STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	165180	A. BUILDING _____ B. WING _____	09/13/2021

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ODEBOLT SPECIALTY CARE	801 SOUTH DES MOINES STREET ODEBOLT, IA 51458

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F 000	INITIAL COMMENTS Correction Date 10-8-21 A recertification health survey was conducted 9/7-9/13/21 and resulted in the following deficiencies. (See Code of Federal Regulations (45CFR) Part 483, Subpart B -C).	F 000	"This Plan of Correction is prepared and submitted as required by law. By submitting this Plan of Correction, **Odebolt Specialty Care** does not admit that the deficiency listed on this form exist, nor does the facility admit to any statements, findings, facts, or conclusions that form the basis for the alleged deficiency. The facility reserves the right to challenge in legal and/or regulatory or administrative proceedings the deficiency, statements, facts, and conclusions that form the basis for the deficiency."	
F 636 SS=D	Comprehensive Assessments & Timing CFR(s): 483.20(b)(1)(2)(i)(iii) §483.20 Resident Assessment The facility must conduct initially and periodically a comprehensive, accurate, standardized reproducible assessment of each resident's functional capacity. §483.20(b) Comprehensive Assessments §483.20(b)(1) Resident Assessment Instrument. A facility must make a comprehensive assessment of a resident's needs, strengths, goals, life history and preferences, using the resident assessment instrument (RAI) specified by CMS. The assessment must include at least the following: (i) Identification and demographic information (ii) Customary routine. (iii) Cognitive patterns. (iv) Communication. (v) Vision. (vi) Mood and behavior patterns. (vii) Psychological well-being. (viii) Physical functioning and structural problems. (ix) Continence. (x) Disease diagnosis and health conditions. (xi) Dental and nutritional status. (xii) Skin Conditions.	F 636		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Ryan Skopec — TITLE: Administrator — (X6) DATE: 10-8-2021

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

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F 636	Continued From page 1 (xiii) Activity pursuit. (xiv) Medications. (xv) Special treatments and procedures. (xvi) Discharge planning. (xvii) Documentation of summary information regarding the additional assessment performed on the care areas triggered by the completion of the Minimum Data Set (MDS). (xviii) Documentation of participation in assessment. The assessment process must include direct observation and communication with the resident, as well as communication with licensed and nonlicensed direct care staff members on all shifts. §483.20(b)(2) When required. Subject to the timeframes prescribed in §413.343(b) of this chapter, a facility must conduct a comprehensive assessment of a resident in accordance with the timeframes specified in paragraphs (b)(2)(i) through (iii) of this section. The timeframes prescribed in §413.343(b) of this chapter do not apply to CAHs. (i) Within 14 calendar days after admission, excluding readmissions in which there is no significant change in the resident's physical or mental condition. (For purposes of this section, "readmission" means a return to the facility following a temporary absence for hospitalization or therapeutic leave.) (iii)Not less than once every 12 months. This REQUIREMENT is not met as evidenced by: Based on clinical record review and staff interview, the facility failed to assess the resident's need for nebulizer treatments on the resident's comprehensive assessment for 1 out of 16 residents sampled for comprehensive assessments (Resident #7). The facility reported	F 636	Deficiency corrected on 09/30/2021 by Regional Director of Clinical Services.	

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F 636	Continued From page 2 a census of 26 residents. Findings include: Resident #7's Minimum Data Set (MDS) dated 07/05/21 identified a Brief Interview for Mental Status (BIMS) score of 11 indicating moderate cognitive impairment. The MDS identified the resident with diagnoses that included: non-Alzheimer's dementia and chronic congestive heart failure (weakening of heart muscle leading to fluid buildup in the lungs causing difficulty breathing). The electronic medical record (EMR) also revealed a diagnosis of interstitial pulmonary disease (a scarring of lung tissue making it difficult to breathe). The MDS revealed the resident received oxygen therapy. The MDS signed and locked on 07/09/21 documented the resident had zero days of respiratory treatment in the preceding 7 days. A review of the EMR revealed a completed physicians order dated 07/03/21 for nebulizer treatments (inhalation medicine used to open the airways in the lungs) four times daily and every four hours as needed for 10 days. The Medication Administration Record (MAR) revealed an active order dated 07/03/21 for a nebulizer treatment every 4 hours as needed for wheezing or shortness of breath. A review of the medication administration record (MAR) reflected Resident #7 received 22 medicated nebulizer inhalation treatments from 07/03/21 thru the MDS assessment completed date 07/09/21. On 09/13/21 9:40 AM , the Director of Nursing stated the resident's recent nebulizer respiratory	F 636	Regional Director of Clinical Services educated MDS Coordinator and Management team on capturing all events on the Minimum Data Set for the look back period. MDS Coordinator and Management team will monitor 1 time per week for four weeks and 1 time per month for 2 months. QA team will address concerns through the QA process thereafter.	

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F 636	Continued From page 3 treatments should have been included in the 7 day look back period specified in the MDS section O, special treatments/respiratory.	F 636		
F 656 SS=D	Develop/Implement Comprehensive Care Plan CFR(s): 483.21(b)(1) §483.21(b) Comprehensive Care Plans §483.21(b)(1) The facility must develop and implement a comprehensive person-centered care plan for each resident, consistent with the resident rights set forth at §483.10(c)(2) and §483.10(c)(3), that includes measurable objectives and timeframes to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment. The comprehensive care plan must describe the following - (i) The services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §483.24, §483.25 or §483.40; and (ii) Any services that would otherwise be required under §483.24, §483.25 or §483.40 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(c)(6). (iii) Any specialized services or specialized rehabilitative services the nursing facility will provide as a result of PASARR recommendations. If a facility disagrees with the findings of the PASARR, it must indicate its rationale in the resident's medical record. (iv)In consultation with the resident and the resident's representative(s)- (A) The resident's goals for admission and desired outcomes. (B) The resident's preference and potential for future discharge. Facilities must document	F 656		

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F 656	Continued From page 4 whether the resident's desire to return to the community was assessed and any referrals to local contact agencies and/or other appropriate entities, for this purpose. (C) Discharge plans in the comprehensive care plan, as appropriate, in accordance with the requirements set forth in paragraph (c) of this section. This REQUIREMENT is not met as evidenced by: Based on clinical record review and staff interview, the facility failed to develop a care plan to address respiratory deficits, goals and interventions for 1 of 16 residents reviewed for comprehensive care plans (Resident #7). The facility reported a census of 26 residents. Findings include: Resident #7's Minimum Data Set (MDS) dated 07/05/21 identified a Brief Interview for Mental Status (BIMS) score of 11 indicating moderate cognitive impairment. The MDS identified the resident with diagnoses that included: non-Alzheimer's dementia and chronic congestive heart failure (weakening of heart muscle leading to fluid buildup in the lungs causing difficulty breathing). The electronic medical record (EMR) also revealed a diagnosis of interstitial pulmonary disease (a scarring of lung tissue making it difficult to breathe). The MDS revealed the resident received oxygen therapy. The EMR revealed a physician order dated 07/03/21 for nebulizer treatments (inhalation medicine used to open the airways in the lungs) four times daily and every four hours as needed for 10 days. The Medication Administration Record (MAR) revealed an active order dated	F 656	Deficiency corrected on 09.30.2021 by Regional Director of Clinical Services Regional Director of Clinical Services educated staff on care planning. Education emphasized importance of including all high risk medications and specific resident needs on the care plan. QA Team will monitor 1 time per week for 4 weeks and 1 time per month for 2 months. QA team will monitor	

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F 656	Continued From page 5 07/03/21 for a nebulizer treatment every 4 hours as needed for wheezing or shortness of breath. A review of the care plan last revised on 07/17/21 lacked any documentation pertaining to the resident's pulmonary (pertaining to the lungs) disease or difficulty in breathing requiring nebulizer treatments. On 09/13/21 at 9:37 AM, the Director of Nursing (DON) stated the resident's pulmonary status should have been addressed on the 07/17/21 care plan.	F 656		
F 812 SS=D	Food Procurement,Store/Prepare/Serve-Sanitary CFR(s): 483.60(i)(1)(2) §483.60(i) Food safety requirements. The facility must - §483.60(i)(1) - Procure food from sources approved or considered satisfactory by federal, state or local authorities. (i) This may include food items obtained directly from local producers, subject to applicable State and local laws or regulations. (ii) This provision does not prohibit or prevent facilities from using produce grown in facility gardens, subject to compliance with applicable safe growing and food-handling practices. (iii) This provision does not preclude residents from consuming foods not procured by the facility. §483.60(i)(2) - Store, prepare, distribute and serve food in accordance with professional standards for food service safety. This REQUIREMENT is not met as evidenced by: Based on observation, staff interview, and record	F 812	Deficiency was corrected by Administrator and Dietary Services Manager on 10/7/2021	

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F 812	Continued From page 6 review, the facility failed to store food in a manner that prevented foodborne illness. The facility also failed to keep equipment clean and sanitary. The facility reported a census of 26. Findings include: An initial kitchen tour conducted on 09/07/21 at 09:30 AM revealed the following observations: a. The dishwasher with loose white crusty flakes and buildup on top of the dishwasher and around the valves and seams. b. The double door freezer with dried liquid and loose food debris in the bottom of the freezer. c. The double door freezer with opened, unlabeled bags of food included: 2 bags of corn, baker potatoes, pizza crusts, steaks and beef cubs. d. The oven with multiple large charred particles of food in the bottom of the oven and the inside covered in thick brown build up. e. A container of peanut butter opened, unlabeled and with peanut butter smeared around the outside of the lid. f. A 25 pound bag of flour and sugar opened, unsealed and unlabeled. g. The spatula drawer with multiple food particles mixed in with the utensils. During the initial kitchen tour on 09/07/21 at 9:30 AM, the Dietary Manager (DM), agreed the white crusty flakes on the dishwasher had the potential to fall onto clean dishes and needed to be removed. She acknowledged that both freezers and the oven should be cleaned and free of debris. The DM stated that all open food bags or containers should be labeled with the date. She also acknowledged the flour and sugar should be in sealed containers.	F 812	Facility implemented daily dietary quality assurance audits to be reported to the Dietary Services Manager daily. Dietary Services Manager updated cleaning schedule to include oven, dish machine, and drawers. Sugar and flour stored in double containers. QA team will monitor daily.	

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F 812	Continued From page 7 The document titled Freezer, Reach-In dated 2/2016 directed to ensure all food items are labeled, dated and properly covered, and to wash all inside and outside surfaces, including the handle with warm detergent solution and clean cloth. The document titled Cleaning Schedule revealed a lack of routine cleaning schedules for the freezers or inside of the oven. The document titled Cleaning Schedule revealed extra cleaning for Lime A Way for the dishwasher but lacked clear direction for frequency. On 9/8/21 at 3:48 AM, the Administrator stated he expected the dishwasher, freezers and spatula drawer to be in sanitary conditions. He expected the flour and sugar stored in containers.	F 812		
F 868 SS=D	QAA Committee CFR(s): 483.75(g)(1)(i)-(iii)(2)(i) §483.75(g) Quality assessment and assurance. §483.75(g)(1) A facility must maintain a quality assessment and assurance committee consisting at a minimum of: (i) The director of nursing services; (ii) The Medical Director or his/her designee; (iii) At least three other members of the facility's staff, at least one of who must be the administrator, owner, a board member or other individual in a leadership role; §483.75(g)(2) The quality assessment and assurance committee must: (i) Meet at least quarterly and as needed to identifying issues with respect to which quality	F 868		

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F 868	Continued From page 8 assessment and assurance activities are necessary. This REQUIREMENT is not met as evidenced by: Based on record and policy review, and staff interview, the facility failed to hold quarterly Quality Assurance and Performance Improvement (QAPI) meetings with the required members and hold quarterly QAPI meetings to ensure continued quality care for the facility's residents. The facility reported a census 26 residents. Findings include: 1. The Quality Assurance (QA) Committee Meeting Sign-In dated 04/30/20 and 07/29/20 revealed the facility mailed the Medical Director (MD) a copy of QAPI meeting minutes. The QA Reports policy dated 01/15 revealed the committee may include the Administrator, Director of Nursing (DON), MD, Department Heads, Care Plan Coordinator, Consultant Pharmacist, Consulting Dietician, and any other key facility personnel. On 09/09/21 at 10:14 AM, the DON reported the MD not able to attend the QAPI meeting on 04/30/20 or 07/29/20 because of Zoom connection issues. In the same interview, the DON reported the MD could attend QAPI meetings virtually after the 07/29/20 meeting.. The QA Committee Sign-In sheet from 01/14/20 through 07/20/21 revealed 3 of the 7 meetings not held. On 09/09/21 at 10:14 AM, the DON reported they	F 868	Regional Director of Clinical Services corrected deficiency on 09.30.2021 Management Team was educated by Regional Director of Clinical Services on assuring that QA&A with the Medical Director is held every 3 months to be in compliance. The QA&A schedule was posted in Administrator's office as a visual reminder. QA Team to monitor quarterly.	

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F 868	Continued From page 9 could not conduct QAPI meetings every quarter starting with the meeting held on 11/08/20 through 06/08/21 due to staffing issues with employee exposure to COVID-19 and not able to work. During the same interview, the DON stated QAPI meetings should be held every quarter. The Quality Assurance Reports policy dated 01/15 revealed the facility will have a program that meets the federal requirements for quarterly meetings.	F 868		
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	F 880		

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F 880	Continued From page 10 procedures for the program, which must include, but are not limited to: (i) A system of surveillance designed to identify possible communicable diseases or infections before they can spread to other persons in the facility; (ii) When and to whom possible incidents of communicable disease or infections should be reported; (iii) Standard and transmission-based precautions to be followed to prevent spread of infections; (iv)When and how isolation should be used for a resident; including but not limited to: (A) The type and duration of the isolation, depending upon the infectious agent or organism involved, and (B) A requirement that the isolation should be the least restrictive possible for the resident under the circumstances. (v) The circumstances under which the facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease; and (vi)The hand hygiene procedures to be followed by staff involved in direct resident contact. §483.80(a)(4) A system for recording incidents identified under the facility's IPCP and the corrective actions taken by the facility. §483.80(e) Linens. Personnel must handle, store, process, and transport linens so as to prevent the spread of infection. §483.80(f) Annual review. The facility will conduct an annual review of its	F 880		

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F 880	Continued From page 11 IPCP and update their program, as necessary. This REQUIREMENT is not met as evidenced by: Based on observation, staff interview, record and policy review, the facility failed to verify screening of staff and visitors when they entered the facility and failed to wear appropriate eye protection to protect staff and residents when county COVID 19 positivity rate was rated as "high". The facility reported a census of 26 residents. Findings include: 1. Observation on 09/01/21 at 01:19 PM of a visitor entering the facility without a staff member verifying the visitor's screening prior to entering the facility. On 09/01/21 at 02:42 PM, Staff A, dietary aide, reported administration informed her that staff can self screen by taking their own temperature at the kiosk and enter self in the free text box next to their temperature and she obtains assistance for other staff to screen visitors prior to their entry into the facility. On 09/09/21 at 09:45 AM Staff B, laundry aide, and Staff C, housekeeping aide, reported they they were told by administration to self screen prior to entering the facility. The electronic kiosk records from 08/26/21 to 09/09/21 revealed 415 out a total of 638 entries on screening log had self, me, or myself listed as the text that was entered into the box to verify temperature screenings. On 09/02/21 at 08:37 AM, the Administrator	F 880	Deficiency corrected on 10.08.2021 On 09.09.2021, Administrator reeducated staff on the process for screening in staff and visitors. Screening process includes a staff member verifying that anyone who enters facility must be screened for new signs/symptoms of COVID-19 and a temperature not exceeding 100 degrees Fahrenheit. On 09.09.2021, Administrator educated staff on proper PPE while county is 5% or above COVID positivity and/or outbreak status. Administrator immediately initiated eyewear use in facility.	

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ODEBOLT SPECIALTY CARE	801 SOUTH DES MOINES STREET ODEBOLT, IA 51458

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F 880	Continued From page 12 reported staff should have screening verified by another staff prior to entering the facility. The Accushield Kiosk - Signing In & Out document dated 09/23/20 directed people using the screening kiosk to enter their temperature and the name of the staff member who assisted. 2. Multiple observations throughout the survey revealed that staff wore no eye protection. The COVID-19 Positivity Rate Report Data document for the week ending 08/31/21 revealed that Sac county had a positivity rate of 5.2% which placed the facility at a moderate level of risk for COVID-19. On 09/02/21 at 09:31, the Administrator reported that source control (face mask) was the only Personal Protective Equipment (PPE) required with county positivity rate between 5-10%. On 09/02/21 at 01:22 PM, the Administrator reported he checked into PPE (personal protective equipment) requirements and will immediately initiate eye protection for all staff. According to the CDC website, the Sac county positivity rate during the survey was "high".	F 880	On 09.10.2021, Administrator and Business Office Manager initiated daily kiosk audits to assure all staff and visitors are properly screened in. Facility locked all entry ways to assure that staff and visitors are unable to enter facility without being properly screened for signs/symptoms of COVID-19. Odebolt Specialty Care conducted a Root-Cause analysis for the Infection Control F880. Staff was educated on infection control by viewing the following videos: PPE Lessons Keep COVID OUT Odebolt Specialty Care staff completed videos on 10.08.2021. Staff that had not completed videos by 10.08.2021 was not allowed to work until acknowledgement of viewing videos as evidenced by completion history on Relias or signature attesting completion. QA team will monitor daily.	