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F 000	INITIAL COMMENTS Correction Date: 03/23/21 A recertification survey and investigation of Complaint #93990-C was conducted 2/9-23/21 and resulted in the following deficiencies. Complaint #93990-C was substantiated. See Code of Federal Regulations (42CFR) Part 483 Subpart B-C.	F 000		
F 582 SS=D	Medicaid/Medicare Coverage/Liability Notice CFR(s): 483.10(g)(17)(18)(i)-(v) §483.10(g)(17) The facility must-- (i) Inform each Medicaid-eligible resident, in writing, at the time of admission to the nursing facility and when the resident becomes eligible for Medicaid of- (A) The items and services that are included in nursing facility services under the State plan and for which the resident may not be charged; (B) Those other items and services that the facility offers and for which the resident may be charged, and the amount of charges for those services; and (ii) Inform each Medicaid-eligible resident when changes are made to the items and services specified in §483.10(g)(17)(i)(A) and (B) of this section. §483.10(g)(18) The facility must inform each resident before, or at the time of admission, and periodically during the resident's stay, of services available in the facility and of charges for those services, including any charges for services not covered under Medicare/ Medicaid or by the	F 582		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Laura Cozo — TITLE: Executive Director — (X6) DATE: 03/19/21

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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facility's per diem rate.
(i) Where changes in coverage are made to items and services covered by Medicare and/or by the Medicaid State plan, the facility must provide notice to residents of the change as soon as is reasonably possible.
(ii) Where changes are made to charges for other items and services that the facility offers, the facility must inform the resident in writing at least 60 days prior to implementation of the change.
(iii) If a resident dies or is hospitalized or is transferred and does not return to the facility, the facility must refund to the resident, resident representative, or estate, as applicable, any deposit or charges already paid, less the facility's per diem rate, for the days the resident actually resided or reserved or retained a bed in the facility, regardless of any minimum stay or discharge notice requirements.
(iv) The facility must refund to the resident or resident representative any and all refunds due the resident within 30 days from the resident's date of discharge from the facility.
(v) The terms of an admission contract by or on behalf of an individual seeking admission to the facility must not conflict with the requirements of these regulations.
This REQUIREMENT is not met as evidenced by:
Based on clinical record review and staff interview, the facility failed to ensure a cognitively intact resident signed his Skilled Nursing Facility Advance Beneficiary Notice of Non-coverage (SBFABN) for 1 of 4 residents reviewed (Resident #198). The facility reported a census of 47 residents.

Findings include:

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F 582	Continued From page 2 Resident #17's Minimum Data Set (MDS) dated 7/23/20 documented diagnoses that included: cerebrovascular accident (CVA), anxiety disorder and neurologic neglect syndrome. The MDS further documented a Brief Interview of Mental Status (BIMS) score of 12 indicating moderate impairment. Records indicated Resident #17 signed the SNFABN notice on 8/6/20 which indicated beginning 8/7/20 he may have to pay out of pocket for skilled speech therapy, physical therapy, occupational therapy and nursing with an estimated cost of $598 per day as he had reached his maximum potential. Resident #17's profile identified his spouse as the financial responsible party. On 2/18/21 at 10:30 AM the Administrator stated she did not know why they had Resident #17 sign the SBFABN form.	F 582		
F 609 SS=D	Reporting of Alleged Violations CFR(s): 483.12(c)(1)(4) §483.12(c) In response to allegations of abuse, neglect, exploitation, or mistreatment, the facility must: §483.12(c)(1) Ensure that all alleged violations involving abuse, neglect, exploitation or mistreatment, including injuries of unknown source and misappropriation of resident property, are reported immediately, but not later than 2 hours after the allegation is made, if the events that cause the allegation involve abuse or result in serious bodily injury, or not later than 24 hours if the events that cause the allegation do not involve	F 609		

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abuse and do not result in serious bodily injury, to the administrator of the facility and to other officials (including to the State Survey Agency and adult protective services where state law provides for jurisdiction in long-term care facilities) in accordance with State law through established procedures.

§483.12(c)(4) Report the results of all investigations to the administrator or his or her designated representative and to other officials in accordance with State law, including to the State Survey Agency, within 5 working days of the incident, and if the alleged violation is verified appropriate corrective action must be taken.
This REQUIREMENT is not met as evidenced by:
Based on observation, record review and staff interview, the facility failed to report an injury of unknown source within 24 hours to the State Survey Agency for one (Resident #18) of sixteen residents reviewed. The facility reported a census of 47 residents.

Findings included:

The Minimum Data Set (MDS) assessment for Resident #18 dated 11/13/20, included diagnoses of Dementia with Lewy Bodies, Anxiety Disorder, and depression. The MDS identified the resident required supervision of one staff for transfers and walking, extensive assistance of one staff for toilet use and dressing, and extensive assistance of two staff for bed mobility. The MDS indicated the resident had a Brief Interview for Mental Status (BIMS) score of 3 (severe cognitive impairment).

The care plan for Resident #18, revised on

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10/30/20, identified the resident as independent with bed mobility and independent with no assistive device for transfers.

Observation showed on 2/09/21 at 12:05 p.m. the resident with a blackish purple, yellow, green bruise under her right eye, approximately 1.5 inch (in.) by 0.5 in. in size.

Progress notes dated 1/21/2021 at 6:15 a.m. documented: Certified Nurse's Assistant (CNA) walked out with resident from her room and reported the resident has a bruise around her right (rt.) eye. Upon assessment, found an abrasion above rt. eyebrow (0.3 c.m. x 0.1 c. m.) (centimeter) with a small hematoma and deep purple bruise around the whole rt. eye. The nurse asked the resident if someone hit her and the resident stated no. The nurse asked the resident if she fell and the resident stated she might have. The nurse asked the night shift CNA about the injury. The CNA stated she did not observed the bruise at 10 p.m. the night before. The resident denied pain to the area and staff initiated neurological checks. Staff sent a facsimile (fax) to the ARNP (Advanced Registered Nurse Practitioner) and left a message for the resident's spouse. A full body assessment identified no other injuries.

Review of facility form titled "Skin Impairment" dated 1/21/21 for Resident #18, documented:
- Nursing Description: "At 6:15 a.m. a CNA walked out with the resident from her room and reported the resident had a bruise around her rt. eye. Upon assessment staff observed an abrasion above rt. eyebrow (0.3 cm. x 0.1 cm) and deep purple bruise around the entire rt. eye. The resident denied someone hit her and when

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asked if she fell, stated she might have.
- Resident Description: Staff noted the resident with a purple eye and searched the resident's room for possible causal factors. The resident stated she used the phone last night and stated she had a hone in her room. Observation showed a black remote control laying on bed, which resident identified as her phone.
- Notes: The resident noted to have purple eye and staff searched the resident's room for possible causal factors. The resident stated she used the phone last night and stated she had a hone in her room. Observation showed a black remote control laying on bed, which resident identified as her phone. Observation showed the remote with sharp corners which appear to match small lesion on forehead (small L shape). Staff placed the remote placed under the mattress on the frame until maintenance ordered new remote.

On 2/16/21 at 3:30 PM, the Director of Nursing (DON) stated the facility completed an investigation into the incident. The DON stated the facility interviewed the staff who worked the shift prior to discovery of the bruise. They denied observing a bruise and denied any witnessed falls during the shift. The DON stated the facility interviewed the staff that discovered the bruise and the resident. The DON stated the resident denied anyone hit her. The DON identified they concluded the injury caused by by a remote control for the bed that laid on the bed. The DON acknowledged staff did not observe an incident with the resident and the remote control.

Documentation titled, "Investigative Summary 1/21/21" signed and dated 1/21/21 by the DON, revealed at the conclusion of the investigation the facility determined the resident received the injury

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F 609	Continued From page 6 from the remote control in the resident's room. The facility's "Online Abuse or Incident Reporting List" printed 2/16/21, lacked documentation of any incidents dated 1/21/21. Facility policy titled "Abuse Prevention, Identification, Investigation, and Reporting Policy" revised 11/2016, documented: "Resident Abuse" is defined as follows: "Injuries of Unknown Source" An injury classified as an "injury of unknown source" when both of the following conditions are met: - The source of the injury not observed by any person or the resident could not explain the source of the injury and - The injury appears suspicious because of the extent of the injury or the location of the injury. Reporting: If a staff member or employee is required to make a report pursuant to the policy section, the staff member or employee shall immediately notify the person in charge or the person's designated agent who then shall notify the Iowa Department of Inspections & Appeals immediately, and in no event later than twenty-four hours. On 2/18/21 at 12:15 P.M., the Administrator confirmed the facility did not report the incident the State Survey Agency and stated she understood the surveyor's concern. Observation showed on 2/17/21 at 9:50 a.m., the bed remote hanging on the footboard of the bed accessible to the resident. The bed remote appeared to have sharp edges.	F 609		
F 686 SS=D	Treatment/Svcs to Prevent/Heal Pressure Ulcer	F 686		

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F 686	Continued From page 7 CFR(s): 483.25(b)(1)(i)(ii) §483.25(b) Skin Integrity §483.25(b)(1) Pressure ulcers. Based on the comprehensive assessment of a resident, the facility must ensure that- (i) A resident receives care, consistent with professional standards of practice, to prevent pressure ulcers and does not develop pressure ulcers unless the individual's clinical condition demonstrates that they were unavoidable; and (ii) A resident with pressure ulcers receives necessary treatment and services, consistent with professional standards of practice, to promote healing, prevent infection and prevent new ulcers from developing. This REQUIREMENT is not met as evidenced by: Based on observation, record review and staff interview, the facility failed to ensure a resident received care consistent with professional standards of practice to prevent pressure ulcers for 1 of 3 residents reviewed (Resident #17). The facility The facility reported a census of 47 residents. Findings include: The MDS (Minimum Data Set) assessment identifies the definition of pressure ulcers: Stage I is an intact skin with non-blanchable redness of a localized area usually over a bony prominence. Darkly pigmented skin may not have a visible blanching; in dark skin tones only it may appear with persistent blue or purple hues. Stage II is partial thickness loss of dermis presenting as a shallow open ulcer with a red or	F 686		

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pink wound bed, without slough (dead tissue, usually cream or yellow in color). May also present as an intact or open/ruptured blister.

Stage III Full thickness tissue loss. Subcutaneous fat may be visible but bone, tendon or muscle is not exposed. Slough may be present but does not obscure the depth of tissue loss. May include undermining and tunneling.

Stage IV is full thickness tissue loss with exposed bone, tendon or muscle. Slough or eschar (dry, black, hard necrotic tissue). may be present on some parts of the wound bed. Often includes undermining and tunneling or eschar.

Unstageable Ulcer: inability to see the wound bed.

Other staging considerations include:
Deep Tissue Pressure Injury (DTPI): Persistent non-blanchable deep red, maroon or purple discoloration. Intact skin with localized area of persistent non-blanchable deep red, maroon, purple discoloration due to damage of underlying soft tissue. This area may be preceded by tissue that is painful, firm, mushy, boggy, warmer or cooler as compared to adjacent tissue. These changes often precede skin color changes and discoloration may appear differently in darkly pigmented skin. This injury results from intense and/or prolonged pressure and shear forces at the bone-muscle interface.

The Minimum Data Set (MDS) assessment for Resident #17 dated 2/2/21 documented diagnoses of diabetes mellitus (DM), cerebrovascular accident (CVA) and other abnormalities of gait and mobility. The resident

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had a Brief Interview for Mental Status (BIMS) of 12 indicating moderate cognitive impairment. The MDS further revealed the resident required extensive 2 person physical assist for bed mobility and transfers and limited one person physical assist for walking in room. The MDS identified the resident as at risk of developing pressure ulcers/injuries and did not have one or more unhealed pressure ulcer/injuries. A Braden Scale assessment dated 2/9/21 revealed a score of 18 identifying the resident at risk for pressure ulcers. The resident readmitted to the facility 1/26/21. The resident's original admission date was 7/30/20.

A Care Plan dated 1/26/21 documented Resident #17 with an actual skin impairment related to sedentary lifestyle, fragility of skin, decreased mobility, incontinence, diabetes mellitus and age related changes. The Care Plan with an intervention date of 2/8/21 directed staff to remind resident to not walk with the moon boot in place.

Progress notes dated 2/5/21 at 1:37 p.m. and documented by Staff B, Licensed Practical Nurse (LPN) revealed Resident #17 with an open blister area on the right foot below the fifth with drainage and not infected. Documentation lacked notification of the physician or a new treatment initiated.

Progress notes dated 2/8/21 at 3:37 p.m. identified staff received a new order for Betadine wet to dry dressings to the outer right foot. The entry identified the resident with an open area with purulent drainage and the physician would see the resident tomorrow. The entry revealed the open area lines up with the rough edge of the moon boot. Staff explained to the resident he

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cannot walk with moon boot on.

Progress notes dated 2/9/21 revealed the physician saw the resident and ordered Cephalexin 500 milligrams (mg.) three times a day for 7 days.

An Incident Report dated 2/5/21 at 4:56 p.m. revealed staff noted Resident #17 to have a fluid vesicle on the foot that opened. The Incident Report further revealed resident with a history of open areas to the foot. The resident admitted to the facility with a pressure ulcer to the heel and the area rubbed on moon boot. Staff educated the resident not to wear boot when walking.

The Weekly Pressure Ulcer Records for Resident #17 revealed the following:
a. 2/8/21-Stage 2 pressure ulcer side of right foot measuring 2.2 centimeters (cm) x 2.5 cm with no depth and purulent exudate.
b. 2/10/21-Stage 2 pressure ulcer side of right foot measuring 2.5 cm x 2.5 cm with 0.1 cm depth and no exudate.
c. 2/17/21- Stage 2 pressure ulcer side of right foot measuring 3 x 3.6 cm with no depth and no exudate.

A February 2021 Medication Administration Record (MAR) revealed order for Cephalexin (antibiotic) 500 milligrams 1 capsule by mouth three times a day for wound on right foot for 7 days with a start date and time of 02/09/2021 at 7:00 PM.

Review of Treatment Administration Records (TAR) revealed the following:
a. Weekly Skin Check: Perform full body skin check and document in notes. Notify physician if

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new areas noted one time a day every Friday with a start date and time of 7/31/20 at 6:00 AM.
b. Betadine Solution (Povidone-Iodine) Apply to right side of foot topically one time a day for fluid filled vesicle saturate gauze pads with Betadine and apply to wound then wrap with Kerlix every day with a start date and time of 02/09/2021 at 6:00 AM and a discontinue date and time of 02/15/2021 at 11:04 AM.
c. Betadine Solution (Povidone-Iodine) Apply to right side of foot topically every day shift for fluid filled vesicle saturate gauze pads with Betadine and apply to wound then wrap with Kerlix every day with a start date and time of 02/16/2021 6:00 AM

The form titled Procedure for Identifying a New Skin Area dated 11/9/20 included the following:
1. Assess area and notify physician by fax, phone or in person if provider in facility
2. Implement treatment if ordered
3. Notify family, Power of Attorney (POA) or Responsible party
4. Complete Incident report in point click care
5. Notify Director of Nursing (DON) if skin area requires treatment at a higher level of care (Emergency room/hospital).

During observation of pressure wound treatment on 2/11/21 at 12:59 p.m., the Assistant Director of Nursing (ADON) identified the pressure wound developed as a result of Resident #17 walking with the moon boot, a current intervention contained in the care plan that identified the resident should continue to wear the moon boot. Prior to the observation of the pressure wound the resident wore the moon boot.

On 2/11/21 at 2:20 p.m., the ADON revealed

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F 686	Continued From page 12 Resident #17 utilized the moon boot to offload pressure to a previous resolved pressure wound. Nurse's Notes dated 2/15/21 2:39 p.m. the Director of Nursing (DON) documented observation of Resident #17 walking in the hallway wearing moon boots. Staff educated the resident not to ambulate while wearing the moon boots as that is the pressure sore developed on his foot and it is a fall risk. On 2/17/21 at 12:10 p.m. the DON stated she expected staff to follow the protocol for any new skin concerns including assessing the area, notifying the physician, contacting the family and initiating a new treatment. During the investigation, the facility changed the moon boot to a soft boot. Observation showed on 2/16/21 at 11:47 a.m. the resident wore a soft boot (not the moon boot) to the right foot while ambulating to the bathroom.	F 686		
F 692 SS=D	Nutrition/Hydration Status Maintenance CFR(s): 483.25(g)(1)-(3) §483.25(g) Assisted nutrition and hydration. (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- §483.25(g)(1) Maintains acceptable parameters of nutritional status, such as usual body weight or desirable body weight range and electrolyte balance, unless the resident's clinical condition demonstrates that this is not possible or resident	F 692		

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preferences indicate otherwise;

§483.25(g)(2) Is offered sufficient fluid intake to maintain proper hydration and health;

§483.25(g)(3) Is offered a therapeutic diet when there is a nutritional problem and the health care provider orders a therapeutic diet.
This REQUIREMENT is not met as evidenced by:
Based on record review and staff interview, the facility failed to adequately address a significant weight loss of 1 of 16 residents reviewed (Resident #198). The facility reported a census of 47 residents.

Findings include:

The Minimum Data Set (MDS) assessment dated 7/23/20 for Resident #198 identified a Brief Interview for Mental Status (BIMS) score of 12 indicating moderate cognitive impairment. The MDS revealed the resident required extensive assistance of 2 with transfers and bed mobility and supervision with 1 person physical assistance with eating. The MDS documented diagnoses that included cerebrovascular accident (CVA), dysphagia following cerebral infarction and hemiplegia.

A care plan initiated 7/17/20 documented resident with a nutritional problem and need for mechanically altered diet, intakes below 50% and low body weight. The care plan directed staff to assess the resident's nutritional status quarterly and as needed, monitor resident's weight and notify the doctor of any significant changes and Registered Dietician (RD) to evaluate and make diet change recommendations as needed.

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Record review indicated the following:
7/16/20 body weight 119.2 pounds
7/23/20 body weight 117.2 pounds
7/30/20 body weight 112.4 pounds
8/5/20 body weight 111.4 pounds with a 6.5% change since 7/16/20 weight 119.2 pounds.

A Nutrition Risk Review dated 7/16/20 and signed by the RD identified Resident #198 with chewing/swallowing problems, ideal weight range (IWR) less than 90%, body mass index (BMI) less than 18.5, leaves 25% plus at most meals and on a mechanically altered/therapeutic diet. The review further indicated a recommendation for weekly weights.

A Medication Administration Record (MAR) identified the resident with an order for 2 Cal three times a day for supplement. The order instructed staff to administer 60 milliliters (ml) with a start date of 7/23/20 at 7:00 PM.

Progress notes dated 7/28/20 at 2:45 PM revealed Staff C, Registered Nurse received a nursing order for the resident to receive 2 Cal three times a day. The progress note further indicated the resident was already receiving 2 Cal three times a day.

A dietician fax to physician form dated 7/25/20 revealed the RD with a concern regarding the resident's weight low for his height. The RD recommended 60 ml of 2 Cal three times a day and the physician signed the order and noted 7/28/20 at 2:40 PM.

A dietician fax to physician form dated 7/28/20 RD revealed concerns of recent CVA. The fax

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F 692	Continued From page 15 included the following information: Resident working with speech therapy (ST), diet is regular with nectar liquids. Intakes below 50%, weight is 20 pounds below usual with BMI 17. Resident appears scared of choking and avoids some foods. Mini-Nutritional Assessment completed on resident with a score of 1. Scores less than 7 indicate malnutrition. Do you feel this resident meets criteria for diagnosis of malnutrition? If yes, please indicate appropriate ICD-10 code. The physician documented diagnoses included: unspecified protein-calorie malnutrition. Clinical record review lacked evidence of physician or family notification or new interventions implemented in regards to the significant weight loss of 6.8 pounds or 5% in 14 days (7/16/20-7/30/20). On 2/18/20 at 2:40 PM, the Director of Nursing (DON) stated she expected staff to notify the physician and family of a significant weight loss and a new intervention would be put in place. On 3/8/21 at 3:14 p.m. the Administrator stated via email that the resident discharged to home on 8/6/20 against the therapy team's advice.	F 692		
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.	F 700		

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§483.25(n)(1) Assess the resident for risk of 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, clinical record review and staff interview, the facility failed to assure an ongoing monitoring and assessment of bed rails and failed to obtain informed consent for 1 of 16 residents reviewed (Resident #35). The facility reported a census of 47 residents.

Findings include:

The Minimum Data Set (MDS) assessment dated 12/13/20 revealed Resident #35 with a Brief Interview of Mental Status (BIMS) of 15 indicating intact memory and cognition. The resident had diagnoses of hip fracture, repeated falls and need for assistance with personal care.

The resident's care plan initiated 6/5/20 with a revision date of 1/1/21 indicated Resident #35 had an activities of daily living (ADL) self-care deficit with an intervention to use halo rails bilaterally on the bed to assist with repositioning and bed mobility.

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F 700	Continued From page 17 Observation 2/10/21 at 11:00 AM revealed Resident #35 had halo side rails attached to each side of his bed. Resident #35 revealed he did not know the purpose of the bilateral side rails. Resident #35's clinical record lacked documentation of a side rail consent including risks/ benefits of the side rails and ongoing monitoring and assessment of the side rails to ensure they are still appropriate. On 2/17/21 at 10:50 AM, the Administrator revealed she drafted a bed rail protocol dated 2/16/21 as she could not locate a prior protocol. The Administrator further revealed she informed maintenance personnel on 12/4/20 to check for bed rail spacing as well as spacing from the head and footboards to the mattress, to document the audit and to conduct a monthly audit of all beds. The Administrator stated maintenance personnel failed to complete the monthly audit as directed in January 2021.	F 700		
F 801 SS=D	Qualified Dietary Staff CFR(s): 483.60(a)(1)(2) §483.60(a) Staffing The facility must employ sufficient staff with the appropriate competencies and skills sets to carry out the functions of the food and nutrition service, taking into consideration resident assessments, individual plans of care and the number, acuity and diagnoses of the facility's resident population in accordance with the facility assessment required at §483.70(e) This includes: §483.60(a)(1) A qualified dietitian or other clinically qualified nutrition professional either	F 801		

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full-time, part-time, or on a consultant basis. A qualified dietitian or other clinically qualified nutrition professional is one who-
(i) Holds a bachelor's or higher degree granted by a regionally accredited college or university in the United States (or an equivalent foreign degree) with completion of the academic requirements of a program in nutrition or dietetics accredited by an appropriate national accreditation organization recognized for this purpose.
(ii) Has completed at least 900 hours of supervised dietetics practice under the supervision of a registered dietitian or nutrition professional.
(iii) Is licensed or certified as a dietitian or nutrition professional by the State in which the services are performed. In a State that does not provide for licensure or certification, the individual will be deemed to have met this requirement if he or she is recognized as a "registered dietitian" by the Commission on Dietetic Registration or its successor organization, or meets the requirements of paragraphs (a)(1)(i) and (ii) of this section.
(iv) For dietitians hired or contracted with prior to November 28, 2016, meets these requirements no later than 5 years after November 28, 2016 or as required by state law.

§483.60(a)(2) If a qualified dietitian or other clinically qualified nutrition professional is not employed full-time, the facility must designate a person to serve as the director of food and nutrition services who-
(i) For designations prior to November 28, 2016, meets the following requirements no later than 5 years after November 28, 2016, or no later than 1 year after November 28, 2016 for designations

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after November 28, 2016, is:
(A) A certified dietary manager; or
(B) A certified food service manager; or
(C) Has similar national certification for food service management and safety from a national certifying body; or
D) Has an associate's or higher degree in food service management or in hospitality, if the course study includes food service or restaurant management, from an accredited institution of higher learning; and
(ii) In States that have established standards for food service managers or dietary managers, meets State requirements for food service managers or dietary managers, and
(iii) Receives frequently scheduled consultations from a qualified dietitian or other clinically qualified nutrition professional.
This REQUIREMENT is not met as evidenced by:
Based on record review and staff interviews, the facility failed to ensure the facility's Dietary Service Manager had the required qualifications in the absence of a full-time dietician. The facility reported a census of 47 residents.

Findings include:

Records indicated the Dietary Manager (DM) had a start date of 10/9/19.

On 2/15/21 at 11:55 AM, the DM reported he completed a dietary management course however he did not take the test to become a Certified Dietary Manager (CDM).

On 2/17/21 at 11:55 AM the Administrator confirmed the DM did not have CDM certification.

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F 812 SS=D	Food Procurement,Store/Prepare/Serve-Sanitary CFR(s): 483.60(i)(1)(2)	F 812		

§483.60(i) Food safety requirements.
The facility must -

§483.60(i)(1) - Procure food from sources approved or considered satisfactory by federal, state or local authorities.
(i) This may include food items obtained directly from local producers, subject to applicable State and local laws or regulations.
(ii) This provision does not prohibit or prevent facilities from using produce grown in facility gardens, subject to compliance with applicable safe growing and food-handling practices.
(iii) This provision does not preclude residents from consuming foods not procured by the facility.

§483.60(i)(2) - Store, prepare, distribute and serve food in accordance with professional standards for food service safety.
This REQUIREMENT is not met as evidenced by:
Based on observations, staff interview and policy review, the facility failed to label and date food items stored in the main kitchen walk in refrigerator and freezer. The facility reported a census of 47 residents.

Findings include:

Observation during initial tour on 2/9/21 at 10:00 a.m. revealed the following:

1 gallon bag of lettuce not dated
32 pancakes in a bag not dated
12 English muffins in a bag not dated
6- 8 ounce cups special nutrition shakes not

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F 812	Continued From page 21 dated 16 chicken breasts in a bag not dated 2 strawberry cream pies not dated Form titled Labeling and Dating Foods (Date Marking) revealed once a refrigerated/freezer storage food items case is opened, the individual food items are dated with the date the item was received into the facility and will be stored using the "first in-first out" method of rotation. On 2/18/21 at 2:40 p.m. the Dietary Manager revealed the facility expected the food dated and labeled.	F 812		
F 868 SS=D	QAA Committee CFR(s): 483.75(g)(1)(i)-(iii)(2)(i) §483.75(g) Quality assessment and assurance. §483.75(g)(1) A facility must maintain a quality assessment and assurance committee consisting at a minimum of: (i) The director of nursing services; (ii) The Medical Director or his/her designee; (iii) At least three other members of the facility's staff, at least one of who must be the administrator, owner, a board member or other individual in a leadership role; §483.75(g)(2) The quality assessment and assurance committee must: (i) Meet at least quarterly and as needed to identifying issues with respect to which quality assessment and assurance activities are necessary. This REQUIREMENT is not met as evidenced by: Based on staff interview and record review the facility failed to have a Quality Assessment and	F 868		

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F 868	Continued From page 22 Assurance committee that met at least quarterly to identify issues. The facility reported a census of 47 residents. Findings included: When asked to provide quarterly QAPI (quality assurance and performance improvement) documentation of QAPI meeting conducted in the past year, the only QAPI meeting sheet provided contained the date 10/22/20 and documented attendance of facility QAPI members. Review of facility form titled "Monthly QAPI Sign-In Sheet" dated 1/19/21, documented attendance of facility QAPI members. On 2/18/21 at 12:49 PM, the Administrator stated she started employment with the facility in September 2020 and the facility could not provide documentation of quarterly QAPI meetings held in the past year, prior to her employment. The Administrator confirmed the facility should hold quarterly meetings with documentation of required QAPI members.	F 868		
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.	F 880		

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The facility must establish an infection prevention and control program (IPCP) that must include, at a minimum, the following elements:

§483.80(a)(1) A system for preventing, identifying, reporting, investigating, and controlling infections and communicable diseases for all residents, staff, volunteers, visitors, and other individuals providing services under a contractual arrangement based upon the facility assessment conducted according to §483.70(e) and following accepted national standards;

§483.80(a)(2) Written standards, policies, and procedures for the program, which must include, but are not limited to:
(i) A system of surveillance designed to identify possible communicable diseases or infections before they can spread to other persons in the facility;
(ii) When and to whom possible incidents of communicable disease or infections should be reported;
(iii) Standard and transmission-based precautions to be followed to prevent spread of infections;
(iv)When and how isolation should be used for a resident; including but not limited to:
(A) The type and duration of the isolation, depending upon the infectious agent or organism involved, and
(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

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(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, staff interview, record review and policy review the facility failed to implement infection control per standards of practice by failing to place a barrier between surface and supplies when completing an Accucheck (finger stick for blood sugar level) for one (Resident #17) of one residents reviewed and no documentation of oxygen tubing changes for one (Resident #35) of one residents reviewed. The facility reported a census of 47 residents.

Findings included:

1. A Minimum Data Set (MDS) assessment for Resident #17 dated 2/2/21, included diagnoses of Diabetes Mellitus, Parkinson's, and coronary artery disease. The MDS identified the resident required extensive assistance of one staff for toilet use and dressing, and extensive assistance of two staff for bed mobility and transfers. The MDS assessed the resident with a Brief Interview

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for Mental Status (BIMS) score of 12 (moderate cognitive impairment).

Observation on 2/11/21 at 7:58 a.m., showed Staff A, Registered Nurse (RN) enter Resident #17's room with a glucometer (instrument for measuring blood glucose level) and container of blood glucose test strips. Staff A, RN, placed the glucometer on the resident's bed, without a barrier. Staff A, RN placed the test strip container on the bedside table, also without a barrier. After completing the blood glucose check, Staff A, RN, exited the room and placed the glucometer on the medication cart, before sanitizing the glucometer. Staff A, RN placed the test strip container in the medication cart with other supplies and failed to sanitize the container.

Facility's policy titled "Procedure for obtaining a Fingerstick Glucose Level" dated 11/9/20, directed staff to place the equipment and supplies on a clean surface, placing barrier between clean surface and equipment/supplies.

On 2/11/21 at 3:05 p.m., the Director of Nursing DON) stated she expected staff to place a barrier between the glucometer, test strip container, and the surface the supplies are placed on.

2. A Minimum Data Set (MDS) dated 12/13/20 for Resident #35 revealed diagnoses that included: chronic obstructive pulmonary disease (COPD), respiratory failure and need for assistance with personal care. A Brief Interview for Mental Status (BIMS) score of 15 indicated intact cognition. The MDS further documented the resident received

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oxygen therapy.

Observation on 2/10/20 at 11:00 a.m. showed the resident in bed with oxygen administered per nasal cannula. The oxygen tubing did not contain a date to identify when staff last changed the tubing.

Observation on 2/17/21 at 10:10 a.m. showed the resident in bed with oxygen administered per nasal cannula. The oxygen tubing did not contain a date to identify when staff last changed the tubing.

A Medication Administration Record revealed an order for oxygen at 3 liters per nasal cannula continuous every shift for shortness of breath with a start date of 9/24/20 at 6:00 p.m.

On 2/18/21 at 2:45 p.m., the Director of Nursing (DON) revealed she updated the resident's Treatment Administration Record (TAR) to include changing the oxygen tubing weekly one time a day as she is unable to verify the hospice agency that provided the oxygen changed the tubing.

F582 Ramsey Village provides SNF Advance Beneficiary Notice (ABN) for residents discharging from skilled nursing services.

Resident #17 is no longer in the facility. The facility submits ABN for signature to the responsible party if the resident is cognitively impaired.

The personnel involved in completion of Advance Beneficiary Notices were educated regarding the need to have a responsible party sign the ABN if the resident is cognitively impaired.

The Executive Director or designee will verify compliance by review of the completed ABN as they are completed for skilled discharges.

Any concerns will be reviewed at the quarterly QAPI Committee meetings.

F609 Ramsey Village reports alleged violations involving abuse, neglect, exploitation or mistreatment, including injuries of unknown origin.

Resident #18 and other residents in the facility have an investigation of injuries of unknown origin to determine the cause.

Nursing staff were educated that any injury of unknown origin must be immediately reported to the Director of Nursing so that a cause may be determined.

The Director of Nursing was educated to inform the Executive Director of any injuries of unknown origin where cause cannot not be determined, so that it may be reported to DIA within the proper reporting timeline.

The Executive Director or designee will verify compliance through weekly review of resident injuries with the nursing management team and ensure that reporting is completed as required.

Any concerns will be reviewed at the quarterly QAPI Committee Meetings.

F686 Ramsey Village ensures care consistent with professional standards of practice to prevent pressure ulcers and does not develop pressures sores that are avoidable.

Resident #17 wound is healing well.

An audit was completed of boots and other devices to verify they are appropriate for the resident.

Nurses were educated to notify the physician and promptly order a treatment for a new pressure ulcer.

Nurse managers were educated that if a device causing a pressure area, they will educate resident and/or family that equipment is causing added pressure and will work with them on finding a more appropriate solution for reducing pressure.

The Director of Nursing or designee will verify compliance by verifying devices causing pressure have been discontinued as it occurs, and that each newly identified pressure ulcer has prompt physician notification and order for treatment.

Any concerns will be taken through the quarterly QAPI Committee process.

F692 Ramsey Village adequately addresses significant weight loss in residents.

Resident #198 is no longer in the facility. Other residents in the facility are monitored for weight changes.

The Weight Committee members were educated regarding the need to put interventions in place for a resident with significant weight loss so that further weight loss does not occur, and to document interventions in the resident chart.

The Director of Nursing or designee will verify compliance through attendance at the weekly Weight Committee meetings and review of nutritional interventions for residents with weight loss concerns.

Any concerns will be taken through the quarterly QAPI process.

F700 Ramsey Village completes ongoing assessment and monitoring of assist rails used in the facility.

Resident #35 no longer resides in the facility.

An audit was completed of resident beds to verify halo or assist rail use. Assessments and informed consents were completed for these residents.

Maintenance personnel was educated to complete and document monthly audits of beds with halos or assist rails for resident safety.

The nursing management and therapy team were educated on the requirement for completion of an assessment and informed consent prior to placement of a halo or assist rail on a resident's bed.

The Executive Director or designee will verify compliance through monthly audits of documentation for halos and assist rails.

Any concerns will be taken through the quarterly QAPI process.

F801 Ramsey Village employs qualified dietary personnel.

The Certified Dietary Manager has completed the required coursework, but had difficulty scheduling the exam due to COVID as many centers were closed. He has the exam scheduled for March 27, 2021.

Once completed, his exam certificate will be placed in his personnel file.

The HR Director was educated regarding the requirement for a Certified Dietary Manager to complete the course as well as the exam.

The Executive Director will verify compliance by visualizing the exam certificate.

Any further concerns will be taken through the quarterly QAPI process.

F812 Ramsey village labels and dates food items stored in the refrigerator and freezer.

Non-dated items found during the survey were immediately discarded.

Dietary staff were educated regarding the guidelines for labeling and dating food items.

The Certified Dietary Manager or designee will verify compliance through twice weekly observation of the refrigerator and freezer for properly labeled and dated food items.

Any concerns will be taken through the quarterly QAPI process.

F868 Ramsey Village holds QAPI meetings at least quarterly as per the requirements.

The Director of Nursing was educated regarding the need to retain a signature sheet that reflects attendees of the quarterly QAPI meetings.

The Executive Director has retained QAPI minutes with signature sheets for the past two quarters. The Executive Director will continue to maintain quarterly QAPI documentation.

Any concerns will be reviewed through the quarterly QAPI process.

F880 Ramsey Village maintains an infection prevention and control program.

1.Resident #17 and other diabetic residents receive glucometer checks that utilize a clean barrier for the glucometer and supplies.

Nurses demonstrated competency in glucometer handling and use for the Director of Nursing.

The Director of Nursing or designee will verify compliance through random monthly observations of glucometer use by the nurses.

Any concerns will be taken through the quarterly QAPI process.

2. Resident #35 no longer resides in the facility. Other residents with oxygen have tubing changed weekly and it is documented on the medication administration record (MAR).

Nurses were educated that oxygen tubing must be changed weekly and documented on the MAR.

The Director of Nursing or designee will verify compliance by monthly review of documentation related to tubing changes and visualization of tubing in resident rooms.

Any concerns will be taken through the quarterly QAPI process.