

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

PRINTED: 03/24/2021
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 165448	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 02/24/2021
NAME OF PROVIDER OR SUPPLIER BISHOP DRUMM RETIREMENT CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 5837 WINWOOD DRIVE JOHNSTON, IA 50131	
(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: <u>4/3/21</u> The facility recertification survey and investigation of complaints #94194-C, #94195-C, #95536-C and #94641-C completed on February 9-24, 2021, resulted in the following deficiencies. Complaint #94194-C substantiated Complaint #94195-C substantiated Complaint #95536-C substantiated Complaint #94641-C not substantiated. Facility census 124 residents. See the Code of Federal Regulations (42CFR) Part 483, Subpart B-C.	F 000	This Plan of Correction does not constitute an admission or agreement by the provider of the truth of the facts alleged or the conclusions set forth in the statement of deficiencies. This plan of correction is prepared solely because State and federal law require it. Please accept this plan as the organization's credible allegation of compliance. Allegation of compliance: 4/3/2021.	
F 554 SS=D	Resident Self-Admin Meds-Clinically Approp CFR(s): 483.10(c)(7) §483.10(c)(7) The right to self-administer medications if the interdisciplinary team, as defined by §483.21(b)(2)(ii), has determined that this practice is clinically appropriate. This REQUIREMENT is not met as evidenced by: Based on observations, interviews, and record reviews, the facility failed to provide ongoing assessments, care planning and get physician orders for residents to self-administer medications for three of seventeen resident's reviewed (Residents #52, #59, and #93). The facility reported a census of 124 residents. Findings include: 1. The Minimum Data Set (MDS) completed for resident #52 with an Assessment Reference Date	F 554	F 554 RESIDENT SELF-ADMIN MEDS-CLINICALLY APPROP CFR(S): 483.10(c)(7) It is the practice of this organization to provide ongoing assessments, care planning, and physician orders for residents to self-administer medications. Residents #52 and #93 were evaluated for the ability to self-administer medications on 3/26/21 by the Director of Nursing (DON) and physician order and care plans were updated. Resident #59 no longer resides in the facility.	

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

William Brecker

TITLE

Executive Director

(X6) DATE

4/13/21

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

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F 554	<p>Continued From page 1</p> <p>(ARD) of 12/16/20 showed a Brief Interview for Mental Status (BIMS) score of 15, indicating intact cognition. The resident had diagnoses of anxiety disorder, unspecified, and Barrette's Esophagus with dysphasia.</p> <p>On 2/10/21 at 10:50 AM observed revealed a bottle of nose spray in the resident's room on table next to the resident's recliner with no nurse present in the resident's room.</p> <p>The February 2021 Medication Administration Record (MAR) showed an order for Flonase Suspension 50 micrograms per actuation (MCG/ACT) with a start date of 6/5/18 to have two sprays in both nostrils one time a day for sinus irritation.</p> <p>The electronic and paper health record lacked an order for the resident to have Flonase at bedside for self-administration.</p> <p>The electronic and paper health record lacked an assessment for the resident to self-administer medications.</p> <p>The care plan lacked a problem or intervention related to the resident having medications at the bedside for self-administration.</p> <p>2. The MDS completed for Resident #59 with an Assessment Reference Date (ARD) of 1/14/21 showed a BIMS score of 9, indicating moderate cognitive impairment. The resident had diagnoses of unspecified glaucoma, sick sinus syndrome, and cognitive communication deficit.</p> <p>On 2/17/21 at 4:21 PM Staff G, Certified Medication Aide (CMA), sanitized his hands and</p>	F 554	<p>The facility interdisciplinary team reviewed residents on 2/24/21 for the ability to self-administer medications; assessments, care plans, and physician orders were updated as indicated.</p> <p>The DON provided education to nursing staff on 3/24/21 regarding the facility policy on resident self-administration of medications.</p> <p>The DON is responsible for the ongoing compliance of this area. The DON, or designee, will conduct periodic reviews of residents that self-administer medications to ensure compliance with facility practice. Results of these reviews will be shared monthly with the Executive Director and Quality Assurance Performance Improvement (QAPI) committee for three months, or longer at the direction of the QAPI committee</p>		

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F 554	<p>Continued From page 2</p> <p>Staff gave the resident's evening medications. Staff gave the resident Pantoprazole 40 mg 1 tab and the resident swallowed this without difficulty. The resident then reminded Staff G that the staff just leave the inhaler and eye drop for him to do on his own. Staff G then left the eye drop and nose spray in the resident's room to complete independently.</p> <p>When interviewed on 2/17/21 at 4:26 PM the resident stated they leave the medications for him to take and pick up again when he goes to bed. He takes one eye drop in each eye for glaucoma and then nose spray due to a history of sinus surgery.</p> <p>On 2/17/21 at 4:31 PM Staff G reported the resident takes Timolol and the inhaler on his own. They leave it and come back later to get it.</p> <p>The February 2021 Medication Administration Record (MAR) showed an order for Ipratropium Bromide Solution 0.06 % with a start date of 12/17/21 to do two sprays in both nostrils two times a day related to Chronic Obstructive Pulmonary Disease (COPD).</p> <p>The February 2021 Medication Administration Record (MAR) showed an order for Stigmatic Solution 0.5 % (Timolol Maleate) with a start date of 12/17/20 to instill one drop in both eyes two times a day related to unspecified glaucoma.</p> <p>The care plan problem dated 12/21/20 indicated the resident had impaired visual function related to bilateral cataracts, Glaucoma, and Macular Degeneration to the left eye. The intervention dated 12/21/20 said to provide eye medications as ordered.</p>	F 554			

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F 554	<p>Continued From page 3</p> <p>The care plan lacked documentation of the resident's use of medications left at the bedside for independent use.</p> <p>The Physician Order Summary dated 1/4/21 lacked documentation that the medications could be left at the bedside for independent use.</p> <p>The paper and electronic chart lacked documentation of an assessment to determine if the resident was appropriate to self-administer his own medications.</p> <p>3. The MDS completed with an ARD of 1/13/21 showed Resident #93 with a BIMS score of 5, indicating severe cognitive impairment. The resident had diagnoses of unspecified intellectual disabilities, unspecified dementia without behavioral disturbance, and type 2 diabetes mellitus with hyperglycemia.</p> <p>Upon entering the resident's room on 2/10/21, at 10:01 AM observation revealed the resident taking medications with no nurse present. The resident stated the nurse usually gives her the medications then leaves the room.</p> <p>The care plan lacked documentation of the resident's use of medications left at the bedside for independent use.</p> <p>The Physician Order Summary dated 1/4/21 lacked documentation that the medications could be left a the bedside for independent use.</p> <p>The paper and electronic chart lacked documentation of an assessment to determine if the resident was appropriate to self-administer</p>	F 554			

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F 554	<p>Continued From page 4 her own medications.</p> <p>When interviewed on 2/23/21 at 1:09 PM the Director of Nursing (DON) explained that there are very few residents that take their medications independently. In order to use medications independently the resident needs assessed to do so and a Doctor's order is required. The DON said the expectation is that the nurses shouldn't leave residents without watching them take their pills, unless care planned for them to do so.</p> <p>The Self-Administration of Medication policy dated 11/16 stated it is the right of the resident to self-administer their medications if the interdisciplinary team has determined that this practice is clinically appropriate. The Procedure explained the following:</p> <ol style="list-style-type: none"> 1. The facility will comply with applicable law and the State Operations Manual with respect to resident Self-Administration of medications. 2. The Interdisciplinary Team will assess and determine, with respect to each resident, whether self-administration of medications is safe and clinically appropriate, based on the resident's functionality and health condition. Narcotics will not be permitted to be self-administered and self-stored. 3. To ensure safe and appropriate self-administration, the facility will educate and document in the clinical record that the resident is able to: <ol style="list-style-type: none"> A. State the name, dose, strength, frequency, and purpose for use of his/her medications B. Understand the possible side effects of his/her medications and that he/she should notify facility staff if he/she experiences any such side effects C. Correctly administer, inject, or apply his/her 	F 554			

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F 554	Continued From page 5 medications D. Correctly store his/her medications in a locked compartment 4. The licensed nursing staff should regularly observe the resident self-administering medications to determine if the resident's functional and cognitive skills permit the resident to self-administer medications safely and appropriately. If the licensed nursing staff observes a decline in the resident's ability to self-administer medication, skips doses, or refuses medication, the facility staff should report this decline to the nursing supervisor immediately. 5. The licensed nursing staff should ensure that orders for self-administration list the specific medications the resident may self-administer.	F 554			
F 584 SS=E	Safe/Clean/Comfortable/Homelike Environment CFR(s): 483.10(i)(1)-(7) §483.10(i) Safe Environment. The resident has a right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely. The facility must provide- §483.10(i)(1) A safe, clean, comfortable, and homelike environment, allowing the resident to use his or her personal belongings to the extent possible. (i) This includes ensuring that the resident can receive care and services safely and that the physical layout of the facility maximizes resident independence and does not pose a safety risk. (ii) The facility shall exercise reasonable care for the protection of the resident's property from loss or theft.	F 584	F 584 SAFE/CLEAN/COMFORTABLE/HOMELIKE ENVIRONMENT CFR(s): 483.10(i)(1)-(7) It is the practice of this organization to assure a safe, clean, comfortable and homelike environment. Resident #45 had wall repair completed on 2/24/2021 by maintenance staff; resident #94 had wheelchair repair completed on 2/19/21 as noted in the statement of deficiencies; maintenance staff corrected temperature in shower rooms on 2/19/21, and nursing staff removed items from shower rooms on 2/19/21. Room #107 was cleaned on 2/9/21		

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F 584	Continued From page 6 §483.10(i)(2) Housekeeping and maintenance services necessary to maintain a sanitary, orderly, and comfortable interior; §483.10(i)(3) Clean bed and bath linens that are in good condition; §483.10(i)(4) Private closet space in each resident room, as specified in §483.90 (e)(2)(iv); §483.10(i)(5) Adequate and comfortable lighting levels in all areas; §483.10(i)(6) Comfortable and safe temperature levels. Facilities initially certified after October 1, 1990 must maintain a temperature range of 71 to 81°F; and §483.10(i)(7) For the maintenance of comfortable sound levels. This REQUIREMENT is not met as evidenced by: Based on observations and interviews the facility failed to assure a safe, clean comfortable and homelike environment for 4 of 25 resident's reviewed (Residents #52, #94, #33, and #45). Due to decreased temperatures in the shower room at least one resident refused to take a shower. The facility reported a census of 124 residents. Findings include: 1. The Minimum Data Set (MDS) completed for resident #45 with an Assessment Reference Date (ARD) of 12/16/20 showed a Brief Interview for Mental Status (BIMS) score of 15, indicating intact cognition. The resident had diagnoses of	F 584	Maintenance staff performed observations of resident rooms and resident care areas on 3/24/21 to identify and address environmental issues. Education was provided to maintenance staff by the Facilities Director 2/17-19/21 regarding facility practices for home-like environment. Education was provided to nursing staff on 3/24-3/31 regarding facility practices for home-like environment. Daily Assignment sheet for nursing staff was updated. The Housekeeping Supervisor and Director of Nursing are responsible for the ongoing compliance of this area. The Housekeeping Supervisor, Director of Nursing, or designee, will conduct random weekly observations of shower rooms and resident care areas to ensure home-like environment. Results of these observations will be shared monthly with the Executive Director and QAPI committee for three months, or longer at the direction of the QAPI committee.	

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F 584	<p>Continued From page 7</p> <p>anxiety disorder, unspecified, and Barrette's Esophagus with dysphasia.</p> <p>On 2/10/21 at 10:42 AM observed a softball size area behind recliner of chipped paint and dry wall.</p> <p>On 2/17/21 at 01:03 PM the Director of Facilities stated the resident is very good about reporting concerns that need repaired. He is not aware of any areas that needed repair in her room and that he would look into it.</p> <p>2. The MDS completed for resident #94 with an ARD of 1/15/21 showed a BIMS score of 5, indicating severe cognitive impairment. The resident required extensive assistance of one staff with locomotion on the unit and extensive assistance of two staff with locomotion off the unit. The resident had diagnoses of pain in the left arm and major depressive disorder, single episode, unspecified.</p> <p>On 2/17/21 at 1:29 PM noted a quarter sized area of the resident's wheelchair arm rest missing covering, leaving exposed foam.</p> <p>On 2/18/21 at 3:30 PM the Director of Nursing (DON) stated that she believed the resident's wheelchair was the facility's.</p> <p>On 2/23/21 at 1:09 PM the DON said staff are to put repairs needed into a work order system for maintenance to fix them. Sometimes work with therapy to get them a wheelchair if necessary.</p> <p>On 2/23/21 at 3:02 PM the DON reported Resident #94's wheelchair repaired last Friday afternoon with a new arm rest by the maintenance director.</p>	F 584			

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F 584	<p>Continued From page 8</p> <p>The Residents' Rights policy dated 1/1/17 explained that the resident has a right to a safe, clean, comfortable and Homelike environment, but not limited to receiving treatment and supports for daily living safely.</p> <p>3. Observation on 2/17/21 at 3:21 PM revealed the following: a. Margery Court shower room cluttered with 4 wheelchairs, lift equipment, and multiple shower chairs. b. The Margery Court shower room temperature felt cool, the thermostat on the wall read 75 degrees Fahrenheit (F) and appeared broken. c. The Central hall shower room thermostat read 70 degrees F.</p> <p>On 2/17/21 at 03:52 PM the Director of Nursing (DON) stated resident shower rooms are not supposed to be used for storage of resident equipment.</p> <p>4. According to the Minimum Data Set (MDS) assessment dated 12/10/20 Resident #45 had a Brief Interview for Mental Status (BIMS) score of 8, indicating moderate cognitive and memory impairment. Resident #45 required the assistance of 1 staff member personal hygiene.</p> <p>During an interview on 2/16/21 at 1:49 PM Resident #45 stated he has refused showers in the past because the shower room is so cold. He said, "even if the aide makes the water hot, once you are moved away from the water you just shiver." When asked, if he had told anyone the resident stated the aides know and he had told his nurse.</p>	F 584			

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F 584	Continued From page 9 On 2/17/21 at 3:21 PM during an observation and interview Staff R, Director of Facilities denied any outstanding work orders for either shower room. Staff R obtained the following temperatures using a laser thermometer: a. Margery Court shower room temperature 63 degrees Fahrenheit (F). He reported the thermostat broken. b. Central hall shower room temperature 70 degrees F. Staff R reported he would fix the temperatures in both shower rooms. On 2/17/21 at 12:05 PM Staff R, completed a recheck of both shower room temperatures: a. Margery Court shower temperature 73.5 degrees F. Staff R reported he replaced the thermostat yesterday. b. Central shower room temperature 71 degrees F. Staff R said he could raise the temperature. 5. During resident observations in Room #107 on 2/9/21 at 1:37 PM observation revealed stool on floor and stool by soiled linen bucket.	F 584			
F 641 SS=B	Accuracy of Assessments CFR(s): 483.20(g) §483.20(g) Accuracy of Assessments. The assessment must accurately reflect the resident's status. This REQUIREMENT is not met as evidenced by: Based on clinical record review and staff interview, the facility failed to accurately complete a Minimum Data Set assessment for one of twenty-five residents reviewed in the sample (Resident #46). The facility reported a census of 124 residents.	F 641	F 641 ACCURACY OF ASSESSMENTS CFR(s): 483.20(g) It is the practice of this organization to accurately complete Minimum Data Set assessments. PASRR and care plan for resident #45 was corrected on 2/11/2021 by Social Worker. MDS assessment for resident #45 was corrected on 2/26/21 by MDS Coordinator.		

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F 641	<p>Continued From page 10</p> <p>Findings include:</p> <p>The admission Minimum Data Set (MDS) assessment dated 12/11/20 revealed Resident #46 admitted to the facility 12/7/20, and had diagnoses of bipolar disorder and depression. The MDS documented the resident not currently considered by the state level II PASRR (pre-admission screening and record review) process to have a serious mental illness and/or intellectual disability or a related condition.</p> <p>The care plan initiated on 12/9/20 revealed the resident had diagnoses of bipolar disorder and depression, and took psychoactive medications.</p> <p>The electronic health record diagnoses list included bipolar disorder and major depressive disorder.</p> <p>The PASRR dated 12/4/20 revealed the resident's PASRR had a 30 days approval. The PASRR documented the resident had a suspected or confirmed mental health disability, and the resident had diagnoses of bipolar disorder, anxiety disorder, and depression. The PASRR evaluation revealed the facility needed to document the resident's PASRR condition on the MDS, by marking "yes" under section A1500 for "resident considered by the state level II PASRR process to have a serious mental illness and/or intellectual disability or a related condition, and under question A1510 the "Level II PASRR conditions"</p> <p>In an interview 02/23/21 at 10:55 AM, Staff X, MDS Coordinator, reported she looked at the resident's clinical record and talked to the</p>	F 641	<p>The facility MDS coordinators conducted a review of MDS assessments on 2/11/21 for residents with 30-day PASRR; MDS, PASRR, and care plans were updated as indicated.</p> <p>Education was provided to MDS coordinators on 2/11/21 by the Director of Nursing regarding the facility practice.</p> <p>The DON is responsible for the ongoing compliance of this area. The DON, or designee, will conduct periodic reviews of MDS assessments to ensure compliance with facility practice. Results of these reviews will be shared monthly with the Executive Director and QAPI committee for three months, or longer at the direction of the QAPI committee.</p>		

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FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 165448	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 02/24/2021
NAME OF PROVIDER OR SUPPLIER BISHOP DRUMM RETIREMENT CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 5837 WINWOOD DRIVE JOHNSTON, IA 50131		
(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 641	Continued From page 11 resident and staff, when she obtained information for completion of the MDS. Staff X stated she also looked at the PASRR as there are questions on the MDS tool that needed filled in. Staff X confirmed Resident #46's admission MDS regarding the PASRR and serious mental health diagnoses would have been oversight, and she needed to submit a correction for the MDS dated 12/11/2020.	F 641			
F 644 SS=B	Coordination of PASARR and Assessments CFR(s): 483.20(e)(1)(2) §483.20(e) Coordination. A facility must coordinate assessments with the pre-admission screening and resident review (PASARR) program under Medicaid in subpart C of this part to the maximum extent practicable to avoid duplicative testing and effort. Coordination includes: §483.20(e)(1) Incorporating the recommendations from the PASARR level II determination and the PASARR evaluation report into a resident's assessment, care planning, and transitions of care. §483.20(e)(2) Referring all level II residents and all residents with newly evident or possible serious mental disorder, intellectual disability, or a related condition for level II resident review upon a significant change in status assessment. This REQUIREMENT is not met as evidenced by: Based on clinical record review and staff interview, the facility failed to refer one of one sampled residents (#46) with a negative Level I result for the Pre-Admission Screening and Resident Review (PASRR), who had a possible	F 644	F 644 COORDINATION OF PASRR AND ASSESSMENTS CFR(s): 483.20(e)(1)(2) It is the practice of this organization to refer residents with a possible serious Mental Disorder, Intellectual Disability, or other related condition, to the appropriate state-designated authority for Level II PASRR evaluation and determination. PASRR for resident #45 was corrected on 2/11/2021 by Social Worker. MDS assessment for resident #45 was corrected on 2/26/21 by MDS Coordinator. The facility Social Workers conducted a review of PASRR's on 2/11/21 for residents with 30-day PASRR; MDS, PASRR, and care plans were updated as indicated. Education was provided to Social Workers on 2/11/21 by the Director of Social Services regarding the facility practice. The Director of Social Services is responsible for the ongoing compliance of this area. The director, or designee, will conduct periodic reviews of residents with 30-day PASSR to ensure compliance with facility practice. Results of these reviews will be shared monthly with the Executive Director and QAPI committee for three months, or longer at the direction of the QAPI committee.		

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F 644	<p>Continued From page 12</p> <p>serious Mental Disorder, Intellectual Disability, or other related condition, to the appropriate state-designated authority for Level II PASRR evaluation and determination. The facility reported a census of 124 residents.</p> <p>Findings include:</p> <p>The admission MDS (minimum data set) assessment dated 12/11/20 for Resident #46 identified the resident NOT considered by the state level II PASRR process to have a serious mental illness and/or intellectual disability or a related condition. The MDS documented diagnoses that included depression and bipolar disorder. The assessment documented the resident admitted to the facility on 12/7/20 for an acute hospitalization. The MDS documented the resident took an antipsychotic and antidepressant four days during the seven day look-back period.</p> <p>The care plan initiated 12/9/20 revealed the resident at risk for alteration in psychosocial well being and took psychoactive medications related to depression and bipolar disorder. The staff directives included to administer medications as ordered, and monitor for side effect and effectiveness of the medications.</p> <p>Review of the electronic health record diagnoses report revealed the resident had diagnoses of major depressive disorder (added 8/3/20) and bipolar disorder (added 8/3/20).</p> <p>Review of the clinical record revealed a Level 1 form PASRR with a notice date 12/4/20. The form indicated Resident #46 had a suspected or confirmed mental health disability. The PASRR</p>	F 644			

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F 644	<p>Continued From page 13</p> <p>revealed an exempted hospital discharge with a level I determination for a 30 day approval at a nursing facility. The PASRR instructions included a rescreening must occur by or before the thirtieth day if the individual expected to remain in the facility beyond the authorized timeframe. The Level 1 screening form listed the resident had bipolar disorder, anxiety disorder, and depression.</p> <p>The census report revealed resident #46 remained in the facility.</p> <p>The progress notes dated 12/2020 - 2/2021 revealed the resident on IV antibiotics until 1/26/21 and resident not able to return to home. The progress note dated 1/27/21 revealed the resident had a doctor appointment on 2/11/21, and planned to continue skilled care after her surgery the following month.</p> <p>The clinical record lacked documentation that facility staff referred Resident #46 for a PASRR re-evaluation and determination, and review.</p> <p>A PASRR Level I screening dated 2/11/21 revealed the resident referred for a Level II onsite evaluation.</p> <p>In an interview 2/16/21 at 03:00 PM, Staff C, Social Services, reported a PASRR completed prior to a resident's admission to facility. Staff C reported Resident #46 had a PASRR approved for 30 days (from 12/4/20), and she submitted another request for PASRR evaluation 2/11/21 when the resident not going home until after her scheduled surgery in 3/2021. Staff C stated resident's mental health status stable and thought no psychiatric services needed at this time.</p>	F 644			

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F 658 SS=D	<p>Services Provided Meet Professional Standards CFR(s): 483.21(b)(3)(i)</p> <p>§483.21(b)(3) Comprehensive Care Plans The services provided or arranged by the facility, as outlined by the comprehensive care plan, must-</p> <p>(i) Meet professional standards of quality. This REQUIREMENT is not met as evidenced by: Based on record review and staff interview the facility failed to prevent constipation and failed to have a glycohemoglobin test (HgbA1C) for one of thirty-two residents (Resident #13). Due to the lack of nursing intervention the resident did not have a bowel movement (BM) for seven days. The HgbA1C test determines the effectiveness of insulin for the treatment of diabetes. The facility reported a census of 124 residents.</p> <p>Findings include:</p> <p>According to the Minimum Data Set (MDS) completed with an Assessment Reference Date (ARD) of 2/15/21 Resident #13 had a Brief Interview for Mental Status (BIMS) score of 8, indicating moderate cognitive impairment. The resident was frequently incontinent of stool without a toileting program to manage the resident's bowel continence and had diagnoses of constipation and low back pain.</p> <p>A. The February 2021 Documentation Survey Report showed no BM charted from 2/3/21 until 2/9/21.</p> <p>The February 2021 Medication Administration Record (MAR) showed an order for polyethylene glycol powder with a start date of 1/18/21 to give 17 grams mixed with four to eight ounces (oz) of</p>	F 658	<p>F 658 SERVICES PROVIDED MEET PROFESSIONAL STANDARDS CFR(s): 483.21(b)(3)(i)</p> <p>It is the practice of this organization to have services as outlined by the comprehensive plan of care meet professional standards of quality.</p> <p>Resident #13 had lab drawn and reported to physician on 2/17/21 with no new orders as noted in the statement of deficiencies.</p> <p>The facility interdisciplinary team reviewed resident labs and bowel/bladder documentation on 2/24/2021.</p> <p>Nursing staff were provided education regarding professional standards for labs and the facility bowel protocol on 3/24/2021 by the DON. Review of Labs and Bowel/Bladder documentation added to the daily (M-F) IDT meeting agenda.</p> <p>The DON is responsible for ongoing compliance in this area. The DON, or designee, will conduct weekly reviews of the lab orders and results, and bowel and bladder documentation to ensure compliance with facility practice and protocol, respectively. Results of the reviews will be reported monthly to the Executive Director and QAPI committee for three months, or longer at the direction of the QAPI committee.</p>		

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F 658	<p>Continued From page 15 liquid by mouth two times a day for constipation.</p> <p>The February 2021 MAR showed an order for docusate sodium capsule 100 MG with a start date of 12/2/19 to give two capsules by mouth one time a day related to constipation, unspecified.</p> <p>The February 2021 MAR showed an order for Milk of Magnesia Concentrate Suspension (Magnesium Hydroxide) with a start date of 11/19/19 to give 30 milliliters (ml) by mouth every 24 hours as needed (PRN) for constipation.</p> <p>The February 2021 MAR showed an order for Bisacodyl Suppository 10 milligrams (MG) with a start date 11/19/19 to insert one suppository rectally every 24 hours PRN to stimulate a BM.</p> <p>The MAR lacked documentation of use of PRN medication to stimulate a BM or for constipation.</p> <p>The February 2021 MAR showed an order for Ferrous Sulfate Tablet 325 (65 elemental iron "Fe") MG with a start date of 11/20/19 to give one tablet by mouth once a day for iron supplementation.</p> <p>The February 2021 MAR showed an order for Tramadol hydrochloride (HCl) tablet 50 MG with a start date of 7/10/20 to give 0.5 tablet by mouth two times a day for pain related to low back pain and starting 5/7/20 to give 0.5 tablet by mouth every six hours PRN pain.</p> <p>The February 2021 MAR showed a PRN dose of Tramadol hydrochloride (HCl) tablet 50 MG on 2/4/21.</p>	F 658		

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F 658	<p>Continued From page 16</p> <p>The Mayo Clinic undated webpage located at https://www.mayoclinic.org/drugs-supplements/Tramadol-oral-route/side-effects indicated constipation as a side effect to the use of Tramadol.</p> <p>The Mayo Clinic undated webpage located at https://www.mayoclinic.org/drugs-supplements/iron-supplement-oral-route-parenteral-route/side-effects indicated constipation as a side effect to the use of Ferrous Sulfate.</p> <p>On 2/23/21 at 1:09 PM the Director of Nursing explained that if a resident doesn't have a BM for three days then they should receive Milk of Magnesia and then after day four a suppository. The facility does have someone in the northeast wing that prefers to go four to five days and it is written in their care plan. A resident waiting seven days would be outside the expectation. Sometimes there are some that are independent residents with dementia so they should have an assessment if its been more then 4 days because they don't always remember if they have dementia.</p> <p>The Bowel Protocol Policy dated 8/4/17 explained the following</p> <ol style="list-style-type: none"> To promote a standardized approach to nursing interventions for the resident with altered bowel elimination (constipation). To consistently monitor residents regarding bowel function by using the nursing process. To recognize resident habits, patterns of bowel evacuation, and utilize nursing measures to promote regularity and comfort. To prevent complications of constipation, including fecal impaction, and need for additional medical services 	F 658		

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F 658	<p>Continued From page 17</p> <p>The Protocol explained that the CNA will report and document any bowel activity for the residents on the caseload to the nurse prior to the end of the shift. A daily report of documented resident bowel movements in the past 9 shifts will be generated.</p> <p>The unit nurse is responsible for following up on the residents listed by:</p> <ol style="list-style-type: none"> Checking with resident and staff to see if documentation is accurate. Completing and documenting a gastrointestinal assessment every shift until the resident expels a complete bowel movement; small hard stools or diarrhea do not constitute a complete bowel movement. Increased fluid intake and ambulation are encouraged if possible. If resident has not had bowel movement in past 9 shifts, a PRN laxative, usually Milk of Magnesia, will be administered at bedtime. <p>The resident's name and condition is added to the 24-hour board for follow up.</p> <ol style="list-style-type: none"> If resident has not had bowel movement by next day, a PRN suppository is given. Prior to notifying the doctor (MD), the nurse will review medical record for history of constipation, medication use including stool softeners and laxatives. The MD is notified and orders followed as given. The family is updated on resident status and MD orders. <p>B. According to the February 2021 MAR Resident #13 had an order for humalog KwikPen solution pen-injector 100 unit/ml with a start date of 4/2/20 to inject 20 units subcutaneously with meals related to type 2 Diabetes Mellitus without complications.</p> <p>The February 2021 MAR showed an order for</p>	F 658			

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F 658	<p>Continued From page 18</p> <p>Lantus SoloStar Solution Pen-injector 100 unit/ml with a start date of 4/2/20 to inject 42 units subcutaneously two times a day related to type 2 Diabetes Mellitus without complications.</p> <p>The February 2021 MAR showed an order for humalog KwikPen solution pen-injector 100 unit/ml with a start date of 11/20/19 to inject per sliding scale subcutaneously four times a day related to type 2 Diabetes Mellitus without complications.</p> <p>Sliding scale orders directed: 151 - 200 = 2 units 201 - 250 = 4 units 251 - 300 = 6 units 301 - 350 = 8 units 351 - 400 = 10 units call Doctor if the resident's blood sugar was greater than (>) 400.</p> <p>The December 2020 MAR showed an order to draw a Comprehensive Metabolic Panel (CMP) and a HgbA1Cone time only for medication monitoring until 12/08/2020. The MAR showed laboratory (lab) completed on 12/8/20.</p> <p>On 2/17/21 at 8:02 AM the Director of Nursing (DON) stated the resident didn't have those labs. She reported then Doctor was notified and the orders were received to do them today. The DON wasn't sure if it was a routine lab.</p> <p>The Chemistry Lab dated 2/17/21 showed a HgbA1C result of 8.2. The Doctor responded with no new orders.</p> <p>The Laboratory/Radiology Services: Physician Order/Results dated 11/16 explained that the facility will ensure that only medically necessary laboratory and radiology services are ordered and</p>	F 658			

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F 658	Continued From page 19 that the physician/prescriber is promptly notified of the results. Procedure 1. The facility will provide or obtain laboratory and radiology services only when ordered by a physician; physician assistant; nurse practitioner or clinical nurse specialist in accordance with State law, including scope of practice laws. 2. The facility will promptly notify the ordering physician, physician assistant, nurse practitioner, or clinical nurse specialist of laboratory results that fall outside of clinical reference ranges in accordance with facility policies and procedures for notification of a practitioner or per the ordering physician's orders.	F 658			
F 677 SS=D	ADL Care Provided for Dependent Residents CFR(s): 483.24(a)(2) §483.24(a)(2) A resident who is unable to carry out activities of daily living receives the necessary services to maintain good nutrition, grooming, and personal and oral hygiene; This REQUIREMENT is not met as evidenced by: Based on observation, clinical record review, and resident interviews, the facility failed to provide assistance to all residents as directed by individual plans of care in order to assure good personal hygiene and to provide complete incontinence per accepted professional standards for 4 (Resident #45, #107, #28 and #94) of 7 residents reviewed for activities of daily living. The facility reported a census of 124 residents. Findings include: 1. The Minimum Data Set (MDS) assessment dated 12/10/20 indicated Resident #45 had a	F 677	F 677 ADL CARE PROVIDED FOR DEPENDENT RESIDENTS CFR(s): 483.24(a)(2) It is the practice of this organization to provide assistance to all residents as directed by individual plans of care. Resident #45 was provided a shower on 2/15/21 by nursing staff; residents #107 and #28 were provided appropriate pericare on 2/15/21 by nursing staff; DON contacted family to replace shirt on 2/23/2021. The facility interdisciplinary team reviewed documentation of resident showers/baths to identify and address any similar situations on 2/24/2021. The DON provided education to the nursing staff regarding facility practice, pericare, and resident rights 3/24 -3/31/21; review of bathing documentation was added to the daily (M-F) IDT meeting agenda. The DON is responsible for ongoing compliance of this area. The DON, or designee, will conduct weekly reviews of shower/bathing documentation, random weekly observations of pericare, and random weekly observations of resident clothing to ensure compliance with facility practice. Results of weekly reviews and observations will be shared monthly with the Executive Director and QAPI committee for three months, or longer at the direction of the QAPI committee.		

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F 677	<p>Continued From page 20</p> <p>diagnosis that included hypertension, dementia, hyperlipidemia, Parkinson's disease, depression, and irritable bowel. The resident had a Brief Interview for Mental Status (BIMS) score of 8, indicating moderate cognitive and memory impairment. Resident #45 required the assistance of 1 staff member with bed mobility, transfers, dressing, and personal hygiene. He ambulated with assistance of 1 staff member and use of a walker.</p> <p>On 2/15/21 at 1:32 PM observation revealed Resident #45 resting in bed with pajamas on and eyes closed. The resident appeared not to have been cleaned up.</p> <p>Record review of Activities of Daily Living (ADL): Bathing, documented in Point Click Care (PCC), for date range of 2/1/21-2/15/21, and revealed lack of documentation for dates of 2/8/21 and 2/11/21 indicating the resident did not receive a shower.</p> <p>The Care Plan dated 12/21/20 directed staff that Resident #45 required assistance of one staff with dressing and personal hygiene.</p> <p>During an interviewed on 2/11/21 at 10:30 AM Resident #45 rested in bed and reported he does not consistently get showered. He reported last week he received 1 shower, and zero this week. He stated, "they told me on Monday that I would get a shower on Thursday I haven't heard anything. I never know when I will get showered but, it should be on Monday and Thursday."</p> <p>During an interview on 2/16/21 at 1:49 PM Resident #45 laid in bed, he stated he feels like he is forgotten on his side of the room because</p>	F 677		

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F 677	<p>Continued From page 21</p> <p>no one ever checks on him unless they are bringing food. The resident reported he has not had a shower this week, the shower room is so cold he cannot stand to take a shower. He reported the CNA's make the water hot but, once moved away from the water he shivers.</p> <p>An observation of 2/17/21 at 3:21 PM revealed the Margery Court shower room chilly with the wall thermostat reading 75 degrees Fahrenheit.</p> <p>During an interview on 2/16/21 at 2:05 PM with Staff F, CNA, reported residents have complained about the shower room being too cold. She said she would notify maintenance if she needed something fixed. She denied having notified maintenance about the temperature of the shower room.</p> <p>On 2/17/21 at 03:52 PM the Director of Nursing (DON) reported the expectation for CNA's if they cannot complete daily showers; she stated they often have to skip it for the day, some staff will come back to complete them if they can. She stated they are to notify her or Assistant Director of Nursing (ADON) if unable to complete showers and to talk with the resident.</p> <p>When interview on 2/22/21 at 3:05 PM the DON reported the facility practice is to offer a shower two times per week or when requested. She stated, "Showers are individualized care so not everyone has the same practice. Some people request a bed bath and some people refuse showers and we work through that with the individual to meet their specific needs."</p> <p>2. The Minimum Data Set (MDS) assessment dated 1/23/21 indicated Resident #107 had a</p>	F 677			

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 165448	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 02/24/2021
NAME OF PROVIDER OR SUPPLIER BISHOP DRUMM RETIREMENT CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE 6837 WINWOOD DRIVE JOHNSTON, IA 50131		
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F 677	<p>Continued From page 22</p> <p>diagnosis that included fractures (hip), diabetes, dementia, hypothyroidism, and dysphagia. The resident had a Brief Interview for Mental Status (BIMS) score of 6, indicating severe cognitive and memory impairment. The resident required the assistance of 2 staff with bed mobility, transfers, dressing and personal hygiene. She ambulated with assistance of 2 staff members. A Braden scale for predicting pressure ulcers dated 1/26/21 indicated a score of 13, which is a Moderate risk for skin breakdown.</p> <p>During an observation on 2/15/21 at 12:45 PM, Staff S, Infection Preventionist (IP) and Staff T, Certified Medical Assistant (CMA) provided wound care to the resident's sacral wound, right heel wound, and left great toe. While changing the sacral wound dressing observation showed brown liquid stool oozed from the resident's rectum. Staff S removed the depends Staff S and Staff T changed the soiled depend and bottom sheet but failed to provide peri care beyond wiping the resident's rectum with a clean portion of the old depend.</p> <p>Record review of Activities of Daily Living (ADL): Bathing, documented in Point Click Care (PCC), for date range of 2/1/21-2/15/21, and lacked documentation for 2/3/21.</p> <p>During an interview on 2/10/21 at 08:54 AM Resident #107 laid in bed with her head elevated and leaning toward the left. The resident's bed sheets were soiled with stool stain observed on 2/9/21. The resident appeared disheveled, she stated she does not know when she last showered.</p> <p>3. The MDS assessment dated 11/24/20 revealed Resident #28 had diagnoses of diabetes, chronic</p>	F 677		

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F 677	<p>Continued From page 23</p> <p>obstructive pulmonary disease, left great toe fracture, and charcot's (a degenerative disorder) to the right ankle and foot. The MDS indicated the resident required extensive assistance of two staff for transfers, limited assist of two staff for toileting and dressing. The MDS documented the resident had bowel and bladder incontinence.</p> <p>The care plan updated 2/16/21 revealed the resident had recurrent UTI's (urinary tract infections) and had an ADL self care performance deficit and incontinence related to limited mobility. The staff directives included provide the resident with only the amount of assistance needed for care delivery, assist with toileting or pericare and incontinence care after each incontinence episode and as needed.</p> <p>During observation 02/16/21 at 10:40 AM, Resident #28 sat on a commode. Staff A, CNA, and Staff B, CNA, donned a pair of gloves. Staff A placed a package of wipes onto an overbed table, removed a few wipes from the package, and placed the wipes on top of the package. Staff A and Staff B used a gait belt and assisted the resident to stand by the commode. Staff A took a disposable wipe, reached under resident's bottom and cleansed the area front to back. The inner buttocks had a whitish cream visible. Staff A took another disposable wipe and cleansed between the resident's buttocks, then used the same wipe to cleanse the area again. Staff A and Staff B pulled the resident's brief up, then transferred the resident to her recliner. Staff A took a remote to lower the resident's recliner seat and elevated her legs. Staff A donned the resident's oxygen cannula, covered the resident with a blanket, then removed her gloves and washed her hands.</p>	F 677			

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F 677	<p>Continued From page 24</p> <p>Staff B, CNA, bagged up the trash, then placed the trash bag inside the bag in the commode. Staff B removed the bag in the commode, tied the bag, then removed one glove and took the bag to the soiled utility room, removed her gloves.</p> <p>In an interview, 02/16/21 at 01:25 PM, Staff A reported Resident #28 had urinary incontinence.</p> <p>A Perineal Care Competency revealed the following procedural steps:</p> <ol style="list-style-type: none"> Gather supplies Perform hand hygiene Don gloves For females, wipe perineum from front to back. Use on wipe for each swipe. Cleanse the labial folds. Cleanse the skin folds thoroughly. Apply a clean incontinence product. Remove gloves and perform hand hygiene. <p>4. The MDS completed for Resident #94 with an Assessment Reference Date (ARD) of 1/15/21 showed a BIMS score of 5, indicating severe cognitive impairment. The resident required extensive assistance of two staff with dressing and personal hygiene.</p> <p>Observation on 2/16/21 at 9:29 AM revealed the entire front of Resident #94's shirt covered in multiple light brown stains. Staff K, Certified Nurses' Aide (CNA) asked the resident what happened to their shirt. Staff L replied it is stains. The resident also had half inch whiskers to her chin.</p> <p>The Care Plan problem dated 1/8/19 explained the resident was at risk for a decline in their</p>	F 677			

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F 677	Continued From page 25 performance of her Activities of Daily Living (ADL's) due to her chronic health conditions. The problem included the intervention dated 1/8/19 to set up the resident's needed items for daily care and assist her as needed to complete the tasks. On 2/23/21 at 1:09 PM the Director of Nursing said there are a few residents that prefer to wear their favorite shirts. If it looks really bad or family wants that then they work with that, then they will work with laundry to get it clean. It is always resident's preference. The facility will replace the clothing if it is unable to remove stains. It is not okay for staff to leave the resident in a stained shirt and her family would probably replace it. On 2/23/21 at 3:02 PM the Director of Nursing reported she would remove the stained shirt from Resident #94's wardrobe and let the family know and see if they want to replace it.	F 677			
F 686 SS=D	Treatment/Svcs to Prevent/Heal Pressure Ulcer 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	F 686	F 686 TREATMENT/SVCS TO PREVENT/HEAL PRESSURE ULCER CFR(s): 483.25(b)(1)(i)(iii) It is the practice of this organization to appropriately provide assessment and interventions for the necessary care and treatment consistent with professional standards of practice, to promote healing, prevent infection and prevent new ulcers from developing. Treatment order directions for resident #40 was corrected on 2/24/21 by DON. The facility interdisciplinary team reviewed residents with pressure areas and those at high risk for appropriate assessment, intervention, and treatments and took action as appropriate on 2/24/2021. The DON provided education to nursing staff on 3/24/2021 regarding the facility practice and policy regarding pressure areas. The DON is responsible for ongoing compliance in this area. The DON, or designee, will conduct weekly reviews of residents with pressure areas or residents at high risk to ensure appropriate assessment, intervention, and treatment is in place according to the facility practice and policy. Results of the reviews will be shared monthly with the Executive Director and QAPI committee for three months, or longer at the direction of the QAPI committee.		

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F 686	<p>Continued From page 26</p> <p>by:</p> <p>Based on observation, clinical record review, and interviews, the facility failed to appropriately provide assessment and interventions for the necessary care and treatment consistent with professional standards of practice, to promote healing, prevent infection and prevent new ulcers from developing for 1 of 4 residents reviewed (Resident #40). Clinical record review revealed the resident did not have breakdown to her heel upon readmission to the facility. The facility reported a census of 124 residents.</p> <p>Findings include:</p> <p>1. The Minimum Data Set (MDS) assessment dated 2/2/21 indicated Resident #40 had a diagnosis that included hypertension, renal insufficiency, urinary tract infections, dementia, malnutrition, depression, and immunodeficiency. The resident had a Brief Interview for Mental Status (BIMS) score of 6 indicating severe cognitive and memory impairment. Resident #40 required the assistance of 2 staff with bed mobility, transfers, dressing and personal hygiene. A Braden scale for predicting pressure ulcers dated 1/29/21 indicated a score of 12, which is a high risk for skin breakdown.</p> <p>Observation on 2/10/21 at 10:41 AM revealed Resident #40 asleep in her recliner with feet elevated and Prevalon boots on feet bilateral. The Sign on the resident's door indicated the resident in Quarantine.</p> <p>Observation and interview on 2/18/21 at 1:15 PM with Staff S, Infection Preventionist (IP). Staff S removed left heel dressing, observation revealed the heel with black middle, red border,</p>	F 686		

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F 686	<p>Continued From page 27</p> <p>approximate size of silver dollar, Staff S reports she will get orders from the doctor and enter them into the computer. She is to change the dressing 3 x per week, the nurses usually change the dressings 2 x per week and she completes the dressing 1 x per week and she verbally notifies staff when she will be changing the dressing. Staff S stated she found the heel breakdown on 2/3/21, and the resident had been wearing Prevalon boots to prevent skin breakdown before she started working at the facility. She continued the floor nurse completed the assessment upon the resident's readmission to the facility on 1/29/21. When inquired if the foam heel dressing is to be changed daily she replied, "yes".</p> <p>The facility report titled Bishop Drumm Retirement Center physician order form, dated 2/3/21 revealed: Administration Record Report Setup, Treatment Administration Record (TAR), dated 2/3/21-2/12/21, Physician order entered. Left heel- Betadine paint and cover with foam heel dressing every day and evening shift for wound care. Change foam heel daily. Paint the heel with Betadine twice per day and change the foam heel daily. (unknown if foam heel was completed as not recorded on TAR).</p> <p>Record review of facility report titled Administration Record Report Setup, Treatment Administration Record (TAR), and dated 2/3/21 revealed Prevalon boots were added 2/3/21, there is lack of documentation for date of 2/9/21.</p> <p>Record review of facility report titled Admit-Readmit Screen, in Point Click Care (PCC)</p>	F 686			

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F 686	<p>Continued From page 28</p> <p>located in the electronic medical record (EMR), for the date of 1/29/21, and revealed Resident #40 did not have any skin breakdown to her left heel.</p> <p>Record review of facility report titled Skin and Wound Weekly Documentation, in PCC located in the EMR, for the date of 2/3/21 revealed: Unstageable pressure injury. 6 cm in diameter with a superficial open are 4.6 x 3.2 cm to lateral aspect of poster heel. Documented by Staff S, IP.</p> <p>Record review of facility report titled Progress notes-Skin/Wound note, dated 2/3/21 revealed: New unstageable ulcer to left heel noted today. Area measures approx. 6 cm in diameter with sf open area to lateral aspect 4.8 x 3.5. Beefy red granulation tissue to visible wound bed. Scant amount of serosanguinous drainage.</p> <p>Record review of facility report titled Progress notes-Nurse's notes, dated 2/3/21 revealed: Staff S documented a conversation with Resident #40 daughter to inform her of her skin breakdown and that staff would be encouraging resident wear pressure relieving boots as she will tolerate.</p> <p>Record review of facility report titled, Skin and Wound Weekly Documentation, in PCC located in the EMR, for the date of 2/10/21 revealed: Unstageable ulcer, black necrotic tissue present 90% of left heel.</p> <p>On 2/23/21 at 10:45 AM the Director of Nursing (DON), stated Staff S is alerted within PCC if a resident has a high Braden score. It will alert their dashboard and they talk about it as a team. The expectation is for Staff S to assess any skin issues within a couple days. If a resident is</p>	F 686		

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F 686	Continued From page 29 returning with a skin issue they proactively order items such as a special mattress and Prevalon boots. If a resident would have the high Braden score with no skin breakdown they would continue to have the floor nurses assess the resident's skin.	F 686			
F 697 SS=D	Pain Management CFR(s): 483.25(k) §483.25(k) Pain Management. The facility must ensure that pain management is provided to residents who require such services, consistent with professional standards of practice, the comprehensive person-centered care plan, and the residents' goals and preferences. This REQUIREMENT is not met as evidenced by: Based on observation, record review, and staff interview, the facility failed to recognize and ensure pain was managed consistent with professional standards and physician order, as well as monitor the effectiveness of pain medication administered on one of two residents (#107). The facility reported a census of 124 residents. Findings include: 1. The Minimum Data Set (MDS) assessment dated 1/23/21 indicated Resident #107 had a diagnosis that included fractures (hip), diabetes, dementia, hypothyroidism, and dysphagia. The resident had a Brief Interview for Mental Status (BIMS) score of 6, indicating severe cognitive and memory impairment. Resident #107. The resident required the assistance of 2 staff with bed mobility, transfers, dressing and personal hygiene. A Braden scale for predicting pressure	F 697	F 697 PAIN MANAGEMENT CFR(s): 483.25(k) It is the practice of this organization recognize and ensure pain was managed consistent with professional standards and physician order, as well as monitor the effectiveness of pain medication administered. Resident #107 no longer resides in the facility. The facility interdisciplinary team reviewed residents with pain management programs on 2/24/2021 to ensure pain was management consistent with professional standards and physician order. The DON provided education to nursing staff on 3/24/2021 regarding the facility practice. The DON is responsible for ongoing compliance in this area. The DON, or designee, will conduct random weekly reviews of residents on pain management programs to ensure compliance with facility practice. The results of these reviews will be shared monthly with the Executive Director and the QAPI committee for three months, or longer at the direction of the QAPI committee.		

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F 697	<p>Continued From page 30</p> <p>ulcers dated 1/26/21 indicated a score of 13, which is a Moderate risk for skin breakdown.</p> <p>During an observation on 2/9/21 at 1:37 PM Resident #107 laid in bed leaning towards the wall on her left side. The resident stated she was in pain and needed pain medicine.</p> <p>During an observation on 2/10/21 at 9:50 AM Resident #107 laid in bed leaned towards the left with head of bed elevated. Resident stated she hurt all over.</p> <p>Observation on 2/15/21 at 9:50 AM Resident #107 in bed asleep, Prevlon boots on bilaterally feet, call light clipped to belly.</p> <p>Observation on 2/15/21 at 11:26 AM Resident #107 in bed asleep. Staff O, Certified Nurse Assistant (CNA) woke her and stated she needed to change her depends, Resident #107 began to yell and said she did not want changed, she yelled to leave her alone. Resident appeared disheveled and sheets soiled, Staff O said the Hospice staff bathed her this morning.</p> <p>Observation on 2/15/21 at 12:45 PM of Staff S, Infection Preventionist (IP), and Staff T, Certified Medication Aide (CMA). Observed Staff T touch Resident #107 arm and explain they would be rolling her to complete dressing change. The resident began shaking her head, yelling "NO," and calling out to God to help her. Staff T told the resident she had just been given a pain pill as she yelled in pain. Per the Medication Administration Record (MAR) she received a scheduled dose of Oxycontin at 12:00 PM for a pain level of 4/10, the nurse who administered the pain medication not present to monitor</p>	F 697			

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F 697	<p>Continued From page 31 effectiveness at time of dressing change.</p> <p>Record review of facility documentation in Point Click Care (PCC) Electronic Medical Record (EMR), titled Skin/Wound Note, dated 2/12/21 at 3:06 PM by Staff S, IP, documented Wound and Ostomy Certified Nurse (WOCN) debrided Residents #107 right heel (5.0 x 8.0 cm) skin ulcer and ordered a new wound care regimen. A review of the MAR indicated Resident #107 received her scheduled doses of Oxycontin and did not receive any additional pain medicine on 2/11/21.</p> <p>Record review of facility documentation in PCC, titled Social Service Note, dated 2/12/21 at 2:20 PM documented Resident #107 continues to be concerned about pain with physician evaluating it. (No new physician pain orders received).</p> <p>Record review of facility documentation in PCC, titled Care Plan, dated 1/19/21 documented the following interventions: a. I have an alteration in musculoskeletal status r/t fracture of one rib on L side b. I will remain free from pain or at a level of discomfort acceptable to the resident through the review date. Target Date: 08/04/2021 d. Anticipate and meet needs. Be sure call light is within reach and respond promptly to all requests for assistance. e. Give analgesics as ordered by the physician. Monitor and document for side effects and effectiveness. f. Heat/cold applications as ordered and as tolerated.</p> <p>Record review of facility documentation in PCC, titled MAR, for date range of 2/1/21 through</p>	F 697			

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F 697	<p>Continued From page 32</p> <p>2/15/21, Resident #107 had the following physician orders:</p> <p>a. Oxycodone HCL tablet 5 mg, give 1 tablet by mouth every 4 hours as needed for moderate pain (4-7); severe pain (8-10).</p> <p>b. Oxycodone HCL 5 mg, give 1 tablet by mouth three times per day for moderate pain (4-7); severe pain (8-10) related to displaced fracture of base of neck of left femur, subsequent encounter of closed fracture with routine healing.</p> <p>Record review revealed Resident #107 received Oxycodone three times per day with recorded pain levels between 0-3, 28 times; she received Oxycodone 23 times without documented effectiveness recorded of pain medication intervention; she received Oxycodone 1 time as needed with recorded pain level between 0-3. Clinical record lacked documentation of effectiveness of pain medication administered and assessment of pain prior to all medication administered.</p> <p>When interview on 2/18/21 at 10:25 AM, Staff N, Registered Nurse (RN) reported Resident #107 demonstrates pain when moved. Staff N replied "no" when asked if Hospice monitors the effectiveness of the residents pain medicine.</p> <p>During an interview on 2/18/21 at 10:27 AM, Staff P, CNA reported Resident #107 yells, and screams "ouch it hurts" when moved. She reports the resident's pain concerns to the nurse and they give her what she can have. Staff P stated other interventions included repositioning.</p> <p>When interviewed on 2/18/21 at 10:32 AM, Staff Q, LPN, stated she assess Resident #107 for pain more than every 4 hours. The resident has a</p>	F 697		

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(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 697	Continued From page 33 tendency to be in pain when asked, therefore you don't know if she is really having pain or if she has behaviors. Staff Q states she reassesses the resident's pain within 30 minutes and documents on MAR but, "it doesn't always take it so, often just tell the next shift if it was effective or not." Staff Q reported non- pharmacological interventions used included repositioning, the resident does not like ice or to be touched.	F 697			
F 700 SS=D	Bedrails CFR(s): 483.25(n)(1)-(4) §483.25(n) Bed Rails. The facility must attempt to use appropriate alternatives prior to installing a side or bed rail. If a bed or side rail is used, the facility must ensure correct installation, use, and maintenance of bed rails, including but not limited to the following elements. §483.25(n)(1) Assess the resident for risk of 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 the Food and Drug Administration's Guide, observations, clinical record review, and	F 700	F 700 BED RAILS CFR(s): 483.25(n)(1)-(4) It is the practice of this organization to assess bed rails for risk of entrapment and obtain consent for the use of side rails. Resident #04 no longer resides in the facility. The facility interdisciplinary team conducted a review of residents with side rails to ensure side rails were assessed for risk of entrapment and consent was obtained for use on 2/24/2021. The DON provided education to nursing staff on assessing for risk of entrapment and obtaining consent for side rails for residents on 3/24/2021. The DON is responsible for ongoing compliance in this area. The DON, or designee, will conduct random weekly reviews and observations of residents with bed rails to ensure compliance with facility practice. Results of reviews will be shared monthly with the Executive Director and QAPI committee for three months, or longer at the direction of the QAPI committee.		

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F 700	<p>Continued From page 34</p> <p>interviews, the facility failed to assess bed rails for risk of entrapment and obtain consent for the use of side rails for 1 of 2 beds reviewed for side rail safety (Resident #04). The facility reported a census of 124 at time of the survey.</p> <p>Findings:</p> <p>1. The Minimum Data Set (MDS) assessment dated 2/1/21 indicated Resident #4 had a diagnosis that included coronary artery disease, hypertension, peripheral vascular disease, hyperlipidemia, ileus, Barrette's esophagus, and abdominal aortic aneurysm without rupture. The resident had a Brief Interview for Mental Status (BIMS) score of 8, indicating he had some cognitive and memory impairment. Resident #4 had the ability to make himself understood and understand others, although he was extremely hard of hearing. The resident required the assistance of 1 with bed mobility, assistance of 2 for transfers, and assistance of 1 for dressing and personal hygiene.</p> <p>Observation on 02/09/21 at 10:26 AM, Res# 4 found to be sitting in wheelchair in room watching TV. Side rails up x2.</p> <p>Observation on 02/15/21 at 11:15 AM Res #4 assisted staff O, Certified Nursing Assistant (CNA) and staff P, CNA with turning while they performed peri cares by attempting to grab a hold of side rails attached to his bed.</p> <p>Record review of Guidance for Industry and FDA Staff: Hospital Bed System Dimensional and Assessment Guidance to Reduce Entrapment, dated March 10, 2006:</p> <p>FDA recommends that healthcare facilities</p>	F 700			

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F 700	<p>Continued From page 35</p> <p>conduct a risk-benefit analysis to ensure that steps taken to mitigate the risk of entrapment do not create different, unintended risks or reduce clinical benefits available to patients using legacy beds. Such steps may include checking with bed system manufacturers to identify compatible mattresses, rails, and accessories.</p> <p>Likewise, healthcare facilities may contact their equipment suppliers for entrapment mitigating solutions that may already be available. Manufacturers should follow the appropriate FDA regulations regarding risk assessment, design controls, and documentation when developing mitigation components, attachments and other accessories to address entrapment risks in legacy hospital beds.</p> <p>Record review of facility document titled, Bed Safety Action Grid, with unknown date, showed 1 of 7 Description of Entrapment Zone, Zone 7 marked compliant, 'Entrapment between head or foot board and mattress.' Risk of Entrapment deemed low. Staff signature and date assessed omitted.</p> <p>Record review of facility document titled, Bed Rail Informed Consent Form, with unknown date, has resident signature and date of 1/9/21. (Resident #4 received side rails 12/18/20).</p> <p>Record review of facility Hospice vendor, Midwest Respiratory Care, Inc, Branch of CHI Health at Home-Mercy Hospice, dated 12/18/20, documented equipment to deliver: 1 Bed High-Low Full Electric, 1 bed rails half length.</p> <p>During an interview on 2/16/21 at 3:30 PM, Staff R, Director of Facilities, which he brought the</p>	F 700			

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F 700	Continued From page 36 maintenance book to demonstrate side rails have been checked for possible entrapment at least quarterly. Staff R showed the current assessment dated 2/12/21 but was unable to provide any assessments prior to 2/12/21 as the all other assessment was not dated or signed nor thoroughly completed (6 of 7 possible entrapments were not assessed). During an interview on 2/17/21 at 12:27 PM, with Mercy One Hospice, I was informed per Midwest Respiratory Care the facility would maintain functionality of the bed. During an interview on 2/17/21 at 3:30 PM, with the DON (Director of Nursing). The DON stated she remembered when the bed was brought in by Hospice, she stated she tried to explain side rails are not recommended in the facility to the resident but he was adamant that he needed the side rails to assist with transfers at which time she accepted a verbal consent from him on 12/18/20. She said she was busy and did not get the written consent until 1/19/21. During an interview on 2/18/21 at 10:40 AM, with Staff Q, LPN (Licensed Practical Nurse), stated she was familiar with Resident #4 Plan of Care and that he had side rails. She stated she did not know of any issues involving the side rails. She did not know who installed the side rails or how often they are assessed for potential of entrapment.	F 700		
F 803 SS=E	Menus Meet Resident Nds/Prep in Adv/Followed CFR(s): 483.60(c)(1)-(7) §483.60(c) Menus and nutritional adequacy. Menus must-	F 803		

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F 803	Continued From page 37 §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: Based on document review, menu review, observations 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 five of five residents on pureed diet received the proper serving size for one of one meals served. The facility identified a census of 124 residents. Findings include: The facility's Week 4 menu identified the following items as part of the planned menu for pureed	F 803	F 803 MENUS MEET RESIDENT NEEDS CFR(s): 483.60(c)(1)-(7) It is the practice of this organization to follow the planned menu for residents on pureed texture diets and ensure residents on pureed texture diets receive the proper serving size. Dietary staff were provided education by the facility dietitian and certified dietary manager on 3/26/2021 regarding following the planned menu for residents on a pureed diet and the appropriate practice to ensure residents on a pureed texture diet receive the proper portion size. Competency evaluation checklist for cooks updated with facility practice and to be used upon hire and annually. The CDM is responsible for ongoing compliance in this area. The CDM, or designee, will make weekly observations of pureed food process and serving size against facility practice and menu. Results of the observations will be shared with the Executive Director and QAPI committee monthly for three months, or longer at the direction of the QAPI committee.		

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F 803	<p>Continued From page 38</p> <p>texture for the lunch meal on Thursday Week 4 (2/11/21): Pureed Chicken Noodle Soup = 6 ounces (oz.) Pureed roast beef sandwich with gravy = 3 oz. Mashed potatoes with gravy = 4 oz. Pureed vegetable = 4 oz. Pureed cookie = 2 oz.</p> <p>The facility's Diet Type Report, dated 2/9/21, identified five residents on pureed texture diet (Resident #12, #18, #72, #97, and #115).</p> <p>On 2/11/21 at 08:05 AM, Staff D, cook, reported she had already pureed entrees for the lunch meal that day, but could pureed entrée again if the surveyor wanted to watch.</p> <p>During observation 2/11/21 at 08:41 AM, Staff D, cook, reported she planned to make seven servings of pureed entrees, which included five residents on pureed diet and two additional servings if needed. Staff D stated five slices of roast beef equaled one serving portion. Staff D placed 35 roast beef slices into a Robot Coupe container, then added 4 oz. of beef broth, and blended the contents together. Staff D continued to add broth mixed with hot water, and blended the contents together until Staff D stated the contents had a pudding thick consistency. Staff D sprayed a metal pan with cooking spray, poured the pureed meat contents into the metal pan, covered the pan with clear wrap, and placed the pan into the oven.</p> <p>During observation 2/11/21 at 08:53 AM, Staff D placed seven 4 oz. scoops of vegetables into a robot coupe and blended the contents together. Staff D sprayed a metal pan with cooking spray, poured the pureed vegetable contents into the</p>	F 803			

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F 803	<p>Continued From page 39</p> <p>pan, covered the pan with clear wrap, and placed the pan into the oven. At 08:57 AM, Staff D reported no other entrees to pureed, except the dessert. Staff E, culinary support, would pureed dessert.</p> <p>During observation 2/11/21 at 08:57 AM, Staff E, culinary support, placed seven chocolate chip cookies into a blender container, added an unmeasured amount of whole milk, and blended the contents together. Staff E opened the lid on the blender and added one additional cookie to the container, replaced the lid, and blended the contents together. Staff E checked the consistency of the pureed cookie, then added thickener, and blended the contents together. Staff E placed two additional cookies into the blender, and blended the contents together. Staff E then reported the pureed cookie contents thick enough. Staff E poured the pureed contents into four individual bowls.</p> <p>At 09:03 AM, Staff E, placed four 4 oz. scoops of mandarin oranges into a blender container, added thickener, and blended the contents together. Staff E added two additional 4 oz. scoops of mandarin oranges to the blender and blended the contents together. Staff E poured the pureed mandarin oranges into four individual bowls. Staff E covered the bowls with clear plastic wrap and placed the tray of desserts into the refrigerator. Observation revealed 300 milliliters of pureed contents left in the blender container.</p> <p>During observation of the lunch meal service 2/11/21 starting at 11:25 AM, the Dietary Manager (DM) plated food for the residents. Resident #115, #97, #18, #72 received pureed meat and pureed vegetable, and mashed potatoes but no</p>	F 803			

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F 803	<p>Continued From page 40</p> <p>chicken noodle soup or pureed bread. At 12:46 PM, the DM reported she didn't have enough pureed vegetable to serve resident #12, but planned to use the vegetable that had been pureed earlier that day. The DM placed pureed vegetable and pureed meat onto Resident #12's plate. No chicken noodle soup or pureed bread served to Resident #12..</p> <p>At 12:49 PM, the DM reported she had plated the last plate of food for residents. The DM confirmed the scoop size used when she served pureed entrees and the amount of contents left in the pan.</p> <p>a. Pureed meat: #12 scoop served which is equaled 2 2/3 oz. At least 1 1/2 scoops of pureed meat left in the pan.</p> <p>b. Pureed vegetable: 4 oz. scoop. The DM reported they had ran out of the pureed vegetable during meal service but had used another pan of pureed vegetable for one resident on a pureed diet.</p> <p>In an interview 2/16/21 at 08:53 AM, the facility's dietician reported she expected staff follow the menus and pureed bread whenever bread or sandwiches listed on the menu. The dietician stated the bread sometimes added to the main entrée or pureed separately. The dietician reported the serving size or scoop size listed on the menu for each entrée, and that was how staff knew what serving size needed served.</p> <p>In an interview 2/18/21 at 10:50 AM, the DM reported she looked at the menu to know what scoop or serving sizes needed served for each entree.</p> <p>The Simplified Diet Manual (page 51), revealed</p>	F 803		

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F 803	Continued From page 41 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.	F 803			
F 804 SS=E	Nutritive Value/Appear, Palatable/Prefer Temp CFR(s): 483.60(d)(1)(2) §483.60(d) Food and drink Each resident receives and the facility provides- §483.60(d)(1) Food prepared by methods that conserve nutritive value, flavor, and appearance; §483.60(d)(2) Food and drink that is palatable, attractive, and at a safe and appetizing temperature. This REQUIREMENT is not met as evidenced by: 1. Based on observation, resident and staff interviews, and policy review, the facility failed to serve and maintain food temperatures for all entrees served to residents during the lunch meal service on 2/11/21, and failed to ensure resident room trays delivered in a timely manner to ensure food hot and palatable. The facility reported a census of 124 residents.	F 804	F 804 NUTRITIVE VALUE/APPEAR, PALATABLE/PREFER TEMP CFR(s): 483.60(d)(1)(2) It is the practice of this organization to serve and maintain food temperatures. The CDM and facility dietitian provided education to dietary staff on 3/26/2021 regarding the facility practice, how to appropriately hold food in warmers, implemented use of plate warmers and covers for room trays to maintain food temperatures. The CDM is responsible for ongoing compliance in this area. The CDM, or designee, will perform random weekly observations of room trays to ensure compliance with facility practice. Results of the observations will be shared monthly with the Executive Director and QAPI committee for three months, or longer at the direction of the QAPI committee.		

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F 804	<p>Continued From page 42</p> <p>Findings include:</p> <p>During observation of the lunch meal service on 2/11/21 starting at 11:30 AM, revealed the Dietary Manager plated food for residents in the dining room and for room trays. After food plated for room trays, staff covered the plates of food with a lid and placed the tray onto a wheeled cart.</p> <p>During observation on 2/11/21 at 12:49 PM, the Dietary Manager confirmed the last resident served a plate of food in the Main Dining Room and room trays completed. At the time, the surveyor requested an extra tray of food placed on the cart of room trays for the last cart sent to the nursing unit. The Dietary Manager checked temperatures of the remaining food in the warming cart, which revealed the following:</p> <p>a. mashed potatoes 135.7 degrees (F) (Fahrenheit) b. ground meat 123.4 F c. pureed meat 134.6 F</p> <p>At 1:05 PM, after all resident room trays had been served to residents on Central Hallway, the surveyor took the test tray from the food cart and checked the food temperatures with the Dietary Director. The food temperatures revealed the following:</p> <p>a. roast beef with mashed potatoes and gravy = 135 degrees F b. vegetables - 101.7 degrees F</p> <p>The roast beef, mashed potatoes with gravy, and vegetable was lukewarm when tasted by the surveyor.</p> <p>At the time, the Dietary Director reported difficulty keeping meal trays hot, even though they used a plate warmer for meal trays served to residents in</p>	F 804		

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F 804	<p>Continued From page 43 their room.</p> <p>In an interview 2/9/21 at 11:28 AM, Resident #46 reported she received meals in her room, and the food not very hot. The resident reported the chicken was cold during the supper meal 2/8/21.</p> <p>In an interview 2/10/21 at 10:31 AM, Resident #28 reported the food not hot. The resident received a room tray for her meals.</p> <p>A facility policy for Holding Food Temperatures and Guidelines revealed acceptable serving line holding temperatures for sliced meats and vegetables equal to or greater than 135 degrees F. Food temperatures served to the resident shall be palatable per the resident's preference.</p> <p>2. The Minimum Data Set (MDS) assessment dated 12/28/20 indicated Resident #66 had a diagnosis that included chronic osteomyelitis of left foot and ankle, anemia, deep vein thrombosis, hypertension, gastroesophageal reflux, renal insufficiency, diabetes mellitus, hyperlipidemia, chronic obstruction pulmonary disease, and depression. The resident had a Brief Interview for Mental Status (BIMS) score of 10 indicating some cognitive and memory impairment.</p> <p>During an interview on 2/15/21 at 9:37 AM Resident #66 revealed that her eggs were cold at breakfast. The resident stated she typically will send her tray back every meal, every day because the food is cold.</p> <p>During an interview on 2/23/2021 at 10:40 AM,</p>	F 804			

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F 804	Continued From page 44 Resident #66 reported her eggs were cold at breakfast and she continues to frequently request her tray be warmed up. During an interview on 2/23/2021 at 10:45 AM, Staff T, Certified Medical Assistant (CMA), reported that Resident #66 frequently request that he warm up her food. He said this increases around her dialysis appointments. 3. The Minimum Data Set (MDS) completed for resident #45 with an Assessment Reference Date (ARD) of 12/16/20 showed a Brief Interview for Mental Status (BIMS) score of 15, indicating intact cognition. On 2/10/21 at 10:55 AM the resident stated their biggest criticism is that the food is not hot. Used to be bring down the food on a steam table. The resident said the scrambled eggs and toast are cold, so she changed to a hard boiled eggs, as she don't mind them cold. The undated Holding Food Temperatures And Guidelines policy stated the temperature of the food as it is served to the resident shall be palatable per resident preference. The cognitive status of the resident shall also be considered for safety reasons (e.g., hot beverages that may be spilled).	F 804			
F 812 SS=E	Food Procurement, Store/Prepare/Serve-Sanitary CFR(s): 483.60(i)(1)(2) §483.60(i) Food safety requirements. The facility must - §483.60(i)(1) - Procure food from sources approved or considered satisfactory by federal,	F 812	F 812 FOOD PROCUREMENT, STORE/ PREPARE/SERVE-SANITARY CFR(s): 483.60(i)(1)(2) It is the practice of this organization to maintain sanitary conditions in the kitchen and store food under sanitary conditions. The housekeeping supervisor cleaned the fridges belonging to Residents #13, #30, #112 and ensured each fridge had a thermometer. The galley fridge was cleaned on 2/16/2021 by dietary staff.		

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F 812	<p>Continued From page 45 state or local authorities.</p> <p>(i) This may include food items obtained directly from local producers, subject to applicable State and local laws or regulations.</p> <p>(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.</p> <p>(iii) This provision does not preclude residents from consuming foods not procured by the facility.</p> <p>§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, document review, policy review and staff interview, the facility staff failed to maintain sanitary conditions in the kitchen, and failed to store food under sanitary condition and monitor refrigerators in resident rooms for 4 of 4 residents' refrigerators randomly checked (Resident #13, #28, #30, and #112) and 1 of 3 nursing unit galleys checked, in order to reduce the risk of contamination and food-borne illness. The facility identified a census 124 residents.</p> <p>Findings include:</p> <p>1. During observation on 2/11/21 at 08:57 AM, Staff E, culinary support, donned a pair of gloves and placed seven chocolate chip cookies into a blender, added an unmeasured amount of whole milk, then blended the contents together. After Staff E pureed the cookie contents, she poured the contents into four individual bowls, then washed the blender container in a 3 compartment sink. Staff E rinsed the container less than 30 seconds in the sink labeled for sanitizing.</p>	F 812	<p>The CDM checked all other galleys on 2/16/2021; housekeeping supervisor reviewed other residents with personal refrigerators on 2/18/2021 and ensured food was stored according to facility practice and each fridge had a thermometer.</p> <p>The preventative maintenance schedule was updated by the housekeeping supervisor on 3/24/2021 to include monthly checks of residents' refrigerators and thermometers. The facility practice on maintaining resident refrigerators and unit galleys was clarified the responsibilities of each department. The DON provided education to nursing staff on 3/31/2021 regarding the updated facility practice. The Housekeeping supervisor provided education to the housekeeping and maintenance staff on the updated facility practice on 3/26/2021. The dietary director provided education to the dietary staff on the update facility practice, the manual ware washing policy, and safe food handling on 3/26/2021.</p> <p>The DON, or designee, will conduct weekly reviews of resident fridge temperature documentation and random weekly observations of resident fridges to ensure compliance with facility practice. The CDM, or designee, will conduct random weekly observations of dietary staff for compliance with manual ware washing policy and safe food handling, weekly reviews of galley fridge temperature documentation, and random weekly observations of galley fridges to ensure compliance with facility practice. The results of the observations and reviews will be shared monthly with the Executive Director and QAPI committee for three months, or longer at the direction of the QAPI committee.</p>	

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F 812	<p>Continued From page 46</p> <p>In an interview during initial kitchen tour on 2/9/21 at 09:00 AM, Staff E, culinary support, reported the 3 compartment sink used for washing pots and pans. Staff E reported items washed with soap and water, then rinsed in the middle sink, and placed into the sanitizing sink for 5-10 minutes before removed and placed onto a metal rack to dry.</p> <p>An undated policy titled Manual Ware Washing revealed items submerged for at least one minute or per sanitizing agent manufacturer's direction in the sanitizing tank or third sink, and then allowed to air dry on a drain board, rack, or cart.</p> <p>2. During observation on 2/11/21 at 09:03 AM, Staff E, placed four 4 oz. scoops of mandarin oranges into a blender container and blended the contents together. Staff E removed the lid from the blender and placed the lid against a red sanitizing bucket that sat on the prep counter. The inside of the blender lid touched the outside surface of the red bucket. Staff E removed a lid from a bulk container of thickener, placed the bulk container of thickener onto the prep counter near the blender, reached into the bulk container, scraped the inside of the container to obtain thickener, and added the thickener to the blender. Staff E placed the blender lid over the container, and blended the contents together.</p> <p>3. Observation of the East Galley on 2/15/21 at 11:00 AM revealed one-half gallon of 2% milk expired on 2/13/21.</p> <p>In an interview 2/16/21 at 08:53 AM, the facility's dietician reported she was uncertain about who checked the refrigerator in the nursing unit</p>	F 812			

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F 812	<p>Continued From page 47</p> <p>galleys. The dietician stated she thought the nursing staff checked those areas.</p> <p>4. Random observation of refrigerators located in resident rooms on 2/16/21 revealed the following:</p> <p>a. At 10:56 AM, Resident #28's refrigerator checked by two surveyors had the following:</p> <ol style="list-style-type: none"> 1. A heavy buildup of ice in the freezer compartment. An ice pack and what appeared to be an ice cream cup were embedded in the ice buildup. The freezer had no thermometer. 2. One container of yogurt had an expiration date of 11/18/20 3. A piece of cheesecake in a plastic container had no label or date listed on it. 4. A container of applesauce had an expiration date of 2/6/21 5. Two hard, dried out grilled cheese sandwiches wrapped in a paper white napkin or paper towel had no label or date listed on the covering 6. Several strips of bacon wrapped in four different white napkins had no date or label 7. Two packages of Golden Italian dressing expired 10/9/20 8. Four packages of Ranch 1.5 oz. dressing expired 1/1/21 <p>At the time, Resident #28 told the surveyor to discard anything found bad in her refrigerator. The resident reported staff never checked the refrigerator in her room.</p> <p>b. Observation of Resident #30's refrigerator on 2/16/21 at 11:05 AM, with the Director of Nursing revealed the following:</p> <ol style="list-style-type: none"> 1. No thermometer in the refrigerator 2. Three small bottles of water frozen in the refrigerator compartment 3. Unidentifiable food item wrapped in a paper napkin had no label or date 	F 812			

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F 812	<p>Continued From page 48</p> <p>4. One bowl of chili in a brown bag had no date listed At the time, Resident #30 reported her refrigerator was extremely cold.</p> <p>c. During observation 2/16/21 at 01:50 PM, Resident #112's refrigerator had no thermometer, and four packages of ranch dressing expired 1/1/21. The resident reported her refrigerator had not been checked for months.</p> <p>In an interview 2/16/21 at 11:00 AM, the DON reported the night shift staff usually checked the resident's refrigerators, and housekeeping and dietary staff checked the refrigerators in the unit galleys for cleanliness and outdates. The DON confirmed she had no documentation to show refrigerators checked in resident rooms or refrigerator temperatures checked, and no documentation of when the resident refrigerators or galley refrigerators had been cleaned. The DON reported Resident #28's family member use to visit the resident and cleaned out the refrigerator but since COVID-19, they had no visitors.</p> <p>In an interview 2/18/21 at 10:18 AM, Staff U, Certified Medication Aide, reported dietary staff checked the refrigerators in resident rooms. Staff U reported whenever food or drink placed in the refrigerator, the items needed labeled with the resident's name, date and time.</p> <p>In an interview 2/18/21 at 10:42 AM, Staff V, housekeeper, reported she cleaned the outside of a resident's refrigerator but had not routinely checked the inside of the refrigerator unless she had checked with the resident first.</p>	F 812			

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F 812	<p>Continued From page 49</p> <p>In an interview 2/18/21 at 1:45 PM, Staff W, Certified Nursing Assistant (CNA), reported housekeeping cleaned the refrigerator in resident rooms. Staff W reported staff placed food in the resident's refrigerator but she had not labeled or dated the food or beverage whenever she placed items in the refrigerator.</p> <p>In an interview 2/18/21 at 1:56 PM, Staff A, CNA, reported she had no idea who checked the refrigerators in the resident's room. Staff A reported she let housekeeping know if the refrigerator needed cleaned or cleaned out.</p> <p>On 2/18/21 at 10:49 AM, the DON stated maintenance staff worked on defrosting resident refrigerators this day, and they now had thermometers to place in the resident's refrigerators.</p> <p>An undated policy for Safe Handling of Food for Resident Consumption revealed any perishable food not consumed right away shall be stored in a clean, sealed container labeled and dated. Food tightly sealed to prevent infestation of pests. Food past the manufacturer's expiration date shall be discarded. Perishable food shall be held at temperature at or below 41 degrees Fahrenheit and discarded per facility's date marking policy.</p> <p>5. The Minimum Data Set (MDS) completed for Resident #13 with an Assessment Reference Date (ARD) of 2/15/21 showed a Brief Interview for Mental Status (BIMS) score of 8, indicating moderate cognitive impairment.</p> <p>On 2/16/21 at 12:45 PM observed the resident's fridge full of unmarked food and a freezer full of</p>	F 812			

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F 812	Continued From page 50 ice. The resident stated she didn't believe the fridge had been cleaned since she moved into that room. The resident's census showed a room change on 6/17/20. The resident's care plan showed no documentation related to the fridge in the resident's care plan.	F 812			
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,	F 880	F 880 INFECTION PREVENTION & CONTROL CFR(s): 483.80(a)(1)(2)(4)(e)(f) It is the practice of this organization to provide appropriate infection control techniques for residents. The Director of Nursing provided education to nursing staff regarding infection control practices on 3/24/2021 - 3/31/2021. Facility staff were assigned the following videos to view by 4/3/2021: PPE Lessons, Sparkling Surfaces, Clean Hands, and Keep COVID Out. The facility conducted a RCA involving the Infection Preventionist, QAPI committee, and representative from the governing body 3/24-4/2/21 and as a result additional break area were made available to staff away from patient care areas; hand's-on skills fair added to in-service schedule for nursing staff; facility practice on isolation signage clarified with nursing staff responsible, and additional rounding by nurse management staff implemented as a part of daily routine. The Director of Nursing is responsible for ongoing compliance in this area. The DON, or designee, will conduct several random weekly observations of staff to ensure compliance with facility practice and policy. Results of observations will be shared monthly with the Executive Director and QAPI committee for three months, or longer at the direction of the QAPI committee.		

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F 880	<p>Continued From page 51 but are not limited to:</p> <p>(i) A system of surveillance designed to identify possible communicable diseases or infections before they can spread to other persons in the facility;</p> <p>(ii) When and to whom possible incidents of communicable disease or infections should be reported;</p> <p>(iii) Standard and transmission-based precautions to be followed to prevent spread of infections;</p> <p>(iv) When and how isolation should be used for a resident; including but not limited to:</p> <p>(A) The type and duration of the isolation, depending upon the infectious agent or organism involved, and</p> <p>(B) A requirement that the isolation should be the least restrictive possible for the resident under the circumstances.</p> <p>(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</p> <p>(vi) The hand hygiene procedures to be followed by staff involved in direct resident contact.</p> <p>§483.80(a)(4) A system for recording incidents identified under the facility's IPCP and the corrective actions taken by the facility.</p> <p>§483.80(e) Linens. Personnel must handle, store, process, and transport linens so as to prevent the spread of infection.</p> <p>§483.80(f) Annual review. The facility will conduct an annual review of its IPCP and update their program, as necessary.</p>	F 880			

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F 880	<p>Continued From page 52</p> <p>This REQUIREMENT is not met as evidenced by:</p> <p>Based on observations, interviews, and record reviews, the facility failed to provide appropriate infection control techniques for 6 of 32 residents' reviewed (Residents #32, #72, #128, #132, and #28). The facility reported a census of 124 residents.</p> <p>Findings include:</p> <p>1. On 2/11/21 at 11:04 AM observation revealed the Restorative Nurse talking to two aides at a table in the common area of the 300 hall with a resident on the other side of the 4 foot table. Observation showed Staff H, Certified Nurses' Aide (CNA) with his mask pulled down to his chin visiting with the other two as a resident sat at the table.</p> <p>Observation on 2/11/21 at 11:52 AM revealed Staff H, CNA using his nebulizer machine, administering his nebulizer treatment, in the 300 hall nurses station with the window open to the common area as another CNA entered the nurses station.</p> <p>General observations on 2/17/21 at 11:42 AM revealed an unidentified CNA with their mask covering their mouth only, leaving their nose exposed, while pushing a resident in their wheelchair to lunch.</p> <p>Observation on 2/17/21 at 11:50 AM revealed Staff H, CNA using his nebulizer machine at the 300 hall nurses' station while a CNA in the room fixed another CNA's hair.</p> <p>When interviewed on 2/17/21 at 12:02 PM the</p>	F 880			

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F 880	<p>Continued From page 53</p> <p>Assistant Director of Nursing (ADON) and the Director of Nursing (DON) stated Staff H, CNA just came back to work last Monday and they would talk to him. They were aware that he needed his nebulizer treatments.</p> <p>On 2/17/21 at 12:04 PM the ADON educated Staff H, CNA concerning the use of his nebulizer treatments. Staff H reported not aware of this.</p> <p>On 2/17/21 at 3:40 PM after testing a resident's blood sugar, Staff J, Registered Nurse (RN) placed the used glucometer back into the cloth pouch, moved the garbage can and then removed her gloves and washed her hands. Staff J then removed the glucometer from the cloth pouch without her gloves and wrapped the glucometer in a wipe.</p> <p>On 2/17/21 at 3:45 PM Staff J reported the residents don't have their own glucometer.</p> <p>2. The Minimum Data Set (MDS) completed for Resident #132 with an Assessment Reference Date (ARD) of 2/7/21 showed a Brief Interview for Mental Status (BIMS) score of 14, indicating intact cognition. The resident had diagnoses of acute on chronic diastolic (congestive) heart failure, chronic obstructive pulmonary disease, unspecified, and type 2 Diabetes Mellitus without complications.</p> <p>On 2/17/21 at 4:09 PM Staff G, Certified Medication Aide (CMA), entered the resident's room wearing a face mask and face shield. The door to the resident's room noted a droplet and contact precautions sign. The droplet precautions sign directed staff to wear face shield, face mask, and gown. Staff G entered the resident's room</p>	F 880			

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F 880	<p>Continued From page 54</p> <p>without donning a gown as directed by the precaution sign. Staff G removed the resident's thickened liquids from the fridge gave the resident medications and took the cup from the resident with ungloved hands. After placing the cup in the trash Staff G sanitized his hands.</p> <p>3. The MDS completed for Resident #128 with an ARD of 2/5/21 showed a BIMS score of 11, indicating moderate cognitive impairment. The resident had diagnoses of anxiety disorder, unspecified, dysthymic disorder, and stress fracture, left ankle, subsequent encounter for fracture with routine healing.</p> <p>On 2/17/21 at 4:36 PM Staff G, CMA entered the resident's room to give medications wearing a face mask and face shield. Noted on the door to the resident's room a droplet and contact precautions sign. The droplet precautions sign indicated staff were to wear face shield, face mask, and gown. Observation revealed Staff G failed to wear a gown as directed.</p> <p>4. The MDS completed for Resident #32 showed a BIMS showed the resident rarely or is never understood. The staff interview showed the resident had a long and short-term memory problem. The resident required extensive assistance of two staff with toileting and personal hygiene. The resident was frequently incontinent of urine. The resident had diagnoses of malignant neoplasm of brain, unspecified, anxiety disorder, unspecified, and weakness.</p> <p>On 2/9/21 at 11:21 AM Staff F, Certified Nurses' Aide (CNA), and Staff I, CNA, donned gloves. Staff I removed the resident's soiled brief and with the same gloves removed clean wipes from</p>	F 880		

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F 880	<p>Continued From page 55</p> <p>the package. Staff I, used her left hand to remove clean wipes from the package and clean the resident's backside. Staff I, then used her right hand to removed clean wipes from the package and cleansed the resident's front side. After completing incontinency care with the same gloves Staff I assisted the resident to her chair. Staff I then removed her gloves and washed her hands. During cares observation showed Staff I's face mask covered her mouth only, leaving her nose exposed.</p> <p>The Care Area Assessment dated 10/11/20 explained that the resident had frequent urinary and bowel incontinence and required staff assistance for toileting tasks with incontinence management to avoid complications. Urinary incontinence will be addressed in the care plan with interventions to assist the resident with toileting tasks and mobility to be able to reduce amount of incontinence episodes to avoid complications from urinary incontinence. Also to assist with urinary incontinence cares to avoid complications from the urinary incontinence.</p> <p>5. According to the MDS with an Assessment Reference Date (ARD) 1/22/21 Resident #72 had a BIMS score of 2, indicating severe cognitive impairment. The resident required extensive assistance of two staff with toileting and extensive assistance of one staff for personal hygiene and always incontinent of urine and stool. The resident had diagnoses of dementia, spinal stenosis, and weakness.</p> <p>On 2/15/21 at 1:13 PM Staff M, Certified Nurses' Aide (CNA), donned gloves and cleansed the resident's front side, with the same gloves Staff M removed wipes from the package and cleansed</p>	F 880			

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F 880	<p>Continued From page 56</p> <p>the resident's backside. Staff M proceeded to removed the resident's Thrombo-Embolus Deterrent (TED) hose, pull up the resident's covers, lower the bed and give the resident the call light. Staff M continued without the benefit of changing gloves putting the wipe package away and placing the mechanical lift sling on to the resident's chair. Staff M did not remove their gloves until after taking care of the garbage.</p> <p>On 2/18/21 at 10:25 AM Staff B, Certified Nurses' Aide (CNA) donned gloves then connected the resident to the mechanical lift as Staff M, CNA controlled the mechanical lift. Staff B removed the resident's pants, and Staff M removed the resident's soiled brief. Staff B cleansed the resident's front three times, taking a new wipe from package each time. Then cleansed the resident's backside three times, removing each individual wipe from package after each wipe. With new gloves and no hand hygiene Staff M placed a clean brief on the resident and pulled up the resident's pants. With new gloves and no hand hygiene, Staff B closed the wipes and placed them in the drawer.</p> <p>When interviewed on 2/23/21 at 1:09 PM the DON stated</p> <ol style="list-style-type: none"> Staff are to wear a gown, mask, and goggles when going into an isolation room. The glucometer pouch should be cleaned before and after use. If staff touch the glucometer before it is cleaned they should wash or sanitize their hands. Staff should wash their hands before starting perineal care. Staff should put on gloves before cares then remove gloves when done with the dirty part of the care. 	F 880			

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F 880	Continued From page 57 The Infection Control Program policy dated 3/20 explained in the section related to Standard Precautions for Infection Control that Prevention, containment, and eradication measures including use of contact precautions are indicated to prevent the spread of resistant microorganisms that have been identified within the facility's Standard Precautions will be used by all staff in the care of all residents regardless of their diagnosis or suspected or confirmed infection status. Standard Precautions - presumes all blood, body fluids, secretions and excretions (excluding sweat), non-intact skin and mucous membranes may contain transmissible infections. The Procedure stated that Standard Precautions include a group of infection prevention practices that apply to all residents, regardless of suspected or confirmed infection status: 1. Hand Washing: This is the primary means of preventing the spread of infection. Employees must wash their hands for a minimum of twenty (20) seconds using soap and water with vigorous rubbing under the following conditions: a. When hands are visibly soiled or dirty with blood or other body fluids or secretions. b. After contact with blood, body fluids, secretions, mucous membranes or non-intact skin. c. After handling potentially contaminated items that contain blood, body fluids or secretions. d. Before and after meals and after using the restroom 2. If hands are not visibly soiled, use of an alcohol based rub containing 60-95% ethanol or isopropanol for all of the following situations is acceptable: a. Before direct contact with residents	F 880			

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F 880	<p>Continued From page 58</p> <p>b. Before donning sterile or clean gloves c. Before handling or preparing medications d. Before handling clean or soiled dressing, gauze pads, etc. e. Before performing any non-surgical invasive procedure f. After contact with objects (e.g., medical equipment) in the immediate area of the resident</p> <p>2. The use of gloves does not replace hand washing/hygiene. Hands are to always be washed after glove removal or when changing gloves to don new gloves. This is in accordance with CDC guidelines.</p> <p>The Infection Control: Transmission Based Precautions dated 3/20 explained that transmission-based precautions will be used when that route of transmission is not completely interrupted using Standard Precautions alone. The following precautions should be used</p> <p>1. Contact Precautions - this is intended to prevent the transmission of infectious agents which are spread by direct or indirect contact with the patient or the patient ' s environment. Contact precautions also apply where the presence of excessive wound drainage, urine or fecal incontinence, or other discharges from the body suggest an increased potential for environmental contamination and risk of transmission. Personal Protective Equipment is recommended.</p> <p>a. Gloves: whenever touching the resident's intact skin or surfaces and articles in close proximity to the resident b. Gowns: whenever anticipating that clothing will have direct contact with the resident or potentially contaminated environmental surfaces or equipment in close proximity to the resident. c. Limit transport and movement of the resident</p>	F 880			

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F 880	Continued From page 59 outside of the room to medically necessary purposes. When transport is necessary ensure that infected or colonized areas of the resident ' s body are contained and covered. d. Resident - Care and Equipment - use disposable non-critical equipment (BP cuffs, stethoscopes, thermometers, etc.) or implement resident dedicated only equipment. If common use of equipment is unavoidable; clean and disinfect the equipment before use on another resident e. Environment: rooms should be cleaned daily with a focus on frequently touched/used items by the resident f. Room placement: single room when available. If a single room is not available: i. Residents should cohort: meaning same residents with infected or colonized pathogen if possible and/or; ii. Avoid placing residents on contact precautions in the same room with immune- suppressed residents (Ex: cancer patients, Neutrogena residents, transplant recipients, etc.) 2. Droplet Precautions- are intended to prevent the transmission of pathogens spread through a close respiratory or mucous membrane contact with respiratory secretions. These pathogens do not remain infectious over duration of time so do not require special air or ventilation to prevent droplet transmission. a. Single patient room is preferred who require droplet precautions, if this is not possible, then review will be required regarding placement options including but may not be limited too; cohorting; and/or keeping the patient with the same roommate. b. Masks are worn for close contact with the resident.	F 880			

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F 880	<p>Continued From page 60</p> <p>c. Gloves, gown and eye protection are worn adhering to Standard Precaution guidelines.</p> <p>d. A sign should be placed on the door frame (or visible prior to entering the resident ' s room), indicating that before entering the person(s) should see the Nurse. The Nurse will inform the visitors then of necessary precautions and PPE; maintaining the resident ' s right to privacy.</p> <p>e. Transmission Based Precautions will remain in effect for a limited time period; during the time the infectious agent persists or for the duration of the illness.</p> <p>The Blood Glucose Monitoring policy dated 3/20 said that The purpose of this policy is to ensure the correct cleaning and disinfection of the Blood Glucose Monitoring System is followed to prevent the potential transmission of infectious organisms through the Blood Glucose Monitoring Device. The Centers for Disease Control (CDC) recommend that precautions be taken during all procedures and in all circumstances in which there is a possibility of exposure to blood or any bodily fluid. It is important that employees prevent contamination of themselves and cross-contamination to residents and other staff by adhering to this Infectious Control Policy for cleaning of blood glucose devices. When cleaning the device you must put on (don) gloves.</p> <p>6. During observation 02/16/21 at 10:40 AM, Staff A, CNA, and Staff B, CNA, donned a pair of gloves, then stood Resident #28 by the commode. Staff A took a disposable wipe, reached under resident's bottom and cleansed the area front to back. Staff A took another disposable wipe and cleansed between the resident's buttocks, then used the same wipe to</p>	F 880			

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F 880	Continued From page 61 cleanse the area again. Staff A and Staff B pulled the resident's brief up, then transferred the resident to her recliner. Staff A took a remote to lower the resident's recliner seat and elevated her legs. Staff A donned the resident's oxygen cannula, covered the resident with a blanket, then removed her gloves and washed her hands. Staff B, CNA, bagged up the trash, then placed the trash bag inside the bag in the commode. Staff B removed the bag in the commode, tied the bag, then removed one glove and took the bag to the soiled utility room, and removed her other glove. An undated policy titled Standard Precautions for Infection Control revealed gloves changed whenever moved between dirty and clean surfaces and when visibly soiled or damaged. The use of gloves doesn't replace hand washing or hand hygiene. Hands needed washed after gloves removed.	F 880			
F 909 SS=D	Resident Bed CFR(s): 483.90(d)(3) §483.90(d)(3) Conduct Regular inspection of all bed frames, mattresses, and bed rails, if any, as part of a regular maintenance program to identify areas of possible entrapment. When bed rails and mattresses are used and purchased separately from the bed frame, the facility must ensure that the bed rails, mattress, and bed frame are compatible. This REQUIREMENT is not met as evidenced by: Based on the Food and Drug Administration's Guide, observations, clinical record review, and interviews, the facility failed to conduct inspection of bed frames, mattresses, and bed rails as part	F 909	F 909 RESIDENT BED CFR(s): 483.90(d)(3) It is the practice of this organization to conduct inspections of bed frames, mattresses, and bed rails as part of a regular maintenance program to identify areas of possible entrapment for the use of side rails. Resident #04 no longer resides in the facility. The facility maintenance staff conducted an inspection of resident beds with side rails to identify areas of possible entrapment on 2/19/2021. The Director of Facilities provided education to maintenance staff on 2/19/2021 on how to use the safety action grid to identify possible areas of entrapment on a bed with side rails. Preventative Maintenance program was updated on 2/19/2021 to include the inspection of beds, mattresses, and side rails for risk of entrapment and documentation of inspection on safety action grid. The Director of Facilities is responsible for ongoing compliance in this area. The director, or designee, will conduct monthly reviews of documentation and random observations of residents with bed rails to ensure compliance with facility practice. Results of reviews will be shared monthly with the Executive Director and QAPI committee for three months, or longer at the direction of the QAPI committee.		

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F 909	<p>Continued From page 62</p> <p>of a regular maintenance program to identify areas of possible entrapment for the use of side rails for 1 of 2 beds (Resident #4). The facility reported a census of 124 residents.</p> <p>Findings include:</p> <p>1. The Minimum Data Set (MDS) assessment dated 2/1/21 indicated Resident #4 had diagnoses that included coronary artery disease, hypertension, peripheral vascular disease, hyperlipidemia, ileus, Barrett's esophagus, and abdominal aortic aneurysm without rupture. The resident had a Brief Interview for Mental Status (BIMS) score of 8, indicating cognitive and memory impairment. Resident #4 had the ability to make himself understood and understand others, although he was extremely hard of hearing. The resident required the assistance of 1 with bed mobility, assistance of 2 for transfers, and assistance of 1 for dressing and personal hygiene.</p> <p>On 02/09/21 at 10:26 AM, observation revealed Resident #4 sitting in his room in his wheelchair watching TV. Observation showed the bed side rails up x2.</p> <p>On 02/15/21 at 11:15 AM, observation showed Resident #4 assisted Staff O, Certified Nursing Assistant (CNA) and Staff P, CNA with turning by attempting to grab a hold of the side rails attached to his bed during peri care.</p> <p>Record review of Guidance for Industry and FDA Staff: Hospital Bed System Dimensional and Assessment Guidance to Reduce Entrapment, dated March 10, 2006: a. FDA recommends that healthcare facilities</p>	F 909			

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F 909	<p>Continued From page 63</p> <p>conduct a risk-benefit analysis to ensure that steps taken to mitigate the risk of entrapment do not create different, unintended risks or reduce clinical benefits available to patients using legacy beds. Such steps may include checking with bed system manufacturers to identify compatible mattresses, rails, and accessories.</p> <p>b. Likewise, healthcare facilities may contact their equipment suppliers for entrapment mitigating solutions that may already be available. Manufacturers should follow the appropriate FDA regulations regarding risk assessment, design controls, and documentation when developing mitigation components, attachments and other accessories to address entrapment risks in legacy hospital beds.</p> <p>Record review of facility document titled, Bed Safety Action Grid, with unknown date, showed 1 of 7 Description of Entrapment Zone, Zone 7 marked compliant, 'Entrapment between head or foot board and mattress.' Risk of Entrapment deemed low. Staff signature and date assessed omitted.</p> <p>Record review of contracted Durable Medical Equipment supplier, Midwest Respiratory Care, Inc/Mercy One, policy titled, 5.1 Equipment, Equipment Maintenance, Repairs, and Quality Checks, with an effective date of 1/25/2008, revealed:</p> <ul style="list-style-type: none"> -Midwest Respiratory care, Inc. provides only durable medical equipment and supplies and other items that meet applicable Food and Drug Administration (FDA) regulations and medical device effectiveness and safety standards. -Preventative maintenance is performed on all equipment in accordance with the manufacturer's recommendations and/or Company policy. 	F 909			

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F 909	Continued From page 64 -All employees who perform repairs, quality checks and maintenance are trained by qualified individuals. Persons without such training are not permitted to attempt to perform repairs, quality checks or preventative maintenance. During an interview on 2/16/21 at 3:30 PM, Staff R, Director of Facilities, revealed the facility maintenance book which demonstrated all facility side rails had been checked for possible entrapment quarterly. Staff R revealed the most current assessment dated 2/12/21, which had all 7 possible entrapments checked as being assessed, the form was dated and signed; he was unable to provide prior entrapment assessments as prior documents noted to have Resident #4 room number were not completed, dated, or signed by the maintenance technician who completed the assessment, 6 of 7 possible entrapments were not assessed. During an interview on 2/18/21 at 10:40 AM, Staff Q, Licensed Practical Nurse, (LPN), stated she was familiar with Resident #4's Plan of Care and that he had side rails. She stated she did not know of any issues involving the side rails, she did not know who installed the side rails or how often they are assessed for potential of entrapment.	F 909			
F 919 SS=D	Resident Call System CFR(s): 483.90(g)(2) §483.90(g) Resident Call System The facility must be adequately equipped to allow residents to call for staff assistance through a communication system which relays the call directly to a staff member or to a centralized staff work area.	F 919			

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F 919	Continued From page 65 §483.90(g)(2) Toilet and bathing facilities. This REQUIREMENT is not met as evidenced by: Based on observations, and resident and staff interview, the facility failed to assure a resident's call light accessible for a resident to call for staff assistance for one of thirty-two residents reviewed. The facility reported a census of 124 residents. Findings include: On 02/15/21 at 09:30 AM, Resident #28 observed lying in bed with the head of bed elevated. The resident's call light cord laid across the top dresser drawer, and the resident unable to reach the call light. On 2/15/21 at 10:31 AM, Resident #28 observed lying in bed. The call light cord laid across the inside of the top dresser drawer and the call light button hung near the floor. When asked if she could reach her call light the resident stated she could not reach the call light. On 02/15/21 at 01:35 PM, observation revealed Resident #28 in bed with the head of the bed up and the bed height at mid-level position. The resident's call light cord hung in the top dresser drawer by the bed and out of the resident's reach. In an interview 2/23/21 at 12:40 PM, the Director of Nursing reported she expected the residents' call light to be within reach of the resident. The DON reported she had recently done some call light audits for timely response to call lights and to ensure residents had their call light within reach. The DON reported they had invested in some	F 919	F 919 RESIDENT CALL SYSTEM CFR(s): 483.90(g)(2) It is the practice of this organization to assure resident's call light is accessible to call for staff assistance. Resident #28 no longer resides at the facility. On 3/26/2021 the facility interdisciplinary team made a check of all call-lights to ensure they were accessible to residents to call for staff assistance. The housekeeping supervisor made additional call light clips available at each nurses station. The DON provided education to nursing staff on 3/24 and 3/31 regarding facility practice. The DON is responsible for ongoing compliance in this area. The DON, or designee, will conduct random weekly observations to ensure resident call-lights are accessible to call for staff assistance. The results of the observations will be shared with monthly with the Executive Director and QAPI committee for three months, or longer at the direction of the committee.		

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F 919	Continued From page 66 pins to attach the call light to a resident's clothing or near the resident.	F 919			