

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

PRINTED: 08/03/2021
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 166567	COMLITIE A BLDG B WING	CONSTRUCTION	(X3) DATE SURVEY COMPLETED 07/29/2021
NAME OF PROVIDER OR SUPPLIER WEST RIDGE CARE CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 3131 F AVENUE NW CEDAR RAPIDS, IA 52405		
(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 OK ✓ TAO	<p>INITIAL COMMENTS</p> <p>Correction Date: 8/12/2021</p> <p>The following deficiencies relate to the Recertification Survey and investigation of a Facility Self-Reported Incident #91050, conducted 7/26/21-7/29/21. Incident #91050 substantiated without a deficiency. (See Code of Federal Regulations (42CFR) Part 483, Subpart B-C).</p> <p>F 693 SS=D</p> <p>Tube Feeding Mgmt/Restore Eating Skills CFR(s): 483.25(g)(4)(5)</p> <p>§483.25(g)(4)-(5) Enteral Nutrition (Includes naso-gastric and gastrostomy tubes, both percutaneous endoscopic gastrostomy and percutaneous endoscopic jejunostomy, and enteral fluids). Based on a resident's comprehensive assessment, the facility must ensure that a resident-</p> <p>§483.25(g)(4) A resident who has been able to eat enough alone or with assistance is not fed by enteral methods unless the resident's clinical condition demonstrates that enteral feeding was clinically indicated and consented to by the resident; and</p> <p>§483.25(g)(5) A resident who is fed by enteral means receives the appropriate treatment and services to restore, if possible, oral eating skills and to prevent complications of enteral feeding including but not limited to aspiration pneumonia, diarrhea, vomiting, dehydration, metabolic abnormalities, and nasal-pharyngeal ulcers. This REQUIREMENT is not met as evidenced by:</p> <p>Based on record review, observation and staff interview, the facility staff failed to check the</p>		F 000 F 693	<p>The statements made on this Plan of Correction are not an admission to and do not constitute an agreement with the alleged deficiencies herein. To remain in compliance with all federal and state regulations, the facility has taken or will take the actions set forth in the following Plan of Correction.</p> <p>The Plan of Correction constitutes the facility's credible allegation of compliance such that all alleged deficiencies cited have been or will be corrected by the date indicated.</p> <p>F693: Westridge Care Center will continue to prevent complication of enteral feeding by providing appropriate treatment and services. This would include checking G-tube placement prior to initiation any cares via the tube (providing medications, flushes, feedings, etc.). Enteral Feeding Policy has been updated to reflect checking placement prior to any use of the G-tube. Regarding Resident #15, all nurses have been educated on the updated Enteral Feeding Policy on 8/12/2021 and each nurse has completed return demonstration on the technique of checking tube feeding placement. Any employee on leave of absence for any reason will be provided</p>	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

Richard Cuskey

TITLE *

(X6) DATE
8/12/2021
Administrator

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.

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

PRINTED: 08/03/2021
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 165567	A BLDG B WING	CONSTRUCTION	(X3) DATE SURVEY COMPLETED 07/29/2021
NAME OF PROVIDER OR SUPPLIER WEST RIDGE CARE CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE 3131 F AVENUE NW CEDAR RAPIDS, IA 52405			
(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 693	<p>Continued From page 1</p> <p>placement of a gastric tube (G-tube) prior to the administration of medications or tube feeding for one of one residents observed with a G-tube(Resident #15). The facility reported a census of 43 residents.</p> <p>Findings include:</p> <p>The Minimum Data Set dated 5/21/21 identified Resident #15 with the following diagnoses: Parkinson's Disease, atrial fibrillation (an abnormal heart rhythm) and arthritis. It also identified the resident with a Brief Interview for Mental Status (BIMS) of 8 which indicated severe cognitive impairment, totally dependent on staff for all activities of daily living and had a feeding tube through which she received 100% of her caloric intake.</p> <p>The Care Plan identified the resident on 6/2/20 with the problem of the potential for fluid deficit as evidenced by tube feeding and the resident can not eat or drink by mouth and on diuretics which can cause fluid issues.</p> <p>Interventions include the following:</p> <ol style="list-style-type: none"> Resident likes staff to give the option to be up out of bed for tube feedings (TF). Provide as ordered: TF/water flushes as ordered. Monitor signs or symptoms of intolerance, gastrointestinal (GI) conditions, bowel/bladder function. Monitor gastric residual volume (GRV) before each feeding and to reinser amount if 200 milliliters (ml) for 2 times or 250 ml for 1 time. Position upright 45 degrees for 30-60 min after feeding. Monitor tube position if ordered. Monitor oral condition. Arrange dentist services as needed. 	F 693	<p>education with same process upon return. A QAPI project has been developed to ensure compliance. Audits will be completed 3 times per week for the next two week and weekly for 4 weeks and then monthly. This will be monitored by the Director of Nursing or designee with reports to the QAPI Committee at least quarterly and as needed.</p>		

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

PRINTED: 08/03/2021
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 165567	POWERTITLE A BUILDING B WING	CONSTRUCTION	(X3) DATE SURVEY COMPLETED 07/29/2021
NAME OF PROVIDER OR SUPPLIER WEST RIDGE CARE CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 3131 F AVENUE NW CEDAR RAPIDS, IA 52405		
(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 693	<p>Continued From page 2</p> <p>Encourage use of dry mouth spray as needed (PRN).</p> <p>A review of the Physician Orders revealed the following:</p> <ul style="list-style-type: none"> a. 15 ml of water before, with, and after all medications. b. Elevate Head of Bed (HOB) 30 to 45 degrees at all times during feeding and for at least 30 to 40 minutes after the feeding is stopped every shift. Elevate HOB 30 to 45 degrees at all times during feeding and for at least 30 to 40 minutes after the feeding is stopped every shift for medication flushes. c. Give Fiber Source HN via tube feeding. 500 ml at 6:00 AM, 250 ml at 11:00 AM, 250 ml at 4:00 PM, and 250 ml at 9:00 PM. d. Flush tube with 30 ml water, one time a day for feeding at 6:00 AM give 500 ml and Flush with 30 ml water and one time a day for feeding at 11:00 AM give 250 ml and flush with 30 ml water. And in the evening for feeding at 4:00 PM give 250 ml and flush with 30 ml water. And at bedtime for feeding at 9:00 PM give 250 ml and flush with 30 ml water. <p>During an observation on 7/28/21 at 11:13 AM, Staff C, Licensed Practical Nurse (LPN) drew up 15 mls water in a cath tipped syringe, did not check placement before she flushed the G-tube with the 15 mls of water without resistance. Staff C then connected the tubing from tube feeding bag and unclamped tube to allow the Fibersource tube feeding to run in, removed her gloves and washed her hands.</p> <p>In an Interview on 7/28/21 at 12:40 PM, the Assistant Director of Nursing (ADON) reported the facility did not have a policy book, they follow</p>		F 693		

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

PRINTED: 08/03/2021
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 166667	(X2) TITLE A. BLDG. B. WNG.	CONSTRUCTION	(X3) DATE SURVEY COMPLETED 07/29/2021
NAME OF PROVIDER OR SUPPLIER WEST RIDGE CARE CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE 3131 F AVENUE NW CEDAR RAPIDS, IA 52405			
(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 693	<p>Continued From page 3</p> <p>Lippincott guidelines and handed surveyor a book which addressed tube feedings for pediatric patients in the home setting. She also provided a form which she reported she uses when she audits nurses on the process which did not direct staff to check for placement prior to administering medications through GT</p> <p>Procedure:</p> <ul style="list-style-type: none"> a. Introduce yourself to the resident. b. Explain procedure. c. Provide privacy. d. Wash hands. e. Apply gloves. f. Set up dental drape. g. Apply barrier on resident between tube and clothes. h. Set up medications crushed in own med cup. i. Apply 15 mls of water in each med cup. j. Administer 15 mls of water into tube for flush prior to medication administration. k. Administer medications one at a time with 15 mls flush after each med. l. Ask resident how they are feeling. m. Clean up supplies. n. Check flush orders. Flush orders are resident specific. <p>In an interview on 7/28/21 at 12:49 PM Staff B, RN reported before giving any medications or starting a feeding through a gastric tube (GT) she would check placement of GT prior to administering medications, need to aspirate for contents.</p> <p>In an interview on 7/28/21 at 2:06 PM the Director Of Nursing (DON) reported she expected her nurses to follow the procedure before they administer tube feedings:</p> <ul style="list-style-type: none"> a. Follow standard of practice as far as hand 		F 693		

CENTERS FOR MEDICARE & MEDICAID SERVICES

OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 165567	(2) TITLE A BLDG B WNG	CONSTRUCTION STREET ADDRESS, CITY, STATE, ZIP CODE 3131 F AVENUE NW CEDAR RAPIDS, IA 52406	(X3) DATE SURVEY COMPLETED 07/29/2021
NAME OF PROVIDER OR SUPPLIER WEST RIDGE CARE CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 3131 F AVENUE NW CEDAR RAPIDS, IA 52406		
(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 693 F 812 SS-E	<p>Continued From page 4</p> <p>washing, gloves, crushing the medications, flushing with whatever is ordered to flush with, following the doctor's orders.</p> <p>b. Usually check placement for the first two feedings of the day.</p> <p>She could not recall the current standards of practice are and would have to check our policy book, which is the Lippincott standards of practice. The standards have changed over time.</p> <p>A review of the facility policy titled: Gastrostomy Tube Feeding with the effective April 2018 had documentation of the following procedure:</p> <ul style="list-style-type: none"> a. Gather equipment and take to bedside b. Explain procedure to resident c. Provide privacy d. Help resident to semi-Fowler position or at least 30 degrees sitting up. e. Check placement if ordered each feeding for a newly placed tube. Established tubes, check placement with the initial tube feeding for the day. Food Procurement, Store/Prepare/Serve-Sanitary CFR(s): 483.60(i)(1)(2) <p>§483.60(i) Food safety requirements.</p> <p>The facility must -</p> <p>§483.60(i)(1) - Procure food from sources approved or considered satisfactory by federal, state or local authorities.</p> <ul style="list-style-type: none"> (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 	F 693 F 812	<p>F812: Westridge Care Center will continue to date opened items when placed in the refrigerators and to properly label and store dried food items that have been opened. The policy on dating and labeling was reviewed with staff on 8/11/2021 with education on the importance of always following the policy. A QAPI project has been developed to ensure compliance. Audits will be completed 3 times per week on varying shifts for 2 weeks and then weekly for 4 weeks then</p>		

CENTERS FOR MEDICARE & MEDICAID SERVICES

OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 166567	A MULTIPLE B BUILDING B WING	CONSTRUCTION	(X3) DATE SURVEY COMPLETED 07/29/2021
NAME OF PROVIDER OR SUPPLIER WEST RIDGE CARE CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 3131 F AVENUE NW CEDAR RAPIDS, IA 52405		
(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 812	<p>Continued From page 5</p> <p>from consuming foods not procured by the facility.</p> <p>\$483.60(l)(2) - Store, prepare, distribute and serve food in accordance with professional standards for food service safety.</p> <p>This REQUIREMENT is not met as evidenced by:</p> <p>Based on observation, record review and staff interview, the facility failed to date opened items when placed in the refrigerator and failed to properly label and store dried food items opened. The facility reported a census of 43 residents.</p> <p>Findings Include:</p> <p>During the initial tour of the kitchen on 7/26/21 which began at 9:55 AM with the Administrator revealed:</p> <p>A review of the Maximum refrigerator revealed the following items that had not been dated when opened</p> <ul style="list-style-type: none"> a. A 2 quart bottle of Ruby Kist of grape juice. b. A 1/2 gallon bottle of Musselmann apple juice which had been approximately 1/4 full. c. Two 64 ounce bottles of Ruby Kist white cranberry juice 64 oz bottles x 2 opened. d. A 64 ounce bottle of Thickit thickened water. e. A 46 ounce bottle of Thick & Easy thickened kiwi strawberry drink. <p>At the time of the initial tour, the Administrator reported he would have expected the staff to write the date items were opened.</p> <p>A review of the dry storage area with the Dietary Manager revealed the following items that had not been dated when opened nor properly sealed:</p> <ul style="list-style-type: none"> a. A 1/4 full 2 pound opened bag of Pioneer powdered sugar. b. A 1/4 full 22 oz bag of Trio Country gravy mix. 	F 812	periodically. This will be monitored by the Director of Dining Services, the Registered Dietitian Nutritionist, or designee with reports to the QAPI Committee at least quarterly and as needed		

CENTERS FOR MEDICARE & MEDICAID SERVICES

OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 165567	QUALITY CONSTRUCTION A BLDG. B WING	(X3) DATE SURVEY COMPLETED 07/29/2021
NAME OF PROVIDER OR SUPPLIER WEST RIDGE CARE CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 3131 F AVENUE NW CEDAR RAPIDS, IA 52405	
(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 812	<p>Continued From page 6</p> <p>c. A less than 1/4 full 5 lb bag Krusteaz pancake mix.</p> <p>In an interview on 7/28/21 at 10:15 AM, Staff A, Dietary Aide reported the following:</p> <ul style="list-style-type: none"> a. When she opens a container that is refrigerated, she would need to date it when opened, then after 7 days, would need to dispose of it and open another. b. Staff A reported she opened up the bottles of thickened juices the morning of 7/26/21, but did not get the chance to write the date that she opened the juices that day. c. Foods in the dried food storage area that are opened, should be placed in a Ziploc bag with the date written on it when opened. d. Staff A also stated 3 recently new hires may not have known to write open dates on items after opened. 	F 812		