STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	165473	A. BUILDING _____ B. WING _____	05/20/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SUNRISE RETIREMENT COMMUNITY	5501 GORDON DRIVE EAST SIOUX CITY, IA 51106

(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: _____ The following deficiencies relate to the facility's annual health survey completed on 5/20/21. (See Code of Federal Regulations (42CFR) Part 483, Subpart B -C).	F 000		
F 658 SS=D	Services Provided Meet Professional Standards CFR(s): 483.21(b)(3)(i) §483.21(b)(3) Comprehensive Care Plans The services provided or arranged by the facility, as outlined by the comprehensive care plan, must- (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 follow physician's orders for weekly weights for 1 of 4 residents reviewed for nutrition (Resident #6). The facility reported a census of 51 residents. Findings include: A Minimum Data Set (MDS) assessment, dated 2/18/21, revealed Resident #6 scored 8 on the Brief Interview for Mental Status (BIMS) indicating severe cognitive impairment. The resident required extensive assistance with activities of daily living (ADL's) including bed mobility, transfer, ambulation, dressing, and toilet use. The resident's diagnoses included: non-Alzheimer's dementia. The Physician Order Report dated 4/1/21 to 5/31/21 included an order for a weekly weight	F 658		

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	165473	A. BUILDING _____ B. WING _____	05/20/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SUNRISE RETIREMENT COMMUNITY	5501 GORDON DRIVE EAST SIOUX CITY, IA 51106

(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 658	Continued From page 1 documented in vitals, and notification of the physician of 3-5 pounds (lb) weight gain/loss in 1 week, initiated 10/10/19. The Care Plan dated of 2/25/21 included information that revealed the resident received a scheduled diuretic and directed staff to obtain weight weekly and notify the Primary Care Provider of weight gain/loss of 3-5 lbs. A Weight Record showed no weights documented between 11/24/20 and 12/28/20 (1 month), 12/28/20 and 1/12/21 (2 weeks), 2/9/21 and 2/27/21 (over 2 weeks), 3/5/21 and 3/18/21 (2 weeks), 3/18/21 and 4/1/21 (2 weeks), 4/1/21 and 4/16/21 (2 weeks), and 4/16/21 and 5/4/21 (over 2 weeks). On 5/19/21 at 7:32 AM Staff E Unit Manager stated the order for weekly weights was entered on the general flow sheet so the staff did not see it and it would not populate for them to sign off. She said they did weights every 2 weeks, so the order not followed.	F 658		
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	F 686		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	165473	A. BUILDING _____ B. WING _____	05/20/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SUNRISE RETIREMENT COMMUNITY	5501 GORDON DRIVE EAST SIOUX CITY, IA 51106

(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 686	Continued From page 2	F 686		

with professional standards of practice, to promote healing, prevent infection and prevent new ulcers from developing.
This REQUIREMENT is not met as evidenced by:
Based on observation, record review and staff interview, the facility failed to provide pressure reduction devices per wound nurse recommendation and physician order for 1 of 3 residents reviewed for pressure ulcers (Resident #5). The facility reported a census of 51 residents.

Findings include:

A Minimum Data Set (MDS) assessment, dated 2/18/21, revealed Resident #5 scored 10 on the Brief Interview for Mental Status indicating moderate cognitive impairment. The resident required extensive assistance with activities of daily living (ADL's) including bed mobility, transfer, locomotion, dressing, toilet use and personal hygiene. The resident's diagnoses included: non-Alzheimer's dementia. The resident had an unstageable pressure ulcer.

The MDS described the following pressure sores:
a Stage I: intact skin with non-blanchable redness of a localized area usually over a bony prominence. Darkly pigmented skin may not have a visible blanching; in dark skin tones only it may appear with persistent blue or purple hues.
b. Stage II: partial thickness loss of dermis presenting as a shallow open ulcer with a red or pink wound bed, without slough. May also present as an intact or open/ruptured blister.
c. Stage III: full thickness tissue loss. Subcutaneous fat may be visible but bone, tendon or muscle not exposed. Slough may be

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	165473	A. BUILDING _____ B. WING _____	05/20/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SUNRISE RETIREMENT COMMUNITY	5501 GORDON DRIVE EAST SIOUX CITY, IA 51106

(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 686	Continued From page 3	F 686		

present but does not obscure the depth of tissue loss. May include undermining and tunneling.

d. Stage IV: full thickness tissue loss with exposed bone, tendon or muscle. Slough or eschar may be present on some parts of the wound bed. Often includes undermining and tunneling.

e. Unstageable: known but not stageable due to coverage of wound bed by slough and/or eschar.

A Progress note dated 12/2/20 at 3:28 PM documented the nurse noted the resident's left heel appeared purple and soft to touch, measuring 4 by 5 cm.

The Physician's Order Sheet and Progress Notes by the Wound Nurse documented:

a. On 12/10/20 the resident seen for a stage 2 pressure injury of the left medial heel measuring 4 by 3 cm with slight encrusted light brown tissue base with clear periwound (surrounding) skin. The wound nurse could not palpate a left dorsal pedis (foot) or posterior tibial (ankle) pulses. The resident used her feet to propel the wheelchair, and wore gripper socks. Unsure if shoes would be beneficial.

b. On 12/24/20 the resident seen for the pressure injury measuring 2.6 by 3 cm, with eschar (necrotic tissue) measuring 2 by 2 cm, and the remainder of the wound base pink with a small amount of red drainage. The resident used her feet to move the wheel chair. The Wound Nurse Recommended Betadine solution moistened 4 by 4 (gauze) to the left heel, secured with tape 2 times a day, no cleansing with dressing changes, and a Prevalon boot to the left lower leg on at all times.

c. On 2/16/21 the resident seen regarding the unstageable pressure injury measuring 1.5 by 1.9

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	165473	A. BUILDING _____ B. WING _____	05/20/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SUNRISE RETIREMENT COMMUNITY	5501 GORDON DRIVE EAST SIOUX CITY, IA 51106

(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 686	Continued From page 4	F 686		

cm with black eschar tissue base, starting to demarcate (separate). The resident had a Prevalon boot.

d. On 2/16/21 the heel pressure injury measured 1.5 by 1.5 cm with a light yellow tissue base, removed easily with cleaning. The resident wore a Prevalon boot.

e. On 3/17/21 the resident seen for follow up of a resolving unstageable pressure injury of the left medial heel which measured 0.9 by 1.3 by 0.2 cm with pink tissue base and clear/intact peri-wound skin

A Physician's Telephone Order dated 12/24/20 directed a Prevalon boot to the left lower leg at all times.

The Progress Notes dated 4/6/21 at 11:53 AM the resident's daughter returned staff's phone call and the nurse asked her about getting slip on shoes for the resident so they could possibly keep the Prevalon boot off and assist with ambulation.

The Care Plan with a start date of 2/25/21 included assessing skin per facility protocol, notifying the physician and family of any changes, and administering treatments as ordered. On 12/2/20 they noted a pressure injury to the back of the resident's left heel, the resident wore gripper socks or soft slippers instead of shoes, and encouraged to float heels while in bed. On 12/10/20 the resident seen by the Wound Nurse for a Stage II pressure injury, with orders for Skin Prep 3 times a day (TID). On 12/24/20 the resident seen by the Wound Nurse and Skin Prep discontinued. They started Betadine Solution treatment and a Prevalon boot to the left foot at all times. On 2/4/21 seen by Wound Nurse, the

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	165473	A. BUILDING _____ B. WING _____	05/20/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SUNRISE RETIREMENT COMMUNITY	5501 GORDON DRIVE EAST SIOUX CITY, IA 51106

(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 686	Continued From page 5	F 686		

left heel unstageable, continued with current treatment and Prevalon boot, improving. On 4/10/2021 the resident could wear shoes, put Prevalon boot to left foot on while in bed.

Observation showed on 5/17/21 at 11:40 AM the resident seated in the wheelchair, with a cushion in the chair. The resident wore shoes and moved around in the wheelchair.

Observation showed on 5/18/21 at 11:43 AM the resident seated in the wheelchair at the dining room table wearing shoes bilaterally.

Observation showed on 5/19/21 at 7 AM Staff D Licensed Practical Nurse (LPN) and Staff F Certified Nursing Assistant (CNA) responded to reports from housekeeping of the resident trying to get up. Staff put the resident's shoes on and assisted with morning cares. Staff made no attempt to place the boot to the left foot.

On 5/19/21 at 7:45 AM Staff E Unit Manager stated the resident wore the boot and still scooted around in the wheel chair. The boot would get displaced. She forgot they had an order to wear the boot at all times. She did not consult with the wound nurse. She said she actually retired in mid April. She wanted to have the resident seen by an actual wound doctor to find out if the wound might be vascular in nature. She revealed the resident hospitalized with Covid prior to admission and she felt the ulcer probably originated during that time and not assessed until after the resident lived at the facility a short time.

On 5/19/21 at 2:15 PM the Director of Nursing (DON) stated she expected staff to follow the physician's order.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	165473	A. BUILDING _____ B. WING _____	05/20/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SUNRISE RETIREMENT COMMUNITY	5501 GORDON DRIVE EAST SIOUX CITY, IA 51106

(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 686	Continued From page 6 The facility Skin Prevention Program reviewed 7/2020 included once a risk identified, staff should initiate preventative measures including using devices that relieved pressure on the heels.	F 686		
F 690 SS=D	Bowel/Bladder Incontinence, Catheter, UTI CFR(s): 483.25(e)(1)-(3) §483.25(e) Incontinence. §483.25(e)(1) The facility must ensure that resident who is continent of bladder and bowel on admission receives services and assistance to maintain continence unless his or her clinical condition is or becomes such that continence is not possible to maintain. §483.25(e)(2)For a resident with urinary incontinence, based on the resident's comprehensive assessment, the facility must ensure that- (i) A resident who enters the facility without an indwelling catheter is not catheterized unless the resident's clinical condition demonstrates that catheterization was necessary; (ii) A resident who enters the facility with an indwelling catheter or subsequently receives one is assessed for removal of the catheter as soon as possible unless the resident's clinical condition demonstrates that catheterization is necessary; and (iii) A resident who is incontinent of bladder receives appropriate treatment and services to prevent urinary tract infections and to restore continence to the extent possible. §483.25(e)(3) For a resident with fecal incontinence, based on the resident's comprehensive assessment, the facility must	F 690		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	165473	A. BUILDING _____ B. WING _____	05/20/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SUNRISE RETIREMENT COMMUNITY	5501 GORDON DRIVE EAST SIOUX CITY, IA 51106

(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 690	Continued From page 7	F 690		

ensure that a resident who is incontinent of bowel receives appropriate treatment and services to restore as much normal bowel function as possible.
This REQUIREMENT is not met as evidenced by:
Based on observation, record review and staff interview, the facility failed to provide perineal care in a manner to prevent urinary tract infection (UTI) for 1 of 3 residents reviewed (Resident #5). The facility reported a census of 51 residents.

Findings include:

A Minimum Data Set (MDS) assessment, dated 2/18/21, revealed Resident #5 scored 10 on the Brief Interview for Mental Status indicating moderate cognitive impairment. The resident required extensive assistance with activities of daily living (ADL's) including bed mobility, transfer, locomotion, dressing, toilet use and personal hygiene. The resident's diagnoses included: non-Alzheimer's dementia.

The Care Plan dated 2/25/21 included toileting with 1-2 assist and 4 wheeled walker for transfers. The resident needed assistance with peri-cares, had urinary incontinence and occasional incontinence with bowel.

A Microbiology Routine Culture of urine collected 4/17/21 and verified 4/20/21 showed the resident with greater than 100,000 colony forming units per milliliter of the bacteria Enterococcus Faecium and citrobacter freundii.

A Physician's Telephone Order dated 4/22/21 directed to administer Cipro (antibiotic) 250 mg 2 times a day (BID) for 7 days for UTI.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	165473	A. BUILDING _____ B. WING _____	05/20/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SUNRISE RETIREMENT COMMUNITY	5501 GORDON DRIVE EAST SIOUX CITY, IA 51106

(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 690	Continued From page 8	F 690		

On 5/19/21 at 7 AM Staff D Licensed Practical Nurse (LPN) responded to reports from housekeeping of the resident trying to get up. The resident stated she needed to go to the bathroom. Staff F Certified Nursing Assistant (CNA) also responded and staff put a gaitbelt and shoes on the resident to transfer to the wheelchair, which required several attempts. Staff wheeled the resident to the bathroom and transferred her to the toilet and removed the wet incontinent pad. The resident stated she had a bowel movement. Staff D took the resident's pants and an incontinent pad to the bathroom area. She put the resident's pants on the grab bar and laid the new incontinent pad on the floor at the residents feet before placing the pad around the resident's thighs. The resident had a bowel movement and staff assisted the resident to stand and hold on to the grab bar. Staff D wiped the resident in the anal area with a wet washcloth turning the side of the cloth 3 times, handling with both gloved hands, then said she would wipe her in the front, and turned the cloth a 4th time and wiped the front perineal area. She then pulled up the new incontinent pad and pants before removing her gloves and doing hand hygiene.

On 5/19/21 at 2:15 PM the Director of Nursing (DON) stated if staff cleaned the resident in the anal area during perineal care, she would expect staff would not use the same cloth to then clean the front perineal area.

On 5/20/21 at 8:50 AM Staff E Unit Manager stated staff should not place incontinent pads, or supplies on the floor, because that would contaminate them.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	165473	A. BUILDING _____ B. WING _____	05/20/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SUNRISE RETIREMENT COMMUNITY	5501 GORDON DRIVE EAST SIOUX CITY, IA 51106

(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 690	Continued From page 9 The facility Incontinence Care policy dated 7/2020 directed washing all soiled skin areas from front to back.	F 690		
F 695 SS=D	Respiratory/Tracheostomy Care and Suctioning CFR(s): 483.25(i) § 483.25(i) Respiratory care, including tracheostomy care and tracheal suctioning. The facility must ensure that a resident who needs respiratory care, including tracheostomy care and tracheal suctioning, is provided such care, consistent with professional standards of practice, the comprehensive person-centered care plan, the residents' goals and preferences, and 483.65 of this subpart. This REQUIREMENT is not met as evidenced by: Based on record review, observation, and staff interview, the facility failed to provide cleaning of a CPAP (continuous positive airway pressure) machine for 1 of 1 residents reviewed for respiratory care (Resident #38). The facility reported a census of 51 residents. Findings include: The Minimum Data Set (MDS) dated 04/14/21 for Resident #38 identified a Brief Interview for Mental Status (BIMS) score of 3. A score of 3 indicated severe cognitive impairment. The MDS revealed the resident required supervision and set up assistance in his activities of daily living. The MDS documented diagnoses that included: Alzheimer's disease with early onset and non-Alzheimer's dementia with Lewy bodies (protein deposits in the brain). The MDS identified the resident received oxygen therapy in	F 695		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	165473	A. BUILDING _____ B. WING _____	05/20/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SUNRISE RETIREMENT COMMUNITY	5501 GORDON DRIVE EAST SIOUX CITY, IA 51106

(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 695	Continued From page 10	F 695		

the form of a CPAP machine. (A CPAP machine delivers a predetermined level of air pressure through a hose to a mask and keeps the upper airway open under continuous pressure.)

The care plan with an approach start date of 04/05/21 identified the resident needed to wear a CPAP at bedtime (HS).

The physician order dated 04/05/21 instructed the resident wear a CPAP during the night which required distilled water. The physician order directed staff to assist with turning on and placing at HS and removing in the morning. Special instructions included: residents' doors shut while CPAP on and staff required to wear PPE (personal protective equipment) while in use.

Observation on 05/17/21 at 04:21 PM revealed a CPAP machine at the resident's bedside.

A review of the electronic clinical records revealed the record lacked documentation of the maintenance, humidification or cleaning of the machine.

On 05/18/21 at 04:10 PM, Staff E, Sunlight Neighborhood Nurse Manager, confirmed no treatment orders for the maintenance of the CPAP and provided the facility policy for CPAP.

On 05/18/21 at 04:29 PM, the Director of Nursing (DON), stated she expected staff to follow policy regarding maintenance and cleaning of the CPAP and she confirmed the maintenance and cleaning did not occur with the resident's CPAP.

The undated facility policy, titled BiPAP(bi-level positive airway pressure)/CPAP Policy, instructed

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	165473	A. BUILDING _____ B. WING _____	05/20/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SUNRISE RETIREMENT COMMUNITY	5501 GORDON DRIVE EAST SIOUX CITY, IA 51106

(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 695	Continued From page 11 staff to wipe off the machine weekly, replace disposable filters monthly or per manufacturer's manual, clean non-disposable filters weekly and replace when needed. Instructions included weekly washing with disinfectant, the mask and nasal pillows, washing tubing weekly with disinfectant, rinsing and drying. Instructions included changing distilled water daily and to clean the chamber weekly. Disinfecting is to place equipment in a container with a cleaning solution, soak for 10 minutes, rinse with clean water and air dry.	F 695		
F 757 SS=D	Drug Regimen is Free from Unnecessary Drugs CFR(s): 483.45(d)(1)-(6) §483.45(d) Unnecessary Drugs-General. Each resident's drug regimen must be free from unnecessary drugs. An unnecessary drug is any drug when used- §483.45(d)(1) In excessive dose (including duplicate drug therapy); or §483.45(d)(2) For excessive duration; or §483.45(d)(3) Without adequate monitoring; or §483.45(d)(4) Without adequate indications for its use; or §483.45(d)(5) In the presence of adverse consequences which indicate the dose should be reduced or discontinued; or §483.45(d)(6) Any combinations of the reasons stated in paragraphs (d)(1) through (5) of this section. This REQUIREMENT is not met as evidenced	F 757		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	165473	A. BUILDING _____ B. WING _____	05/20/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SUNRISE RETIREMENT COMMUNITY	5501 GORDON DRIVE EAST SIOUX CITY, IA 51106

(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 757	Continued From page 12	F 757		

by:
Based on observation, record review, resident, staff and physician interview, the facility failed to ensure an international normalized ratio (INR) was monitored for 1 of 4 residents reviewed (Resident #50) taking anticoagulant medications (blood thinners). INR testing is completed to determine a resident's blood clotting time when the resident is taking a blood thinner. The physician directed staff to complete a follow up INR on 2/12/21, after an increase in the anticoagulant dosage on 2/5/21 due to an INR of 1.6 (normal value 2-3). On 2/18/21, Resident #50 transferred from the facility to the local emergency room (ER) due to an INR of 8.0. The facility reported a census of 51 residents.

Findings include:

Resident #50's Minimum Data Set (MDS) with a completion date of 2/15/21, listed diagnoses that included: atrial fibrillation, end stage renal disease (ESRD), diabetes mellitus (DM), and hypertension. The Brief Interview for Mental Status (BIMS), documented a 15 out of 15 indicating no cognitive impairment. The MDS revealed the resident received an anticoagulant daily during the observation period.

Care Plan:

A Care Plan problem with a start date of 2/4/21, identified the resident admitted to the facility due to the need for nursing assistance with ESRD, DM, and atrial fibrillation. The care plan contained directives dated 5/6/21 that included: monitor for signs and symptoms of increased bleeding related to anticoagulant medication use such as: blood in urine or stool, sever bruising, prolonged

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	165473	A. BUILDING _____ B. WING _____	05/20/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SUNRISE RETIREMENT COMMUNITY	5501 GORDON DRIVE EAST SIOUX CITY, IA 51106

(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 757	Continued From page 13	F 757		

nose bleeds, bleeding gums, vomiting blood, sudden severe back pain, difficulty breathing, or chest pain. Check INR per primary care providers orders.

During initial tour on 05/17/21 at 3:13 PM, Resident #50 revealed he received an anticoagulant with INR completed weekly. The resident stated he transferred to the hospital the last time he had issues with increased bleeding.

Progress notes revealed:
a. 2/4/21 at 2:05 PM - recorded as late entry on 2/5/21 at 11:08 AM, Resident admit charting: the resident sat up in recliner when staff arrived and dressed. The resident stated he took most of his medications in the afternoon.
b. 2/5/21 at 2:00 PM - The resident went to dialysis and then straight to an appointment with physician.
c. 2/6/21 at 2:30 PM - The resident representative called and the facility updated the representative on telephone orders for Warfarin (anticoagulant) 5 milligrams (mg) Monday through Saturday and 2.5 mg on Sunday.
d. 2/12/21 at 11:57 PM - The resident went to dialysis that morning. The resident looked weak during that shift.
e. 2/13/21 at 4:10 AM - Staff noted a small amount of cream colored emesis on the right side of the resident's beard and small amount of orange emesis on his blanket.
f. 2/17/21 at 1:38 PM - The resident returned from dialysis at 1:30 PM, in a wheelchair. Dialysis sent a new communication requesting the facility send a hoyer pad to dialysis with the resident.
g. 2/17/21 at 3:44 PM - A finger stick INR completed resulted in INR greater than 8.0 (high). Staff immediately ensured the resident did not

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	165473	A. BUILDING _____ B. WING _____	05/20/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SUNRISE RETIREMENT COMMUNITY	5501 GORDON DRIVE EAST SIOUX CITY, IA 51106

(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 757	Continued From page 14	F 757		

receive the day's dose of warfarin. Staff placed a call to the resident's primary care provider (PCP) and informed the physician's nurse that his INR measured greater than 8.0 and his current warfarin dose. The clinic nurse identified the resident's PCP out of the office, and would review with the doctor on call. Staff notified the resident's responsibility party and the resident.

h. 2/17/21 at 3:58 PM - The physician responded with new orders to hold the warfarin today and recheck INR tomorrow. Staff wrote a telephone order, notified the resident and responsible party and documented the INR order on the calendar for tomorrow.

i. 2/17/21 at 9:41 PM - The resident appeared very sleepy this shift, awake long enough for supper, and sleeps in recliner.

j. 2/18/21 at 11:38 AM - INR retaken and 8.0 results. Call placed to the resident's PCP.

k. 2/18/21 at 12:09 PM - The resident's PCP out of the office and the doctor on call gave order to send to the local emergency room (ER) of choice to recheck INR. The physician wanted an accurate reading of the INR. The doctor on call stated to send the resident as soon as possible in case the resident needed a Vitamin K (given to lower INR values within 24-48 hours) injection. Staff sent a copy of the resident's medication administration record and progress notes to ER.

l. 2/18/21 at 12:09 PM - The resident left with the facility van driver in a wheelchair. Medication list sent with the resident. The resident's responsible party would meet the resident at the ER.

m. 2/18/21 at 8:10 PM - The resident returned to the facility from the local ER at 6:30 PM. The resident received Vitamin K 5 mg orally while in the ER. The physician directed staff to administer Vitamin K 2.5 mg orally the next 2 days and

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	165473	A. BUILDING _____ B. WING _____	05/20/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SUNRISE RETIREMENT COMMUNITY	5501 GORDON DRIVE EAST SIOUX CITY, IA 51106

(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 757	Continued From page 15	F 757		

check INR on Monday and continue to hold warfarin until after the INR on Monday.

A Physician Transfer Order Report encounter date 1/29/21, and print date 2/2/21, included:
a. additional medication order to check INR in 3 days with results faxed to the resident's PCP for warfarin dosing
b. Warfarin 2.5 mg three times a week (Monday, Wednesday, & Friday)
c. Warfarin 5 mg four times a week (Sunday, Tuesday, Thursday, & Saturday)

A Clinical Lab report with a collected date of 2/5/21 revealed INR 1.6.

A Physician order sheet and progress note dated 2/5/21, from the resident's PCP office visit, included an order to increase warfarin to 5 mg Monday through Saturday and 2.5 mg on Sundays. Recheck INR in one week.

Physician's telephone orders revealed:
a. 2/17/21 - Hold Warfarin and recheck INR tomorrow
b. 2/18/21 - Ok to go to ER per the doctor on call, the resident PCP out of office. INR above 8.0 at the facility.

Emergency Department Provider Notes dated 2/18/21 at 2:16 PM, revealed:
a. History provided by the patient and the nursing home
b. The resident reported he was sent to the ER for an INR greater than 8.0. the resident had some bleeding from a sore on his scrotum, nosebleed, and bleeding from his fistula site.
c. Physical exam: no obvious signs of bleeding. Right and left nostril no epistaxis.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	165473	A. BUILDING _____ B. WING _____	05/20/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SUNRISE RETIREMENT COMMUNITY	5501 GORDON DRIVE EAST SIOUX CITY, IA 51106

(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 757	Continued From page 16 d. 2/18/21 at 5:23 PM, Vitamin K 2.5 mg given orally e. INR result 6.9 The Clinical record lacked documentation of an INR completed on 2/12/21 per the physician order, resulting in Resident #50's transfer to the local hospital on 2/18/21 due to a critical INR value. On 5/18/21 at 12:44 PM, Staff H Registered Nurse (RN) Unit Manager confirmed staff should have tested Resident #50's INR on 2/12/21. Following staff failure to complete the INR test, the facility attempted to setup a new process with warfarin orders due to medication errors occurring. Staff H stated when the nurse puts an order into the electronic health record, they are to put a stop date the day before the INR is due to alert the staff. On 5/19/21 at 9:59 AM, Staff H RN Unit Manager stated she did not work at the facility on 2/17/21, when staff checked Resident #50's INR and did not know if staff noticed the INR test not completed. Staff H stated she thought the resident felt extra fatigued and maybe the staff thought to check the INR because of that. Staff H stated when staff checked the INR on 2/17/21, she did not think the resident showed any signs of bleeding. Staff H stated 8 residents in the facility required INR's due to taking warfarin. Staff H stated she did not know of any other missed INRs. Staff H identified the system in place prior to the missed INR: Staff placed orders received for labs on the lab calendar in the nurse's station. Staff H stated the facility performed lab draws on Resident #50, due to him in isolation. Staff H stated the facility had an INR machine and they	F 757		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	165473	A. BUILDING _____ B. WING _____	05/20/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SUNRISE RETIREMENT COMMUNITY	5501 GORDON DRIVE EAST SIOUX CITY, IA 51106

(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 757	Continued From page 17	F 757		

performed INRs in house, however, unsure if staff used the INR machine on 2/12/21, when they missed Resident #50's INR. Staff H identified Resident #50's INR as on the lab calendar for 2/12/21. Staff H identified the nurse on duty as responsible to check the lab calendar for labs due that day. Staff H revealed the system in place now: when the facility receives an order for warfarin and INR, the nurse implements a stop date on the warfarin, to alert the nurse for the need for an INR to continue the warfarin. Staff H stated the nurse continues to place the INR on the lab calendar and updates the resident INR flowsheet. Staff H stated approximately 2-3 weeks ago, they implemented an INR binder with INR flowsheets for each resident. Staff H stated the INR flowsheet contained date, current dose, result of INR, who they notified, and when new orders received, what new dose was and who gave the orders. Staff H identified a process alert change put out for the nurses and education provided.

On 5/19/21 at 10:55 AM the Director of Nursing (DON) stated she did not remember if she checked the resident's INR on 2/17/21, however, stated if she charted it then she checked it. The DON stated the floor nurse called her and informed her Resident #50 needed an INR tested on 2/17/21. The DON stated she did not know Resident #50, did not have an INR completed on 2/12/21 as ordered. The DON stated the floor nurses called her with any labs that required completion. The DON stated the facility used their own INR machine since January 2021. The DON stated she did not know if Resident #50 exhibited any symptoms of bleeding on 2/17/21 when the INR read high. The DON stated the facility implemented yellow INR binders, with INR

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	165473	A. BUILDING _____ B. WING _____	05/20/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SUNRISE RETIREMENT COMMUNITY	5501 GORDON DRIVE EAST SIOUX CITY, IA 51106

(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 757	Continued From page 18	F 757		

flowsheets for each resident on 4/20/21/or 4/21/21 with all residents requiring warfarin and INR testing so she could audit completed INRs. The DON did not know of any other residents that missed INRs or other residents that required ER visits related to elevated INRs. The DON stated when a resident transfers to the hospital, the nurse on duty print off face sheet, medication sheet, bed hold, and advanced directives. The DON stated a progress should would contain pertinent information including labs and vitals and staff sent it with the resident. The DON stated the nurse on duty calls ER and gives a verbal report.

On 5/19/21 at 2:25 PM Staff I RN stated she changed Resident #50's dressing to his fistula site 2/18/21, and remembered the area oozed blood and Staff I applied a new dressing to the area. The RN stated she removed the dressing on 2/17/21 and the area did not contain a lot of blood.. Staff I stated she did not know why Resident #50's INR completed on 2/17/21. Staff I stated she attempted to check the INR on 2/17/21, but had difficulty with the machine to read and used several test strips before she called the DON to assist. Staff I stated she did not remember the resident with a bloody nose when he transferred to the ER on 2/18/21.

On 5/19/21 at 2:20 PM, the business office manager (BOM) who communicated with Resident #50's PCP identified the PCP stated the resident missing the 2/12/21 INR as potentially life threatening. The PCP identified to the BOM that the ER visit on 2/18/21 as unavoidable due to the resident requiring Vitamin K. The PCP could not answer if the ER visit unavoidable if the facility checked the INR as ordered on 2/12/21, due to not knowing the INR value on that date.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	165473	A. BUILDING _____ B. WING _____	05/20/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SUNRISE RETIREMENT COMMUNITY	5501 GORDON DRIVE EAST SIOUX CITY, IA 51106

(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 757	Continued From page 19	F 757		

On 5/19/21 at 2:20 PM, the BOM who communicated with the doctor on call on 2/18/21 that gave the facility the order to transfer Resident #50 to the local hospital, revealed he agreed with the resident's PCP statement regarding the missed the INR.

On 5/19/21 at 2:42 PM, Staff J Certified Nursing Assistant (CNA) identified self as no longer an employee at the facility, however, confirmed she cared for Resident #50 in February 2021. The CNA stated she remembered Resident #50 with bloody noses, however, did not remember the date. The CNA stated she did know the resident had bleeding issues.

On 5/19/21 at 2:52 PM, Staff K CNA identified self as a former employee at the facility, however, confirmed she worked with Resident #50 in February 2021. The CNA stated someone told her the resident transferred to the local hospital on 2/18/21, due to bleeding. The CNA stated she thought the resident's weakness from dialysis treatment and did not witness bleeding.

On 5/19/21 at 2:55 PM, the DON stated she did not recall Resident #50 with bleeding prior to transfer to the ER on 2/18/21. The DON stated facility staff would have informed her if the resident exhibited bleeding. The DON stated the charge nurse would have called the hospital with a verbal report when the resident transferred on 2/18/21. The DON identified the facility uses and has transfer sheet available, however, staff does not always complete the form.

On 5/19/21 at 3:12 PM, Staff L RN confirmed she worked 2:00 PM - 10:00 PM on 2/18/21, however,

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	165473	A. BUILDING _____ B. WING _____	05/20/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SUNRISE RETIREMENT COMMUNITY	5501 GORDON DRIVE EAST SIOUX CITY, IA 51106

(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 757	Continued From page 20 Resident #50 already transferred to the hospital when she arrived at work. The RN stated she did not know of the resident having bleeding issues. On 5/19/21 at 3:15 PM, Staff I RN stated the DON requested she check Resident #50's dressing at the fistula site. Staff I stated when she removed the dressing, the area oozed blood, however, identified the bleeding as "not excessive amount". Staff I stated she cleaned the area and applied a new dressing. Staff I stated she did not know of the resident having a nose bleed. Staff I stated when the resident returned from dialysis on 2/17/21, he appeared fatigued, gray in color and did not act like himself. Staff I stated INR was checked at the time due to the resident not feeling well. On 5/19/21 at 3:57 PM, observation showed Resident #50 resting in his recliner with feet elevated, well groomed, and non-skid footwear on. Resident #50's left forearm contained a white dressing, no bleeding noted on dressing. Resident #50 stated when he went to the ER the last time his fistula site had increased bleeding. The resident identified his INR as 8 and he received Vitamin K in the ER. The resident stated when he returned to the facility he received Vitamin K for a couple of more days. The resident stated he did not remember if his nose bled at that time. On 5/20/21 at 9:13 AM the DON stated she expected staff to complete INRs as ordered and she expected staff to complete the INR test on 2/12/21, as ordered.	F 757		
F 758 SS=D	Free from Unnec Psychotropic Meds/PRN Use CFR(s): 483.45(c)(3)(e)(1)-(5)	F 758		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	165473	A. BUILDING _____ B. WING _____	05/20/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SUNRISE RETIREMENT COMMUNITY	5501 GORDON DRIVE EAST SIOUX CITY, IA 51106

(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 758	Continued From page 21	F 758		

§483.45(e) Psychotropic Drugs.
§483.45(c)(3) A psychotropic drug is any drug that affects brain activities associated with mental processes and behavior. These drugs include, but are not limited to, drugs in the following categories:
(i) Anti-psychotic;
(ii) Anti-depressant;
(iii) Anti-anxiety; and
(iv) Hypnotic

Based on a comprehensive assessment of a resident, the facility must ensure that---

§483.45(e)(1) Residents who have not used psychotropic drugs are not given these drugs unless the medication is necessary to treat a specific condition as diagnosed and documented in the clinical record;

§483.45(e)(2) Residents who use psychotropic drugs receive gradual dose reductions, and behavioral interventions, unless clinically contraindicated, in an effort to discontinue these drugs;

§483.45(e)(3) Residents do not receive psychotropic drugs pursuant to a PRN order unless that medication is necessary to treat a diagnosed specific condition that is documented in the clinical record; and

§483.45(e)(4) PRN orders for psychotropic drugs are limited to 14 days. Except as provided in §483.45(e)(5), if the attending physician or prescribing practitioner believes that it is appropriate for the PRN order to be extended

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	165473	A. BUILDING _____ B. WING _____	05/20/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SUNRISE RETIREMENT COMMUNITY	5501 GORDON DRIVE EAST SIOUX CITY, IA 51106

(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 758	Continued From page 22	F 758		

beyond 14 days, he or she should document their rationale in the resident's medical record and indicate the duration for the PRN order.

§483.45(e)(5) PRN orders for anti-psychotic drugs are limited to 14 days and cannot be renewed unless the attending physician or prescribing practitioner evaluates the resident for the appropriateness of that medication.
This REQUIREMENT is not met as evidenced by:
Based on record review and staff interview, the facility failed to assure they limited PRN (as needed) psychotropic drugs to 14 days unless the attending physician or prescribing practitioner identified it as appropriate to extend the PRN order for the drug beyond 14 days, and document the rationale in the resident's medical record and indicate the duration for the PRN order for 1 of 5 resident reviewed (Resident #5). The facility reported a census of 51 residents.

Findings include:

A Minimum Data Set (MDS) assessment, dated 2/18/21, revealed Resident #5 scored "10" on the Brief Interview for Mental Status (BIMS) indicating moderate cognitive impairment. The resident required extensive assistance with activities of daily living (ADL's) including bed mobility, transfer, locomotion, dressing, toilet use and personal hygiene. The resident's diagnoses included non-Alzheimer's dementia.

A Care Plan dated 2/25/2021 included information that the resident received a scheduled antianxiety medication, and directed staff to monitor for side effects of anti-anxiety medication such as: nausea, nervousness/restlessness, dizziness,

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	165473	A. BUILDING _____ B. WING _____	05/20/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SUNRISE RETIREMENT COMMUNITY	5501 GORDON DRIVE EAST SIOUX CITY, IA 51106

(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 758	Continued From page 23	F 758		

reduced sexual drive, drowsiness, insomnia, weight gain/loss, and headache. On 2/8/21 the anti-anxiety medication increased due to increased anxiety in the afternoons and into the night.

The residents admission orders included a Physician Order Report with Lorazepam 0.5 mg 2 times a day PRN for feeling anxious in addition to scheduled dose, with a start date of 11/20/20, and open ended (no stop date).

A facsimile (fax) dated 1/4/21 notified the physician the resident experienced increased agitation after 2 PM. The resident had orders for Sertraline 100 mg and Lorazepam 0.5 mg daily and PRN available 2 times a day, with the PRN frequently used in the evenings. The physician responded by increasing the Sertraline and did not address the PRN Lorazepam.

A Physician Order Report for 4/1/21 to 5/31/21 included the order for Lorazepam 0.5 mg 2 times a day PRN for feeling anxious in addition to the scheduled dose, with a start date of 11/20/20, and open ended.

On 5/20/21 at 8:39 AM Staff E Unit Manager stated they did not have a rationale or duration for the PRN Lorazepam prior to yesterday.

The facility anti-Anxiety Policy reviewed 2/2020 directed the facility to evaluate the need for all PRN psychotropic drugs prescribed every 14 days unless the attending physician provided a rationale for use. The Prescriber could extend the duration of the medication but must provide documentation of rationale and duration.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	165473	A. BUILDING _____ B. WING _____	05/20/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SUNRISE RETIREMENT COMMUNITY	5501 GORDON DRIVE EAST SIOUX CITY, IA 51106

(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 803	Continued From page 24	F 803		
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- §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 observation, record review and staff interview, the facility failed to serve appropriate portions to 6 of 6 residents on a mechanical soft diet, and 6 of 6 residents on a pureed diet in one unite. The facility reported a census of 51 residents. Findings include:	F 803		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	165473	A. BUILDING _____ B. WING _____	05/20/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SUNRISE RETIREMENT COMMUNITY	5501 GORDON DRIVE EAST SIOUX CITY, IA 51106

(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 803	Continued From page 25	F 803		

The house mechanical soft diet for noon on 5/18/21 included 1 baked potato with margarine, with no skin. The pureed diet included 1 serving of pureed smoked pork chop with cherry sauce.

The Diet Roster printed 5/17/21 showed 6 residents on mechanical soft diets and 6 residents on pureed diets in the Bernstein unit.

On 5/18/21 at 7:54 AM Staff G Cook identified 6 residents on pureed diets in the Bernstein unit. At that time, observation showed Staff G wash her hands and apply gloves. Staff G then placed 8 pork chops and 8 slices buttered bread in the robot coupe. She added cherry sauce and water to the robot coupe and pureed. She measured the contents at 7 cups and by checking the chart stated each resident would need a #8 and a #10 scoop of the pureed pork. She portioned out 6 #8 scoops and 6 #10 scoops into a pan for the Bernstein unit.

Observation on 5/18/21 at 11:51 AM showed Staff A Dietary Aide begin serving the noon meal (on the Bernstein unit). Staff A served residents on mechanical soft diets 1/2 of a baked potato with the skin removed. She served 6 residents mechanical soft diets. Staff A served residents on a pureed diet 1 scoop of pureed pork. She served 6 residents the pureed pork.

On 5/18/21 at 12:23 PM Staff A finished the meal service. Staff A stated she used a #10 scoop to serve the pureed pork and confirmed the pan of pureed pork remained 1/2 full.

On 5/18/21 at 2 PM the Dietary Supervisor (DS) stated dietary personnel should check the menu

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	165473	A. BUILDING _____ B. WING _____	05/20/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SUNRISE RETIREMENT COMMUNITY	5501 GORDON DRIVE EAST SIOUX CITY, IA 51106

(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 803	Continued From page 26 in the kitchen for the scoop size needed for pureed foods. She said Staff A did not check. The residents on pureed diets should have received a #8 and a #10 scoop of the pureed pork. Residents did not receive the appropriate portion of pork and received too little. On 5/20/21 at 9:27 AM the DS revealed no residents in the Bernstein unit on small portions. All residents having baked potato should have received a whole potato. The facility Portion Control 2005 directed staff to provide residents appropriate portions of food as planned on the menu. Serving too small portions resulted in the residents not receiving the nutrients needed.	F 803		
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, 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	F 812		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	165473	A. BUILDING _____ B. WING _____	05/20/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SUNRISE RETIREMENT COMMUNITY	5501 GORDON DRIVE EAST SIOUX CITY, IA 51106

(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 812	Continued From page 27	F 812		

standards for food service safety.
This REQUIREMENT is not met as evidenced by:
Based on observation, record review and staff interview, the facility failed to prepare and serve food in accordance with professional standards for food service safety. The facility reported a census of 51 residents.

Findings include:

1. Observation on 5/17/21 at 12:05 PM showed Staff B Licensed Practical Nurse (LPN) wash his hands and put peanut butter on bread, handling the bread with bare hands. He left the area and obtained jelly, washed his hands and put the jelly on the bread, handling the bread with bare hands. He cut the sandwich and placed the sandwich on a plate with bare hands and served it to Resident #39.

2. Observation on 5/18/21 at 7:54 AM showed Staff G Cook wash her hands apply gloves. Staff G placed 8 pork chops in the robot coupe. She changed gloves without hand washing, buttered 8 slices of bread, placed them in the robot coupe, and removed the gloves without handwashing. She added cherry sauce and water to the robot coupe and pureed. She measured the contents. She portioned out 6 #8 scoops and 6 #10 scoops into a pan for the Bernstein unit. She put on gloves and prepared 2 additional pork chops, changed gloves without washing her hands and added bread. She placed 8 stuffed peppers into a cleaned robot coupe, put on gloves without washing hands and placed butter on 8 slices of bread and then into the robot coupe. She removed gloves without washing her hands and poured tomato juice into the robot coupe and

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	165473	A. BUILDING _____ B. WING _____	05/20/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SUNRISE RETIREMENT COMMUNITY	5501 GORDON DRIVE EAST SIOUX CITY, IA 51106

(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 812	Continued From page 28 pureed. She measured the contents and stated residents on pureed diet would receive a #8 and #10 scoop of pureed stuffed peppers. Staff G washed her hands before preparing additional stuffed peppers. On 5/18/21 at 2 PM the Dietary Supervisor (DS) said staff should wash their hands before putting on gloves, when gloves are changed, and when gloves are removed. Staff should not use bare hand contact with food that would be served to residents. The facility policy Handwashing 2005 documented the procedure included washing hands before donning gloves for working with food. The policy updated 6/15/09 Use of Plastic Gloves documented staff should wear plastic gloves when handling food directly with hands to ensure bacteria not transferred from the food handler's hands to the food product being served. Staff should wash hands when entering the kitchen and before applying plastic gloves, and after removing gloves.	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	F 880		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	165473	A. BUILDING _____ B. WING _____	05/20/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SUNRISE RETIREMENT COMMUNITY	5501 GORDON DRIVE EAST SIOUX CITY, IA 51106

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 880	Continued From page 29	F 880		

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

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

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	165473	A. BUILDING _____ B. WING _____	05/20/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SUNRISE RETIREMENT COMMUNITY	5501 GORDON DRIVE EAST SIOUX CITY, IA 51106

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 880	Continued From page 30	F 880		

contact will transmit the disease; and
(vi)The hand hygiene procedures to be followed by staff involved in direct resident contact.

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

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

§483.80(f) Annual review.
The facility will conduct an annual review of its IPCP and update their program, as necessary.
This REQUIREMENT is not met as evidenced by:
Based on record review, observation, staff interview, and policy review, the facility failed to provide appropriate infection control practices during personal care for 1 of 6 residents observed (Resident #34), handling linen during wound care for 1 resident of 3 residents observed (Resident 5), and for 2 residents observed during medication administration (Residents #13 and #30). The facility reported a census of 51 residents.

Findings include:

1. The Minimum Data Set Assessment (MDS) dated 11/25/20, documented Resident #34 with short term memory impairment, moderately impaired cognitive skills for daily decision making, required extensive assistance with toileting and personal hygiene, and always incontinent of bowel and bladder. The MDS revealed the resident's diagnoses included: renal insufficiency,

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	165473	A. BUILDING _____ B. WING _____	05/20/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SUNRISE RETIREMENT COMMUNITY	5501 GORDON DRIVE EAST SIOUX CITY, IA 51106

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 880	Continued From page 31	F 880		

non-Alzheimer's Dementia, and stage 4 chronic kidney disease.

The resident's care plan, with most recent update on 1/31/21, revealed the resident with a history of urinary tract infections and dementia. Interventions revealed the resident wore incontinence briefs and directed staff to check and change the resident every 2 to 3 hours and when needed and to apply Tena cream to prevent skin breakdown.

Observation on 05/18/21 at 12:17 p.m., showed Staff N, CNA (Certified Nursing Assistant) and Staff O, LPN (Licensed Practical Nurse) used a full body lift and transferred Resident #34 from a wheel chair to bed. Staff N provided incontinence care and identified the resident as incontinent of bowel and bladder. Staff N used folded wash cloths and provided anterior incontinence care in an appropriate manner. Staff turned the resident to her side and used several folded wash cloths to provide incontinence care in an appropriate manner for a large amount of soft stool until the resident clean. Staff N failed to change gloves, patted the resident dry with clean wash cloths, placed a clean brief under the resident's buttocks, removed her gloves, and secured the brief tabs before sanitizing her hands.

On 5/19/21 at 4:30 p.m., the Applewood Unit Manager verified Staff N needed to remove gloves and wash hands or sanitize after completion of bowel incontinence before the clean brief applied.

The facility procedure, Hand Hygiene Techniques, dated 5/2018, directed staff to remove gloves when hand contamination activities completed

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	165473	A. BUILDING _____ B. WING _____	05/20/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SUNRISE RETIREMENT COMMUNITY	5501 GORDON DRIVE EAST SIOUX CITY, IA 51106

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 880	Continued From page 32	F 880		

and when moving from one procedure to another during cares and to wash hands after glove removal.

2. A 5/1/21 to 5/31/21 Medications Flowsheet documented Resident #13 received Calcitonin (salmon) non aerosol nasal spray (used to slow down bone loss due to osteoporosis), 200 units, 1 spray daily.

Observation of the resident's medication administration on 5/18/21 at 10:00 a.m., revealed Staff M, LPN (Licensed Practical Nurse) dropped the Calcitonin box on the floor while preparing medication for administration. Staff M picked the box up and placed the box in the resident's medication storage cabinet without sanitizing the box. Staff M placed the Calcitonin bottle into the box after administered to the resident.

On 5/20/21 at 8:50 a.m., the DON (Director of Nursing) stated since the Calcitonin box fell on the floor, staff member needed to obtain a plastic bag to store the Calcitonin bottle since a box can not be sanitized.

3. A 5/1/21 to 5/31/21 Medications Flowsheet documented Resident #30 received Systane eye drops (used to treat dry eyes), one drop to each eye 3 times daily.

Observation showed on 5/19/21 at 9:10 a.m., Staff D, LPN remove the Systane eye drops from a plastic bag, place the plastic bag on the resident's bedspread without a barrier underneath, and administered the Systane eye drops. Staff D placed the Systane bottle into the same bag and placed the bag into the medication cart.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	165473	A. BUILDING _____ B. WING _____	05/20/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SUNRISE RETIREMENT COMMUNITY	5501 GORDON DRIVE EAST SIOUX CITY, IA 51106

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 880	Continued From page 33	F 880		

On 5/19/21 at 8:50 a.m. the DON stated staff should have replaced the plastic bag with a clean bag before storing the Systane in the medication cart.

4. A Minimum Data Set (MDS) assessment, dated 2/18/21, revealed Resident #5 scored 10 on the Brief Interview for Mental Status indicating moderate cognitive impairment. The resident required extensive assistance with activities of daily living (ADL's) including bed mobility, transfer, locomotion, dressing, toilet use and personal hygiene. The resident's diagnoses included non-Alzheimer's dementia.

a. Observation revealed on 5/19/21 at 9:21 AM Staff C Certified Nursing Assistant (CNA) enter the resident's room to get the resident on the bath chair. Staff C called for the nurse because the resident refused a bath. Staff C threw the resident's pajamas on the floor and removed the sheets from the bed. She picked the pajamas up from the floor and the sheets from the bed and held them up against her uniform as she exited the room.

b. Observation showed on 5/19/21 at 9:21 AM Staff D Licensed Practical Nurse (LPN) enter the resident room with dressing/treatment supplies and place them on the resident's dresser without a barrier. She then placed some items directly on the floor, 2 rolls of tape, 2 paper measuring devices, and a plastic medicine cup with what she identified as Vaseline. She put barriers with gauze on them on the floor as well. She used one of the barriers under the resident's foot. She removed the dressing (from the left heel) that appeared dark brown, indicating she thought from Betadine (antiseptic). She picked up one of the

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	165473	A. BUILDING _____ B. WING _____	05/20/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SUNRISE RETIREMENT COMMUNITY	5501 GORDON DRIVE EAST SIOUX CITY, IA 51106

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 880	Continued From page 34	F 880		

measuring tapes from the floor and measured the wound. The area to the medial left heel measured 1.2 by 0.8 centimeters (cm) and appeared white. Staff D walked over to the sink and soaked a 2 by 2 guaze with Betadine and applied it to the ulcer, covered it with a 4 by 4 gauze , picked up the tape from the floor and applied pieces of tape over the 4 by 4 gauze. She removed her gloves, opened a drawer of the resident's dresser and obtained clean socks, put them on the resident and then washed her hands. She donned gloves, removed a dressing from the resident's chest revealing a dark area. She picked up the 2nd measuring device from the floor, and held it to her chest to measure the area at 1 by 0.7 cm. She applied the Vaseline (from the med cup on the floor) and covered the area. After handling the items from the floor, she handled both the bottle of Betadine and the plastic bag it came in. After taking the resident out of the room, she returned and placed the Betadine in the med cart.

On 5/19/21 at 2:15 PM the Director of Nursing (DON) stated staff should not hold linen against their uniforms, or place treatment/dressing supplies on the floor.

The policy Infection Control-Linen Handling dated 7/2020 included directives that soiled linen should not come in contact with the floor or furniture, and do not hold linens against clothing when transporting.