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
	165372	A. BUILDING _____ B. WING _____	10/05/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ELM CREST RETIREMENT COMMUNITY	2104 12TH STREET HARLAN, IA 51537

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 000	INITIAL COMMENTS Correction date: 11/3/2023 The following deficiencies resulted from the facility's annual recertification survey conducted on October 2, 2023 to October 5, 2022. See the Code of Federal Regulations (42CFR) Part 483, Subpart B-C.	F 000		
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 observation, interview, and operator manual review the facility failed to ensure that staff used safe transfer techniques for 1 of 3 residents reviewed (Resident #22). Resident #22 required the use of a sit to stand mechanical lift for transfers. As the staff transferred Resident #22, they failed to tighten the belt around her torso before moving her from the wheel chair to the bed. Findings include: Resident #22's Minimum Data Set (MDS) assessment dated 7/12/23 identified a Brief Interview for Mental Status (BIMS) score of 5, indicating severely impaired cognition. She	F 689	See Attached.	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Timothy Maurer | TITLE: Administrator | (X6) DATE: 10/18/2023

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 689	Continued From page 1 required extensive assistance from two persons for bed mobility, transfers and toilet use. The Care Plan Focus revised 8/7/23 indicated that Resident #22 had a risk for falls due to cognitive impairment and impaired mobility. She had a fall risk score of 12 as of 7/9/23, indicating high risk for falls. The Intervention dated 8/14/20 directed to use an assist of two with the sit to stand mechanical lift for transfers. On 10/2/23 at 1:37 PM observed Staff A, Certified Nurse Assistance (CNA), and Staff B, CNA, use the mechanical sit to stand lift to transfer Resident #22 from her wheelchair to her bed. While still seated, the staff attached the belt around her torso and lifted her to a standing position. Without tightening the belt after she stood, the staff moved her to the bed. Resident #22's arms appeared parallel to the floor with the harness in her armpits. The EZ Way Smart Stand Operator's Guide, reviewed on 6/14/23, instructed that when raising the patient, as they are raised simultaneously tighten the safety strap buckled around the torso.	F 689		
F 755 SS=D	Pharmacy Srvcs/Procedures/Pharmacist/Records CFR(s): 483.45(a)(b)(1)-(3) §483.45 Pharmacy Services The facility must provide routine and emergency drugs and biologicals to its residents, or obtain them under an agreement described in §483.70(g). The facility may permit unlicensed personnel to administer drugs if State law permits, but only under the general supervision of a licensed nurse.	F 755	See Attached	

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F 755	Continued From page 2 §483.45(a) Procedures. A facility must provide pharmaceutical services (including procedures that assure the accurate acquiring, receiving, dispensing, and administering of all drugs and biologicals) to meet the needs of each resident. §483.45(b) Service Consultation. The facility must employ or obtain the services of a licensed pharmacist who- §483.45(b)(1) Provides consultation on all aspects of the provision of pharmacy services in the facility. §483.45(b)(2) Establishes a system of records of receipt and disposition of all controlled drugs in sufficient detail to enable an accurate reconciliation; and §483.45(b)(3) Determines that drug records are in order and that an account of all controlled drugs is maintained and periodically reconciled. This REQUIREMENT is not met as evidenced by: Based on observation, interviews, and policy review the facility failed to dispose of narcotic medications after the doctor gave an order to discontinue them for two of two residents reviewed (Residents #91 and #36). 1. Resident #91 passed away on 8/20/23. During the survey in October 2023, discovered some of her medications still in the refrigerator. 2. Resident #36 had an order for tramadol to use for pain as needed that got discontinued on 6/1/23. During the survey in October 2023, the narcotic drawer still contained 60 tablets of tramadol. The facility reported a census of 40 residents.	F 755		

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F 755	Continued From page 3 Findings include: 1. Resident #91's Minimum Data Set (MDS) assessment listed that she used opioids for four out of the seven days in the lookback period. The Alert Note dated 8/20/23 at 7:39 PM indicated that two nurses verified that Resident #91 no longer had signs of life. The facility contacted the hospice nurse and the funeral home. A nursing note dated 8/20/23 at 10:38 PM showed that Resident #91 passed away at the facility on that date. The Clinical Physician's Orders reviewed on 10/4/23 reflected that Resident #91 had the following medication orders: a. Dated 8/20/23: lorazepam oral concentrate 2 milligrams per milliliter (mg/ml). b. Dated 7/20/23: Dronabinol Capsule 2.5 mg. dated 7/20/23 (cannabinoid medication used to treat nausea and loss of appetite). c. Dated: 7/20/23: Dronabinol Capsule 5 mg. On 10/3/23 at 7:29 AM during the medication storage room observation, discovered Resident #91 had a full bottle of liquid Ativan in the refrigerator, with a baggie that contained two bubble packages of Dronabinol. One bubble package contained 17 tablets of the 2.5 mg dose, and the other had 18 tabs of the 5 mg dose. On 10/4/23 at 1:26 PM, Staff C, Licensed Practical Nurse (LPN), said that the nurses continued to count all the narcotics at shift change. If no resident used the medication, they had a line through the rest of the page in the	F 755		

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F 755	Continued From page 4 documentation book. The observation of the narcotic documentation revealed that the page containing the 2.5 mg Dronabinol count had a line, while the 5 mg Dronabinol did not. In addition, the page for the narcotic documentation of 2 mg Ativan did not have line on the bottom of the page. 2. Resident #36's Minimum Data Set assessment dated 9/6/23 indicated that she did not use an opioid during the seven day lookback period. The Clinical Physician's Orders reviewed on 10/4/23 listed an order dated 5/26/23 for Ultram (tramadol, opioid pain medication) 50 mg to use as needed for pain. The order reflected a discontinuation date of 6/1/23. The review of the medication cart on 10/3/23 revealed a bubble pack of Ultram 50 mg for Resident #36 containing 60 tablets still in the drawer. On 10/4/23 at 3:00, the Director of Nursing (DON) said that she expected the staff to destroy narcotic medication about a week after discontinuing the order or the resident discharges from the facility. She did not know that two residents had narcotics in the drawer for so long. The Disposition of Medications policy revised March 2020 directed that if a medication is a controlled substance, the medication must be marked discontinued with the date and left in the locked cabinet until it can be destroyed.	F 755		
F 812 SS=E	Food Procurement,Store/Prepare/Serve-Sanitary CFR(s): 483.60(i)(1)(2)	F 812	see Attached	

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F 812	Continued From page 5 §483.60(i) Food safety requirements. The facility must - §483.60(i)(1) - Procure food from sources approved or considered satisfactory by federal, state or local authorities. (i) This may include food items obtained directly from local producers, subject to applicable State and local laws or regulations. (ii) This provision does not prohibit or prevent facilities from using produce grown in facility gardens, subject to compliance with applicable safe growing and food-handling practices. (iii) This provision does not preclude residents from consuming foods not procured by the facility. §483.60(i)(2) - Store, prepare, distribute and serve food in accordance with professional standards for food service safety. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and service record review the facility failed to keep the ice machine clean and sanitary. The facility reported a census of 40 residents. Findings include: In a tour of the kitchen on 10/2/23 at 8:15 AM, discovered the inside the ice machine had a protective cover hanging just above the ice that contained random, round, dark, dirt spots. On 10/3/23 at 11:57 AM, the Dietary Manager (DM) looked at the spots reported that he did not know what the substance may be. He put a barrier down on the ice, got a washcloth and rubbed the black spotted substance off. He said that he did not clean the machine himself, as the	F 812		

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F 812	Continued From page 6 facility had a contracted company that cleaned it but he wasn't sure how often. The Marking Refrigerator servicing company invoice, reflected that were last at the facility on 12/9/22. At that time they emptied the ice machine and cleaned it.	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	F 880	See Attached	

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F 880	Continued From page 7 infections before they can spread to other persons in the facility; (ii) When and to whom possible incidents of communicable disease or infections should be reported; (iii) Standard and transmission-based precautions to be followed to prevent spread of infections; (iv)When and how isolation should be used for a resident; including but not limited to: (A) The type and duration of the isolation, depending upon the infectious agent or organism involved, and (B) A requirement that the isolation should be the least restrictive possible for the resident under the circumstances. (v) The circumstances under which the facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease; and (vi)The hand hygiene procedures to be followed by staff involved in direct resident contact. §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, interview, and policy review the facility failed to ensure that staff	F 880		

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F 880	Continued From page 8 practiced recommended hand hygiene to prevent the spread of pathogens during the meal service. The facility reported a census of 40 residents. Findings include: On 10/2/23, from 11:41 AM through 11:50 AM, observed Staff D, Dietary Aide, set up the resident tables in the dining room for the lunch meal. She picked up the container of glasses filled with water and on the top of rim with ungloved hands. Throughout the entire observation time, Staff D did not wash her hands or use hand sanitizer. On 10/5/23 at 9:00 AM, the Dietary Manager said that he expected his staff to grab the water glassed from the bottom of the glass and not put their hands on the rim when serving, or at least use disposable gloves. The Hand Washing/Hand Hygiene policy dated 2019, instructed all personnel to follow handwashing/hand hygiene procedures to prevent the spread of infections.	F 880		

Elm Crest Retirement Community
License #830051, Provider/Supplier/CLIA #165372
Harlan, Iowa 51537

Plan of Correction
Preparation of the Plan of Correction does not constitute admission or agreement by the provider of the truths 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 the federal and state law. Submission of the plan of correction shall not be construed as a waiver of this provider's right to contest any and all deficiencies, nor is such submission an admission that the facts are as alleged, or that any regulatory violation occurred.

The following is to be considered our Credible Allegation of Compliance.

F689 Free of Accidents Hazards/Supervision/Devices

Correct deficiency to individual:
Resident #22 has been assessed with no negative outcomes observed.

Protect res. in similar situation:
All nursing staff were educated to follow the EZ Way Smart Stand "Operator's Guide" in tightening the straps as resident is raised. The Operator's Guide especially in the lifting/transferring of the residents is for safety of both the residents and the staff and based on the nursing and therapy's assessment of the resident. This along with the "Seat Strap" is to be used when using the lift. All residents currently in the facility have been assessed for the proper type of transfer and lifting to be used.

Measures/system prevent reoccur:
Nursing staff were and will be educated on the need for following the instructions of the "Operator's Guide" especially the tightening of the strap individually addressing each of the resident's ability to be lifted and/or transferred based on their Care Plan, designed by Inter-Disciplinary Team. This along with the "Seat Strap" is to be used when using the lift and this education will be conducted at Shift Huddles, Team Times 3X/week and at the next two All Staffs, 10/10/23 and 11/14/23.

Monitor permanent solution:
Audits will be conducted 3times/weekly for the next four weeks then weekly for the next eight weeks by the DON/Designee regarding the staff following Operator's Guide during transfers and assessed for following the proper transfer techniques used.

Results of audits will be taken to the monthly QAPI meeting and evaluated for compliance for the next 3 monthly meetings.

Date of Completion: 11/03/23

F755 Pharmacy Srvs/procedures/pharmacist/records

Correct deficiency to individual:
No residents were immediately affected.

Protect res. in similar situation:
Upon learning that discontinued controlled substances were still stored in the refrigerator those meds were destroyed, and a new process for moving refrigerated D/C medications was created in order to move them into the separate locked bin in the medication cart until they could be destroyed. DON held 3 separate nursing meetings on Monday 10/16/23 to educate the staff and had staff sign their education acknowledgement.
Upon learning that nursing staff were not moving D/C Auto-Stops, new process for moving the D/C Auto-Stop medications was created in order to move them into the separate locked bin in the medication cart until they could be destroyed. All nursing staff were educated on the importance of doing this according to this new protocol. DON held 3 separate nursing meetings on Monday 10/16/23 to educate the staff and had staff sign their education acknowledgement.

Measures/system prevent reoccur:
The Clinical Manager/ designee will monitor the med room refrigerator to insure it has no D/C meds or meds from residents who have been discharged.
The red bag already placed into a locked bin inside the west hall medication cart. This bin is labeled that it is for discontinued medications only and any and all D/Ced medication either from an Auto-Stop or from a discharged resident will be stored. The medication kept in this bin will still be counted each shift during the narcotics count until it is destroyed. When a nurse places a discontinued medication into this bin, she will be alerting DON or Clinical Manager that a medication is needing destroyed so it can be done as soon as possible.
Nursing staff were educated on all these areas for the plan of correction at 3 Nurse's meetings on 10/16/23 and signed off on receiving this education.

Monitor permanent solution:
Clinical Manager/designee will perform Quality audits three times per week for four weeks and twice/week for the next 4 weeks and once/week for another four weeks. Results of audits will be taken to the monthly QAPI meeting and evaluated for compliance for next 3 monthly meetings.

Date of Completion: 11/03/2023

F812 Food Procurement, store/prepare/serve-sanitary

Correct deficiency to individual:
No residents were immediately affected nor have any residents since been affected.

Protect res. in similar situation:
The ice machines were immediately cleaned and disinfected the same day to protect all residents from any potential injury. All dietary staff were educated on the importance of cleanliness of both themselves and their work environment including how to properly clean the ice machines both in the kitchen and in the West hall on a regular basis.
Marking Refrigeration was called this same day and was able to come in on 10/11/2023 to give both of the Ice Machines a thorough top to bottom sanitizing and cleaning as well as preventive maintenance.

Measures/system prevent reoccur:
Dietary Mgr/Designee has put together a schedule for cleaning the ice machines. The cleaning will include the doors inside and out, the flap piece that is inside the ice machine, cleaning of the top, front and sides of the machine as well as the ice scoops and their holders. This will be done weekly. Marking Refrigeration will be coming in twice a year for the deep clean as part of their preventative maintenance. The importance of cleaning is being reiterated at our Team Times three times a week and our next two All Staffs, 10/10/2023 and 11/14/2023.

Measures/system prevent reoccur:
The Ice Machines Cleaning log will be audited will be checked by the dietary manager, dietitian, or designee 3 times a week for 30 days, followed by 2 x a week for 30 days, followed by 1 x a week for 30 days. Thereafter, the Ice Machine log will be spot checked by dietitian/ designee. Results of audits will be taken to the monthly QAPI meeting and evaluated for compliance for next 3 monthly meetings.

Date of Completion: 11/03/2023

F880 Infection Prevention & Control

Correct deficiency to individual:
No residents were immediately affected nor have any residents since been affected.

Protect res. in similar situation:
Education of the dietary staff was conducted immediately by the Dietary Supervisor as to the proper way to pass glasses and follow the Infection Control protocol and its relationship to the passing of liquids and food. This action to the passing and filling of cups and mugs for residents

must be done with the Cups upside down, which is the same way the cups and mugs come out of the dishwasher.

Measures/system prevent reoccur:
Education was provided to all of our staff at our Team Times 3x a week and at our next two All Staff meetings on 10/10/23 and 11/14/2023. We are holding a Dietary in-service on 10/23 to go over the specific requirements in Dietary to make sure infection Control protocols are followed. These include the pouring of liquids, serving plates to residents, passing and setting up of the table settings. We will also review the use of gloves and proper changing of gloves as this relates to dietary and food service.

Monitor permanent solution:
Dietary Mgr. /Designee will perform audits of staff as the staff set up meal service and pass meals to residents 3X/week twice a day to catch two meals per day for the first 30days, then 2X/week twice a day for the next 30 days and then the last 30 days 1X/week twice a day. This will also allow us to see two sets of staff with one day team and one evening team. Results of audits will be taken to the monthly QAPI meeting and evaluated for compliance for the next 3 monthly meetings.

Date of Completion: 11/03/2023

Timothy J Nauslar
Administrator
Elm Crest Retirement Community
9/22/2022