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	165390	A. BUILDING _____ B. WING _____	C 01/25/2017

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STATE CENTER SPECIALTY CARE	702 THIRD STREET NW STATE CENTER, IA 50247

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F 000	INITIAL COMMENTS VKK 2/15/17 Correction date 1/31/17 The following deficiencies relate to the investigation of incident #64886 & complaint #65323.(See code of federal regulations (42CFR) Part 483, Subpart B-C) Incident #65222 was not substantiated.	F 000	Preparation and/or execution of this plan of correction does not constitute admission or agreement by this provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies The plan of correction is prepared and/or executed solely because it is required by the provision of federal and/or state law.	
F 309 SS=G	483.24, 483.25(k)(l) PROVIDE CARE/SERVICES FOR HIGHEST WELL BEING 483.24 Quality of life Quality of life is a fundamental principle that applies to all care and services provided to facility residents. Each resident must receive and the facility must provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being, consistent with the resident's comprehensive assessment and plan of care. 483.25 (k) Pain Management. The facility must ensure that pain management is provided to residents who require such services, consistent with professional standards of practice, the comprehensive person-centered care plan, and the residents' goals and preferences. (l) Dialysis. The facility must ensure that residents who require dialysis receive such services, consistent with professional standards of practice, the comprehensive person-centered care plan, and the residents' goals and preferences. This REQUIREMENT is not met as evidenced	F 309	This is my credible allegation of compliance to F309. This allegation does not constitute guilt but that the facility is in compliance with F309. Education was provided to all charge nurses on 1-31-2017. Nurses were reeducated on facility's procedure of change of condition and hot chart protocol regarding nursing assessment, intervention and follow-up. Education included: - Family and Physician notification regarding timeliness and appropriate method (fax machine vs. telephone). - Documentation Standards and Protocols; ensuring documentation is captured time specific of event and documentation includes the full assessment, physician notification including route used, and family notification including the name of family member contacted. - Physician orders that are given at separate times must be processed separately; therefore each order must be written on its own individual physician order form. Process will be monitored by Director of Nursing and/or Designee as part of the QA process.	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE — TITLE: Administrator — (X6) DATE: 2/14/17

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 309	Continued From page 1 by: Based on clinical record review, physician and staff interviews, the facility failed to provide ongoing assessment and interventions for 1 of 4 residents who needed respiratory intervention due to shortness of breath and difficulty breathing (Resident # 1). The facility reported a census of 33 residents. Findings include: A Minimum Data Set (MDS) dated 11/24/16 documented Resident #1 with diagnoses of non-Alzheimer's dementia, hypertension and primary osteoarthritis. The MDS indicated the resident needed extensive assistance of 1 staff to physically assist the resident with bed mobility, transfer and ambulation. A Staff Assessment for Mental Status documented a score of 2. A score of 2 indicated severe cognitive impairment. A speech therapy evaluation dated 1/5/13 revealed the resident had a medical diagnosis of traumatic subarachnoid hemorrhage with a secondary diagnosis of dysphagia. A PA's order dated 11/10/16 documented an order for the resident to receive a pureed/nectar diet with thickened liquids. A care plan with a problem onset dated 6/12/16 indicated impaired communication due to a diagnosis of dementia. Interventions directed staff to monitor for non-verbal behaviors such as facial expressions, body language and increased restlessness. A 60 day "Nursing Home Evaluation" dated 12/8/16 at 1:45 p.m. by the resident's primary PA documented no respiratory concerns.	F 309		

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Auscultation revealed no wheezing, rales, crackles or rhonchi. Breath sounds are normal with good air movement.

Interdisciplinary progress notes dated 11/28/16 documented the resident is aware of self when spoken to but did not speak often.

Nurse's notes dated 12/12/16 at 4:00 p.m. documented the resident had vomited. Vital signs (VS) taken revealed a Temperature T) of 96.7 degrees Fahrenheit (F), Respirations (R) at 16 breaths per minute (bpm), blood pressure (BP) 149/56 and oxygen(O2) levels in the blood) at 93% on room air. Notes indicated the facility notified the resident's primary physician of the vomiting by fax at 6:08 p.m.

A facility flow sheet dated 12/12/16 with Resident #1's first name and without a time revealed VS - T-98.4, P-76, R-18, BP-1/29/72 and O2-92%. On the back of the flow sheet a record of Resident #1's VS for 7:25 [p.m.] without date listed - VS - T-96.3, P-82, R-18, BP-109.77 and O2-94%.

A Physician Assistant's (PA) telephone order dated 12/12/16 at 8:30 p.m. indicated the resident may be suctioned as needed and to send to the resident to a local hospital emergency room. Please note Staff B reported the PA's order she had written dated 12/12/16 at 8:30 p.m. indicated the resident may be suctioned as needed and to send to the resident to a local hospital emergency room had been written in error. She had combined both orders (given at different times on 12/12/16).

Nurse's notes dated 12/12/16 (without a time listed) documented by Staff B, a licensed

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practical nurse (LPN); the resident had vomited this evening (time not specified). Lung sounds were coarse and congested. VS taken revealed T-98.4 F, P-76, R-18, BP-129/72 and O2-92% room air. Notes indicated family present. The facility called the on-call PA due to the resident attempting to cough congestion without success. An order to suction had been given. The resident's family requested the resident be sent to a local hospital emergency room for evaluation and treatment. Staff placed a call to emergency medical services; an ambulance arrived at 9:00 p.m. and transported the resident.
(During an interview dated 1/25/17 at 1:10 p.m. Staff B reported the nurse's notes written on 12/12/16 without a time listed had been written after the events the evening of 12/12/16.) She reported the nurse's notes did not contain accurate documentation of the events the evening of 12/12/16.)

Nurse's notes dated 12/13/16 at 1:00 a.m. documented facility staff called the hospital and told resident had been admitted to the intensive care unit with pneumonia and sepsis.

Prehospital care report dated 12/12/16, section " Scene Management" from emergency medical services (EMS) documented being dispatched at 8:52 p.m., arriving at the facility at 9:13 p.m., departing the facility at 9:28 p.m. and arriving at the hospital at 9:56 p.m.

Upon arrival the Emergency Medical Service (EMS) staff completed an assessment which included the following: resident was assisted to stand and pivot to the cart. The resident's SpO2 (measurement of oxygen in the blood) read 86% on room air, however the resident's lips did not

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F 309	Continued From page 4 appear dusky or cyanotic. The resident had a heavy coat of nail polish [on his/her fingers.] The physical examination identified the resident's skin looked normal in color, warm and dry. The resident's chest equally rise and fell; and his/her respirations slightly rapid and labored. The upper airway noted gurgling and his/her lungs course throughout with crackles noted. In route to the hospital EMS staff administered a nebulizer treatment resulting in the resident breathing better and the audible gurgling had been greatly reduced. Hospital records dated 12/12/16 at 10:11 p.m. revealed the resident arrived at the hospital with SpO2 at 92% without a fever. At 11:16 p.m. the resident had wheezing, crackles and gurgling in all lung fields and tachypneic (abnormal rapid breathing) and in severe respiratory distress. An assessment revealed the resident had severe sepsis due to aspiration pneumonitis - at risk for aspiration pneumonia, acute renal failure due to dehydration with an elevated BNP (brain natriuretic peptide) greater than 5000 - likely due to hypoxia and acute respiratory failure and appears dehydrated. Laboratory results revealed a white blood count of 19.8 with normal reference range of 4.9-10.0/ul., P-112 and R- 28. The Hospital X-ray impression of chronic obstructive pulmonary disease [COPD/ constricted airway] with bibasilar atelectasis [complete or partial collapse of a lung] or pneumonia and pleural effusion (a buildup of fluid between the tissues that line the lungs and chest). The diagnostic imaging dated 12/12/16 at 10:18	F 309		

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F 309	Continued From page 5 p.m., revealed one view completed for x-ray with the following findings: a). There is an elevation of the medial aspect of the right hemidiaphragm (likely a hiatal hernia or other hernia). b). There is hyperexpansion of the lungs which could be seen with COPD. [Hyperexpanded lungs, is a condition in which the lungs have overinflated, causing them to grow beyond their usual size. This condition can cause respiratory problems, especially when exhaling. A person with hyperexpanded lungs cannot fully exhale, which leaves air trapped inside the lungs.] c). There are moderate bilateral pleural effusions and bibasilar atelectasis which is all worst on the left than right. d). Pneumonia was not excluded. e). There was no pneumothorax (presence of air or gas in the cavity between the lungs and chest wall causing collapse of lungs. Hospital records dated 12/13/16 at 1:30 a.m. revealed the resident passed away. The resident had been placed on BiPAP for respirator support and became bradycardic and unresponsive. The cause of death listed as severe sepsis, acute respiratory failure and aspiration and aspiration pneumonitis. During an interview dated 1/25/17 at 7:50 p.m. the emergency physician reported the resident presented multiple issues at the time h/she arrived at the emergency room. It was unlikely that suctioning the resident would have benefited the resident prior to arrival. EMS had administered a nebulizer treatment during transport to the hospital and this procedure increased her blood oxygen saturation levels.	F 309		

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F 309	Continued From page 6 In a written statement; as part of the facility's investigation dated 12/15/16, Staff A, reported a certified nursing assistant (CNA) reported the resident had vomited. She went to the resident's room and noted the vomit had been red/white in color and smelled like spaghetti. She completed a set of vital signs which were normal. She faxed the primary physician and told the on-coming nurse, Staff B, a licensed practical nurse (LPN) of the resident ' s vomit episode and the fax she had sent to the primary physician. She told Staff B she had not called the family about the resident vomiting earlier that day. During an interview dated 1/9/17 at 1:05 p.m., Staff D, a paid nutritional assistant reported the resident had a pureed prepared meal for lunch at 12:00 p.m. and finished at 12:40 p.m. The resident had no difficulty with eating. During an interview dated 1/19/17 at 11:00 a.m. Staff A reported Staff C CNA reported the resident had vomited. She confirmed she had faxed the primary physician at 6:08 p.m. of the vomiting episode at 4:15 p.m. Staff A reported she hadn't expected the physician to respond to her fax until the next day. She reported the resident didn't look distressed. In a written statement: as part of the facility's investigation dated 12/18/16, Staff C reported the resident had vomited on 12/12/16 at 4:15 p.m. She gave the resident water and the resident drank without any problem. She cleaned the resident and assisted the resident to bed. Sometime between 6:30 p.m. - 7:00 p.m. she and Staff F CNA went to the resident's room and noted the resident pale white, having gray discoloration in h/her lips and eyelids and had a	F 309		

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F 309	Continued From page 7 gurgle sound when breathing. The resident's eyes were rolling back and the resident was ice cold to the touch. She reported to Staff B of the resident's status. Staff B replied, stating she had been in the resident's room 3 times and the resident was fine. Staff C asked Staff B if she had asked for an order to suction the resident. Staff B reportedly replied that she had been working on it. Staff C asked if family had been notified and Staff B said she had notified the family. During an interview dated 1/23/16 at 2:11 p.m. Staff C reported she went on her lunch break from 6:15 p.m. to 6:45 p.m. At 7:00 p.m. she went into the resident's room and saw the resident trying to push out - coughing out something from h/her throat but the resident couldn't. Staff C reported the family arrived sometime after 8:00 p.m. In a written statement: as part of the facility's investigation dated 12/15/16, Staff E CNA and Staff F CNA reported at 6:30 p.m. both went into the resident's room and found the resident had vomited. The resident had been lying on h/her side with vomit coming out of h/her mouth. The resident had a "bad color" and made a gurgling noise. Staff E left and reported to Staff B the resident had vomited and had difficulty breathing. Staff E asked if the resident could be moved to a recliner in case the resident threw up again. Staff B reportedly said that was fine and she would be down to look at the resident. Staff E reported once they placed the resident into a recliner the resident's color improved and smiled at one of the CNA's. Both Staff E and Staff F left the resident's room as Staff B entered the resident's room and started to take vital signs. Staff E reported she	F 309		

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returned later, after helping other residents and noted the resident cold, clammy and had difficulty breathing. She left and reported her findings to Staff B who told her she had been in the resident's room 3 times and the resident was fine. Staff F reported she returned to the resident's room after she assisted other residents. She reported the resident continued making gurgling sounds and cold/clammy to the touch. Staff F stated she left the room saw Staff B and yelled" are we going to do something". Staff F reported she couldn't hear what Staff B had said. As she walked back up the hall Staff F heard Staff B tell two other CNA's she had been to the resident's room 3 times.

During an interview dated 1/23/17 at 3:20 p.m. Staff E reported she went to the Administrator and voiced her concern of the resident's health status.

In a written statement; as part of the facility's investigation dated 12/12/16 at 7:00 p.m., the Administrator reported on Staff E came to her office reporting the resident was passing away, as the resident had difficulty breathing, had been cold and clammy to touch. The Administrator asked Staff E if the nurse (Staff B) knew about the resident's status. Staff E reported Staff B had been aware. At 7:05 p.m. the Administrator went to the resident's room and saw Staff B standing in the resident's doorway. Staff B asked her if the aides had come to her, accusing her of not doing her job. Staff B reassured her she had everything under control and family had been notified and were on their way to the facility.

During an interview dated 1/19/17 at 9:30 a.m., the Administrator reported the evening of

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F 309	Continued From page 9 12/12/16 a 7:25 p.m. Staff B asked her where the facility stored the suction machine. Both she and Staff B looked throughout the facility but could not find the device. The Administrator reported the family wanted the resident to go the hospital. During an interview dated 1/25/17 at 3:30 p.m., the Administrator reported she directed Staff B to call the director of nursing (DON) the evening of 12/12/16, but Staff B called another nurse. The Administrator reported she called the DON. In a typed written statement dated 1/23/17, the DON documented she had checked her phone log and she received the first call at 8:43 p.m. and the second call at 8:56 p.m. In a written statement; as part of the facility's investigation dated 12/15/16, Staff B reported a CNA (not identified), came to her at 6:30 p.m., reporting the resident had vomited again and could staff get the resident up out of bed. Staff B reported this was the only time a CNA approached her the entire night. Staff B reported she went down to the resident's room with the CNA's and assessed the resident. Staff B reported the vomit was yellow/white in color and looked like phlegm. She completed VS, which were normal. She reported the resident seemed to have congestion and sounded like the resident just needed to cough it up. The resident showed no signs of distress and noted the resident sitting up in a recliner and smiling. Staff B reported she called the on-call PA to update him on the resident's condition but he did not answer so left a message to call back. Staff B reported family arrived and she completed a second set of VS at 7:25 p.m. and noted no abnormal findings. Family requested the resident be suctioned. She called and spoke to the on-call	F 309		

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F 309	Continued From page 10 PA, gave an update on the resident's status and asked for and was given an order to suction the resident. She asked the Administrator if she knew where the suction machine had been stored and both she and the Administrator looked for but couldn't find the device. She told family she could not find the suction machine and family requested the resident be sent to a local hospital emergency room for evaluation and treatment. Staff B reported the resident had been sent out per family request. Staff B stated she had not called family. Staff A had told her during report she had called the family and they were on their way in. Staff B reported suctioning the resident was an appropriate intervention and if she had suctioned the resident the congestion would have been resolved. During an interview dated 1/19/17 at 1:10 p.m. Staff B stated she arrived at 6:00 p.m., received report from Staff A the resident had thrown up at lunch and the resident's physician had been notified by fax. At 6:30 p.m. a CNA reported the resident vomited again. At 6:35 p.m. she completed VS which were normal, listened to the resident's lungs which were clear. She placed a call to the on-call PA, no one answered so she left a message the resident had vomited again and the color of the vomit. While waiting for the PA to call back she started her medication pass. At 7:30 p.m. the resident's family members arrived. She told the family the resident had vomited and h/her VS were normal and the lungs were clear with no signs of distress. She completed another set of VS, left and administered medications to residents. During her medication administration, a family member asked if the resident could be suctioned	F 309		

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F 309	Continued From page 11 to remove something in h/her throat. Staff B reported she listened to the resident's lungs and noted the lungs were clear in the bases and congestion in the upper throat. She told family she would call the on-call PA again and see what could be done. She called the on-call PA and reported the resident's lungs were clear but asked for an order to suction the resident as needed (prn). She notified the resident's family member she received an order to suction. She looked in the medication and supply room, asked the Administrator if she knew where the machine had been stored but neither one could find the device. Staff B told family the suction machine could not be found and the resident's family requested the resident be taken to a local hospital emergency room. She called the on-call PA and obtained an order to send the resident to the hospital. During a phone interview dated 1/19/17 at 3:39 p.m. the resident's family member reported h/she and another family member had been shopping in a nearby town and stopped at the facility at 8:05 p.m. When they arrived he resident appeared to have difficulty breathing. Family voiced concerns to the nurse and asked if the resident could be suctioned. The nurse reported she would have to get an order from the physician. The nurse returned 20 minutes later and told family an order had been given to suction the resident and then the nurse left. The nurse returned 30 minutes later and told family the suction machine couldn't be located. Family requested the resident be sent to a local hospital emergency room. An ambulance arrived at 9:00 p.m. and transported the resident to the hospital. During a second interview dated 1/25/17 at 1:10	F 309		

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F 309	Continued From page 12 p.m. Staff B reported she had called to on-call PA at 8:00 p.m. when family arrived at the facility. Family requested the resident be suctioned. She reported the PA had never called her back from her first phone call. She called the PA and reported the suction machine could not be located and asked to transfer the resident to a local hospital emergency room for evaluation and treatment. During an interview dated 1/19/17 at 10:40 a.m., the director of nursing (DON) stated LPN's and RN's are within their scope of practice to use a suction machine and she expected staff to know where the device is located and to use the device when a provider has ordered its use. During an interview dated 1/19/17 at 1:35 p.m., the resident's primary physician confirmed he had received a fax from the facility regarding the resident's vomiting episode, but the fax had been sent after work hours and he didn't see the fax until the following morning. He stated the resident didn't have a history of vomiting and he had not been notified of any change of condition prior to 12/12/16. He stated if the resident needed to be suctioned then the resident needed to be sent to a hospital for evaluation and treatment. During an interview dated 1/19/17 at 2:00 p.m., and 1/25/17 at 3:30 p.m. the on-call PA reported he received a call at 8:37 p.m. from a nurse asking for an order to suction, as the resident had difficulty breathing and the resident had previously benefited from suctioning in the past. He received another call at 8:47 p.m. from a nurse who reported the suctioning had not improved the resident's respiratory status. The	F 309		

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	165390	A. BUILDING _____ B. WING _____	C 01/25/2017

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F 309	Continued From page 13 nurse asked for and received an order to send the resident by ambulance to a local hospital emergency room for evaluation and treatment. He reported he didn't receive a phone message from the facility earlier in the evening.	F 309		
F 328 SS=D	483.25(b)(2)(f)(g)(5)(h)(i)(j) TREATMENT/CARE FOR SPECIAL NEEDS (b)(2) Foot care. To ensure that residents receive proper treatment and care to maintain mobility and good foot health, the facility must: (i) Provide foot care and treatment, in accordance with professional standards of practice, including to prevent complications from the resident's medical condition(s) and (ii) If necessary, assist the resident in making appointments with a qualified person, and arranging for transportation to and from such appointments (f) Colostomy, ureterostomy, or ileostomy care. The facility must ensure that residents who require colostomy, ureterostomy, or ileostomy services, receive such care consistent with professional standards of practice, the comprehensive person-centered care plan, and the resident's goals and preferences. (g)(5) A resident who is fed by enteral means receives the appropriate treatment and services to ... prevent complications of enteral feeding including but not limited to aspiration pneumonia, diarrhea, vomiting, dehydration, metabolic abnormalities, and nasal-pharyngeal ulcers. (h) Parenteral Fluids. Parenteral fluids must be	F 328	This is my credible allegation of compliance to F328. This allegation does not constitute guilt but that the facility is in compliance with F328. On 12/17/16 an additional suction machine was borrowed from a sister facility, Southridge Specialty Care. On 12/19/16 facility ordered a new suction machine from Northwest Respiratory. On 12/21/16 an action plan developed regarding suction machine storage and function. Action plan included: education to all charge nurses on suction machine function and storage; routine audit on the location of suction machine, beginning as a twice daily check off then transitioning to a daily check off to ensure proper location's maintained. . On 12/22/16 an additional suction machine was purchased from Northwest Respiratory. Appointment set up to have Respiratory Therapist from Northwest Respiratory come out to do staff education on suctioning and suction machine. Appointment was scheduled for 1/17/17; due to scheduling oversight of Respiratory Therapist appointment was rescheduled for 2/7/17. Facility contacted Northwest Respiratory inquiring of earlier availability. 01/27/17, a different Respiratory Therapist from Northwest Respiratory, came on-site and conducted the staff education on suctioning and suction machine function.	

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F 328	Continued From page 14 administered consistent with professional standards of practice and in accordance with physician orders, the comprehensive person-centered care plan, and the resident's goals and preferences. (i) Respiratory care, including tracheostomy care and tracheal suctioning. The facility must ensure that a resident who needs respiratory care, including tracheostomy care and tracheal suctioning, is provided such care, consistent with professional standards of practice, the comprehensive person-centered care plan, the residents' goals and preferences, and 483.65 of this subpart. (j) Prostheses. The facility must ensure that a resident who has a prosthesis is provided care and assistance, consistent with professional standards of practice, the comprehensive person-centered care plan, the residents' goals and preferences, to wear and be able to use the prosthetic device. This REQUIREMENT is not met as evidenced by: Based on clinical record review, physician and staff interviews, the facility failed to ensure a suction machine was readily available for use for one of one resident reviewed. (Resident # 1). The facility census was 33 residents. Findings include: 1. The Minimum Data Set (MDS) dated 11/24/16, documented Resident #1 had diagnoses of non-Alzheimer's dementia, hypertension and primary osteoarthritis and required extensive assistance with bed mobility, transfer and ambulation.	F 328	On 1/19/17 education was started for nursing staff on oral suctioning. All nursing staff have been educated on oral suctioning procedure. Process will be monitored by Director of Nursing and/or Designee as part of the QA Process.	

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F 328	Continued From page 15 A Physician Assistant telephone order dated 12/12/16 at 8:30 p.m. indicated the resident may be suctioned as needed and to send to the resident to a local hospital emergency room. Nurse notes dated 12/12/16, documented the resident had vomited this evening. Lung sounds were coarse and congested. Vital signs revealed T-98.4 F, P-76, R-18, BP-129/72 and O2-92% room air. Notes indicated family present. The facility called the on-call physician due to the resident attempting to cough congestion without success. An order to suction was given. The resident's family requested the resident be sent to a local hospital emergency room for evaluation and treatment. Staff placed a call to emergency medical services; an ambulance arrived at 9:00 p.m. and transported the resident. Upon arrival EMS staff completed an assessment noting the resident's SpO2 (measurement of oxygen in the blood) read 86% on room air, however the resident had a heavy coat of " sparkly nail polish on. " The resident did not appear dusky or cyanotic. In route to the hospital EMS staff administered a nebulizer treatment resulting in the resident breathing better and the audible gurgling had been greatly reduced. During interview on 1/19/17 at 9:30 a.m., the Administrator stated they and Staff B looked throughout the facility but could not find a suction machine. Staff B called Staff G to ask where the facility stored the device. The Administrator reported she prepared to go to a sister facility to get a suction machine when Staff B reported she did not need to go as the family wanted the resident to go the hospital.	F 328		

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F 328	Continued From page 16 During interview on 1/25/17 at 7:50 p.m., the emergency physician reported the resident presented multiple issues at the time h/she arrived at the emergency room. It was unlikely that suctioning the resident would have benefited the resident prior to arrival. EMS had administered a nebulizer treatment during transport to the hospital and this procedure increased her blood oxygen saturation levels.	F 328		