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	165006	A. BUILDING _____ B. WING _____	01/09/2020

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IOWA JEWISH SENIOR LIFE CENTER	900 POLK BOULEVARD DES MOINES, IA 50312

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F 000	INITIAL COMMENTS Correction date_____ The following deficiencies result from the facility's annual health survey completed 1/6/-1/9/2020. See the 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 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	F 582		

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

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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 facility record review and staff interview, the facility failed to provide Mandatory Denial Notice (Centers for Medicare Services [CMS] form 10055) for 2 of 3 skilled residents reviewed (Resident # 54 and #104). The facility reported a census of 52.

Findings include:

1.The information provide from the facility documented Resident # 54 received skilled services at the facility from 9/25/19 through 10/18/19.

Review of the documents provided for Resident

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#54, Skilled Nursing Facility Advance Beneficiary Notice (SNFABN) revealed the resident's therapy services would end 10/18/19. The facility failed to provide Mandatory Denial Notice form 10055 to Resident # 54 that would have notified the resident of the right to have a claim submitted to Medicare and of the standard claim appeal rights that apply if the claims denied by Medicare.

2.The information provided from the facility documented Resident #104 received skilled services at the facility from 6/23/19 through 7/1/19.

Review of the documents provided for Resident #104, Skilled Nursing Facility Advance Beneficiary Notice (SNFABN) revealed the resident's therapy services would end 7/1/19. The facility failed to provide Mandatory Denial Notice form 10055 to Resident # 54 that would have notified the resident of the right to have a claim submitted to Medicare and of the standard claim appeal rights that apply if the claims denied by Medicare.

During an interview on 1/9/2020 at 8:37 AM, the Staff H, Admissions Coordinator explained the vendor had changed the form they used last year. Staff H acknowledged she had not been using form 10055 since the change and only used the Detailed Explanation of Non-coverage. During a subsequent interview on 1/9/2020 at 9:47 AM, Staff H explained she printed the form 10055 and acknowledged she did get confused since the Detailed Explanation of Non coverage goes over the same things as the form 10055. Staff H realized the Detailed Explanation of Non coverage did not give the resident the option of continuing the coverage for a cost, appealing the

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F 582	Continued From page 3 decision, or not to have the coverage.	F 582		
F 607 SS=D	Develop/Implement Abuse/Neglect Policies CFR(s): 483.12(b)(1)-(3) §483.12(b) The facility must develop and implement written policies and procedures that: §483.12(b)(1) Prohibit and prevent abuse, neglect, and exploitation of residents and misappropriation of resident property, §483.12(b)(2) Establish policies and procedures to investigate any such allegations, and §483.12(b)(3) Include training as required at paragraph §483.95, This REQUIREMENT is not met as evidenced by: Based on record review and staff interviews the facility failed to have staff complete the Mandatory Reporter for Dependent Adult 2 hour class within 6 months of hire. The facility reported a census of 52. Findings include; According to the new hire list provided by the facility, Staff A, Certified Nursing Aide (CNA) had an employment start date of 3/20/19. Staff A provided a certificate for Mandatory Reporter: Child and Dependent Adult dated 7/25/2018 for 2 contact hours. During an interview on 1/8/2020 at 10:39 AM, Staff B, Accounting Assistant explained she did not have any other information for Staff A, CNA. Staff B acknowledged information she had on Staff A showed her dependent adult abuse done	F 607		

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F 607	Continued From page 4 7/25/18 that is the same date on the certificate for 2 hours combined for child and adult. During an interview on 1/9/20 at 10:52 AM Staff C, Nursing Support acknowledged the facility knew the required 2 hours for adult only, for the Mandatory Reporter of Dependent Adult Training.	F 607		
F 803 SS=D	Menus Meet Resident Nds/Prep in Adv/Followed CFR(s): 483.60(c)(1)-(7) §483.60(c) Menus and nutritional adequacy. Menus must- §483.60(c)(1) Meet the nutritional needs of residents in accordance with established national guidelines.; §483.60(c)(2) Be prepared in advance; §483.60(c)(3) Be followed; §483.60(c)(4) Reflect, based on a facility's reasonable efforts, the religious, cultural and ethnic needs of the resident population, as well as input received from residents and resident groups; §483.60(c)(5) Be updated periodically; §483.60(c)(6) Be reviewed by the facility's dietitian or other clinically qualified nutrition professional for nutritional adequacy; and §483.60(c)(7) Nothing in this paragraph should be construed to limit the resident's right to make personal dietary choices. This REQUIREMENT is not met as evidenced by:	F 803		

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Based on menu review, observation, diet resource manual and staff interviews the facility failed to follow the planned menu for residents on pureed texture diets for one of one meals observed, and failed to ensure one of five residents on pureed diet received the proper serving size for one of one meals served (Resident # 37). The facility identified a census of 52 residents.

Findings include:

The facility's Week 1 menu identified the following items as part of the planned menu for pureed texture for the lunch meal on 1/7/19:
1 serving chicken and broccoli stir fry
1 serving noodles
1 serving white bread

The facility Diet Type Report, dated 1/1/20, and provided to the survey team on 1/6/20, identified five residents on pureed texture diet (Resident # 7, #18, #22, #37, and #44).

Observation on 1/7/20 at 10:19 AM, revealed Staff F, Dietary Cook, assigned to prepare the pureed texture items for the noon meal. Staff F reported five residents on pureed texture diet, but she planned to puree 6 servings to have one extra serving. Staff F placed six 4 ounce (oz.) servings of chicken and broccoli mixture into a robot coupe container, added an unmeasured amount of broth and blended the contents together. Staff F poured the contents into a measuring cup and reported a total of 3 cups. Staff F checked the pureed portion serving chart and reported the serving size of a #8 scoop. Staff F measured out six #8 scoops of pureed chicken and broccoli and placed them into a metal pan,

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covered the pan with foil and placed the pan in the oven. The measuring cup had a moderate portion (approximately ¼ cup) of pureed contents left inside. Staff F took the robot coupe container and dirty dishes to dishwashing area and washed her hands. At the time, Staff F reported none of the residents wanted the alternate entree (stuffed peppers), noodles or rice, so she had no other items to pureed. Staff F did not puree bread separately or use bread when she pureed the stirfry.

Observation on 1/7/20 starting at 12:11 PM, Staff F served residents in the CCDI (memory care) unit and then the first floor dining room. Staff F served four of the five residents (#7, #18, #22, and #44) one #8 scoop (equivalent to 4 oz. or approximately 1/2 cup). Staff F used the #8 scoop and scraped the sides and bottom of the metal pan but only had enough pureed chicken and broccoli stirfry to fill only half of the #8 scoop for the last resident served a pureed diet (Resident #37).

On 1/7/20 at 12:17 PM, before the surveyor left the CCDI unit, observed no pureed bread served to residents on a pureed diet. At 12:55 PM, the surveyor checked residents seated in the first floor dining room and observed no pureed bread served to residents on a pureed diet.

On 1/7/20 at 12:44 PM, Staff F confirmed a #8 scoop used when she served the pureed chicken and broccoli stirfry. The pan had a small amount of crumbs left the in pan.

During an interview on 1/7/20 at 1:40 PM, the dietician reported she expected staff added the noodles or bread when staff pureed the stirfry

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entree. The dietician reported she had performed an audit on the pureed process with staff on 11/26/19, and at that time had provided education to Staff F on the proper method for pureed. The dietician reported she had witnessed Staff F use a scoop and measure each pureed serving into a pan and then place it in the oven, rather than place the all of the pureed contents into the pan. The dietician reported staff needed to allow for the pureed textured food to cook down when heated, because whenever pureed food heated, it cooked down and then ended up with less volume. The dietician reported if a portion of pureed contents left in the robot coupe container and measuring cup, Staff F possibly would have had enough for a full serving size for each resident.

During in interview on 1/7/20 at 2:00 PM, the Dietary Manager (DM) acknowledged she noticed one resident did not get a full scoop of pureed stirfry during the lunch meal service on 1/7/20.

On 1/7/20 at 3:15 PM, the DM approached the surveyor and reported if the residents didn't circle bread on the menu card, they don't serve bread to those residents. If a resident not able to fill out their menu card, often a family member or staff person filled out the menu slip for them. The DM reported the residents who received pureed diet, only had one item on their plate during the lunch meal on this day, so the portion of food looked small in comparison to other meals served.

During an interview on 1/8/20 at 1:00 PM, the Dietician reported she didn't think they had a policy for the pureed process but an annual staff competency done on how to pureed food. The dietician reported they had a recipe book for staff

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to follow and what to add to an entree whenever pureed food.

During an interview on 1/9/20 at 9:10 AM, Staff F reported she looked at the menu for the day and resident menu slips to know what items she needed to puree. Staff F reported if bread not circled, she didn't puree the bread. Staff F reported no recipe for pureed items, she used the pureed serving chart to know what serving size to serve.

During an interview on 1/9/20 at 9:55 AM, the DM reported no policy for pureed process but a staff competency skill fair held annually and had went over the pureed process and serving sizes. The DM reported she expected staff use the serving chart to know the proper portion size. The DM stated bread had no nutritive value, it's just flour and water and staff usually had not added bread to the pureed entrees.

The Simplified Diet Manual (page 51), revealed foods often change in volume when modified in consistency and texture. In order to ensure the nutritional adequacy maintained, the following guidelines may be used when several portions of a consistency altered food, such as pureed, is needed:
a. Measure out desired number of servings into a container for pureeing. Puree the food. Add any necessary thickener or liquid to obtain desired consistency.
b. Measure the volume of food after it has been pureed
c. Divide the total volume of the pureed food by the original number of portions. This is the new portion size. Note: some foods may have a smaller, rather than larger portion after pureeing.

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F 880 SS=E	Infection Prevention & Control CFR(s): 483.80(a)(1)(2)(4)(e)(f) §483.80 Infection Control The facility must establish and maintain an infection prevention and control program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of communicable diseases and infections. §483.80(a) Infection prevention and control program. The facility must establish an infection prevention and control program (IPCP) that must include, at a minimum, the following elements: §483.80(a)(1) A system for preventing, identifying, reporting, investigating, and controlling infections and communicable diseases for all residents, staff, volunteers, visitors, and other individuals providing services under a contractual arrangement based upon the facility assessment conducted according to §483.70(e) and following accepted national standards; §483.80(a)(2) Written standards, policies, and procedures for the program, which must include, but are not limited to: (i) A system of surveillance designed to identify possible communicable diseases or 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:	F 880		

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(A) The type and duration of the isolation, depending upon the infectious agent or organism involved, and
(B) A requirement that the isolation should be the least restrictive possible for the resident under the circumstances.
(v) The circumstances under which the facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease; and
(vi)The hand hygiene procedures to be followed by staff involved in direct resident contact.

§483.80(a)(4) A system for recording incidents identified under the facility's IPCP and the corrective actions taken by the facility.

§483.80(e) Linens.
Personnel must handle, store, process, and transport linens so as to prevent the spread of infection.

§483.80(f) Annual review.
The facility will conduct an annual review of its IPCP and update their program, as necessary.
This REQUIREMENT is not met as evidenced by:
Based on observation, policy review, record review and staff interviews the facility failed to cleanse contaminated surfaces after performing a treatment for 2 of 4 residents, (Resident #17 and #30) and ensure staff utilized infection control techniques for 2 of 3 residents (Resident #2 and #49). The facility also failed to annually review their infection prevention and control program.
The facility reported a census of 52 residents.

Findings include:

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1. During observation for Resident #17 with a diagnoses of shortness of breath and Chronic Obstructive Pulmonary Disease (COPD), on 1/8/20 at 7:31 AM, Staff G, Registered Nurse (RN), provided Resident #17 with her inhaler. After giving the inhaler Staff G dropped the inhaler on the floor in the residents room and proceeded to pick up the inhaler. At 7:34 AM Staff G placed the inhaler on top of the medication cart without a barrier and then proceeded to unlock the medication cart and place the inhaler in the medication cart without sanitizing the inhaler.

2. On 1/8/20 at 7:47 AM, during an observation of administration of eye drops and an inhaler for Resident #30. Staff G entered the residents room and placed the inhaler and eye drops that were stored in plastic bags on the residents bedside table that also had the resident's lotion, water and remote on it. Staff G did not sanitize the surface prior to setting the treatments down. After completing the treatments, while walking back to the medication cart Staff G dropped the bottle of eye drops in the hallway. She placed them into the medication cart without sanitizing or changing out the bag.

The Director of Nursing (DON) provided an undated and unsigned procedure titled, Administration of Ophthalmic Medications. The procedure directed staff to place a barrier on a clean and dry surface before setting down the bag with the ophthalmic drops. Approved barriers may include but are not limited to: a paper towel, a new clean plastic bag and tin foil or parchment paper.

Review of Staff G's, Nurse Orientation Checklist,

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lacked education regarding inhalers and eye drop medication distribution.

During an interview on 1/8/20 at 3:30 PM, the DON stated she would expect the nurse to use a barrier when setting down medications in a resident room and sanitize if anything is dropped on the floor.

3. The facility provided a policy titled, Infection Control Program Standard of Practice, dated 11/2016. During an interview on 1/8/20 at 10:10 AM, Staff C, Registered Nurse (RN), revealed this was their current infection control program.

During an interview on 1/8/20 at 3:15 PM, the DON and Staff C revealed the facility did not know the facility was to review the policy annually.

The facility provided the same policy, with no changes, signed by Staff C and a Doctor, dated 1/8/20.

The facility failed to annually review their infection control policy.

4. The Minimum Data Set (MDS) assessment dated 12/24/19, revealed Resident #2 had moisture associated skin disorder, Alzheimer's disease, and dementia. The resident required extensive assistance of one staff for toileting, hygiene and dressing. The MDS indicated the resident had frequent urinary and bowel incontinence.

During observation on 1/8/20 at 7:52 AM, Staff E, Certified Nursing Assistant (CNA) ambulated Resident #2 to the shower room on the CCDI

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F 880	Continued From page 13	F 880		

(memory care) unit. Staff E donned a pair of gloves and removed Resident #2's pants and brief. The resident sat down on the toilet. Staff E obtained washcloths, placed soap on the top washcloth, placed the washcloth into the bowl of the sink and turned on the water with her gloved hand. Staff E used the same gloved hand and pulled the soiled linen cart closer to the sink area. Staff E removed the resident's partially wet brief and then donned a clean pull up inside the resident's pants. At 7:55 AM, Staff E assisted the resident to stand by the toilet. Staff E took a wet washcloth from the sink and provided pericare. Staff E took another washcloth from the sink and cleansed the buttocks area. The resident's inner buttocks area had a reddened area. Staff E pulled the resident's pull up brief and pants up, then removed her gloves.

During an interview 1/9/20 at 8:00 AM, the DON stated she expected staff take residents to the bathroom in the resident's room rather than use the bathroom in the shower room to toilet the resident and provide pericare. The DON reported she expected staff not place washcloths in the sink and then use those washcloths for pericare. The DON expected staff to change gloves when soiled or contaminated.

In a policy titled Pericare, revealed the following:
a. Assemble wash cloths and soap. Bring garbage bag to area.
b. Perform hand hygiene and don gloves
c. Remove soiled pad and place in trash can.
d. Remove soiled gloves. Perform hand hygiene and don gloves.
e. Wet washcloth with soap and water, wet another washcloth with warm water for rinsing, and prepare a dry washcloth

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	165006	A. BUILDING _____ B. WING _____	01/09/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
IOWA JEWISH SENIOR LIFE CENTER	900 POLK BOULEVARD DES MOINES, IA 50312

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F 880	Continued From page 14 f. Wash resident from least soiling to buttocks area. g. Dry thoroughly with dry cloth h. Doff (remove) soiled gloves and perform hand hygiene. 5. The MDS assessment dated 12/10/19 revealed Resident #49 had dementia. The resident required extensive assistance of one staff for toileting and dressing and limited assistance for hygiene. During observation on 1/8/20 at 8:03 AM, Staff D, CNA, ambulated Resident #49 to the toilet in the shower room. Staff D donned a pair of gloves and removed the resident's pants and underwear. Staff D reported the resident's underwear a little wet, turned the call light on in the shower room and requested another CNA to bring in a clean pair of underwear. At 8:06 AM, Staff D donned a clean pair of pull ups inside the residents pants. At 8:07 AM, Staff D used her same gloved hand, placed wash cloths in the sink, and turned on the water. At 8:09 AM, Staff D stood the resident up by the toilet, then took a wet washcloth from the sink and cleansed the resident's peri area. Staff D took another washcloth from the sink and cleansed the buttocks area. Staff D took a dry washcloth from the edge of the sink and dried the resident's front and backside. Staff D removed her gloves, then pulled the resident's pull up and pants up. Staff D had the resident wash her hands in the sink. Staff D then ambulated the resident to the recliner in the common area.	F 880		