STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	165362	A. BUILDING _____ B. WING _____	12/08/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CLARION WELLNESS AND REHABILITATION CENTER	110 13TH AVENUE SW CLARION, IA 50525

(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: 12/29/16 The following deficiencies are the result of the recertification survey completed 12/5-8/16. See Code of Federal Regulations (42CFR) Part 483, Subpart B-C.	F 000	**F 000** *PREPARATION AND EXECUTION OF THIS RESPONSE AND PLAN OF CORRECTION DOES NOT CONSTITUTE AN ADMISSION OR AGREEMENT BY THE PROVIDER OF THE FACTS ALLEGED OR CONCLUSION SET FORTH IN THE STATEMENT OF DEFICIENCES. THIS PLAN OF CORRECTION IS PREPARED AND/OR EXECUTED SOLELY BECAUSE IT IS REQUIRED BY THE PROVISION OF FEDERAL AND STATE LAW. FOR THE PURPOSE OF ANY ALLEGATION THAT THE FACILITY IS NOT IN SUBSTANTIAL COMPLIANCE WITH FEDERAL REQUIREMENTS OF PARTICIPATION, THIS RESPONSE AND PLAN OF CORRECTINO CONSITITUTES THE FACILITY ALLEGATION OF COMPLIANCE.*	12/30/16
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 and staff interview, the facility failed to follow the physician's order and provide 15 minutes checks to a resident that displayed a suicide attempt (Resident #7). The sample consisted of 12 residents and the facility reported a census of 49 residents. Findings include: Resident #7 had a Minimum Data Set (MDS) assessment with a reference date of 11/8/16. The MDS identified a BIMS (Brief Interview for Mental Status) score of 9. A score of 9 indicated the resident had a moderate impairment for cognitive status. The MDS indicated the resident experienced hallucinations and delusions. Resident #7's diagnoses included non-Alzheimer's dementia. The Progress Notes dated 11/8/16 at 8:23 a.m. documented staff reported Resident #7 making fearful statements at the breakfast table.	F 281	**F 281** On 11/8/16, the call cord and belts were removed from resident #7 room. The Social Service Director will complete an audit of PASSAR's of current residents of the facility on 12/29/16 to identify other residents of the facility that are at risk for suicide ideation. The Director of Nursing Services (DNS) will provide in-service to nursing department staff related to following physician orders for visual checks and time frame of checks of residents who have displayed a suicide attempt, including resident #7 and other like residents of the facility.	12/29/16

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

ADMINISTRATOR 12/30/16

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 281	Continued From page 1 Resident #7 talked about being afraid of what they're doing to him/her and having no idea what he/she should be doing. Resident #7 had difficulty finding words and forming sentences, and jumped from the subject often. He/she talked about bad things happening at night stating he/she and seen and heard things that scared him/her but unable to elaborate on what things he/she saw or heard. When asked what he/she meant, Resident #7 stated not understanding the question. Staff placed a call to the psychiatric practitioner to have him call back ASAP (as soon as possible). The Telehealth chart notation dated 11/8/16 at 9:40 a.m. documented the Assistant Director Of Nursing (ADON) said Resident #7 heard a lot of voices. He/she said he/she didn't know to walk out, freak out or kill him/herself. We just had a nurse go to his/her room and the resident had a belt around his/her neck. The note directed to please immediately remove all means of self-harm from his/her room, start 15 minute checks until further notice, give Haldol (antipsychotic) 1 mg now, and we'll see him at 5:00 PM today for a visit. The Progress Notes dated 11/8/16 at 9:48 a.m. documented new orders received for Haldol 1 mg, 15 minute visual checks, and psychiatric health appointment scheduled for 5:00 p.m. Call cords were replaced with call bell, and belts removed from room. A psychiatric Telehealth visit dated 11/8/16 at 5:00 p.m. documented the ADON stated Resident #7 had no other issues the rest of the day. There was nothing else in his/her room that could hurt the resident. Resident #7 made no further	F 281	**F 281 (Continued)** The DNS or designee will review any ordered active visual checks of residents, 2 times daily for completeness, until discontinued. This approach will be on an ongoing basis. The DNS and or designee will report findings of above monitoring system(s) monthly through the facility Quality Assurance Program. The plan will be reviewed and revised as indicated and staff will be re-educated as needed.	

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F 281	Continued From page 2 verbalizations of wanting to hurt self and stated they had been doing the 15 minute safety checks. Resident #7 did not remember trying to strangle self with a belt this morning and stated everyone over rated it really bad. Resident #7 did not completely remember the mornings suicide attempt. Please continue 15 minute safety checks for 24 hours. The Progress Notes dated 11/8/16 documented continuation of frequent visual checks. A Frequent Checks form dated 11/9/16 lacked documentation of Resident #7 having every 15 minute safety checks. The facility failed to produce documentation of Resident #7 having 15 minute checks on 11/8/16 as ordered. During a findings meeting with facility staff on 12/7/16 at 3:30 PM the Director Of Nursing (DON) stated they did frequent checks on Resident #7 (not 15 minute checks). During an interview on 12/8/16 at 9:45 AM the DON stated they could not find documentation for the frequent checks on 11/8/16.	F 281		
F 282 SS=D	483.20(k)(3)(ii) SERVICES BY QUALIFIED PERSONS/PER CARE PLAN The services provided or arranged by the facility must be provided by qualified persons in accordance with each resident's written plan of care. This REQUIREMENT is not met as evidenced by: Based on observation, record review, and staff	F 282		

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F 282	Continued From page 3 interview, the facility failed to follow the care plan for 1 of 12 active residents reviewed (Resident #8). The facility reported a census of 49 residents. Findings include: According to the Minimum Data Set (MDS) assessment, dated 9/16/16, Resident #8 scored 11 on the Brief Interview for Mental Status (BIMS) indicating cognitive impairment. Resident #8 required extensive assistance with activities of daily living (ADL's) including transfer and ambulation. Resident #8 was not steady moving from a seated to a standing position or walking. Resident #8's diagnoses included muscle weakness and difficulty walking. The current Care Plan initiated 11/22/15 identified Resident #8 with skin impairment. The interventions included Rojo (pressure reduction) cushion to wheelchair, power chair, and move to recliner with a start date of the 11/10/16. During an observation on 12/6/16 at 1:20 p.m. Resident #8 sat in the recliner with no cushion. Staff A Certified Nursing Assistant (CNA) asked Resident #8 if he/she moved the cushion to his/her wheelchair. During an observation on 12/7/16 at 2:15 p.m. Resident #8 sat in the recliner with no cushion. During an interview on 12/8/16 at 8:45 a.m. the Director of Nursing (DON) said they would put a gel cushion in Resident #8's recliner so they would not need to move the cushion from the electric wheelchair.	F 282	**F 282** On 12/8/16 an additional pressure relieving cushion was placed in resident #8 room, in the recliner so that there is a cushion in each chair that the resident uses so that the CNA's do not need to move one cushion from chair to chair throughout the day. On 12/20/16 the Director of Nursing Services (DNS) will provide in-service to nursing department staff related to following the residents care plan, including provision of pressure reduction pads in chairs that the resident uses. DNS or designee will complete an audit of the current residents care plans to identify those residents who have pressure relieving devices on their care plan and will provide the appropriate number of devices for resident #8 and other like residents of the facility. The DNS or designee will monitor that appropriate devices are in place as care planned via walking rounds 3 times weekly, times 8 weeks to assure consistent compliance. The DNS and or designee will report findings of above monitoring system(s) monthly times two months through the facility Quality Assurance Improvement Program, then review/assess for need to continue. The plan will be reviewed and revised as indicated and staff will be re-educated as needed.	12/29/16

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F 314 F 314 SS=G	Continued From page 4 483.25(c) TREATMENT/SVCS TO PREVENT/HEAL PRESSURE SORES Based on the comprehensive assessment of a resident, the facility must ensure that a resident who enters the facility without pressure sores does not develop pressure sores unless the individual's clinical condition demonstrates that they were unavoidable; and a resident having pressure sores receives necessary treatment and services to promote healing, prevent infection and prevent new sores from developing. This REQUIREMENT is not met as evidenced by: Based on observation, record review, and staff interview, the facility failed to prevent AN avoidable pressure ulcer and provide necessary treatment and services to promote healing and prevent infection of A pressure ulcer for 1 of 2 residents with pressure ulcers (Resident #3). The facility reported a census of 49 residents. Resident #3 developed an ulcer to the great toe on 10/8/16. The facility identified the area as open, draining and red, but failed to document a complete assessment. The facility asked for treatment of betadine 2 times a day to the area until healed. On 10/28/16 the facility received orders for antibiotic for the toe, indicating decline, but lacked any assessment of the area and failed to address the treatment. On 11/3/16 the physician saw Resident #3 and ordered a podiatrist consult. The facility completed assessment of the area on 11/4/16. In November 2016, the podiatrist diagnosed the ulcer as pressure, related most likely to a sock rolled up in the shoe causing irritation. The Director of Nursing confirmed the resident did not put socks	F 314 F 314	F 314 Starting 11/8/16 to present, a complete pressure ulcer assessment is documented for resident #3, pressure ulcer assessments will continue to be completed weekly until healed. On 12/20/16 the DNS provided in-service to nursing staff related to skin and ulcer assessment requirements and expectations that assessment is to be completed at the time of identification of skin problem and weekly thereafter until healed to assure appropriate skin and wound assessment for resident #3 and other current residents of the facility. The in-service also included reminder to direct care staff to be sure to check resident shoes for objects before putting them on resident. On 1/4/16, additional training will be initiated with current nursing staff and will be provided by Telligen. On 12/20/16 the DNS completed an audit of current resident's skin assessments. The DNS has initiated assigning weekly skin assessments for current residents and weekly wound assessments for residents with wounds to the nursing staff and will review 3 times weekly times 6 weeks, the 1 time weekly on an ongoing basis to assure that appropriate assessments are completed.	12/20/16

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F 314	Continued From page 5 and shoes on him/herself or take them off him/herself. The podiatrist debrided the ulcer 3 times in November of necrotic tissue, and changed the treatment. The bone was visible at the base of the ulcer, and the podiatrist documented high suspicion of bone erosion related to osteomyelitis. Findings include: 1. Resident #3 had a Minimum Data Set (MDS) assessment, with a reference date of 9/23/16, Resident #3 scored 9 on the Brief Interview for Mental Status (BIMS) indicating cognitive impairment. Resident #3 required extensive assistance of 2 people with activities of daily living (ADL's) including bed mobility, transfer, dressing, toilet use, personal hygiene, and bathing. Resident #3's diagnoses included non-Alzheimer's dementia. Resident #3 had no pressure ulcers but identified at risk for the development of pressure ulcers. The MDS defined a Stage IV pressure ulcer as full thickness tissue loss with exposed bone, tendon, or muscle. Slough or eschar (dead tissue) may be present on some parts of the wound bed, and often included undermining and tunneling. The Care Plan dated 6/20/16 identified Resident #3 with actual skin impairment, history of left heel pressure wound and right great toe wound. The interventions included to identify potential causative factors and eliminate/resolve when possible, and monitor/document location, size and treatment of skin. Report abnormalities, failure to heal, signs and symptoms of infection, maceration, etc. to the physician. The Progress Notes dated 10/8/16 at 11:14 AM	F 314	**F 314 (Continued)** The DNS and or designee will report findings of above monitoring system(s) monthly times two months through the facility Quality Assurance Improvement Program, then review/assess for need to continue. The plan will be reviewed and revised as indicated and staff will be re-educated as needed.	

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F 314	Continued From page 6 documented Resident #3 noted with right great toe redness, warmth to touch, denied any discomfort, and noted yellow discharge from site. Staff cleansed the area and left open to air dry. They applied no shoe, bilateral TED (improves circulation and reduced risk of blood clots) stockings, and gripper socks. Staff faxed the physician, updating on right great toe and requesting treatment until resolved. At 12:04 PM, the facility received a signed fax back from the physician with orders for treatment with betadine 2 times a day to the right great toe until resolved. A facsimile dated 10/8/16 notified the physician Resident #3 had a right great toe open area with yellow discharge, warm to touch. The fax questioned if the physician would recommend Betadine 2 times a day until the area resolved, no shoe, transfer with gripper on, and continue with TED stockings. The physician responded okay. The clinical record lacked an assessment including size, ulcer bed and surrounding skin appearance, extent of redness, or cause of the ulcer. The Progress Notes dated 10/9/16 at 6:46 a.m. documented treatment completed to right great toe, no redness or drainage noted. The Progress Notes dated 10/10/16 at 11:22 p.m. documented Resident #3 continued with the reddened area to his/her great toe. The Progress Notes dated 10/11/16 at 12:05 a.m. documented Residents #3 denied pain to his/her right great toe. The toe was red with no swelling, increased warmth, or drainage. A Weekly Nursing Summary dated 10/12/16	F 314		

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F 314	Continued From page 7 documented Resident #3 free of any open areas. The summary lacked any documentation of the status of the toe. A Weekly Nursing Summary dated 10/19/16 documented Resident #3 free of any open areas. The summary lacked any documentation of the status of the toe. The Progress Notes dated 10/28/16 at 3:25 p.m. documented a new verbal order from a Physician for Augmentin 2 times a day for 5 days. At 5:45 p.m. antibiotic initiated for right great toe. The clinical record lacked any assessment of the right great toe. A Weekly Nursing Summary dated 10/26/16 documented Resident #3 had a treatment to the right great toe. The summary lacked any documentation of the status of the toe. A Weekly Nursing Assessment dated 11/2/16 documented Resident #3 had a red right toe, on antibiotic. The summary lacked any documentation of the status of the toe. A clinic visit dated 11/3/16 documented Resident #3 had infection in his/her right foot finishing antibiotic, and ulcer of the right 1st toe. The right first toe had a 5 mm ulcer with some drainage. The plan included a podiatry consult and physical therapy consult for ulcer treatment. A Weekly Skin Ulcer Non-Pressure report dated 11/04/16 documented an initial review with an unknown start date of the right great toe. The area measured 0.9 by 0.8 cm. The area was scabbed with 0.2 cm diameter dark area central to the outer reddened area. The area was tender	F 314		

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F 314	Continued From page 8 to touch, with no drainage or odor, and treated with betadine. A Weekly Skin Pressure Ulcer report dated 11/08/16 documented the right toe area measured 0.8 by 0.7 cm, with serous drainage. A Weekly Skin Pressure Ulcer report dated 11/15/16 documented the right toe measured 1.1 by 0.8 cm and unstageable due to slough/eschar. A Weekly Skin Pressure Ulcer report dated 11/22/16 documented the right toe measured 0.8 by 0.9 cm and unstageable due to slough/eschar. A Weekly Skin Pressure Ulcer report dated 11/29/16 documented the right toe measured 0.8 by 0.8 cm and unstageable due to slough/eschar. A Weekly Skin Pressure Ulcer report dated 12/6/16 documented the right toe measured 0.8 by 0.7 cm and unstageable due to slough/eschar. Then podiatry consult dated 11/8/16 at 8:32 AM documented Resident #3 seen for right foot ulcer, stating pain at three out of 10 on the pain scale. The family thought the cause of the ulcer most likely a sock rolled up in his/her shoe causing irritation. It had been open for the past couple of weeks and quite painful. Resident #3 had one short course of antibiotics which consisted of Augmentin. Pre-debridement measurements of the wound at 0.4 by 0.2 cm with anatomic depth probes to the bone. The wound base and edges with fibrous necrosis in the base and hyper keratosis around the edges. Probing of the base of the wound showed no undermining and no exposed tendon, but there was exposed bone directly in the base of the wound. The	F 314		

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F 314	Continued From page 9 surrounding tissue showed mild erythema and edema, and mild cellulitis. The x-ray and clinical findings were suggestive of bone erosion secondary to osteomyelitis (inflammation/infection of bone). The wound was debrided of all abnormal tissue. A podiatry note dated 11/16/16 at 2:38 p.m. documented Resident #3 returned for follow-up of the ulcer on the right great toe with pre-debridement measurements of 0.4 by 0.3 cm. There was a large flood of fibrous necrosis well adhered to the base of the ulceration. Probing of the base of the wound showed no undermining and no exposed tendon but there was exposed bone in the base of the ulceration. There was mild surrounding erythema and edema which was markedly improved from the previous visit. Culture report was reviewed with the family which showed Methicillin Resistant Staphylococcus Aureus (MRSA) which was sensitive to his/her current antibiotics. The ulcer was sharply debrided of all abnormal tissue using a combination of a scalpel, sharp curette, and tissue nipper to remove all abnormal tissue. The debridement carried to healthy bleeding tissue at the base of the ulceration and the edges. Excision of both subcutaneous and fascial (connective) tissue was carried out. The post procedure dimensions measured at 0.5 by 0.6 cm with anatomical death of 0.4 cm into the fascial space. They extended the course of antibiotics due to the high likelihood of osteomyelitis with exposed bone. The podiatry follow-up dated 11/30/16 at 2:13 p.m. documented Resident #3 returned for follow-up of the ulcer with pre-debridement measurements of 0.2 by 0.2 cm with an atomic	F 314		

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F 314	Continued From page 10 death indeterminate with a complete covering of fibrous necrosis in the base of the ulceration. The ulcer was sharply debrided of all abnormal tissue. Post procedure dimensions measured 0.4 by 0.4 cm with an atomic death of 0.3 cm. During an observation on 12/6/16 at 8:45 a.m. Staff A Certified Nursing Assistant (CNA) and Staff B CNA assisted Resident #3 with a.m. cares. Resident #3 had a small ulcer to the right big toe, with no redness. Staff put Resident #3's TED socks on and Resident #3's right shoe had cut out (open) for toes. During an interview on 12/6/16 at 2:10 p.m. the Director of Nursing (DON) stated initially they thought the ulcer was venous because the family member stated Resident #3 had a venous ulcer on the 2nd toe, but the family member also stated they had found a TED stocking in the shoe which may have caused pressure. The Podiatrist diagnosed a pressure ulcer. The DON started doing skin assessments in November. She could not say what the toe looked like before that. She did not know why they did not complete wound assessments before then; normally they did wound assessments weekly. She could not find documentation of the area for 10/28/16 when they 1st started the antibiotic. She could not say how big the ulcer was when 1st discovered because no one documented it. During an interview on 12/7/16 at 3:30 p.m. the DON stated Resident #3 would/could not put on or take off his/her own TED socks or shoes. Someone had to do that for him/her. The facility policy and procedures titled Wound Management, reviewed 7/2016, documented a	F 314		

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F 314	Continued From page 11 resident having pressure ulcers received necessary treatment and services to promote healing, prevent infection, and prevent new, avoidable sores from developing. The policy indicated in order prevent existing pressure ulcers from worsening, nursing staff should implement approaches including monitoring the impact of interventions and modifying interventions as appropriate based on any identified changes. They should review and/or re-evaluate existing treatment regimens in connection with the resident's clinical presentation, to include interventions and care plan considerations, if any wound was non-healing or not showing signs of improvement after a given time or any time a wound worsened.	F 314		
F 315 SS=D	483.25(d) NO CATHETER, PREVENT UTI, RESTORE BLADDER Based on the resident's comprehensive assessment, the facility must ensure that a resident who enters the facility without an indwelling catheter is not catheterized unless the resident's clinical condition demonstrates that catheterization was necessary; and a resident who is incontinent of bladder receives appropriate treatment and services to prevent urinary tract infections and to restore as much normal bladder function as possible. This REQUIREMENT is not met as evidenced by: Based on observation, record review, and staff interview, the facility failed to provide appropriate care of a catheter for 1 of 2 residents reviewed (Resident #8). The facility reported a census of 49 residents.	F 315		

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	165362	A. BUILDING _____ B. WING _____	12/08/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CLARION WELLNESS AND REHABILITATION CENTER	110 13TH AVENUE SW CLARION, IA 50525

(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 315	Continued From page 12 Findings include: According to the Minimum Data Set (MDS) assessment, dated 9/16/16, Resident #8 scored 11 on the Brief Interview for Mental Status (BIMS) indicating cognitive impairment. Resident #8 required extensive assistance with activities of daily living (ADL's) including toilet use. Resident #8 had an indwelling urinary catheter. Resident #8's diagnoses included chronic kidney disease. The initial Care Plan dated 12/12/13 identified Resident #8 with an indwelling catheter. An intervention dated 3/3/16 documented Resident #8 used a 14 french, 10 cc Coude catheter. Other interventions included observe/record/report to MD for signs and symptoms of UTI and staff to assist in catheter cares every shift. The current Care Plan initiated 5/20/16 identified Resident #8 with chronic urinary tract infection (UTI). During an observation on 12/6/16 at 1:20 p.m. Staff A Certified Nursing Assistant (CNA) assisted Resident #8 transfer from the wheelchair to the recliner. During the transfer Resident #8's catheter bag laid on the floor. After the transfer Staff A moved the catheter bag over with her foot. She left the catheter bag on the floor and left the room. She returned about 5 minutes later and put the catheter bag in a dignity bag (cover) and hung it from Resident #8's walker. During an observation on 12/7/16 at 7:50 a.m. Resident #8 sat in his/her electric scooter in the hall. Observation showed the catheter bag in a	F 315	F 315 On 12/29/16 the DNS reviewed with staff A, proper cath care including location of catheter bag during transfer assist, not moving cath bags with foot, keeping cath tubing from contact with dirty surface. On 12/20/16 the DNS provided in-service to nursing staff related to appropriate care of a catheter, including location of catheter bag during transfer assist, not moving cath bags with foot, keeping cath tubing from contact with dirty surface to assure proper catheter care for resident #8 and other like residents of the facility. The DNS and or designee will observe 3 random CNA's providing cares of residents with catheters weekly times 6 weeks to assure proper catheter care is provided to resident #8 and other residents with a catheter of the facility. The DNS and or designee will report findings of above monitoring system(s) monthly times two months through the facility Quality Assurance Improvement Program, then review/assess for need to continue. The plan will be reviewed and revised as indicated and staff will be re-educated as needed.	12/29/16

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F 315	Continued From page 13 dark dignity bag at the residents posterior feet with the catheter tubing in contact with the foot pedals and the resident's shoes. During an interview on 12/7/16 at 3:45 p.m. the Director of Nursing stated the catheter bag should not be on the floor.	F 315	F 323 On 12/29/16 the DNS reviewed with staff A, proper transfer assist technique policy, specific to use of a gait belt. On 12/20/16 the DNS provided in-service to nursing staff related to proper transfer assist technique policy, specific to use of a gait belt to assure proper transfer technique to prevent accidents. On 12/30/16 the DNS completed an audit of the current residents of the facility to identify residents who require assist with transfers. The DNS and or designee will observe 3 random CNA's providing transfer assist for residents, weekly times 6 weeks to assure proper transfer technique for accident prevention to resident #8 and other residents who require transfer assist of the facility. The DNS and or designee will report findings of above monitoring system(s) monthly times two months through the facility Quality Assurance Improvement Program, then review/assess for need to continue. The plan will be reviewed and revised as indicated and staff will be re-educated as needed.	12/29/16
F 323 SS=D	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 observation, record review, and staff interview, the facility failed to perform transfer technique to prevent accidents for 1 of 12 active residents reviewed (Resident #8). The facility reported a census of 49 residents. Findings include: According to the Minimum Data Set (MDS) assessment, dated 9/16/16, Resident #8 scored 11 on the Brief Interview for Mental Status (BIMS) indicating cognitive impairment. Resident #8 required extensive assistance with activities of daily living (ADL's) including transfer and ambulation. Resident #8 was not steady moving from a seated to a standing position or walking. Resident #8's diagnoses included muscle	F 323		

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F 323	Continued From page 14 weakness and difficulty walking. Resident #8 had a fall with no injury. The current Care Plan initiated 6/13/13 identified Resident #8 at risk for an ADL self care performance deficit. The interventions included Resident #8 required staff participation with transfers with front wheeled walker and gait belt, and used the sit to stand lift as needed. During an observation on 12/6/16 at 1:20 p.m. Staff A Certified Nursing Assistant (CNA) assisted Resident #8 to transfer from the wheelchair to the recliner without a gait belt. Staff A stated she should have used the gait belt, but she didn't. During an interview on 12/7/16 at 9:45 a.m. the Director of Nursing stated the gait belt was part of the staff's uniform and they were to use it when assisting residents with transfers.	F 323		
F 371 SS=E	483.35(i) FOOD PROCURE, STORE/PREPARE/SERVE - SANITARY The facility must - (1) Procure food from sources approved or considered satisfactory by Federal, State or local authorities; and (2) Store, prepare, distribute and serve food under sanitary conditions This REQUIREMENT is not met as evidenced by: Based on observation, and staff interview, the facility failed to handle ready to eat food in a	F 371		

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F 371	Continued From page 15 sanitary manner in the special care unit. The facility reported a census of 49 residents. Findings include: During an observation on 12/6/16 at 11:33 a.m. Staff C Cook served the noon meal wearing gloves. Staff C touched the steam table, utensils, etc... Staff C then reached into the bag and removed buns wearing the same gloves. During an interview on 12/7/16 at 7:40 a.m. the Dietary Manager stated she talked with Staff C, and she said she did not have tongs for the buns and she panicked. She said the cook normally did not wear gloves during the meal service and used tongs or utensils to serve food. The undated facility policy, Use of Plastic Gloves documented gloves were to be worn whenever handling the food directly. Gloves were just like hands, they get soiled. Anytime a contaminated surface was touched, they must be changed. According to the Food and Drug Administration (FDA) Food Code 2013, 3-304.15, if used, single use gloves should be used for only 1 task such as working with ready to eat food or raw animal food, used for no other purpose and discarded when damaged, soiled, or when an interruptions occurred in the operation.	F 371	F 371 On 12/6/16 the Dietary Supervisor corrected staff C related to handling ready to eat foods in a sanitary manner. On 12/29/16 the Dietary Supervisor provided in-service to dietary staff related to policy and expectations of proper handling of foods. The Dietary Supervisor will monitor food service, including food handling, 1 meal, 3 days weekly times 6 weeks to assure that foods are handled appropriately for current residents of the facility. The Dietary Supervisor and or designee will report findings of above monitoring system(s) monthly times two months through the facility Quality Assurance Improvement Program, then review/assess for need to continue. The plan will be reviewed and revised as indicated and staff will be re-educated as needed.	12/29/16

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
	IA0713	A. BUILDING: _____ B. WING _____	12/08/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CLARION WELLNESS AND REHABILITATION CENTEF	110 13TH AVENUE SW CLARION, IA 50525

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C 148	50.7(5) 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: 50.7(5) When a resident attempts suicide, regardless of injury. This REQUIREMENT is not met as evidenced by: 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: 50.7(5) When a resident attempts suicide, regardless of injury. Based on record review and staff interview, the facility failed to report to the Iowa Department of Inspections and appeals of a resident attempted suicide (Resident #7). The sample consisted of 12 residents and the facility reported a census of 49 residents. Findings include: Resident #7 had a Minimum Data Set (MDS) assessment with a reference date of 11/8/16. The MDS identified a BIMS (Brief Interview for Mental Status) score of 9. A score of 9 indicated the resident had a moderate impairment for cognitive status. The MDS indicated the resident experienced hallucinations and delusions. Resident #7's diagnoses included non-Alzheimer's dementia.	C 148	C 148 On 12/29/16 the Company Resource Nurse discussed what is reportable, including Suicidal statements and Physical self-abuse, with the Director of Nursing Services (DNS) and provided her with the Dependent Adult Abuse Guide for Mandatory Reporting. The DNS, will in-service the facility staff related to reporting any resident suicidal comments or actions to her immediately, she will report to the Department of Inspections and appeals within 2 hours of being aware. The DNS also in-serviced the facility nurses related to initiating an investigation immediately. The DNS or designee will review daily reports/progress notes at least 5 days per week to identify any possible resident suicidal concerns. The Interdisciplinary Team (IDT) will discuss any care needed changes and update the resident care plan accordingly. The DNS or designee will report findings of above monitoring system(s) monthly times two months through the facility Quality Assurance Improvement Program, then review/assess for need to continue. The plan will be reviewed and revised as indicated and staff will be re-educated as needed.	12/29/16

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C 148	Continued From page 1 The Progress Notes dated 11/8/16 at 8:23 a.m. documented staff reported Resident #7 making fearful statements at the breakfast table. Resident #7 talked about being afraid of what they're doing to him/her and having no idea what he/she should be doing. Resident #7 had difficulty finding words and forming sentences, and jumped from the subject often. He/she talked about bad things happening at night stating he/she and seen and heard things that scared him/her but unable to elaborate on what things he/she saw or heard. When asked what he/she meant, Resident #7 stated not understanding the question. Staff placed a call to the psychiatric practitioner to have him call back ASAP (as soon as possible). The Telehealth chart notation dated 11/8/16 at 9:40 a.m. documented the Assistant Director Of Nursing (ADON) said Resident #7 heard a lot of voices. He/she said he/she didn't know to walk out, freak out or kill him/herself. We just had a nurse go to his/her room and the resident had a belt around his/her neck. The note directed to please immediately remove all means of self-harm from his/her room, start 15 minute checks until further notice, give Haldol (antipsychotic) 1 mg now, and we'll see him at 5:00 PM today for a visit. The Progress Notes dated 11/8/16 at 9:48 a.m. documented new orders received for Haldol 1 mg, 15 minute visual checks, and psychiatric health appointment scheduled for 5:00 p.m. Call cords were replaced with call bell, and belts removed from room. A psychiatric Telehealth visit dated 11/8/16 at 5:00 p.m. documented the ADON stated Resident #7	C 148		

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C 148	Continued From page 2 had no other issues the rest of the day. There was nothing else in his/her room that could hurt the resident. Resident #7 made no further verbalizations of wanting to hurt self and stated they had been doing the 15 minute safety checks. Resident #7 did not remember trying to strangle self with a belt this morning and stated everyone over rated it really bad. Resident #7 did not completely remember the mornings suicide attempt. Please continue 15 minute safety checks for 24 hours. The Progress Notes dated 11/8/16 documented continuation of frequent visual checks. A Frequent Checks form dated 11/9/16 lacked documentation of Resident #7 having every 15 minute safety checks. The facility failed to produce documentation of Resident #7 having 15 minute checks on 11/8/16 as ordered. During a findings meeting with facility staff on 12/7/16 at 3:30 PM the Director Of Nursing (DON) stated they did frequent checks on Resident #7 (not 15 minute checks). During an interview on 12/8/16 at 9:45 AM the DON stated they could not find documentation for the frequent checks on 11/8/16. On 12:05 p.m. on 12/7/16, the DON stated she did not report an attempted suicide because it was not an attempted suicide. The DON stated the resident frequently has something hanging around his/her neck.	C 148		