STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	165161	A. BUILDING _____ B. WING _____	C 12/14/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
TOUCHSTONE HEALTHCARE COMMUNITY	1800 INDIAN HILLS DRIVE SIOUX CITY, IA 51104

(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 1/18/17 1/5/17-225,373,507 The following deficiencies were identified during the facility's investigation of 9/22/16 to 12/14/16. Complaints #62408-C, #62592-C, #62889-C, #62936-C, #63361-C, #63420-C, #64377-C and #64509-C were substantiated. Investigation of mandatory report #62893-M and facility-reported incidents #64575-I and # 64576-I resulted in deficiency. See Code of Federal Regulations (45 CFR) Part 483, Subpart B-C.	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).	F 157		

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

Administrator | 01/05/2017

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 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 interview, the facility failed to always notify interested family members of a change in condition for 1 of 19 residents reviewed (Resident #14). The facility identified a census of 98 current residents. Findings include: 1. According to the MDS (Minimum Data Set) assessment dated 5/22/16, Resident #14 had diagnoses that included Non-Alzheimer's dementia and Parkinson's disease. The MDS identified the resident had severely impaired cognitive skills for daily decision making. According to the MDS, the resident required extensive assistance with bed mobility, transfers and dressing. The resident's care plan revised on 3/10/16 instructed staff to keep family members up to date with changes in condition.	F 157		

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F 157	Continued From page 2 Review of the Progress Notes dated 7/13/16 at 10:00 AM revealed at 9:00 AM, a CNA (certified nursing assistant) reported the resident had a nose bleed during dressing. Staff assessed the resident and noted a fast flow. While staff applied toilet paper to the nose, the resident started to cough and stated he/she choked on the blood. The blood ran down his/her nose into the mouth and on the chin. At 9:05 AM, staff contacted the resident's physician and received an order to send Resident #14 to the emergency room for evaluation and treatment. At 10:05 AM the resident left for the emergency room with facility transport. At 10:05 AM staff spoke with the resident's family regarding resident to the emergency room. At 12:39 PM the resident returned to the facility per facility van and the resident's spouse returned with the paperwork. During an interview on 10/21/16 at 10:30 AM with the family member who received notice on 7/13/16, s/he stated the hospital actually notified them of Resident #14's nose bleed as the resident had been alone for 2 hours. The family member did not receive a notice from the facility and identified he/she was the responsible party. During an interview with the Administrator on 10/21/16 at 1:30 PM she stated the situation had been brought to their attention and investigated. The family member that had been notified had been a staff member at the facility. Family made the facility aware of the concern and it had been investigated.	F 157		
F 225 SS=D	483.13(c)(1)(ii)-(iii), (c)(2) - (4) INVESTIGATE/REPORT ALLEGATIONS/INDIVIDUALS	F 225		

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F 225	Continued From page 3 The facility must not employ individuals who have been found guilty of abusing, neglecting, or mistreating residents by a court of law; or have had a finding entered into the State nurse aide registry concerning abuse, neglect, mistreatment of residents or misappropriation of their property; and report any knowledge it has of actions by a court of law against an employee, which would indicate unfitness for service as a nurse aide or other facility staff to the State nurse aide registry or licensing authorities. The facility must ensure that all alleged violations involving mistreatment, neglect, or abuse, including injuries of unknown source and misappropriation of resident property are reported immediately to the administrator of the facility and to other officials in accordance with State law through established procedures (including to the State survey and certification agency). The facility must have evidence that all alleged violations are thoroughly investigated, and must prevent further potential abuse while the investigation is in progress. The results of all investigations must be reported to the administrator or his designated representative and to other officials in accordance with State law (including to the State survey and certification agency) within 5 working days of the incident, and if the alleged violation is verified appropriate corrective action must be taken. This REQUIREMENT is not met as evidenced by: Based on record review, staff interviews and	F 225		

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F 225	Continued From page 4 review of policy and procedures, the facility staff failed to follow their abuse policy and immediately report allegation of misappropriation of money (Resident #1) and an alleged assault (Resident #18) to the Administrator or designated person. The facility identified a census of 98 residents and the sample consisted of 18 residents. Findings include: 1. According to the MDS (Minimum Data Set) assessment dated 8/21/16, Resident #1 had diagnoses that included diabetes mellitus, hemiplegia and post procedural cerebrovascular infarction. The MDS identified the resident had a BIMs (brief interview for mental status) score of 15 which indicated no short and long term memory problems. According to the MDS, the resident required limited assistance with bed mobility and extensive assistance with transfers, dressing and toilet use. The care plan dated 11/20/15 directed staff to assist the resident with extensive assistance of 1 staff with bed mobility, transfers and ambulation. During an interview with Staff F, CNA (certified nursing assistant) on 10/13/16 at 2:45 PM, she stated the resident had told her he/she had money missing. She asked the resident if he/she reported the missing money. The resident said he/she did not. Staff F stated she did not report the missing money and it would be the resident's right if he/she wanted this reported or not. During an interview with Staff M, CMA (certified medication assistant) on 10/20/16 at 9:50 AM he stated the resident reported he/she had missing money. He further stated he told the nurse on duty and also reported to the Social Service	F 225		

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F 225	Continued From page 5 Director right away on Monday (11/12/16). During an interview with Staff O, CNA on 10/20/16 at 3:20 PM she stated the resident told her he/she had missing money on 9/11/16 or 9/12/16. She specifically asked the resident if he/she had reported it to management and he/she said no. She further stated she did not report it and did not know how, but should have. During an interview with the Administrator on 10/19/16 at 2:05 PM she stated the resident reported to Staff M he/she had missing money on Monday. (11/12/16) 2. According to the MDS dated 10/16/16, Resident #18 had diagnoses that included diabetes mellitus, anxiety and depression. The MDS identified the resident had a BIMs score of 12 which indicated moderate cognitive impairment. According to the MDS the resident required extensive assistance with bed mobility, transfers and toilet use. The care plan dated 12/6/16 directed staff to arrange an appointment with the therapist as needed and redirect following behavior. Review of the Progress Notes dated 11/20/16 at 1:59 PM revealed the resident came out of the room in the wheelchair in his/her nightgown and stated at 7:20 AM that he/she just been raped. The resident seemed very calm about it. The resident had gotten him/herself out of bed. The male CNAs had not been in the resident ' s room yet. The resident stated it happened last night. The resident could not remember what the person looked like but walked into the room and assaulted him/her. The resident denied feeling	F 225		

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F 225	Continued From page 6 any pain or discomfort. A male CA later took the resident into his/her room to help get dressed. The resident okay with the CNA and told the CNA that he/she was assaulted and pointed to the roommate in the room in bed and told the CNA he/she did it. During an interview with Staff Y, RN (registered nurse) on 12/13/16 at 10:40 AM she stated the incident reported to the Unit Manager and she failed to report to anyone else. The incident identified after Administration read the progress notes and did not report to the Department timely. Review of the Policy and Procedure titled Abuse Prevention Plan, revised August 2016, identified all staff are required to report suspected maltreatment of a vulnerable adult to the Administrator If the Administration not in the building, direct care staff will report to the Nursing Supervisor, at the time of suspicion. Nursing Supervisor of the building may report to the Director of Nursing who will in turn report to the Administrator. The Administrator, Director of Nursing or Nursing Supervisor will make sure that a report is filed, that the internal investigation begins immediately, the appropriate reporting takes place and that interventions are implemented to provide the vulnerable adult with a safe living environment.	F 225		
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.	F 241		

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F 241	Continued From page 7 This REQUIREMENT is not met as evidenced by: Based on clinical record review, observation and facility policy review, the facility failed to ensure staff cared for residents in a manner that promoted dignity and respect for 2 of 19 residents reviewed (Residents # 11 & #14) The facility identified a census of 98 current residents. Findings include: 1. According to the MDS (Minimum Data Set) assessment dated 9/4/16, Resident #11 had diagnoses that included diabetes mellitus, heart failure, anxiety disorder, unspecified disorientation and disorder of the kidney and ureter. The MDS identified the resident had short and long term memory problems and severely impaired cognitive skills for daily decision making. The assessment documented Residents #11 had no hearing deficits, s/he could usually understand others and s/he could usually make him/herself understood. According to the MDS, the resident required the assistance of 2 with bed mobility, transfers, locomotion, dressing and toilet use. The resident experienced routine incontinence of bowel and bladder. The care plan revised on 6/7/16 directed staff to assist Resident #11 with toileting, clothing and hygiene and provide the resident with incontinence supplies. Observation on 10/19/16 at 5:10 PM revealed Staff P, CNA (certified nursing assistant) and Staff R, CNA provided incontinent care for the resident. Staff P worked in the room and prepared supplies for cares with the door closed.	F 241		

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F 241	Continued From page 8 Staff R entered the room and failed to knock prior to opening the door. Review of the Policy and Procedure titled Resident Rights Guidelines for All Nursing Procedures dated 8/16 directed staff to knock and gain permission before entering the resident's room. 2. According to the MDS assessment dated 11/11/16, Resident #14 had diagnoses that included dementia and Parkinson's disease. The MDS identified the resident had moderately impaired cognitive skills for daily decision making. According to the MDS, the resident required the assistance of 2 with bed mobility transfers, dressing and personal hygiene. The care plan dated 1/7/16 directed staff to provide assistance with bathing, grooming and dressing. Observation on 10/21/16 revealed the resident sat in the wheel chair in the TV lounge area along with other residents. The resident had visible food particles down the front area of their shirt. During an interview with the resident's family member on 11/21/16 at 10:30 AM, s/he stated the resident has the same clothes on 3 days in a row. The family member said something to the staff and they stated the clothes were in his/her wheelchair so they put them on the resident. The family member stated the facility had been notified of the concerns and were well aware.	F 241		
F 248 SS=E	483.15(f)(1) ACTIVITIES MEET INTERESTS/NEEDS OF EACH RES	F 248		

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F 248	Continued From page 9 The facility must provide for an ongoing program of activities designed to meet, in accordance with the comprehensive assessment, the interests and the physical, mental, and psychosocial well-being of each resident. This REQUIREMENT is not met as evidenced by: Based on record review, observation and staff interview the facility failed to provide meaningful activities on an ongoing basis for 4 of 19 total residents reviewed (Residents #3, #5, #11 and #13). The facility identified a census of 98 current residents. Findings include: 1. According to the MDS (minimum data set) assessment dated 8/7/16, Resident #3 had diagnoses that included fracture, hyponatremia (low blood sodium) and hyperkalemia (high blood potassium). The MDS identified the resident had a BIMS (brief interview for mental status) score of 7 which indicated severe cognitive impairment. According to the MDS the resident required the assistance of one with bed mobility, transfers, ambulation, dressing and toilet use. The care plan dated 6/7/16 revealed the resident had dementia and directed staff to encourage the resident to talk about their family and children. The care plan also directed staff to anticipate the resident's social needs and provide for them and to provide calendars and reminders of activity events and activities. Review of the Activity Calendars dated September 2016 revealed the resident attended	F 248		

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F 248	Continued From page 10 only 2 activities that month (9/19 & 9/28/16). The activity calendar dated October 2016 revealed no activities attended. The medical record revealed no documentation of any 1 to 1 activity provided. 2. According to the MDS assessment dated 6/21/16, Resident #5 had diagnoses that included pneumonia, septicemia, diabetes mellitus, atherosclerotic heart disease and atrial fibrillation. The MDS identified the resident had a BIMs score of 9 which indicated moderate cognitive impairment. According to the MDS the resident required limited assistance with bed mobility, transfers, dressing and toilet use. The care plan dated 6/10/16 directed staff to provide the resident with calendars and reminders of facility events and activities. The care plan identified the resident would like to attend games, crafts, exercise, religious activities, shopping, outdoors and outings. The care plan also identified the resident preferred activities in room including cards, music, reading,writing, TV and movies and visiting with friends and family. Review of the Activity Calendars dated September 2016 revealed the resident attended 3 activities (9/1, 9/2 & 9/9/16). The activity calendar dated October 2016 revealed no activities attended. The medical record revealed no documentation of any 1 to 1 activity provided. 3. According to the MDS assessment dated 9/4/16 Resident #11 had diagnoses that included diabetes mellitus, heart failure, anxiety disorder and disorder of the kidney and ureter. The MDS identified the resident had short and long term memory problems and severely impaired cognitive skills for daily decision making.	F 248		

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F 248	Continued From page 11 According to the MDS the resident had total dependence with bed mobility, transfers, locomotion, eating and toilet use. The care plan dated 6/24/16 directed staff to bring the resident to stimulating activities he/she might enjoy. Review of the Activity Calendars dated September 2016 revealed 1 activity attended (9/28/16). The activity calendar dated October 2016 revealed no activities attended. The medical record revealed no documentation of any 1 to 1 activity provided. Continuous observation on 10/19/16 from 9:45 AM to 11:20 AM revealed the resident sat in the wheel chair in the TV/lounge area near the nurses station. The television on and the sound low and unable to understand. Staff provided no activities during the observation. 4. According to the MDS assessment dated 10/9/16 Resident #13 had diagnoses that included diabetes mellitus, Alzheimer's disease and dermatitis. The MDS identified the resident had short and long term memory problems and moderately impaired cognitive skills for daily decision making. The assessment documented the following activity preferences: listening to music, being around animals, doing things with groups, doing his/her favorite activities and participating in religious services. The care plan dated 9/8/16 directed staff to give the resident one on one time and listen if anxious, even if staff did not understand what the resident saying. The care plan identified the resident enjoyed listening to the Spanish station on TV	F 248		

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F 248	Continued From page 12 and to put it on when possible. The care plan also identified the resident enjoyed napping and people watching in the Cherry Blossom and south living areas. Review of the Activity Calendars dated September 2016 revealed the resident attended one activity (9/13/16) during the month. The activity calendar dated October 2016 revealed no activities attended. The medical record revealed no documentation of 1 to 1 activities provided. Observation on 10/18/16 from 9:30 AM through 11:30 AM and 2:00 PM through 5:45 PM revealed the resident asleep in the recliner in the Cherry Blossom lining area. The TV set on English speaking shows and movie with no activity provided. Review of the activity calendar and observation on 10/19/16 at 10:00 AM to 10:30 AM revealed no activity per scheduled bowling and Pastor services in the Dining room. The South lounge had a TV on and 14 residents sat stationary and 4 mobile residents moved in and out of the area. Staff provided no meaningful activities in the lounge area. During an interview with Staff J, Activity Assistant on 10/20/16 at 8:10 AM she stated the morning activities were not completed as she had been unable to get to them. She stated she had been doing the best she can. She further stated the Activity Director had been out on leave and Staff J was unsure if any 1 on 1's had been implemented. She stated she had not done any 1 on 1 activities.	F 248		
F 279	483.20(d), 483.20(k)(1) DEVELOP	F 279		

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F 279 SS=D	Continued From page 13 COMPREHENSIVE CARE PLANS A facility must use the results of the assessment to develop, review and revise the resident's comprehensive plan of care. The facility must develop a comprehensive care plan for each resident that includes measurable objectives and timetables to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment. The care plan must describe the services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §483.25; and any services that would otherwise be required under §483.25 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(b)(4). This REQUIREMENT is not met as evidenced by: Based on clinical record review and staff interview, the facility failed to update the care plan to include all interventions to promote resident safety from elopement and accidents for 2 of 19 residents reviewed (Residents #16 & #17). The facility identified a census of 98 current residents. Findings include: 1. According to the MDS (minimum data set) assessment dated 9/11/16 revealed Resident #16 had diagnoses that included heart failure, chronic lung disease, end stage renal disease and	F 279		

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metabolic encephalopathy. The resident had a BIMS (brief interview for mental status) score of 13 which indicated intact cognition. According to the MDS the resident required the assistance of one with bed mobility, transfers, dressing and toilet use. The resident used a walker and wheelchair for mobility.

The care plan dated 6/15/16 recorded Resident #16 as at risk to elope as s/he made statements of wanting to leave, intending to leave and had sufficient mobility to exit unescorted. The care plan directed staff to do the following:
a. If pushing on door attempt to redirect/distract from door.
b. If unable to redirect, utilize other staff to escort person served to appropriate part of unit or room.
c. If elopes, follow elopement policy.
The facility identified all interventions as resolved effective 11/28/16.

Review of the Elopement Risk Assessment dated 6/15/16 and 9/11/16 revealed the resident displayed tactile wandering: explored environment with hands, recreational wandering: wandering based upon previous active lifestyle and talked about leaving. The assessment summary revealed the resident had a wanderguard in place due to making statements of wanting to leave and had mobility to escort self out the door unattended.

Review of the Elopement Risk Assessment dated 11/28/16 revealed the resident had no wandering but did talk about leaving and made statements of wanting to go home. The assessment summary revealed the resident had a BIMs of 13 and alert and oriented and able to make his/her own decisions. Does go outside independently

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F 279	Continued From page 15 and will sometimes wait outside for the bus to go to appointments. The facility failed to identify the need for a wandergaurd on the care plan to alert staff of safety interventions for elopement. During an interview with Staff Z, RN (Registered Nurse) on 12/1/16 at 3:50 PM she concurred the wandergaurd safety intervention had not been added to the care plan. 2. According to the MDS assessment dated 8/17/16 documented that Resident #17 had diagnoses that included Non-Alzheimer's dementia, hypothyroidism (low thyroid levels) and hyperlipidemia (high blood lipids). The assessment documented the resident had a BIMs score of 2 which indicated severe cognitive impairment. The assessment documented the resident required the assistance of 2 with bed mobility, transfers and walking in their room. The care plan dated 11/1/16 directed staff to do the following: a. Ensure the wheel chair in good repair and available at all times. b. Toileted before and after meals. In between meals place out in the television viewing room as tolerated. c. Encourage to wear non skid socks or shoes when transferring. Assist of 1 for transfers. d. Utilize wireless call light. Review of the Incident Report dated 10/14/16 at 9:45 AM revealed the resident found laying on the floor on back by the roommate's bed and their wheel chair by the closet door. The resident stated he/she tried to go to the bathroom. The	F 279		

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resident did not use the call light. Staff assessed the resident and noted a skin tear to the right elbow. Staff cleansed the area and applied a dressing. The Incident Report documented addition of an intervention to ask for a urinalysis and assist to the bathroom after meals. The care plan did not document the and the chart did not contain a urinalysis.

Review of the Incident Report dated 10/20/16 in the evening revealed the resident fell in his/her room. No interventions included or added to the care plan.

The MDS assessment dated 11/17/16, documented Resident #17 now had a BIMs score of 3 which indicated severe cognitive impairment. According to the MDS the resident required the assistance with bed mobility, transfers and toilet use. The MDS identified the resident as occasionally incontinent of urine and had falls since the last assessment.

Review of the Incident Report dated 11/19/16 at 12:45 PM revealed the resident found lying in the doorway of the resident's room. The resident lay on his/her left side and s/he could not say how he/she fell or where he/she was going.

During an interview with Staff Z, RN (Registered Nurse) on 12/13/16 at 12:00 PM she stated the facility did not have a policy and procedure for updating care plans. The facility expects staff to update the resident's care plan when new interventions are put in place and to be updated quarterly. On 12/14/16 staff clarified the care plan intervention to toilet before and after meals and place in the television viewing room not actually placed on the care plan until 11/19/16.

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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 clinical record review, observation and medication instructional review, the facility failed to always follow physician orders as written and/or administer medications per professional standards for 3 of 19 residents reviewed (Residents #2, #5 & #19). The facility identified a census of 98 current residents. Findings include: 1. According to the MDS (minimum data set) assessment dated 10/3/16, Resident #2 had diagnoses that included diabetes mellitus, sleep apnea and chronic kidney disease. The MDS identified the resident had a BIMs (brief interview for mental status) score of 15 which indicated intact cognition. According to the MDS the resident required the assistance of one with bed mobility, transfers, dressing and toilet use. Review of the Physician orders dated 9/15/16 revealed instruction to obtain the resident's weight daily for monitoring and call if s/he had a weight gain greater than 3 pounds in a day. Review of the MAR (medication administration record) dated 10/1/16 through 10/31/16 staff did complete the daily weight measurements as ordered. 2. According to the MDS assessment dated	F 281		

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F 281	Continued From page 18 6/21/16, Resident #5 had diagnoses that included heart failure, pneumonia, septicemia, diabetes mellitus, atherosclerotic heart disease and atrial fibrillation. The MDS identified the resident had a BIMs score of 9 which indicated moderate cognitive impairment. According to the MDS the resident required limited assistance with bed mobility, transfers, dressing and toilet use. Review of the Physician's Order dated August 2016 revealed the order for daily weight. If the resident gained 2 to 3 pounds per 1 night or 4 to 5 pounds in 5 days, to notify the Medical Doctor. The order was discontinued on 9/21/16. Review of the MARs dated August 2016 and September 2016 revealed the daily weights not documented on the following dates: a. 8/4, 8/10, 8/12, 8/13, 8/18 and 8/24/16. b. 9/3 to 9/11, 9/13, 9/14, 9/16 and 9/19 to 9/20/16. 3. Review of the Physician Orders dated 9/16/16 for Resident #19 revealed the order for Atropine 1%, one drop in the right eye 2 times a day (anticholinergic). Review of the MAR dated 10/1/16 through 10/31/16 revealed the order for atropine care solution 1% instill 1 drop in right eye 2 times a day for eye irritation. Observation on 10/19/16 at 8:00 AM revealed Staff M, CMA (certified mediation assistant) administered medications to the resident. Staff M instilled 1 drop of atropine 1% in the resident's right eye. He did not instruct the resident to hold the lacrimal duct and the resident did not hold his/her lacrimal duct following administration.	F 281		

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F 281	Continued From page 19 Review of the Pharmacy Drug Information document dated 10/20/16 directed staff to do the following: a. Look downward and gently close eyes for 1-2 minutes. b. Place 1 finger at the corner of the eye (near the nose) and apply gentle pressure for 2 to 3 minutes. (to prevent the medication from draining out)	F 281		
F 312 SS=E	483.25(a)(3) ADL CARE PROVIDED FOR DEPENDENT RESIDENTS A resident who is unable to carry out activities of daily living receives the necessary services to maintain good nutrition, grooming, and personal and oral hygiene. This REQUIREMENT is not met as evidenced by: Based on clinical record review, observation and staff and family interviews and facility policy review, the facility failed to ensure residents received grooming, bathing and toileting assistance when indicated for 5 of 19 residents reviewed (Residents #2, #9, #11, #13 & #14). The facility identified a census of 98 current residents. Findings include: 1. According to the MDS (minimum data set) assessment dated 10/3/16, Resident #2 had diagnoses that included diabetes mellitus, sleep apnea and chronic kidney disease. The MDS identified the resident had a BIMs (brief interview	F 312		

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F 312	Continued From page 20 for mental status) score of 15 which indicated intact cognition. According to the MDS the resident required the assistance of one with bed mobility, transfers, dressing and toilet use. The care plan dated 10/4/16 directed staff to provide extensive assistance of one staff with dressing, grooming and bathing. Review of the bathing record dated October 2016 (on 10/20/16) revealed the facility provided one bath on 10/5/16. During an interview with Resident #2 on 10/21/16 at 2:00 PM, s/he stated the facility scheduled only 2 showers a week and the resident does not even get that anymore. The resident was supposed to get a shower yesterday and did not. The facility put it off until today and s/he still had not received it. 2. According to the MDS assessment dated 8/28/16 Resident #9 had diagnoses that included peripheral vascular disease, diabetes mellitus, anxiety disorder, sleep apnea and a chronic non-pressure ulcer of skin sites. The MDS identified the resident had a BIMs score of 6 which indicated severe cognitive impairment. According to the MDS the resident required the assistance of 2 with bed mobility toilet use and the assistance of one with transfers, dressing and bathing. The care plan dated 7/15/16 directed staff to provide extensive assistance of one staff with dressing, grooming and bathing. The care plan identified the resident liked to take showers. Review of the bathing record dated September	F 312		

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F 312	Continued From page 21 2016 revealed the facility provided resident baths on 9/5, 9/7, 9/14 & 9/19/16. Review of the October 2016 bathing record revealed the facility provided resident baths on 10/15, 10/16 & 10/19. Observation on 10/19/16 at 10:15 AM revealed the resident sat in the wheel chair in his/her room. The resident had not been shaved, had moderately long whiskers and his/her hair appeared greasy. Observation on 10/20/16 at 1:00 PM revealed the resident sat in the wheel chair and moved independently in the hall. The resident continued to be unshaven with moderately long whiskers and his/her hair appeared greasy. 3. According to the MDS assessment dated 9/4/16, Resident #11 had diagnoses that included diabetes mellitus, heart failure, anxiety disorder and disorder of the kidney and ureter. The MDS identified the resident had short and long term memory problems and severely impaired cognitive skills for daily decision making. The assessment documented that Resident #11 required the assistance of 2 staff for bed mobility, transfers and toilet use. The MDS identified that bathing had not been completed during the 7-day assessment period. The resident experienced routine bowel and bladder incontinence. The care plan dated 5/26/15 directed staff to assist the resident with toileting, clothing and hygiene and provide the resident with incontinence supplies. Review of the bathing record dated September 2016 revealed the facility proved a bath for Resident #11 on 9/5, 9/21 and 9/26/16. The	F 312		

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F 312	Continued From page 22 October bathing record revealed bathing completed on 10/17/16 only. Observation on 10/19/16 at 11:20 AM revealed Staff P, CNA (certified nursing assistant) and Staff Q, CNA provided incontinent care for the resident. The resident had been incontinent of bowel and bladder. Staff rolled the resident to the right and cleansed their peri-rectal area front to back and then applied a new brief. Staff failed to cleanse the groin area or buttocks, which came into contact with urine. Observation on 10/19/16 at 5:10 PM revealed Staff P and Staff R, CNA provided incontinent care for the resident, who had been incontinent of bladder. Staff turned the resident to the right side, cleansed resident's peri-rectal area front to back and applied a new brief. Staff failed to cleanse the resident's groin area or buttocks. Review of the Policy and Procedure titled Perineal Care dated October 2015 directed staff to do the following: a. Wet washcloth and apply skin cleansing agent, or use perineal wipes. b. Wash perineal area, wiping from front to back. c. Instruct or assist the resident to turn on his/her side with top leg slightly bent, if able. d. Apply skin cleansing spray to washcloth, or use perineal wipes. Wash the rectal area thoroughly, wiping from the base of the labia towards and extending over the buttocks. e. Gently pat dry area, if needed. f. Discard disposable items into designated containers. g. If changing brief or dressing/undressing resident, apply new gloves before proceeding with these items.	F 312		

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4. According to the MDS assessment dated 10/9/16, Resident #13 had diagnoses that included diabetes mellitus, Alzheimer's disease and dermatitis. The MDS identified the resident had short and long term memory problems and moderately impaired cognitive skills for daily decision making. The MDS identified the resident required the assistance of 2 with bed mobility, transfers, dressing, toilet use and bathing. The MDS identified the resident as frequently incontinent of bowel and bladder.

The care plan dated 10/11/16 directed staff to assist using 2 staff with transfers and toilet use. The care plan also directed staff to let the resident sleep and wait to check, change and toilet when wake up.

Review of the Braden Scale Assessment for Predicting Pressure Sore Risk dated 10/7/16 revealed the resident had a total score of 15 which indicated the resident at risk for pressure ulcer development.

Review of the Bathing Document dated September 2016 revealed the facility provided baths on 9/7, 9/19 and 9/26/16. The October bathing record dated October 2016 revealed baths provided on 10/5, 10/10 and 10/19/16.

Continuous observation on 10/19/16 from 2:00 PM to 5:45 PM revealed Resident #13 sat in the recliner and positioned leaning on their right hip. At 5:45 PM Staff F, CNA and Staff L, LPN (Licensed Practical Nurse) assisted the resident from the recliner and walked him/her to the bathroom for toilet assistance. The recliner and the resident's pants were visibly wet. The resident

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F 312	Continued From page 24 had 2 briefs in place and the brief closest to the skin was saturated with urine and the 2nd brief had urine wetness on the edges. Staff F cleansed the resident's groin area and then assisted the resident to stand. Staff L cleansed the resident's peri-rectal area front to back and lightly patted a small area on the buttocks. Staff failed to cleanse the entire buttocks or hips that had been contaminated with urine. During an interview with Staff G, CNA on 11/17/16 at 4:40 PM she stated she documented on the bathing record for assisting the residents with bedtime cares. She does not bath the residents at that time but provides hygiene. 5. According to the MDS assessment dated 11/11/16, Resident #14 had diagnoses that included Non-Alzheimer's dementia and Parkinson's disease. The MDS identified the resident had short and long term memory problems and moderately impaired cognitive skills for daily decision making. The assessment documented s/he required the assistance of 2 with bed mobility transfers, dressing and personal hygiene activities. The assessment did not document that Resident #14 rejected care during the 7-day assessment period. The care plan dated 1/7/16 directed staff to provide assistance with bathing, grooming and dressing. Observation on 10/21/16 at 10:30 AM revealed the resident sat in the wheel chair in the TV lounge area. The resident had long facial whiskers and dirty un-clipped fingernails. An interview with a family member at the time revealed Resident #14 not been shaved for 4	F 312		

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F 312	Continued From page 25 days. The family member also stated he/she had spoke to the facility on other occasions and they agreed to shave the resident every other day. However, the facility had not been shaving the resident every other day.	F 312		
F 314 SS=D	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 clinical record review, observation, staff interview and policy review the facility failed to provide timely skin assessments to identify changes in skin integrity in a prompt manner for 1 of 19 current residents reviewed (Resident #3). The facility identified a census of 98 current residents. Findings include: 1. According to the MDS (minimum data set) assessment dated 8/7/16, Resident #3 had diagnoses that included hyponatremia (low blood sodium), hyperlipidemia (high blood lipids), fracture and repeated falls. The MDS identified the resident had a BIMS (brief interview for mental status) score of 7 which indicated severe	F 314		

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F 314	Continued From page 26 cognitive impairment. The assessment documented that Resident #3 required the assistance of one with bed mobility, transfers, dressing and toilet use. The assessment also documented the resident had no risk of developing pressure ulcers and s/he had no ulcers at the time of the assessment. The resident's care plan dated 5/23/16 directed one staff to provide assistance with dressing, grooming and bathing. On 9/22/16, staff updated the care plan directing to elevate the resident's heels off the bed and provide non-skid socks at the hour of sleep. Review of the Braden Scale Assessment For Predicting Pressure Sore Risk dated 11/4/16 revealed the resident had a total score of 18 which indicated the resident as at risk. Review of the facsimile to the physician dated 11/15/16 revealed during the assessment from a fall staff observed an area to the right heel. The area appeared black and had necrotic skin. The open area measured 1.7 cm (centimeter) by 1 cm. and staff could not stage the wound due to the necrotic dark black scab. Staff documented an area of undermining that measured 0.2 cm from 1 o'clock to 5 o'clock. The wound was black in color at 12 o'clock at the widest point and 0.5 cm and 0.3 cm at 3 o'clock and 7 o'clock. Staff noted no drainage present, area dry, black, peri wound red and the resident reported pain. The resident also had an area to the left heel which measured 0.3 cm by 0.3 cm and appeared dark brown. Staff received an order for evaluation at the wound clinic. Review of the Medical Doctor/Nursing	F 314		

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F 314	Continued From page 27 Communication document dated 11/17/16 revealed the resident's wound measurements per the wound clinic as follows: a. Left heel 0.3 cm by 0.5 cm. b. Right heel 2.5 cm by 1.9 cm by 0.3 cm. Review of the document titled Body Audits dated 11/12/16 revealed the resident had no skin issues reported by Staff T, CNA to the licensed nurse. Review of the Schedule for November 2016 revealed no bath skin checks documented from 11/1/16 through 11/21/16. Review of the CNA (certified nursing assistant) assignment/communication document revealed the resident received a bath on 11/5/16 and 11/12/16. Review of the TAR (Treatment Administration Record) dated 10/1/16 through 10/31/16 and 11/1/16 through 11/30/16 revealed the resident's weekly skin assessment had not been completed on 10/28/16 and 11/4/16. The entry documented staff did a skin assessment on 11/11/16. (identified by the Administrator and not signed by a licensed nurse) Review of the Progress Notes dated 11/15/16 at 9:04 AM revealed the resident observed sitting on their buttocks in the middle of the hall way. The resident was alert to person and place. Resident #3 wanted to get up but didn't remember why. The reported pain the the right heel. The resident reported no pain during the transfer to the bed per Hoyer lift. Observation on 11/23/16 at 2:00 PM revealed the Staff V, LPN (licensed practical nurse) completed	F 314		

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F 314	Continued From page 28 wound care for the resident. The resident had open wounds on both the left and right heels. During an interview with Staff T, CNA on 11/23/16 at 2:30 PM she stated the staff could not get baths done per the schedule. She works on the resident's hall and gave the residents showers. She stated she tried her best to look at the resident's skin but did not see Resident #3's wounds. She further stated the nurse will come to look at the skin only if she sees an issue and asks them to come. During an interview with Staff A, LPN (Licensed Practical Nurse) on 11/2916 at 2:20 PM she stated if a CNA did not call the nurse in the the bath area a full assessment may not get done. It does happen and the assessments have been inconsistent. During an interview with Staff V, LPN on 11/29/16 at 2:20 PM she stated she could not remember if she did a skin assessment on the resident. She stated the skin checks are not consistent. During an interview with the Administrator on 11/30/16 at 10:15 AM, she stated the expectation every time bathing is completed, staff should do skin checks. The facility had identified skin checks not being done after the resident's wounds were brought to their attention. That prompted the managers to provide a facility wide skin sweep. She further stated the documentation is not always consistent for completion. The resident's TAR signed by a CMA (certified medication assistant) on 11/11/16 and she would not be the staff member to perform the skin assessments; skin assessments are done by the Licensed nurse.	F 314		

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F 314	Continued From page 29 During an interview with staff at the Wound Clinic on 127/16 at 1:30 PM she stated the resident was seen at the wound clinic on 11/17/16 and had bilateral heel ulcers that were not stagable. The resident had numerous falls and dementia. She stated that Doppler studies were done with no evidence of venous insufficiency. On 11/28/16, the resident received wound debriedment to the right heel, which resulted in 100% devitalized tissue and measurements of 2.4 cm by 2 cm by 0.3 cm. Review of the Policy and Procedure titled Skin Program dated September 2016 directed staff to do the following to ensure a resident who enters the facility without pressure ulcers does not develop pressure ulcers unless the individual's clinical condition demonstrates that they were unavoidable: a. On admission a baseline assessment of the resident's skin status will be completed within 2 hours of admission. b. Further comprehensive skin assessments will be completed with readmission, annually, with change of condition or surface. c. Further Risk Assessments will be completed with readmission, quarterly, annually, with change in condition or surface. d. Nursing personnel will utilize the result of the physical exam and the Pressure Ulcer Assessment tools to determine an individualized pressure ulcer prevention program for each at-risk resident. e. A comprehensive wound assessment will be completed. f. Nursing personnel who will be providing care for the resident will receive pressure ulcer training, to include checking potential pressure	F 314		

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F 314	Continued From page 30 areas and recognize pressure ulcers in "at-risk" residents, and instructed to notify the nurse when this is observed. They will also be instructed in individual interventions for each resident. Nursing personnel will periodically monitor response to the plan of care to ensure implementation of the plan of care. g. Nursing personnel will develop a plan of care with interventions consistent with resident and family preferences, goals and abilities to create an environment to the resident's adherence to the pressure ulcer prevention/treatment plan. h. Monitoring results will be brought to the pressure ulcer team who will meet to review current practices related to pressure ulcer management, determine current practice, assessment tools and schedules and to identify persons responsible for monitoring. Review of the Nursing Department Meeting dated 11/21/16 revealed the following re-education for skin: a. Check skin while performing cares. b. Interventions. c. Head to toe weekly skin assessment to be completed by licensed nurse.	F 314		
F 323 SS=J	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.	F 323		

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F 323	Continued From page 31 This REQUIREMENT is not met as evidenced by: Based on record review, observation, staff interviews and review of policy and procedures, the facility failed to provide appropriate nursing supervision to ensure against hazards from self or elements in the environment for 3 of 18 residents reviewed (Resident #12, #16 & #17). The facility identified a census of 98 current residents. Findings include: 1. According to the MDS (Minimum Data Set) assessment dated 9/11/16, Resident #16 had diagnoses that included heart failure, chronic obstructive pulmonary disease (breathing disorder), end stage renal disease (kidney disease) and metabolic encephalopathy (brain disorder). The resident had a BIMS (brief interview for mental status) score of 13 which indicated intact cognition. According to the MDS the resident required limited assistance with bed mobility, transfers, dressing and extensive assistance with toilet use. The MDS identified the resident required the use of a walker and wheelchair for mobility. The Care Plan dated 6/15/16 as initiated, identified the resident at risk to elope and the resident made statements of wanting to leave, intending to leave and had sufficient mobility to exit unescorted. The Care Plan interventions included and directed staff to do the following: a. If pushing on door attempt to redirect/distract from door. b. If unable to redirect, utilize other staff to escort person served to appropriate part of unit or room. c. If elopes, follow elopement policy.	F 323		

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F 323	Continued From page 32 All interventions resolved effective 11/28/16. Review of the Elopement Risk Assessment dated 6/15/16 and 9/11/16 indicated the resident displayed tactile wandering: explored environment with hands, recreational wandering: wandering based upon previous active lifestyle and talked about leaving. The assessment summary revealed the resident had a Wanderguard (device to alert staff when attempting to exit the building via a door alarmed with a Wanderguard) in place due to making statements of wanting to leave and had the mobility to escort self out the door unattended. Review of the Elopement Risk Assessment dated 11/28/16 identified the resident had no wandering but did talk about leaving and made statements of wanting to go home. The assessment summary indicated the resident had BIMs of 13 and alert and oriented and able to make his/her own decisions. The assessment indicated the resident would go outside independently and will sometimes wait outside for the bus to go to appointments. Review of the Observation Flow Sheet dated 10/25/16 5:45 AM through 10/26/16 at 8:15 AM identified 15 minute observations of the resident as completed. Review the facsimile from the Occupational Therapy Department to the Physician dated 8/8/16 indicated the resident had increased confusion and delusions and did not appear to be dementia related. The delusions impacted his/her safety and performance. The facility received an order for a psychological evaluation.	F 323		

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F 323	Continued From page 33 Review of the facsimile to the physician dated 10/26/16, indicated the resident had a BIMs score of 13 out of 15 and 28 of 30 on his/her mental exam. The resident could self-transfer surface to surface and performs all activities of daily living independently. The resident requested to return home. The facility requested an order to discharge from the facility to home with current medications, treatments and orders. The order included the physician statement as long as resident could care for self. Review of the TAR (Treatment Administration Record) dated June (July) 2016 directed staff to check Wanderguard every shift. The order documented the treatment completed on 7/1/16 and 7/2/16 and discontinued on 7/2/16. The TAR dated 9/1/16 through 9/30/16 indicated the Wanderguard start date of 9/23/16. The document completed on 9/29/16 and 9/30/16. The TAR dated 10/1/16 through 10/31/16 identified documentation of the Wanderguard present 10/1/16 through 10/7/16. Documentation from 10/8/16 through 10/31/16 varied from in place to refused. The TAR dated 11/1/16 through 11/30/16 identified the Wander- guard discontinued on 11/2/16 at 4:14 PM. Review of the Progress Notes dated 6/16/16 at 12:07 PM identified the staff removed the Wander- guard from the right wrist and replaced with a new Wanderguard that operated correctly to the right wrist. The resident stated the Wanderguard felt good and not too tight. On 7/19/16 at 3:47 AM the notes indicated the resident continued to have episodes of confusion during the shift. At 9:44 AM the resident was admitted to the hospital for urinary tract infection, low blood sugars and confusion. On 7/30/16 at	F 323		

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F 323	Continued From page 34 1:16 PM the notes indicated dialysis called at 10:30 AM and reported the resident acting confused and stated the nurses have a secret hiding place for his/her cell phone in his/her pants so he/she couldn't get it. The resident made nonsensical thoughts/statements and not orientated at times. Review of the Progress Notes on 8/1/16 at 9:21 PM indicated the resident very confused and stated the facility is the Governor ' s Mansion. The resident stated him/her and another resident to testify. Took several staff members to redirect to his/her room. On 8/3/16 at 1:41 PM the resident stated he/she had been waiting for the President to come to the facility. The resident saw the nurse and stated the nurse had been trying to kill him/her. The resident also stated he/she had been waiting for the president's wife and his/her family to get to the facility and the president's wife to get up on stage with the resident. On 8/8/16 at 2:32 PM the therapy department reported the resident continued to be very confused. The resident stated he/she had been waiting for the President to arrive at the facility. Staff requested a psych evaluation. On 8/13/16 at 10:10 PM the resident reported everything had been fine until the president left today. On 8/14/16 at 9:50 PM he/she stated to staff not to leave pills because he/she is not here. The resident asked staff to touch him/her because she would not be able to feel him/her. When staff touched him/her, they said oh I guess I am here. On 8/1616 at 11:29 PM the resident stated the president going to send him/her to Kentucky and he/she wasn't going. Review of the Progress Notes dated 9/9/16 at 10:00 PM reveled the resident became argumentative after supper, packed a few	F 323		

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F 323	Continued From page 35 clothing items and stated he/she wanted to leave to go to the educational building across the street. A CNA (certified nursing assistant) stayed with the resident. The resident went to the front door with the CNA and attempted to open the door. The alarm sounded appropriately. The resident redirected the resident back to his/her room. On 9/10/16 at 3:41 AM the resident got up in the middle of the night and had stuff packed to go to Berlin for dialysis and to meet the Pope. Confusion seemed to always be on the night before going out to dialysis. Review of the Progress Notes dated 10/7/16 at 2:22 PM identified at 2:10 PM the resident yelled the facility as a prison and he/she's not wearing anything anymore. The resident cut it [Wander-guard] off and threw it out of his/her room door. Administration notified Social Services to tell staff to replace the Wanderguard and make 15 minute checks through the weekend. Review of the Progress Notes dated 10/25/16 at 5:17 AM indicated at 4:15 AM staff received a telephone call from a person stating they lived nearby and noticed a person in a wheelchair at the side of the road in front of the facility. The nurse and CMA (certified medication assistant) found the resident in the wheelchair beside the road on the grass area heading towards the east. The resident kept saying he/she needed to go get clothes and kept pointing towards a building. The resident very agitated and needed much persuasion to return to the facility. The resident fully clothed and wore a light jacket. No alarm sounded when the resident left out the door. Upon entering, the facility staff attempted to apply a wander-guard bracelet. The resident again became agitated and stated he/she would just cut	F 323		

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F 323	Continued From page 36 it off like the last one. Staff did get a Wanderguard on the wheelchair. The resident attempted to leave the facility again and staff alerted per Wanderguard alarm. The resident stated he/she needed to go get clothes at the apartment and had it all arranged with the president. The resident redirected to his/her room. The resident refused dialysis and medications. The resident's family and on call physician notified. During an interview with the State Climatologist on 11/30/16 at 11:10 AM, identified the weather for Sioux City Iowa reported on 10/25/16 at 3:52 AM: Temperature at 53 degrees Fahrenheit, wind Southeast at 8 mile per hour and cloudy. On 11/22/16 at 5:30 PM Staff S, LPN (licensed practical nurse) was interviewed and stated the resident did exit the facility on 10/25/16 at 4:25 AM and did not wear the Wanderguard device. Staff S stated the resident had previously worn a Wanderguard device but he/she kept taking it off. Staff S stated she had worked the evening prior and left at 2:00 AM and the resident had no exit seeking behaviors. On 11/29/16 at 12:20 PM, Staff E, LPN was interviewed and stated she received a telephone call from an outside source on 10/25/16 at approximately 4:15 AM to alert her resident in a wheelchair seen near the street. She went out of the facility with Staff K, CMA (certified medication assistant) and found the resident in the wheelchair on the grass near the street. The staff found the resident approximately 10 feet from the driveway on the grass and agitated and confused. The resident stated he/she wanted to go to a building (across the street) and get his/her	F 323		

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clothes. The resident did not wear a Wanderguard device and refused to have one on his/her wrist. Staff E then placed a Wanderguard on the wheelchair.

On 11/30/16 at 11:40 AM Staff B, CNA was interviewed and stated the resident had a normal shift and had no behaviors or confusion. The resident normally got self-up and dressed around 5:00 AM every morning and waited by the front door for the van to pick him/her up for dialysis. He stated the resident did get confused time to time. Staff did not see the resident exit the facility and no door alarm sounded. He had been told the resident had been out of the facility and went to help if needed. The nurse was with the resident and assisted the resident back to the facility. Staff B stated the resident should have had a Wanderguard [device] on but did not have one at that time and the Wanderguard alarm did not sound when returned. Staff B stated the door used to have a sign that identified the code for the door alarm instructions to enter backwards. The sign had been removed and the code to the door changed after the resident exited.

On 11/29/16 at 11:15 AM the Administrator stated she interviewed the resident the day he/she left the facility. The resident had told her he/she got up early to wait up front and go to dialysis. The Administrator stated the resident then stated he/she went out the door to wait for the bus and then went down the hill to catch the bus to get missing clothes. The Administrator stated the resident had been to another facility and returned home prior to his/her hospital stay and transferred to the facility. The resident had thought some clothes had been missing. After she interviewed the resident he/she pulled her aside and stated

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F 323	Continued From page 38 he/she wanted to go home and be in the facility. The talked to the Doctor and receive the OK to discharge to home. The discharge did not happen and they moved the resident to a private room and him/her no longer pursuing going home. The Administrator stated the staff had used the Wanderguard [device] inappropriately and the resident should not have had a Wanderguard in the 1st place. The facility investigation found the resident did not have a Wanderguard on and had not had it on. She identified the documentation not always correct. Staff education completed on 10/25/16 for use of a Wanderguard. She further stated the resident had told her the code for the front door alarm and the facility changed the code on 10/25/16. The facility no longer posted a sign to identify the code for the alarm. During an interview with Staff U, CMA on 11/30/16 at 4:50 PM she stated she had seen the resident approximately 30 minutes prior to the elopement. The resident had been in the bathroom and toileted him/herself which had been normal. Staff U stated the resident did not have a Wanderguard [device] on but had in the past. The resident would take it off. Staff U stated they had 15 minute checks that had been discontinued due to him/her not trying to leave the facility. On 12/1/16 at 8:45 AM the social service person was interviewed and stated she did the elopement assessments on admission and quarterly. She did discuss the resident with the unit manager and knew he/she had a high assessment and wanted to go home. The social service person stated they knew the resident had moments of confusion so they made the decision to place a Wanderguard on the resident. She	F 323		

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F 323	Continued From page 39 stated if she had been notified of the discontinuance of a Wanderguard, she would do another elopement assessment. She stated she completed an elopement assessment last week after staff brought this to her attention and it had not been done when the Wanderguard was discontinued. Review of the Policy and Procedures titled Elopement, revised on July 2013, included and directed staff to do the following: a. It is the responsibility of all personnel to report any resident attempting to leave the premises, or suspected of being missing, to the charge nurse as soon as practical. b. Should an employee discover that a resident is missing from the facility, he/she should: Determine if the resident is out on an authorized leave or pass. It not, make a thorough search of the building and premises. c. Upon return of the resident to the facility, the DON or charge nurse should: examine the resident for injuries, contact the attending physician and report findings and conditions of the resident, Notify the resident's legal representative, complete and file an incident report and make appropriate entries into the resident's medical record. Note: At the time of the complaint investigation, the complaint was coded as a "J", immediate and serious jeopardy. By 10/25/16, the facility had placed a Wanderguard device on the resident and removed the code to disable the alarm at the entrance door. Staff received in-service training about the Wanderguard, The grid placement was lowered to a "G" due to additional supervision issues which resulted in falls by Resident #17.	F 323		

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	165161	A. BUILDING _____ B. WING _____	C 12/14/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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F 323	Continued From page 40 As of the 12/14/16 exit conference, the facility needed to: Continue to in-service staff about the wanderguard system and the facility policy/procedure titled Elopement. Continue to ensure devices for supevision are used as planned and assess for additional supervision as needed. Continue to monitor and ensure the codes to disarm door alarms are not left at the door for residents to use and then elope. 2. According to the MDS dated 8/14/16, Resident #12 had diagnoses that included diabetes mellitus, heart failure, respiratory failure and atherosclerotic heart disease. The MDS identified the resident had a BIMS (brief interview for mental status) total of 15 which indicated intact cognition. According to the MDS the resident required extensive assistance with bed mobility and transfers and independent with locomotion on the unit. The MDS identified the resident normally used a wheelchair for mobility. The care plan dated 5/3/16 directed staff to use an EZ stand for transfers and provide an anti-roll back device on the wheel chair. Review of the Fall Risk Assessment dated 10/7/16, identified the resident with a total score of 13. A score of 10 or above indicated a risk of falling. Observation on 10/14/16 at 8:00 AM revealed the resident sitting in the wheel chair in Aspenwood hall next to the nurse ' s station. Staff P, (CNA (certified nursing assistant) told the resident to pick up his/her feet and pushed the resident from	F 323		

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F 323	Continued From page 41 the nurses station to the dining room. The wheelchair did not have pedals to rest the resident ' s feet and Staff P pushed the wheelchair a distance of approximately 40 feet. During an interview with the DON (Director of Nursing) on 10/14/16 at 8:30 AM, she stated she educates staff to not push residents in the wheel chair without wheel chair foot pedals. The DON stated she had been educating staff as she sees it happen and had not held an in-service. 3. According to the MDS assessment dated 8/17/16 documented that Resident #17 had diagnoses that included non-Alzheimer's dementia, hypothyroidism (low thyroid levels) and hyperlipidemia (high blood lipids). The assessment documented the resident had a BIMs score of 2 which indicated severe cognitive impairment. The assessment documented the resident required the assistance of 2 with bed mobility, transfers and walking in their room. According to the MDS dated 11/17/6, revealed Resident #17 had a BIMs of 3. According to the MDS the resident required extensive assistance with bed mobility, transfers and toilet use. The MDS identified the resident occasionally incontinent of urine and had falls since the last assessment. The care plan dated 11/1/16 directed staff to do the following: a. Ensure the wheel chair in good repair and available at all times. B. Toileted before and after meals. In between meals place out in the television viewing room as tolerated. c. Encourage to wear non-skid socks or shoes	F 323		

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F 323	Continued From page 42 when transferring. Assist of 1 for transfers. d. Utilize wireless call light. Review of the Fall Risk Assessment dated 8/11/16 revealed the resident had a total score of 19. A score of 10 or above indicated a risk of falling. The fall prevention protocol initiated included assist of 2 for all transfers. Room next to the nurse ' s station and frequent room checks to ensure safety due to confusion. Review of the Incident Report dated 8/26/16 at 11:00 AM revealed the resident found on the floor laying on the right side with the call light cord around his/her legs. The resident would not state what he/she had been doing to get the cord wrapped up in the legs. The intervention included to remove the call cord and use a hand held call system. Review of the Incident Report dated 10/14/16 at 9:45 PM revealed the resident found lying on the floor on back by the roommate ' s bed. The wheel chair by the closet door. The resident stated he/she tried to go to the bathroom. The resident did not use the call light. The intervention included to ask for a urinalysis and assist to the bathroom after meals. The intervention not added to the care plan and a urinalysis not requested. Review of the facsimile to the Physician dated 10/14/16 at 10:15 AM revealed the resident found on the floor and he/she stated had been trying to go to the bathroom. The resident did not use the call light and confused per usual. The resident did hit his/her head Review of the Incident Report dated 10/20/16 in the evening, identified the resident had a fall in his/her room. The report and the care plan identified no interventions to prevent	F 323		

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F 323	Continued From page 43 further falls. Review of the Fall Report dated 11/19/16 at 12:45 PM indicated the staff found the resident lying in the doorway of the resident's room. The resident laid on his/her left side and unsure how he/she fell or where he/she was going. The resident complained of left leg pain and could not straighten the leg. The physician gave orders to send to the hospital for an evaluation. The resident left the facility at 1:15 PM per non-emergent ambulance. Review of the Radiology report dated 11/19/16 revealed a non-displaced impacted femoral neck fracture. During an interview with Staff Y, RN on 12/14/16 at 4:00 PM she stated and verified the care plan intervention to toilet before and after meals and to keep the resident in the television viewing area placed on the care plan 11/19/16. The date identified 11/1/16 should have read 11/19/16.	F 323		
F 363 SS=E	483.35(c) MENUS MEET RES NEEDS/PREP IN ADVANCE/FOLLOWED Menus must meet the nutritional needs of residents in accordance with the recommended dietary allowances of the Food and Nutrition Board of the National Research Council, National Academy of Sciences; be prepared in advance; and be followed. This REQUIREMENT is not met as evidenced by: Based on record review, observation, staff interview and policy review the facility failed to	F 363		

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F 363	Continued From page 44 follow the menu as written for the evening meal and puree diets. The facility identified a census of 98 current residents. Findings include: 1. Review of the menu titled Week 2 Day 5 Lunch revealed the following items planned for residents who received pureed diets: a. 3 ounces of Sweet and Sour Chicken (#8 scoop). b. 1/2 cup of puree rice (#8 scoop). c. 1/2 cup of cauliflower (#10 scoop). d. Dinner roll or bread (#20 scoop). e. Margarine 1 packet per serving f. 1/12 slice of cheesecake with fruit topping (#12 scoop). The Lunch menu for regular diets included: a. 1/2 cup Cauliflower (4 ounces). Observation on 10/20/16 at 11:10 AM revealed Staff X, Cook prepared puree diets for the noon meal. She prepared the puree diets of 8 servings for 7 puree diet orders. She prepared 3 ounces cauliflower times 8 servings and 3 1/2 slices of bread (totaling 7 - 1/2 slice bread serving). She failed to add 1 packet of margarine for the diets. Observation on 10/20/16 at 11:30 AM revealed Staff X served the noon meal. She served all residents would get 3-ounce servings of cauliflower and failed follow the menu that identified provision of 4-ounce servings. She failed to serve rice to any of the residents that had orders for puree diets. During an interview with Staff X on 10/20/16 at 12:30 PM she stated she did not puree the rice because it just gets all goopy. She further stated	F 363		

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F 363	Continued From page 45 she had planned to serve the puree diets mashed potatoes instead of the rice but forgot. Review of the Policy and Procedure titled Pureed Vegetable/Starch Procedure (not dated) directed staff to do the following: a. Count the number of pureed portions of the item you need. b. Add 1 or 2 additional portions to allow for extras. Follow the portion size for the general menu for the item to be pureed. Place that total amount in the Robot Coupe. c. Puree until veggies are ground, then add 1/2 piece buttered bread or 1/2 dinner roll for each portion of vegetable you are pureeing.	F 363		
F 371 SS=F	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 facility record review, observation and staff interview, the facility failed to store, prepare and serve food under sanitary conditions. The facility identified a census of 98 current residents. Findings include:	F 371		

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F 371	Continued From page 46 1. Observation on 10/12/16 at 5:00 PM revealed Staff W, Dietary Aid served room trays from the steam table at Cherry Blossom hall. Staff W served turkey burgers or hot dogs on buns. He handled the buns with bare hands and handled the plates and ladle/scoop handles without washing his hands. 2. Observation of the kitchen on 10/20/16 at 11:30 AM revealed the following: a. The stove had a large amount of build up on the burner areas. b. A large amount of grease build-up on the hood above the stove and the sides/front of stove. c. The deep fryer had a large cookie sheet placed on top and 2 dirty metal baskets with visible oil dripping from the baskets to the kitchen floor. d. A dried substance on the stainless steel 2 tier table bottom shelf. e. Steam table with loose debrie on the bottom shelf. f. Dried debrie on scoop stored in drawer. g. Loose debrie inside drawer with stored scoops. h. 5 spatulas with large amount cracks and chips. Review of the Daily Checklist dated October 2016 revealed the cleaning duties not documented as completed by Night Aide 10/1- 10/4/16, 10/7 - 10/9/16 and 10/15 -10/16/16. The Day Aide Daily Checklist not completed 10/1- 10/10/16 and 10/9/16. The Day Cook checklist not completed 10/8 - 10/9/16 and the night cook checklist not completed 10/1-10/4/16, 10/7-10/9/16 and 10/15-10/16/16. During an interview with Staff X, Cook on 10/20/16 at 11:10 AM she stated the last time the fryer had been used had been for waffle fries on Tuesday (10/18/16).	F 371		

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F 425 SS=D	483.60(a),(b) PHARMACEUTICAL SVC - ACCURATE PROCEDURES, RPH The facility must provide routine and emergency drugs and biologicals to its residents, or obtain them under an agreement described in §483.75(h) of this part. The facility may permit unlicensed personnel to administer drugs if State law permits, but only under the general supervision of a licensed nurse. A facility must provide pharmaceutical services (including procedures that assure the accurate acquiring, receiving, dispensing, and administering of all drugs and biologicals) to meet the needs of each resident. The facility must employ or obtain the services of a licensed pharmacist who provides consultation on all aspects of the provision of pharmacy services in the facility. This REQUIREMENT is not met as evidenced by: Based on clinical record review and staff and resident interview, the facility failed to always ensure medications delivered from the pharmacy in a timely manner to treat for pain for 1 of 19 residents reviewed (Resident #2). The facility identified a census of 98 current residents. Findings include: 1. According to the MDS (minimum data set) assessment dated 10/3/16 Resident #2 had diagnoses that included diabetes mellitus, fracture, anxiety, sleep apnea and chronic kidney	F 425		

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F 425	Continued From page 48 disease. The MDS identified the resident had a BIMs (brief interview for mental status) score of 15 which indicated intact memory and cognition. The MDS identified the resident had frequent moderate pain in the last 5 days of the assessment period. The care plan dated 4/13/16 documented the resident had a fractured left malleolus (heel) and the resident experienced a great deal of pain. The care plan instructed staff to evaluate the resident's pain every shift and as needed and to offer pain medication after other interventions have been tried. Review of the Medication Review Report dated 10/21/16 revealed a physician's order for the following pain medications: a. Hydrocodone/acetaminophen 7.5-325 mg give 1 tablet every 6 hours as needed for pain. b. Acetaminophen 325 mg (milligram) give 2 tablet every 6 hour as needed for pain. Review of the MAR (medication administration record) dated 10/1/16 through 10/31/16 revealed the resident had a pain assessment every shift. The document included the following scores for pain on a scale 1 to 10. a. 10/13/16-day 8, evening 4 and night 0. b. 10/14/16-day 4, evening 3 and night 0. c. 10/15/16-day 6, evening 6 and night 0. d. 10/16/16-day 7, evening 5 and night 0. e. 10/17/16 day 7, evening 4 and night 0. The MAR recorded that staff did not administer hydrocodone from 10/13/16 through 10/17/16. Staff administered acetaminophen on 10/14/16 at 9:10 PM and 10/16/16 at 8:15 PM.	F 425		

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F 425	Continued From page 49 During an interview with Staff M, CMA (certified medication aide) on 10/20/16 at 9:45 AM he stated the resident did not have the ordered pain medication in the facility. He stated he reported it but could not remember who he reported it to. During an interview with the resident on 10/21/16 at 10:00 AM he/she stated did not always get pain medications when requested. The resident went without and took Tylenol instead, but it had not been effective for his/her pain.	F 425		
F 465 SS=E	483.70(h) SAFE/FUNCTIONAL/SANITARY/COMFORTABLE ENVIRON The facility must provide a safe, functional, sanitary, and comfortable environment for residents, staff and the public. This REQUIREMENT is not met as evidenced by: Based on observation and staff interview the facility failed to provide a clean sanitary environment for the residents. The facility identified a census of 98 current residents. Findings include: 1. Observation of the environment on 10/13/16 at 11:00 AM revealed the following: a. Dust in the window ledges of the Dining Room. b. The Cherry Blossom coffee maker base contained a moderate amount of a thick substance on the plastic grate and debrie on the floor beneath. c. The Daisy Lane had a plastic cup wedged in-between the handrail and wall with a plastic	F 465		

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F 465	Continued From page 50 medication cup and used alcohol pad inside. d. A mat on floor next to bed in Room 12 was dirty. e. The South lounge dining area coffee maker base had moderate amount thick substance on the plastic grate. During a walk through and interview with the Administrator on 10/21/16 at 10:30 AM she concurred with the findings.	F 465		

The plan of correction represents Touchstone Healthcare Community's allegation of compliance. The following combined plan of correction and allegation of compliance are not an admission to any of the alleged deficiencies. The plan of correction is submitted at the request of the Iowa Department of Public Health. Preparations and execution of this response and plan of correction does not constitute an admission or agreement by the provider of the truth of facts alleged or conclusion set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because it is required by the provision of federal and state law.

Touchstone Healthcare Community Plan of Correction

Date: 01/16/2017

F157 Notify of Changes (Injury, Decline, Room, etc.)

Immediate corrective action:

R14 returned to facility and continues to reside at the facility and has suffered no ill effects from the deficient practice.

Action as it applies to others:

All residents residing in the facility have the potential to be affected.

Education on Notification of Changes has been completed with all licensed nursing staff.

Date of completion: 01/18/2017

Recurrence will be prevented by:

Progress notes will be reviewed five days a week with random audits completed three times a week for four weeks to ensure notification of changes to physician and family/representative has been completed. The results of these audits will be brought to the Quality Conference Meeting for review.

The correction will be monitored by: DON/designee

F225 Investigate/Report Allegations/Individuals

Immediate corrective action:

R1 money was replaced and he continues to reside at the facility and has suffered no ill effects from the deficient practice.

R18 continues to reside at the facility and has suffered no ill effects from the deficient practice. Unit Manager was terminated from employment with Touchstone Healthcare for not reporting to the Abuse Coordinator at time of occurrence.

Action as it applies to others:

All residents residing in the facility have the potential to be affected.

All staff have been educated on abuse/neglect/misappropriation reporting guidelines

Date of completion: ~~01/18/2017~~ 1/5/17

Recurrence will be prevented by:

Random audits will be completed three times weekly to ensure any form of abuse/neglect/misappropriation has been investigated and reported to the proper authorities. The results of these audits will be brought to the Quality Conference Meeting for review.

The correction will be monitored by: Administrator/Designee

F241 Dignity and Respect of Individuality

Immediate corrective action:

R11 continues to reside at the facility and has suffered no ill effects from the deficient practice.

R14 continues to reside at the facility and has suffered no ill effects from the deficient practice.

Action as it applies to others:

All residents residing in the facility have the potential to be affected.

Education has been provided to all staff on privacy and knocking on resident doors prior to entering the room.

Education has been provided to the nursing department on ensuring residents are free of debris on clothing, w/c, face and hands, changing soiled clothing, changing clothes every day.

Date of completion: 01/18/2017

Recurrence will be prevented by:

Random audits will be completed three times a week for four weeks to ensure compliance. The results of these audits will be brought to the Quality Conference Meeting for review.

The correction will be monitored by: DON/Designee

F279 Comprehensive Care Plans

Immediate corrective action:

R16 was discharged home and no longer resides at the facility.

R17 continues to reside at the facility and has had no change in ADL status.

Action as it applies to others:

All residents residing in the facility have the potential to be affected.

Education has been provided to department managers on updating care plans, updating care plans timely, completing accurate assessments, care plan accuracy.

Education was also provided to nursing staff on notifying supervisor with wandering behaviors, exit seeking and implementation of wanderguard system.

Education also included implementation of new intervention post fall and updating fall care plan.

Date of completion: 01/18/2017

Recurrence will be prevented by:

Random audits will be completed three times a week for four weeks to ensure compliance. The results of these audits will be brought to the Quality Conference Meeting for review.

The correction will be monitored by: DON/Designee

F281 Services Provided Meet Professional Standards

Immediate corrective action:

R5 no longer resides at the facility.

R2, R19 continue to reside at the facility and have suffered no ill effects.

Action as it applies to others:

All residents residing in the facility being weighed or receiving eye gtts have the potential to be affected.

Education has been provided to licensed staff weight P&P, documentation in E-MAR/E-TAR, and eye gtt instillation.

Eye gtt installation competencies have been conducted for all licensed nursing staff and Med Aides.

Date of completion: 01/18/2017

Recurrence will be prevented by:

Random audits will be completed three times a week for four weeks to ensure compliance. The results of these audits will be brought to the Quality Conference Meeting for review.

The correction will be monitored by: DON/Designee

F312 ADL Care Provided for Dependent Residents

Immediate corrective action:

R2, R9, R11, R13, and R14 continue to reside at the facility and have suffered no ill effects from the deficient practice.

Action as it applies to others:

All residents residing in the facility have the potential to be affected.

Bath aides have been put into place to perform showers daily, grooming and toileting.

Education has been provided to the nursing department staff on peri-care, showering/bathing, grooming, and toileting.

Peri-care competencies have been completed on all nursing department staff.

Date of completion: 01/18/2017

Recurrence will be prevented by:

Random audits will be completed three times a week for four weeks to ensure compliance. The results of these audits will be brought to the Quality Conference Meeting for review.

The correction will be monitored by: DON/Designee

F314 Treatment/SVCS to Prevent/Heal Pressure Sores

Immediate corrective action:

R3 continues to reside at the facility. Her left heel is now healed and her right heel continues to improve.

Action as it applies to others:

All residents residing in the facility have the potential to be affected.

Education has been provided to nursing department staff on Skin Program Policy and Procedure including weekly skin checks by licensed nurse and documentation of skin checks, and skin checks by nurse aide during cares.

Date of completion: 01/18/2017

Recurrence will be prevented by:

Random audits will be completed three times a week for four weeks to ensure compliance. The results of these audits will be brought to the Quality Conference Meeting for review.

The correction will be monitored by: DON/Designee

F323 Free of Accident Hazards/Supervision/Devices

Immediate corrective action:

R12 and R17 continue to reside at the facility.

R17 has had no change in her ADL status.

R16 discharged to home and no longer resides at the facility.

Action as it applies to others:

All residents residing in the facility have the potential to be affected.

The facility no longer posts a sign to identify the code for the alarm on the exit door.

Elopement Policy and Procedure education has been completed with Nursing Department staff and Social Services staff.

Fall program Policy and Procedure education has been completed with Nursing Department staff including fall intervention implementation and follow through.

Date of completion: ~~01/18/2017~~ 1/5/17

Recurrence will be prevented by:

Random audits will be completed three times a week for four weeks to ensure compliance. The results of these audits will be brought to the Quality Conference Meeting for review.

The correction will be monitored by: DON/Designee

F363 Menus Meet Res Needs/Prep in Advance/Followed

Immediate corrective action:

There were no ill effects from the deficient practice.

Action as it applies to others:

All residents on mechanically altered diets residing in the facility have the potential to be affected.

Education has been provided to all dietary staff on Pureed Vegetable/Starch Policy and Procedure and following menus.

Date of completion: 01/18/2017

Recurrence will be prevented by:

Random audits will be completed three times a week for four weeks to ensure compliance. The results of these audits will be brought to the Quality Conference Meeting for review.

The correction will be monitored by: Administrator/Designee

F371 Food Procure, Store/Prepare/Serve-Sanitary

Immediate corrective action:

There were no ill effects from the deficient practice.

Stove burners, hood above stove along with sides and front of stove, deep fryer baskets, stainless steel 2 tier table, steam table scoops and scoop storage drawer were cleaned.

5 scoops were replaced.

Action as it applies to others:

All residents residing in the facility have the potential to be affected.

Education has been provided to dietary staff on glove use, handwashing and dietary daily checklist.

Date of completion: 01/18/2017

Recurrence will be prevented by:

Random audits will be completed three times a week for four weeks to ensure compliance. The results of these audits will be brought to the Quality Conference Meeting for review.

The correction will be monitored by: Administrator/Designee

F425 Pharmaceutical services-accurate procedures, RPH

Immediate corrective action:

R2 was referred to and has been evaluated at the pain clinic for chronic pain. Resident is currently in the hospital for a possible surgical procedure.

Action as it applies to others:

All residents in the facility experiencing pain the potential to be affected.

Audits of resident pain medication was completed and medications are available.

Education was provided to staff on pain management and how to handle situations if a medication is unavailable.

Date of completion: 01/18/2017

Recurrence will be prevented by:

Random audits will be completed three times weekly by the DON/Designee. The results of these audits will be brought to the Quality Conference Meeting for review.

The correction will be monitored by: DON/Designee

F248 Activities Meet Interests/Needs of Each Resident

Immediate corrective action:

R5 no longer resides at the facility.

R3 currently attends Serenity Circle Program two times weekly and attendance/participation is documented.

R13 currently attends 1:1 two times weekly and attendance/participation is documented.

R11 currently attends Serenity Circle five times weekly and attendance/participation is documented.

Action as it applies to others:

All residents residing in the facility have the potential to be affected.

Education has been provided to Activity Dept. staff on involving residents with cognitive deficits in meaningful activities, assisting them to activities, and documentation of activities attended/participation.

Date of completion: 01/18/2017

Recurrence will be prevented by:

Random audits will be completed three times a week for four weeks to ensure compliance. The results of these audits will be brought to the Quality Conference Meeting for review.

The correction will be monitored by: ADM/Designee

F465 Safe/Functional/Safe/Sanitary/Comfortable Environment

Immediate corrective action:

Window ledges in the dining room, the coffee maker on Cherry Blossom, the floor beneath the coffee maker on Cherry Blossom, the coffee maker in the dining area on South lounge, and the mat on the floor in room 12 were all cleaned.

The plastic cup with med cup and alcohol pad were removed and thrown away.

Action as it applies to others:

All residents residing in the facility have the potential to be affected.

Education has been provided to Housekeeping Dept. completing duties on Cleaning Schedule.

Date of completion: 01/18/2017

Recurrence will be prevented by:

Random audits will be completed three times a week for four weeks to ensure compliance. The results of these audits will be brought to the Quality Conference Meeting for review.

The correction will be monitored by: Administrator/Designee

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
	IA0429	A. BUILDING: _____ B. WING _____	C 12/14/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
TOUCHSTONE HEALTHCARE COMMUNITY	1800 INDIAN HILLS DRIVE SIOUX CITY, IA 51104

(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 SS=D	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 record review, staff interviews and policy review the facility failed to report a resident elopement to the Iowa Department of Inspections and Appeals (Resident #16). The sample consisted of 18 residents and the facility identified a census of 98 residents. Findings include: 1. According to the MDS (minimum data set) dated 9/11/16 revealed Resident #16 had diagnoses that included heart failure, chronic obstructive pulmonary disease, end stage renal disease (kidney disease) and metabolic encephalopathy (brain disorder). The resident had a BIMS (brief interview for mental status) score of 13 which indicated intact cognition. According to the MDS, the resident required limited assistance with bed mobility, transfers, dressing and extensive assistance with toilet use. The MDS identified the resident required the use of a walker and wheelchair for mobility.	N 104		

N104 Notification to the Department

Immediate corrective action:

R16 no longer resides at the facility and suffered no ill effects from the deficient practice.

Action as it applies to others:

All residents residing in the facility who are at elopement risk have the potential to be affected.

All staff have been educated reporting guidelines.

Date of completion: ~~01/18/2017~~ 1/5/17

Recurrence will be prevented by:

Random audits will be completed three times weekly to ensure any form of abuse/neglect/misappropriation has been investigated and reported to the proper authorities. The results of these audits will be brought to the Quality Conference Meeting for review.

The correction will be monitored by: Administrator/Designee