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
	165151	A. BUILDING _____ B. WING _____	10/14/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MISSISSIPPI VALLEY	PO BOX 1270 KEOKUK, IA 52632

(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: 11/5/21 The following relates to the Recertification Survey, Complaints #94382, #95219, #96664, #97247, #97926, #98155, #98953, and #99173, and Facility Reported Incidents #95789, #95790, #97310 conducted October 4 - 14, 2021. Complaint #99173-C was substantiated. See Code of Federal Regulations (42CFR) Part 483, Subpart B-C.	F 000		11/5/21
F 644 SS=D	Coordination of PASARR and Assessments CFR(s): 483.20(e)(1)(2) §483.20(e) Coordination. A facility must coordinate assessments with the pre-admission screening and resident review (PASARR) program under Medicaid in subpart C of this part to the maximum extent practicable to avoid duplicative testing and effort. Coordination includes: §483.20(e)(1)Incorporating the recommendations from the PASARR level II determination and the PASARR evaluation report into a resident's assessment, care planning, and transitions of care. §483.20(e)(2) Referring all level II residents and all residents with newly evident or possible serious mental disorder, intellectual disability, or a related condition for level II resident review upon a significant change in status assessment. This REQUIREMENT is not met as evidenced by: Based on clinical record review and staff interviews the facility failed to resubmit a Preadmission Screening and Resident Review	F 644		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Rose Hansen — TITLE: Administrator — (X6) DATE: 11/5/21

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 644	Continued From page 1 (PASRR) after a change in diagnosis and new antipsychotic medication for 1 of 1 resident reviewed for PASRR (Resident #15). The facility reported a census of 63. Findings include: 1. The Minimum Data Set (MDS) assessment dated 5/20/21 identified Resident #15 to be not considered by the state level II PASRR process to have a serious mental illness and/or intellectual disability or a related condition and he entered the facility on 5/22/19. The MDS revealed Resident #15 had a Brief Interview of Mental Status (BIMS) score of 12 out of 15 indicated moderate impaired cognition for daily decision-making. The MDS included diagnosis of hypertension and traumatic ischemia of muscle. The MDS further revealed Resident #15 had little interest or pleasure in doing things, had feeling of down, depressed or hopeless 7 of the 14 days during the look back period. The MDS assessment dated 7/18/21 with a readmission of 7/12/21 identified Resident #15 to be not be not considered by the state level II PASRR process to have a serious mental illness and/or intellectual disability or a related condition and he entered the facility on 5/22/19. The MDS revealed Resident # had a BIMS score of 12 out of 15 indicated moderate impaired cognition for daily decision-making. The MDS included diagnosis of hypertension, bipolar disorder and Paranoid personality disorder. The MDS further revealed Resident #15 had little interest or pleasure in doing things, had feeling of down, depressed or hopeless, trouble falling or staying asleep or sleeping too much and feeling tired or having little energy 7 of the 14 days during the	F 644		

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F 644	Continued From page 2 look back period and took antipsychotic medications seven of the seven days during the look-back period. Resident #15's Care Plan dated 4/7/21 included problem area of paranoid personality disorder and to monitor him for any increase in doubt of commitment, loyalty or trustworthiness of others believing others are using or deceiving him. The Care Plan revealed Resident #30 received antipsychotic medication and to assess, record the effectiveness of the drug treatment. The PASRR for Resident # 15 dated 5/20/19 indicated he did any major mental illness or take any psychotropic medications. Based on the information received with no major mental illness, intellectual disability or related condition reported, no level II condition will be given. Your PASRR level I screen remain valid for your stay at the nursing facility and should be transferred with you if you relocate. No further Level I screening is required unless you are known to have or are suspected of having a major mental illness or an intellectual or development disability and exhibit a significant change in treatment needs The Psychiatry Telehealth Visit form dated 3/31/21 for Resident #15 included diagnoses of paranoia (psychosis) and to start Risperdal (antipsychotic) 0.5 milligrams (mg) twice a day. The Psychiatry Telehealth Visit form dated 6/2/21 for Resident #15 included diagnoses of paranoia (psychosis) and to continue Risperdal 0.5 mg twice a day. During an interview on 10/21/21 at 8:55 AM Staff B Social Services explained she started back in	F 644		

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F 644	Continued From page 3 April of this year. In review of Resident #15 chart the PASRR should have been resubmitted back in April since in March psychiatry added a new diagnoses and a new antipsychotic medication.	F 644		
F 656 SS=D	Develop/Implement Comprehensive Care Plan CFR(s): 483.21(b)(1) §483.21(b) Comprehensive Care Plans §483.21(b)(1) The facility must develop and implement a comprehensive person-centered care plan for each resident, consistent with the resident rights set forth at §483.10(c)(2) and §483.10(c)(3), that includes measurable objectives and timeframes to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment. The comprehensive care plan must describe the following - (i) The services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §483.24, §483.25 or §483.40; and (ii) Any services that would otherwise be required under §483.24, §483.25 or §483.40 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(c)(6). (iii) Any specialized services or specialized rehabilitative services the nursing facility will provide as a result of PASARR recommendations. If a facility disagrees with the findings of the PASARR, it must indicate its rationale in the resident's medical record. (iv)In consultation with the resident and the resident's representative(s)- (A) The resident's goals for admission and desired outcomes. (B) The resident's preference and potential for	F 656		

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F 656	Continued From page 4 future discharge. Facilities must document whether the resident's desire to return to the community was assessed and any referrals to local contact agencies and/or other appropriate entities, for this purpose. (C) Discharge plans in the comprehensive care plan, as appropriate, in accordance with the requirements set forth in paragraph (c) of this section. This REQUIREMENT is not met as evidenced by: Based on observation, record review and staff interview the facility failed to complete a comprehensive Care Plan for 2 of 2 residents sampled (Residents #52 and #59). The facility reported a census of 63 Findings include: 1. The Minimum Data Set (MDS) dated 10/5/21 documented Resident #52 had a Brief Interview for Mental Status (BIMS) score of 99, indicating severe cognitive impairments. The MDS documented extensive assist for bed mobility and total dependence for transfers. The MDS documented diagnosis of Parkinson, depression and diabetes. The Care Plan dated 8/31/2021 failed to direct the staff on the use of side rails, Dycem in wheelchair, arm and leg protectors, and elevation of head of bed 30 degrees. The care plan documented transfer with non mechanical Stand-aid and assist x2 with gait belt Observations showed the following: a. On 10/05/21 11:26 AM, wraps noted on both upper extremities and both lower extremities.	F 656		

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F 656	Continued From page 5 b. On 10/05/21 11:29 AM, total mechanical lift used and, dycem in chair. c. On 10/11/21 01:20 PM, Resident #52 with head of bed at 30 degree elevation. d. On 10/12/21 11:09 AM, showed Resident #52 lying in bed with both side rails up. e. On 10/13/21 09:17 AM, showed Resident #52 lying in bed, side rails up. Head of bed elevated at 30 degrees. f. On 10/12/21 09:00 AM, showed a transfer with total mechanical lift and positioning the resident with the head of the bed flat. 2. The MDS dated 10/5/2021 documented Resident #59 had a BIMS score of 8, indicating moderate cognitive impairments. The MDS documented extensive assist for bed mobility and extensive assist for transfer. The MDS documented diagnosis, coronary artery disease, end stage renal disease, and history of humerus fracture. The Care Plan dated 8/24/21 failed to direct staff on the use of side rails. Observations showed the following: a. On 10/04/21 03:31 PM, showed resident with side rail on left with call light, side rail on right with bed controls. b. On 10/11/21 01:30 PM, showed Resident #59 lying in bed with Full side rails up.	F 656		

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F 656	Continued From page 6 c. On 10/12/21 11:04 AM, showed Resident #59 Lying in bed with side rails up. During an interview on 10/13/21 08:02 AM, Staff E (Certified Nurse Aide) stated she is able to know if the resident uses side rails based on the Care Plan and other special equipment as identified by therapy paper located at the nurses station or the paper hanging on the wall in the resident room. States she can check the therapy paper whenever she wants. During an interview on 10/13/21 10:18 AM, Staff D (Certified Nurse Aide) stated a therapy book is placed at the nurses station that is updated with transfers and special equipment. She stated they can look at daily and it was the main source of communication. During an interview on 10/13/21 at 10:30 AM, Staff G (Registered Nurse) and Staff F (Registered Nurse) reported an expectation that adaptive equipment, transfers and side rails be documented on the care plan.	F 656		
F 688 SS=D	Increase/Prevent Decrease in ROM/Mobility CFR(s): 483.25(c)(1)-(3) §483.25(c) Mobility. §483.25(c)(1) The facility must ensure that a resident who enters the facility without limited range of motion does not experience reduction in range of motion unless the resident's clinical condition demonstrates that a reduction in range of motion is unavoidable; and §483.25(c)(2) A resident with limited range of motion receives appropriate treatment and services to increase range of motion and/or to	F 688		

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F 688	Continued From page 7 prevent further decrease in range of motion. §483.25(c)(3) A resident with limited mobility receives appropriate services, equipment, and assistance to maintain or improve mobility with the maximum practicable independence unless a reduction in mobility is demonstrably unavoidable. This REQUIREMENT is not met as evidenced by: Based on clinical record review, observation, resident and staff interviews, and policy review, the facility failed to perform a restorative maintenance program for range of motion for 1 of 7 residents reviewed who displayed a limitation in range of motion (Resident #25). The facility reported a census of 63 residents. Findings include: 1. The Minimum Data Set (MDS) dated 8/12/21 for Resident #25 included a Brief Interview for Mental Status (BIMS) score of 15 that indicated intact cognition. The MDS revealed she required total dependence on 2 staff for bed mobility, transfers, dressing, toilet use and personal hygiene. The MDS revealed diagnoses of anxiety disorder, depression, respiratory failure, muscular dystrophy and functional quadriplegia and had no Restorative Nursing Program documented. Resident #25's Care Plan dated 6/25/19 documented a functional rehabilitation program and and required assist with all of her activities of daily living and directed staff to provide restorative nursing programs. The Physician Order Report dated 10/11/21 for Resident #25 listed a Restorative AROM (Active Range of Motion) program: Restorative Staff	F 688		

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F 688	Continued From page 8 exercise BUE (Bilateral Upper Extremities) with yellow therapy band or manual resistance, digit and wrist with stress ball squeeze and AROM wrist, BLE (Bilateral Lower Extremities) PROM (Passive Range of Motion) 2 to 3 times a week. The Physician Order Report dated 10/11/21 for Resident #25 listed a Restorative PROM Program: PROM. Verbally communicate Restorative ROM. Pick 2 extremities every time providing cares w/ patient and alternate to the other 2 the next time. Focus on major joints performing 2-5 reps. With BLE, include ankles. Patient will inform you of limits d/t pain/discomfort. Restorative Staff: Full PROM w/ stretching as tolerated. Three Times a Day The Nursing Rehab Time Log for Resident #25 dated from 9/1/21- 10/11/21 staff worked with her 3 times a day for 10 days, 2 times a day for 16 days, and 1 time a day 9 days. The Restorative Nursing Services policy effective March 2016 had a purpose to ensure that appropriate restorative nursing services are being provided to residents that reside within the facility under the guidance of the Director of Nursing (DON) or designee, the facility shall provide restorative nursing services that assist resident in achieving and/or maintaining the highest possible degree of functioning, self-care and independence and she be based upon resident choice, where practicable. The policy included the following: a. The restorative services provided shall be in accordance with the developed restorative methods used to provide actual services and are reflective for accepted standards of practice.	F 688		

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F 688	Continued From page 9 b. Following areas shall be addressed as part of the provided restorative nursing services. Assisting residents to adjust to their physical challenges/limitations or perceived physical disabilities and assisting resident by providing exercises that focus on maintaining and /or improving range of motion. During an interview on 10/4/21 at 3:14 PM, with Resident # 25 stated she does not get the ROM (Range of Motion) she needs because the of lack staff to work with her. Review of Restorative Documentation forms lacked Resident # 25's name as receiving restorative from 9/1/21- 10/11/21. Resident #25's Progress Notes lacked notes regarding refusals for restorative. During an observation on 10/6/21 at 07:58 AM, Resident # 25 awake watching TV.. During an interview on 10/12/21 at 7:24 AM, with Staff A (Restorative Nurse) stated he put the orders in a book for quick access to show what needs to be done. He explained he did not like matrix since if the time is put in it doesn't show up blue any more but they still can put in time. Staff A provided a copy of the Nursing Rehab Time Log and explained with the looks of this the restorative staff has not documented any time for the last week for Resident #25. If not documented not done the names on the list are all nurse aides not the restorative staff. Had him pull the list since 9/1/21. During an observation and interview on 10/12/21	F 688		

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F 688	Continued From page 10 07:53 AM, Staff A (Restorative Nurse) provided a print out from 9/1/21 to 10/1/21. Staff A confirmed the facility lacked documentation to reflect Resident #25 received the physician's ordered restorative program. During an interview on 10/12/21 at 10:52 AM, Staff C (Restorative Aide) explained her process for who to work with for restorative they had a priority list of residents that they see daily. Staff C explained she document residents seen on the Restorative Documentation paper and later document in the computer. They have a rotating list to see for restorative when the daily list is completed. The paper documentation is so they can see who received restorative that way they can see others when they have time. Staff C stated she had not worked with Resident # 25 for the last month. She explained she just did not have time to see everyone. Asked why stated sometimes she got pulled to the floor and the other aide that helps her out works overnights. Staff C stated she does got pulled to floor, but not that often sometimes it's just part of a day.	F 688		
F 695 SS=D	Respiratory/Tracheostomy Care and Suctioning CFR(s): 483.25(i) § 483.25(i) Respiratory care, including tracheostomy care and tracheal suctioning. The facility must ensure that a resident who needs respiratory care, including tracheostomy care and tracheal suctioning, is provided such care, consistent with professional standards of practice, the comprehensive person-centered care plan, the residents' goals and preferences, and 483.65 of this subpart. This REQUIREMENT is not met as evidenced by:	F 695		

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F 695	Continued From page 11 Based on observation, record review, policy review and staff interviews the facility failed to provide respiratory services in accordance with professional standards for 1 of 1 residents sampled. The facility reported a census of 63. The Minimum Data Set (MDS) dated 7/22/2021 documented Resident #11 had a BIMS score of 15. A BIMS of 15 indicates an intact cognitive impairment. MDS documented diagnosis of chronic obstructive pulmonary disease, coronary artery disease (heart disease)and hypertension (high blood pressure). The Care Plan dated 7/27/2021 documented the use of continuous oxygen. Record Review revealed an order dated 9/14/2021 to change oxygen and nebulizer equipment weekly. Observations showed the following: a. On 10/12/21 11:12 AM, showed oxygen tubing on both the portable tank and the concentrator dated 8/22. b. On 10/12/21 01:38 PM, showed oxygen tubing on both the portable tank and the concentrator dated 8/22. c. On 10/13/21 08:08 AM, showed oxygen tubing on both the portable tank and the concentrator dated 8/22. d. On 10/14/21 08:54 AM, showed oxygen tubing on both the portable tank and the concentrator dated 8/22.	F 695		

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F 695	Continued From page 12 Interview on 10/12/2021 at 2:30 PM, Staff H (Licensed Practical Nurse) revealed that Respiratory Therapy (RT) is responsible for the change of oxygen tubing weekly. She identified that RT was not allowed to work on the west unit due to COVID precautions. Interview on 10/13/21 at 08:19 AM, Staff I (Licensed Practical Nurse) stated Respiratory Therapy is responsible for changing out oxygen tubing. She believes it is done weekly but unsure of how often. Interview on 10/13/2021 at 10:30 AM, Staff J (Respiratory Therapist) reported it was the expectation oxygen tubing be changed weekly. Staff J stated that in the absence of Respiratory Therapist availability nursing would be expected to change the tubing. Interview on 10/13/2021 at 11:00 AM, the Administrator acknowledged respiratory staff were isolated from the west unit (location of Resident #11) from dates of 9/8 through 10/4. She acknowledged nursing staff should have been responsible for the changing of tubing.	F 695		
F 700 SS=D	Bedrails CFR(s): 483.25(n)(1)-(4) §483.25(n) Bed Rails. The facility must attempt to use appropriate alternatives prior to installing a side or bed rail. If a bed or side rail is used, the facility must ensure correct installation, use, and maintenance of bed rails, including but not limited to the following elements. §483.25(n)(1) Assess the resident for risk of	F 700		

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F 700	Continued From page 13 entrapment from bed rails prior to installation. §483.25(n)(2) Review the risks and benefits of bed rails with the resident or resident representative and obtain informed consent prior to installation. §483.25(n)(3) Ensure that the bed's dimensions are appropriate for the resident's size and weight. §483.25(n)(4) Follow the manufacturers' recommendations and specifications for installing and maintaining bed rails. This REQUIREMENT is not met as evidenced by: Based on observation, staff interview, record review the facility failed to provide a complete side rail assessment on 3 of 5 residents. The facility reported a census of 63. Findings include: 1. The MDS Minimum Data Set (MDS) for Resident #8 dated 7/15/2021 documented a Brief Interview for Mental Status (BIMS) score of 11, which indicated moderate cognitive impairments. The MDS documented a diagnosis of cerebral palsy, paraplegia, and anxiety. The MDS documented total dependence for bed mobility and total dependence for transfer. The Care Plan dated 7/20/2021 documented the risk for falls and to keep bed in low position. Observations showed the following: a. On 10/05/21 at 10:52 AM, showed both upper side rails up.	F 700		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	165151	A. BUILDING _____ B. WING _____	10/14/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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F 700	Continued From page 14 b. On 10/12/21 at 09:23 AM, both upper side rails up. c. On 10/14/21 10:41 AM, lying in bed in high position, both upper side rails up. Record Review showed an incomplete side rail assessment dated 4/15/2021. The assessment failed to indicate the use of side rails and acknowledge the risk and benefits of side rail use. 2. Minimum Data Set (MDS) dated 7/22/2021 for Resident #11 documented a BIMS of 15, which indicated intact cognitive status. The MDS documented diagnoses of chronic obstructive pulmonary disease, coronary artery disease and hypertension. The MDS documented independence with bed mobility and transfers. The Care Plan dated 7/27/2021 documented a risk for falls and vision impairment. Record Review showed an incomplete side rail assessment dated 4/23/2021. The assessment failed to indicate the use of side rails and acknowledge the risk and benefits of side rail use. 3. The Minimum Data Set (MDS) dated 10/5/2021 documented Resident #59 had a BIMS score of 8, which indicated moderate cognitive impairments. The MDS documented diagnosis of history of humerus fracture, coronary artery disease, and end stage renal disease. The MDS documented extensive assist for bed mobility and extensive assist for transfer. The Care plan dated 8/24/21 failed to direct staff	F 700		

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F 700	Continued From page 15 on the use of side rails. Observations showed the following: a. On 10/04/21 at 03:31 PM, showed Resident #59 lying in bed with side rails up. b. On 10/11/21 at 01:30 PM, showed Resident #59 lying in bed with side rails up. c. On 10/12/21 at 11:04 AM, showed Resident #59 lying in bed with side rails up. d. On 10/14/21 at 09:20 AM, showed Resident #59 lying in bed with side rails up. Record review showed an incomplete side rail assessment dated 8/23/2021. The assessment failed to indicate the use of side rails and acknowledge the risk and benefits of side rail use. Interview on 10/13/2021 at 2:30 PM, Staff G (Registered Nurse) and Staff F (Registered Nurse) revealed that the side rail assessment should be done on admission, readmission and annually, the assessment should indicate the use of side rails including how many are to be used and which sides they are to be used, and the assessment would have checked boxes to show completion with recommendations.	F 700		
F 812 SS=E	Food Procurement,Store/Prepare/Serve-Sanitary CFR(s): 483.60(i)(1)(2) §483.60(i) Food safety requirements. The facility must - §483.60(i)(1) - Procure food from sources	F 812		

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F 812	Continued From page 16 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, staff interview, and policy review, the facility failed to maintain proper storage of food items in accordance with professional standards for food service safety. The facility reported a census of 63 residents. Findings include: Observation of the freezer on 10/4/2021 1:49 PM, revealed 3 frozen pizza crusts not sealed, not labeled and not dated, 1 bag of frozen pepperoni not labeled, ¼ bag of frozen sausage links not sealed, not labeled and not dated, ½ a bag of frozen vegetables with no open date. Observation of the dry storage on 10/4/2021 at 2:07 PM, revealed a bag of 12 dinner rolls with hand written dates of 8/18 and 8/26 and had an accumulation of a green substance. Interview on 10/4/2021 at 2:10 PM, Staff K (Cook) confirmed the outdated rolls had mold and he	F 812		

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F 812	Continued From page 17 immediately discarded the rolls. Interview on 10/14/2021 at 12:00 PM, with Dietary Manager revealed an expectation of staff to check food dates daily. She confirmed it was all staffs responsibility to label, date and discard items per policy. The Labeled Food Storage (Dry, Refrigerated and Frozen) policy dated 2016 directed staff to label all food items and label needs to include the name of the food and the date by which it should be sold, consumed or discarded.	F 812		

Mississippi Valley Healthcare and Rehabilitation
Recertification Survey, Complaints and Facility Reported Incidents: 10/4/2021-10/14/2021
Plan of Correction

F644

Regarding Resident #15 and all other similarly situated residents, Social Services was educated on the types of changes that trigger for a PASRR to be reviewed and updated. PASRR for resident #15 was updated and resubmitted. Social Services and Director of Nursing will monitor for compliance on an ongoing basis.

Completion Date: 10/12/2021

F656

MDS/Care Plan Coordinator were educated to include in care plans the type of side rail use, adaptive equipment, orders pertinent to care of resident and ensure transfer status is updated in all areas of care plan. Regarding resident #52 and #59 and all other similarly situated residents, care plans have been reviewed and updated. Changes to care plans will be monitored and reviewed by the MDS/Care Plan Coordinator and Director of Nursing on an ongoing basis.

Completion Date: 11/4/2021

F688

Regarding resident #25 and all other similarly situated residents, Restorative nurse, restorative aides, and nursing staff was educated on Restorative programs and documentation standards. Restorative nurse was educated on documentation to include a monthly summary of resident on a restorative program. Restorative Nurse and Director of Nursing will monitor for compliance on an ongoing basis.

Completion Date: 11/2/2021

F695

Respiratory Manager revised the Oxygen Protocol Policy to include oxygen tubing change protocol in the event respiratory staff are quarantined from the non-ventilator area the tubing change task will change from a respiratory task to a nursing task/flowsheet in Matrix. Resident #15 oxygen tubing was changed upon discovery of oversight.

Completion Date: 11/2/2021

F700

MDS/Care Plan Coordinator educated on Side Rail Assessment completion and obtaining resident signature upon admission, change in side rail status and annually. Side rail assessments for resident #8, #11 and all other similarly situated residents were reviewed and updated. MDS/Care Plan Coordinator and Director of Nursing will monitor for compliance on an ongoing basis.

Completion Date: 11/1/2021

F812

Dietary manager placed markers in suction cup holders at each station for easy access for labeling/dating items. Dietary manager removed top two trays from bread rack to keep all trays at eye level or below. Dietary staff was educated on labeling/dating food items when opening, ensuring items are sealed for storage and rotating bread with each delivery. Dietary manager will monitor for compliance on an ongoing basis.

Completion Date: 10/14/2021