

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

PRINTED: 09/19/2016
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 165251	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 07/07/2016
NAME OF PROVIDER OR SUPPLIER RAVENWOOD SPECIALTY CARE			STREET ADDRESS, CITY, STATE, ZIP CODE 2651 ST FRANCIS DRIVE WATERLOO, IA 50702		
(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 Amended after IDR-IC held on August 31, 2016. Correction Date <u>7/28/16</u> Complaints # 59575-C, # 59618-C, # 59598-C and # 59599-C were investigated and substantiated. The following deficiencies relate to the complaint investigation.	F 000			
F 157 SS=D	483.10(b)(11) NOTIFY OF CHANGES (INJURY/DECLINE/ROOM, ETC) A facility must immediately inform the resident; 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.	F 157			

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

TITLE

(X6) DATE

07/28/2016

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

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F 157	Continued From page 1 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 record review, the facility did not always notify the resident's family/legal representative when there was an incident which had the potential for requiring physician intervention for one of seven residents reviewed (Resident #3). The facility reported a census of 156 residents. Findings include: According to documentation in the clinical record, Resident #3 entered the facility on 04-12-16 and had diagnoses which included Alzheimer's disease. Documentation in a notation titled IDT (interdisciplinary team) dated 04-13-16, revealed on the afternoon of 04-12-16, a staff member heard the south therapy door alarm sound and witnessed Resident #3 exiting the building. The notation indicated the staff person was able to reach Resident #3 as he/she stepped outside the second door and onto the sidewalk. The staff easily redirected Resident #3 back into the building. A notation following the above notation, dated 04-12-16 indicated the nursing staff had been notified (by the alarm) of Resident #3's exit through the physical therapy door. The notation indicated that Resident #3 had a functioning wanderguard placed on admission. The notation also indicated staff initiated 15 minute checks on	F 157			

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F 157	Continued From page 2 Resident #3 due to his/her confusion and wandering. Review of the nurse's notes indicated staff did not notify Resident #3's family of the attempted exit from the facility.	F 157			
F 281 SS=D	483.20(k)(3)(i) SERVICES PROVIDED MEET PROFESSIONAL STANDARDS The services provided or arranged by the facility must meet professional standards of quality. This REQUIREMENT is not met as evidenced by: Based on record review, staff and resident interviews, the facility did not always ensure that services provided met professional standards of quality (failure to follow physician's orders) for 2 of 7 residents reviewed (Resident # 4 & #6). The facility reported a census of 156 residents. Findings include: 1. Observation on 04-25-16 at 4:22 p.m. indicated Staff A administered medications to Resident #4. At that time, Staff A indicated she could not locate Resident #4's symbicort inhaler, and initialed and circled the box on the medication administration record (MAR). This indicated Resident #4 did not receive that dose of medication as ordered. Based on review of the clinical record, Resident #4 had physician's orders dated 04-16-16 which directed staff to administer Formoterol Fumerate (Symbicort) 12 mcg (microgram), 1 ampule inhaled two times a day. Review of the MAR dated April 17th through April 25th, indicated most	F 281			

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F 281	Continued From page 3 of the entries were circled (as many as 17 doses), indicating the medication had not been given. (Documentation on the MAR was difficult to read). During an interview on 04-26-16 at 7:50 a.m., the director of nursing confirmed staff had not administered the inhaler to Resident #4 for several days. The director of nursing stated the inhaler had been placed in the refrigerator and staff did not look in the refrigerator for the inhaler. 2. Based on clinical record review, Resident # 6 entered the facility on 04-04-16 with diagnoses which included a recent total knee replacement (TNR) surgery on 04-01-16, history of degenerative joint disease and Parkinson's disease. The physician's order sheet dated 04-01-16, indicated Resident #1 would use CPM (continuous passive motion) for the right lower extremity as directed by another physician. A physicians prescription order dated 04-01-16 indicated Resident #6 was to use CPM for home use for two weeks. The facility treatment record reflected staff to document when CPM treatment was done. According to documentation in the nurse's notes dated 04-06-16 at 2:46 p.m., staff placed a phone call to Resident #6's physician to clarify the CPM, including how often Resident #6 should be using the treatment as well as specific settings on the machine. Documentation in the nurse's notes dated 04-11-16, revealed staff sent another facsimile to Resident #6's physician to clarify the usage of the	F 281			

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F 281	Continued From page 4 CPM machine. Physician's orders dated 04-14-16 indicated Resident #6 was to use the CPM machine at 0 to 60 degrees, (increasing it 5 degrees daily) for 2 to 4 hours a day. Staff added this treatment to the treatment record dated 04-14-16 indicating the treatment should be completed in the "a.m., noon. p.m. and HS" (hour of sleep). During the twelve day time frame 04-14-16 through 04-25-16 staff signed the treatment record as the CPM treatment had been completed 12 times. According to documentation on the treatment record, the first time Resident #6 used the CPM machine was documented on 04-20-16, sixteen days after Resident #6 entered the facility. During an interview on 04-26-16 at 9:50 a.m., Staff A stated she had not completed the treatment for Resident #6 yet on this date. Staff A stated she had completed the treatment for Resident #6 on the prior date (04-25-16). Staff A then looked at the treatment record for Resident #6 and verified her signature on 04-25-16 that the treatment had been completed at 8:00 a.m. Staff A then stated "oops" indicating the treatment was ordered (per the treatment record) to be four times a day, and Staff A verified Resident #6 had only completed it one time on her shift. During an interview on 04-26-16 at 9:40 a.m. Staff B, a certified nursing assistant stated she did the CPM treatment for Resident #6 only when the resident wanted to do it. She stated she had assisted Resident #6 with the CPM treatment three times. At 9:45 a.m. (04-26-16), Staff C stated she did not assist Resident #6 with the treatment as it is the nurse's job, not the certified	F 281			

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F 281	Continued From page 5	F 281			
F 309 SS=G	483.25 PROVIDE CARE/SERVICES FOR HIGHEST WELL BEING Each resident must receive and the facility must provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being, in accordance with the comprehensive assessment and plan of care. This REQUIREMENT is not met as evidenced by: Based on record review and staff interviews, the facility did not always provide the necessary care and services to attain or maintain the highest practicable physical well-being in accordance with the comprehensive assessment and plan of care. Concerns were noted for one resident (Resident #7) in which facility staff failed to complete on going physical assessments and intervention. The facility reported a census of 156 residents. Findings include: According to documentation in the Minimum Data Set (MDS) assessment form dated 04-05-16 Resident #7 scored 10 (of 15) on the Brief Interview for Mental Status (BIMS) indicating moderate cognitive decline. The assessment form also described Resident #7 as requiring staff assistance with completing activities of daily living such as transfers, ambulation, dressing, bathing and toilet assistance. Review of the clinical record revealed that	F 309			

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F 309	Continued From page 6 Resident #7 had diagnoses which included recent history of pneumonia, hypertension and chronic obstructive pulmonary disease, on two liters of oxygen at bedtime. The care plan dated 12/28/15 documented Resident #7 staff would monitor the resident's health status including but not limited to oxygen saturation, blood pressure, pulse, lung sounds, signs/symptoms of shortness of breath and notify the physician of significant changes in any of the prior. According to documentation the clinical record, Resident #7 was hospitalized for 23 hour out patient observation from 04-10-16 to 04-11-16. Resident #7 returned to the facility on skilled care on 04-11-16. Review of the nurse's notes revealed staff completed skilled assessment documentation via flow sheet on 04-12-16, 04-13-16, 04-14-16, 04-15-16 and 04-16-16. Review of the clinical record revealed staff did not complete the skilled assessment documentation for 04-17-16 or 04-18-16. Documentation in the nurse's notes dated 04-17-16 at 1:50 a.m. indicated Resident #7 had no complaints of pain and had an oxygen saturation level of 92 % and refused oxygen. Documentation in the nurse's notes dated 04-17-16 at 8:00 a.m. indicated Resident #7 refused morning cares, the morning meal, weight, vitals and meals after numerous attempts. The notation indicated Resident #7 swung at staff and told staff to get out of the room. The next documentation in the nurse's notes at 10: 30 p.m. indicated Resident #7 refused a pain medication at 8:30 p.m. but requested a pain medication at 10:10 p.m.	F 309			

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F 309	Continued From page 7 Documentation in the nurse's notes dated 04-18-16 at 6:05 a.m. included vital signs and an oxygen saturation level of 88 % on room air. The notation addressed Resident #7's behaviors and refusal to take medications. Staff indicated a facsimile was sent to Resident #7's physician addressing vital signs, refusal of oxygen, nebulizer treatments and medications. The notation also indicated Resident #7 had no edema to lower legs, lung sounds posterior decreased, lobes with crackles to lower right bases, combative and rude to staff. Documentation on 04-18-16 at 1:45 p.m. indicated staff received a return order from Resident #7 physician with direction to hold Lasix for today (04-18-16). The next documentation on 04-18-16 at 8:30 p.m. indicated staff received a physician's order to send Resident #7 to the emergency room for evaluation due to an elevated temperature. Review of the clinical record for Resident #7 indicated staff completed a SBAR (Situation Background Assessment Recommendation) form on 04-18-16 at 7:50 p.m. At this time the summary of observations and evaluation documented, "Resident appears to be acutely ill with respiratory illness". Resident #7's condition, symptom had worsened since it started. The description identified Resident #7 a primary diagnosis of sepsis, with pulse oximetry at 84% room air Documentation in the emergency room chart dated 04-18-2016 at 8:52 p.m. indicated Resident #7 was "dropped off at the ER (emergency room)	F 309			

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F 309	Continued From page 8 registration desk by Dolly's Taxi", patient was unaware of why he/she was brought to ER. Triage nurse was told by the facility registered nurse, "patient is septic". Review of the emergency room chart dated 04-18-16 at 8:52 p.m. triage is documented as "urgent". Additional assessment indicated Resident #7 arrived by taxi. Resident #7's family stated the resident has a decreased amount of fluid intake and fever today. Resident has audible wheezing and oxygen saturation initially at 89%. "Nurse states patient was sent by taxi with instruction by unit manager". Resident was at 85% (oxygen saturation) at the facility on 2 liters of oxygen per nasal cannula. Upon arrival Resident #7 was at 88% (oxygen saturation) on 2 liters of oxygen. Resident states he/she "hurts all over". During an interview on 04-26-16 at 3:45 p.m. Nurse Manager Staff D indicated the nursing staff were to complete daily flow sheet skilled charting. Staff D also indicated he completed an assessment of Resident #7 the evening of 04-18-16 and stated he did had tried to keep Resident #7 at the facility. Staff D stated he saw Resident #7 as "sick", non-emergent, but not acutely ill. Staff D stated Resident #7's lungs sounded "nasty" but added not a lot different, and not remarkably different from day to day. Staff D did state he was concerned with Resident #7's (elevated) temperature. Staff D stated the change in Resident #7's mental status seemed to alarm the resident's family member most, and perhaps Resident #7 had a little dehydration due to no urine output. Staff D went on to add one can get pneumonia "just like that".	F 309			

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F 309	Continued From page 9 Staff D stated he set up a ride through Dolly's Taxi as a non-emergent transfer. Staff D stated there was about a 20 minute wait, but the taxi service was encouraged verses an ambulance transfer due to the cost involved. During an interview on 06-21-16 the emergency room physician stated Resident #7 had been dropped off at the emergency room by a taxi. No phone call to the emergency room preceded the resident's appearance and Resident #7 was not competent enough to be dropped off and left alone in the emergency room. The emergency room physician also stated the emergency room nurses were horrified that Resident #7 had been transferred by a taxi. The physician stated Resident #7 had a low oxygen saturation level, a fever and a cough. He stated that Resident #7 was quite ill/sick and a transfer by taxi rather than by ambulance was not appropriate. According to documentation in the hospital history and physical, dated 04-19-16, Resident #7 was admitted to the hospital with severe lethargy, somnolence, UTI (urinary track infection) and pneumonia. The general observation described Resident #7 as very frail looking, and currently in respiratory distress. The laboratory results showed a urinalysis which showed greater than 900 WBC's (white blood cells), positive for bacteria and RBC's (red blood cells). The CBC (complete blood count) showed a WBC (white blood count) of 19.7 X10**3/ul (Normal = 4.3 - 11.3) On 04-26-16 at 11:47 a.m. the facility assistant Director of Nursing indicated skilled nursing flow sheet records for Resident # 7 for 04-17-16 and	F 309			

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F 309	Continued From page 10 04-18-16 could not be located. At 11:57 a.m. the facility director of nursing indicated that if no skilled flow sheets could be located, then the only assessments completed for Resident #7 was the documentation in the nurse's notes.	F 309			

F000 Please accept this as the facility's credible allegation of compliance as of July 28th, 2016 for F tags 157, 281, and 514. Please accept this as the facility's credible allegation of compliance as of July 20th, 2016 for F tag 309.

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

F157

In respect to resident #3 and any similarly situated resident, staff was educated on notifying the physician and the resident's legal representatives of changes on 7/8/16, 7/21/16, and 7/28/16.

The ADON or designee will audit the completion of documentation and following of physician orders weekly x 4 weeks then as needed to ensure compliance.

The Quality Assurance team will determine the need for further auditing.

F281

In respect to resident #4 & #6, and any similarly situated residents, Staff were educated on the process for delivery of medications from the pharmacy and the process for dealing with medications that cannot be located. Staff were also educated on the process for clarifying medication and treatment orders. Education on these processes was completed on 5/2/16, 7/8/2016, and 7/28/16.

The DON/ADON and/or designee will audit these processes as needed to ensure compliance.

The Quality Assurance team will determine the need for further auditing.

F309

With respect to resident #7 and any similarly situated resident, staff was educated on 4/26/16, 7/8/16, and 7/28/16 of the importance of assessing and completing skilled nursing assessments. In regards to mode of transportation to the ER, per nursing assessment, residents will be sent out by appropriate transportation

The nurse manager or designee will audit documentation 3x a week for 4 weeks then as needed to ensure compliance.

The Quality Assurance team will determine the need for further auditing.