STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	165171	A. BUILDING _____ B. WING KK on 10/11/15	C 09/16/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WILLOW GARDENS CARE CENTER	455 31ST STREET MARION, IA 52302

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PREGEDED 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 10/3/13 The following deficiencies relate to the investigation of complaint #44919 & #45144 and incident #45213. (See code of Federal Regulations (45 CFR) Part 483, Subpart B-C).	F 000		
F 226 SS=D	483.13(c) DEVELOP/IMPLMENT ABUSE/NEGLECT, ETC POLICIES The facility must develop and implement written policies and procedures that prohibit mistreatment, neglect, and abuse of residents and misappropriation of resident property. ✓ KK 10/11/15 This REQUIREMENT is not met as evidenced by: Based on observation, clinical record review and staff interviews, the facility failed to report a possible resident to resident abuse to the department as policy directed. (Resident #9 & #11) The facility reported a census of 69 residents. Findings include: The facility Abuse Prevention and Reporting Policy undated included: It is the policy of Willow Gardens Care Center to protect its residents from mistreatment, neglect, abuse and misappropriation of resident property and that all allegations of abuse will be reported and investigated. Sexual Abuse is defined as but not limited to sexual harassment, sexual coercion or sexual	F 226	Please See Attached.	10/2/2013

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Mike GC	Administrator	10/15/2013

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 226	Continued From page 1 assault. As an employee of a nursing facility, you are a mandatory reporter and as such, you are to make an immediate report of suspected dependent adult abuse to the Department of Inspections and Appeals as well as the person in charge at the time. Supervisory staff to identify inappropriate behaviors. 1. During interview on 9/9/2013 at 11:15 a.m., the Administrator reported Staff N, certified nurse aide, CNA first observed Resident #9 inappropriately touch Resident #11, and reported it to Staff O, licensed practical nurse, LPN on 7/4/13. Staff O indicated he/she reported the observation to Staff K, registered nurse, RN, but Staff K failed to recall the report. On 8/25/2013, Staff N observed Resident #9 kiss Resident #10 on the lips. Staff provided 15 minute checks of Resident #9 until his/her discharge from the facility. The administrator reported all staff received education regarding the reporting of alleged abuse. During interview on 9/5/2013 at 11:50 a.m., Staff N, CNA reported on 7/4/13, during the day shift, he/she entered the resident's lounge and observed Resident #9 standing near Resident #11's wheel chair, cupping and rubbing the residents right breast and rubbing the resident's arm. Staff N said "excuse me" and Resident #9 told Resident #11 he/she would see them later, as if Resident #11 could respond. Staff N reported the observation to Resident #9's charge nurse, Staff O, LPN and they put Resident #11 in bed. On 8/25/13 Staff N observed Resident #9 kiss and embrace Resident #10 mutually. Staff N coughed loudly to get their attention and the	F 226		

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F 226	Continued From page 2 residents separated. Staff N wrote a statement to the administrator and reported it to the charge nurse. During interview on 9/5/2013 at 12:01 p.m., Staff O, LPN reported on 7/4/13 Staff N reported observing Resident #9 touching Resident #11 inappropriately. Staff O told Resident #9 he/she "couldn't do that" as the resident walked past the nurse's station, and reported it to Staff K. During interview on 9/5/13 at 11:15 a.m., Staff M, Social Services reported Resident #9 liked to help the residents, they educated the resident about relationships with cognitively impaired residents, and behaviors that included hand holding and kissing. On July 4th the resident touched Resident #11 inappropriately on the breast, and stated he/she attempted to get a reaction from the resident. The administrator read Resident #9's progress notes on approximately 8/22/13, and they followed up with an investigation and reports to physicians and families. On July 4, Staff O, LPN failed to report the observation to supervisors. During interview on 9/5/13 at 12:45 p.m., Staff K, RN indicated staff failed to report the inappropriate behaviors observed on July 4. Staff K had prior observation of Resident #9 holding hands with other residents and nothing more. On 8/25/13 staff reported observing Resident #9 and #11 kissing, and Staff K reported it to the administrator and director of nursing, DON and made frequent observations of the residents. Since then they educated staff regarding the reporting of potential abuse. During interview on 9/9/13 at 12:00 p.m., Staff P,	F 226		

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F 226	Continued From page 3 CNA reported previously observing Resident #9 with his/her hand on Resident #11's thigh and Resident #9 kissed Resident #11 on the cheek. Staff P failed to report the observation until the administrator questioned him/her. a. The minimum data set (MDS) assessment dated 6/5/13, documented Resident #11 had severely impaired cognitive skills for daily decision making and long and short term memory impairment, rarely/never made self understood, and sometimes able to understand others. The resident required total staff assistance to dress, eat, and transfer from one surface to another with the use of a mechanical lift. The MDS indicated the resident had diagnoses including aphasia, unspecified intellectual disabilities, and muscle weakness. The Care Plan directed staff to provide supervision, cues and provide stimuli, calm resident if signs of distress develops, and observe for changes in condition that may effect cognition. Resident #11's progress notes failed to include an entry for 7/4/13. Observation on 9/5/13 at 10:00 a.m., revealed Resident #11 seated in a high back wheel chair with foot pedals. The resident failed to verbally respond to questions. b. The MDS assessment dated 8/7/13 revealed Resident #9 had moderately impaired cognitive skills for daily decision making, ambulated in the facility independently with supervision, oversight, encouragement or cues. The MDS revealed the	F 226		

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F 226	Continued From page 4 resident had diagnoses including stroke, dementia and depression. The Care Plan with last care plan conference dated 8/27/13 indicated Resident #9 had a problem initiated 11/10/2010: potential for problems with behavior related to history of resident becoming involved with female residents snd refusing to stop behavior when educated. Long Term Goal: resident will not overstep boundaries with female residents. It directed staff to use approaches including redirect resident if inappropriate with female residents, supervise resident in facility as needed, allow resident to make as many decisions as is practical related to care. Resident #9's Nurse Progress Notes documented on 7/4/13 at 9:15 a.m., Staff documented the resident was seen by staff fondling, rubbing a confused resident's breast. When staff explained to Resident #9 the behavior was inappropriate, he/she walked away.	F 226		
F 281 SS=D	483.20(k)(3)(i) SERVICES PROVIDED MEET PROFESSIONAL STANDARDS The services provided or arranged by the facility must meet professional standards of quality. This REQUIREMENT is not met as evidenced by: Based on observation, staff and family interview, the facility failed to follow physician orders for one of eleven residents reviewed. (Resident #7). The facility census was Findings include:	F 281		

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1. The Minimum Data Set (MDS) assessment dated 8/20/13, revealed Resident #7 had moderately impaired cognitive skills for daily decision making, required extensive assistance of one staff to transfer from one surface to another, use the toilet and ambulate in the room. The MDS indicated the resident had diagnoses including anemia, hypertension, diabetes, altered mental status, gastrointestinal hemorrhage, difficulty in walking, muscle weakness, and symptoms of lack of coordination.

The Physician Order Report dated 8/26/13 included knee sleeve on right knee to be used as patient transfers or is ambulating, not needed when patient is resting.

Nurse notes on 8/27/13, documented the facility received facsimiles from the physician with several new orders including knee sleeve to right knee to be used during transfers and ambulation.

Observation on 9/4/13 at 10:50 a.m., revealed Resident #7 in the wheel chair in the room. Observation revealed a sign from therapy in the room on the closet door directing staff to have resident wear right knee sleeve during all transfers. Observation revealed an empty knee sleeve box on the night stand near the resident's bed.

Observation at 12:15 p.m., revealed the resident seated in the room in the wheel chair without a right knee sleeve.

Staff I, certified nurse aide, CNA reported looking for the knee sleeve earlier that morning but failed to find it.

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F 281	Continued From page 6 During interview on 9/4/13 at 12:00 p.m., Resident #7's family member reported staff called asking if he/she took the knee sleeve home. The family member reported labeling the knee sleeve, the facility lost it and it had been missing a long time.	F 281		
F 309 SS=G	483.25 PROVIDE CARE/SERVICES FOR HIGHEST WELL BEING Each resident must receive and the facility must provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being, in accordance with the comprehensive assessment and plan of care. This REQUIREMENT is not met as evidenced by: Based on clinical record review, and staff and physician interviews, the facility failed to appropriately assess and provide intervention, and notify one resident's physician in a *timely* manner for a significant change in condition for one of eleven residents reviewed (Resident #2). The facility reported a census of 69 residents. Findings include: 1. According to the MDS (Minimum Data Set) dated 06/28/2013, Resident #2 had moderately impaired cognitive skills for daily decision making, usually hed the ability to make self understood and understand others. The resident required extensive assistance of one staff to transfer from one surface to another, used a wheel chair and	F 309		

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walker for locomotion. Resident #2 had diagnoses including Schizophrenia, atrial fibrillation, reflux disease, hypertension and peripheral vascular disease. The MDS also indicated the resident had no shortness of breath (dyspnea).

The Care Plan indicated the facility addressed Resident #2's problems including:
a. Infection related to respiratory infection with a start date of 07/18/2013 and directed staff to encourage fluids, provide medications and treatments as ordered and monitor condition and notify doctor of worsening symptoms.
b. Ineffective airway clearance related to accumulated lung secretions secondary to pneumonia, and directed staff to administer medications and monitor efficacy, auscultate breath sounds as needed, provide treatments including nebulizers/inhalers/oxygen as ordered and monitory efficacy, notify MD of resident illness and any changes in condition, and vital signs as ordered and pulse oximetry as ordered and as needed.
c. Other problems identified included required restorative nursing, potential for complications related to Barret's esophagus/GERD, bladder incontinence, anemia, antipsychotic medication use, potential for signs and symptoms of dehydration, impaired skin integrity, behavioral symptoms manifested by resisting cares at times, activities, at risk for fluid volume deficit, pain, need for assistance with activities of daily living, and short term memory loss.

Resident #2's Physician's Orders included the following:
a. 07/17/2013 - Tessalon capsule; 200 mg (milligrams), one oral three times a day at 8:00

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F 309	Continued From page 8 a.m., 5:00 p.m., and 8:00 p.m. for cough. And, one capsule three times a day as needed for cough. b. 07/01/2013 - Tussin DM liquid 5 ml (milliliters); two teaspoons as needed for cough four times s day. c. 07/17/2013 - Chest x-ray d. 07/18/2013 - Levaquin 500 mg daily for ten days (antibiotic). Repeat chest x-ray in two weeks. e. 08/02/2013 - No new orders following the repeat chest x-ray results on 08/01/2013. Chest X-ray results included: a. 07/18/2013: impression: Mild hazy right basilar density. In clinical context of cough, fever, elevated white blood count, or other signs of lung infection, findings would be compatible with pneumonia; otherwise etelectasis should be considered. Findings are new in comparison to prior study. Follow up chest x-ray suggested as clinically warranted. Mild Cardiomegaly, COPD (amphysematous changes), mild osteoporosis, mild degree of osteoarthritis. b. 08/01/2013: Impression: No radiographic evidence of acute cardiopulmonary disease, interval reeolution of right basilar hazy opacity. Right apical pleural thickening, unchanged, mild prominence of heart size, chronic obstructive pulmonary disease, mild osteoporosis and osteoarthritia. The Medication Administrstion Record included the following: a. On 08/01/2013, Staff A, LPN (Licensed Practical Nurse) administered prn (as needed) Tessalon capsule and Tussin DM syrup. The	F 309		

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F 309	Continued From page 9 record failed to identify time administered. b. On 08/01/2D13, Staff A administered scheduled medications including Tessalon capsule at 5 o'clock p.m. and 8 o'clock p.m. c. The July medication administration record revealed the resident received Levaquin 500 mg once a day from July 18,2013 through July 27, 2D13. The Psychiatric Physician's Progress Note dated 08/01/2013 reported Resident #2 had e hospitalization a couple of months prior related to dehydration. Resident #2's Progress Notes on 08/02/2013 included: a. 10:46 a.m. - Physician returned chest x-ray results, no new orders. b. 8:08 p.m. - Staff A noted resident coughing, resident had dry croupy cough without phlegm. Lung sounds clear throughout bilaterally, oxygan saturation (O 2 SAT) on room air at 91%. Repeatedly asked resident if he/she had pain. Resident would not or could not communicate needs to nurse. Resident alert and sitting on bed side. BP (blood pressure) 132/68, P (pulse) 80, R (Respiration) 22. Resident given Tussin DM 10 ml for cough at this time. c. 8:42 p.m. - Staff A noted resident continues to cough, sounding like e bark. No phlegm brought up, lung sounds claar throughout. Rasident does not communicate needs, waving arms through air stating "this is it" over and over. Trying to lay resident down and calm, head of bed up at 45 degrees. Apparent Tussin DM had no effective results. Given Tessalon capsule 200 mg. O 2 SAT 91% on room air. BP 148/70, P 80, R 22, Temp 97.7 degrees. d. 9:48 p.m. - Staff A noted no effective results	F 309		

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from Tessalon capsule. Resident continues bark like cough, though less frequent. Lying in bed with HOP up at 45 degrees and O 2 SAT on room air at 88%, respirations increasing to 24, no lung congestion and no phlegm. Temp 98.0 degrees.
e. 10:00 p.m. - Staff A documented resident had small emesis of pink liquid which may be Tussin DM. Resident barking cough continues, resident alert but not making sense with verbalization to staff. P 90, R 24, BP 140/72, O 2 SAT on room air at 81%.
f. 10:16 p.m. - Staff A documented resident experiencing extreme respiratory distress, shaking severely. BP 184/98, R 16, D 2 SAT on room air 80%. Resident unable to communicate needs. Nursing intervention to place resident on oxygen at 2 liters via nasal cannula, and call to the physician.
g. 10:30 p.m. - Staff A documented the on call physician called and ordered the resident transfer to the hospital.
h. 10:35 p.m.- Staff A documented a call to the ambulance for transport and notification of the DON (Director of Nursing).
I. 10:40 p.m.- Staff A documented a call to the hospital to provide information regarding transport of resident with extreme respiratory distress with O 2 SAT at 70% on room air with nursing intervention of O 2 at 2 liters bringing SAT up to 88%. Resident continues croupy/hoarse cough and hyperventilation. Staff faxed the resident's IPOST to the hospital (Iowa Physician's Orders for Scope of Treatment). On 04/12/2013 the resident requested CPR (Cardiopulmonary Resuscitation attempt) with limited additional interventions induding: Do Not use intubation or mechanical ventilation. Transfer to hospital if indicated, may include critical care.
j. 08/03/2013 at 5:10 a.m., the facility received

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F 309	Continued From page 11 notice the resident passed away. Hospital records revealed Resident #2 passed away at the hospital on 08/03/2013 at 4:07 a.m. The Discharge Summary dated 08/03/2013 included: Discharge Diagnoses included Respiratory failure, failure to thrive, Schizophrenia, and Cachexia. The History and Physical dated 08/03/2013 reported the facility notified the physician that Resident #2 had respiratory distress with a request to transfer to the emergency room for further evaluation. The emergency room staff intubated the resident due to respiratory distress and hypoxemia. The cause of death had been listed as cardiorespiratory failure and acute, chronic respiratory failure with hypoxemia and failure to thrive. Emergency Department notes included: At 10:00 p.m. patient vomited, possible aspiration. Blood glucose 223, patient became slowly unresponsive in ambulance, began bagging, patient has weak respiratory effort. Shortness of breath with gradual onset, duration of two hours, severe and constant, and worsening. Chronicity: New. Clinical impression: primary encounter diagnosis was aspiration pneumonia, and also pertinent diagnosis of respiratory failure. Chest X-ray 08/03/2013 at 1:37 a.m. - New dense consolidation is present in the left lung base, increased patchy airspace disease in the perihilar regions and upper lobes, possible small left pleural effusion, pulmonary vascular markings are poorly visualized, cardiac silhouette is poorly visualized. Impression: New dense pleural-parenchymal changes in the left lung base, increased patchy, bilateral perihilar and	F 309		

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F 309	Continued From page 12 upper lobe airspace disease. The facility Physician's Discharge Summary dated 08/30/2013 revealed Resident #2's final diagnosis "as above". The form revealed the admitting diagnoses included: rehabilitation, atrial flutter, muscle weakness, hypertension, anemia of chronic disease, esophagitis, Barrett's esophagus, peripheral vascular disease, hypothyroidism, chronic Schizophrenia, obsessive compulsive disorder, GERD, generalized pain. Expired at hospital on 08/03/2013. During a phone interview on 09/09/2013 at 3:20 p.m., Resident #2's primary physician reported he/she would have expected notification from facility staff when the resident's O 2 saturation level fell below 90%, especially after what the resident experienced a couple of months prior including hospitalization related to dehydration and renal failure. The physician felt the facility should have reacted, and stated "I would have thought they would have been all over that". The physician indicated when a resident starts saying things like "this is it" and "help me", they usually know, and usually know when they are dying. The resident really didn't have much of an underlying respiratory disease, they should have called. During an interview on 09/03/2013 at 2:20 p.m., Staff A reported Resident #2 had an acute respiratory episode with a bark like cough that began around 8 o'clock p.m. Staff A administered two prn [as needed] medications, raised the head of bed, but the coughing continued. When the night shift nurse arrived Staff A and Staff B, RN (Registered Nurse) checked on the resident again and started oxygen. When a resident's O 2 SAT fall below 90% they usually notify the	F 309		

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F 309	Continued From page 13	F 309		

physician since most doctors want it maintained at 90%. Staff C, RN came into the resident's room as well. The resident denied pain but stated "This is it". As soon as Staff B arrived, the resident declined and they decided to start oxygen and notify the physician. The resident's symptoms began around 8 o'clock p.m. On 09/09/2013 at 2:20 p.m. Staff A told the surveyor he/she should have notified the physician when the resident's O 2 SAT were at 88% at 9:48 p.m. according to the nurse's notes. Staff A indicated the two entries for prn [as needed] cough medicine entered on 08/01/2013 were actually given on 08/02/2013 with no times on the medication record.

During an interview on 09/03/2013 at 3:49 p.m., the DON revealed if Staff D did the resident assessment, he/she should have documented the assessment. Staff should have provided interventions for Resident #2 including cough and deep breathing with O 2 SAT at 88%, and if that fails to work, notify the physician. If O 2 SAT fall below 90%, staff need to provide interventions depending on the resident. The DON and Administrator interviewed staff regarding the resident's change in condition and death because some staff voiced concerns. When Staff A reported interventions provided and not documented. The administrator asked Staff A to enter the information in the nurse's notes identified with * (asterisk) as a late entry. The nurse's notes revealed Staff B made late entries including 10:15 p.m. and 10:35 p.m. documentation on 08/02/2013 in the computerized notes. The computerized charting fails to document the time nurse's actually enter the information.

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	165171	A. BUILDING _____ B. WING _____	C 09/16/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WILLOW GARDENS CARE CENTER	465 31ST STREET MARION, IA 52302

(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 309	Continued From page 14 During interviews on 09/03/2013 and 09/09/2013 the Administrator reported during the investigation he determined staff assisted the resident to bed around 7:00 p.m., and Staff A attended the resident's cough around 8:00 p.m. After that Staff D went into the resident's room to do a treatment on the resident's roommate and Staff E, CNA put the roommate to bed. Around shift change, Resident #2's coughing increased, had an emesis, and three nurses; Staff A, Staff B, and Staff D attended to the resident's needs, and Staff A notified the physician. With the chain of events that occurred, the assessment and interventions appeared appropriate. The DON heard from staff they had concerns, that's why they did the investigation. During an interview on 09/03/2013 at 2:33 p.m., Staff D, RN reported orienting at the facility 08/02/2013 on second shift with Staff A, LPN. At approximately 7:30 p.m. Staff D performed Resident #2's treatment and failed to note any unusual signs or symptoms. At approximately 8:00 - 8:30 p.m., an aide reported the resident experienced loud coughing. Staff D stayed busy providing resident treatments. A little before shift change, at approximataly 9:50 p.m., Staff D heard the cough from near the nurse's station. Staff F and Staff G, CNA's (Certified Nurse's Aides) asked Staff D to assess Resident #2. The resident appeared red and Staff D told Staff A the resident didn't appear "right". Staff D assessed the resident and found he/she had O 2 SAT in the low 70's. Staff D asked the night shift nurse, Staff B, to get oxygen and they administered O 2 via nasal cannula and raised the head of bed up. They asked the night shift supervisor to assist. Staff D assessed the resident's vital signs three times and monitored his/he oxygen saturation	F 309		

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WILLOW GARDENS CARE CENTER	455 31ST STREET MARION, IA 52302

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F 309	Continued From page 15	F 309		

levels. The resident communicated "help me". The cough changed to a bark like sound near shift change. Staff A reported he/she administered something for the cough and there was nothing more they could do for him/her. Staff D instructed Staff A to call the physician with O 2 SAT in the 70's, and dropped further into the 60's. With the oxygen the saturation levels increased to 80. Staff D reported he/she did not administer any cough syrup, and did not see Staff A administer any cough medicine. Staff D indicated he/she checked the resident's vitals and O 2 SATS three times, documented on paper and handed to Staff A to document in the nurse's Progress Notes.

During an interview by phone, Staff G, CNA reported working second shift on 08/02/2013. Resident #2 began coughing at the end of second shift. Staff G and Staff F heard the resident say "Please help me, can't breathe". That wasn't normal for the resident. Staff F asked Staff A to please send the resident to the hospital. Staff G observed Staff A administer cough syrup around 10 o'clock p.m. Staff G reported staff were very upset over the incident, and he/she quit working at the facility.

During an interview on 09/09/2013 at 9:45 a.m., Staff B, RN reported working from 6:00 p.m. on 08/02/2013 until 6:00 a.m. on 08/03/2013. Staff B went to Staff A at approximately 10 minutes after 10:00 p.m. to get report for the remainder of the night shift. Staff O was in Resident #2's room. Staff A told Staff B "I'll let you take over". Staff B told Staff A, "No, let's see what's going on". Resident #2 had Oxygen Saturation levels in the 60's. Staff B ran to get oxygen and told Staff A to call the physician. The aides working reported they told Staff A for a couple of hours the resident

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F 309	Continued From page 16	F 309		

needed something. The resident appeared clammy and had distressed breath sounds.

During an interview on 09/09/2013 at 10:00 a.m., Staff C, RN reported working the night shift on 08/02/2013. At 10:00 p.m. Staff C went to Resident #2's unit, heard about the low oxygen levels, and observed the resident with shortness of breath, awake, but not responsive and not talking. Staff A said the resident "was fine" and "just coughing".

During an interview on 09/04/2013 at 6:00 p.m., Staff F, CNA reported working the night shift on 08/02/2013. When Staff F arrived on the unit, he/she heard Resident #2 coughing. Staff F and Staff G did rounds at the change of shift. Staff G became upset and reported Resident #2 stated "help me", and continued to cough. Staff F told Staff A, he/she needed to assess the resident, that was not normal for the resident. Staff A stood in the hall and said the resident was " fine", had a normal x-ray yesterday, and that he/she had coughed for two hours. Staff F observed Staff D and asked him/her to assess the resident. Staff D assessed the resident and found the oxygen saturation level in the 60's. Staff B and Staff D put oxygen on the resident and it [O 2 level] did increase somewhat. Staff F observed Staff A administer cough syrup at approximately 10:00 p.m. Staff F reported being very upset over the incident.

During an interview on 09/03/2013 at 2:00 p.m. Staff H, CNA reported working second shift on 08/02/2013. Around 8 o'clock p.m. Resident #2 reported not feeling well, had coughing and wanted to speak to the nurse. Staff H reported it to Staff A.

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F 323 SS=G	483.25(h) FREE OF ACCIDENT HAZARDS/SUPERVISION/DEVICES The facility must ensure that the resident environment remains as free of accident hazards as is possible; and each resident receives adequate supervision and assistance devices to prevent accidents. This REQUIREMENT is not met as evidenced by: Based on clinical record review, staff and family interviews, the facility failed to plan for and direct nursing services to ensure Resident #7 received adequate supervision against hazards in the environment. Concerns were identified for one (1) of eleven (11) residents. The facility reported a census of 69 residents. Findings include: 1. The MDS (Minimum Data Set) dated 08/20/2013 revealed Resident #7 had moderetely impaired cognitive skills for daily decision making skills. The resident required extensive assistance of one staff to transfer from one surface to another, use the toilet and ambulate in the room. The MDS reported the resident's balance as not steady and only able to stabilized with staff assistance during transition and walking including moving from seated to standing, walking, turning around, moving on and off toilet, and during surface to surface transfer. The MDS indicated the resident had diagnoses including anemia, hypertension, diabetes, altered mental status, gastrointestinal hemorrhage, difficulty in walking, muscle weakness, and symptoms of lack of	F 323		

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F 323	Continued From page 18 coordination. The resident's Care Plan with last care conference dated 08/20/2013 included: 1. Problem: Resident unable to complete ADL care needs independently, related to weakness from UTI (urinary tract infection), arthritis, macular degeneration, contraction of fingers with a start date of 06/11/2013. 2. Problem: Potential for injury from falls related to weakness, macular degeneration, arthritis with a start date of 06/11/2013. 3. Altered visual function related to macular degeneration. 4. Potential for injury related to diagnosis of osteopenia. On 07/18/2013 the care plan added knee sleeve on to right knee during transfers or when ambulating. Not needed when resident was resting as resident will comply." On 06/11/2013 the care plan added fall risk assessment as needed, keep floors clean, dry, free of clutter, encourage and assist resident to wear well fitted shoes or nonskid socks when out of bed, keep frequently used items within easy reach, call light within reach, answer requests for assistance promptly, PT (Physical Therapy) consult as needed. On 06/22/2013 the care plan added, explain all care/procedures, maintain safe environment, avoid twisting motions when moving/positioning to avoid pathological fractures, provide assistive devices for safety, provide needed assistance with bed mobility, transfers, and ambulation. On 08/22/2013 the Care Plan added Resident #7 had bed and chair alarms. The August Physician's Order forms failed to include Resident #7's alarms.	F 323		

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F 323	Continued From page 19 The September Treatment flow sheet identified Resident #7 had a pressure alarm in the bed and chair on 08/26/2013, open ended. The Incident/Accident Report dated 08/22/2013 at 10:00 a.m. reported Resident #7 stood up from toilet and fell, alerted by resident's roommate, found lying on back with head against wall, without bumps, bleeding, lacerations noted. Staff re-educated. The Nurse's Notes dated 08/22/2013 at 10:15 a.m. revealed Resident #7 sustained a fall in the bathroom. Staff K found the resident on the floor with his/her head up against the wall. The resident denied pain until he/she attempted to straighten the legs, and then complained of right hip pain. Staff assessed the resident, notified physician and family and transferred the resident to the emergency room. The Nurse's Notes at 1:15 p.m. documented the resident admitted to the hospital with a right hip contusion and head injury. The Nurse's Notes on 08/26/2013 at 9:45 a.m. revealed the resident returned to the facility, and admitted to a skilled level of care with history of fall, weakness, alert and oriented to self and place. The resident stated "ouch" when extremities touched. According to the Nurse's Notes on 08/27/2013 the facility received faxes from physician with several new orders including knee sleeve to right knee to be used during transfers and ambulation. The Physician Discharge Summary signed 08/26/2013 included: Discharge Diagnoses: head injury, closed without LOC (loss of consciousness); hypertension, type	F 323		

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F 323	Continued From page 20 ll diabetes. Hospital Course: Closed head injury after a fall, CT head showed two small foci of hemorrhage within the left lateral ventricle, repeat head CT was done in 24 hours to assess for stability, showed slightly expansion of hematoma, but no active bleeding, neuro stable. The *Encounter* notes, Progress Notes dated 08/22/2013 revealed Resident #7 admitted to inpatient and discharged to the facility on 08/26/2013. During an interview on 09/04/2013 Resident #7's family member reported on 08/22/2013 the resident fell from the toilet. The resident had a brain bleed and spent the weekend in the hospital. Normally staff stayed with the resident while on the toilet. The resident had a GI (gastrointestinal) bleed in August and had been getting stronger. During an interview on 09/04/2013 at 4:00 p.m. the DON reported Resident #7 had a bed alarm at the time of the fall on 08/22/2013. The facility gave Staff I, CNA a verbal warning for leaving the resident alone on the toilet. The facility policy is that any resident with an alerm needs staff to remain at the toilet. During an interview on 09/09/2013 at 11:30 a.m., the Administrator reported Resident #7 had a bed alarm, the standard of care required staff to remain with the resident while on the toilet if they have any alarm, including a bed alarm. Staff I received a verbal warning for leaving the resident on the toilet. During an interview on 09/04/2013 at 5:00 p.m.,	F 323		

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F 323	Continued From page 21 Staff K, RN reported on 08/22/2013 Resident #7 fell from the toilet onto the bathroom floor. The resident's CNA, Staff I failed to remain in the resident's room after assisting to the toilet. The facility re-educated Staff I. According to the facility policy, when a resident has an alarm, staff are required to remain with them while on the toilet. The resident admitted to the hospital for 3-4 days with a minor brain bleed. On 09/09/2013 at 3:00 p.m. the surveyor called Staff I, who declined the interview at that time, but requested it later in the week. On 09/13/201 at 12:14 p.m. during an interview by phone, Staff I reported on 08/22/2013 he/she worked Resident #7's hall, and it was her first day off training. Staff I revealed he/she never worked on that hall alone and never assisted the resident to the toilet until that day. Staff I reported he/she assisted the resident to the toilet and instructed the resident to use the call light near the toilet when finished. The resident agreed. The resident at that time had a bed alarm only. Though Staff I received no instructions regarding resident alarms upon hire; from past experience he/she knew if a resident had a chair alarm they required supervision and were at risk for falls. After the resident fell on 08/22/2013, staff added a chair alarm. Staff I received re-training, and had been told that residents with bed alarms should also have chair alarms. Staff I had no knowledge of who checked alarms, and if he/she had questions regarding resident cares, he/she asked the nurse. The facility Fall Policy indicated the facility used alarms as a means of fall prevention, but failed to indicate that staff were to remain with residents with alarms while on the toilet.	F 323		

Preparation and/or execution of this plan of correction does not constitute admission or agreement by this provider of the facts alleged, or conclusion set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because it is required by the provisions of federal and/or state law. The plan of correction constitutes our credible allegation of compliance.

F-226 Abuse and Neglect Policies

For Resident #9, #10, #11 and similarly situated residents, the facility will develop and implement written policies and procedures that prohibit mistreatment, neglect and abuse of residents. Resident #11 was reported. Resident #9 and #10 were investigated by the Department of Health during survey. Resident #9 is no longer in the facility. Residents were reviewed for resident to resident altercations and no other residents were identified.

The facility's Abuse policy has been reviewed and revised to include Resident to Resident allegations of abuse. Staff was educated on the revised policy and reporting practices regarding possible resident to resident abuse on 8/22/13 and 9/26/13.

The Administrator, Social Service Director and/or Designee will complete random audits of documentation or reporting of resident to resident allegations weekly for 4 weeks, monthly for 3 months and quarterly for 2 quarters. Results of the audits will be reviewed at the Quality Assurance meetings for revisions as needed.

Compliance Date: October 3, 2013

F-281 Professional Services

For Resident #7 and similarly situated residents, the facility will provide services that meet professional standards of quality. Resident #7 is receiving cares as per physician orders. On 9/4/13, Resident #7's knee sleeve was discontinued by his/her primary physician during facility rounds due to ineffectiveness of the device to control resident knee discomfort.

Nursing staff has been re-educated on providing cares as per physician orders.

The Director of Nursing, RN Supervisor and/or Designee will complete random audits of physician orders weekly for 4 weeks, monthly for 3 months, then quarterly for 2 quarters. Results of the audits will be reviewed at the Quality Assurance meetings for revisions as needed.

Completion Date: October 3, 2013

F-309 Care and Services

For Resident #2 and similarly situated residents, the facility will provide the necessary care and services to attain or maintain the highest practicable physical, mental and psychosocial well-being in accordance with the comprehensive assessment and plan of care. Resident #2 is no longer in the facility. Residents with a significant change of condition have been assessed, interventions provided, physician notified and documentation completed.

Staff A is no longer employed at the facility. Licensed Nurses have been re-educated on physical assessments, providing nursing interventions, following physician orders, notifying the physician for a significant change of condition on 9/16/13 and 9/20/13, by the Director of Nursing. The Medical Director provided an education session for the nursing staff on 9/20/13, on assessment, providing interventions and notification. On 9/28/13 and 9/30/13, the Quality Assurance Nurse provided an education /training session including an education guide provided by the pharmacy services on "Improving Safety in LTC Facilities". This guide and discussion included assessments, interventions and notification. The licensed nurses have been educated to communicate with the Director of Nursing and/or RN Nursing Supervisor for residents with a significant change of condition to discuss interventions and notification if needed.

The Director of Nursing, RN Supervisor and/or Designee will complete audits 5 days a week for documentation of assessments, interventions and notification for significant change of condition for 2 weeks, weekly for 2 months, monthly for 3 months, then quarterly for 3 quarters. Results of the audits will be reviewed at the Quality Assurance meetings for revisions as needed.

Completion Date: October 3, 2013

F-323 Accident/Injury

For Resident #7 and similarly situated residents, the facility will ensure that the resident environment remains as free of accident hazards as is possible; and residents receive adequate supervision and assistance devices to prevent accidents. Resident #7 is receiving supervision for toileting and ADLs as per plan of care. Resident #7 is using fall prevention measures as per physician orders and plan of care. Residents will fall prevention alarms are receiving supervision while toileting. Residents with fall prevention devices have been checked and are being monitored for placement and function as per plan of care.

Licensed nurses and nursing staff has been re-educated on providing supervision while toileting for resident with fall prevention alarms in use. On 9/29/13, nursing staff and other disciplines were educated by the Administrator on responding to alarms. On 10/1/13, nursing staff was re-educated by the Director of Nursing on providing supervision, checking placement and function of fall prevention devices. On 9/30/13, and 10/1/13, nursing staff was provided additional

educatinn by the Quality Assurance nurse regarding providing supervisinn, assessing that fall interventinns are in place, nnt to leave the resident unattended if anxinus, and to use the call light to request additional assistance or supplies if needed.

The Director of Nursing, RN Supervisor and/or Designee will complete audits 5 days a week on staff nbservations of providing supervision and placement of fall prevention devices for 2 weeks, weekly for 2 months, monthly fnr 3 months, then quarterly for 3 quarters. Results of the audits will be reviewed at the Quality Assurance meetings for revisions as needed.

Completion Date: October 3, 2013

DEPARTMENT OF INSPECTIONS AND APPEALS

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	IA0847	A. BUILDING: _____ B. WING KKon 10/16/13	C 09/16/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WILLOW GARDENS CARE CENTER	455 31ST STREET MARION, IA 52302

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N 101	50.7(1) 481- 50.7 (10A,135C) Additional notification. 481-50.7 (10A,135C) Additional notification. The director or the director's designee shall be notified within 24 hours, or the next business day, by the most expeditious means available (I,II,III): 50.7(1) Of any accident causing major injury. a. "Major injury" shall be defined as any injury which: (1) Results in death; or (2) Requires admission to a higher level of care for treatment, other than for observation; or (3) Requires consultation with the attending physician, designee of the physician, or physician extender who determines, in writing on a form designated by the department, that an injury is a "major injury" based upon the circumstances of the accident, the previous functional ability of the resident, and the resident's prognosis. b. The following are not reportable accidents: (1) An ambulatory resident, as defined in rules 481-57.1(135C), 481-58.1(135C), and 481-63.1(135C), who falls when neither the facility nor its employees have culpability related to the fall, even if the resident sustains a major injury; or (2) Spontaneous fractures; or (3) Hairline fractures. This Statute is not met as evidenced by: Based on record review and staff interview, the facility failed to report to the Department of Inspections and Appeals (DIA) a fall experienced	N 101	Please See Attached	10/8/13

V KK 10/16/13

DIVISION OF HEALTH FACILITIES - STATE OF IOWA

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Mitch GC	Administrator	10/15/2013

DEPARTMENT OF INSPECTIONS AND APPEALS

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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N 101	Continued From page 1 by Resident #7 which resulted in hospitalization. The facility reported a census of 69 residents. Findings include: 1. The MDS (Minimum Data Set) dated 08/20/2013 revealed Resident #7 had moderately impaired cognitive skills for daily decision making. The resident required extensive assistance of one staff to transfer from one surface to another, use the toilet and ambulate in the room. The MDS indicated the resident had diagnoses including anemia, hypertension, diabetes, altered mental status, difficulty in walking, muscle weakness, and symptoms of lack of coordination. The resident's Care Plan with last care conference dated 08/20/2013 included: 1. Problem: Resident unable to complete ADL care needs independently related to weakness from UTI (urinary tract infection), arthritis, macular degeneration, contraction of fingers with a start date of 06/11/2013. On 06/11/2013 the care plan added fall risk assessment as needed, keep floors clean, dry, free of clutter, encourage and assist resident to wear well fitted shoes or nonskid socks when out of bed, keep frequently used items within easy reach, call light within reach, answer requests for assistance promptly, PT (Physical Therapy) consult as needed. On 06/22/2013 the care plan added, explain all care/procedures, maintain safe environment, avoid twisting motions when moving/positioning to avoid pathological fractures, provide assistive devices for safety, provide needed assistance with bed mobility, transfers, and ambulation. The Incident/Accident Report dated 08/22/2013 at 10:00 a.m. reported Resident #7 stood up from	N 101		

DEPARTMENT OF INSPECTIONS AND APPEALS

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WILLOW GARDENS CARE CENTER	455 31ST STREET MARION, IA 52302

(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) COMPLETE DATE
N 101	Continued From page 2 toilet and fell, alerted by resident's roommate, found lying on back with head against wall, without bumps, bleeding, lacerations noted. Staff re-educated. The Nurse's Notes dated 08/22/2013 at 10:15 a.m. revealed Resident #7 sustained a fall in the bathroom. Staff K found the resident on the floor with his/her head up against the wall. The resident denied pain until he/sha attempted to straighten the legs, and then complained of right hip pain. Staff assessed the resident, notified physician and family and transferred the resident to the emergency room. The Nurse's Notes at 1:15 p.m. documented the rasident admitted to the hospital with a right hip contusion and head injury. The Nurse's Notes on 08/26/2013 at 9:45 a.m. revealed the resident returned from the hospital to the facility, and admitted to skilled level of care. The Physician Discharge Summary signed 08/26/2013 included: Discharge Diagnoses: head injury, closed without LOC (loss of consciousness); hypertension, type II diabetes. Hospital Course: Closed head injury after a fall, CT head showed two small foci of hemorrhage within the left lateral ventricle, repeat head CT was done in 24 hours to assess for stability, showed slightly expansion of hematoma, but no active bleeding, neuro stable. During an interview on 09/09/2013 at 11:30 the Administrator revealed he/she reported major injuries to DIA, the physician failed to complete the major injury form, the facility over looked the incident and failed to report it.	N 101		

DEPARTMENT OF INSPECTIONS AND APPEALS

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	IA0847	A. BUILDING: _____ B. WING _____	C 09/16/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WILLDW GARDENS CARE CENTER	455 31ST STREET MARIDN, IA 52302

(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) COMPLETE DATE
N 101	Continued From page 3 During an interview on 09/04/2013 at 4:00 p.m. the DON reported Resident #7 had no fracture, therefore no major injury determination form, and therefore not reported to DIA, the resident just had a head injury. During the interview the DON determined the resident admitted to the hospital after the fall, and should have reported it.	N 101		

N 101 Additional Notification

Preparation and/or execution of this plan of correction does not constitute admission or agreement by this provider of the facts alleged, or conclusion set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because it is required by the provisions of federal and/or state law. The plan of correction constitutes our credible allegation of compliance.

Willow Gardens Care Center will meet additional notification requirement of any accident causing major injury for Resident #7 and similarly situated residents. Resident #7 was assessed and sent to the emergency room for an evaluation and treatment. Resident #7 returned to Willow Gardens in stable condition. The administrator and the director of nursing were educated on timely reporting to the Department of Inspections and Appeals on Major injury as defined in 481-50.7(1) (10A, 135C). The administrator and director of nursing were provided a reporting tree from department of inspections and appeals. The Quality Assurance nurse and/or designee will complete random audits to ensure compliance. The findings will be reviewed at Quality Assurance Meetings.

Compliance Date: 10/03/2013