STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	165265	A. BUILDING _____ B. WING RS 8-1-2014	C 06/19/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CARLISLE CENTER FOR WELLNESS AND REHAB	680 COLE STREET CARLISLE, IA 50047

(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 7/31/14 Complaints #48212-C, #48419-C, # 48600-C and # 48726-C were substantiated. Investigation of facility-reported incidents # 48623-I and # 48671-I resulted in deficiency. (See Code of Federal Regulations (42CFR) Part 483, Subpart B-C.)	F 000	Please see last pages for POC.	
F 155 SS=D	483.10(b)(4) RIGHT TO REFUSE; FORMULATE ADVANCE DIRECTIVES The resident has the right to refuse treatment, to refuse to participate in experimental research, and to formulate an advance directive as specified in paragraph (B) of this section. The facility must comply with the requirements specified in subpart I of part 489 of this chapter related to maintaining written policies and procedures regarding advance directives. These requirements include provisions to inform and provide written information to all adult residents concerning the right to accept or refuse medical or surgical treatment and, at the individual's option, formulate an advance directive. This includes a written description of the facility's policies to implement advance directives and applicable State law. This REQUIREMENT is not met as evidenced by:	F 155		

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

Administrator 7/31/14

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.

POC accepted 8/1/14 KS

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F 155	Continued From page 1 Based on review of clinical records, staff and family interviews the facility failed to honor a resident's right to refuse life sustaining measures when they began C.P.R. (cardio-pulmonary resuscitation) on one resident when the clinical record clearly revealed a D.N.R. (do not resuscitate) order. Concerns identified for 1 of 2 closed records sampled for review (Resident #9). The facility reported a census of 87 residents. Findings include: Review of the facility's policy and procedure, Resuscitation Guidelines (CPR and DNR) dated 4/7/14 noted Do Not Resuscitate Order (DNR) was an order issued by the resident's treating physician which directed, in the event of an acute cardiac respiratory; arrest, that no cardiopulmonary resuscitation measures would be initiated for crisis situation where there was no cardiac or respiratory arrest. The policy also noted if a resident or resident's legal representative communicated a revocation of a DNR order, a physician telephone order would be initiated for the status change and be faxed to the physician. In the situation of any resident who suffered cardiac or respiratory arrest, the resident's medical chart would be checked for code status. If a resident had elected a Full Code (CPR) status, CPR would be immediately started and a "911" emergency medical service would be called. Review of the Record of Admission report for Resident #9 revealed an original admission date of 8/5/13, with a DNR advance directive. A Durable Power of Attorney for Health Care Decisions report dated 12/10/10, found in the	F 155		

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F 155	Continued From page 2 resident's clinical record revealed Do Not Resuscitate as an additional provision and No Life Support if in a coma. A physician's document dated 6/19/13 indicated the neurologist found the resident had poor insight into his/her capabilities physically and mentally and the neurologist felt the resident was not able to make appropriate healthcare decisions. Social Service Admission Progress Note dated 3/4/14 indicated the resident remained DNR status. An Acknowledgement of Receipt Advance Directives/Medical Treatment Decisions indicated on 8/5/13 the resident/or legal representative chose Do Not Resuscitate. A CPR-No CPR Authorization report dated 8/5/13 and signed by a physician on 9/5/13 indicated the resident did not wish CPR under any circumstances. The physician accordingly instructed a No CPR order. A Mercy Clinics Geriatric Services report dated 4/28/14 assessed the resident as a 88-year-old resident, chronically debilitated secondary to multiple sclerosis (MS) and Parkinson's. The Active Problems included: acute conjunctivitis, acute upper respiratory infection, chronic pain, debility, dementia, depression, diabetes mellitus, diabetic peripheral neuropathy, multiple sclerosis and Parkinson's. The neurological exam revealed memory loss, difficulty walking, confusion, loss of strength and depression. The physical exam revealed impaired insight and impaired judgment, incoherent speech, disoriented to time, impaired	F 155		

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F 155	Continued From page 3 short term memory and impaired remote memory. Nurse's Notes for Resident #9 included the following: The first nurse's note since 4/30/14 at 3:00 p.m. dated 5/8/14 at 5:25 a.m. oxygen saturation 83%. Ibuprofen, and cough syrup given, and supplemental oxygen given at 2 L by nasal cannula. Non-productive cough, profuse sweating, and anxiety noted with expiratory wheezing/raspy cough at 5:20 a.m. The next entry dated 5/8/14 at 10:00 a.m. noted poor appetite, repositioned often, oxygen on, no cough, course lung sounds. 5/9/14 at 8:00 a.m. resident lethargic, low grade fever, states hurting all over, lung sounds left lobe decreased and adventitious. Right lobe clear. Resident SOB (short of breath) at rest. Oxygen level: 84%, oxygen applied at 2 L. Ibuprofen given. Moist cough. Call placed to physician office, new order received for chest x-rey. Call placed to resident's family member regarding change in condition and interventions. 5/9/14 at 10:00 a.m. chest x-ray results in and faxed to physician with current assessment. Resident responsive to physical and tectile. 5/9/14 at 12:00 noon, no improvement in status, in fact oxygen level 87%. Resident lethargic. Lung sound continues with decreased air movement. Moist cough. Short of breath at rest. Resident declines emergency room evaluation and treatment. Call placed to nurse practitioner with nurse's concern and current assessment. New order received for Rocephin and if condition continued to deteriorate, contact office. Call placed to resident's family regarding resident's condition and intervention taken. 5/9/14 at 5:50 p.m. resident currently in bed with eyes closed. Will report to oncoming nurse if	F 155		

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F 155	Continued From page 4 condition worsens send to emergency room per family (POA/power of attorney) request. The original copy/review of this resident's clinical record revealed no entry dated 5/9/14 at 5:55 p.m. Review and copy of the clinical record revealed an additional entry made for 5/9/14 at 5:55 p.m. made sometime after 6/1/14. 5/9/14 at 5:55 p.m. again nurse spoke with resident regarding emergency room evaluation and treatment and again the resident refused. Nurse placed call to family regarding nurse's concerns and DNR wishes. The next entry dated 5/9/14 at 10:30 p.m. noted the nurse went to help C.N.A. (certified nursing assistant) check and change the resident. Before entering the resident's bedroom, the C.N.A. stated the resident was not breathing. The nurse then went and called the physician on call of the change in condition. New order received to send the resident to the emergency room for evaluation. 5/9/14 at 10:35 p.m. nurse called ambulance for transfer to emergency room. 5/9/14 at 10:30 p.m. responsible party contacted and notified of intent to transfer. 5/9/14 at 10:50 p.m. ambulance arrived, no breath sounds upon entering room. Nurse instructed by ambulance attendants to call POA back and make sure no life saving efforts were wanted. At this time, nurse called responsible party. Responsible party requested attempt to stabilize resident. Compressions and breaths started (CPR) until parametric called it according to code status DNR. 5/9/14 at 10:30 p.m. another nurse, Staff BB documented an entry at a later date, periods of apnea, start/stop breathing with wet breath sounds, pulse 108, respirations 52, oxygen level 86%, pupils fixed and non-responsive. Non	F 155		

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F 155	Continued From page 5	F 155		

productive cough earlier in the evening. Gasping for breaths and periods of non-breathing. Resident DNR. Family requested compression per telephone. EMT (emergency medical technician) intubated patient. Both nurses provided compression to resident. Resident vomited and did not respond. Continued to intubate and compressions. Resident with no vital signs. EMT called time of death at 10:50 p.m. Family notified and arrived to visit with resident and have time to say goodbye. Family came by morning of 5/10/14 and get resident belongings. A late entry dated 5/11/14 at 1:30 p.m., Staff BB documented resident sitting up in bed on 5/9/14 at 10:35 p.m., pale in color, skin dusky, resident had difficulty breathing with chest congestion throughout both lung fields, heart sounds distant, oxygen 85%, nurse offered Ibuprofen and cough syrup, resident temperature 100.3, nurse informed resident that he/she may have to go to hospital, resident started to have more difficulty breathing at 10:30 p.m., this nurse summoned to resident room by another nurse, resident cyanotic and taking gasping breaths. Oxygen 84% and temperature 97.6. Heart rate 108. Resident had periods of stop/start breathing. Resident sitting at 45 degrees. Staff changed the resident's shirt and applied cool wash cloths to forehead. Resident not responding to staff. Mouth slightly open with raspy wet breathing. Resident's pupils non-responsive to light. This nurse stayed with resident in room and patted resident's chest, telling resident to continue to breathe. Resident continued periods of gasping breaths, lips cyanotic. Resident was sweating profusely with air conditioner on high. At 10:38 p.m. resident sighed one last breath and closed his/her eyes and stopped breathing altogether. Resident's family requested life-saving measures be started.

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F 155	Continued From page 6 This nurse and another nurse started chest compressions, followed by 2 breaths, 30 compressions to 2 breaths. This nurse and other nurse and EMT's continued to give chest compressions. EMT's checked for pulse and instructed nurses to stop chest compressions. EMT called time of death at approximately 10:50 p.m. A late entry written on 5/13/14 for 5/8/14 at 12:35 p.m. resident up to dining room table. Resident requested to lay back down in bed. Nurse instructed resident he/she could not lay flat in bed and instructed the resident it was not good for him/her. The nurse instructed the resident he/she needed to eat and he/she needed the head of his/her bed up. At 4:00 p.m. the nurse educated the resident on the importance of getting up for meals and asked the resident again if he/she would like to go to the hospital to be checked over. At 6:30 p.m. the nurse instructed the C.N.A. the resident needed to get up for the evening meal. When interviewed on 6/11/14 at 9:52 a.m. a licensed practical nurse, Staff AA stated she was routinely this resident's nurse. She had a couple days off and when she returned to work, four different staff members told her the resident had been ill since Monday [5/5/14]. The resident was very lethargic and leaning over. The resident was almost leaning over on his/her own lap. She had the staff lay the resident back down in bed. She informed the resident he/she needed to go to the hospital. She called the nurse practitioner. The resident's lung sounds were course throughout with very little movement, she started the resident on oxygen. The nurse practitioner ordered Levoquin at which time Staff AA informed the	F 155		

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F 155	Continued From page 7	F 155		

nurse practitioner the resident was beyond Levoquin and he/she needed an IM (intramuscular) antibiotic. She then called the resident's family member, power of attorney. She contacted the POA throughout her shift. The last time she called the POA was 5:55 p.m. She called the POA multiple times throughout her shift. The POA instructed her if the resident got any worse to send the resident to the hospital. From the beginning of her shift to the end of her shift, she felt the resident was going to die. She informed the resident that was all she could do for him/her. The resident could not breathe. The resident was struggling to breathe. His/her lungs were full. She reviewed his/her record and determined the resident was a DNR. She discussed the resident's DNR status with the POA. The POA wanted the DNR order to be honored. The POA asked the nurse why she was the first one to call and inform him/her of the resident's condition. The nurse stated at 8:00 a.m. that morning the resident had a low grade fever. She believed if the fever was below 100, she did not need to call the physician. She would just give Tylenol. Staff AA stated she called the POA prior to 8:00 a.m. at which time she informed the POA exactly what she had documented in the nurse's notes. She informed the POA she believed the resident needed an antibiotic. The POA asked her to keep in contact with him/her. Staff AA reported from 8:00 a.m. to noon, the resident's condition deteriorated. She called the POA and informed the POA she believed the resident's condition was grave. Staff AA stated she called the POA again at 5:55 p.m. Staff AA stated she was on the phone with the POA when the next nurse came on duty at 6:00 p.m. The POA informed her the resident wanted to be with his/her spouse. The POA stated if the

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F 155	Continued From page 8 resident got to where he/she was not comfortable, the POA wanted the resident sent to the hospital. When interviewed on 6/3/14 at 2:02 p.m. the resident's family member/POA stated the facility staff had not informed him/her that the resident had been ill. Staff AA called him/her and stated the resident began on an antibiotic. This was the first time he/she was informed of any change in the resident. The resident had a history of taking antibiotics due to respiratory issues, so the POA did not think anything about it. The staff did not tell him/her of any fever or distress. The next thing he/she knew the facility called about 10:30 p.m. the nurse stated they had the resident as a DNR and asked if that was still his/her desire. The POA asked the staff to stabilize the resident until he/she arrived. The staff did not say the resident had ceased breathing and had no heartbeat. The POA stated the resident had a DNR and the POA did not wish to change the order. The POA voiced dissatisfaction due to the staff failed to call him/her earlier and failed to inform him/her of the resident's decline in condition and the resident had died. The POA stated had the staff called him/her earlier and reported the resident's actual change in condition, the POA could have come to the facility and seen the resident prior to the resident's death and the POA could have asked for the resident to be transfer to the hospital earlier and received a greater level of care during the resident's physical decline. The POA stated the facility normally called him/her with changes in the resident ' s condition. The POA last saw the resident on 5/1/14. The POA was totally unaware of any change in the resident's condition from 5/1/14 through 5/9/14. The POA would have expected a	F 155		

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

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F 155	Continued From page 9	F 155		

call and updste on the resident at the first sign of a change in condition. The POA stated had the facility informed him/her earlier of the resident's decline in condition the POA and family members could have come to the facility, visited the resident and participated in the decisions regarding seeking hospitalization to ensure care and comfort. The resident desired DNR status and no one ever asked him/her if they wanted to change the resident's DNR status, no one informed him/her the resident had died, and no one asked him/her if they wanted CPR or life saving measures. The POA was under the impression the resident was alive and preparing to go to the hospital by ambulance, and the POA only asked the staff to stabilize the resident until he/she arrived. Had the POA known the resident was dead, he/she would have asked the staff to honor the resident's DNR status.

Review of the phone records for the resident's POA revealed the POA first received a phone call from the facility on 5/9/14 at 2:09 p.m. and the call lasted less than 2 minutes. The next phone call from the facility was on 5/9/14 at 10:36 p.m. and lasted less than 1 minute. The POA then received a phone call from the facility on 5/9/14 at 10:46 p.m. The telephone records were also reviewed and revealed no calls from the cell phone number of Staff AA. This report revealed Staff AA did not call the POA as documented on 5/9/14 at 8:00 a.m., at noon, or at 5:55 p.m.

When interviewed on 6/11/14 at 9:52 a.m. Staff AA had been shown the POA's telephone records after she stated multiple times that she had called the resident's POA/family on 5/9/14 at 8:00 a.m., noon and 5:55 p.m. Staff AA then stated she knew for sure she called the POA with the new

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F 155	Continued From page 10 Rocephin order. Staff AA then stated she did not call the POA in the morning. After reviewing the telephone records with Staff AA, Staff AA stated she could have sworn she called the POA, but obviously she did not. Staff AA reported maybe she was thinking about another resident, and another resident's family member that she had called that day. When interviewed on 6/4/14 at 4:45 p.m. e licensed practical nurse, Staff BB stated a couple of nights before the resident died, she noted the resident was restless. She placed the resident on oxygen a couple of nights before he/she died due to the resident's blood oxygen levels dropped below 91%. She gave the resident Tylenol due to an elevate fever of 101. The resident had a cough and congestion. She knew the resident's lungs were not good. She told the next shift nurse to watch him/her. The next night she worked, the resident still wasn't on anything for his/her fever and cough. The resident still wasn't doing well. Other resident came up to her and asked her what was wrong with the resident. The resident was not him/herself and was not feeling well. Staff BB stated she did not call the resident's family/POA to report the resident's decline in condition. On the third day she noticed he/she was still not doing well. The resident had periods of apnea, where he/she would stop breathing. The resident had a fever and was clammy. She did not call the resident's family/POA. About 10:30 p.m. the other nurse called for help. When she entered the resident's bedroom, she saw the resident went periods about 10 seconds without breathing. She told the resident to keep breathing. The resident's eyes were glassed over. The resident stopped breathing two minutes	F 155		

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F 155	Continued From page 11	F 155		

before the EMT's arrived. Nurse C came to the room and stated the resident's family requested they try to resuscitate the resident and try any means possible to get the resident back. Staff C began chest compressions, and Staff BB and Staff C took turns performing chest compressions for approximately 10 minutes. The EMT's then instructed them to stop. Staff BB stated she wished she had called the resident's family when the resident first got sick.

When interviewed on 6/3/14 at 6:20 p.m. Staff C stated she worked on Wednesday [5/7/14], Thursday [5/8/14] and Friday [5/8/14], however she was not assigned to this resident. On Wednesday the resident was having increased respiratory issues and was mouth breathing. The resident was on oxygen and was not getting up as usual. The resident was not doing his/her range of motion exercises and was not walking as usual. On Wednesday, other staff reported their concerns regarding this resident to her. The resident progressively went down hill. She heard on Thursday the resident had a pulse oxygan level of 77 %. On Friday she was not working with this resident, however a C.N.A. asked her for assistance. When they entered the resident's bedroom, the C.N.A. stated the resident stopped breathing. She observed the resident take one big gasp. The resident's pupils were fixed. The resident's color was gray. She ran and checked the resident's chart and saw the resident was a DNR. She called the other nurse. She then called for an ambulance to transfer the resident to the hospital. She then called the physician on call. She informed the physician the resident had respiratory issues, had one episode of apnea and asked the physician if they could send the resident out. She called the resident's family/POA

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 155	Continued From page 12 and informed the POA they were sending the resident to the hospital. She verified which hospital the POA desired. She did not tell the POA of the resident's condition. When she called the ambulance she informed them the resident had been declining since Wednesday [5/7/14]. She then went with the EMT's to the resident's bedroom. The resident was gone. The EMT's assessed the resident. The EMT's asked for the resident's code status. The EMT's then asked her to call the family and make sure they did not want any life saving measures. She called the POA. She did not tell the POA the resident was not breathing and did not have a heartbeat. She asked the POA if he/she wanted stabilization. The POA stated to do what they could to stabilize the resident. She then hung up the phone and grabbed the back board, went to the resident's room. They then began to perform CPR. The nurses did the compressions and the EMT's attempted to intubate the resident. The EMT's then stopped the CPR. The EMT's then asked her to get the POA on the phone at which time they informed the POA of the resident's death. Staff C stated she wrote out her nurse's notes after the fact. The Physician Discharge Summary dated 5/9/14 documented the resident's final diagnosis as end stage Parkinson's and MS. The Pertinent Physical findings noted the resident's condition continued to decline, had numerous falls secondary to poor judgment skills. The resident expired.	F 155		
F 157 SS=D	483.10(b)(11) NOTIFY OF CHANGES (INJURY/DECLINE/ROOM, ETC) A facility must immediately inform the resident;	F 157		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	166255	A. BUILDING _____ B. WING _____	C 06/19/2014

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CARLISLE CENTER FOR WELLNESS AND REHAB	660 COLE STREET CARLISLE, IA 50047

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F 157	Continued From page 13 consult with the resident's physician; and if known, notify the resident's legal representative or an interested family member when there is an accident involving the resident which results in injury and has the potential for requiring physician intervention; a significant change in the resident's physical, mental, or psychosocial status (i.e., a deterioration in health, mental, or psychosocial status in either life threatening conditions or clinical complications); a need to alter treatment significantly (i.e., a need to discontinue an existing form of treatment due to adverse consequences, or to commence a new form of treatment); or a decision to transfer or discharge the resident from the facility as specified in §483.12(a). The facility must also promptly notify the resident and, if known, the resident's legal representative or interested family member when there is a change in room or roommate assignment as specified in §483.15(e)(2); or a change in resident rights under Federal or State law or regulations as specified in paragraph (b)(1) of this section. The facility must record and periodically update the address and phone number of the resident's legal representative or interested family member. This REQUIREMENT is not met as evidenced by: Based on clinical record review and staff and family member interviews, the facility failed to immediately inform the resident's interested family member following a significant change in a resident's physical condition for 1 of 17 residents sampled for review (Resident #9). The facility	F 157		

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	165265	A. BUILDING _____ B. WING _____	C 06/19/2014

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F 157	Continued From page 14 reported a census of 87 residents. Findings include: A Geriatric Services report dated 4/28/14 documented Resident #9 had chronic debility secondary to multiple sclerosis (MS) and Parkinson's disease. The resident ' s active problems included acute conjunctivitis, acute upper respiratory infection, chronic pain, debility, dementia, depression, diabetes mellitus, diabetic peripheral neuropathy, multiple sclerosis and Parkinsonism. The neurological exam revealed memory loss, difficulty walking, confusion, loss of strength and depression. The physical exam revealed impaired insight and impaired judgment, incoherent speech, disorientation to time, impaired short term memory and impaired remote memory. Review of the Restorative Nursing Services Progress Notes revealed on 5/7/14 the resident refused therapy three times. The resident complained of not feeling well; too weak to do exercises. The restorative staff member, Staff B, documented she informed the nurse, Staff S, of the resident's refusal and complaints of not feeling well. When interviewed on 6/3/14 at 3:40 p.m. Staff B stated on 5/7/14, the resident stated he/she did not want to do the exercises in the morning and felt like s/he would always be sick. The resident complained of a cough in the afternoon and did not feel well. Staff B stated she informed the resident's nurse, Staff S, of the resident's statements and refusal. The resident stated he/she had his/her cold for a long time, complained of his/her chest and of difficulty	F 157		

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F 157	Continued From page 15 breathing. The nurse informed Staff B she would go and assess the resident. When interviewed on 6/3/14 at 4:55 p.m., Staff S (licensed practical nurse) stated when Staff B reported the resident refused therapy and did not feel well, she went to the resident's bedroom and found the resident wearing oxygen. Night shift staff had started the oxygen. Staff S stated she normally documented in the nurse's notes when she assessed a resident, but she did not document her assessment of the resident that day. On Tuesday (5/6/14), the resident refused to get out of bed. The nurse told Resident # 9 to get up for the evening meal; the resident did not get out of bed on Tuesday. Staff S stated she did not document on the resident that day. On Wednesday she told the resident he/she had to get up out of bed for the noon meal and the resident refused to get up out of bed for the evening meal. They put oxygen on the resident on Wednesday. When asked why she failed to document her assessment of the resident, the nurse stated the resident had times when he/she did not want to do anything. She thought the resident was very stubborn. During report on Thursday, (5/8/14) the off going nurse reported the resident was sweaty and the pulse ox (oxygen saturation level) had dropped before breakfast. She told the CNAs they had to get the resident up out of bed for breakfast. The resident's lung sounds sounded course, the resident was sweaty and their color was a little different (more pale). By the end of breakfast the resident leaned over in the chair and had a loose, moist cough. She then had the staff get the resident up and out of bed for the noon meal. Staff S stated she did not call the resident's family regarding the resident's decline in condition.	F 157		

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F 157	Continued From page 16	F 157		

When interviewed on 6/3/14 at 5:30 p.m. a Staff L, CNA stated first noticed a decline in this resident's condition on Monday (5/5/14). The resident had oxygen on and sounded horrible; congested like he/she had a chest cold. The resident acted "out of it", not his/her normal self. The resident continued to get worse. In the past when the resident would get sick it would only be for one day. On Tuesday the resident sat up a little bit better. Staff L did not work on Wednesday. When he worked on Thursday, he immediately talked to the nurse Staff AA as it looked like the resident was not breathing. The nurse increased the resident's oxygen and when they got the resident up for the noon meal, s/he leaned over to the side so they assisted the resident back to bed. Staff L thought the resident should go to the hospital. The resident's color appeared gray and the resident felt sweaty. The resident felt like he/she was burning up, did not eat or drink and Staff L thought the resident was uncomfortable.

Nurse's Notes documented:

a. On 5/8/14 at 5:25 a.m. staff documented he resident ' s oxygen saturation measured 83%. Staff administered ibuprofen, cough syrup and supplemental oxygen at 2 L by nasal cannula. Staff documented the resident had a nonproductive cough, profuse sweating and anxiety with expiratory wheezing/raspy cough at 5:20 a.m.
b. The next entry dated 5/8/14 at 10:00 a.m. noted poor appetite, staff repositioned the resident often, s/he used oxygen, had no cough and course lung sounds.
c. On 5/9/14 at 8:00 a.m. the resident displayed

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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CARLISLE CENTER FOR WELLNESS AND REHAB	680 COLE STREET CARLISLE, IA 50047

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F 157	Continued From page 17 lethargy, had a low grade fever, hurt all over and had decreased lung sounds in the left lobe. The right lobe sounded clear. The resident had SOB (shortness of breath) at rest. Resident #9 ' s oxygen level measured 84% and staff placed oxygen at 2 L and administered Ibuprofen. Staff also noted a moist cough. Staff placed a call to the physician office and received a new order for a chest x-ray. Staff documented calling the resident's family member regarding the change in condition and interventions. d. On 5/9/14 at 10:00 a.m. the chest x-ray results were in and faxed to physician with current assessment. Resident #9 responded to physical and tactile stimuli. e. On 5/9/14 at 12:00 noon, staff noted no improvement in the resident ' s status and documented an oxygen level 87%. The resident remained lethargic. The resident ' s lung sounds continued with decreased air movement and s/he had a moist cough and SOB at rest. The resident declined emergency room evaluation and treatment. Staff placed a call to the nurse practitioner and received a new order for Rocephin. Staff documented calling the resident's family regarding resident's condition and intervention taken. f. On 5/9/14 at 5:55 p.m. the nurse spoke to the resident again regarding emergency room evaluation and treatment and again the resident refused. The nurse placed call to family regarding nurse's concerns and DNR wishes. g. On 5/9/14 at 10:30 p.m., the nurse documented going to help the CNA to check and change the resident. Before entering the resident's bedroom, the CNA stated the resident was not breathing. The nurse then called the on-call physician of the change in condition. Staff received an order to send the resident to the	F 157		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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F 157	Continued From page 18	F 157		

emergency room for evaluation.
h. On 5/9/14 at 10:35 p.m. the nurse called ambulance for transfer to emergency room.
i. On 5/9/14 at 10:30 p.m. staff documented contacted the resident ' s responsible party to notify them of the intent to transfer the resident.
j. On 5/9/14 at 10:50 p.m. ambulance arrived and the resident had no breath sounds upon entering room. The ambulance attendants asked the nurse to call POA back and make sure no lifesaving efforts were wanted. At this time, nurse called responsible party who requested attempts to stabilize resident. The staff started compressions and rescue breathing (CPR) until the parametric called the code due to the resident ' s DNR (do not resuscitate) status.
k. On 5/9/14 at 10:30 p.m. another nurse, Staff BB, documented Resident #9 experienced periods of apnea and start/stop breathing with wet breath sounds. The resident ' s pulse measured 108, respirations at 52 and oxygen level at 86%. The resident ' s pupils appeared fixed and s/he did not respond. The resident had a nonproductive cough earlier in the evening, gasped for breath and had periods of non-breathing. The resident did not wish to be resuscitated and the family requested compression per telephone. The EMT (emergency medical technician) intubated the patient and both nurses provided compression to resident. The resident vomited and did not respond. Staff continued with intubation and compressions. The resident had no vital signs and EMT called time of death at 10:50 p.m. Staff notified the resident's family.

When interviewed on 6/11/14 at 9:52 a.m., Staff AA, LPN stated she worked routinely with Resident #9. She had a couple days off and when

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	165255	A. BUILDING _____ B. WING _____	C 06/19/2014

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CARLISLE CENTER FOR WELLNESS AND REHAB	680 COLE STREET CARLISLE, IA 50047

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F 157	Continued From page 19 she returned to work, 4 different staff members told her the resident had been ill since Monday. The resident was very lethargic and leaning over; almost on his/her own lap. After talking with the nurse practitioner, Staff AA stated she stated she called the resident's family member and power of attorney (POA). She contacted the POA throughout her shift, the last time at 5:55 p.m. When interviewed on 6/3/14 at 2:02 p.m. the resident's family member/POA stated the facility staff had not informed him/her that the resident had been ill. Staff AA called him/her and stated the resident began an antibiotic and this was the first time he/she was informed of any change in the resident. The staff did not tell him/her of any fever or distress. The next thing he/she knew, the facility called about 10:30 p.m., the nurse stated they had the resident as a DNR and asked if that was still his/her desire. The POA last saw the resident on 5/1/14 and was totally unaware of any change in the resident's condition from 5/1/14 through 5/9/14. The POA would have expected a call and update on the resident at the first sign of a change in condition. Review of the phone records provided by the resident's POA revealed the POA first received a phone call from the facility on 5/9/14 at 2:09 p.m. and the call lasted less than 2 minutes. The next phone call from the facility occurred on 5/9/14 at 10:36 p.m. and lasted less than 1 minute. The POA then received a phone call from the facility on 5/9/14 at 10:46 p.m. This report revealed Staff AA did not call the POA as documented on 5/9/14 at 8:00 a.m., at noon, or at 5:55 p.m. When interviewed on 6/11/14 at 9:52 a.m. Staff AA was shown the POA's telephone records after	F 157		

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F 157	Continued From page 20 she stated multiple times that she had called the resident's POA/family on 5/9/14 at 8:00 a.m., noon and 5:55 p.m. Staff AA then stated she knew for sure she called the POA with the new Rocephin order. Staff AA then stated she did not call the POA in the morning. After reviewing the telephone records, Staff AA stated she could have sworn she called the POA, but obviously she did not. Staff AA reported maybe she remembered another resident and another family member that she had called that day. Staff AA stated she was working very hard and maybe she got the two families mixed up. The Physician Discharge Summary dated 5/9/14 documented the resident's final diagnosis as end stage Parkinson's disease and MS. The Pertinent Physical findings noted the resident's condition continued to decline, had numerous falls secondary to poor judgment skills. The resident expired.	F 157		
F 164 SS=D	483.10(e), 483.75(l)(4) PERSONAL PRIVACY/CONFIDENTIALITY OF RECORDS The resident has the right to personal privecy and confidentiality of his or her personal and clinical records. Personal privacy includes accommodations, medical treatment, written and telephone communications, personal care, visits, and meetings of family and resident groups, but this does not require the facility to provide a private room for each resident. Except as provided in paragraph (e)(3) of this section, the resident may approve or refuse the	F 164		

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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F 164	Continued From page 21 release of personal and clinical records to any individual outside the facility. The resident's right to refuse release of personal and clinical records does not apply when the resident is transferred to another health care institution; or record release is required by law. The facility must keep confidential all information contained in the resident's records, regardless of the form or storage methods, except when release is required by transfer to another healthcare institution; law; third party payment contract; or the resident. This REQUIREMENT is not met as evidenced by: Based on observation, clinical record review and staff and resident interviews, the facility failed to maintain resident's bodily privacy during the provision of care for 2 of 17 residents reviewed (Residents #2 and #3). The facility reported a census of 87 residents. Findings include: 1. The Minimum Data Set (MDS) assessment for Resident #2 dated 4/16/14 documented diagnoses that included hypertension,multi-drug-resistant organism, urinary tract infection, Alzheimer's disease, seizure disorder or epilepsy. The resident required extensive assistance with bed mobility and bathing and limited assistance with transfers, dressing, eating, toilet use and personal hygiene. The resident had short-term memory loss and moderate cognitive impairments.	F 164		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	165255	A. BUILDING _____ B. WING _____	C 06/19/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CARLISLE CENTER FOR WELLNESS AND REHAB	680 COLE STREET CARLISLE, IA 50047

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F 164	Continued From page 22 The Plan of Care dated 5/6/14 identified the resident had dementia and depression. The goals included the resident would not show increased signs and symptoms of depression. The plan of care instructed the staff to encourage social interaction. A random observation on 5/20/14 at 11:50 a.m. revealed Resident #2's bedroom door as wide open. The resident lay in bed on his/her right side, unclothed from the waist down. Observation also revealed the privacy curtains open. The resident's roommate lay in his/her bed with his/her head of bed elevated and the roommate facing the resident. Two CNAs (certified nursing assistants), Staff L and Staff M stood on either side of the resident's bed. The staff were providing care for this resident. Observation revealed this resident lay partially unclothed and uncovered in full visual view to the resident's roommate and to anyone passing in the hallway. When interviewed on 5/20/14 at 11:52 a.m. Staff M verified providing personal care for the resident with the bedroom door open. Staff M stated she did not provide visual privacy for this resident. Staff M stated she had been instructed/taught to pull the privacy curtain and close the bedroom door prior to providing any resident with personal care. Staff M stated she was in a hurry. When interviewed on 5/20/14 at 11:55 a.m. Staff L verified providing personal care for this resident with the bedroom door and privacy curtain open. Staff L did not give any explanation as to why he/she failed to provide personal privacy for this resident. When interviewed on 5/21/14 at 10:15 a.m. the	F 164		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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F 164	Continued From page 23 roommate of Resident #2 stated he/she did not like it when the staff failed to pull the privacy curtain prior to providing personal care for Resident #2. The roommate, Resident #1, stated he/she did not like seeing the resident's butt. 2. The MDS assessment dated 4/27/14 for Resident #3 documented diagnoses that included heart failure, hypertension, Alzheimer's Disease, depression and chronic lung disease. The resident had severe cognitive and memory impairment. The assessment documented Resident #3 required extensive assistance with bed mobility and transfers and limited assistance with dressing, toilet use and personal hygiene. The resident experienced urinary and bowel incontinence. The Plan of Care dated 6/27/13 identified the resident had a self care deficit related to dementia. The plan of care documented the resident as incontinent of bowel and bladder and instructed staff to check, change and provide perineal care routinely and as needed. Observation on 5/20/14 at 3:00 p.m. revealed Resident #3 lying on his/her bed with the bedroom door wide open. The resident lay on the bed wearing clothing on his/her upper body and a disposable brief. The resident called out for assistance, calling 'help, I don't have any pants on'. At this time, two CNAs (certified nursing assistants) Staff A and Staff E came to the resident's room and prepared to provide personal care for this resident. Staff closed the bedroom door. Observation revealed the resident lived in a semi private bedroom. The staff pulled a curtain between the two beds, but did not pull the privacy curtain at the foot of the bed to provide full visual	F 164		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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F 164	Continued From page 24 privacy. The resident lay supine on the bed. Staff A unfastened the resident's brief and stated the brief was soiled with urine. At this time, the resident's roommate exited the bathroom and walked to his/her bed. The roommate had full visual view of the resident lying on the bed uncovered from the waist down. Staff made no attempt to cover the resident and/or to provide visual privacy. The staff put the resident's pant on just to the resident's ankles. Staff A then instructed Staff E to exit the bedroom to obtain a clean pad for the bed. Staff E then opened the bedroom door and exposed the unclothed resident to anyone walking past in the hallway. Staff A failed to cover the resident and/or provide privacy.	F 164		
F 241 SS=D	483.15(a) DIGNITY AND RESPECT OF INDIVIDUALITY The facility must promote care for residents in a manner and in an environment that maintains or enhances each resident's dignity and respect in full recognition of his or her individuality. This REQUIREMENT is not met as evidenced by: Based on observation, clinical record review and staff and resident interviews, the facility failed to always provide care and services for residents in a manner that maintained or enhanced each resident's dignity for 3 of 17 residents sampled for review. (Residents #3, #4 and #16). The facility identified a census of 87 current residents. Findings include: 1. The MDS (Minimum Data Set) assessment	F 241		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	165265	A. BUILDING _____ B. WING _____	C 05/19/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 241	Continued From page 25 dated 4/27/14 for Resident #3 documented diagnoses that included heart failure, hypertension, Alzheimer's Disease, depression and chronic lung disease. The resident had severe cognitive and memory impairment. The assessment documented Resident #3 required extensive assistance with bed mobility and transfers and limited assistance with dressing, toilet use and personal hygiene. The resident experienced urinary and bowel incontinence. The Plan of Care dated 6/27/13 identified the resident had a self care deficit related to dementia. The plan of care documented the resident as incontinent of bowel and bladder and instructed staff to check, change and provide perineal care routinely and as needed. Observation on 5/20/14 at 3:00 p.m. revealed Resident #3 lying on his/her bed. Two CNAs (certified nursing assistants) Staff A and Staff E came to the resident's room and prepared to provide personal care for this resident. During care provision, Staff A called the resident honey. When interviewed at the time, the resident stated he/she preferred to be called by his/her first name. Staff A then attempted to removed the fecal and urine soiled brief out from under the resident. Staff A pulled on the brief and stated, "I need to get this brief out of here babe." Staff A then directed the resident to "roll with me honey." The staff then rolled the resident to one side. Staff A stated, "I'm gonna clean you bottom mother." The resident asked Staff A if she was done yet. Staff A failed to acknowledge and/or answer the resident's question. The resident stated, "Come on." Staff A then stated "I'm sorry honey" and "almost done honey."	F 241		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	166255	A. BUILDING _____ B. WING _____	C 06/19/2014

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F 241	Continued From page 26 When interviewed on 5/20/14 at 4:50 p.m. the resident stated he/she did not like being called babe, honey or mother. The resident stated he/she liked to be called by his/her first name. 2. The MDS assessment for Resident #4 dated 3/16/14 documented diagnoses that included heart failure, hypertension, cerebrovascular accident (CVA/stoke), Non-Alzheimer's dementia, depression and anxiety. The assessment documented the resident felt down, depressed or hopeless on 2 - 6 days of the assessment period. The resident required assistance for transfers, dressing, toilet use, bathing and supervision for personal hygiene. The assessment documented Resident #4 had severe cognitive and memory impairment. The resident's Plan of Care dated 3/24/14 documented the resident had a self care deficit related to dementia. Observation on 5/21/14 at 9:04 a.m. and at 3:45 p.m. revealed long facial/chin hair on Resident #4. When interviewed on 5/21/14 at 4:00 p.m. Resident #4 stated he/she did not like having long chin hair. The resident stated he/she would shave the hair him/herself, however he/she did not have a razor. 3. The MDS assessment for Resident #16 dated 5/25/14 listed active diagnoses that included anemia, heart failure, hyperlipidemia and depression. The assessment documented the resident had moderate cognitive and memory impairment. The resident ate independently and required limited staff assistance to meet his/her	F 241		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	165255	A. BUILDING _____ B. WING _____	C 06/19/2014

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F 241	Continued From page 27 dressing and personal hygiene needs. The Plan of Care dated dated 9/6/13 identified the resident had a self care deficit. The plan of care instructed staff that Resident #16 took a shower twice a week with the assistance of one and that s/he required the assistance of one to two staff in order to dress. Observation on 6/12/14 at 11:00 a.m. revealed the resident sat in a wheelchair in the 500 hallway. Observation revealed the resident's shirt highly soiled for dried on food substances. When interviewed on 6/12/14 at 11:05 a.m. the Assistant Director of Nursing stated the resident had a shower scheduled and staff planned to change the resident's soiled shirt at the time of the shower.	F 241		
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 record review, observation, staff and resident interviews, the facility failed to complete assessment and implement timely interventions for 2 of 17 residents (Residents #9 and Residents #14). The facility reported a census of 87	F 309		

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F 309	Continued From page 28 residents. 1. Record review for Resident #9 revealed diagnoses of Parkinson syndrome, dementia, and myelopathy, spasticity. Nurse's Notes for Resident #9 included the following: The first nurse's note since 4/30/14 at 3:00 p.m. dated 5/8/14 at 5:25 a.m. oxygen saturation 83%. Ibuprofen, and cough syrup given, and supplemental oxygen given at 2 L by nasal cannula. Non-productive cough, profuse sweating, and anxiety noted with expiratory wheezing/raspy cough at 5:20 a.m. The next entry dated 5/8/14 at 10:00 a.m. notad poor appatite, repositioned often, oxygen on, no cough, course lung sounds. 5/9/14 at 8:00 a.m. resident lethargic, low grada fever, states hurting all over, lung sounds left lobe decreased and adventitious. Right loba clear. Resident SOB (short of breath) at rast. Oxygan leval: 84%, oxygen applied at 2 L. Ibuprofen given. Moist cough. Call placed to physician office, new order received for chest x-ray. Call placed to resident's family membar regarding change in condition and intervantions. 5/9/14 at 10:00 a.m. chest x-ray results in and faxed to physician with current assessment. Resident responsive to physical and tactile. 5/9/14 at 12:00 noon, no improvement in status, in fact oxygen leval 87%. Resident lathargic. Lung sound continues with decreased air movement. Moist cough. Short of breath at rest. Resident declines emergancy room evaluation and treatment. Call placed to nurse practitioner with nurse's concern and current assessment. New order received for Rocephin and if condition continued to deteriorate, contact office. Call	F 309		

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F 309	Continued From page 29 placed to resident's family regarding resident's condition and intervention taken. 5/9/14 at 5:50 p.m. resident currently in bed with eyes closed. Will report to oncoming nurse if condition worsens send to emergency room per family (POA/power of attorney) request. The original copy/review of this resident's clinical record revealed no entry dated 5/9/14 at 5:55 p.m. Review and copy of the clinical record revealed an additional entry made for 5/9/14 at 5:55 p.m. made sometime after 6/1/14. 5/9/14 at 5:55 p.m. again nurse spoke with resident regarding emergency room evaluation and treatment and again the resident refused. Nurse placed call to family regarding nurse's concerns and DNR wishes. The next entry dated 5/9/14 at 10:30 p.m. noted the nurse went to help C.N.A. (certified nursing assistant) check and change the resident. Before entering the resident's bedroom, the C.N.A. stated the resident was not breathing. The nurse then went and called the physician on call of the change in condition. New order received to send the resident to the emergency room for evaluation. 5/9/14 at 10:35 p.m. nurse called ambulance for transfer to emergency room. 5/9/14 at 10:30 p.m. responsible party contacted and notified of intent to transfer. 5/9/14 at 10:50 p.m. ambulance arrived, no breath sounds upon entering room. Nurse instructed by ambulance attendants to call POA back and make sure no life saving efforts were wanted. At this time, nurse called responsible party. Responsible party requested attempt to stabilize resident. Compressions and breaths started (CPR) until parametric called it according to code status DNR. 5/9/14 at 10:30 p.m. another nurse, Staff BB	F 309		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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F 309	Continued From page 30	F 309		

documented an entry at a later date, periods of apnea, start/stop breathing with wet breath sounds, pulse 108, respirations 52, oxygen level 86%, pupils fixed and non-responsive. Non productive cough earlier in the evening. Gasping for breaths and periods of non-breathing. Resident DNR. Family requested compression per telephone. EMT (emergency medical technician) intubated patient. Both nurses provided compression to resident. Resident vomited and did not respond. Continued to intubate and compressions. Resident with no vital signs. EMT called time of death at 10:50 p.m. Family notified and arrived to visit with resident and have time to say goodbye. Family came by morning of 5/10/14 and get resident belongings. A late entry dated 5/11/14 at 1:30 p.m., Staff BB documented resident sitting up in bed on 5/9/14 at 10:35 p.m., pale in color, skin dusky, resident had difficulty breathing with chest congestion throughout both lung fields, heart sounds distant, oxygen 85%, nurse offered Ibuprofen and cough syrup, resident temperature 100.3, nurse informed resident that he/she may have to go to hospital, resident started to have more difficulty breathing at 10:30 p.m., this nurse summoned to resident room by another nurse, resident cyanotic and taking gasping breaths. Oxygen 84% and temperature 97.6. Heart rate 108. Resident had periods of stop/start breathing. Resident sitting at 45 degrees. Staff changed the resident's shirt and applied cool wash cloths to forehead. Resident not responding to staff. Mouth slightly open with raspy wet breathing. Resident's pupils non-responsive to light. This nurse stayed with resident in room and patted resident's chest, telling resident to continue to breathe. Resident continued periods of gasping breaths, lips cyanotic. Resident was sweating profusely with

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F 309	Continued From page 31 air conditioner on high. At 10:38 p.m. resident sighed one last breath and closed his/her eyes and stopped breathing altogether. Resident's family requested life-saving measures be started. This nurse and another nurse started chest compressions, followed by 2 breaths, 30 compressions to 2 breaths. This nurse and other nurse and EMT's continued to give chest compressions. EMT's checked for pulse and instructed nurses to stop chest compressions. EMT called time of death at approximately 10:50 p.m. A late entry written on 5/13/14 for 5/8/14 at 12:35 p.m. resident up to dining room table. Resident requested to lay back down in bed. Nurse instructed resident he/she could not lay flat in bed and instructed the resident it was not good for him/her. The nurse instructed the resident he/she needed to eat and he/she needed the head of his/her bed up. At 4:00 p.m. the nurse educated the resident on the importance of getting up for meals and asked the resident again if he/she would like to go to the hospital to be checked over. At 6:30 p.m. the nurse instructed the C.N.A. the resident needed to get up for the evening meal. Review of the Ambulation Program for May of 2014 revealed the resident walked 240 feet on 5/1/14, walked 250 feet on 5/2/14, walked 216 feet on 5/3/14, walked 178 feet on 5/4/14, walked 152 feet on 5/5/14 and again on 5/6/14. This form indicated the resident then refused to walk on 5/7/14 and again on 5/8/14. Review of the Range of Motion Passive or Active form for May 2014 revealed the resident refused therapy on 5/7/14 and again on 5/8/14.	F 309		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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F 309	Continued From page 32 Review of the Restorative Nursing Services Progress Notes revealed on 5/7/14 the resident refused therapy three times. The resident complained of not feeling well, too weak to do exercises. The restorative staff member, Staff B documented she informed the nurse, Staff S of the resident's refusal and complaints of not feeling well. Interviews: When interviewed on 6/3/14 at 3:40 p.m. the restorative staff member, Staff B stated the resident was a nice resident. On May 7th the resident stated he/she did not want to do the exercises in the morning and stated he/she was always going to be sick. The resident complained of a cough in the afternoon and stated he/she did not feel well. Staff B reported she informed the resident's nurse, Staff S of the resident's statements and refusal. The resident stated he/she had his/her cold for a long time and he/she complained of his/her chest and difficulty breathing. The nurse informed Staff B she would go and assess the resident. When interviewed on 6/3/14 at 4:55 p.m. a licensed practical nurse (LPN), Staff S stated she called the day Staff B came to her and reported the resident refused therapy and did not feel well. She went to the resident's bedroom and found the resident wearing oxygen. The night shift had started the oxygen. Staff S stated she normally documented in the nurse's notes when she assessed a resident. Staff S stated she did not document her assessment of the resident that day. On Thursday [5/8/14] the resident refused to get out of bed. The nurse told the resident he/she needed to get up for the evening meal. The	F 309		

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F 309	Continued From page 33	F 309		

resident then threw a really big fit. The nurse told the resident he/she had to get out of bed. The nurse told the resident he/she could not stay in bed all day long due to his/her lungs. Staff S stated the resident did not get out of bed on Tuesday [5/6/14]. Staff S stated she did not document on the resident that day. On Tuesday she went to the resident's bedroom and told the resident he/she had to get up out of bed for the evening meal. On Wednesday [5/7/14] she told the resident he/she had to get up out of bed for the noon meal. On Wednesday the resident refused to get up out of bed for the evening meal. They put oxygen on the resident on Wednesday. She then went down to the resident's room to tell the resident he/she had to get up out of bed for the evening meal. When asked why she failed to document her assessment of the resident, the nurse stated the resident had times when he/she did not want to do anything. The nurse stated the resident was very stubborn. During report on Thursday [5/8/14] the off going nurse reported the resident was sweaty and the pulse ox, oxygen saturation level had dropped before breakfast. She told the C.N.A.'s they had to get the resident up out of bed for breakfast. The resident's lung sounds were course. The resident was sweaty. The resident's color was a little different, he/she was a little more pale. By the end of breakfast the resident was leaning over in the chair. The resident had a loose, moist cough. She then had the staff get the resident up, out of bed for the noon meal. The staff then asked her if the resident could eat lunch in bed. The nurse then went and asked the resident if he/she wanted to her to send him/her to the hospital. The nurse stated the resident had a history of getting upper respiratory infections easily. She stated the resident was sweaty on and off that day, which

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F 309	Continued From page 34 was unusual for the resident. Staff S denied documenting in the clinical record for 5/7/14 or on 5/8/14. Staff S stated after the resident died, she documented on his/her condition. Staff S denied calling the physician with this resident's change in condition and she failed to call the resident's family regarding the resident's decline in condition. Staff S stated she worked with this resident on 5/5/14, 5/8/14, 5/7/14 and again on 5/8/14. Staff S stated the resident was not sweaty on 5/5/14 or on 5/6/14. She stated the resident got up for meals on 5/5/14 and on 5/6/14. She also stated the resident's color was normal for this resident on 5/5/14 and again on 5/6/14. Staff S stated the changes she noticed in this resident's physical condition on 5/7/14 and 5/8/14 were the sweatiness, the refusal to get out of bed, the poor color, poor appetite and the need for staff to reposition the resident frequently when up due to the resident would lean to the side. Staff S denied giving the resident any pain medication or cough syrup. When interviewed on 6/3/14 at 5:30 p.m. a C.N.A. Staff L stated the resident would get up for meals. Staff L stated he first noticed a decline in this resident's condition on Monday 5/5//14. The resident had oxygen on and the resident sounded horrible. The resident sounded congested like he/she had a chest cold. The resident was "out of it", not his/her normal self. The resident continued to get worse. In the past when the resident would get sick it would only be for one day. Monday the resident appeared worse than he had ever seen the resident before. The resident was leaning way over, and that was unusual. The nurse, Staff S asked the resident if he/she wanted to go to the hospital and the resident said no. On [5/6/14]Tuesday the resident sat up a little bit better.	F 309		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	165255	A. BUILDING _____ B. WING _____	C 06/19/2014

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F 309	Continued From page 35 Staff L was off on 5/7/14, Wednesday. Staff L worked on Thursday 5/8/14 and immediataly talked to the nursa Staff AA due to it looked like ths resident was not breathing. The nurse increased the resident's oxygen to 2 1/2 L. When they got the resident up for the noon meal, the resident was really leaning over to the side so they assisted the resident back to bed. Staff L thought the resident should go to the hospital. The resident's color was gray, and the resident was sweaty. The resident felt like he/she was burning up. The resident was not eating or drinking. When interviewed on 6/11/14 at 9:52 a.m. a licensed practical nurse, Staff AA stated she was routinely this resident's nurse. She had a couple days off and when she returned to work, four different staff members told her the resident had been ill since Monday [5/5/14]. The resident was very lethargic and leaning over. The resident was almost leaning over on his/her own lap. She had the staff lay the resident back down in bed. She informed the resident he/she needed to go to the hospital. She called the nurse practitioner. The resident's lung sounds were course throughout with very little movement, she started the resident on oxygen. Tha nurse practitioner ordered Levoquin at which time Staff AA informed the nurse practitioner the resident was beyond Levoquin and he/she needad an IM (intramuscular) antibiotic. She then called the resident's family member, power of attorney. She contacted the POA throughout her shift. The last time she called the POA was 5:55 p.m. She called the POA multiple times throughout her shift. The POA instructed her if the resident got any worse to send the resident to the hospital. From the beginning of her shift to the end of her	F 309		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	165255	A. BUILDING _____ B. WING _____	C 06/19/2014

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F 309	Continued From page 36	F 309		

shift, she felt the resident was going to die. She informed the resident that was all she could do for him/her. The resident could not breathe. The resident was struggling to breathe. His/her lungs were full. She reviewed his/her record and determined the resident was a DNR. She discussed the resident's DNR status with the POA. The POA wanted the DNR order to be honored. The POA asked the nurse why she was the first one to call and inform him/her of the resident's condition. The nurse stated at 8:00 a.m. that morning the resident had a low grade fever. She believed if the fever was below 100, she did not need to call the physician. She would just give Tylenol. Staff AA stated she called the POA prior to 8:00 a.m. at which time she informed the POA exactly what she had documented in the nurse's notes. She informed the POA she believed the resident needed an antibiotic. The POA asked her to keep in contact with him/her. Staff AA reported from 8:00 a.m. to noon, the resident's condition deteriorated. She called the POA and informed the POA she believed the resident's condition was grave. Staff AA stated she called the POA again at 5:55 p.m. Staff AA stated she was on the phone with the POA when the next nurse came on duty at 6:00 p.m. The POA informed her the resident wanted to be with his/her spouse. The POA stated if the resident got to where he/she was not comfortable, the POA wanted the resident sent to the hospital.

When interviewed on 6/3/14 at 2:02 p.m. the resident's family member/POA stated the facility staff had not informed him/her that the resident had been ill. Staff AA called him/her and stated the resident began on an antibiotic. This was the first time he/she was informed of any change in

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	165255	A. BUILDING _____ B. WING _____	C 06/19/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CARLISLE CENTER FOR WELLNESS AND REHAB	688 COLE STREET CARLISLE, IA 68047

(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 37	F 309		

the resident. The resident had a history of taking antibiotics due to respiratory issues, so the POA did not think anything about it. The staff did not tell him/her of any fever or distress. The next thing he/she knew the facility called about 10:30 p.m. the nurse stated they had the resident as a DNR and asked if that was still his/her desire. The POA asked the staff to stabilize the resident until he/she arrived. The staff did not say the resident had ceased breathing and had no heartbeat. The POA stated the resident had a DNR and the POA did not wish to change the order. The POA voiced dissatisfaction due to the staff failed to call him/her earlier and failed to inform him/her of the resident's decline in condition and the resident had died. The POA stated had the staff called him/her earlier and reported the resident's actual change in condition, the POA could have come to the facility and seen the resident prior to the resident's death and the POA could have asked for the resident to be transfer to the hospital earlier and received a greater level of care during the resident's physical decline. The POA stated the facility normally called him/her with changes in the residents condition. The POA last saw the resident on 5/1/14. The POA was totally unaware of any change in the resident's condition from 5/1/14 through 5/9/14. The POA would have expected a call and update on the resident at the first sign of a change in condition. The POA stated had the facility informed him/her earlier of the resident's decline in condition the POA and family members could have come to the facility, visited the resident and participated in the decisions regarding seeking hospitalization to ensure care and comfort. The resident desired DNR status and no one ever asked him/her if they wanted to change the resident's DNR status, no one

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	165255	A. BUILDING _____ B. WING _____	C 06/19/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CARLISLE CENTER FOR WELLNESS AND REHAB	680 COLE STREET CARLISLE, IA 50047

(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 38	F 309		

informed him/her the resident had died, and no one asked him/her if they wanted CPR or life saving measures. The POA was under the impression the resident was alive and preparing to go to the hospital by ambulance, and the POA only asked the staff to stabilize the resident until he/she arrived. Had the POA known the resident was dead, he/she would have asked the staff to honor the resident's DNR status.

Review of the phone records for the resident's POA revealed the POA first received a phone call from the facility on 5/9/14 at 2:09 p.m. and the call lasted less than 2 minutes. The next phone call from the facility was on 5/9/14 at 10:36 p.m. and lasted less than 1 minute. The POA then received a phone call from the facility on 5/9/14 at 10:46 p.m. The telephone records were also reviewed and revealed no calls from the cell phone number of Staff AA. This report revealed Staff AA did not call the POA as documented on 5/9/14 at 6:00 a.m., at noon, or at 5:55 p.m.

When interviewed on 6/11/14 at 9:52 a.m. Staff AA had been shown the POA's telephone records after she stated multiple times that she had called the resident's POA/family on 5/9/14 at 8:00 a.m., noon and 5:55 p.m. Staff AA then stated she knew for sure she called the POA with the new Rocephin order. Staff AA then stated she did not call the POA in the morning.
After reviewing the telephone records with Staff AA, Staff AA stated she could have sworn she called the POA, but obviously she did not. Staff AA reported maybe she was thinking about another resident, and another resident's family member that she had called that day.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	165255	A. BUILDING _____ B. WING _____	C 06/19/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CARLISLE CENTER FOR WELLNESS AND REHAB	680 COLE STREET CARLISLE, IA 50047

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F 309	Continued From page 39 When interviewed on 6/4/14 at 4:45 p.m. a licensed practical nurse, Staff BB stated a couple of nights before the resident died, she noted the resident was restless. She placed the resident on oxygen a couple of nights before he/she died due to the resident's blood oxygen levels dropped below 91%. She gave the resident Tylenol due to an elevate fever of 101. The resident had a cough and congestion. She knew the resident's lungs were not good. She told the next shift nurse to watch him/her. The next night she worked, the resident still wasn't on anything for his/her fever and cough. The resident still wasn't doing well. Other resident came up to her and asked her what was wrong with the resident. The resident was not him/herself and was not feeling well. Staff BB stated she did not call the resident's family/POA to report the resident's decline in condition. On the third day she noticed he/she was still not doing well. The resident had periods of apnea, where he/she would stop breathing. The resident had a fever and was clammy. She did not call the resident's family/POA. About 10:30 p.m. the other nurse called for help. When she entered the resident's bedroom, she saw the resident went periods about 10 seconds without breathing. She told the resident to keep breathing. The resident's eyes were glassed over. The resident stopped breathing two minutes before the EMT's arrived. Nurse C came to the room and stated the resident's family requested they try to resuscitate the resident and try any means possible to get the resident back. Staff C began chest compressions, and Staff BB and Staff C took turns performing chest compressions for approximately 10 minutes. The EMT's then instructed them to stop. Staff BB stated she wished she had called the resident's family when the resident first got sick.	F 309		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	165255	A. BUILDING _____ B. WING _____	C 06/19/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CARLISLE CENTER FOR WELLNESS AND REHAB	688 COLE STREET CARLISLE, IA 50047

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F 309	Continued From page 40 When interviewed on 6/3/14 at 6:20 p.m. Staff C stated she worked on Wednesday [5/7/14], Thursday [5/8/14] and Friday [5/8/14], however she was not assigned to this resident. On Wednesday the resident was having increased respiratory issues and was mouth breathing. The resident was on oxygen and was not getting up as usual. The resident was not doing his/her range of motion exercises and was not walking as usual. On Wednesday, other staff reported their concerns regarding this resident to her. The resident progressively went down hill. She heard on Thursday the resident had a pulse oxygen level of 77 %. On Friday she was not working with this resident, however a C.N.A. asked her for assistance. When they entered the resident's bedroom, the C.N.A. stated the resident stopped breathing. She observed the resident take one big gasp. The resident's pupils were fixed. The resident's color was gray. She ran and checked the resident's chart and saw the resident was a DNR. She called the other nurse. She then called for an ambulance to transfer the resident to the hospital. She then called the physician on call. She informed the physician the resident had respiratory issues, had one episode of apnea and asked the physician if they could send the resident out. She called the resident's family/POA and informed the POA they were sending the resident to the hospital. She verified which hospital the POA desired. She did not tell the POA of the resident's condition. When she called the ambulance she informed them the resident had been declining since Wednesday [5/7/14]. She then went with the EMT's to the resident's bedroom. The resident was gone. The EMT's assessed the resident. The EMT's asked for the resident's code status. The EMT's then asked her	F 309		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	165255	A. BUILDING _____ B. WING _____	C 06/19/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CARLISLE CENTER FOR WELLNESS AND REHAB	680 COLE STREET CARLISLE, IA 50047

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F 309	Continued From page 41 to call the family and make sure they did not want any life saving measures. She called the POA. She did not tell the POA the resident was not breathing and did not have a heartbeat. She asked the POA if he/she wanted stabilization. The POA stated to do what they could to stabilize the resident. She then hung up the phone and grabbed the back board, went to the resident's room. They then began to perform CPR. The nurses did the compressions and the EMT's attempted to intubate the resident. The EMT's then stopped the CPR. The EMT's then asked her to get the POA on the phone at which time they informed the POA of the resident's death. Staff C stated she wrote out her nurse's notes after the fact. The Physician Discharge Summary dated 5/9/14 documented the resident's final diagnosis as end stage Parkinson's and MS. The Pertinent Physical findings noted the resident's condition continued to decline, had numerous falls secondary to poor judgment skills. The resident expired. 2. A MDS (Minimum Data Set) assessment with a reference date of 3/16/14 identified Resident #14 scored 14 out of 15 in cognitive testing. The mood testing section revealed the resident had little interest or pleasure in doing things, the resident felt down, depressed or hopeless and the resident felt tired or had little energy. The resident had delusions, required limited assistance with transfers, walking, dressing, and toilet use. The active diagnoses included hypertension, hyperlipidemia, non-Alzheimer's dementia, seizure disorder and depression. The pain assessment interview indicated the resident experienced frequent pain. The resident rated the	F 309		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	165255	A. BUILDING _____ B. WING _____	C 06/19/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CARLISLE CENTER FOR WELLNESS AND REHAB	680 COLE STREET CARLISLE, IA 50047

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F 309	Continued From page 42	F 309		

pain at a 10 on a scale of 1 to 10 with 10 being the most severe. The resident received antipsychotic and antidepressant medications on a daily basis.

The Plan of Care dated 3/17/14 noted one problem first identified on 11/2/13 of psychotropic drug use related to depression, as evidenced by use of antidepressant medications. The plan of care listed three goals for this problem: resident would not require an increase in medication, the resident would not require an increase in madication and resident would not exhibit adverse side effects from medication. The interventions listed on the plan of care included dose reduction as ordered by the physician, administer medication daily as ordered by the physician, monitor for adverse side effects and report to physician as needed, monitor mood and behavior, report changes to physician as needed, consult social services as needed and consult psych services as needed.

The Physician's Orders for February 2014 revealed the resident received an antipsychotic medication Quetiapine (Seroquel) 25 mg (milligrams) two times a day, Donepezul HCL (Aricept) 10 mg every day, the main therapeutic use is in the palliative treatment of Alzheimer's disease, an antidepressant medication Sertraline HCL (Zoloft) 150 mg at bedtime, an antidepressant medication Trazodone (Desyrel) 150 mg at bedtime, and an antianxiety medication Lorazepam (Ativan) 0.5 mg on an as needed basis.

A progress note by a nurse practitioner dated 5/12/14 noted this resident's active problems included depression. The psychiatric exam

STATEMENT OF OEFICIENCIES ANO PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	165255	A. BUILDING _____ B. WING _____	C 06/19/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COOE
CARLISLE CENTER FOR WELLNESS AND REHAB	680 COLE STREET CARLISLE, IA 50047

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F 309	Continued From page 43	F 309		

revealed the resident exhibited a decreased attention span, a decrease in ability to concentrate and inadequate visual attention. The resident's mood and affect were calm, depressed, flat, indifferent and quiet. The resident appeared poorly developed, poorly nourished, lethargic, chronically ill, frail, debilitated, minimally responsive and unkempt grooming.

A Social Service Progress Note dated 6/6/14 noted the resident appeared disheveled and wore a dirty coat. The resident admitted to feelings of depression and hopelessness, feeling like having little energy, and when asked if he/she had any thoughts related to death, the resident stated he/she frequently thought he/she would like their life to end now. The resident spoke about not wanting to live since he/she never had visitors, especially family. The social worker informed the charge nurse and 15 minute checks were instituted and all items that could be used to harm him/herself were removed. Later in the day another nurse sent the resident to the emergency room due to significant mental status change.

When interviewed on 6/17/14 at 3:00 p.m. the social worker stated the resident became tearful and expressed boredom. The resident told the social worker he/she did not want to live anymore. The resident appeared depressed. The resident sat with head down and flat eyes, no sparkle to the eyes. The resident stated he/she wanted to die. The social worker alerted the nurse who stated she would place the resident on 15 minute checks. The social worker then reported the resident's statements to the director of nursing. The director of nursing then instructed the staff to get rid of the resident's call light, give the resident a bell to ring for assistance, take the plastic bags

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	165255	A. BUILDING _____ B. WING _____	C 06/19/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CARLISLE CENTER FOR WELLNESS AND REHAB	680 COLE STREET CARLISLE, IA 50047

(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 44 out of the resident's room, and take the metal hangers out of the resident's closet. The social worker informed the nurse of the director of nursing instructions. When interviewed on 6/17/14 at 9:45 a.m. a licensed practical nurse, Staff DD stated the resident normally stayed to him/herself. The resident did not like to be bothered. The resident was normally very quiet. The resident's normal daily activities included going to the dining room for coffee, go outside to smoke and go to his/her room. The social worker came to her around 4:00 p.m. or 4:30 p.m. and informed her of the resident's desire to die. Staff DD told the social worker she would place the resident on 15 minute checks. The nurse did not check on the resident, she did not ask the resident how he/she was feeling and she did not notify the resident's physician of the comments on his/her desire to die. The director of nursing instructions included to remove the resident's pillow cases, remove the call light and give the resident a bell and take the trash bags out of his/her bedroom. The nurse stated she removed the trash bags from the resident's bedroom. She did not remove the call light cord due to she did not know where to find a bell. She did not inform housekeeping about the suicide precautions to not use plastic bags in this resident's bedroom, due to the housekeepers had left for the day. She stated the facility had a communication book for nurses to write in, to inform all certified nursing assistants of any changes. She stated she failed to document these suicidal precautions in the communication book to alert all staff and every shift of these new precautions. She stated she did not implement any new interventions to ensure this resident's safety while alone in his/her bedroom until a bell	F 309		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	165255	A. BUILDING _____ B. WING _____	C 06/19/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CARLISLE CENTER FOR WELLNESS AND REHAB	680 COLE STREET CARLISLE, IA 50047

(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 45 could be located and the call light cord could be removed. Staff DD reported they never found a bell before she left work that day at 6:00 p.m. A Nurse's Notes dated 6/6/14 at 4:15 p.m. written by Staff DD noted resident reported to social worker his/her desire to end it all. 15 minute checks started. The next Nurse's Note dated 6/7/14 at 5:50 a.m. noted resident compliant with bedtime medications. Resident's family called to send resident to hospital. Unable to contact resident's family. Received order to send to hospital at 7:17 p.m. Resident returned at 10:50 p.m. Resident's call light removed from room. Resident call bell provided. Resident stated he/she did not eat all day, except breakfast. Resident offered a snack. Resident upset that his/her shirt was damaged on leaving the facility. Resident did not make any comments to this staff or exhibit behaviors. Resident continued on 15 minute checks. A hospital Summary Of Care dated 6/6/14 documented encounter diagnoses of depression and suicidal ideation. The form indicated the primary symptoms included dysphoric mood and negative symptoms. The current episode started more than one month ago. The mood worsened since onset. The resident characterized the problem as moderate. the mood included feelings of sadness, irritability and despair. The resident kept telling the staff at the nursing home that he/she wished he/she were dead. The resident stated he/she felt like no one cared about him/her. The negative symptoms began this week. The negative symptoms appear to have worsened since their onset. The degree of incapacity that he/she was experiencing as a	F 309		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	165255	A. BUILDING _____ B. WING _____	C 06/19/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CARLISLE CENTER FOR WELLNESS AND REHAB	680 COLE STREET CARLISLE, IA 50047

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F 309	Continued From page 46	F 309		

consequence of his/her illness was moderate. Additional symptoms of the illness included agitation and feelings of worthlessness. The resident denied having a plan to harm him/herself. The resident admitted to suicidal ideas. Review of symptoms included: psychiatric/behavioral: positive for suicidal ideas, dysphoric mood and agitation. the resident stated that all his/her family members were deceased and that he/she felt like no one at the nursing home cared about him/her. He/she stated when he/she needed something, the nursing home staff did not respond to him/her so he/she would say things like he/she wished he/she were dead and might as well be dead.

When interviewed on 6/16/14 at 4:07 p.m. Staff BB stated on 6/6/14 she sent the resident to the emergency room due to the resident was a threat to him/herself. When the resident returned she noted the resident was lonely and depressed. The resident was a bit confused that day. The resident informed her his/her life was not worth living anymore. She asked the resident why, at which time the resident told her to forget it. She thought the resident was embarrassed.

A Nurse's Note dated 6/12/14 at 10:45 a.m. noted call light cord placed above resident's bed, out of reach three times this shift, noted bell on floor under sink twice, removed plastic trash bags from room three times.

Observation on 6/16/14 at 10:45 a.m. resident in his/her bedroom. Call light hanging on the wall by the head of the resident's bed, within easy reach.

Observation on 6/17/14 at 4:50 p.m. revealed resident lying on bed with call light fastened to

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	165255	A. BUILDING _____ B. WING _____	C 06/19/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CARLISLE CENTER FOR WELLNESS AND REHAB	680 COLE STREET CARLISLE, IA 50047

(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 47 side rail on the bed. When interviewed on 6/12/14 at 12:20 p.m. the assistsnt director of nursing stated she could not find a policy and procedure for suicide precautions in their facility and the facility asked another nursing home to send them their policy and procedure for suicide precautions. The assistant director of nursing stated they could not remove the call light from the resident's room. When interviewed on 6/12/14 at 11:30 a.m. a staff nurse, Staff S stated they did not have a policy or procedure for suicide precautions. Their common practice for suicide precaution was to do 15 minute checks, remove the call light from the room and not to allow utensils (knife, fork, spoon) in the residents room. When interviewed on 6/12/14 at 11:40 a.m. a staff nurse, Staff EE stated the resident was on suicide precautions. Staff EE stated she knew what to do for suicide precautions from nurse's training. She stated the standard of practice was to remove call light, remove plastic bags from the room and to remove any hazards from the room. Observation on 6/12/14 at 11:47 a.m. revealed multiple plastic bags in the waste cans in this resident's bedroom. Two disposable razors on the counter by the hand washing sink next to the resident's bed. Call light cord hanging by the resident's bed. Light string hanging by the resident's bed. A belt in the resident's drawer. Wire clothes hangers in the resident's closet. Plastic bags noted in the resident's bathroom. When interviewed on 6/19/14 at 12:45 p.m. the resident visited freely in the privacy of his/her	F 309		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	165255	A. BUILDING _____ B. WING _____	C 06/19/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CARLISLE CENTER FOR WELLNESS AND REHAB	680 COLE STREET CARLISLE, IA 50047

(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 48	F 309		

bedroom. The resident stated he/she had lost everything in his/her life, including home, possessions and family. The resident verbalized how angry he/she was when he/she was brought to this facility after discharge from the hospital. The resident felt tricked as no one discussed admission to the nursing home with the resident and the resident had no say as to the admission to the nursing home. The resident stated he/she did not want to be in the nursing home. The resident stated he/she felt and believed no one at the nursing home cared for him/her. When asked if the resident believed the staff did not care for him/her, was it one or more of the staff, the resident responded it was the whole bunch. The resident stated he/she tried not to be a bother to the staff and had never hurt anyone. The resident steted he/she did not cause any trouble for the staff. The resident stated he/she just kept to him/herself. The resident stated he/she tried to put their negative thoughts out of his/her mind however sometimes it got the best of him/her. The resident repeated again, no one cared. The resident reported he/she had no one. The resident stated he/she thought he/she would be better off dead. The resident denied ever trying to take his/her own life, however he/she admitted to thinking about committing suicide from time to time. When asked if the resident ever thought about how he/she would commit the suicide, the resident stated he/she thought about stepping out in front of a truck and/or jumping off a bridge. The resident stated when the facility sent him/her to the hospital he/she was really down and was thinking about killing him/herself. Due to the resident's expression of suicidal thoughts and his/her plan for committing sulcide, the surveyor summoned the administrator to this resident's bedroom. At this time the resident verified his/her

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	165255	A. BUILDING _____ B. WING _____	C 06/19/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CARLISLE CENTER FOR WELLNESS AND REHAB	680 COLE STREET CARLISLE, IA 50047

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F 309	Continued From page 49 thoughts of suicide to the administrator. The resident also verified he/she felt no one in the nursing home cared about him/her. The resident also verified his/her thoughts of either jumping off a bridge or stepping in front of a truck to end his/her life.	F 309		
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 reviews, observation, interviews the facility failed to plan for and direct nursing care and services to ensure residents received adequate supervision. Concerns noted for 6 of 8 current residents sampled for review (Residents #10, #6, #3, #4, #7, and Resident #5). The facility reported a census of 87 residents. Findings include: 1.The Minimum Data Set (MDS) assessment dated 5/22/14 reported Resident #10 had impaired cognitive skills for daily decision making skills. The resident transferred with assistance of one staff, had no falls since admission. The resident had diagnoses including atrial fibrillation and hypertension. The Plan of Care dated 5/29/2014 identified	F 323		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	165255	A. BUILDING _____ B. WING _____	C 06/19/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CARLISLE CENTER FOR WELLNESS AND REHAB	660 COLE STREET CARLISLE, IA 50047

(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 323	Continued From page 50 Resident #10 had a risk for falls and directed staff to apply a Personal Safety Alarm (PSA) at all times, assist of one staff for transfers, place bed in low position with two side rails for bed boundaries and positioning. The CNA Care Plan directed the aides to apply a PSA at times, bed in low position, and ambulate with assist of one and walker. The Nursing Documentation and Fall Assessment Form dated 6/2/14 at 5:15 p.m., reported staff found Resident #10 lying on the floor on the left side. The resident attempted to get up from the chair and walk to the bathroom. The resident had dementia and unsteady gait, had a PSA alarm, not hooked to the resident. On 6/3/2014 the physician signed the Major Injury Determination Form, and determined Resident #10 sustained a major injury. The Radiology report dated 6/2/14 revealed Resident #10 had a displaced prosthetic fracture of the left hip. During an interview on 6/4/14 at 3:00 p.m., Resident #10's family member reported the resident got up without calling for help. The resident had dementia and had alarms in the bed and chairs. The family member had observed the alarms not in place when he/she visited on occasion. The resident now resided at the hospice house. During an interview on 6/4/2014 at 12:51 p.m., the D.O.N. (Director of Nursing) reported on 6/2/2014 he/she got a call to go to Resident #10's room. Staff T, RN (Registered Nurse) reported the resident complained of left hip pain and arm pain. Staff called for emergency services and remained with the resident on the floor. The clip alarm sat in the resident's recliner with the tab in the box. The residents in the room across the hall put their call light on when they observed the	F 323		

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F 323	Continued From page 51 resident fall. The resident had a fall score of 18, indicating he/she had a high risk for falls. The resident had a history of falls and had alarms on in the hospital prior to admission to the facility. They continued to provide personal alarms when admitted to the facility. During an interview on 6/4/2014 at 3:45 p.m., the A.D.O.N., (Assistant Director of Nursing) reported Resident #10 had no falls since admission, but had falls at home. The facility changed the alarm to clip alarm only and staff made sure he/she had the call light within reach. The resident's goal was to admit to hospice, but needed to get stronger to go home with hospice services. The resident had no history of removing alarms or attempts at self-transfers. The physician signed admission orders on 5/15/2014 via facsimile and on 6/3/2014 in person, that included chair pad and bed pad alarms. However, the resident only had a clip alarm at the time of the fall. During an interview on 6/4/14 at 1:00 p.m., Staff T reported on 6/4/2014 he/she worked on Resident #10's wing. The resident had intermittent confusion since admission, shut off his/her alarms, and unclipped the alarm on two occasions that day that Staff T had observed. Staff T witnessed the resident early that morning walking to the bathroom. The resident failed to put his/her call light on and had removed the clip alarm. Tha second time, the resident just started to stand up from the bed. Staff T intervened. Staff T indicated the resident had a clip alarm that staff moved from the bed to chairs. During an interview on 8/4/2014 at 3:09 p.m., Staff Y, LPN (Licensed Practical Nurse) reported Resident #10 removed the alarm, removed the batteries, very much noncompliant with the alarms. The resident attempted to self- transfer and ambulate. Staff re-educated the resident.	F 323		

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F 323	Continued From page 52 The resident resided near the end of the hall, away from the nurse's station. The aides reported the resident's noncompliance, and Staff Y witnessed it as well. During an interview on 6/4/2014 at 3:09 p.m., Staff Z, RN (Registered Nurse) reported Resident #10 ignored the alarms, and stood before staff could get to him. The bed had a pressure pad alarm. The aides reported the resident ' s noncompliance as well. During an interview on 6/4/2014 at 1:20 p.m., Staff L, CNA reported working on Hall #2 on 6/2/2014. The call light across the hall from Resident #10 went off and Resident #11 and #12 reported witnessing Resident #10 fall. Staff L observed Resident #10 on the floor lying on the left side to the left of the recliner. No alarm sounded, the clip alarm remained intact, in the recliner. The resident reported he/she needed to go to the bathroom. The CNA care plan directed staff to apply a personal safety alarm at times (PSA). The resident had a pressure alarm on the bed, not on the care plan. During an interview on 6/4/2014 at 1:30 p.m., Staff U, CNA reported working on 6/2/2014. Staff U responded to the call light across the hall from Resident #10. When Staff U entered Resident #10 ' s room, he she witnessed no call light, no alarm sounding, and the resident lay on the floor, on his/her left side with drops of blood on the floor by his/her head. The resident reported feeling like his/her arm had broken. The TAB alarm sat in the resident ' s recliner, with the tab intact. Staff U had observed the resident attempt to self-transfer, but never observed the resident attempt to remove the alarm. For a while the resident had a pressure alarm on the bed, but it had been removed. During an interview on 6/4/2014 at 2:00 p.m.,	F 323		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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F 323	Continued From page 53 Staff V, CNA reported working the day shift on 6/2/2014 and left at 2:15 p.m. prior to Resident #10 ' s fall. Staff V observed the resident attempt to self- transfer and unclip the alarm from his/her shirt. The resident had a TAB (clip) alarm that staff moved from the bed to chair. The CNA care plan instructed them to apply the personal alarm at times, but Staff V applied it at all times since the resident had unsteady gait. During an interview on 6/4/2014 at 2:30 p.m., Staff W, CNA reported working second shift at the facility. Staff W revealed Resident #10 had a clip alarm at all times. The resident often refused help, wanting to do things independently. The pressure alarm sounded, but the resident unclipped the personal clip alarm. Staff knew the resident unclipped it, because they would connect it, and respond to the pressure alarm, with the personal clip alarm disconnected. During an interview on 6/4/2014 at 3:10 p.m., Staff X, CNA reported working on 6/2/2014. At approximately 3 o ' clock p.m., Resident #10 Staff X observed the resident seated at the edge of the recliner, preparing to stand. Staff X disconnected the personal alarm and assisted the resident to the bathroom. Staff X connected the alarm after the resident returned to the chair, and placed the call light within reach. At approximately 5 o ' clock p.m. Staff X and Staff U responded to the call light across the hall from Resident #10. They observed Resident #10 on the floor on the left side, near the recliner. Resident #10 ' s call light and alarm failed to sound. The resident never used the call light, either staff would respond to the alarm, or they would just catch the resident up. Everyone knew the resident had a risk for falls and was noncompliant with the alarm. 2. The Minimum Data Set (MDS) for Resident #6 completed 4/6/14, included active diagnoses of	F 323		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	165255	A. BUILDING _____ B. WING _____	C 06/19/2014

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F 323	Continued From page 54 anemia, hypertension, Alzheimer ' s Disease, and depression. The MDS reported the resident required extensive assistance for bed mobility and transfers, the resident required total assist for dressing, toilet use and personal hygiene. The form indicated the resident had long and short-term memory impairment and severe cognitive impairment, hallucinations and delusions. The balance test for transitions and walking determined the resident was not steady and only able to stabilize with staff assistance for moving from seated to standing position, walking, turning around, and moving on and off the toilet. A Geriatric Services note dated 5/5/14 documented resident did not respond and did not follow commands. The form indicated the resident had advanced dementia and chronic pain. The resident appeared lethargic and chronically ill. The form indicated the resident had weakness in both upper and lower extremities. The resident utilized a wheelchair for locomotion. The Plan of Care first documented the resident at risk for falls due to disturbed gait related to dementia, osteoarthritis and debility on 10/4/13. The form instructed the staff to provide assistance as needed with transfers to reduce the risk for falls. The resident could transfer independently at times and staff provided assistance with dressing, hygiene and toileting. The form noted the resident usually incontinent of bowel and bladder and wore adult incontinent products. A Nursing Documentation and Fall Assessment Form dated 5/9/14 at 1:15 p.m. indicated Resident #6 fell from the toilet when a C.N.A. turned to grab a washcloth. The resident	F 323		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	165255	A. BUILDING _____ B. WING _____	C 06/19/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CARLISLE CENTER FOR WELLNESS AND REHAB	680 COLE STREET CARLISLE, IA 50047

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F 323	Continued From page 55 sustained a 2.5 cm slightly raised bump and a 1.3 cm laceration. The Conclusions and Findings noted C.N.A.'s would provide standby assistance with toileting. The Fall Investigation Tool dated 5/9/14 indicated Resident #6 had been seated on the toilet when the staff member went to the sink to get a wet wash cloth and heard a loud thud. The staff then went to the bathroom and found the resident lying face first on the floor. The C.N.A. stated he/she last saw the resident one minute prior to the fall. A Non-Pressure Skin Condition Report dated 5/9/14 documented resident sustained a 2.5 cm (centimater) by 2.5 cm laceration on the right side of his/her forehead. The C.N.A. pocket plan of care, printed on 5/20/14 instructed the staff to not leave the resident alone in the bathroom. Observation on 5/20/14 at 4:55 p.m. revealed the resident had an injury on their left forehead measuring approximately 1 centimeter (cm) with an approximate 3 cm by 2 cm surrounding pink area. Observation on 5/21/14 at 9:10 a.m. revealed Staff D prepared to assist the resident from the dining room to his/her bathroom. Staff D set up supplies on an over bed table in the resident's semiprivate bedroom. Staff D then placed a gait belt around the resident, assisted the resident to a standing position and then walked backwards while holding the resident's hands. Staff D walked the resident into his/her bedroom, past the roommate and into the bathroom. Staff D lowered the resident's pants, removed the urine soiled	F 323		

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	165265	A. BUILDING _____ B. WING _____	C 06/19/2014

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F 323	Continued From page 56 brief and sat the resident down on the toilet. Staff D then left the bathroom. Staff D changed his/her gloves and closed the privacy curtain in the bedroom. Staff D was not visible from the bathroom. When Staff D left the bathroom, the resident voided in the toilet and then began to stand up, unassisted. The Assistant Director of Nursing, present in the bathroom to observe the care, intervened and instructed the resident to sit down. When interviewed on 5/21/14 at 9:28 a.m. Staff D verified she left the resident on the toilet while she left the bathroom to close the privacy curtain, change her gloves, and obtain supplies. Staff D stated this was typical for her. Staff D verified she could not see the resident while she was in the bedroom. Staff D verified she was not aware the resident stood up from the toilet. 3. The MDS for Resident #3 completed 2/2/14, included active diagnoses of heart failure, hypertension, Alzheimer's Disease, depression and chronic lung disease. The MDS reported the resident required assistance for bed mobility and transfers, and required total assist for dressing, eating, personal hygiene and bathing. The form indicated the resident had lower extremity impairments on both sides. According to the Brief Interview for Mental Status (BIMS) cognitive test, Resident #3 scored 0 of 15 which revealed the resident had severe cognitive impairments. A Portable X-Ray report dated 4/18/14 revealed three x-rays taken of the resident's right shoulder due to pain and bruising after a fall. The images of the right shoulder demonstrated obliquely oriented nondisplaced fracture of the distal clavicle. This was thought to be an acute fracture.	F 323		

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	165255	A. BUILDING _____ B. WING _____	C 06/19/2014

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F 323	Continued From page 57	F 323		

A Physician's order dated 4/18/14 instructed the staff to give the resident Norco 5/325 (Hydrocodone/Acetaminophen narcotic pain killer), one tablet orally every four hours as needed for pain.

A Physician report dated 5/6/14 noted the resident's fractured clavicle, advanced dementia and hospice status for comfort. The physician noted the resident's deformity of the right clavicle and tenderness and instructed the staff to continue current hospice care and comfort measures.

Observation on 5/20/14 at 3:00 p.m. revealed Resident #3 lying on his/her bed. Observation revealed a arm/sling on the resident's right arm. Two C.N.A.'s, Staff A and Staff E came to the resident's room and prepared to provide personal care for this resident. Staff A unfastened the resident's brief. Observation revealed the resident incontinent of bowel and bladder. While turning the resident onto his/her side, Staff A placed her hand on the resident's right shoulder and pulled the resident towards her. The resident instructed the staff not to pull on his/her shoulder. The staff completed the care, dressed the resident and then sat the resident on the side of the bed. The staff then reached under the resident's right arm, grabbed the resident's right upper arm with her hand. The surveyor then asked the Assistant Director of Nursing (ADON) to intervene and prevent the staff from lift the resident by the arm/shoulder.

The C.N.A. pocket care plan printed on 5/20/14 instructed the staff to utilize a clip alarm when resident in bed and to place a mat on the floor

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F 323	Continued From page 58 next to the bed. Observation on 5/21/14 at 3:20 p.m. revealed the resident laying in bed. The resident's wheelchair parked next to the resident's bed. Observation revealed the floor mat folded up and stored upright. Observation also revealed no PSA (personal safety alarm) on the resident at this time. When interviewed on 5/21/14 at 3:25 p.m. a C.N.A. Staff N atated she had not been in this resident's room since she came on duty. When interviewed on 5/21/14 at 3:25 p.m. a C.N.A. Staff O stated she had come into the resident's bedroom to bring the resident fresh ice water. Staff O stated she did not notice the fall mat not in place and the PSA alarm not on the resident as planned. When interviewed on 5/21/14 at 3:25 p.m. a nurse, Staff P stated she had come into the resident room to do a treatment on the resident's roommate. Staff P stated she did not notice the fall mat not in place and the PSA alarm not on the resident as planned. The Plan of Care dated 5/8/14 addressed this resident's risk for falls related to Alzheimer's Disease and debility, the form instructed the staff to utilize a pressure alarm at all times, utilize bed and wheelchair alarm at all time, provide a safe, clutter free environment. The care plan directed two staff to assist with transfers to reduce the resident ' s risk for falls. The plan of care also addressed the resident's altered comfort related to complaints of back pain.	F 323		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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F 323	Continued From page 59 4. The MDS for Resident #4 completed 3/16/14, included active diagnoses of heart failure, hypertension, C.V.A. (stroke), Non-Alzheimer's Dementia, anxiety and depression. The MDS reported the resident required limited assistance for transfers, walking, dressing, toilet use, and bathing. According to the Brief Interview for Mental Status (BIMS) cognitive test, Resident #4 scored 3 of 15 which revealed the resident had severe cognitive impairments. According to the balance test for transition and walking, the resident was unsteady, and only able to stabilize with staff assistance when walking, moving on and off toilet and during surface to surface transfers. The resident sustained one fall since the last assessment. According to a Doctor's Progress Notes dated 1/22/14 the physician instructed the staff to utilize fall and skin precautions. According to the Fall Risk Evaluation dated 3/20/14 indicated Resident #4 was at high risk for falls due to his/her intermittent confusion, a history of falls in the last three months, resident chair bound, medication usage and predisposing diseases. The Plan of Care held on 3/27/14 addressed the resident's risk for falls related to dementia, and the need for assistance with ADL's (activities of daily living). The interventions included the resident would receive limited assistance of one staff with gait belt with transfers to reduce the risk for falls, provide a safe and clutter free environment. A new intervention for risk for falls dated 5/18/14 noted resident moved to room closer to nurse's station. The current interventions, first dated 10/2/13 included	F 323		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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F 323	Continued From page 60 pressure alarm to bed and wheelchair. A Nursing Documentation and Fall Assessment Form dated 4/28/14 noted at 1:05 p.m. noted staff found resident on the floor, next to bed, wheelchair at resident's feet. Resident reported attempting to transfer self from wheelchair to bed and fell to the floor. A communication sheet sent to the physician on 4/29/14 noted resident returned from the emergency room with stitches to left lag laceration. Nurse's Notes dated 5/18/14 at 9:10 a.m. heard pressure alarm sound. C.N.A. went into resident's room and found resident lying down on stomach in front of wheelchair. Nurse's Notes dated 5/20/14 at 5:00 a.m. resident denied any pain or discomfort. Resident did have altercation with roommate earlier this evening. Roommate was moved to another room for night. Nurse's Notes dated 5/20/14 at 6:00 p.m. indicated staff moved this resident to another bedroom down another hallway. No injury noted from his/her shirt on 5/19/14. No injury noted past hip dislocation from fall. Nurse's Notes dated 5/21/14 at 2:20 p.m. staff re-directed resident from old bedroom. Nurse's Notes dated 5/24/14 at 2:00 p.m. resident required re-direction on two occasions to get to his/her room. Observation on 6/3/14 at 10:15 a.m. revealed resident lying on the bed in the bedroom he/she	F 323		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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F 323	Continued From page 61 used to occupy. Observation revealed no alarm on the bed. When interviewed on 6/3/14 at 10:20 a.m. a C.N.A., Staff Q denied knowing the resident laid in his/her former bed. Staff Q verified the resident laid in the bed without any alarms. When interviewed on 6/3/14 at 10:25 a.m. a nurse, Staff R denied knowing the resident laid in his/her former bed. When interviewed on 6/3/14 at 10:33 a.m. C.N.A. Staff G denied knowing resident laid on his/her former bed. When interviewed on 6/3/14 at 10:35 a.m. C.N.A. Staff M denied assisting resident to his/her former bed. When interviewed on 6/3/14 at 10:40 a.m. C.N.A. Staff FF denied assisting this resident on this day. When interviewed on 6/3/14 at 10:42 a.m. C.N.A. Staff GG denied assisting this resident on this day. When interviewed on 6/3/14 at 10:45 a.m. R.N. Staff HH denied assisting this resident on this day. When interviewed on 6/3/14 at 10:47 a.m. C.N.A. Staff II stated she last observed this resident earlier that day when she gave this resident a shower. Staff II stated the resident had been going into his/her old bedroom and transferring him/herself into his/her old bed a lot lately. When interviewed on 6/3/14 at 1:20 p.m. the	F 323		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 323	Continued From page 62 Director of Nursing stated she knew the resident continued to go to his/her old room and transfer him/herself into his/her old bed since they moved the resident to another bedroom. The Director of Nursing stated their only intervention for this potential problem was for the staff to intervene when they saw the resident go into his/her old bedroom. The director of nursing denied implementing any interventions to alert staff when the resident entered the old room and denied the use of any alarms to the resident's old bedroom and/or bed. The Pocket Plan of Care dated 5/19/14 noted pressure alarm at all times and transfer with assistance of one. The Social Service Progress Note dated 12/23/13 noted this resident's diagnoses included Alzheimer's disease and depression. The resident scored 6 out of 15 on the BIMS which indicated severe cognitive deficits. 5. The MDS for Resident #7 completed 2/2/14, included active diagnoses of anemia, Alzheimer's Disease, and psychotic disorder. The MDS reported the resident required extensive assistance for transfers, and required limited assist for dressing and personal hygiene. The form indicated the resident had a lower leg impairment impairments on one side. According to the Brief Interview for Mental Status (BIMS) cognitive test, Resident #7 scored 3 of 15 which revealed the resident had severe cognitive impairments. The form indicated the resident had sustained a fall since admission to the facility. The Plan of Care dated 5/30/14 identified the resident's risk for falls related to dementia and	F 323		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	165255	A. BUILDING _____ B. WING _____	C 06/19/2014

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F 323	Continued From page 63 poor safety awareness. Resident #7 had a history of fractured right hip and arthritis. Observation on 5/20/14 at 9:21 a.m. revealed Resident #7 seated in a wheelchair by the nurse's station. Observation revealed a large hematoma above the resident's right eye. A Non-Pressure Skin Condition Report dated 5/16/14 noted resident sustained a 9 cm by 10 cm hematoma down to below ear/cheek in corner of right eye, gray, red and purple in color. The C.N.A. pocket plan of care, printed off on 5/20/14 indicated the resident a fall risk and required assistance of two persons for transfers. Observation on 5/20/14 at 9:45 a.m. revealed Staff G and Staff F transferred the resident by placing their arms under the resident's underarms and pulling up on the resident's arms/shoulders. The staff failed to use a gait belt for the assisted transfer. When interviewed on 5/20/14 at 9:55 a.m. the Director of Nursing (DON) described the transfer as good. When asked the facility's policy for assisted transfers, the Director of Nursing stated staff were to use a gait belt for all assisted transfers. The DON verified the staff lifted the resident under the resident's arms and failed to use a gait belt. When interviewed on 5/20/14 at 9:58 a.m. Staff F stated she totally failed to remember to use a gait belt. Review of the facility's undated policy and procedure, "Pacifica Health Services, LLC	F 323		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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F 323	Continued From page 64 Modified Lifting Policy and Procedure" noted all employees were to exercise proper safety techniques when lifting and transferring residents and utilize safety materials, equipment and training designed to prevent personal and patient injury. The purpose of this policy was to set a consistent standard from which all employees exercised proper lifting and transfer techniques for each individual resident in order to achieve an accident-free environment. The guidelines in determining proper transfer methods included gait belts must be used 100% (percent) of the time. The facility's Therapy Orientation instructed staff gait belts were mandatory with all transfers. The facility's Transfer Training instructed staff to always use a gait/transfer belt and never pull up on resident arms. This document also noted if a resident required assistance to transfer, a transfer belt was required. The belt was used to hold onto the resident during the transfer. When interviewed on 5/20/14 at 12:32 p.m. the resident stated he/she hit his/her head when he/she stood up and tripped. The resident stated his/her head still hurt. Observation revealed an approximate 5 cm by 4 cm purple hematoma raised approximately 2.5 cm. Observation revealed purple bruising of the resident's right neck and cheek. 6. Review of the clinical record for Resident #5 revealed the admission date of 1/16/13 to the facility. An undated Pre-Admission Assessment Form listed the resident's admitting diagnoses included	F 323		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	165255	A. BUILDING _____ B. WING _____	C 06/19/2014

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F 323	Continued From page 65	F 323		

Alzheimer's Dementia, depression and anxiety. Pertinent Information included the resident exhibited increased agitation in evenings as evidenced by anxiousness, would get up and down repeatedly. The resident did not like male caregivers and wandered. Listed behaviors included the resident tried to leave his/her home and would get mad with redirection attempts.

A Minimum Data Set (MDS) assessment tool dated 2/16/14 indicated the resident had short and long-term memory loss and severe cognitive impairment. Behaviors included delusions, physical aggression and wandering on a daily basis. The resident required two staff to assist with bed mobility, transfers, dressing, toilet use and bathing. The resident required two staff assistance with walking in the bedroom and in hallways and personal hygiene. The resident required staff assistance to stabilize his/her balance while changing positions, walking and turning. Active diagnoses included hypertension, diabetes, Alzheimer's Disease and anxiety. The resident was always incontinent of bowel and bladder. The resident weighed 198 pounds.

The Plan of Care dated 10/10/13, (updated 2/19/14) noted resident at risk for elopement due to dementia as evidenced by the resident approached exit doors frequently and made statements of wanting to get out. The interventions instructed the staff to monitor the resident while up in merry walker and redirect as needed if resident seen near exit doors. The wandering care plan first dated 9/25/13 identified the resident's elopement risk as evidenced by a history of attempts to leave the facility unattended, wandered aimlessly, impaired safety awareness and disoriented to place. The plan of

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	165255	A. BUILDING _____ B. WING _____	C 06/19/2014

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F 323	Continued From page 66 care also identified the resident's risk for falls due to dementia and poor safety awareness and instructed the staff to check frequently. The Psychosocial Care Plan dated 10/10/14 noted the resident's ineffective coping skills and failure to adjust to lifestyle change. A Social Service Progress Note dated 2/19/14 assessed the resident as a 71-year-old resident with significant long and short-term memory deficits and severely impaired decision making skills. The resident continued to utilize his/her merry-walker throughout the facility. The resident had exit seeking behaviors and would attempt to get out the doors several times a day. Staff continued to keep a close eye on the resident regularly. An Incident/Accident Report dated 4/24/14 at 7:50 p.m. noted the nurse was completing his/her report when notified by a C.N.A. (certified nursing assistant) that the resident was in front of the facility. The nurse noted the incident was unwitnessed. Nurse's notes dated 4/24/14 at 8:00 p.m. noted at 7:50 p.m. the nurse was alerted by a C.N.A. that the resident had exited the facility through the west door down the 200 hallway. At 7:53 p.m. three staff members rushed outside. They found the resident on the grassy area out front of the care center. The nurse re-educated the resident that he/she needed staff to accompany him/her & the nurse initiated 15 minutes check on the resident. An undated, unsigned typed facility report indicated on 4/24/14 the resident exited the building through the 200 hall exit door. A C.N.A.,	F 323		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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F 323	Continued From page 67	F 323		

Staff J was in another resident's bedroom when he noted this resident outside the building and immediately went to the dining room and alerted the nurse of the resident being outside. The facility installed a new alarm on the 200 hall door awaiting a wander guard alarm system for the 200 hall door. The facility held a mini in-service to educate staff members on correct use of alarm system.

A communication form sent to this resident's physician dated 4/25/14 informed the physician the staff found the resident outside, on the front lawn. The staff began 15 minute checks on this resident.

Observation on an environment tour beginning at 8:21 a.m. on 5/20/14 revealed an alarmed door at the end of the 200 resident hallway led to an enclosed area. This area contained a doorway to the physical therapy room, an incline to an alarmed doorway to the assisted living center and two alarmed doors to the outside. One of the alarmed exit doors led to the front yard and parking lot.

A written statement by an assisted living employee, Staff K dated 4/25/14 indicated about 8:00 p.m. to 8:20 p.m. he/she and another assisted living employee, Staff I were busy passing medications in the assisted living when their pagers alerted and the computer was going crazy. The computer kept saying "West Door". Staff K and Staff I went to the beauty shop to reset the door alarm. He/she was unable to reset the alarm. Staff K then went to the facility's nurse's station and asked the staff why they were getting the alerts in the assisted living. The facility staff then informed the assisted living staff the

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	165255	A. BUILDING _____ B. WING _____	C 06/19/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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F 323	Continued From page 68 resident was outside. A written statement by an assisted living employee, Staff I indicated on 4/24/14 the alarm sounded for the west door. The alarm kept popping up on their system for about 20 minutes. They tried to cancel the alarm. They attempted to get the facility staff to assist them. A second written statement by Staff I indicated on 4/24/14 around 7:55 p.m. the alarm for the west door went off, the pagers were going off as well as the alarm on the computer. The alarm went off for a few minutes so Staff I and Staff K decided to go and check it out. They went and tried to cancel the alarm. They were unable to cancel the alarm so they went to get assistance from the facility staff to cancel the alarm. When interviewed on 5/20/14 at 12:03 p.m. the assisted living employee, Staff I stated he/she had worded at the assisted living for one year. Staff I stated when the alarm and pagers alerted on 4/24/14 it felt like 20 minutes, however it could have been shorter. Staff I stated he/she was wondering why the alarm continued to sound. Staff I stated after what seemed like 20 minutes, he/she and Staff K went to see why the alarm continued to sound. A written statement by a C.N.A., Staff J indicated Staff J last observed the resident by the dining area. Staff J was in a resident's bedroom down the 300 hallway, closing the window blinds when he/she observed the resident outside of the care center. Staff J then alerted the nurse and went outside to assist the resident. When interviewed on 5/20/14 at 2:00 p.m. Staff J stated about 7:30 p.m. to 8:00 p.m. he/she was in a bedroom down the 300 hallway. Staff J looked outside the	F 323		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	165255	A. BUILDING _____ B. WING _____	C 06/19/2014

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F 323	Continued From page 69	F 323		

window and observed the resident outside the building. Staff J denied hearing any alarms sound. Staff J then went down the hall, to the front dining room area and alerted the nurse the resident was outside the building. They found the resident outside, behind the handicapped parking sign, on the grass, down a slope, approximately 12 feet from the sidewalk. It took three staff members to get the resident in the Merry Walker back up to the sidewalk. Steff J denied hearing any alarms sounding when outside. Steff J stated no staff knew the resident was outside the building until he/she saw the resident out the window. Staff J stated the 200 door had a quiet alarm that turned off when the door was closed. Staff J stated a resident who lived down the 200 hall, Resident #1 reported hearing the alarm sound. Staff J stated he/she felt this was an elopement due to no one knew the resident had exited the 200 door.

When interviewed on 5/20/14 at 1:25 p.m. a licensed registered nurse, Staff C stated on 4/24/14 staff assisted the resident into a Merry Walker after the evening meal. Staff C stated the 200 door had an alarm that quit after the door was closed. At 7:50 p.m. Staff C was checking medications when Staff J came from the 300 hall, running towards the front door. Staff J informed the nurse, the resident was outside the building. Staff C followed Staff J out the door. They found the resident outside, behind the handicapped parking sign in a wet, soft grassy area. The resident normally would go to every exit door and attempt to exit the building. After this incident, they moved the resident to another room and put a new alarm on the 200 hall door. Staff C denied getting a pager alert until after he/she observed Staff J running down the 300 hallway. Staff C

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	165255	A. BUILDING _____ B. WING _____	C 06/19/2014

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CARLISLE CENTER FOR WELLNESS AND REHAB	680 COLE STREET CARLISLE, IA 50047

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F 323	Continued From page 70 denied hearing any alarm. When interviewed on 5/21/14 at 10:15 a.m., Resident #1 stated on 4/24/14 he/she sat in his/her chair in the 200 hallway awaiting staff assistance into his/her bedroom to his/her bed. Staff #1 stated he/she observed the resident come down the 200 hallway in Merry Walker and go towards the exit door. Resident #1 hear the alarm sound, however due to physical limitations, he/she could not alert the staff of the resident's exit from the facility. Resident #1 stated no one came to see why the alarm sounded. Resident #1 stated he/she did not wear a watch and could not see a clock, however Resident #1 estimated it was about 10 minutes before anyone came to reset the exit door (assisted living exit) alarm. A facility Mini In-Service Report dated 4/25/14 noted topic of the in-service: door alarms/wander guard alarms. Topic of the in-service indicated it was everyone's responsibility to respond to alarms and instructed the staff to locate the location of what alarm was sounding, announce which door was sounding over the pagar system, everyone should respond to the alarm, if no one was at the door, staff should proceed to the outside to walk the area to assure no residents had gotten out of tha facility. A new alarm had bean placed on the 200 hall door awaiting wander guard placement. When interviewed on 5/20/14 at 4:07 p.m. a C.N.A. Staff H stated on 4/24/14 at about 6:45 p.m. they assisted the resident into a Merry Walker. Normally after supper the resident liked to hang around the nurse's station and help the nurses shuffle papers. Staff H last saw the resident around 7:15 p.m. to about 7:30 p.m.	F 323		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	166265	A. BUILDING _____ B. WING _____	C 06/19/2014

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CARLISLE CENTER FOR WELLNESS AND REHAB	650 COLE STREET CARLISLE, IA 50047

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F 323	Continued From page 71 Staff H later heard Staff J state the resident was outside. Staff H denied hearing any alarms sounding. Staff H went outside and observed the resident in the middle of a puddle. They had to lift the Merry Walker to get it back up on the sidewalk. Staff H denied hearing any door alarms sounding. Staff H stated approximately one month prior to this incident the resident exited the same door and then exited the outer exit door. When interviewed on 5/20/14 at 12:00 noon, the Director of Nursing stated at the time of the incident, the 200 hall door had an alarm that only sounded while the door was open. The 200 hall door did not have a wander guard alarm at the time of the incident.	F 323		
F 328 SS=D	483.25(k) TREATMENT/CARE FOR SPECIAL NEEDS The facility must ensure that residents receive proper treatment and care for the following special services: Injections; Parenteral and enteral fluids; Colostomy, ureterostomy, or ileostomy care; Tracheostomy care; Tracheal suctioning; Respiratory care; Foot care; and Prostheses. This REQUIREMENT is not met as evidenced by: Based on clinical record review and staff interviews, the facility staff failed to ensure that residents received proper treatment and care for residents dependent on oxygen. Concerns noted	F 328		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	165255	A. BUILDING _____ B. WING _____	C 06/19/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CARLISLE CENTER FOR WELLNESS AND REHAB	680 COLE STREET CARLISLE, IA 50047

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F 328	Continued From page 72 for 3 of 3 residents sampled for respiratory care. The facility reported a census of 87 residents. (Residents #15, #4 and #16) Findings include: 1. A hospital Physician Discharge Summary dated 5/18/14 noted Resident #15 admitted to the hospital on 4/29/14 and discharged on 5/18/14. The resident used oxygen at 2 liters chronically for unknown reasons. The resident received one dose of Rocephin. He/she became hypoxic with O2 Sats (oxygen saturations) around 84% on 2 L which required oxygen to be increased to 4 L in order to get O2 Sats greater than 90%. The hospital course included thoracentesis and diuresed 950 ml (milliliters) of pleural fluid. Acute hypoxic respiratory failure, new diagnosis of lung cancer with brain (and possible bone) metastases, right obstructive pneumonia, recurrent right pleural effusion, atelectasis right lower lobe due to an endobronhial lesion. The Hospital Discharge Orders dated 5/18/14 problem list included acute hypoxemic respiratory failure and chronic hypoxia. This form instructed staff to provide oxygen as directed. A Physician Admission/Monthly Orders dated 5/19/14 lacked orders for oxygen use. A Clarification Physician Order dated 5/19/14 instructed staff to administer O2 at 5 L to maintain O2 Sats above 90%. The TAR (treatment administration record) for May 2014 included a physician order dated 5/19/14 for oxygen at 5 L to maintain the O2 sat above 90%.	F 328		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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F 328	Continued From page 73 A physician's note dated 5/22/14 documented Resident #15 had a recent hospitalization with right lower lobe lung mass presumed to be lung cancer with cerebral metastasis. The resident had advanced chronic obstructive pulmonary disease (COPD) on 7 L (liters) of O2 by nasal cannula. Active Problems included anemia, anxiety, chronic constipation, COPD, chronic pain, congestive heart failure (CHF), debility, depression, edema, esophageal reflux, generalized osteoarthritis, hypertension, hypokalemia, lumbago, lung cancer, nicotine dependence, peripheral nauropathy, shortness of breath and venous insufficiency. The assessment of respiratory/pulmonary noted splinting and increased work of breathing, crackles over both lungs and wheezing heard diffusely over both lungs. The physician's assessment noted lung cancer, chronic obstructive pulmonary disease, congestive heart failure and debility. The physician's plan included continue current oxygen. Physician's Orders dated 5/22/14 instructed staff to provide oxygen at 5 L to maintain SAT (oxygen saturation levels) above 90%. The Plan of Care dated 6/2/14 identified one problem/strength on 6/2/14 as Oxygen therapy related to lung cancer and shortness of breath. The goal noted resident would not have complications from oxygen therapy through next review period. The interventions instructed staff to administer oxygen per physician order and to observe for shortness of breath, cyanosis, anxiety and report abnormal findings to physician with follow up as indicated.	F 328		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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F 328	Continued From page 74 The Pocket Plan of Care dated 5/29/14 instructed staff this resident utilized oxygen at 5 L. Nurse's Notes documented: a. On 5/19/14 at 3:45 p.m., the resident arrived on a stretcher. The resident used O2 at 5 L per nasal cannula and their Pulse Ox (O2 sat) measured 94%. b. On 5/30/14 at 1 p.m. the resident requested a specific company to provide Hospice services and requested one nurse to be his/her caregiver. The resident's physician ordered no change in medications and ordered to switch the resident to the requested Hospice provider. The resident's lung sounds were very diminished, his/her respirations were rapid with any exertion or talking and their skin appeared warm and gray. This entry lacked documentation of his/her oxygen saturation. c. On 5/30/14 at 11:50 p.m. the resident had diminished lung sounds, felt very weak and could hardly speak. This entry lacked documentation of oxygen saturation levels. d. On 5/31/14 at 8:00 p.m., the resident's O2 sat measured 94% on O2, no level given. e. On 6/5/14 at 12:00 p.m., staff documented an O2 Sat of 92% and the resident received oxygen at 8 L (the record revealed a lack of documentation to show an reason for the increase in oxygen a lack of physician notification or an order for 8 L). f. On 6/6/14 at 2:00 a.m. the resident's O2 sat measured 90%. g. On 8/6/14 at 2:00 p.m. staff noted cyanosis to the resident's lips and nail beds. Staff documented his/her lung sounds were adventitious to upper lobes and it appeared resident had difficulty expectorating at times. The	F 328		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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F 328	Continued From page 75 resident experienced SOB while in supine position. The physician acknowledged the issues on 6/4/14 and the resident's O2 sat measured 96%. h. On 6/6/14 at 5:00 p.m. staff placed a call to the resident's family and left a detailed message regarding a move to another room due to the high voltage need for oxygen use (the record lacked documentation regarding concerns for voltage). i. On 6/8/14 at 10:00 a.m. staff noted cyanosis to the resident's nail beds and lips. The resident's eyes were fixed and s/he did not respond to tactile stimuli. The resident experienced labored breathing with 5 second apnea. The resident received oxygen at 15 liters per order and family request. Staff talked with the Hospice nurse regarding the resident's pain and air hunger and received a new order to increase Roxanol every hour as needed for air hunger. The resident's O2 sat measured 86%. j. On 6/8/14 at 4:30 p.m. the resident's O2 Sat measured 83%. k. On 6/9/14 at 1:00 a.m. staff noted coarse lung sounds, labored breathing, increased SOB, use of accessory muscles to breath, abdominal distension, purple/blue skin color to the feet and cyanotic lips. l. On 6/9/14 at 2:42 a.m. the resident expired. When interviewed on 6/17/14 at 9:45 a.m. the Hospice RN (registered nurse) assigned to this resident stated she supplied the resident with two oxygen concentrators upon admission to their Hospice services as she had heard in the past the hospital had titrated this resident's oxygen from 2 L up to 15 L. The Hospice nurse stated the resident had an order for 5 L of oxygen. The nurse's assessments conducted on 5/31/14, 6/1/14, 6/2/14, 6/5/14 and on 6/6/14 revealed the	F 328		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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F 328	Continued From page 76 resident's oxygen levels good, especially considering the resident's respiratory status. The nurse stated she never thought the resident required oxygen above the ordered 5 L and she never asked the physician to increase the resident's oxygen level. She stated no facility nurse ever expressed concerns regarding the resident's oxygen level. The nurse stated with COPD she would never ask for increased oxygen level before further testing, certainly not without a physician's order and she would never increase oxygen from 5 L to 15 L. The nurse stated she would not change a resident's oxygen level. She would ask a physician and then inform the nursing staff of any new order. The facility Oxygen Administration policy and procedure dated 2012 instructed staff to check physician's order for liter flow and method of administration and to monitor resident's response to therapy with pulse oximetry as necessary. The policy also noted documentation may include date, time, method of administration and liter flow as ordered. During interview on 6/18/14 at 7:31 a.m., Staff R LPN (licensed practical nurse) stated when sha worked on 6/4/14 the resident's oxygen ran at 5 L. When she returned on 6/5/15 the resident's oxygen ran at 8 L. Staff R denied being informed in report of any concerns regarding the resident's respiratory status or low saturation levels. Staff R did not know why the oxygen ran at 8 L and did not check the clinical record for the physician's order for oxygen. Staff R stated the resident was on a titration system for the oxygen and they could adjust the oxygen from either 4 or 5 L up to 12 L. She stated the resident did well on 6/5/14 so sha left the oxygen at 8 L.	F 328		

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F 328	Continued From page 77 Review of the June 2014 TAR revealed a physician order dated 5/19/14 for Dxygen: 5 L to maintain SAT above 90%. The TAR contained a handwritten addition to the order; a 1 was placed in front of the typed 5 L. The TAR lacked documentation to show who changed the 5 L to 15 L and on what date. When interviewed on 6/12/14 at 9:00 a.m., Staff AA LPN stated she changed the oxygen to 15 L per direction of the Hospice nurse. Staff AA reported changing the oxygen to 15 L the day they changed the resident to another bedroom because when they ran the oxygen at 15 L, they needed to run two oxygen concentrators and the circuit in the resident's bedroom could not handle the voltage needed. Staff AA reported the Hospice nurse obtained the physician order for oxygen at 15 L at the same time the physician ordered to discontinue routine medications, except the comfort medications. Staff AA reported she wrote a 1 in front of the 5 on the June TAR to change the physician's order from 5 L to 15 L. Staff AA reported the resident's O2 Sat was very good. Staff AA never talked to a physician regarding the oxygen level. When interviewed on 6/17/14 at 2:32 p.m. Resident #15's family member stated the resident never received oxygen at 15 L in the hospital. The family member reported the resident received either 9 - 10 liters at the highest level while in the hospital. The family member saw a significant decline in the resident after the staff moved the resident to another room and began oxygen at 15 L. The family member reported the staff never discussed the oxygen; s/he assumed the physician or Hospice staff order the 15 L of	F 328		

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F 328	Continued From page 78 oxygen. The family member reported that after the room change, the resident could no longer speak, gasped for air and never regained any sort of consciousness. The resident had a quick and sudden decline. When interviewed on 6/18/14 at 8:03 a.m. the resident's POA (power of attorney) stated the facility staff never talked to him/her about the resident's oxygen use and/or rate. The POA denied ever requesting the oxygen be raised. When interviewed on 6/18/14 at 3:15 p.m. the resident's physician could not recall raising the resident's oxygen level. The physician stated the resident's oxygen saturation level was good while on 5 L of oxygen. The facility nurses were required to call the physician and obtain a new order prior to changing the oxygen level. The clinical record revealed no reason to increase the oxygen level. The physician stated the nurse was stupid for changing the oxygen to 15 L; however he did not believe it was a malicious act. The physician stated the increase of oxygen did not hasten the resident's death. 2. The MDS assessment for Resident #4 dated 3/16/14 documented diagnoses that included heart failure, hypertension, CVA (stroke), Non-Alzheimer's dementia, anxiety and depression. The assessment documented the resident had sever cognitive and memory impairment and that s/he received oxygen therapy. The Plan of Care dated 3/24/14 addressed the resident's oxygen therapy related to chronic respiratory failure. The plan instructed to administer oxygen as physician ordered.	F 328		

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F 328	Continued From page 79 A Doctor's Progress Notes dated 1/22/14 documented a diagnoses of chronic respiratory failure and the resident received oxygen. The physician's plan included continue oxygen. The Pocket Plan of Care dated 5/19/14 indicated staff to administer oxygen at 2 L. Observation on 5/21/14 at 9:04 a.m. revealed resident in wheelchair by the nurse's station. Observation revealed resident wore nasal cannula in both nostrils. The small oxygen container on the back of the resident's wheelchair registered empty. When interviewed on 6/12/14 at 9:00 a.m. Staff AA. LPN stated that last Thursday she noted the resident without oxygen. She instructed the staff to apply oxygen. She tested the resident's oxygen saturation level. The oxygen saturation level tested 77%. She then applied oxygen at 2 L and sent a message to the resident's physician regarding the oxygen saturation levels. She was informed the resident's oxygen had been discontinued as the resident tripped over the oxygen tubing. 3. The MDS assessment dated 5/25/14 listed diagnoses for Resident #16 that included anemia, heart failure, hyperlipidemia and depression. The MDS noted the resident received oxygen therapy. The Plan of Care dated June 2014 included a problem of impaired gas exchange related to hypoxia of unknown origin as evidence by daily use of oxygen. Staff listed the resident would have no signs of symptoms of shortness of breath as the goal. The interventions included	F 328		

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F 328	Continued From page 80 monitor for shortness of breath and report to physician if occurred as appropriate and administer oxygen as ordered by physician daily. A Mercy Clinics Geriatric Services dated 4/28/14 documented Resident #16 received oxygen at 2.5 L continuously. The resident's respiratory effort revealed shallow respiration. Respiratory findings included a dry cough. Oxygen on at 2.5 L by nasal cannula continuously. On auscultation breath sounds were decreased diffusely, expiratory wheezing heard and inspiratory wheezing also heard. Wheezing was heard diffusely over both lungs. The pocket plan of care dated 6/13/14 noted resident utilized oxygen at 2 L. Physician's Orders dated 4/23/14 noted the physician first ordered oxygen on 3/7/11. The current physician order instructed the staff to administer oxygen at 2 L on a continuous basis. May remove oxygen for short periods of time. The order also instructed the staff to check the resident's oxygen saturation levels very shift. The TAR (treatment administration record) for June 2014 included a physician order dated 3/7/11 to check the portable oxygen tank twice daily and fill as needed. Review of the TAR on 6/19/14 at 11:00 a.m. revealed the last documented oxygen tank check occurred on the overnight shift from 6:00 p.m. to 6:00 a.m. on 6/19/14. The last recorded oxygen saturation level tested 93% on the night shift. Observation on 6/19/14 at 10:40 a.m. revealed the resident in a wheelchair in the dining room. Observation of the resident's portable oxygen	F 328		

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F 328	Continued From page 81 tank revealed the tank registered empty and the resident as short of breath. The resident stated he/she felt tired. The surveyor summoned the nurse, Staff R to the dining room and Staff R verified the resident's oxygen tank was empty. Staff R attempted to test the resident's oxygen saturation level by using a Pulse Ox device. The nurse could not obtain a reading. The nurse tested the oxygen tank and stated she could not feel any oxygen coming from the machine. She also placed the nasal cannula in a glass of water and no bubbles came out, which indicated no oxygen coming out of the cannula. Staff then took the resident to his/her room to hook the resident up to another oxygen supply. While in the bedroom, the nurse checked the resident's oxygen saturation level again at which time it tested low at 75%. Staff R verified the resident appeared short of breath, not normal for the resident. After being on the new source of oxygen the resident's pulse ox rose to 93% and the resident stated it felt easier to breath. When interviewed on 6/19/14 at 11:36 a.m. the Assistant Director of Nursing stated they did not have any policy or procedure for the use of portable oxygen machines.	F 328		
F 514 SS=D	483.75(l)(1) RES RECORDS-COMPLETE/ACCURATE/ACCESSIBLE The facility must maintain clinical records on each resident in accordance with accepted professional standards and practices that are complete; accurately documented; readily accessible; and systematically organized. The clinical record must contain sufficient	F 514		

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F 514	Continued From page 82 information to identify the resident; a record of the resident's assessments; the plan of care and services provided; the results of any preadmission screening conducted by the State; and progress notes. This REQUIREMENT is not met as evidenced by: Based on clinical record review, staff and family member interview and review of phone records, the facility staff failed to accurately document in a resident's clinical record for 1 of 17 residents reviewed (Resident #9). The facility identified a census of 87 current residents. Findings include: A Geriatric Services report dated 4/28/14 documented Resident #9 had chronic debility secondary to multiple sclerosis (MS) and Parkinson's disease. The resident ' s active problems included acute conjunctivitis, acute upper respiratory infection, chronic pain, debility, dementia, depression, diabetes mellitus, diabetic peripheral neuropathy, multiple sclerosis and Parkinsonism. The neurological exam revealed memory loss, difficulty walking, confusion, loss of strength and depression. The physical exam revealed impaired insight and impaired judgment, incoherent speech, disorientation to time, impaired short term memory and impaired remote memory. Review of the Restorative Nursing Services Progress Notes revealed on 5/7/14 the resident refused therapy three times. The resident complained of not feeling well; too weak to do exercises. The restorative staff member, Staff B,	F 514		

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F 514	Continued From page 83 documented she informed the nurse, Staff S, of the resident's refusal and complaints of not feeling well. When interviewed on 6/3/14 at 3:40 p.m. Staff B stated on 5/7/14, the resident stated he/she did not want to do the exercises in the morning and felt like s/he would always be sick. The resident complained of a cough in the afternoon and did not feel well. Staff B stated she informed the resident's nurse, Staff S, of the resident's statements and refusal. The resident stated he/she had his/her cold for a long time, complained of his/her chest and of difficulty breathing. The nurse informed Staff B she would go and assess the resident. When interviewed on 6/3/14 at 4:55 p.m., Staff S (licensed practical nurse) stated when Staff B reported the resident refused therapy and did not feel well, she went to the resident's bedroom and found the resident wearing oxygen. Night shift staff had started the oxygen. Staff S stated she normally documented in the nurse's notes when she assessed a resident, but she did not document her assessment of the resident that day. On Tuesday (5/6/14), the resident refused to get out of bed. The nurse told Resident # 9 to get up for the evening meal; the resident did not get out of bad on Tuesday. Staff S stated she did not document on the resident that day. On Wednesday she told the resident he/she had to get up out of bed for the noon meal and the resident refused to get up out of bed for the evening meal. They put oxygen on the resident on Wednesday. When asked why she failed to document her assessment of the resident, the nurse stated the resident had times when he/she did not want to do anything. She thought the	F 514		

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F 514	Continued From page 84 resident was very stubborn. During report on Thursday, (5/8/14) the off going nurse reported the resident was sweaty and the pulse ox (oxygen saturation level) had dropped before breakfast. She told the CNAs they had to get the resident up out of bed for breakfast. The resident's lung sounds sounded course, the resident was sweaty and their color was a little different (more pale). By the end of breakfast the resident leaned over in the chair and had a loose, moist cough. She then had the staff get the resident up and out of bed for the noon meal. Staff S stated she did not call the resident's family regarding the resident's decline in condition. When interviewed on 6/3/14 at 5:30 p.m. a Staff L, CNA stated first noticed a decline in this resident's condition on Monday (5/5/14). The resident had oxygen on and sounded horrible; congested like he/she had a chest cold. The resident acted "out of it", not his/her normal self. The resident continued to get worse. In the past when the resident would get sick it would only be for one day. On Tuesday the resident sat up a little bit better. Staff L did not work on Wednesday. When he worked on Thursday, he immediately talked to the nurse Staff AA as it looked like the resident was not breathing. The nurse increased the resident's oxygen and when they got the resident up for the noon meal, s/he leaned over to the side so they assisted the resident back to bed. Staff L thought the resident should go to the hospital. The resident's color appeared gray and the resident felt sweaty. The resident felt like he/she was burning up, did not eat or drink and Staff L thought the resident was uncomfortable. Nurse's Notes documented:	F 514		

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F 514	Continued From page 85 a. On 5/8/14 at 5:25 a.m. staff documented he resident ' s oxygen saturation measured 83%. Staff administered Ibuprofen, cough syrup and supplemental oxygen at 2 L by nasal cannula. Staff documented the resident had a nonproductive cough, profuse sweating and anxiety with expiratory wheezing/raspy cough at 5:20 a.m. b. The next entry dated 5/8/14 at 10:00 a.m. noted poor appetite, staff repositioned the resident often, s/he used oxygen, had no cough and course lung sounds. c. On 5/9/14 at 8:00 a.m. the resident displayed lethargy, had a low grade fever, hurt all over and had decreased lung sounds in the left lobe. The right lobe sounded clear. The resident had SOB (shortness of breath) at rest. Resident #9's oxygen level measured 84% and staff placed oxygen at 2 L and administered Ibuprofen. Staff also noted a moist cough. Staff placed a call to the physician office and received a new order for a chest x-ray. Staff documented calling the resident's family member regarding the change in condition and interventions. d. On 5/9/14 at 10:00 a.m. the chest x-ray results were in and faxed to physician with current assessment. Resident #9 responded to physical and tactile stimuli. e. On 5/9/14 at 12:00 noon, staff noted no improvement in the resident's status and documented an oxygen level 87%. The resident remained lethargic. The resident's lung sounds continued with decreased air movement and s/he had a moist cough and SOB at rest. The resident declined emergency room evaluation and treatment. Staff placed a call to the nurse practitioner and received a new order for Rocephin. Staff documented calling the	F 514		

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F 514	Continued From page 86 resident's family regarding resident's condition and intervention taken. f. On 5/9/14 at 5:55 p.m. the nurse spoke to the resident again regarding emergency room evaluation and treatment and again the resident refused. The nurse placed call to family regarding nurse's concerns and DNR wishes. g. On 5/9/14 at 10:30 p.m., the nurse documented going to help the CNA to check and change the resident. Before entering the resident's bedroom, the CNA stated the resident was not breathing. The nurse then called the on-call physician of the change in condition. Staff received an order to send the resident to the emergency room for evaluation. h. On 5/9/14 at 10:35 p.m. the nurse called ambulance for transfer to emergency room. i. On 5/9/14 at 10:30 p.m. staff documented contacted the resident ' s responsible party to notify them of the intent to transfer the resident. j. On 5/9/14 at 10:50 p.m. ambulance arrived and the resident had no breath sounds upon entering room. The ambulance attendants asked the nurse to call POA back and make sure no lifesaving efforts were wanted. At this time, nurse called responsible party who requested attempts to stabilize resident. The staff started compressions and rescue breathing (CPR) until the parametric called the code due to the resident ' s DNR (do not resuscitate) status. k. On 5/9/14 at 10:30 p.m. another nurse, Staff BB, documented Resident #9 experienced periods of apnea and start/stop breathing with wet breath sounds. The resident ' s pulse measured 108, raspirations at 52 and oxygen level at 86%. The resident ' s pupils appeared fixed and s/he did not respond. The resident had a nonproductive cough earlier in the evening, gasped for breath and had periods of	F 514		

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F 514	Continued From page 87	F 514		

non-breathing. The resident did not wish to be resuscitated and the family requested compression per telephone. The EMT (emergency medical technician) intubated the patient and both nurses provided compression to resident. The resident vomited and did not respond. Staff continued with intubation and compressions. The resident had no vital signs and EMT called time of death at 10:50 p.m. Staff notified the resident's family.

When interviewed on 6/11/14 at 9:52 a.m. a licence practical nurse, Staff AA stated she routinely worked as this resident's nurse. She had a couple days off and when she returned to work, four different staff members told her the resident had been ill since Monday. The resident was very lethargic and leaning over. The resident almost leaned over on his/her own lap. She had the staff lay the resident back down in bed. She informed the resident he/she needed to go to the hospital. She called the nurse practitioner. The resident's lung sounds were course throughout with very little movement, she started the resident on oxygen. The nurse practitioner ordered Levoquin at which time Staff AA informed the nurse practitioner the resident was beyond Levoquin and he/she needed an IM (intramuscular) antibiotic. She then called the resident's family member, power of attorney (POA). She contacted the POA throughout her shift. The last time she called the POA was 5:55 p.m. She called the POA multiple times throughout her shift. The POA instructed her if the resident got any worse to send the resident to the hospital. From the beginning of her shift to the end of her shift, she felt the resident was going to die. She informed the resident that was all she could do for him/her. The resident could not

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 514	Continued From page 88	F 514		

breathe. The resident was struggling to breathe. His/her lungs were full. She reviewed his/her record and determined the resident did not want to be resuscitated (DNR.) She discussed the resident's DNR status with the POA and the POA wanted the DNR order to be honored. Staff AA stated she called the POA prior to 8:00 a.m. at which time she informed the POA exactly what she had documented in the nurse's notes. She informed the POA she believed the resident needed an antibiotic. The POA asked her to keep in contact with him/her. Staff AA reported from 8:00 a.m. to noon, the resident's condition deteriorated. She called the POA and informed the POA she believed the resident's condition was grave. Staff AA stated she called the POA again at 5:55 p.m. Staff AA stated she was on the phone with the POA when the next nurse came on duty at 6:00 p.m. The POA informed her the resident wanted to be with his/her spouse. The POA stated if the resident got to where he/she was not comfortable, the POA wanted the resident sent to the hospital.

When interviewed on 6/3/14 at 2:02 p.m. the resident's family member/POA stated the facility staff had not informed him/her that the resident had been ill. Staff AA called him/her and stated the resident began on an antibiotic. This was the first time he/she was informed of any change in the resident. The resident had a history of taking antibiotics due to respiratory issues, so the POA did not think anything about it. The staff did not tell him/her of any fever or distress. The next thing he/she knew the facility called about 10:30 p.m. the nurse stated they had the resident as a DNR and asked if that was still his/her desire. The POA asked the staff to stabilize the resident until he/she arrived. The staff did not say the

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	165255	A. BUILDING _____ B. WING _____	C 06/19/2014

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F 514	Continued From page 89 resident had ceased breathing and had no heart beat. The POA stated the resident was a DNR and the POA did not wish to change the order. The POA voiced dissatisfaction due to the staff failed to call him/her earlier and failed to inform him/her of the resident's decline in condition and the resident had died. The POA stated had the staff called him/her earlier and reported the resident's actual change in condition, the POA could have come to the facility and seen the resident prior to the resident's death and the POA could have asked for the resident to be transfer to the hospital earlier and received a greater level of care during the resident's physical decline. The POA stated the facility normally called him/her with changes in the residents condition. The POA last saw the resident on 5/1/14. The POA was totally unaware of any change in the resident's condition from 5/1/14 through 5/9/14. The POA would have expected a call and update on the resident at the first sign of a change in condition. The POA stated had the facility informed him/her earlier of the resident's decline in condition the POA and family members could have come to the facility, visited the resident and participated in the decisions regarding seeking hospitalization to ensure care and comfort. The resident desired DNR status and no one ever asked him/her if they wanted to change the resident's DNR status, no one informed him/her the resident had died, and no one asked him/her if they wanted CPR or life saving measures. The POA was under the impression the resident wes alive and preparing to go to the hospital by ambulance, and the POA only asked the staff to stabilize the resident until he/she arrived. Had the POA known the resident was dead, he/she would have asked the staff to honor the resident's DNR status.	F 514		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	165255	A. BUILDING _____ B. WING _____	C 06/19/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CARLISLE CENTER FOR WELLNESS AND REHAB	588 COLE STREET CARLISLE, IA 50047

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F 514	Continued From page 90 Review of the phone records for the resident's POA revealed the POA first received a phone call from the facility on 5/9/14 at 2:09 p.m. and the call lasted less than 2 minutes. The next phone call from the facility was on 5/9/14 at 10:36 p.m. and lasted less than 1 minute. The POA then received a phone call from the facility on 5/9/14 at 10:46 p.m. The telephone records were also reviewed and revealed no calls from the cell phone number of Staff AA. This report revealed Staff AA did not call the POA as documented on 5/9/14 at 8:00 a.m., at noon, or at 5:55 p.m. When interviewed on 6/11/14 at 9:52 a.m. Staff AA was shown the POA's telephone records after she stated multiple times that she had called the resident's POA/family on 5/9/14 at 8:00 a.m., noon and 5:55 p.m. Staff AA then stated she knew for sure she called the POA with the new Rocephin order. Staff AA then stated she did not call the POA in the morning. Staff AA stated she could have sworn she called the POA, but obviously she did not. Staff AA reported maybe she was thinking about another resident, and another resident's family member that she had called that day. Staff AA stated she was working very hard and maybe she got the two families mixed up.	F 514		

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
	IA0604	A. BUILDING: _____ B. WING _____	C 06/19/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CARLISLE CENTER FOR WELLNESS AND REI	680 COLE STREET CARLISLE, IA 50047

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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 clinical record review and staff interview, the facility failed to notify the department within 24 hours, or the next business	N 101		

DIVISION OF HEALTH FACILITIES - STATE OF IOWA
LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

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
	IA0604	A. BUILDING: _____ B. WING _____	C 06/19/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CARLISLE CENTER FOR WELLNESS AND REH	680 COLE STREET CARLISLE, IA 50047

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N 101	Continued From page 1	N 101		

day, by the most expeditious means available of a fall which resulted in admission to a higher level of care for 1 of 17 residents reviewed (Resident #8). Resident #8's fall resulted in multiple facial fractures and required hospitalization for extensive testing and pain control. The facility reported a census of 87 residents.
Findings include:
1. Review of the clinical record for Resident #8 revealed a Record of Admission. The Record of Admission indicated the resident admitted to the facility on 3/19/10.
A Major Injury Determination Form completed/signed by the resident's primary physician/facility co-owner indicated the resident fell on 5/5/14 at 5:30 p.m. The resident sustained a 2 cm (centimeter) laceration, 7 sutures to the left forehead, fracture of the left orbital (eye socket) floor, and left lateral (side) orbital wall, a fracture of the anterior and posterior wall of the left maxillary sinus (area above teeth, below cheek) and a questionable hairline fracture of the anterior wall of the right maxillary sinus. The fall occurred when resident sitting in the dining room awaiting the evening meal. Resident fell out of wheelchair, striking his/her head. The report noted the resident's total dependence for all cares. The physician/owner documented he believed the injury sustained was not a major injury.
The Patient Transfer Form dated 5/5/14 indicated the staff sent the resident to the hospital after resident fell from his/her wheelchair in the dining room. The resident hit his/her head and sustained a head wound. The staff documented the diagnoses at the time of transfer: Head wound.
A Nurse's Note dated 5/5/14 at 5:30 p.m. indicated two staff members heard a loud thud and found resident lying on the floor in the dining room. The nurse noted blood on the resident's left

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
	IA0604	A. BUILDING: _____ B. WING _____	C 06/19/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CARLISLE CENTER FOR WELLNESS AND REH	680 COLE STREET CARLISLE, IA 50047

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N 101	Continued From page 2	N 101		

forehead. The staff called 911 and sent the resident by ambulance to the hospital.
A Nurse's Note dated 10:00 p.m. indicated the hospital called and reported the resident admitted to the hospital with multiple facial fractures and seven sutures to the left side of face.
A Nurse's Note dated 5/6/14 at 10:30 a.m. the assistant Director of Nursing documented a call was placed to the hospital. Resident in observation bed awaiting speech evaluation. The resident had not been admitted at that time.
A Fall Investigation Tool dated 5/5/14 indicated the resident required the assistance of two persons for mobility prior to the fall. The tool also noted the resident required supervision while up in the wheelchair to prevent falls.
The emergency department history dated 5/5/14 at 7:00 p.m. indicated the 91-year-old resident arrived after a fall from wheelchair. The resident hit his/her face and head. Resident appeared distressed. A 2 cm full thickness laceration over the left eyebrow with continued mild bleeding.
A CT (computed tomography) Maxillofacial without contrast dated 5/5/14 at 7:34 p.m. indicated blood and mucosal products noted in the sinuses, greater in the left maxillary sinus. Fractures of the anterior wall and posterior wall of the left maxillary sinus. Premaxillary and periorbital soft tissue swelling noted with periorbital emphysema and premaxillary soft tissue emphysema. Minimally displaced fractures noted involving the left orbital floor. Minimally displaced fracture noted involving the left lateral orbital wall. Questionable hairline fracture of the anterior wall right maxillary sinus.
A Physician's assistant documented on 5/5/14 at 9:15 p.m. the resident arrived at the emergency department after falling from wheelchair at the nursing home and hit left side of face. Patient non-verbal. CT facial bones showed left orbital

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	IA0604	A. BUILDING: _____ B. WING _____	C 06/19/2014

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CARLISLE CENTER FOR WELLNESS AND REI	680 COLE STREET CARLISLE, IA 50047

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N 101	Continued From page 3	N 101		

and maxillary fractures. Will keep patient overnight in observation. A physician accepted patient for observation. Another physician consulted for facial fractures and would see patient in the hospital the next day. Assessment: multiple facial bone fractures, neck strain, head injury and fall at nursing home. Disposition: Admit. Number of diagnoses or management options: fall at nursing home: new and required workup, head injury: new and required workup, multiple facial bone fractures: new and required workup, and neck strain: new and required workup.

On 5/5/14 at 9:09 p.m. a physician documented the 91-year-old with severe dementia presented after a fall from a wheelchair. Physical examination revealed resident cachectic, significant bruising on left cheek, patient somnolent, oriented to self only. Patient believed it was 1970. Active problems: fall from chair, facial fracture, dementia, coronary artery disease. Plan: appreciate trauma surgery evaluation and recommendations. Will continue pain control.

On 5/5/14 at 10:00 p.m. a physician documented testing revealed facial fractures and requested trauma consultation to help exclude any other injury. Assessment: several facial fractures from this fall and a forehead laceration which required closure. Plan: Will check CXR (chest x-ray) to help exclude rib fracture. Is being admitted under the care of Internal Medicine and OMFS (oral and Maxillofacial surgery).

On 5/6/14 at 1:19 a.m. a physician documented he/she had a long discussion with the resident's family. The family requested focus care be on comfort. Plan: Hospice consult in morning. Pain control as needed.

On 5/6/14 at 7:00 a.m. a dietician documented plans reviewed for comfort measures/transfer to hospice care.

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 4 A CT Spine Cervical exam revealed fractures of both maxillary sinuses, left greater than right. A hospital document dated 5/21/14 indicated the resident converted to inpatient level of care due to inpatient order and resident surpassed two midnight, and attestation. Reason for admission: facial fracture from a fall from the wheelchair.	N 101		
N 104	50.7(4) 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(4) When a resident elopes from a facility. For the purposes of this subrule, " elopes " means when a resident who has impaired decision-making ability leaves the facility without the knowledge or authorization of staff. This Statute is not met as evidenced by: Based on observation, clinical record review and staff interview, the facility failed to notify the Iowa Department of Inspections and Appeals of an elopement of 1 of 17 residents reviewed (Resident #5). The facility reported a census of 87 residents. Findings include: 1. Review of the clinical record for Resident #5 revealed The Record of Admission. This document indicated the resident admitted to the facility on 1/16/13.	N 104		

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
	IA0604	A. BUILDING: _____ B. WING _____	C 06/19/2014

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N 104	Continued From page 5	N 104		

A Minimum Data Set (MDS) assessment todl dated 3/14/14 indicated the resident had short and long-term memory loss and severe cognitive impairment. Behaviors included delusions, physical aggression and wandering on a daily basis. The resident required total assistance for bed mobility, transfers, dressing, toilet use and bathing. The resident required extensive assistance with walking in the bedroom and in hallways and personal hygiene.

The Plan of Care dated 2/17/14 noted resident at risk for elopement due to dementia as evidenced by the resident approached exit doors frequently and made statements of wanting to get out.

A Social Service Progress Note dated 2/19/14 assessed the resident as a 71-year-old resident with significant long and short-term memory deficits and severely impaired decision making skills. The resident continued to utilize his/her merry-walker throughout the facility. The resident had exit seeking behaviors and would attempt to get out the doors several times a day. Staff continued to keep a close eye on the resident regularly.

An Incident/Accident Report dated 4/24/14 at 7:50 p.m. noted the nurse was completing his/her report when notified by a C.N.A. (certified nursing assistant) that the resident was in front of the facility. The nurse noted the incident was unwitnessed.

Nurse's notes dated 4/24/14 at 8:00 p.m. noted at 7:50 p.m. the nurse was alerted by a C.N.A. that the resident had exited the facility through the west door down the 200 hallway. At 7:53 p.m. three staff members rushed outside. They found

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	IA0604	A. BUILDING: _____ B. WING _____	C 06/19/2014

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N 104	Continued From page 6	N 104		

the resident on the grassy area out front of the care center. The nurse re-educated the resident on the need to be accompanied by staff. The nurse initiated 15 minutes on the resident.

An undated, unsigned typed facility report indicated on 4/24/14 the resident exited the building through the 200 hall exit door. A C.N.A., Staff J was in another resident's bedroom when he noted this resident outside the building and immediately went to the dining room and alerted the nurse of the resident being outside. The facility installed a new alarm on the 200 hall door awaiting a wander guard alarm system for the 200 hall door. The facility held a mini in-service to educate staff members on correct use of alarm system.

A communication form sent to this resident's physician dated 4/25/14 informed the physician the staff found the resident outside, on the front lawn. The staff began 15 minute checks on this resident.

A written statement by an assisted living employee, Staff K dated 4/25/14 indicated about 8:00 p.m. to 8:20 p.m. he/she and another assisted living employee, Staff I were busy passing medications in the assisted living when their pagers alerted and the computer was going crazy. The computer kept saying "West Door". Staff K and Staff I went to the beauty shop to reset the door alarm. He/she was unable to reset the alarm. Staff K then went to the facility's nurse's station and asked the staff why they were getting the alerts in the assisted living. The facility staff then informed the assisted living staff the resident was outside.

A written statement by an assisted living

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
	IA0604	A. BUILDING: _____ B. WING _____	C 06/19/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
N 104	Continued From page 7	N 104		

employee, Staff I indicated on 4/24/14 the alarm sounded for the west door. The alarm kept popping up on their system for about 20 minutes. They tried to cancel the alarm. They attempted to get the facility staff to assist them. A second written statement by Staff I indicated on 4/24/14 around 7:55 p.m. the alarm for the west door went off, the pagers were going off as well as the alarm on the computer. The alarm went off for a few minutes so Staff I and Staff K decided to go and check it out. They went and tried to cancel the alarm. They were unable to cancel the alarm so they went to get assistance from the facility staff to cancel the alarm.

When interviewed on 5/20/14 at 12:03 p.m. the assisted living employee, Staff I stated he/she had worded at the assisted living for one year. Staff I stated when the alarm and pagers alerted on 4/24/14 it felt like 20 minutes, however it could have been shorter. Staff I stated he/she was wondering why the alarm continued to sound. Staff I stated after what seemed like 20 minutes, he/she and Staff K went to see why the alarm continued to sound.

A written statement by a C.N.A., Staff J indicated Staff J last observed the resident by the dining area. Staff J was in a resident's bedroom down the 300 hallway, closing the window blinds when he/she observed the resident outside of the care center. Staff J then alerted the nurse and went out side to assist the resident. When interviewed on 5/20/14 at 2:00 p.m. Staff J stated about 7:30 p.m. to 8:00 p.m. he/she was in a bedroom down the 300 hallway. Staff J looked outside the window and observed the resident outside the building. Staff J denied hearing any alarms sound. Staff J then went down the hall, to the front dining room area and alerted the nurse the

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	IA0604	A. BUILDING: _____ B. WING _____	C 06/19/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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N 104	Continued From page 8	N 104		

resident was outside the building. They found the resident outside, behind the handicapped parking sign, on the grass, down a slope, approximately 12 feet from the sidewalk. It took three staff members to get the resident in the Merry Walker back up to the sidewalk. Staff J denied hearing any alarms sounding when outside. Staff J stated no staff knew the resident was outside the building until he/she saw the resident out the window. Staff J stated the 200 door had a quiet alarm that turned off when the door was closed. Staff J stated a resident who lived down the 200 hall, Resident #1 reported hearing the alarm sound. Staff J stated he/she felt this was an elopement due to no one knew the resident had exited the 200 door.

When interviewed on 5/20/14 at 1:25 p.m. a licensed registered nurse, Staff C stated on 4/24/14 staff assisted the resident into a Merry Walker after the evening meal. Staff C stated the 200 door had an alarm that quit after the door was closed. At 7:50 p.m. Staff C was checking medications when Staff J came from the 300 hall, running towards the front door. Staff J informed the nurse, the resident was outside the building. Staff C followed Staff J out the door. They found the resident outside, behind the handicapped parking sign in a wet, soft grassy area. The resident normally would go to every exit door and attempt to exit the building. After this incident, they moved the resident to another room and put a new alarm on the 200 hall door. Staff C denied getting a pager alert until after he/she observed Staff J running down the 300 hallway. Staff C denied hearing any alarm.

A facility Mini In-Service Report dated 4/25/14 noted topic of the in-service: door alarms/wander guard alarms. Topic of the in-service indicated it

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
	IA0604	A. BUILDING: _____ B. WING _____	C 06/19/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CARLISLE CENTER FOR WELLNESS AND REH	680 COLE STREET CARLISLE, IA 50047

(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 104	Continued From page 9	N 104		

was everyone's responsibility to respond to alarms and instructed the staff to locate the location of what alarm was sounding, announce which door was sounding over the pager system, everyone should respond to the alarm, if no one was at the door, staff should proceed to the outside to walk the area to assure no residents had gotten out of the facility. A new alarm had been placed on the 200 hall door awaiting wander guard placement.

When interviewed on 5/20/14 at 4:07 p.m. a C.N.A. Staff H stated on 4/24/14 at about 6:45 p.m. they assisted the resident into a Merry Walker. Normally after supper the resident liked to hang around the nurse's station and help the nurses shuffle papers. Staff H last saw the resident around 7:15 p.m. to about 7:30 p.m. Staff H later heard Staff J state the resident was outside. Staff H denied hearing any alarms sounding. Staff H went outside and observed the resident in the middle of a puddle. They had to lift the Merry Walker to get it back up on the sidewalk. Staff H denied hearing any door alarms sounding. Staff H stated approximately one month prior to this incident the resident exited the same door and then exited the outer exit door. She

When interviewed on 5/20/14 at 12:00 noon. the Director of Nursing stated at the time of the incident, the 200 hall door had an alarm that only sounded while the door was open. The 200 hall door did not have a wander guard alarm at the time of the incident.

CARLISLE CENTER FOR ASSISTED LIVING
CARLISLE CENTER FOR INDEPENDENT LIVING
CARLISLE CENTER FOR WELLNESS AND REHAB
FLEURHEIGHTS CENTER FOR WELLNESS AND REHAB

"Professional Staff...Exceptional Care"

July 31, 2014

Plan of Correction for:
Carlisle Center for Wellness and Rehabilitation
(Provider #165255)
680 Cole Street
Carlisle, IA 50049
515-989-0871
Carlisle_admin@pacificahealth.com

Preparation and/or execution of this plan of correction does not constitute admission or agreement by the Provider of the truth of the statement of deficiencies. The plan of correction is prepared and/or executed solely because the provisions of Federal and State law require it. This constitutes our credible allegation of compliance as of July 31, 2014.

F 155

For Resident 9 and other similarly situated Residents, Carlisle Center for Wellness and Rehab provides the right to accept or refuse medical treatment or hospitalization, and at the individual's option, formulate an advanced directive.

Resident 9 no longer resides in facility

Staff AA, BB and C are no longer employed by the facility.

Mini in-services have been completed with all nursing staff on DNR status, full-code, and resident's rights.

Completed an audit that verifies every resident's DNR status. Pocket care plans are designated if a resident is a full-code status.

Full codes are listed on the pocket care plans and Full Code lists have been placed in the front of each MAR in the charts.

Care Plan coordinator will review periodically and PRN and update pocket care plans and Full Code lists as needed.

Code statuses will be reviewed quarterly at resident/family care plan conferences.

Staff educated on company policy of DNR upon hire.

Audits to be completed through the quality assurance process to ensure all residents have the right to accept or refuse medical treatment or hospitalization, and to formulate an advanced directive per request on a random basis for the next 3 months. Then random audits for the next 2 quarters. Further audits will be determined as needed by the quality Assurance committee.

F 157

For Resident 9 and other similarly situated Residents, Carlisle Center for Wellness and Rehab will inform the resident, the resident's physician, and if known, the resident's legal representative or interested family member when there is a change in condition or treatment.

Resident 9 no longer resides at the facility.

Staff AA, BB, C are no longer employed at the facility.

Education on assessments and notification to physician and family of residents when significant changes occur with resident for staff S.

All nursing staff have been educated on documentation and assessments which includes notification to physician and family.

Random QA audits by DON or Designee of nursing documentation, assessment, and notification will be performed.

Audits to be completed through the quality assurance process to ensure all residents, resident's physicians, resident's legal representative, or interested family member have been notified of significant changes in the residents physical, mental, or psychosocial status, as well as changes in room or roommates, on a random basis for the next 3 months. Then random audits for the next 2 quarters. Further audits will be determined as needed by the quality Assurance committee.

F 164

For Resident's 2 and 3, and other similarly situated Residents, Carlisle Center for Wellness and Rehab provides the resident the right to personal privacy and confidentiality of his or her right to personal and clinical records.

Resident 2 was relocated to a different room to offer additional privacy due to case of transfer. Resident 3's room was assessed for availability of proper curtain width and length as well as proper function of curtains to assure that resident was provided privacy during cares.

Education and disciplinary action was provided to staff A, E, and M for use of privacy concerns.

Staff L is no longer employed at facility.

All nursing staff were re-educated on providing privacy to include making sure that all curtains and/or doors are closed before initiating cares for residents.

Facility continues to routinely monitor nursing staff for continued use of privacy curtains and door closure while providing personal cares.

Audits to be completed through the quality assurance process to ensure all residents have been provided with the right to personal privacy and confidentiality of his or her right to personal and clinical records, on a random basis for the next 3 months. Then random audits for the next 2 quarters. Further audits will be determined as needed by the quality Assurance committee.

F 241

For Resident 3, 4, and 16, and other similarly situated Residents, Carlisle Center for Wellness and Rehab provides an environment that maintains or enhances each resident's dignity and respect in full recognition of his or her individuality.

Resident 3 has requested to be addressed by birth name and staff have educated to follow resident's preference. Resident 4 was provided assistance with removal of facial hair. Clothing protector is available for resident 16 during meal times.

Staff A and E have both been educated on addressing residents by their birth name and/or documented name of preference.

All nursing staff have been educated to address each resident by their birth name unless otherwise care planned.

All nursing staff have been educated to offer assistance with all residents in need of removal of facial hair.

All nursing staff have been educated to assist residents with changing soiled clothing within a timely manner.

Random audits are performed to ensure that privacy is being maintained during cares for residents, unwanted facial hair is removed from residents as needed, and management team will continue to monitor staff's verbal address and use of birth names when addressing residents.

Audits to be completed through the quality assurance process to ensure all residents receive an environment that maintains or enhances each resident's dignity and respect in full recognition of his or her individuality on a random basis for the next 3 months. Then random audits for the next 2 quarters. Further audits will be determined as needed by the quality Assurance committee.

F 309

For Resident 9 and other similarly situated Residents, Carlisle Center for Wellness and Rehab provides 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 9 is no longer in the facility. Resident #14 was transferred to emergency room for physician's immediate evaluation.

Staff AA, BB, and C are no longer employed with the facility.

Staff S has been educated on proper assessment of residents, timeliness of documentation, and family notification of significant change of condition of resident.

Staff DD has been educated on how to respond when a resident makes a negative comment.

Staff EE has been educated on how to respond when a resident makes a negative comment.

All staff have been educated on assessment and notification to physician and family.

All staff have been educated on how to respond to residents when they make negative comments.

A negative comment policy has been implemented and posted at each nurse's station.

Ongoing reviews of documentation of nursing staff by nursing management will be performed to identify the presence of any negative statements and appropriate assessment and intervention has been completed.

Audits to be completed through the quality assurance process to ensure all residents received the necessary care and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being on a random basis for the next 3 months. Then random audits for the next 2 quarters. Further audits will be determined as needed by the quality Assurance committee.

F 323

For Resident 10, 6, 3, 4, 7, and 5, and other similarly situated Residents, Carlisle Center for Wellness and Rehab provides an environment that remains free of accident hazards as is possible; and each Resident receives adequate supervision and assistive devices to prevent accidents.

Resident 10 no longer resides at the facility.

A mini in-service shall be completed to educate nursing staff in regards to informing management/care plan team of concerns or changes needed with fall prevention devices.

An audit has been completed with care plans and pocket care plans to assure that proper alarms are being used for residents.

The ADON intervened with resident 6 to prevent a fall.

Staff D is no longer employed at the facility.

All nursing staff were educated on reading care plans prior to assisting residents with care.

Staff A and E were individually educated on transfers and use of gait belts.

Random audits are conducted to ensure that nursing staff continue to carry pocket care plans.

All nursing staff have been instructed and observed in the proper procedures on one and two person transfers.

Audits continue with nursing staff on transfer techniques and for proper use of gait belt.

Education provided for all nursing staff to include N, O, and P to ensure that all safety devices are in place.

Resident 4 is consistently redirected to new room and has acclimated to new room.

Staff have been educated on following pocket care plans and placement of alarms.

Previous DON is no longer employed at facility.

Staff F and G involved with improper transfer of resident 7 were immediately educated on the proper use of transfer techniques.

Staff G and F were provided with a written disciplinary for not using gait belt when assisting resident during transfer.

Staff F and G were re-educated on the mandatory use of a gait belt when transferring a resident.

Transfer audits were completed on proper transferring techniques for all nursing staff.

Resident 5 was immediately redirected back into the facility at which time 15 minute checks were implemented.

A wander guard system was installed at the end of the 200 hall.

All nursing staff have been educated on resident elopement procedures.

Mandatory Root Cause Analysis training will be provided on 7/31, 8/4, and 8/6 department supervisors and nursing staff.

Audits to be completed through the quality assurance process to ensure all residents received the highest level of care, on a random basis for the next 3 months. Then random audits for the next 2 quarters. Further audits will be determined as needed by the quality Assurance committee.

N 101

For Resident 8 and other similarly situated Residents, Carlisle Center for Wellness and Rehab will ensure that the director or director's designee is notified within 24 hours or the next business day of any accident causing major injury that requires admission to a higher level of care for treatment.

A wheelchair audit was completed on residents. Physical therapy and occupational therapy will continue wheelchair audits on all new residents for appropriateness of positioning in chair. The audits included but were not limited to positioning, correct fitting pedals for each individual, replacement of cushions as needed, alarms in place as needed, and dysum on seats as well.

Quarterly reviews or as needs arise of wheelchair positioning continue.

Discussions of resident comfort and concerns during quarterly care plans with staff, residents, and resident's family will continue.

Resident 8 no longer resides in facility.

Facility continues to assess each incident for appropriateness of reporting to state agency on an individual basis.

The administrator has reviewed criteria for determination of a major injury and requirement to report.

Audits to be completed through the quality assurance process to ensure that notification to the director or director's designee is completed within 24 hours, or the next business day, of any accident causing major injury that requires admission to higher level of care for treatment on a

random basis for the next 3 months. Then random audits for the next 2 quarters. Further audits will be determined as needed by the quality Assurance committee.

N 104

For Resident 5 and other similarly situated Residents, Carlisle Center for Wellness and Rehab ensure that notification to the director or director's designee is completed within 24 hours, or the next business day, of any elopement from the facility.

A new wander guard alarm system has been installed at the end of the 200 hall. This system will activate when any resident wearing a wander guard device is approximately 30 inches within the doorway which will notify staff that a resident is approaching the exit for this hallway.

Placement of the system and ongoing maintenance.

Weekly checks of the wander guard exit system.

The administrator has reviewed criteria for determination of elopement and requirement to report.

Mini in-services with staff involving physician's orders, falls, contacting 911 emergency response, telephone orders, DNR's, assessments, and documentation. DNR audits have been done as well. Nurses have had one-on-one education regarding documentation and assessments. All nursing staff have had a mini in-service regarding documentation and assessments as well.

All new staff upon hire will be educated on documentation and assessment with annual instruction review.

QA process with QA nurse providing random audits of proper documentation and assessments will continue.

Audits to he completed through the quality assurance process to ensure that the director or director's designee is notified with 24 hours or the next business day when a resident elopes on a random basis for the next 3 months. Then random audits for the next 2 quarters. Further audits will be determined as needed by the quality Assurance committee.

F 328

For Resident 15, 4, and 16, and other similarly situated Residents, Carlisle Center for Wellness and Rehab will ensure that residents receive proper treatment and care for special services.

Resident 15 no longer resides in facility. Resident #4's portable oxygen tank was immediately filled. Resident 16 was immediately taken to room and placed on room concentrator while the portable oxygen tank was filled for next use.

Staff AA no longer is employed with the facility.

Staff R has been educated on following physician's orders without deviation and to contact physician when changes are needed.

All nursing staff have been educated on guidelines for checking liquid oxygen tanks to ensure adequate supply levels are maintained and ensuring adequate flow rate.

Audits to be completed through the quality assurance process to ensure all residents received proper treatment and care for special services on a random basis for the next 3 months. Then random audits for the next 2 quarters. Further audits will be determined as needed by the quality Assurance committee.

F 514

For Resident 9 and other similarly situated Residents, Carlisle Center for Wellness and Rehab will maintain clinical records on each resident in accordance with accepted professional standards and practices that are complete; accurately documented; readily accessible; and systematically organized.

Resident 9 no longer resides at the facility.

Staff AA no longer is employed with facility.

Staff S has received education on resident rights, assessments, physician and family notification, and documentation.

Mini in-services have been completed with all nursing staff on DNR status, full-code, and resident's rights.

Completed an audit that verifies every resident's DNR status. Pocket care plans are designated if a resident is a full-code status.

Full codes are listed on the pocket care plans and Full Code lists have been placed in the front of each MAR in the charts.

Care Plan coordinator will review periodically and PRN and update pocket care plans and Full Code lists as needed.

Staff will be educated on company policy of DNR upon hire. Review DNR status with quarterly care plans and after hospitalization.

Audits to be completed through the quality assurance process to ensure all residents clinical records are maintained in accordance with accepted professional standards and practices, completed; accurately documented; accessible; and organized on a random basis for the next 3 months. Then random audits for the next 2 quarters. Further audits will be determined as needed by the quality Assurance committee.