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	165161	A. BUILDING _____ B. WING _____	C 02/15/2022

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

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F 000	INITIAL COMMENTS Correction Date: 3-15-22 An investigation of Complaints #99212, #100404, #100847, #100931, #101685, and #101823 was conducted 1/24-27/22, 2/1-3/22, 2/7-10/22, and 2/14-15/22 and resulted in the following deficiencies. Complaint #99212-C was substantiated. Complaint #100404-C was substantiated. Complaint #100847-C was substantiated. Complaint #100931-C was substantiated. Complaint #101685-C was substantiated. Complaint #101823-C was substantiated See the Code of Federal Regulations (42CFR) Part 483, Subpart B-C.	F 000		
F 550 SS=D	Resident Rights/Exercise of Rights CFR(s): 483.10(a)(1)(2)(b)(1)(2) §483.10(a) Resident Rights. The resident has a right to a dignified existence, self-determination, and communication with and access to persons and services inside and outside the facility, including those specified in this section. §483.10(a)(1) A facility must treat each resident with respect and dignity 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	F 550		

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

Administrator | 02/23/2022

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 550	Continued From page 1 individuality. The facility must protect and promote the rights of the resident. §483.10(a)(2) The facility must provide equal access to quality care regardless of diagnosis, severity of condition, or payment source. A facility must establish and maintain identical policies and practices regarding transfer, discharge, and the provision of services under the State plan for all residents regardless of payment source. §483.10(b) Exercise of Rights. The resident has the right to exercise his or her rights as a resident of the facility and as a citizen or resident of the United States. §483.10(b)(1) The facility must ensure that the resident can exercise his or her rights without interference, coercion, discrimination, or reprisal from the facility. §483.10(b)(2) The resident has the right to be free of interference, coercion, discrimination, and reprisal from the facility in exercising his or her rights and to be supported by the facility in the exercise of his or her rights as required under this subpart. This REQUIREMENT is not met as evidenced by: Based on observation, record review and staff interviews the facility failed to ensure that resident rights were respected and all residents were treated with dignity and respect for 2 of 15 residents reviewed. The facility reported a census of 58 residents. Findings include. 1. A Minimum Data Set (MDS) dated 10/25/21	F 550		

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F 550	Continued From page 2	F 550		

assessed Resident #12 with a Brief Interview for Mental Status (BIMS) score of 14 (no cognitive impairment). The MDS revealed diagnoses that included: diabetes, muscle weakness and repeated falls. The resident required extensive assistance of one staff for bed mobility, transferring and toileting.

The care plan updated on 8/13/20 showed Resident #12 had repeated falls and required the assistance of the mechanical sit to stand lift for transfers.

On 1/27/22 at 10:34 the call light was on outside the room of Resident #12 and the resident told Staff O Certified Nursing Assistant (CNA) that he needed to use the restroom. The CNA quickly asked him if he could wait because she had another resident to assist. The resident hesitated and she again asked in a loud voice in the hallway if he could hold it or not because Staff O did not want the resident to make a mess for her to have to clean up.

2. A MDS dated 1/17/22 assessed Resident #4 with a BIMS score of 8 out of 15 (moderate cognitive impairment). The resident was totally dependent on two staff for transfers and bed mobility and totally dependent on one staff for toileting.

The care plan for Resident #4 last updated on 1/27/22, identified the resident at risk for skin breakdown and directed staff to encourage repositioning and assess the skin frequently.

A Braden scale (used to determine risk for developing pressure sores) dated 1/13/22 at 11:38 AM revealed Resident #4 scored 8 out of

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F 550	Continued From page 3 18, indicating very high risk for pressure sores. On 1/27/22 at 1:03 Resident #4 activated the call light and called out to staff as they passed by her room that she needed help. Staff O CNA went into the resident's room and came back out of the room and with a loud voice in the hallway told the nurse the resident had diarrhea and shouldn't receive Miralax (laxative) in the morning. On 2/10/22 at 1:30 AM the Administrator and Director of Nursing agreed that it was not appropriate for staff to speak in disrespectful tones to the residents.	F 550		
F 607 SS=E	Develop/Implement Abuse/Neglect Policies CFR(s): 483.12(b)(1)-(3) §483.12(b) The facility must develop and implement written policies and procedures that: §483.12(b)(1) Prohibit and prevent abuse, neglect, and exploitation of residents and misappropriation of resident property, §483.12(b)(2) Establish policies and procedures to investigate any such allegations, and §483.12(b)(3) Include training as required at paragraph §483.95, This REQUIREMENT is not met as evidenced by: Based on personnel file review and staff interviews, the facility failed complete a criminal background and abuse background check prior to employment for 5 of 10 employees reviewed. The facility reported a census of 58 residents. Findings include:	F 607		

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F 607	Continued From page 4 A review of employee files revealed the following: 1. A new hire reporting form identified Staff E Temporary Nurse's Aide (TNA) began employment 11/21/21. A background check form revealed the check not completed until 12/24/21. The background check did not identify a criminal or abuse background. Timesheets showed Staff E started work on 10/21/21 and worked 15 shifts from 10/25 through 11/24/21. 2. A new hire reporting form identified Staff P Registered Nurse (RN) start date as 11/21/21. A background check form revealed the check not completed until 12/27/21. The background check did not identify a criminal or abuse background. Timesheets revealed Staff P worked the following dates in 2021: 11/20, 11/21, 11/27, 11/28, 12/4, 12/5, 12/7, 12/12, 12/18, 12/19, and 12/25. 3. A new hire reporting form identified Staff Q Hospitality Aide began employment on 11/28/21. A background check not completed until 12/3/21 at 12:51 PM. The background check did not identify a criminal or abuse background. Timesheets showed Staff Q worked 11/27/21 and 11/28/21. 4. A new hire reporting form identified Staff R RN hired 1/25/22. A background check form revealed the check not completed until 2/8/22. The background check did not identify a criminal or abuse background. Timesheets revealed Staff R worked on 1/26/22, 1/27/22, and 2/2/22. 5. A new hire reporting form identified Staff S RN hired on 11/1/21. A background check form revealed the check not completed until 11/9/21.	F 607		

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F 607	Continued From page 5 The background check did not identify a criminal or abuse background. Timesheets revealed Staff S worked on 11/4/21 and 11/5/21. On 2/3/22 at 1:54 PM, the Administrator acknowledged not all background checks completed before hire. On 2/3/22 at 3:19 PM Staff T business office staff stated many background checks not completed before hire. She said in August of 2021 the facility went through a change in management and the transition was not very smooth. An undated policy titled: Credentialing of Nursing Services Personnel, nursing personnel that required a license/certification not permitted to perform direct resident care services until all licensing checks completed. Upon obtaining the applicants informed consent to conduct a license/certification background investigation, the Director of Nursing Services or designee would: contact the appropriate state licensing board to obtain a letter of verification/computer printout of such license/certification. Contact facilities authorized vendor/service organization to perform a background check in accordance with current state law and facility policy. An undated policy titled: Background Screening Investigations revealed, the Director of Personnel or designee would conduct background checks, reference checks and criminal conviction investigation checks on all applicants for positions with direct access to residents. Background checks to be initiated within two days of an offer of employment.	F 607		
F 658 SS=E	Services Provided Meet Professional Standards	F 658		

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F 658	Continued From page 6 CFR(s): 483.21(b)(3)(i) §483.21(b)(3) Comprehensive Care Plans The services provided or arranged by the facility, as outlined by the comprehensive care plan, must- (i) Meet professional standards of quality. This REQUIREMENT is not met as evidenced by: Based on record review and staff interviews the facility failed to ensure residents received medications in a timely manner and according to physician's orders. Medication Administration Records (MAR) revealed Residents #11, #6, #7 and #5 did not receive medications within the recommended time frame according to policy. The facility reported a census of 58 residents. Findings include: 1. A Minimum Data Set (MDS) dated 10/11/21 assessed Resident #11 with a Brief Interview for Mental Status (BIMS) score of 0 (severe cognitive impairment). The resident was totally dependent on one staff for dressing and eating. The care plan updated on 11/9/21 identified the resident with diagnoses that included: human immunodeficiency virus (HIV) and seizures. The care plan revealed the resident had chronic pain and received food through tube feeding. The care plan directed staff to administer all medications as ordered. Medication Administration Records (MAR) revealed the evening doses of the following medications not administered: a. Order dated 9/27/21 at 2:00 PM for gabapentin solution 100 milligrams (mg) via Percutaneous	F 658		

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F 658	Continued From page 7 Endoscopic Gastrostomy (PEG) tube 3 times a day for seizures. Missed on December 8, 14, 21 and 23, 2021. January 7, 15, 20, 21, 2022 b. Order dated 9/27/21 at 2:00 PM for Dilantin solution 125 mg/5 milliliters (ml) give 4 ml via PEG tube 3 times a day for seizures. Missed on December 8, 14, 21 and 23, 2021. January 7, 15, 20, and 21, 2022. c. Order dated 9/27/21 at 9:00 PM for levetiracetam solution 100 mg/ml give 15 ml 2 times a day. Missed on December 8, 14, 21 and 23, 2021 for seizures. January 7, 15, 20 and 21, 2022. d. Order dated 9/27/21 at 2:00 PM haloperidol lactate 1 mg via PEG tube 3 times a day for agitation. Missed on December 8, 14, 21 and 23, 2021 January 7, 15, 20 and 21, 2022 The record lacked any documentation to explain the missed medication doses. 2. The MDS dated 11/1/21 assessed Resident #6 with a BIMS score 3 (severe cognitive impairment.) The resident required extensive assistance of one staff for bed mobility, transferring, dressing and toileting. The MDS identified the resident with diagnoses that included: unspecified psychosis, epilepsy, congenital malformation and intellectual disability. A care plan last updated on 1/27/22 revealed Resident #6 had an extensive history of seizure activity and received psychotropic medications for	F 658		

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F 658	Continued From page 8 depression, psychosis and seizure activity. The care plan directed staff to administer medications as ordered. On 2/2/22 at 1:14 PM observation showed Resident #6 in bed with the bedside table containing lunch over his lap. At 2:11 PM the resident remained in bed. Staff H Certified Nursing Assistant (CNA) Staff H stated the resident preferred to stay in bed late into the morning and he sometimes resisted care. A review of the MAR showed that Resident #6 had physician orders for the following medications: Felbamate 1,000 milligrams (mg) (anticonvulsant) with a doctor specified direction to administer in the morning, at noon and after supper. Depakote 1000 mg 3 times a day (for seizures) with physician orders to give at 8 AM, 1:00 PM and 7:00 PM VimPat 200 mg 2 times a day for seizures at noon and at 8:00 PM. According to a generated report of times of medication administration for the month of December 2021, the three medications used to control seizure activity were not given in a timely manner. a. Felbamate 1000 mg one tab in the morning, one at noon and one dose after supper. 12/1/21: Morning dose give at 9:48 AM. (along with all of the scheduled morning medications) 12/11/21: Morning dose given at 10:40 (along with all of the scheduled morning medications) 12/13/21: Morning dose given at 9:53 (along with all of the scheduled morning medications) 12/25/21: Second dose given at 2:32 PM 12/27/21: Morning dose given at 10:49 AM (along	F 658		

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F 658	Continued From page 9 with all scheduled morning medications and noon dose given at 2:02 PM) 12/30/21: Morning dose given at 10:04 AM (along with all scheduled morning medications) b. Depakote 3 times a day 8:00, 1:00 PM, and 7:00 PM 12/1/21: Morning dose given at 9:48 AM (with all morning medications) second dose at 4:34 PM. 12/2/21: Second dose given at 4:01 PM (other medications were documented as given at 12:06 PM) 12/3/21: Second dose given at 5:12 PM (Other medications were documented as given at 11:52 PM) 12/4/21: Second dose given at 4:01 PM (other medications were documented as given at 1:34 PM) 12/5/21: Second dose given at 4:05 PM (other medications were documented as given at 1:16 PM) 12/6/21: Second dose given at 4:08 PM (other medications were documented as given at 1:24 PM) 12/7/21: Second dose given at 4:08 PM (other medications were documented as given at 12:28 PM) 12/9/21: Second dose given at 4:48 PM (other medications were documented as given at 11:15 AM) 12/11/21: Morning dose given at 10:40 AM (along with all other morning medications) 12/13/21: Morning dose given at 9:53 AM (along with all other morning medications) and second dose at 4:39 PM (other medications documented as given at 1:09 PM) 12/14/21: Second dose given at 4:27 PM (other medications documented as given at 12:08 PM) 12/25/21: Second dose given at 2:32 PM 12/27/21: Morning dose given at 10:49 AM (along	F 658		

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F 658	Continued From page 10 with all other morning medications noon dose at 2:02 PM) 12/30/21: Morning dose given at 10:04 AM (along with all scheduled morning medications) c. VimPat noon and 9:00 PM 12/25/21 Noon dose given at 2:32 PM 12/27/21 Noon dose given at 2:02 PM On 2/2/22 at 10:31 the pharmacist that provides medication for Resident #6 said that the administration times for three specific medications: Felbamate, Depakote and VimPat were specifically written with times to administer because of the residents history of seizures. The record lacked rationale regarding the late medication administration. 3. A MDS dated 1/31/22 assessed Resident #7 with a BIMS score of 15 (no cognitive impairment). The resident required extensive assistance of two staff for bed mobility and toileting and totally assistance of two staff and the use of Hoyer lift for transfers. The MDS identified diagnoses that included: diabetes mellitus, cirrhosis of the liver, morbid obesity and bipolar disorder. The care plan for Resident #7 dated 11/8/21, showed that he was at risk for skin breakdown related to decrease mobility, obesity and incontinence. The care plan indicated that he had a history of pressure ulcers. A review of the MAR for December of 2021 revealed the resident with orders dated 12/22/21 at 5:00 PM for morphine sulfate 20 mg/milliliter (ml), (narcotic) give 0.13 ml 4 times a day for chronic pain, and an order dated 9/27/21 at 9:00	F 658		

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F 658	Continued From page 11 PM for lactulose solution 10 Gm/15 ml, give 67.5 ml 4 times a day for cirrhosis of the liver. The MAR for the month of December, 2021 showed the following: a. On 12/27/21, the morning medication pass not completed until 12:27 PM and the lactulose solution administered at 12:28 PM and at 12:29 PM. The morphine administered at 12:27 PM and at 12:29 PM. b. On 12/28/21, the morning medication pass not completed until 11:27 AM and the lactulose administered at 11:27 AM. The MAR showed morphine administered at 11:27 AM and 11:30 AM. c. On 12/29/21 the morning mediation pass not completed until 10:29 AM and lactulose solution administered at 10:29 AM and at 11:17 AM (other charting of medications completed at 8:04 AM) The morphine administered at 10:42 AM and 11:17 AM. d. On 12/30/21 the morning medication pass completed at 10:20 AM and the lactulose solution administered at 10:20 AM and 12:19 PM. The morphine administered at 10:21 AM and 12:19 PM. e. On 12/31/21 the morning medication pass completed at 10:39 AM (other documentation of medications completed at 7:20 AM) and the lactulose solution administered at 10:39 AM and at 12:03 PM. The morphine administered at 10:42 AM and 12:03 PM. The record lacked rationale for the late medication administration. 4. A MDS dated 1/17/22 assessed Resident #5 with a BIMS score of 14 (no cognitive impairment). The resident required extensive	F 658		

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F 658	Continued From page 12 assistance of one staff for bed mobility, toileting, hygiene and extensive assistance of two staff for transfers. The MDS identified diagnoses that included: paraplegia and bipolar disorder. The resident's care plan dated 12/3/21 identified the resident at risk for urinary tract infections and directed staff to administer medications as ordered. The December MAR revealed the resident had an order for gabapentin 100 mg 3 times a day for pain. Staff were directed to watch for sedation and confusion. The resident also had an order for tizanidine 2 mg. one tablet 3 times a day related to neuromuscular dysfunction of the bladder. a. On 12/21/21 the evening dose of gabapentin not given b. On 12/30/21 the morning medication pass not completed until 1:01 PM. The MAR showed staff administered tizanidine at 1:02 PM and again at 1:12 PM. c. On 12/30/21 the MAR showed gabapentin administered at 1:02 PM and again at 1:12 PM. The record lacked rationale regarding the missed dose of gabapentin and the late morning medication administration. On 2/7/22 at 1:25 the Director of Nursing (DON) stated there were just two explanations for why medications were not documented as given; the resident didn't get it, or the nurse forgot to document. On 2/15/22 at 3:40 PM Certified Medication Aide (CMA) Staff Z stated there are times when the Internet goes down and they are not able to document the medication pass until hours later	F 658		

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 658	Continued From page 13 than the scheduled time. She said if/when that happens, she is not able to document in the nursing notes a Licensed Practicing Nurse of Registered Nurse would have to do that. A policy dated 2001 titled: Administration of Medications revealed medications were to be administered in accordance with prescribed orders, including any required timeframe. Medications were to be administered within 1 hour of prescribed time unless otherwise specified.	F 658		
F 684 SS=D	Quality of Care CFR(s): 483.25 § 483.25 Quality of care Quality of care is a fundamental principle that applies to all treatment and care provided to facility residents. Based on the comprehensive assessment of a resident, the facility must ensure that residents receive treatment and care in accordance with professional standards of practice, the comprehensive person-centered care plan, and the residents' choices. This REQUIREMENT is not met as evidenced by: Based on observation, interviews and record review the facility failed to accurately and timely identify and monitor skin conditions for 5 of 5 residents reviewed. Resident's #4, #3, #9, #2, developed open skin conditions that were not documented or monitored for healing. The facility reported a census of 58 residents. Findings include: 1. A Minimum Data Set (MDS) dated 1/17/22 assessed Resident #4 with a Brief Interview for	F 684		

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F 684	Continued From page 14 Mental Status (BIMS) score of 8 (moderate cognitive impairment). The resident was totally dependent on two staff for transfers and totally dependent on one staff for toileting. Resident #4 required extensive assistance of two staff for bed mobility. The care plan for Resident #4 last updated on 1/27/22, identified the resident at risk for skin breakdown and directed staff to encourage repositioning and assess the skin frequently. A Braden scale (used to determine risk for developing pressure sores) dated 1/13/22 at 11:38 AM revealed the resident scored 8 out of 18, indicating very high risk for pressure sores. The most recent skin assessment in the record dated 10/11/21 at 1:31 PM did not identify skin impairment. On 1/27/22 at 1:03 Resident #4 called out from her bed and asked to be changed. She told Staff O Certified Nursing Assistant (CNA) she had diarrhea and asked Staff O to change her brief. At 1:06 PM Staff O CNA used disposable wipes to clean the periarea, buttocks and thighs. The thighs contained some bowel movement. Observation also showed dried bowel movement on the urinary catheter tubing which required more aggressive cleaning. The resident had reddened areas on her inner thighs and the left buttock had a red and open spot. The right thigh had three, red and open areas. The residents said that her periarea itched. On 1/31/22 at 8:45 AM Resident #4 was in the shower room receiving a bath and stated it felt sore between her legs especially on her thighs.	F 684		

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F 684	Continued From page 15 The record lacked any documentation of reddened or open skin areas. A nursing note dated 1/31/22 at 2:53 PM indicated that a weekly skin assessment had been completed and the resident had no new skin issues noted or reported. A Medication and Treatment Administration Record (MAR, TAR) revealed a physician order dated 9/4/20 at 6:00 AM for micro guard powder. The order directed staff to apply the powder to moistened areas every day shift under bilateral breast, abdominal folds and groin. Staff L Licensed Practical Nurse (LPN) initialed she completed the treatment on 2/1/22 in the morning. The resident also had a physician order dated 9/29/21 at 6:00 AM for antifungal powder. The order directed staff to apply the powder to redness of right buttock and left abdominal fold every day and evening shift. Staff L LPN initialed she completed the treatment on the morning of 2/1/22. On 2/1/22 at 1:23 PM, Staff L LPN and Staff O certified nurse aide (CNA) acknowledged he resident had the following skin concerns: right inner thigh, right lateral abdomen and on the left buttock. Staff L LPN stated she completed the morning treatments and didn't see those areas. Staff L stated skin concerns should already have a skin sheet started. She said the facility previously had a nurse work and responsible for skin assessments but she didn't know who was responsible for assessments now. On 2/1/2022 at 3:13 PM a nurses note identified Resident #4 with skin impairment to right	F 684		

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F 684	Continued From page 16 buttocks/thigh red/raw measuring 30 centimeters (cm) x 4 cm and left buttock open area measuring 2 cm. diameter with no bleeding noted. Staff requested barrier cream for the area. 2. A MDS dated 12/13/21 assessed Resident #3 with a BIMS score of 0 (severe cognitive impairment). The MDS identified the resident with diagnoses that included: diabetes, difficulty walking and morbid obesity, The resident required extensive assistance of one staff for bed mobility, transfers and toileting. A Braden assessment dated 12/9/21 at 10:02 AM revealed a score 9 out of 18 indicating very high risk of pressure sores. A care plan dated 10/7/21 identified the resident as incontinent of bowel and bladder and at risk for alteration in skin integrity and a history of pressure sores. On 1/31/22 at 9:40 AM, observation showed Staff B CNA transfer the resident to the bathroom with the use of a sit to stand mechanical lift. Before setting the resident on the toilet, the CNA observed a small red spot on the resident's left buttock. Staff B stated she would probably just put some baby powder on the spot. The resident said that area to the left buttock caused discomfort. The record lacked any documentation of the skin concern. A nursing note/weekly skin assessment for Resident #3 dated 2/1/22 at 12:50 PM revealed the resident did not have any new skin issues noted or reported.	F 684		

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F 684	Continued From page 17 A nursing note dated 2/1/22 at 11:46 PM stated that the resident had an abrasion to the left groin that measured 3 cm and an abrasion to the left buttocks measuring 2 cm. 3. A MDS dated 1/17/22 assessed Resident #9 with a BIMS score of 9 (moderate cognitive impairment). The MDS revealed diagnoses that included: diabetes mellitus, obesity, dependence on wheel chair, and kidney disease. The resident required extensive assistance of one staff for bed mobility, transfers and toileting. A care plan dated 8/23/21 identified Resident #9 at risk for skin breakdown due to decreased mobility and revealed the resident tended to develop redness in the periarea area and buttocks due to moisture. The care plan directed a nurse to assess the resident's skin condition weekly. A Braden assessment date 1/14/22 at 10:12 AM revealed of 12 out of 18, indicating high risk of pressure sores. A skin document dated 1/5/22 identified Resident #9 with a 1.8 cm abrasion of left buttock. The document included entries on 1/12/22, 1/18/22 and 1/25/22 and lacked measurements or descriptions. A request at the bottom of the skin document revealed a request sent to the physician for micro guard powder and triad cream twice a day and as needed until healed. The physician signed the order on 1/6/22 and the order entered on the TAR 1/7/22 at 8:00 AM. On 1/27/22 at 10:34 Resident #9 stated she had a sore on her bottom and it had been there for	F 684		

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F 684	Continued From page 18 about a month. She stated it caused pain. She said the cream used did not help and she asked staff for something different many times. She stated she needed to lay down after lunch and there are days when the staff are too busy and they don't get her repositioned during the day. On 1/27/22 at 1:30 PM Staff L LPN stated Resident #9 did not have any open areas that they currently treated or measured. On 1/27/22 at 1:35 PM, Resident #9 informed Staff O CNA that the area on her bottom hurt and she wanted to get into bed. Staff O CNA told the resident to put powder on it, not cream because that's what Staff O thought would be best. At 1:49 PM, Staff O used sit to stand to transfer the resident to bed and as the resident stood in the lift observation showed areas on her bottom. The left buttock contained a closed and crusted area and the right buttock contained a red open area which was the area that the resident said caused pain. At 2:07 PM, Staff L LPN looked at the areas and identified them as chronic areas. Staff L then applied barrier cream on the resident's buttocks. A nursing note dated 2/1/2022 at 6:08 PM revealed the resident returned from the Pain Clinic with new orders to see wound care outpatient for the left buttock ulcer. 4. A MDS dated 1/31/22 assessed Resident #2 with a BIMS score of 15 (no cognitive impairment). The resident was totally dependent on two staff for transfers and toileting and required extensive assistance one staff with bed mobility and dressing. The diagnosis tab of the electronic chart revealed Resident #2 had diagnoses that included: diabetes mellitus,	F 684		

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F 684	Continued From page 19	F 684		

chronic ulcer of left lower leg, chronic obstructive pulmonary disease (COPD) and contracture of the left ankle.

A care plan dated 11/30/21 identified the resident at risk for skin breakdown related to decrease mobility and bowel incontinence. The care plan revealed the resident had poor wound healing and history of pressures on coccyx. The care plan directed staff to monitor wounds and report changes.

A Braden assessment dated 10/28/21 at 8:11 AM revealed the resident with a score of 7 out of 18, indicating severe risk of developing pressure sores and very limited mobility.

On 2/1/22 at 9:45 AM observation showed Resident #2 in bed with the head of the bed slightly elevated. Follow up observations at 10:04 AM , 10:30 AM, 10:54 AM, 11:48 AM, 12:35 AM, 12:55 AM, 1:30 PM, 1:57 PM, 2:24 PM and 2:50 PM showed the resident in the same position. At 2:50 PM the resident asked for help.

Information obtained from Nursing Fundamentals on 2/9/22 at 8:04 a.m. revealed interventions to prevent pressures included: repositioning every 1-2 hours.

10.5 Braden Scale - Nursing Fundamentals (pressbooks.pub)

On 1/27/22 at 2:23 PM Staff G CNA stated she provided incontinence cares for the resident in December and noticed the resident had red areas on her thighs and periarea that Staff G he described as looking like "raw hamburger". She stated she reported this to the overnight nurse

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several times and the nurse said that she would let the doctor know, but Staff G did not know if that happened. The resident stated the thighs hurt.

On 1/27/22 at 1:30 Staff A CNA stated she gave Resident #2 bed baths in the month of December and noticed red areas in the groin and periarea. He said that he told the nurse.

On 1/27/22 at 12:41 Staff O CNA stated she gave Resident #2 bed baths in December and noticed at that time that the skin in the resident's inner thighs appeared red and sore and she reported it to the nursing staff.

The following is documentation from the bath sheets for Resident #2 from 11/6 through 12/29/21:
a. 11/10/21 butt open
b. 11/17/21 open area
c. 11/24/21 bottom red, nurse aware
d. 12/1/21 sore bottom
e. 12/8/21 red between the legs
f. 12/15/21 red bottom
g. 12/22/21 bottom is peeling
h. 12/24/21 bottom sore
i. 12/29/21 bottom red.

The record lacked any documentation of skin concerns in the periarea or coccyx area.

5. On 2/1/22 at 2:10 PM the Director of Nursing (DON) stated when staff identifies an open area on a resident that they should initiate a skin sheet with the measurements and description of the wound.

On 2/1/22 at 8:04 AM, the DON said they do not

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F 684	Continued From page 21 have a policy on skin monitoring and documentation.	F 684		
F 686 SS=D	Treatment/Svcs to Prevent/Heal Pressure Ulcer CFR(s): 483.25(b)(1)(i)(ii) §483.25(b) Skin Integrity §483.25(b)(1) Pressure ulcers. Based on the comprehensive assessment of a resident, the facility must ensure that- (i) A resident receives care, consistent with professional standards of practice, to prevent pressure ulcers and does not develop pressure ulcers unless the individual's clinical condition demonstrates that they were unavoidable; and (ii) A resident with pressure ulcers receives necessary treatment and services, consistent with professional standards of practice, to promote healing, prevent infection and prevent new ulcers from developing. This REQUIREMENT is not met as evidenced by: Based on observation, staff interviews and record review the facility failed to ensure that a resident with pressure sores received the necessary treatment and services to promote healing for 1 of 5 residents reviewed. Resident #2 had a history of chronic pressure ulcer to the coccyx and the care plan directed staff to reposition the resident often. Observation showed the resident in the same position for 5 hours. The facility reported a census of 58 residents. Findings include: A Minimum Data Set (MDS) dated 1/31/22 assessed Resident #2 with a Brief Interview for Mental Status (BIMS) score of 15 (no cognitive impairment). The resident was totally dependent	F 686		

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F 686	Continued From page 22	F 686		

on two staff for transfers and toileting and required extensive assistance of one staff for bed mobility and dressing. The diagnosis tab of the electronic chart showed diagnoses that included: diabetes mellitus, chronic ulcer of left lower leg, chronic obstructive pulmonary disease (COPD) and contracture of the left ankle.

The care plan dated 11/30/21 identified the resident at risk for skin breakdown related to decreased mobility and bowel incontinence. The care plan revealed the resident had poor wound healing and history of coccyx pressure sores.

A Braden assessment (tool to determine risk for pressure sores) dated 10/28/21 at 8:11 AM, identified Resident #2 with a score of 7 out of 18, indicating severe risk of developing pressure sores and very limited mobility.

A readmission after hospitalization skin assessment dated 1/26/22 at 2:05 PM, revealed the resident had an area on the left ankle and reddened areas on the coccyx and the sacrum.

On 2/1/22 at 9:45 AM observation showed Resident #2 in bed with the head of the bed slightly elevated in bed.. Follow up observations at 10:04 AM, 10:30 AM, 10:54 AM, 11:48 AM, 12:35 AM, 12:55 AM, 1:30 PM, 1:57 PM, and 2:24 PM showed the resident in the same position in bed. At 2:50 PM the resident asked for help to move.

According to Nursing Fundamentals (pressbooks.pub), residents with impaired mobility required every 1-2 hour repositioning.

On 2/1/22 at 2:10 PM the Director Of Nursing

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F 686	Continued From page 23 (DON) stated when staff discovers an open area, the nurse should initiate a skin sheet.. On 2/15/22 at 10:47 AM the DON stated she expected staff to reposition residents every 2 hours. On 2/1/22 at 8:04 AM DON stated the facility did not have a skin assessment and monitoring policy or a policy on documentation required for a resident with pressure sores. The facility only had a policy for wound care.	F 686		
F 689 SS=D	Free of Accident Hazards/Supervision/Devices CFR(s): 483.25(d)(1)(2) §483.25(d) Accidents. The facility must ensure that - §483.25(d)(1) The resident environment remains as free of accident hazards as is possible; and §483.25(d)(2)Each resident receives adequate supervision and assistance devices to prevent accidents. This REQUIREMENT is not met as evidenced by: Based on observations, record review and staff interviews the facility failed to ensure the resident environment remained free from hazards and residents received adequate supervision and assistance devices to prevent accidents for 3 of 12 residents reviewed. Residents #9 and #12 required the use of a mechanical sit to stand lift for transfers. The Certified Nursing Assistant (CNA) that transferred the residents failed to use the lift safety buckles during the transfer. Resident #7 required a protective apron while smoking and observation during the investigation showed the resident smoking without the apron. The facility reported a census of 58 residents.	F 689		

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F 689	Continued From page 24 Findings include: 1. A Minimum Data Set (MDS) dated 1/17/22 assessed Resident #9 with a Brief Interview for Mental Status score of 9 (moderate cognitive impairment). The resident had diagnoses that included: diabetes mellitus, obesity, dependence on wheel chair, and kidney disease. The resident required extensive assistance of one staff for bed mobility, transfers and toileting. A care plan dated 8/23/21 revealed Resident #9 required an EZ stand (mechanical sit to stand lift) for transfers. On 1/27/22 at 1:49 PM observation showed Staff O Certified Nursing Assistant (CNA) utilize the sit to stand lift to transfer Resident #9 from the wheel chair to the bed. Staff O did not buckle the leg strap or the chest strap prior to the transfer. 2. A MDS dated 10/25/21 assessed Resident #12 with a BIMS score of 14 (no cognitive impairment). The resident had diagnoses that included: diabetes, muscle weakness and repeated falls. The resident required extensive assistance of one staff for bed mobility, transferring and toileting. The care plan updated on 8/13/20 revealed the resident had repeated falls and required the assistance of the mechanical sit to stand lift for transfers. On 1/27/22 at 1:32 PM observation showed Staff O CNA transfer Resident #12 from the toilet to the wheel chair without fastening the leg or chest straps.	F 689		

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F 689	Continued From page 25 The Operation Manuel for EZ stand lift dated January 2001, directed staff to securely fasten the safety strap around the patient's chest, to secure the buckle and pull the loose strap to tighten around the chest. Facility policy dated 2001, titled: Lifting Machine, using a Mechanical Lift, directed two staff used to safely move a resident with a mechanical lift. The policy directed staff to examine all the hooks, clips and fasteners before moving the resident. 3. A MDS dated 1/31/22 assessed Resident #7 with a BIMS score of 15 (no cognitive impairment). The resident required extensive assistance of two staff for bed mobility and toileting and totally dependent on 2 staff for transfers with the Hoyer lift. The resident had diagnoses that included: diabetes, cirrhosis of the liver, morbid obesity and bipolar disorder. The care plan updated on 11/8/21 identified the resident at risk for skin breakdown related to decrease mobility, obesity and incontinence. The care plan revealed a history of pressure ulcers related to moisture and skin breakdown to bilateral buttocks and the back of right thigh. A smoking assessment dated 1/30/22 at 10:55 AM revealed Resident #7 required protective adaptive equipment including a smoking apron. On 1/31/22 at 2:40 PM observation showed Resident #12 seated outside on the patio smoking a cigarette. The resident appeared drowsy with his eyes closed and head hanging down. He had a blanket in his lap and his cigarette was down to the butt. The resident did not wear a protective smoking apron.	F 689		

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F 689	Continued From page 26 Facility policy dated 2001 titled: Smoking Policy-Residents, revealed the facility would evaluate residents on admission to determine the resident's ability to smoke safely with or without supervision.	F 689		
F 725 SS=D	Sufficient Nursing Staff CFR(s): 483.35(a)(1)(2) §483.35(a) Sufficient Staff. The facility must have sufficient nursing staff with the appropriate competencies and skills sets to provide nursing and related services to assure resident safety and attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident, as determined by resident assessments and individual plans of care and considering the number, acuity and diagnoses of the facility's resident population in accordance with the facility assessment required at §483.70(e). §483.35(a)(1) The facility must provide services by sufficient numbers of each of the following types of personnel on a 24-hour basis to provide nursing care to all residents in accordance with resident care plans: (i) Except when waived under paragraph (e) of this section, licensed nurses; and (ii) Other nursing personnel, including but not limited to nurse aides. §483.35(a)(2) Except when waived under paragraph (e) of this section, the facility must designate a licensed nurse to serve as a charge nurse on each tour of duty. This REQUIREMENT is not met as evidenced by:	F 725		

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

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F 725	Continued From page 27 Based on observation, record review, resident and staff interviews the facility failed to provide sufficient staff to ensure timely call light response (within 15 minutes). The facility reported a census of 58 residents. Findings include: 1. A Minimum Data Set (MDS) dated 1/17/22 assessed Resident #13 with a Brief Interview for Mental Status (BIMS) score of 14 (no cognitive impairment). The resident required extensive assistance of one staff for bed mobility, transfers, dressing and personal hygiene. The care plan updated on 8/16/21. identified the resident at risk for falls due to unsteady gait. The care plan identified the resident required reminders to ask for assistance. Observation on 2/2/22 at 6:20 AM showed call lights activated in Resident #13's room and B12. At 6:24 AM the light for B12 was turned off. At 6:30 AM Resident #13's call light remained on and there were 4 staff in nurse's station as they transitioned from the night to the dayshift. At 6:44 AM Resident #13's call light remained on. At 6:48 AM Staff U Registered Nurse (RN) walked past Resident #13's room and went down the hallway and at 6:50 AM she went into Resident #13's room. Resident #13's call light went off and Staff U walked back out into the hallway. At 6:54 Resident #13 stated he wanted to get up. At 7:02 AM there was no staff with him and the light was still off. At 7:06 AM Resident #13's call light went back on and at 7:13 AM the call lights for B6, B1 and B14 were also turned on. At 7:21 AM RN Staff U went into B6, B1, B14 and Resident #13's rooms and each one of the lights went off. At 7:27 AM a Certified Nursing Aide (CNA) went into	F 725		

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F 725	Continued From page 28 Resident #13's room and assisted the resident to get ready for the morning. 2. A MDS dated 1/31/22 assessed Resident #7 with a BIMS score of 15 (no cognitive impairment). The resident required extensive assistance of two staff for bed mobility and toileting and totally depended on two staff and use of Hoyer lift for transfers. The resident had diagnoses that included: diabetes, cirrhosis of the liver, morbid obesity and bipolar. On 1/27/22 1:35 Resident #7 said that sometimes at night the call light response is over 2 hours wait. 3. A MDS dated 1/25/22 assessed Resident #14 with a BIMS score of 6 (severe cognitive impairment). The resident required extensive assistance of two staff for toileting, bed mobility and transferring. On 1/27/22 at 12:50 PM Resident #14 stated it sometimes takes staff a while to respond to the call light and she had been close to having an accident waiting for help to get to the bathroom. On 2/15/22 at 10:47 AM the Director of Nursing stated she expected staff to answer call lights in 15 minutes or less.	F 725		
F 726 SS=E	Competent Nursing Staff CFR(s): 483.35(a)(3)(4)(c) §483.35 Nursing Services 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	F 726		

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F 726	Continued From page 29 well-being of each resident, as determined by resident assessments and individual plans of care and considering the number, acuity and diagnoses of the facility's resident population in accordance with the facility assessment required at §483.70(e). §483.35(a)(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. §483.35(a)(4) Providing care includes but is not limited to assessing, evaluating, planning and implementing resident care plans and responding to resident's needs. §483.35(c) Proficiency of nurse aides. The facility must ensure that nurse aides are able to demonstrate competency in skills and techniques necessary to care for residents' needs, as identified through resident assessments, and described in the plan of care. This REQUIREMENT is not met as evidenced by: Based on record and policy review and staff interviews the facility failed to provide adequate staff training before the staff worked independently with residents for three of three staff files reviewed for an orientation checklist. The facility reported a census of 58 residents. Findings include: 1. A review of staff personnel files revealed that the staff files lacked an orientation or competency checklist or system to ensure proper training for the following staff:	F 726		

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F 726	Continued From page 30 a. Staff R, Registered Nurse (RN) hire date 1/25/22 b. Staff P RN hire date 11/21/21 c. Staff S RN hire date 11/1/21 2. On 2/9/22 at 2:10 PM Staff J Certified Nursing Aide (CNA) stated she was hired a couple of months previously. She said that there was not a skills checklist used to ensure that she had proper training and competencies. She said she just followed a couple of different staff for about a week and did not have formal orientation or training. 3. On 2/9/22 at 2:25 PM Staff V Licensed Practical Nurse (LPN) stated she worked at the facility for almost 1 year and did not remember any formal training. She said that she was just put out on the floor and told to ask questions when needed. She said that it was a difficult start and didn't remember a checklist of competencies. 4. A policy undated titled: Orientation Program for Newly Hired Employees Transfers and Volunteers revealed All newly hired personnel/volunteers/transfers/contractors must attend and complete the orientation program. Each department will also orient new hires to their department's policies and procedures as well as other data that will aid them in understanding the team concept, attitudes and approaches to resident care. A written record is to be maintained of each employee's orientation. Records of orientation are filed in the personnel file upon completion of the orientation program.	F 726		
F 804 SS=D	Nutritive Value/Appear, Palatable/Prefer Temp CFR(s): 483.60(d)(1)(2)	F 804		

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F 804	Continued From page 31 §483.60(d) Food and drink Each resident receives and the facility provides- §483.60(d)(1) Food prepared by methods that conserve nutritive value, flavor, and appearance; §483.60(d)(2) Food and drink that is palatable, attractive, and at a safe and appetizing temperature. This REQUIREMENT is not met as evidenced by: Based on observations, menu review and staff interviews the facility failed to provide food that was at a palatable temperature for 2 of 3 residents reviewed. Residents #3 and #4 were served meat that was below the recommended temperature of 165 degrees for poultry. The facility reported a census of 58 residents. Findings include: Observation of the kitchen on 2/3/22 at 12:10 PM showed the staff prepare food trays and place them on a wheeled rack for distribution to residents in their rooms. According to the Week at a Glance Week 3 menu for the day was creamy mushroom chicken, baked potato with sour cream, buttered carrots, dinner roll and pumpkin bar. Staff X dietary and Staff Y dietary and the dietary manager (DM) used several different thermometers to determine if the food was all hot enough to serve. At 12:35 PM at 12:45 the pureed meat temperature measured 155 degrees and the carrots measured 180 degrees so they continued to prepare the plates. At 12:48 PM the tray for Resident #4 was retrieved from the cart	F 804		

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F 804	Continued From page 32 and the meat temperature measured 80 degrees, carrots at 70 degrees and the potato 90 degrees. Staff X put the tray back on the cart. At 12:50 PM Staff W dietary aide pushed the cart out to the resident rooms and served a plate to Resident #4. She got a thermometer and found the meat temperature 113 degrees. The ground meat for Resident #3 measured 120 degrees. Staff W did not offer to reheat the meals. A Minimum Data Set (MDS) dated 1/17/22 assessed Resident #4 with a Brief Interview for Mental Status (BIMS) score of 8 (moderate cognitive impairment). The resident required set up only and supervision with eating. A MDS dated 12/13/21, Resident #3 had a BIMS score of 0 (severe cognitive impairment). The resident had diagnoses that included: diabetes, difficulty walking and morbid obesity, The resident required extensive assistance of one staff for eating. On 2/7/22 at 1:13 PM the DM stated the facility did not have any policies in the kitchen. He said that he is a new employee and was working on establishing polices with the dietician along with staff education related to food temperatures. According to the food temperature log document the appropriate temperature for poultry was 165 degrees.	F 804		
F 880 SS=D	Infection Prevention & Control CFR(s): 483.80(a)(1)(2)(4)(e)(f) §483.80 Infection Control The facility must establish and maintain an	F 880		

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F 880	Continued From page 33 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 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	F 880		

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F 880	Continued From page 34 (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 observations, record review, resident interviews the facility failed to utilize proper infection control practices to mitigate the spread of pathogens for 2 of 5 residents reviewed. Staff failed to use appropriate Personal Protective Equipment (PPE) and hand hygiene while caring for Residents #9 and #14 and #4. The facility reported a census of 58 residents. Findings include: 1. A Minimum Data Set (MDS) dated 1/17/22 assessed Resident #9 with a Brief Interview for Mental Status (BIMS) score of 9 (moderate	F 880		

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F 880	Continued From page 35	F 880		

cognitive impairment). The resident had diagnoses that included: diabetes mellitus, obesity, dependence on wheel chair, and kidney disease. The resident required extensive assistance of one staff for bed mobility, transfers and toileting.

A care plan dated 8/23/21 identified Resident #9 at risk for skin breakdown due to decreased mobility and revealed the resident with potential to develop redness in the periarea and buttocks due to moisture. The care plan directed a nurse to observe the skin weekly.

A Braden assessment date 1/14/22 at 10:12 AM revealed a score of 12 out of 18, indicating high risk of pressure sores.

On 1/27/22 at 10:34 AM Resident #9 stated staff don't always clean her periarea as well as they should and sometimes they just change her brief without cleaning her.

On 1/27/22 at 1:49 PM Staff O Certified Nursing Aide (CNA) pushed the mechanical sit to stand lift into the residents room and proceeded to hook up the straps. Staff O failed to wash her hands when entering the room or after using the lift. As the resident was standing at the machine, and with gloved hands, Staff O lowered the resident's brief to point out some chronic skin concerns on the resident's bottom. Staff O pulled the brief back up and without changing the gloves or washing hands, continued to transfer the resident to the bed and pulled the covers over her. Staff O then left the room without removing the gloves or washing hands.

2. A MDS dated 1/25/22 assessed Resident #14

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F 880	Continued From page 36 with a BIMS score of 6 (severe cognitive impairment). The resident required extensive assistance of two staff for toileting, bed mobility and transferring. On 1/27/22 at 12:50 PM observation showed, Resident #14 seated in a wheel chair in her room with a bedside table in front of her with her finished lunch meal. An unidentified staff person came into the resident's room and wheeled the resident back to the closed off unit where the Covid-19 positive residents were isolated. The staff person did not wear a gown or gloves. 3. A MDS dated 1/17/22 assessed Resident #4 with a BIMS score of 8 (moderate cognitive impairment). The resident totally depended on two staff for transfers and one staff for toileting. The care plan for Resident #4 last updated on 1/27/22, identified the resident at risk for skin breakdown and staff should encourage repositioning and assess the skin frequently. A Braden scale (used to determine risk for developing pressure sores) dated 1/13/22 at 11:38, Resident #4 scored 8 out of 18, indicating very high risk for pressure injuries. On 1/27/22 at 1:03 PM Resident #4 called out from her bedroom that she had diarrhea and needed to be changed. Staff O CNA went into the resident's room and cleaned the residents periarea and buttocks of bowel movement with gloved hands. With the same gloves, Staff O applied a clean brief under the resident and pulled the covers over her. Staff O took off the gloves before leaving the resident's room but failed to wash her hands.	F 880		

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F 880	Continued From page 37 On 1/31/22 at 8:45 AM Resident #4 sat in a shower chair in the shower room and Staff O CNA provided the shower. The shower chair contained a tub underneath the seat and the resident stated she was having a bowel movement. After Resident #4 finished, Staff O removed the tub out and dumped the feces into the toilet. Without changing gloves Staff O took a clean wash cloth and wiped the resident's buttocks, then touched the resident's face and asked her if she would like to have her chin shaved. Staff O put shaving cream on the residents chin and shaved her chin without having changed gloves. A facility policy titled Washing/Hand Hygiene dated 2001 revealed the use of alcohol-based rub or soap and water is recommended to prevent the spread of pathogen before and after direct contact with the resident and before moving from a contaminated body site to clean body site during cares.	F 880		

F550

1. Residents #12 and #4 have shown no ill effects from comments made by C.N.A
2. All residents residing in the facility have the potential to be affected and have the right to be treated with dignity and respect.
3. Staff member "O" will be educated regarding Promoting/Maintaining resident dignity and treating with respect.
4. DON or designee to educate staff on Promoting/Maintaining resident dignity and be respectful.
5. DON or designee will complete an audit to ensure residents are treated with dignity and respect per resident interview or observation 3x/wk for 2 months. These audits will be brought to QAPI committee for review.
6. Date of completion: 3/15/2022

F607

1. Personnel files identified during the survey process as not having criminal and abuse back ground checks were completed during survey visit.
2. A checklist for personnel files has been implemented to ensure files are complete.
3. Administrator to educate HR and all department heads regarding on-boarding of new staff procedures including background check completion.
4. Administrator or designee will complete audit of new hire personnel files weekly x2 months. These audits will be brought to the QAPI committee for review.
5. Date of completion 2/23/2022

F658

1. Residents #11, #6, #7, and #5 did not show any ill effects from not receiving scheduled medications in a timely manner and according to physician's orders.
2. All current residents residing in the facility have the potential to be affected
3. Nurses and C.M.A.s will be educated regarding timely administration of medications and following physicians' orders.
4. DON or designee to complete audit of medication administration times and administration of medications as ordered 3x/wk for 2 months. These audits will be brought to QAPI committee for review.
5. Date of completion 3/15/2022

F684

1. Residents # 4, #3, #9, and #2 have not developed any pressure areas.
2. All current residents residing in the facility have the potential to be affected.
3. DON or designee to educate nurses and C.N.As regarding reporting and documentation of skin issues in a timely manner and repositioning schedules. Nurses educated on utilizing the Weekly Skin Assessment in PCC.
4. DON or designee will complete an audit of skin assessment documentation 3x/wk for 2 months. These audits will be brought to QAPI committee for review.
5. Date of completion 3/15/2022

F686

1. Resident #2 assessed for skin issues upon return from hospital on 2/24/2022. Skin issues were documented.
2. All current residents residing in the facility have the potential to be affected.
3. DON or designee will educate nursing staff on repositioning schedules. DON has contacted Telligen in attempt to schedule additional training regarding pressure ulcer prevention.
4. DON or designee will complete an audit 3x/wk for 2 months. These audits will be brought to QAPI committee for review.
5. Date of completion 3/15/2022

F689

1. Residents #9 and #12 have not had any falls/sustained any injuries during transfer with EZ Stand. Resident #7 has not sustained any injuries related to smoking.
2. All current residents residing in the facility who are transferred with EZ Stand have the potential to be affected. All residents who are to utilize a safe smoking device have the potential to be affected.
3. DON or designee will educate nursing staff regarding proper use of EZ Stand equipment. Staff will be educated on usage of safe smoking devices.
4. DON or designee will complete an audit of EZ Stand transfers 3x/wk for 2 months. These audits will be brought to QAPI committee for review. DON or designee will complete an audit of safe smoking devices 3x/wk for 2 months.
5. Date of completion 3/15/2022

F725

1. Residents #13, #7, and #14 showed no ill effects from call light response times
2. All current residents residing in the facility have the potential to be affected
3. Staff will be educated regarding answering call light in a timely manner and the need of the resident was met.
4. DON or designee will audit call light response times and that need of resident was met per resident interview 3x/wk for 2 months. These audits will be brought to QAPI committee for review
5. Date of completion 3/15/2022

F726

1. A new hire checklist and competencies list initiated. No new nursing staff has been hired since survey visit.
2. Administrator will educate department heads regarding new hire check lists and competency list
3. Administrator or designee will audit new employee files weekly x2 months for completion of checklists and competencies. These audits will be brought to QAPI committee for review.
4. Date of completion 3/15/2022

F804

1. Residents #3 and #4 were interviewed on 3/4/2022 regarding food temperatures with no concerns voiced.
2. All current residents residing in the facility have the potential to be affected
3. Dietary Manager or Dietitian will educate dietary staff regarding proper food temperatures.
4. Dietary Manager or Dietitian to audit food temp logs 3x/wk for 2 months. These audits will be brought to QAPI committee to review.
5. Date of completion 3/15/2022

F880

Staff will be educated at mandatory in-service scheduled 3/11/2022 regarding use of PPE, hand-washing, and donning/doffing of gloves. Education to include viewing of the "Clean Hands" video.

1. Resident #9 and #4 have had no recent infections. Resident #9 was seen by her medical prescriber on 2/8/2022 and observed to have no adverse effects from the potential deficiency. Resident #4 was seen by her medical prescriber on 1/31/2022 and observed to have no adverse effects from the potential deficiency. Resident #14 remained asymptomatic during isolation period for COVID 19.
2. All current residents residing within the facility have the potential to be affected. There have been no new admissions to the COVID unit since 2/28/2022 and there have been no resident diagnosis with a new onset of COVID 19 since 2/17/2022.
3. Current staff will be educated on donning, doffing PPE, infection control practices when entering/exiting the COVID unit, and hand hygiene with the "Clean Hands" video. The QIO was contacted by the DON on 3/4/2022 for assistance with infection control education. New hire staff will be educated during the orientation period on donning/doffing of PPE, infection control practices when entering/exiting the COVID unit, and hand hygiene.
4. Root Cause Analysis completed 3/9/2022
5. The DON or designee will audit 3x/wk for 2 months, weekly x4 weeks and monthly x2 months and randomly thereafter for ongoing surveillance. The results of the audit will be presented monthly by the DON to the QAPI committee for recommendations and trends.
6. Date of completion 3/10/2022