STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	165605	A. BUILDING _____ B. WING _____	07/28/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
KENNYBROOK VILLAGE	200 SW BROOKSIDE DRIVE GRIMES, IA 50111

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 000	INITIAL COMMENTS Correction Date 8-24-2021 The following deficiencies relate to the facility's annual health survey and investigation of complaints 98659-C, 91141-C, 89527-C, and 89045-C. Complaints 98659-C, 91141-C, 89527-C, and 89045-C were not substantiated. (See Code of Federal Regulations (42CFR) Part 483, Subpart B -C).	F 000		
F 637 SS=D	Comprehensive Assessment After Signifcant Chg CFR(s): 483.20(b)(2)(ii) §483.20(b)(2)(ii) Within 14 days after the facility determines, or should have determined, that there has been a significant change in the resident's physical or mental condition. (For purpose of this section, a "significant change" means a major decline or improvement in the resident's status that will not normally resolve itself without further intervention by staff or by implementing standard disease-related clinical interventions, that has an impact on more than one area of the resident's health status, and requires interdisciplinary review or revision of the care plan, or both.) This REQUIREMENT is not met as evidenced by: Based on clinical record review and staff interview, the facility failed to complete a Significant Change Minimum Data Set (MDS) assessment in 14 days for a resident placed on hospice care for one (#21) of sixteen residents reviewed. The facility reported a census of 38 residents.	F 637		

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

Executive Director 8-26-2021

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See Instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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F 637	Continued From page 1 Findings include: The Minimum Data Set (MDS) assessment dated 5/17/21 for Resident #21, included diagnoses of Non-Alzheimer's Dementia, Diabetes Mellitus and Malnutrition. The MDS identified the resident required extensive assistance of one staff for personal hygiene and dressing and extensive assistance of two staff for bed mobility, transfers, and toilet use. A Brief Interview for Mental Status (BIMS) score of 8 indicated moderate cognitive impairment for decision-making. Review of resident's physician order summary report revealed the following order that directed admit to hospice 6/11/21. Review of resident's clinical record revealed a Significant Change MDS completed 5/17/21 and a Quarterly MDS in progress dated 8/17/21. During an interview on 7/22/21 at 11:32, the Assistant Director of Nursing confirmed a significant change MDS was not completed when the resident was placed on hospice as required.	F 637		
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	F 644		

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F 644	Continued From page 2 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 interview, the facility failed to complete a Level I Preadmission Screening and Resident Review (PASRR) within 30 days of admission and refer a resident to the appropriate state-designated authority for a Level II PASRR evaluation and determination who was identified with a newly evident mental disorder for one of one residents reviewed (Resident #35). The facility reported a census of 38 residents. Findings include: The Minimum Data Set (MDS) assessment for Resident #35 dated 6/24/21, with resident admitted on 6/17/21, included diagnoses of Depression and Post Traumatic Stress Disorder. Review of PASRR Level I Screen Outcome completed and dated 7/20/21, 33 days after admission, documented no mental health diagnosis is known or suspected. During an interview on 7/20/21 at 3:51 PM, the Admission Coordinator stated she completed the PASRR on 7/20/21 and acknowledged it was not completed within 30 days of admission as	F 644		

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F 644	Continued From page 3 required.	F 644		
F 657 SS=D	Care Plan Timing and Revision CFR(s): 483.21(b)(2)(i)-(iii) §483.21(b) Comprehensive Care Plans §483.21(b)(2) A comprehensive care plan must be- (i) Developed within 7 days after completion of the comprehensive assessment. (ii) Prepared by an interdisciplinary team, that includes but is not limited to-- (A) The attending physician. (B) A registered nurse with responsibility for the resident. (C) A nurse aide with responsibility for the resident. (D) A member of food and nutrition services staff. (E) To the extent practicable, the participation of the resident and the resident's representative(s). An explanation must be included in a resident's medical record if the participation of the resident and their resident representative is determined not practicable for the development of the resident's care plan. (F) Other appropriate staff or professionals in disciplines as determined by the resident's needs or as requested by the resident. (iii)Reviewed and revised by the interdisciplinary team after each assessment, including both the comprehensive and quarterly review assessments. This REQUIREMENT is not met as evidenced by: Based on clinical record review, resident, and staff interview, the facility failed to update the comprehensive care plan for one (#21) of sixteen residents reviewed and failed to include a resident in the care plan conference meeting for	F 657		

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F 657	Continued From page 4 one (#25) of sixteen residents reviewed. The facility reported a census of 38 residents. Findings include: 1. The Minimum Data Set (MDS) assessment dated 5/17/21 for Resident #21, included diagnoses of Non-Alzheimer's Dementia, Diabetes Mellitus and Malnutrition. The MDS identified the resident required extensive assistance of one staff for personal hygiene and dressing and extensive assistance of two staff for bed mobility, transfers, and toilet use. A Brief Interview for Mental Status (BIMS) score of 8 indicated moderate cognitive impairment for decision-making. Review of the Non Pressure Skin Record for Resident #21, dated 7/4/21 documented a 1.0 centimeter (cm) X 1.0 cm wound to the coccyx/gluteal cleft(tailbone/split between buttocks). The form described the wound as superficial, wound bed with dark pink granulation (surface of skin as part of healing process), dry with no drainage or odor, rolled wound edges and reoccurring. Review of Resident #21's Medication Administration Record documented a physician's order with start date of 7/6/21 that directed: Cleanse coccyx with normal saline, pat dry. Apply skin prep around wound and triad paste (absorbs liquid present in the wound) to the wound. Cover with Optifoam dressing (dressing that has a silicone adhesive border and waterproof backing) and change every other day and as needed (PRN) - 14 days and re-evaluate every 48 hours for altered skin integrity for 14 days.	F 657		

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F 657	Continued From page 5 An observation on 7/21/21 at 1:45 PM revealed the coccyx/gluteal cleft wound had a superficial area that measured approximately 2 cm X 2 cm with red excoriation. During an interview on 7/21/21 at 2 PM , the Quality Assurance Nurse stated they coded the wound as a pressure ulcer due to the area having granulation tissue after a verbal consultation with a wound care specialist Resident #21's care plan with target date 8/17/21 lacked documentation that addressed the wound and treatment on coccyx/gluteal cleft. During an interview on 7/22/21 at 1:10 PM, the Executive Director stated she expected staff to address skin impairment and related treatments on the resident's care plan. 2. The MDS dated 6/2/21 documented Resident #25 had diagnoses of Diabetes Mellitus and Depression. The MDS identified the resident required limited assistance of one staff for personal hygiene and extensive assistance of two staff for bed mobility, transfers, dressing, and toilet use. A BIMS score of 14 indicated the resident demonstrated no cognitive impairment problems. During an interview on 7/20/21 at 11:05 AM, Resident #25 stated he did not remember attending a care plan meeting. Review of the facility document titled "Care Plan Conference Attendance Signature Page" documented a care plan conference date of 7/9/21 for Resident #25 with resident not in	F 657		

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F 657	Continued From page 6 attendance. During an interview on 7/21/21 at 4:21 PM, the Admission Coordinator stated they did not invite the resident to the care conference because they discussed different issues regarding the resident. During an interview on 7/26/21 at 12:19 PM, the Executive Director stated she expected staff to invite residents to the care plan meeting.	F 657		
F 732 SS=B	Posted Nurse Staffing Information CFR(s): 483.35(g)(1)-(4) §483.35(g) Nurse Staffing Information. §483.35(g)(1) Data requirements. The facility must post the following information on a daily basis: (i) Facility name. (ii) The current date. (iii) The total number and the actual hours worked by the following categories of licensed and unlicensed nursing staff directly responsible for resident care per shift: (A) Registered nurses. (B) Licensed practical nurses or licensed vocational nurses (as defined under State law). (C) Certified nurse aides. (iv) Resident census. §483.35(g)(2) Posting requirements. (i) The facility must post the nurse staffing data specified in paragraph (g)(1) of this section on a daily basis at the beginning of each shift. (ii) Data must be posted as follows: (A) Clear and readable format. (B) In a prominent place readily accessible to residents and visitors.	F 732		

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F 732	Continued From page 7 §483.35(g)(3) Public access to posted nurse staffing data. The facility must, upon oral or written request, make nurse staffing data available to the public for review at a cost not to exceed the community standard. §483.35(g)(4) Facility data retention requirements. The facility must maintain the posted daily nurse staffing data for a minimum of 18 months, or as required by State law, whichever is greater. This REQUIREMENT is not met as evidenced by: Based on observation and staff interview, the facility failed to post nurse-staffing data in a prominent location visible to residents and visitors. The facility reported a census of 37 residents. Findings included: Observation on 7/20/21 at 11 a.m. and again on 7/27/19 at 1:00 p.m. revealed no visible daily staff posting found anywhere throughout the health center unit. An interview with the RN admissions coordinator on 7/21/21 at 1:47 p.m. revealed the facility recently painted the walls. They usually posted the nurse staffing sheets on the bulletin board, which also contained the ombudsman notification information by the RN admissions office.	F 732		
F 812 SS=D	Food Procurement,Store/Prepare/Serve-Sanitary CFR(s): 483.60(i)(1)(2) §483.60(i) Food safety requirements. The facility must -	F 812		

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F 812	Continued From page 8 §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, facility policy and staff interviews, the facility failed to maintain staff hair in a hair net and provide a clean and sanitary environment for residents during a dining observation. Findings included: 1. During a lunch dining observation 7/19/21, Staff A, dietary aide, served plates to residents while wearing a hat that allowed at least three inches of hair to hang outside the hat not contained by a hair net or the hat. During an interview on 7/21/22, the administrator reported staff should restrain their hair under a hair net or hat. Review of the facility policy for food preparation and service revealed staff are to wear hair restraints (hair net, hat, beard restraint) so hair	F 812		

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F 812	Continued From page 9 does not contact food. 2. During an observation on 7/21/21 at 12:15 pm, Staff B, dietary aide, washed her hands and laid the paper towel she used to dry her hand on the countertop. As she served resident trays she moved the damp paper towel to a different location on the counter top. During the observation, the paper towel touched Resident #2 and at 12:25 pm, the paper towel touched the plate for Resident #14. A policy for food preparation and service directed staff to adhere to proper hygiene and sanitary practices to prevent the spread of foodborne illness during food preparation.	F 812		
F 880 SS=D	Infection Prevention & Control CFR(s): 483.80(a)(1)(2)(4)(e)(f) §483.80 Infection Control The facility must establish and maintain an infection prevention and control program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of communicable diseases and infections. §483.80(a) Infection prevention and control program. The facility must establish an infection prevention and control program (IPCP) that must include, at a minimum, the following elements: §483.80(a)(1) A system for preventing, identifying, reporting, investigating, and controlling infections and communicable diseases for all residents, staff, volunteers, visitors, and other individuals	F 880		

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F 880	Continued From page 10 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 (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.	F 880		

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F 880	Continued From page 11 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 observations, review of facility policies and staff interviews the facility failed to provide a sanitary environment for four of four residents observed that received water pitchers. The facility also failed to ensure an environment free of possible infections when staff failed to follow proper mask hygiene. The facility to provide a sanitary environment for one of three residents (#9) observed for perineal cares. The facility reported a census of 37 residents. Findings included: 1. A dining observation on 7/19/21 at 12:30 pm revealed a staff member touched her mask and then touched a cupboard in the kitchenette area. A 2nd staff member touched her mask and then assisted a resident with his wheelchair and pushed his wheelchair for him. A third staff member, Staff C, activity assistant, wore her mask below her nose throughout the dining process and served multiple residents during lunch. A personal protective equipment policy for face masks directed staff to cover their mouths and noses while wearing a facemask during treatment and services for residents, to not remove their mask while providing treatment or services for patient cares, and not to touch the mask while it	F 880		

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F 880	Continued From page 12 is in use. Staff should handle masks by the string ties. In an interview on 7/27/21 at 1:12 pm, the infection preventionist reported she educated staff to hold each other accountable with regard to PPE use, especially to make sure everyone is wearing their masks correctly. 2. Review of the Minimum Data Set dated 4/20/21 documented Resident #9 had diagnoses that included hemiplegia, contracture of left hand, cancer, atrial fibrillation (heart arrhythmia), coronary artery disease, non-Alzheimer's dementia, and urinary incontinence. The MDS revealed the resident required extensive assistance of two staff for bed mobility and toilet use and experienced incontinence of both bowel and bladder. . The care plan identified the resident displayed self-care deficits and required assistance of one to two staff for toilet use and hygiene. The care plan revealed the resident to have impaired urinary and bowel elimination. An observation on 07/22/21 at 1:50 pm revealed Staff D, certified nurse's aide assistant (CNA) and an agency staff CNA assisted the resident after an episode of stool incontinence. The agency staff CNA provided incontinence care and Staff D applied ointment to the resident's bottom. Staff D failed to remove her gloves and then assisted the resident to position himself on his back, gave him his foam footrest for his feet, and rolled his blanket over him. Staff D then removed her gloves to wash her hands. Staff D failed to remove her gloves after placing the cream on the resident's bottom before touching his personal	F 880		

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F 880	Continued From page 13 belongings. The Hand Hygiene policy directed staff to wash their hands in the following circumstances: a.) before and after direct contact with residents b.) before moving from a contaminated body site to a clean body site c.) after contact with the resident's intact skin d.) after contact with blood or bodily fluids e.) after contact with the objects in the immediate vicinity of the resident f.) after removing gloves Review of a personal protective equipment policy for gloves revealed staff are to wash their hands after removing their gloves. 3. During an observation on 7/19/21 at 2:52 PM, in Room 21-A, Staff C, Activities Assistant sat next to a resident painting their nails. Staff C's face mask sat just below her nose and only covered her mouth. 4. During an observation on 7/21/21 at 9:30 AM, Staff D, pushed a cart down the hallway that contained 12 mugs filled with ice and not covered with lids. Staff D took a mug into a resident's room, filled it with water, removed the lid from the mug already present in the resident's room, placed the lid on the mug filled with water, and placed a new straw in the mug. Staff D continued down the hallway and passed 3 more mugs from the cart to 3 different residents while repeating the same process. During an interview at the time of the observation, Staff D she knew the process the mugs required covers, but the facility staff told her to pass the	F 880		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	165605	A. BUILDING _____ B. WING _____	07/28/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
KENNYBROOK VILLAGE	200 SW BROOKSIDE DRIVE GRIMES, IA 50111

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 880	Continued From page 14 mugs in that manner because they did not have enough lids for all the mugs. Review of the facility's Assistance with Meals policy revised on October 2018 directed staff to cover all food and fluids during delivery to residents' rooms. During an interview on 7/22/21 at 1:07 PM, the Executive Director stated she expected staff to cover water mugs whey they transport them through hallways and also expected staff to wear their masks over their noses and mouths.	F 880		

Kennybrook Village Plan of Correction

Date Survey Completed: 7/28/2021

The enclosed Plan of Correction should constitute our credible allegation of compliance and we trust you will find it adequate and acceptable.
This Plan of Correction is submitted as required under State and Federal law. The submission of this Plan of Correction does not constitute an admission on the part of the Facility as to the accuracy of the surveyors' findings nor the conclusions drawn therefrom. The Facility's submission of this Plan of Correction does not constitute an admission on the part of the Facility that the findings cited are accurate, that the findings constitute a deficiency, or that the scope and severity regarding any of the deficiencies cited are correctly applied.

F637
1. In continuing compliance with **F 637** Comprehensive Assessment after Significant change; **483.20 (b)(2)(i)(i)**

No residents had negative outcomes or adverse effects.

The significant change for resident #21 was completed on 7/22/2021 by MDS coordinator.

2. To correct the deficiency to ensure the problem does not reoccur, the interdisciplinary team was educated on 8/25/2021 by MDS Coordinator on when a significant change should be completed and reviewed regulations on significant change.

3. As part of Kennybrook Village's ongoing commitment to quality assurance the Director of Nursing or designee will complete random audits of Comprehensive Assessment for residents who have had a significant change in physical or mental status. Audit results will be reported and reviewed at the monthly quality assurance performance improvement meetings and recommendations discussed, as needed.

F 644
1. In continuing compliance with **F 644** Coordination of PASARR and Assessments; **483.20(e)(1)(2)**

No resident had negative outcomes of adverse effects.

An updated PASARR on resident #35 was submitted on 8/24/2021 and is pending review. This PASARR was updated with included diagnosis of Depression and Post Traumatic Stress Disorder by the Social Service RN.

2. To correct the deficiency to ensure the problem does not reoccur, the Social Service RN was educated on the regulation on running a PASARR prior to admission or having a copy of the PASARR prior to admit if the resident is coming from another facility.

3. As part of Kennybrook Village's ongoing commitment to quality assurance the Director of Nursing, Social Service RN or designee will complete random audits of PASARR documentation for residents. Audit results will be reported and reviewed at the monthly quality assurance performance improvement meetings and recommendations discussed, as needed.

F 657
1. In continuing compliance with F **657** Care Plan Timing and Revision;
483.21 (b)(2)(i)-(iii)

No residents had negative outcomes or adverse effects.

The care plan for resident #21 was updated on 7/22/2021 by the MDS Coordinator.

2. To correct the deficiency and ensure the problem does not reoccur, the interdisciplinary team was educated on 8/25/2021 by MDS Coordinator to update care plans accordingly along with educating the team on the process to revised and update per care plan requirements.

3. As part of Kennybrook Village's ongoing commitment to quality assurance the Director of Nursing or designee will randomly audit to ensure care plans are updated with relevant resident information or changes when noted/observed and with annual, quarterly, and significant change assessments within the residents care plan. Audit results will be reported and reviewed at the monthly quality assurance performance improvement meetings and recommendations discussed, as needed.

F 732
1. In continuing compliance with F **742** Posted Nurse Staffing Information;
483.35(g)(1)-(4)

No residents had negative outcomes or adverse effects.

Nurse Staffing Information location updated by the DON on 8/25/2021

2. To correct the deficiency and ensure the problem does not reoccur, the interdisciplinary team was educated on 8/25/2021 by DON and MDS Coordinator to update nurse staffing information after midnight for the current day; updates to the information will take place if changes occur.

3. As part of Kennybrook Village's ongoing commitment to quality assurance the Director of Nursing or designee will randomly audit to ensure nurse staffing information is posted. Audit results will be reported and reviewed at the monthly quality assurance performance improvement meetings and recommendations discussed, as needed.

F 812

1. In continuing compliance with **F 812** Food Procurement, Store/Prepare/Serve-Sanitary; **483.60(i)(1)(2)**

No residents had negative outcomes or adverse effects.

Dietary Manager educated Staff A on wearing a hair net on 7/27/2021. Dietary Manager educated Staff B on hand hygiene on 7/27/2021.

2. To correct the deficiency and ensure the problem does not reoccur, the dietary team was educated on or before 8/26/2021 on Kennybrook's food preparation and service policy and hand hygiene.

3. As part of Kennybrook Village's ongoing commitment to quality assurance the Dietary Manager or designee will randomly audit to ensure staff are wearing the proper hair restraint and performing proper hand hygiene. Audit results will be reported and reviewed at the monthly quality assurance performance improvement meetings and recommendations discussed, as needed.

F 880

1. In continuing compliance with **F 880** Infection Prevention & Control; **483.80(a)(1)(2)(4)(e)(f)**

No residents had negative outcomes or adverse effects.

2. To correct the deficiency and ensure the problem does not reoccur, the interdisciplinary team will be educated on the following policies on or before 9/30/2021, per the directed plan of correction 488.402(f):
    a. Videos
        i. PPE Lessons
        ii. Sparkling Surfaces
        iii. Clean Hands
        iv. Keep COVID Out
    b. Policy review of: hand hygiene, gloving, and wearing of masks
    c. Gina Anderson at Telligen was emailed on 8/25/2021 to schedule a root cause analysis of Infection control practice

3. As part of Kennybrook Village's ongoing commitment to quality assurance the Director of Nursing, Infection Control Nurse, or designee will randomly audit to ensure staff are following infection control practices for: gloving, masks, and hand hygiene. Audit results will be reported and reviewed at the monthly quality assurance performance improvement meetings and recommendations discussed, as needed.