STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	16E758	A. BUILDING _____ B. WING _____	C 07/22/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MOUNT CARMEL BLUFFS	1160 CARMEL DRIVE DUBUQUE, IA 52003

(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 8/21/21 The Iowa Department of Inspections and Appeals (DIA) in accordance with the Medicare Conditions of Participation and Requirements set forth in 42 CFR 483, Subpart B-C conducted this Medicare Initial Certification Survey and Investigation of complaint and a facility reported incident. The facility was found to be NOT IN COMPLIANCE. Total residents: 36 Onsite dates: 7/19/21 - 7/22/21 Facility Reported Incident and Complaint # reviewed #98168-I not substantiated #98384-C not substantiated	F 000	F 000 ALLEGATION OF COMPLIANCE DATE: 8/11/2021 PLAN OF CORRECTION This plan of correction does not constitute an admission or agreement by the provider to the accuracy of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of corrections is prepared and/or executed solely because it is required by the provisions of federal and state law. Completion dates are provided for procedural processing purposes and correlation with the most recently completed or accomplished corrective action and do not correspond chronologically to the date the facility maintains it is in compliance with the requirements of participation, or that corrective action was necessary.	
F 625 SS=B	Notice of Bed Hold Policy Before/Upon Trnsfr 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;	F 625	In continuing compliance with F 625, Regulation 483.15(d)(1)(2) Notice of Bed Hold Policy Before/Upon Transfer, Mount Carmel corrected the deficiency as follows: For resident #106 and #51, verification of Bed Hold Policy completed at time of admission, noted on 7/21/2021. Bed Hold Policy and Procedure policy reviewed, and all Licensed Nursing	Date of Compliance 8/12/2021

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

Sarah Renty | Campus Administrator | 8-11-2021

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 (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. This REQUIREMENT is not met as evidenced by: Based on clinical record review, document review, resident and staff interviews, the facility failed to provide bed hold notification for facility-initiated transfers for 3 out of 3 residents (Resident #51, 58, 106) sampled. The facility identified a census of 36 residents. Findings include: 1. A Clinical Census Sheet, provided by the facility, showed Resident #106 discharged to the hospital on 7/4/21 and readmitted to the facility on 7/8/21. A Progress Note dated 7/4/21 at 8:02 a.m., documented Resident #106 agreeable to go to the emergency room (E.R.), and transferred out to a local hospital E.R. The Progress Notes dated 7/4/21 thru 7/8/21 lacked documentation of a bed hold notification being addressed with the resident or medical	F 625	staff re-educated on policy and procedure, including the requirement to document the Bed Hold notification at time of transfer. As part of ongoing commitment to quality assurance, the Clinical Administrator will conduct a weekly audit on all unplanned transfers. Audits will continue for one month and be reviewed through the QA process. **F689** In continuing compliance with F 689, Regulation 483.25(d)(1)(2) Free of Accident Hazards/Supervision/Devices, Mount Carmel corrected the deficiency as follows: For resident #103 and #110, care plan and pocket care plan reviewed. Transfer and Ambulation Policy reviewed with all clinical staff at daily Stand-Up Meetings for the weeks of 7/26/2021 and 8/2/2021. All clinical staff received retraining and skills competency checklist completed. Relias module Safe Transfers was assigned to all care center staff. All pocket care plans were reviewed for accuracy and updated as needed. As part of ongoing commitment to quality assurance, the Clinical Administrator or designee will conduct	Date of Compliance 8/21/2021

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F 625	Continued From page 2 power of attorney. During an interview on 7/19/21 at 3:45 p.m., Resident #106 stated she did not recall if the facility had addressed a bed hold with her regarding her last hospitalization. On 7/20/21 at 2:42 p.m., the Administrative Consultant reported the facility did not have a bed hold for the date of 7/4/21. She reported the resident had gone to the E.R. and then admitted from there. The resident had signed a blanket bed hold notice on 2/23/21 when she admitted to the facility stating that she wanted her bed held if she went to the hospital. The Administrative Consultant submitted a copy of the Bed Hold and Readmission Form - Iowa form signed by the Resident's Power of Attorney on 2/18/21. Interview on 7/20/21 at 3:10 p.m., Administrative Consultant stated it is difficult when resident's go to E.R. because the facility does not know if they are going to be admitted. Typically, the nurse informs the resident of the bed hold when sending them out. They should notify family within 24 hours regarding the bed hold and document in the progress notes once completed. During an interview on 7/21/21 at 12:16 p.m. Staff B, Registered Nurse, (RN), reported they are to follow-up with the family or legal representative regarding the bed hold at the time they send the resident to the E.R. and document in the progress notes. Interview on 7/21/21 at 2:13 p.m., Clinical Administrator stated that upon admission the resident's sign a bed hold notice as part of the admission contract. Then at the time of a transfer	F 625	weekly audits on resident transfers. Audits will continue for one month and be reviewed through the QA process. **F800** In continuing compliance with F800, Regulation 483.60, Provided Diet Meets Needs of Each Resident, Mount Carmel corrected the deficiency as follows: Hot table setting was adjusted, and increased to #10, from #7. Thermometers were recalibrated the week of 8/2/2021. Staff were re-educated on Safe Handling of Potentially Hazardous Food. A review of the Culinary Employee Orientation Check list was completed for servers and cooks, emphasizing the importance of proper food temperatures and expectations for proper procedure to complete temperature checks As part of ongoing commitment to quality assurance, the Culinary Director or designee will conduct weekly audits of food temperatures pre and post meal service to assure temps are holding at 135 degrees. Audits will continue for one month and be reviewed through the QA process **F803** In continuing compliance with F803, Regulation 483.60(2)(1)-(7) Menus Meet Resident Needs Prep in	Date of Compliance 8/21/2021 Date of Compliance 8/21/2021

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F 625	Continued From page 3 out, the charge nurse should be asking the resident or legal representative about the bed hold notice and documenting that the conversation with the durable health care power of attorney or resident in the progress notes. If not completed at the time of discharge, then follow-up should be done within 24 hours. The Bed Hold Policy - Iowa, modified November 2018, identified upon admission and when a facility transfer a resident to a hospital or a resident goes on therapeutic leave (absences for purposes other than required hospitalization), the facility will provide notification of the bed hold policy to the resident and/or resident representative. The Bed Hold Procedure identified the following: 1. Upon admission, the resident or the resident's representative will sign the Bed Hold and Readmission Policy in the Admission Packet. 2. Before a resident leaves for hospitalization or therapeutic leave, the facility will attempt to give the resident or Responsible Party a copy of the bed hold policy. 3. The Resident Services staff or designee will Contact the resident/responsible party to inquire about bed hold and verify their bed hold decision within 24 hours of transfer. 4. Discussion regarding the bed hold will be documented in the progress notes. 2. The Minimum Data Set (MDS) dated 6/1/21 identified Resident #51 with the following diagnoses: neurogenic bladder, urinary tract infection, and congenital malformation of the spinal cord, a BIMS of 14 that indicated cognition intact. It also identified the resident required extensive staff assistance with most activities of	F 625	ADV/Followed, Mount Carmel corrected the deficiency as follows: All Culinary Staff completed re-education on department policies, including: Safe Handling of Potentially Hazardous Food Policy, Bare Hand Contact with Ready to Eat Foods Policy, Handwashing and Glove Use, Diet Policy and Menu and NCM Diet Manual Policy. All Clinical staff completed Relias module Food Safety Fundamentals. Facility has purchased additional serving/portion control utensils to ensure that the correct sizes are available according to the diet spread sheet signed by Dietician. Any menu changes will be reviewed in advance by Corporate or Contracted Dietician and signed off for nutritional value prior to any preparation of meal. As part of ongoing commitment to quality assurance, the Culinary Director or designee will conduct weekly audits of dining service. Audits will continue for one month and be reviewed through the QA process **F880** In continuing compliance with F880, Regulation	Date of Compliance 8/21/2021

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F 625	Continued From page 4 daily living. A review of the Nurse's Notes revealed the following: On 5/20/21 at 8:00 a.m., resident left this morning to the hospital for planned surgery. On 5/25/21 at 1:52 p.m., resident returned with unit with staff member propelling the wheelchair. Review of the Bed Hold and Readmission form signed by the resident on 2/18/21 contained an acknowledgement of understanding of the policy and showed preference for initiation of the bed hold at the time of transfer. 3. The MDS dated 5/27/21 identified Resident #58 with the following diagnoses: Non-Alzheimer's dementia, hypertension, and hyperlipidemia, a BIMS of 8, which indicated severe cognitive impairment. It also identified the resident only required extensive staff assistance with locomotion off the unit, otherwise the resident had been independent with the remainder of activities of daily living. A review of the Nurse's Notes revealed the following: On 5/3/2021 at 4:31 p.m., resident lost her balance and fell, given orange juice. The DPOA (durable power of attorney), case manager, and physician all contacted. Received orders to transfer her to the hospital. On 5/3/21 at 5:00 p.m., resident had been sent to the hospital via ambulance On 5/4/2021 at 10:00 p.m., resident readmitted to room from the hospital at 3:45 p.m. The Nurse's Notes did not include documentation to show the DPOA informed of the bed hold policy within 24 hours of the resident's transfer.	F 625	483.80(a)(1)(2)(4)(e)(f) Infection Prevention and Control, Mount Carmel corrected the deficiency as follows: All facility staff have completed re-education on PPE and Infection Control Practices. All staff have completed CDC training videos, including: PPE Lessons, Clean Hands, and Keep COVID Out. All Clinical staff completed Relias training videos Food Safety Fundamentals, Infection Control and Prevention, and Personal Protective Equipment. QAPI meeting held August 10th, to include Medical Director, Clinical Administrator, Administrator, Environmental Services Director, Housekeeping Supervisor, Culinary Director, Infection Preventionist. Members of management team attended Telligen Root Cause Analysis (RCA) training and RCA was developed and reviewed. All Housekeeping staff have completed Relias modules Infection Control and Infection and Personal Protective Equipment. Staff have been reeducated on the Infection Prevention and Control Manual. As part of ongoing commitment to quality assurance, the Infection	

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F 625	Continued From page 5 Review of the Bed Hold and Readmission form signed by the resident on 2/18/21 contained an acknowledgement of understanding of the policy and showed preference for initiation of the bed hold at the time of transfer. In an interview on 7/21/21 at 12:08 p.m., Staff B, RN reported when residents are transferred out to the hospital, the nurse who sent the resident out is responsible for reviewing the bed hold policy before the resident is sent out to the ER (emergency room). This should be documented this in the progress notes within twenty-four hours.	F 625	Specialist, Housekeeping Supervisor, or designee will conduct weekly audits of PPE use, including Transmission Based and Standard Precautions. Audits will continue for one month and be reviewed through the QA process.	
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, clinical record review, and staff interviews, the facility failed to utilize a gait belt for transfer and ambulation for safety for 2 of 3 residents (Resident #103 and 110) observed for transfers. The facility identified a census of 36 residents.	F 689		

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F 689	Continued From page 6 Findings include: 1. The Minimum Data Set (MDS) Assessment, dated 6/16/21, for Resident #103 showed a Brief Interview for Mental Status (BIMS) score of 11 indicating mild cognitive loss. The resident required extensive assistance of two staff for transfers and toileting as well as extensive assistance of one staff member for walking in the room/corridor. The MDS documented Resident #103 as frequently incontinent of urine and occasionally incontinent of bowel. The MDS identified Resident had falls prior to admission and two or more falls since admission to the facility. The MDS listed a diagnoses of Parkinson's disease, anemia, peripheral vascular disease (PVD), diabetes mellitus (DM), osteoporosis, and Alzheimer's disease. The Care Plan, revised 6/28/21, identified the resident had limited physical mobility, weakness, impaired balance, Parkinson's Disease, involuntary movements, Alzheimer's Dementia and a history of fall with compression fractures. The Care Plan directed the staff to transfer/ambulate the resident with assistance of one and a gait belt, effective 6/10/21. The Physical Therapy Progress and Updated Plan of Care, dated 7/9/21, documented the resident remains with poor safety judgment and weakness/balance deficits, which place her at a high fall risk. A review of facility Resident Occurrence Reports from 6/1/21 thru 7/22/21 documented the resident fell on the following dates: - 6/15/21 - 6/16/21	F 689		

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F 689	Continued From page 7 - 6/25/21 - 7/01/21 - 7/12/21 During an observation on 7/21/21 at 7:15 a.m. Staff J, Resident Assistant, assisted the resident to stand as she held onto the wheeled walker. Staff J failed to place a gait belt around the resident's waist. Staff J held the back of the resident's pajama pants as the resident walked to the bathroom. After toileting, Staff K, Registered Nurse, held the back of the resident's pajama pants and walked the resident approximately 10 feet from the toilet to the wheelchair without a gait belt. 2. The Clinical Resident Profile for Resident #110 showed the resident admitted to the facility on 7/13/21. The Care Plan, dated 7/13/21, documented the resident had limited physical mobility and directed the staff to provide assist of one person using a gait belt and walker for ambulation/transfer. The Physical Therapy Plan of Care, dated 7/14/21, documented Resident #110 had repeated falls due to balance impairments. The resident had complained of sudden lurching without control with resulting impairments in transfer and ambulation safety. The Plan of Care documented the resident as a high fall risk. The Occupational Therapy Plan of Care, dated 7/14/21, documented the resident had a history of frequent falls with the resident falling approximately 5 times within the past 2 weeks and 6 time in the previous month. The Therapy Necessity documented without therapy the	F 689		

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F 689	Continued From page 8 resident is at a high risk for falls and injury. During an observation on 07/21/21 at 11:22 a.m. Staff G, Resident Assistant, explained to resident #110 that she would assist her to the bathroom. Staff G locked the wheelchair brakes and assisted the resident to stand without applying a gait belt. Resident #110 turned around and walked approximately 10-12 feet backward into the bathroom with Staff G standing in front of the resident's walker. After toileting, the resident stood from the toilet and proceeded to take two steps forward while Staff G removed her gloves and turned away from the resident to place the gloves in the trash can. The resident ambulated and stood in front of the sink. The resident stood with her right knee bent leaning to the right side. Staff G stepped several feet away from the resident twice while the resident stood at the sink with no gait belt on. The resident proceeded to walk from the sink approximately 10 feet out of the bathroom to her wheelchair using the walker. Staff G walked behind the resident removing another set of gloves to throw in the trash. Staff G did not have a hand on the resident. Staff G failed to apply a gait belt for transfer and ambulation as stated on the Care Plan. On 07/21/21 at 1:02 p.m. Staff G, reported she has worked at the facility for so long that she just knows the residents and knows which residents do and do not want a gait belt. She reported resident #110 would sometimes bat her hand away and state she does not want the gait belt. Staff G reported resident set in her ways so she did not use the belt and did not offer the belt earlier when she assisted her. The staff follow the Pocket Care Plan to know how much assistance each resident needs.	F 689		

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F 689	Continued From page 9 A review of the Pocket Care Plan for Resident #103 and #110 lacked documentation regarding if a gait belt should be used for ambulation and transfer. During an interview on 7/21/21 at 1:47 a.m., the Rehabilitation Services Manager reported she has worked with both of the residents. She reported Resident #103 and #110 both need one assist and need to have a gait belt used for safety. The resident's may just need verbal cueing or minimal assistance but the gait belt should be on for safety. Resident #103 and #110 remain on caseload. On 7/21/21 at 2:10 p.m. the Clinical Administrator report if the resident requires more than stand by assistance, then the resident assistants need to use a gait belt for ambulation and transfer. She reported they recently supplied each resident room with a gait belt. The assistance level communicated on the Pocket Care Plan is updated as needed. She reported her expectation is that the staff check the Pocket Care Plan before every shift for changes. The Gait Belt for Transfer and Ambulation Policy, approved December 2014, provided by the facility identified the following: a. Purpose: gait belts are provided to assist staff to safely transfer or ambulate residents. b. Policy: gait belts are not used as a restraint and will be used for all transfers of weight bearing residents who require assistance with transfer and/or ambulation if indicated on the Care Plan/ The Gait Belt for Transfers and Ambulation Policy detailed the following procedure:	F 689		

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F 689	Continued From page 10 1. Explain procedure to the resident and provide privacy. 2. Apply belt around resident's waist. a. Pass the metal-tipped end through the buckle under the teeth. b. Bring tip of belt across the front of buckle and slip it through to the other side. c. Tuck any excess through the belt. d. Ensure belt is snug but allow enough room for your hand to comfortably grasp it. 3. Stand as close to the resident as possible, maintaining a broad base support. 4. Transfer a. Assist resident to a standing position by grasping belt at the waist from underneath. b. Pivot resident into chair or bed. 5. To ambulate: a. Assist resident to standing position by grasping belt at the waist from underneath. b. Standing on weaker side of resident, wrap your arm around waist of the resident and grasp belt from underneath. c. Maintain a firm grasp on the belt and proceed to ambulate. 6. When transfer is complete, remove belt and return to storage area. 7. Report any changes to the nurse.	F 689		
F 800 SS=E	- Provided Diet Meets Needs of Each Resident CFR(s): 483.60 §483.60 Food and nutrition services. The facility must provide each resident with a nourishing, palatable, well-balanced diet that	F 800		

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F 800	Continued From page 11 meets his or her daily nutritional and special dietary needs, taking into consideration the preferences of each resident. This REQUIREMENT is not met as evidenced by: - Based on observation, document review, resident and staff interviews, the facility failed to maintain hot food holding temperature above 135 degrees throughout the meal service. The facility identified a census of 36 residents. Findings include: During a resident council meeting on 7/19/21 at approximately 2:00 p.m., 3 of 4 residents reported the food is good, but could be hotter. During an observation on 7/20/21 at 11:42 a.m., Staff I, Server, put the steam pans of food into the steam table and performed the following temperature checks prior to starting meal service on the second floor kitchen: - Ginger chicken thighs - 154 degrees - Swedish meatballs - 144 degrees - Buttered noodles - 154 degrees - Carrots - 150 degrees - Tomato basil soup - 167 degrees On 7/20/21 at 11:56 a.m. Staff H, Cook/Chef, started meal service for the resident's in the second floor dining room. On 7/20/21 at 12:37 p.m. the Certified Dietary Manager, (CDM), served out the final two resident meals to the second floor dining room and proceeded to perform post meal temperatures: - Ginger Chicken thighs - 124 degrees	F 800		

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F 800	Continued From page 12 - Swedish meatballs - 138 degrees - Buttered noodles - 100.1 degrees - Carrots - 117 degrees - Tomato basil soup - 132 degrees. At approximately 7/20/21 at 12:49 p.m., the Surveyor sampled the ginger chicken thigh, Swedish meatballs, buttered noodles, carrots, and tomato basil soup. The food tasted cold. On 7/20/21 at 12:44 p.m. the CDM reported they like to have the food at a holding temperature of 145 degrees or higher on the steam table. On 7/20/21 at 12:50 p.m., Staff H checked the steam table in the second floor kitchen and reported the steam table had been set at 7 and should be set at 10 to keep food up to temperature. On 7/20/21 at 12: 51 p.m., the CDM entered the kitchen and stated the steam table is set correctly at 7. If the steam table is at 10 it actually cooks the food. During an interview on 7/20/21 at approximately 1:30 p.m., the CDM reported she would expect the staff to follow the dietician-approved menu and keep food at the appropriate holding temperature. On 7/21/21 at 3:54 p.m., the Consulting Dietician reported she would expect the dietary staff to serve the menu as written and the food held on the steam table above 135 degrees. The steam table should hold the temperature of the food. Review of the Employee Orientation Checklist - Cook, updated 10/16/2019, provided by the	F 800		

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F 800	Continued From page 13 facility, directed staff to recognize and demonstrate daily responsibilities that included the following: Take and record food temperatures: a. Hot food must be held at, and leave the kitchen at, above 135 degrees Fahrenheit. Review of the Employee Orientation Checklist - Plating Server, updated 10/16/2019, provided by the facility, directed the staff to recognize and demonstrate daily responsibilities that include the following: Take and record food temperatures: a. Hot food must be held at, and leave the kitchen at above 135 degrees Fahrenheit. Review of the Safe Food Handling Handout, dated 6/2018, provided by the facility lacked documentation that directed staff to hold hot food on the steam table at 135 degrees Fahrenheit or higher.	F 800		
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;	F 803		

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F 803	Continued From page 14 §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; §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, document review and staff interview the facility failed to prevent kitchen staff from touching food with bare hands during food preparation, serve the dietician signed menu, serve correct menu portion sizes for soup, serve correct menu portion sizes for protein for 22 residents on regular diet/portion sizes and serve the physician ordered diet for 1 of 1 (Resident #112, not part of formal sample) residents on pureed diet. The facility identified a census of 36 residents. Findings include: During an observation of meal preparation in the third floor kitchen on 7/20/21 at 10:59 a.m. Staff N, Cook/Chef, used a spatula to remove Swedish meatballs from the baking sheet to a large steam pan. Staff N flipped two meatballs off the baking	F 803		

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pan with a spatula, then used her bare hand to pick up the two meatballs and throw them back on the baking pan.

On Tuesday, 7/20/21 at 11:00 a.m. the posted Spring/Summer 2021 menu, provided by the facility, included the following:
- Tomato basil soup
- Tossed garden salad
- Swedish meatballs
- Ginger chicken thigh(s)
- Herb buttered noodles
- Carrots
- Milk of choice
- Dessert of choice

The Tuesday Week 2-Lunch extension menu, provided by the facility, listed the following menu:
- 6 ounces (oz.) regular serving/4 oz. small serving tomato basil soup.
- 10 oz. regular serving/half portion small serving beef stir-fry.
- 1/2 cup regular serving/1/4 cup small serving brown rice.

The Monday Week 2-Lunch extension menu, provided by the facility, listed the following menu:
- 4 oz. regular serving/2 oz. small serving Swedish meatballs
- 1/2 cup regular serving/1/4 cup small serving herb buttered noodles.
- 1/2 cup regular and small serving sizes for carrots.

The Spring/Summer 2021 menu, provided by the facility, signed by the Corporate Dietician, posted the following menu for Tuesday, week 2:
- Tomato basil soup
- Beef Stir fry

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F 803	Continued From page 16 - Brown rice - Milk of choice - Dessert of choice Observation on 7/20/21 at 11:56 a.m. revealed Staff H, Cook/Chef, started serving the tomato basil soup using a 4 oz. gray ladle. Staff H reported he used a #10 (3 oz.) scoop to serve the soup. Staff H failed to serve the 6 oz. portion size for the soup as listed on the Tuesday, Week 2-Lunch meal extension for residents receiving regular portion sizes. On 7/20/21 at 12:10 p.m. Staff H serve Resident #112, resident not included in the formal sample, 3 oz. of pureed meat and 4 oz. serving of mash potatoes. Staff H ladled a small amount of gravy over the mash potatoes only. Resident #112's Order Summary Report, signed by the Provider 6/4/21, documented a pureed meat with extra gravy/sauce diet order. Staff H failed to provide extra gravy/sauce over the pureed meat. While under continuous observation on 7/20/21 from 11:56 a.m. - 12:32 a.m., Staff H served 3 Swedish meatballs as the 4 oz. serving for 22 residents. On 7/20/21 at 12:34 p.m., the Certified Dietary Manager (CDM) took over serving for Staff H and served the last two residents, regular portion diets. She served out 4 (Swedish) meatballs as a portion for the 4 oz. serving size. On 7/20/21 at 12:36 p.m., the CDM reported the (Swedish) meatballs are 1 oz. meatballs and the correct serving size is 4 meatballs. She asked Staff H what he had been instructed to do. Staff H reported he had been instructed before he left the	F 803		

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F 803	Continued From page 17	F 803		

third floor kitchen to serve 3 (Swedish) meatballs as a serving size. The CDM correct Staff H and informed the correct serving size for the (Swedish) meatballs had been 4 meatballs.

During an interview on 7/20/21 at 1:30 p.m., the CDM reported she would expect the staff to serve the dietician-approved menu. She reported they use the Sysco menus. They noticed the menus were off from the days but the issue has been corrected and the correct printed menus will come out with the fall rotation. She reported she would expect the staff to serve the correct portion sizes, correct diet and staff should not touch food with bare hands during food preparation.

On 7/21/21 at 3:54 p.m., the Consulting Dietician reported she would expect the dietary staff to serve the menu as written including portion sizes.

On 7/22/21 at 8:11 a.m., the Corporate Dietician reported the menus may be off by a day, but the residents would still get the basic protein, carbohydrates, and fat from the menu. She reported if the CDM stated the meatballs were 1 oz. meatballs, then the menu extension should be followed. She stated she would expect them to serve out the portion sizes from the extension menu as planned.

The Safe Food Handling Handout, dated 6/2018, provided by the facility, filed to address/direct staff not to touch food during food preparation.

The Employee Orientation Checklist - Cook, updated 10/16/19, provided by the facility showed Cook/Chefs receive training on following hand washing, glove use, and other infection control practices.

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F 803	Continued From page 18 The Core Menu and Nutritional Care Manual (NCM) Manual Policy (Care Center) dated 9/2020, provided by the facility documented the following procedure: - Menus will be prepared in advanced and followed. - Menus are updated periodically. - Menus are reviewed by a Registered Dietician, Nutritionist, other clinical qualified nutrition professional for nutritional adequacy. The Diet Extension -Resource Guide Policy, undated, provided by the facility documented the following guidelines: 1. Copies of menu extensions should be available in the main kitchen (cooks, culinary staff) and each serving location (servers, nursing assistants, registered nurses and other staff). 2. Ensure the day, week, and meal of the menu cycle match the diet extensions referenced. 3. Read diet extensions: - Vertically to identify the full meal offered to a resident/guest on that diet. - Horizontally to identify menu items and alternate items by each diet. 4. Serving size = amount served (use appropriate serving utensil to ensure correct amounts) Common Scoop sizes/portions: - # 4 scoop = 8 oz. = 1 cup - # 5 scoop = 6 oz. = 3/4 cup - # 6 scoop = 5 oz. = 2/3 cup - # 8 scoop = 4 oz. = 1/2 cup - #12 scoop = 3 oz. = 1/3 cup - #16 scoop = 2 oz. = 1/4 cup - #30 scoop = 1 oz. = 1/8 cup 5. Regular diet - indicates the general menu that is offered and correlates with the serving size	F 803		

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F 803	Continued From page 19 indicated in the left hand column. The Portion Control Chart, undated, provided by the facility showed the gray scoop size as a #8 scoop, 4 oz portion size.	F 803		
F 880 SS=D	Infection Prevention & Control CFR(s): 483.80(a)(1)(2)(4)(e)(f) §483.80 Infection Control The facility must establish and maintain an infection prevention and control program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of communicable diseases and infections. §483.80(a) Infection prevention and control program. The facility must establish an infection prevention and control program (IPCP) that must include, at a minimum, the following elements: §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		

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F 880	Continued From page 20 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, record review and staff	F 880		

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interview, the facility failed to follow proper infection control techniques for 1 of 1 residents revlewed In transmission based precautions (Resident #53) and for one out of twelve residents observed during meals (Resident #109). The facility reported a census of 36 residents.

Findings include:

1. The Minimum Data Set (MDS) dated 7/5/21 identified Resident #53 with the following diagnoses: peripheral vascular disease, multidrug resistant organism, and acquired absence of left leg above the knee, and with a Brief Interview for Mental Status (BIMS) of 15, which indicated cognition intact. It also identified the resident required extensive staff assistance with bed mobility, transfers, toileting, and bathing.

The care plan identified the resident with the problem on 3/8/21 of a MRSA (methicillin resistant staphylococcus aureus, a type of infection resistant to many antibiotics) to an ulcer to the right malleolus (ankle) and directed staff to:
a. Change dressing per orders.
b. Follow CONTACT precautions when caring for the resident.
c. Give medications per orders.
d. Monitor for increased symptoms of infection, which may include increased temperature, altered mental status or vs (vital signs), increased drainage, lethargy or redness of site.
e. Monitor my lab results per my physician orders.
f. Monitor my vital signs per protocol.
g. Update my physician/NP (nurse practitioner) as needed.

An observation on 7/19/21 at 11:29 AM revealed

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F 880	Continued From page 22 Staff O, housekeeper stood outside the room which had storage bin in hall with personal protective equipment stored in it, one bin labeled laundry and the other labeled trash. Staff O wore only goggles and gloves before she entered the room and said "I am here to clean your bathroom and your sink" She did not don isolation gown. Signs posted outside the door with "CONTACT PRECAUTIONS" staff to wear gown, gloves and use dedicated equipment in the room. Staff O did not remove her gloves when she exited the room and proceeded to touch the housekeeping cart and the outside of the trash bin in the hall. A review of the wound culture report of drainage from the ankle collected 6/1/21 revealed a moderate amount of MRSA. In an interview on 7/21/21 at 11:10 AM, the clinical administrator reported she would have expected the housekeeper to wear a gown to clean the resident's room. In an interview on 7/21/21 at 12:08 PM, Staff B, RN reported all staff should wear an isolation gown, gloves, mask, and goggles when entering the resident's room. In an interview on 7/21/21 at 1:41 PM, Staff C, housekeeper reported when going in to the resident's room, she should wear an isolation gown, gloves, goggles, and mask. In an interview on 7/22/21 at 7:46 AM Staff A, reported when going in to the resident's room, she should wear an isolation gown, gloves, goggles and mask. She also reported when finished cleaning the room, she should change her gloves before leaving the room.	F 880		

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F 880	Continued From page 23 In an interview on 7/22/21 at 7:50 AM, Staff L, housekeeper reported when going into a room with contact isolation, she should wear gloves, an isolation gown, goggles, and a mask. After cleaning the room, she would remove her gloves at the doorway. She also reported she received training on isolation procedures before the facility opened. She could not remember putting on an isolation gown before she entered the resident's room on 7/19/21, she did remember seeing the sign on the door with instructions on PPE. She reported she did not work that floor that often and thought she may have been in a hurry to clean the room. A review of the Infection Prevention and Control Manual dated 2020 instructed for contact precautions to do the following: a. Wear gloves whenever touching the resident's intact skin or surfaces and articles near the resident. Don gloves upon entry into the room or cubicle. b. Gloves should also be worn when handling items potentially contaminated by MDROs (multi drug resistant organisms). This may include such items such as bedside tables, over-bed tables, bed rails, bathroom fixtures, television and bed controls, suction, and oxygen tubing c. Gloves will be removed and discarded before leaving the resident's room, followed by hand hygiene. d. After glove removal and hand hygiene, staff should ensure that hands do not touch potentially contaminated environmental surfaces or items in the resident's room to avoid transfer of microorganisms to other residents or environments. e. Don gown upon entry into the room or cubicle.	F 880		

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F 880	Continued From page 24 Remove the gown and observe hand hygiene before leaving the resident care environment. 2. The Minimum Data Set (MDS) Assessment, dated 5/17/21, showed Resident #109 with a long/short term memory impairment and severely impaired decision-making ability. The resident required extensive assistance of one staff person for eating. The MDS identified diagnoses of Alzheimer's disease with late onset, diabetes mellitus, hyperlipidemia, and atrial fibrillation. The Care Plan, revised 3/11/21, identified the resident with activities of daily living (ADL's) self-care performance deficit and directed the resident required one assistance for eating. An Order Summary Report, signed by the Provider on 6/11/21, documented an order for a consistent carbohydrate, regular texture, and thin liquid diet. On 07/20/21 at 8:52 AM Staff M, Health Information Specialist/Resident Assistant picked up a piece of bacon with her bare hand and handed the piece of bacon to Resident #109 to eat. She continued to assist another random resident, not included in the sample, with his or her breakfast, without performing hand hygiene. During an observation on 7/20/21 at 8:54 AM Staff M picked up a piece of bacon with her bare hand and handed the piece of bacon to the resident to eat. Staff M continued to assist another random res not included in the sample with breakfast without performing hand hygiene. On 7/20/21 at 1:20 PM Staff M reported she did watch a Relias video on food handling, but has not received any formal training in food handling	F 880		

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MOUNT CARMEL BLUFFS	1160 CARMEL DRIVE DUBUQUE, IA 52003

(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 880	Continued From page 25 from the facility. She stated she knew after she had touched the bacon she should have used a glove to pick up the bacon. She reported she had done hand hygiene shortly before that. During an interview on 7/21/21 at 12:17 PM Staff B, Registered Nurse, (RN) reported the resident assistants received competency skill training and health care academy training on different types of diets and choking risks. Staff should not touch food with their bare hands. They should use a glove if they have to touch resident food. On 7/21/21 at 2:10 PM, The Clinical Administrator reported the resident assistants receive food-handling education through Relias. She reported resident food should not be touched with care hands. She would expect the resident assistants to use gloves with handling resident food.	F 880		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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F 880	Continued From page 23 In an interview on 7/22/21 at 7:50 AM, Staff L, housekeeper reported when going into a room with contact isolation, she should wear gloves, an isolation gown, goggles, and a mask. After cleaning the room, she would remove her gloves at the doorway. She also reported she received training on isolation procedures before the facility opened. She could not remember putting on an isolation gown before she entered the resident's room on 7/19/21, she did remember seeing the sign on the door with instructions on PPE. She reported she did not work that floor that often and thought she may have been in a hurry to clean the room. A review of the Infection Prevention and Control Manual dated 2020 instructed for contact precautions to do the following: a. Wear gloves whenever touching the resident's intact skin or surfaces and articles near the resident. Don gloves upon entry into the room or cubicle. b. Gloves should also be worn when handling items potentially contaminated by MDROs (multi drug resistant organisms). This may include such items such as bedside tables, over-bed tables, bed rails, bathroom fixtures, television and bed controls, suction, and oxygen tubing c. Gloves will be removed and discarded before leaving the resident's room, followed by hand hygiene. d. After glove removal and hand hygiene, staff should ensure that hands do not touch potentially contaminated environmental surfaces or items in the resident's room to avoid transfer of microorganisms to other residents or environments. e. Don gown upon entry into the room or cubicle.	F 880		

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F 880	Continued From page 24 Remove the gown and observe hand hygiene before leaving the resident care environment. 2. The Minimum Data Set (MDS) Assessment, dated 5/17/21, showed Resident #109 with a long/short term memory impairment and severely impaired decision-making ability. The resident required extensive assistance of one staff person for eating. The MDS identified diagnoses of Alzheimer's disease with late onset, diabetes mellitus, hyperlipidemia, and atrial fibrillation. The Care Plan, revised 3/11/21, identified the resident with activities of daily living (ADL's) self-care performance deficit and directed the resident required one assistance for eating. An Order Summary Report, signed by the Provider on 6/11/21, documented an order for a consistent carbohydrate, regular texture, and thin liquid diet. On 07/20/21 at 8:52 AM Staff M, Health Information Specialist/Resident Assistant picked up a piece of bacon with her bare hand and handed the piece of bacon to Resident #109 to eat. She continued to assist another random resident, not included in the sample, with his or her breakfast, without performing hand hygiene. During an observation on 7/20/21 at 8:54 AM Staff M picked up a piece of bacon with her bare hand and handed the piece of bacon to the resident to eat. Staff M continued to assist another random res not included in the sample with breakfast without performing hand hygiene. On 7/20/21 at 1:20 PM Staff M reported she did watch a Relias video on food handling, but has not received any formal training in food handling	F 880		

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