.35(b)(1) Except when waived under paragraph (e) or (f) of this section, the facility must use the services of a registered nurse for at least 8 consecutive hours a day, 7 days a week. §483.35(b)(2) Except when waived under paragraph (e) or (f) of this section, the facility must designate a registered nurse to serve as the director of nursing on a full time basis. §483.35(b)(3) The director of nursing may serve as a charge nurse only when the facility has an average daily occupancy of 60 or fewer residents. This REQUIREMENT is not met as evidenced by: Based on facility schedule review and staff interview the facility failed to assure a Registered Nurse was on duty 8 hours daily seven days per week. The facility reported a census of 28. Findings include: Review of the June 2019 schedule indicated a Licensed Practical Nurse worked from 6:00 a.m. until 6:00 p.m. on 6/8/19. The Registered Nurse worked from 6:00 p.m. on 6/8/19 until 6:00 a.m. on 6/9/19. During an interview on 6/11/19 at 11:03 a.m., the Director of Nursing, Registered Nurse reported no other nurses worked that day. The facility recently changed from eight-hour shifts to twelve-hour shifts. She stated the person who completed the schedule might not have known the RN coverage ended daily at midnight.	F 727		
F 758 SS=D	Free from Unnec Psychotropic Meds/PRN Use CFR(s): 483.45(c)(3)(e)(1)-(5)	F 758		

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F 758	Continued From page 10 §483.45(e) Psychotropic Drugs. §483.45(c)(3) A psychotropic drug is any drug that affects brain activities associated with mental processes and behavior. These drugs include, but are not limited to, drugs in the following categories: (i) Anti-psychotic; (ii) Anti-depressant; (iii) Anti-anxiety; and (iv) Hypnotic Based on a comprehensive assessment of a resident, the facility must ensure that— §483.45(e)(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; §483.45(e)(2) Residents who use psychotropic drugs receive gradual dose reductions, and behavioral interventions, unless clinically contraindicated, in an effort to discontinue these drugs; §483.45(e)(3) Residents do not receive psychotropic drugs pursuant to a PRN order unless that medication is necessary to treat a diagnosed specific condition that is documented in the clinical record; and §483.45(e)(4) PRN orders for psychotropic drugs are limited to 14 days. Except as provided in §483.45(e)(5), if the attending physician or prescribing practitioner believes that it is appropriate for the PRN order to be extended beyond 14 days, he or she should document their	F 758		

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F 758	Continued From page 11 rationale in the resident's medical record and indicate the duration for the PRN order. §483.45(e)(5) PRN orders for anti-psychotic drugs are limited to 14 days and cannot be renewed unless the attending physician or prescribing practitioner evaluates the resident for the appropriateness of that medication. This REQUIREMENT is not met as evidenced by: Based on clinical record review, observation and staff interview the facility failed to document a rationale for not reducing the dose of antidepressant medication for 1 of 5 residents reviewed (Resident #14). The facility reported a census of 28. Findings include: The Minimum Data Set completed for Resident #14 with an Assessment Reference Date of 4/12/19 showed a Brief Interview for Mental Status score of 10, indicating moderate cognitive impairment. The resident had the diagnoses Methicillin-Resistant Staphylococcus Aureus (MRSA), Major Depressive Disorder, recurrent, severe with psychotic symptoms, and Arthritis. The MDS indicated the resident utilized antidepressants for 7 of the 7 days in the look-back period. A Prescription form showed Resident #14 received an order for Mirtazapine (antidepressant) 15 milligrams (mg) on 7/30/18. A Gradual Dose Reduction Review signed by the physician on 2/21/19 indicated the resident had an order for Mirtazapine 15 mg and the resident should continue with the same dose. The	F 758		

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F 758	Continued From page 12 recommendation showed no documented rationale to keep the same dose. During an interview on 6/11/19 at 10:35 a.m. the Director of Nursing (DON), Registered Nurse, reported she was not able to find any other communication from the Physician with rationale for the decline to the gradual dose reduction of the Mirtazapine,(Remeron). During an interview on 6/12/19 at 8:40 a.m., the DON reported she visited with the Pharmacist. The Pharmacist told her the previous DON was going to resubmit the request for a rationale. She was not sure what happened to the request at the time. The Psychotropic Medication Policy and Procedure with a revision date of 6/17 indicated during the first year of medication use, an attempt to taper the medication should be done at least two separate quarters with at least one month in between unless clinically contraindicated. Tapering is considered clinically contraindicated if: the continued use was in accordance with relevant current standards of practice, and the physician had documented the clinical rationale for why any additional attempted dose reduction at that time would be likely to impair the resident's function or cause psychiatric instability by exacerbating an underlying medical or psychiatric disorder.	F 758		
F 759 SS=D	Free of Medication Error Rts 5 Prcnt or More CFR(s): 483.45(f)(1) §483.45(f) Medication Errors. The facility must ensure that its-	F 759		

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F 759	Continued From page 13 §483.45(f)(1) Medication error rates are not 5 percent or greater; This REQUIREMENT is not met as evidenced by: Based on observation, record review, and staff interview, the facility had a medication error rate greater than 5%, with 2 errors (Resident #3 and #16) out of 29 administrations (6.9%). The facility reported a census of 28 residents. Findings include: 1. The June 2019 Medication Administration Record (MAR) documented Resident #3 had an order for Prilosec Capsule Delayed Release 20 mg (Omeprazole) 1 capsule by mouth one time a day for esophageal reflux, before breakfast. During an observation on 6/11/19 at 7:20 a.m. Staff F, Certified Medication Aide (CMA) administered the resident's medications including Omeprazole 20 mg. The resident received breakfast within minutes of taking her medication. The facility drug reference, the Nursing 2017 Drug Handbook, page 1078 documented to give Omeprazole at least 1 hour before meals.. 2. The June 2019 MAR documented Resident #16 had an order for Advair Diskus 250-50 mcg/dose, 1 puff inhale orally two times a day, rinse mouth after use, and Umeclidinium Bromide (Incruse Ellpta) 62.5 mcg, 1 puff inhale orally one time a day. During an observation on 6/10/19 at 9:10 a.m. Staff F took the resident her inhalers. The resident took 1 inhalation of the Advair 250/50	F 759		

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	165249	A. BUILDING _____ B. WING _____	06/12/2019

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F 759	Continued From page 14 inhaler, and then 1 inhalation of the Incruse Elipta inhaler. The resident took a drink after the 2nd inhaler, but did not rinse her mouth. The facility drug reference, the Nursing 2017 Drug Handbook, page 660 documented after administration of Advair discus, have the patient rinse his/her mouth without swallowing. During an interview on 6/11/19 at 1:07 p.m. the Director of Nursing (DON) stated she understood the instructions for the medications and the errors. During an interview on 6/12/19 at 9:14 a.m. the DON stated she had contacted the pharmacy and the physician about changing the order for the time of the Omeprazole.	F 759		
F 803 SS=E	Menus Meet Resident Nds/Prep in Adv/Followed CFR(s): 483.60(c)(1)-(7) §483.60(c) Menus and nutritional adequacy. Menus must- §483.60(c)(1) Meet the nutritional needs of residents in accordance with established national guidelines.; §483.60(c)(2) Be prepared in advance; §483.60(c)(3) Be followed; §483.60(c)(4) Reflect, based on a facility's reasonable efforts, the religious, cultural and ethnic needs of the resident population, as well as input received from residents and resident groups;	F 803		

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F 803	Continued From page 15 §483.60(c)(5) Be updated periodically; §483.60(c)(6) Be reviewed by the facility's dietitian or other clinically qualified nutrition professional for nutritional adequacy; and §483.60(c)(7) Nothing in this paragraph should be construed to limit the resident's right to make personal dietary choices. This REQUIREMENT is not met as evidenced by: Based on observation, record review and staff interview, the facility failed to serve the menu as written for residents on regular, small portion, and mechanically altered diets. The facility reported a census of 28 residents. Findings include: The Regular menu for Sunday 6/9/19 included a 1/2 cup of mashed potatoes, and 1 each bread selection. The Small Portions hand written included 1/4 cup mashed potatoes and 1/2 the bread selection. The Dysphagia 1 diet (pureed) included 1/2 cup mashed potatoes and 1 each bread selection pureed. The Dysphagia 2 diet included 1/2 cup mashed potatoes, and 1 pureed bread selection. The Dysphagia 3 diet included 1/2 cup mashed potatoes and 1 bread selection. The Diet Type Report dated 6/9/19 identified 1 resident on a Regular Pureed diet (not small portions), and 25 residents on a Regular diet, with 6 residents on Small Portions, 1 on Dysphagia level 2 and 1 on Dysphagia level 3. During an observation on 6/9/19 at 10:55 a.m.	F 803		

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

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	165249	A. BUILDING _____ B. WING _____	06/12/2019

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F 803	Continued From page 16 Staff E, Cook ,pureed 1 serving of roast beef, 1/2 of a bun and beef broth. During an observation on 6/9/19 at 11:48 a.m. Staff E started serving resident's meals. She served all residents who received potatoes (most residents received mashed potatoes) a 1/3 scoop and gave residents who got bread 1/2 of a bun. The dietary manager gave resident's on a Regular diet a whole bun (serving the bread to 5 residents). The Dysphagia level 2 diet received preformed pureed bread. One resident received the alternate menu. During an interview on 6/9/19 at 12:18 p.m. Staff E stated she always gave the residents about 1/3 cup of mashed potatoes and stated she gave residents 1/2 of a bun because she thought that was the serving size. She looked at the menu and confirmed the serving sizes listed for Regular, Small Portions, Pureed and Ground diets. The facility Menu Requirements policy identified menus were prepared to meet the balanced nutritional needs of the residents in accordance with established national standards	F 803		
F 812 SS=F	Food Procurement,Store/Prepare/Serve-Sanitary CFR(s): 483.60(i)(1)(2) §483.60(i) Food safety requirements. The facility must - §483.60(i)(1) - Procure food from sources approved or considered satisfactory by federal, state or local authorities. (i) This may include food items obtained directly from local producers, subject to applicable State and local laws or regulations.	F 812		

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F 812	Continued From page 17 (ii) This provision does not prohibit or prevent facilities from using produce grown in facility gardens, subject to compliance with applicable safe growing and food-handling practices. (iii) This provision does not preclude residents from consuming foods not procured by the facility. §483.60(i)(2) - Store, prepare, distribute and serve food in accordance with professional standards for food service safety. This REQUIREMENT is not met as evidenced by: Based on observation and staff interview the facility failed to assure appropriate temperatures and chemical concentrations for cleaning dishes. The facility reported a census of 28 residents. Findings include: During an observation on 6/9/19 at 12:53 p.m. the Dietary Manager (DM) ran the dishwasher, with a wash temperature of 92 degrees, and a rinse temperature of 109 degrees. A 2nd wash recorded the temperature of 107 degrees, and a rinse temperature of 120 degrees. A chemical strip showed 10 part per million (ppm) of bleach. A 3rd wash showed 114 degrees, and rinse 123 degrees, and chemical concentration of 10 ppm. The DM stated she would call both the maintenance man and Ecolab. A Dish Machine Temperature Log, Chemical Sanitizing noted to please document the temperature of wash and final rinse cycles. The log contained areas to document morning, noon, and evening. The log included the wash and rinse cycles to reach 120 degrees and the chemical concentration to reach 50 ppm. The log for May 2019 documented the dishwasher temps	F 812		

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CENTERS FOR MEDICARE & MEDICAID SERVICES

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F 812	Continued From page 18 registering below 120 degrees 8 times, and the rinse below 120 degrees 2 times and lacked any documentation of wash and rinse temps or chemical concentration 42 times. The log lacked documentation of any action taken related to the low temps. A Dish Machine Temperature Log Chemical Sanitizing for June 2019 through 6/8/19 included wash temperatures below 120 degrees 10 times, final rinse below 120 degrees 5 times, and the the chemical concentration of only 10 ppm on 6/7/19 and 6/8/19. The log lacked any documentation of action taken of the low temps or low chemical concentration. During an interview on 6/9/19 at 1:56 p.m. the DM stated the Ecolab and maintenance both in the building and they discovered there was a pellet blocking the chemical and they fixed that. They were working on the water temperature. During an interview on 6/11/19 at 9:50 a.m. the DM stated they thought the dish machine was not reading the temps correctly so they were checking the water temps with a thermometer until they were able to correct the readings of the dish machine. The facility Dish Machine Failure policy directed problems with temperature/chemical levels or water pressure being outside acceptable ranges were to be reported immediately to the director of food and nutrition services, maintenance employees or the person in charge. When the dish machine temperatures, water supply, water pressure or chemical concentrations were not within the appropriate guidelines, the ware washing process to stop immediately and not	F 812		

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F 812	Continued From page 19 restarted until the problem resolved.	F 812		
F 880 SS=E	Infection Prevention & Control CFR(s): 483.80(a)(1)(2)(4)(e)(f) §483.80 Infection Control The facility must establish and maintain an infection prevention and control program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of communicable diseases and infections. §483.80(a) Infection prevention and control program. The facility must establish an infection prevention and control program (IPCP) that must include, at a minimum, the following elements: §483.80(a)(1) A system for preventing, identifying, reporting, investigating, and controlling infections and communicable diseases for all residents, staff, volunteers, visitors, and other individuals providing services under a contractual arrangement based upon the facility assessment conducted according to §483.70(e) and following accepted national standards; §483.80(a)(2) Written standards, policies, and procedures for the program, which must include, but are not limited to: (i) A system of surveillance designed to identify possible communicable diseases or infections before they can spread to other persons in the facility; (ii) When and to whom possible incidents of communicable disease or infections should be reported; (iii) Standard and transmission-based precautions	F 880		

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CENTERS FOR MEDICARE & MEDICAID SERVICES

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F 880	Continued From page 20 to be followed to prevent spread of infections; (iv)When and how isolation should be used for a resident; including but not limited to: (A) The type and duration of the isolation, depending upon the infectious agent or organism involved, and (B) A requirement that the isolation should be the least restrictive possible for the resident under the circumstances. (v) The circumstances under which the facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease; and (vi)The hand hygiene procedures to be followed by staff involved in direct resident contact. §483.80(a)(4) A system for recording incidents identified under the facility's IPCP and the corrective actions taken by the facility. §483.80(e) Linens. Personnel must handle, store, process, and transport linens so as to prevent the spread of infection. §483.80(f) Annual review. The facility will conduct an annual review of its IPCP and update their program, as necessary. This REQUIREMENT is not met as evidenced by: Based on observation, record review, and staff interview the facility failed to ensure appropriate infection control procedures for 3 of 14 residents reviewed (Residents #27, Resident #24, and Resident #20). The facility reported a census of 28. Findings include:	F 880		

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F 880	Continued From page 21 1. The Minimum Data Set (MDS) for Resident #27 completed with an Assessment Reference Date (ARD) of 5/14/19 showed a Brief Interview for Mental Status score of 15, indicating intact cognition. The resident had the diagnoses Chronic Cystitis without hematuria, Non-Infective Gastroenteritis, and Colitis. During an observation on 6/10/19 at 09:10 a.m., Staff D, Certified Nurses' Aide (CNA) washed the resident's perineal area from the resident's backside using wet wipes. Then with dry wipes, the aide wiped the front area of the perineum from the backside of the resident. The aide continued the process from back to front without completing hand hygiene or changing gloves. During an interview on 6/11/19 12:01 p.m., the DON indicated that she would not expect staff to only wash from the backside. She stated they have protocols for correct peri-care. 2. The MDS completed for Resident #24 with an ARD of 5/8/19 showed a BIMS score of 11, indicating moderate cognitive impairment. The resident had diagnoses Dementia and Diabetes Mellitus Type II. During an observation on 6/10/19 at 9:26 a.m., Staff C, CNA, and Staff A, CNA, assisted the resident with the standing mechanical lift after washing their hands, then applied gloves. After standing the resident up, Staff C removed a dirty pull-up and sat on the floor. Staff C applied a new brief without hand hygiene completed. After Staff C got off the floor, she cleaned her hands with	F 880		

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F 880	Continued From page 22 hand sanitizer. Staff A washed her hands with soap & water then shut off the water with the used paper towel. After the resident requested to try again later, they assisted the resident to stand up with the standing mechanical lift. Staff A prepared wipes as Staff C helped the resident with perineal care. Staff C moved to the front of the resident without changing gloves or completing hand hygiene and washed the front perineal area. Staff A pulled up the resident's brief and pants while Staff C washed her hands. The Perineal Care Policy with a revision date of 10/17 indicated that staff should wash their hands or use hand sanitizer before touching objects in the environment. The staff should re-glove to resume perineal care. The procedure to provide perineal care for women stated to separate the labia with one hand and wash with the other, using gentle downward strokes from the front to the back of the perineum. The staff should avoid around the anus, and use a clean section of the washcloth for each stroke by folding each section inward. The staff then should turn the resident on their side to wash, rinse, and dry the anal area. 3. According to the Minimum Data Set (MDS) assessment, dated 4/30/19, Resident #20 was rarely/never understood and had severely impaired skills for daily decision making. The resident depended on staff for all activities of daily living (ADL's) including toilet use and personal hygiene. The resident's diagnoses included a Seizure Disorder.	F 880		

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F 880	Continued From page 23 During an observation on 6/10/19 at 9:52 a.m. Staff C, Certified Nursing Assistant (CNA) and Staff A, CNA prepared to lay the resident down. Both staff wore gloves to transfer the resident. Staff C performed incontinent care in the front wearing the same gloves. Staff rolled the resident left and the resident had had a large loose bowel movement (bm). Staff C wiped the buttocks of bm several times then changed gloves and did hand hygiene. She wiped the buttocks area several more times and changed gloves without performing hand hygiene. She finished wiping the resident and removed her gloves, touching the resident's bedding and pillows before completing hand hygiene. During an interview on 6/11/19 at 1:41 p.m. the Director of Nursing (DON) stated she planned education on gloving and hand hygiene. A facility Infection Control policy on putting on and taking off personal protective equipment directed always wash hands between gloving. The facility Hand Hygiene and Handwashing Procedure directed if hands were not visibly soiled use an alcohol based hand rub after removing gloves.	F 880		

GD Newell

Preparation and execution of this response and plan of correction does not constitute an admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because it is required by the provisions of federal and state law. For the purposes of any allegation, that the center is now in substantial compliance with federal requirements of participation, this response and plan of correction constitutes the center's allegation of compliance in accordance with section 7305 of the State Operations Manual.

F 625

1. Resident's #20 returned to the facility and family was notified of the bed hold policy and offered a copy on 6/24/19 by the social services director.
2. All residents have the potential to be affected.
3. The Administrator educated licensed nursing and social services staff on 6/21/2019 on the facility bed hold policy and procedure.
4. The Administrator or designee will audit all transfers/discharges to ensure bed hold's completed weekly x 4 weeks then to QAPI for review and any further recommendations.
5. Compliance date: July 12th, 2019

F 637

1. Resident #2 was reviewed for a significant change requirement on 6/25/19 by the MDS Nurse.
2. All residents could have been affected.
3. The Administrator educated the MDS nurses on the RAI manual requirements for significant change MDS on 6/24/19.
4. The MDS nurse or designee will audit residents conditions weekly X4 weeks and then to QAPI for review.
5. Compliance Date: July 12th, 2019

F 655

1. Resident #19's care plan was reviewed with resident and family on 6/21/19 by MDS nurse. Resident #12 care plan was reviewed with resident and family on 6/24/19 by MDS nurse. Resident #30 care plan was reviewed with resident and family on 6/24/19 by MDS nurse.
2. All new residents have the potential to be affected.
3. The Administrator provided education to the care plan team regarding the baseline care plan and requirements on 6/21/2019.
4. The DNS or designee will audit baseline care plans weekly X4 weeks then to QAPI for review and any further recommendations.
5. Compliance date: July 12th, 2019

F 657

1. Resident's #14 and #24 care plans were reviewed and updated on 6/11/2019.
2. All residents could have the potential to be affected.