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

2/20/17 PH.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	165535	A. BUILDING _____ B. WING _____	01/17/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SUNSET KNOLL CARE AND REHAB CENTER	401 WEST FIFTH STREET AURELIA, IA 51005

(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 The following deficiencies were identified during the recertification survey and investigation of #64114-C and #65075-I conducted 1/9/17 to 1/17/17. Complaint #64114-C substantiated. Incident #64114-I substantiated. (See Code of Federal Regulations (42 CFR) Part 483, Subpart B-C.)	F 000	Please see attached POC.	
F 225 SS=F	483.13(c)(1)(ii)-(iii), (c)(2) - (4) INVESTIGATE/REPORT ALLEGATIONS/INDIVIDUALS 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	F 225		

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

[signature] | Administrator | 1/18/2017

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 225	Continued From page 1 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 review of the facility abuse policy, the facility failed to thoroughly investigate a resident's allegation of resident to resident abuse and report the findings to the state agency within 24 hours of the occurrence. The facility reported a census of 20 residents. Findings included: 1. Resident #7 had a MDS (Minimum Data Set) assessment with a reference date of 11/8/16. The resident had a BIMS (Brief interview for Mental Status) score of 15. A score of 15 indicated the resident had no cognitive problems for daily decision making. The MDS identified the resident did have hallucinations and delusions. The MDS indicated the resident was independent with transfers, ambulation, and eating. The resident required staff supervision with toilet use and personal hygiene. The MDS documented the resident's diagnoses included depression and schizophrenia. The care plan, with a revision date of 8/4/16	F 225		

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F 225	Continued From page 2	F 225		

indicated the resident had behavior and mood problems, lacked motivation, and had a history of paranoia, delusional thinking, and hallucinations. The interventions informed the staff that the resident saw a mental health specialist every 3 months, enjoyed family visits, and enjoyed visiting with the social worker and staff about past and current interests when having a bad day. The care plan indicated the resident sometimes reported concerns, he/she thought happened, they had not happened, and they seemed real to the resident.

On 1/11/17 at 10:50 a.m., Staff A, CNA (Certified Nursing Assistant) was interviewed and stated on 1/4/17 at approximately 10:30 to 10:45 a.m., she assisted Resident #7 with exercises. Staff A stated the resident told her she/he had been sexually assaulted during the night by another resident. Staff A stated she informed the charge nurse and the charge nurse stated she would take care of it. After Staff A reviewed the staff schedule, she confirmed the the charge nurse to be Staff M. LPN (Licensed Practical Nurse).

On 1/11/17 at 2:35 p.m., Staff M was interviewed and stated Resident #7 told her on 1/4/17 during the noon medication pass, that another resident had sexually assaulted him/her. Staff M stated Resident #7 had made the statement in a calm manner while walking down the hall. Staff M asked the resident if he/she had pain and the resident stated he/she had a headache. Staff M stated she wrote the resident's allegation on a note and informed the Interim DON (Director of Nursing) at approximately 2:00 p.m. Staff M stated the DON stated the resident's Invega (an antipsychotic) medication was due and the resident had delusions. Staff M stated she met

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F 225	Continued From page 3 the mandatory reporter requirement by telling the Interim DON about the resident's allegation. On 1/11/17 at 2:50 p.m., the Interim DON stated she had no recollection of Staff M informing her of the resident's allegation of sexual assault on 1/4/17. The resident's medical record lacked any documentation of the resident's allegation on 1/4/17. The record lacked documentation of an assessment and family and physician notification. On 1/12/17 at 8:17 a.m., the Administrator was interviewed and stated all staff had been trained on the updated abuse policy in December 2016, including mandatory reporting within 24 hours of an alleged occurrence. The facility policy/procedure titled Abuse Prevention, Identification, Investigation, and Reporting Policy, revised 12/7/16, directed staff that all allegations of abuse needed reported to the Iowa Department of Inspections and Appeals (DIA) within 2 hours if the resident had a serious bodily injury. Staff needed to report the concern to DIA within 24 hours if the allegation had not resulted in serious bodily injury.	F 225		
F 226 SS=D	483.13(c) DEVELOP/IMPLMENT ABUSE/NEGLECT, ETC POLICIES The facility must develop and implement written policies and procedures that prohibit mistreatment, neglect, and abuse of residents and misappropriation of resident property.	F 226		

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F 226	Continued From page 4 This REQUIREMENT is not met as evidenced by: Based on review of personnel files, staff interview and review of facility policy and procedures, the facility failed to obtain a criminal background and abuse check prior to hire (Staff C) and failed to ensure the staff person had completed Mandatory Reporter Training program within 6 months of hire or within 5 years prior to the hire date (Staff D). The sample consisted of 9 personnel files reviewed and the facility reported a census of 20 residents. Findings included: 1. A facility Employee Activity Report, printed 1/9/17, indicated Staff D (dietary) had a date of hire as 4/14/16. On 1/10/17 at 2:00 p.m., the Business Office Manager was interviewed and stated the facility had no record to verify Staff D had completed Mandatory Reporter Training prior to or after employment at the facility. The facility policy and procedure titled Abuse Prevention, Identification, Investigation, and Reporting Policy, revised 12/7/16, documented each staff needed to complete 2 hours of dependent adult abuse training within 6 months of hire. 2. The personnel file identified Staff C (nursing) had a date of termination from the facility on 10/7/16. A New Employee Worksheet identified Staff C had a date of hire as 12/6/16. The personnel file lacked a criminal background and abuse history check prior to the hiring of Staff	F 226		

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F 226	Continued From page 5 C on 12/6/16. On 1/12/17 at 11:35 a.m. the Business Office Manager was interviewed and stated she thought she had rechecked the criminal background and abuse history checks when the facility rehired Staff C. The Business Office Manager stated when she looked on the Single Contact License and Background Check (SING) site; it only showed the check from her previous employment	F 226		
F 317 SS=D	483.25(e)(1) NO REDUCTION IN ROM UNLESS UNAVOIDABLE Based on the comprehensive assessment of a resident, the facility must ensure that a resident who enters the facility without a limited range of motion does not experience reduction in range of motion unless the resident's clinical condition demonstrates that a reduction in range of motion is unavoidable. This REQUIREMENT is not met as evidenced by: Based on observation, record review, and staff interviews, the facility failed to assure a resident without a limitation in range of motion (ROM) did not experience reduction in ROM unless the for 1 of 8 active residents reviewed (Resident #4). The facility reported a census of 20 residents. Findings include: 1. Resident #4 had a quarterly MDS (Minimum Data Set) assessment with a reference date of 7/3/16. The MDS identified the resident had long and short term memory problems and severely impaired skills for daily decision making. The	F 317		

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F 317	Continued From page 6 MDS indicated Resident #4 depended on staff for activities of daily living (ADL's) skills including bed mobility, transfer, dressing, eating, toilet use, and personal hygiene. The assessment indicated the resident demonstrated no functional limitation in ROM (range of motion) in the upper or lower extremities. Resident #4 received no ROM [exercises]. Resident #4's diagnoses included non-Alzheimer's dementia. Resident #4 received hospice care. A Functional Maintenance Program Form for March 2016 documented to please discontinue all above exercises on 3/31/16. A Physical Therapy Rehab Screen dated 7/12/16 documented Resident #4 had upper and lower extremity ROM within full limits. The form documented Resident #4 was a hospice patient. Hospice discontinued the functional maintenance program. An Occupational Therapy Rehab Screening dated 8/9/16 documented Resident #4 had passive ROM in the upper extremities within full limits. A MDS assessment with a reference date of 10/2/16, indicated the resident had a BIMS score of 0. Zero identified the resident as severely cognitively impaired. Resident #4 demonstrated altered level of consciousness. Resident #4 depended on staff for activities of daily living (ADL's) including bed mobility, transfer, dressing, eating, toilet use, and personal hygiene. Resident #4 demonstrated a functional limitation in ROM in both upper and lower extremities. Resident #4 received no ROM. Resident #4's diagnoses included non-Alzheimer's dementia.	F 317		

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F 317	Continued From page 7 The clinical record lacked documentation of Resident #4 having any ROM in April, May, June, July, August, September, October or November 2016. A Functional Maintenance Program Form for December 2016 showed Resident #4 received passive ROM starting 12/13/16. During an observation on 1/11/17 at 8:16 a.m. Staff A Restorative Aide (RA)/Certified Nursing Assistant (CNA) performed passive ROM with Resident #4. During an interview on 1/11/17 at 8:18 a.m., Staff A stated Resident #4 started back on ROM after he/she discontinued from hospice. Staff A stated Resident #4 may have had some decline in ROM. During an interview on 1/12/17 at 8:40 a.m. the Director of Nursing (DON) stated she could not find anything from hospice saying they should not do ROM with Resident #4.	F 317		
F 323 SS=D	483.25(h) FREE OF ACCIDENT HAZARDS/SUPERVISION/DEVICES The facility must ensure that the resident environment remains as free of accident hazards as is possible; and each resident receives adequate supervision and assistance devices to prevent accidents. This REQUIREMENT is not met as evidenced by: Based on record review and staff interview, the	F 323		

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F 323	Continued From page 8 facility failed to provide adequate supervision to prevent falls for 2 of 9 residents reviewed (Resident #1, #3). The facility reported a census of 20 residents. Findings include: 1. According to the Minimum Data Set (MDS) assessment dated 7/24/16, Resident #1 scored 9 on the Brief Interview for Mental Status (BIMS) indicating moderately impaired cognition and the resident had not walked. Resident #1 had total dependence from 2 staff for Activities of Daily Living (ADL's) including bed mobility, transfers, dressing, and personal hygiene and had upper and lower body range of motion impairment. Resident #1 had an indwelling urinary catheter. Resident #1's diagnoses included Multiple Sclerosis, non-Alzheimer's disease, neurogenic bladder, anxiety, depression, and an unspecified joint contracture. The care plan with an initiation date of 3/4/16 and revision date of 12/8/16, identified Resident #1 needed total care for all activities of daily living skills. The resident required 2 staff to assist with dressing and undressing, and had contractures of the arms, feet, and legs. A Progress Notes entry dated 9/13/16 1:53 p.m., revealed a nurse entered the resident's room that morning at 8:40 a.m. and the resident was on the floor by the bed. The entry stated the resident's legs slipped off the bed when staff rolled the resident to the side, 2 staff lowered the resident to the floor, and the resident did not receive an injury. A Change of Condition/Reportable Incident report	F 323		

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F 323	Continued From page 9 to the physician, dated 9/13/16 at 2:00 p.m., documented the fall and that 2 staff planned to assist the resident with dressing and repositioning. During an interview on 1/11/17 at 3:30 p.m., the interim Director of Nursing (DON) stated 1 aide was dressing and preparing the resident for transfer on 9/13/16, rolled the resident to the side, the resident's legs fell off the bed, and the aide called for additional help to ease the resident to the floor. The DON stated she thought the resident only needed 1 staff for getting dressed at the time of the fall. During an interview on 1/17/17 at 1:00 p.m., the interim DON stated at the time of the fall, the staff member should not have dressed the resident alone because the resident required 2 staff for dressing. 2. Resident #3 had a MDS assessment with a reference date of 6/19/16. The MDS identified the resident had BIMS score of 0. A score of 0 identified the resident as severely cognitively impaired. Resident #3 required extensive assistance for activities of daily living (ADL's) including bed mobility, transfer and ambulation. A Diagnosis Report dated 1/12/17 showed Resident #3's diagnoses included dementia. The Nurse's Notes dated 8/15/16 at 6:41 p.m. indicated the staff observed Resident #3 turning around in front of the recliner in the common area, before staff could assist the resident. Resident #3 sat on the floor in front of the chair. The pressure alarm did not sound from where he/she originally sat. The new intervention directed staff to recheck function of pressure	F 323		

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F 323	Continued From page 10 alarm for working status before leaving the resident. The Nurse's Notes dated 8/29/16 at 9:28 p.m. documented Resident #3 observed self transferring from chair in common area. Resident #3 had repeatedly gotten up from bed and was supervised in this area. Staff were occupied with other issues and the pressure alarm did not activate to alert staff. Resident #3 ambulated 10 feet and sat on the floor then slumped to his/her left side. No injuries were noted. Precautions correct in place, except alarm malfunctioned. The Nurse's Notes dated 9/29/16 at 9:15 p.m. documented the staff observed Resident #3 on the floor, float boots in place on feet and the pressure alarm did not function. Resident #3 was unsure why he/she got out of bed. Resident #3 had a 5 cm lump on the left occipital of his/her scalp, and an ice pack applied. The new intervention directed staff to be to be sure pressure alarms worked. The care Plan revised 6/5/16 identified Resident #3 at risk for falls related to resident unaware of safety needs. The interventions included: a. Ensure Resident #3 wore gripper socks when walking, b. Observe and keep in supervised area when out of bed. c. TABS pressure alarm in place at all times, d. Chair alarm replaced 8/29/16, e. New pressure pads ordered, pad replaced 9/29/16. The care plan did not direct staff to check the alarm for function, and the clinical record lacked	F 323		

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F 323	Continued From page 11 documentation staff checked the alarm for functioning. The Nurse's Notes dated 1/9/17 at 9:04 a.m. documented Resident #3's bed pad alarm malfunctioned, a cog wheel tabs applied, alarms on order, awaiting ordered pads. During an interview on 1/10/17 at 1:05 p.m. the interim Director of Nursing (DON) stated she ordered new pad alarms that would be checked daily, but they had not initiated it. The DON stated she did not know if they had checked alarms for functioning the past 6 months.	F 323		
F 329 SS=D	483.25(l) DRUG REGIMEN IS FREE FROM UNNECESSARY DRUGS Each resident's drug regimen must be free from unnecessary drugs. An unnecessary drug is any drug when used in excessive dose (including duplicate therapy); or for excessive duration; or without adequate monitoring; or without adequate indications for its use; or in the presence of adverse consequences which indicate the dose should be reduced or discontinued; or any combinations of the reasons above. Based on a comprehensive assessment of a resident, the facility must ensure that residents who have not used antipsychotic drugs are not given these drugs unless antipsychotic drug therapy is necessary to treat a specific condition as diagnosed and documented in the clinical record; and residents who use antipsychotic drugs receive gradual dose reductions, and behavioral interventions, unless clinically contraindicated, in an effort to discontinue these drugs.	F 329		

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This REQUIREMENT is not met as evidenced by:
Based on observation, record review, and staff interview, the facility failed to assure residents who received antipsychotic medication received a gradual dose reduction (GDR) unless clinically contraindicated for 2 of 3 residents reviewed (Resident #2 and #4). The facility reported a census of 20 residents.

Findings include:

1) According to the Minimum Data Set (MDS) assessment dated 12/5/16, Resident #2 scored 0 on the Brief Interview for Mental Status (BIMS) indicating severe cognitive impairment. Resident #2 exhibited verbal behaviors 1 to 3 days. Resident #4 depended on staff for activities of daily living (ADL's) including bed mobility, transfer, toilet use, and bathing. Resident #4's diagnoses included a stroke, anxiety and depression.

A Change of Condition/Reportable Incident form dated 5/18/16 notified the physician Resident #2 had increased behaviors, became combative, easily agitated, spitting out medications and food. They tried Acetaminophen as needed for pain management for splint application without success. Resident #2 took Sertraline 100 mg daily, Wellbutrin XL 150 mg daily, and Trazadone 50 mg at bedtime (HS), (antidepressants). Resident #2 did have Risperdal (antipsychotic) 0.5 mg 1/2 tab every day, but discontinued

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F 329	Continued From page 13 1/14/16. The physician responded with order for Risperdal 0.5 mg every a.m. The Care Plan dated 3/18/16 and revised 6/15/16 identified Resident #2 took psychotropic medication daily. The interventions included to consult with pharmacy and physician to consider dosage reduction at least quarterly. A Note to Attending Physician/Prescriber printed 10/28/16 notified the provider CMS required a gradual dose reduction for most psychopharmacological medications at specified intervals unless clinically contraindicated with a rationale provided. A medication review was due on Risperdal 0.5 mg every day and Bupropion (Wellbutrin) every day. The note questioned if they could try to reduce the Risperdal to 0.25 mg every day for 2 weeks then discontinue. The physician responded no with no rationale provided. 2) According to the MDS assessment dated 10/2/16, Resident #4 scored 0 on the BIMS indicating severe cognitive impairment. Resident #4 demonstrated altered level of consciousness indicated by 1 of the following: vigilance (startled easily to any sound or touch), lethargy, stuporousness, or comatose. Staff assessment of resident mood indicated Resident #4 felt tired or had little energy nearly every day. Resident #4 exhibited no behaviors. Resident #4 depended on staff for activities of daily living (ADL's) including bed mobility, transfer, dressing, eating, toilet use, and personal hygiene. Resident #4's diagnoses included non-Alzheimer's dementia. Resident #4 received hospice care.	F 329		

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	165535	A. BUILDING _____ B. WING _____	01/17/2017

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F 329	Continued From page 14 According to the Physician' Order Report dated 6/16/16 to 8/18/16 Resident #4 received Seroquel (antipsychotic/mood altering medication) 50 mg three times a day with a start date of 1/14/16, and Haldol (antipsychotic) 2 mg/ml, 0.5 ml 3 times day with a start date of 3/14/16. The Care Plan dated 5/31/16 and revised 11/17/16 identified Resident #4 received psychotropic medication daily. The interventions included to consult with the pharmacy and physician to consider GDR when clinically appropriate at least quarterly. The Care Plan identified Resident #4 at nutritional risk. The interventions included Resident #4 often got sleepy at meal time and did not open eyes or want to eat. A Note to Attending Physician/Prescriber (Psychiatric Advanced Registered Nurse Practitioner ARNP) printed 7/21/16 notified the provider CMS required a gradual dose reduction for most psychopharmacological medications at specified intervals unless clinically contraindicated with a rational provided. A medication review was due on Lexapro 10 mg every day, and Seroquel 50 mg 3 times a day. The provider responded 8/25/16 Resident #4 no longer received Lexapro, and recommended to hospice team to discontinue scheduled Haldol, not Seroquel. Per hospice team discussion Resident #4's symptoms were managed due to medication therapeutic level. Discontinuation of medication may cause increased symptoms/discomfort. An Outpatient Psychiatric/Mental Health Progress Note dated 8/28/16 documented Resident #4 had a significant history of aggression with care,	F 329		

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F 329	Continued From page 15 confusion, sundowning behaviors, combativeness, and times of playing possum. The note documented Resident #4 was nonresponsive, Resident #4's diagnoses included dementia, Alzheimer's type with behavioral disturbance severe and depressive disorder. A letter from the Hospice Case Manager dated 8/29/16 notified the physician Resident #4 started on Haldol due to increased behaviors and patient hitting and scratching staff when first admitted into hospice services, per the hospice pharmacist recommendation. The physician agreed to continue the current med regime. A Hospice Order dated 9/23/16 directed to discontinue further psychiatric nurse visits, all behaviors to be managed by hospice. A Note to Attending Physician/Prescriber printed 10/28/16 notified the provider a medication review was due on Haldol 1 mg 3 times a day, and questioned if they could decrease the Haldol to 1 mg 2 times a day. The physician responded no on 10/31/16, with no rationale provided. During an observation 1/10/17 at 8:10 a.m. Resident #4 sat in the wheelchair with with his/her eyes closed and neck pillow in place. At 8:45 a.m. Staff B Certified Nursing Assistant and Staff E CNA transferred Resident #4 to bed with the (mechanical) lift. Resident #4's eyes remained closed. Staff B and Staff E both stated Resident #4 was usually sleepy, stating it was rare to catch him/her awake. Resident #4 did respond with a few 1 word responses but did not open his/her eyes. At 11:50 a.m. Resident #4 sat in the wheelchair at the dining room table with his/her	F 329		

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F 329	Continued From page 16 eyes closed. At 11:53 a.m. Staff A Restorative Aide/CNA rubbed Resident #4's left arm saying wake up. Resident #4 did not open his/her eyes. At 12:20 p.m. Staff E fed Resident #4 with his/her eyes closed and head laid back. Resident #4 only took a few bites. At 3:00 p.m. Resident #4 sat in the recliner in his/her room with his/her eyes closed. During an interview on 1/10/17 the Director of Nursing stated Resident #4 hit and spit at 1 point, but said it had probably been awhile. She said they did not have behavior sheets. They made a note in the Nurse's Notes if Resident #4 had behavior. The clinical record reviewed from June 2016 to present lacked documentation Resident #4 exhibited the behaviors that lead to the initiation of the Haldol. During an observation on 1/11/17 at 8:16 a.m. the Staff A provided passive range of motion for Resident #4. Staff A stated he/she was awake, so a prime time to do it. During the exercises Staff A stated Resident #4 was going to sleep on her. At 8:48 a.m. Staff A stated mornings were the best time for Resident #4 for eating and being awake. He/she had not opened his/her eyes for a long while.	F 329		
F 497 SS=E	483.75(e)(8) NURSE AIDE PERFORM REVIEW-12 HR/YR INSERVICE The facility must complete a performance review of every nurse aide at least once every 12 months, and must provide regular in-service education based on the outcome of these reviews. The in-service training must be	F 497		

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F 497	Continued From page 17 sufficient to ensure the continuing competence of nurse aides, but must be no less than 12 hours per year; address areas of weakness as determined in nurse aides' performance reviews and may address the special needs of residents as determined by the facility staff; and for nurse aides providing services to individuals with cognitive impairments, also address the care of the cognitively impaired. This REQUIREMENT is not met as evidenced by: Based on Nurse Aide Roster review and staff interview, the facility failed to ensure staff performance reviews were completed every 12 months for 8 of 20 current CNA's (Certified Nurse's Aide) employed by the facility. The facility reported a census of 20 residents. Findings included: The Nurse Aide Roster documented the following staff hire dates: a. Staff A had a hire date of 5/12/04. b. Staff B had a hire date of 10/21/15. c. Staff I had a hire date of 5/6/13 d. Staff J had a hire date of 6/23/97. e. Staff F had a hire date of 10/13/15. f. Staff G had a hire date of 8/13/15. g. Staff K had a hire date of 11/12/14. During an interview 1/17/17 at 9:30 a.m., the Administrator stated that CNA evaluations had not been completed routinely since sometime in 2014. The Administrator stated CNA evaluation needed completed 90 days after hire date and	F 497		

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F 497	Continued From page 18 yearly on the anniversary of their hire date.	F 497		
F 499 SS=D	483.75(g) EMPLOY QUALIFIED FT/PT/CONSULT PROFESSIONALS The facility must employ on a full-time, part-time or consultant basis those professionals necessary to carry out the provisions of these requirements. Professional staff must be licensed, certified, or registered in accordance with applicable State laws. This REQUIREMENT is not met as evidenced by: Based on employee record review, staff interview, and policy, the facility failed to verify nursing licensure prior to employment for 2 of 2 nurse files reviewed. The facility reported a census of 20 residents. Findings included: 1. A facility Employee Activity Report, printed 1/9/17, revealed the Interim DON (Director of Nursing) had a hire date of 4/15/16. The personnel file lacked verification of the employee's licensure. During an interview on 1/10/17 at 2:00 p.m., the Business Office Manager confirmed the Interim DON's licensure verification had not yet been completed. 2. A facility Employee Activity Report, printed 1/9/17, revealed Staff C, Licensed Practical Nurse (LPN), had a hire date of 12/6/16. The personnel file lacked verification of the LPN's	F 499		

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F 499	Continued From page 19 licensure. During an interview on 1/12/17 at 11:25 a.m., the Business Office Manager stated Staff C's nursing license had not been verified prior to rehire. The facility Abuse Prevention, Identification, Investigation, and Reporting Policy, revised 12/7/16, documented the facility needed to check with the licensing board to assure a nurse's license in good standing prior to hire.	F 499		

Sunset Knoll Care and Rehab Center (SSK)
P.O. Box 67, 401 W. 5th Street
Aurelia, IA 51005

Provider's Plan of Correction

DATE: February 10, 2017
Survey Completed on January 17, 2017

The preparation of the following plan of correction for these deficiencies does not constitute and should not be interpreted as an admission nor an agreement by the facility of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction prepared for this deficiency was executed solely because it is required by provisions of state and federal law.

1. F 225

- Completion Date: February 9, 2017
- Corrective Measures: Per F 225, SSK will continue to 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 or Director of Nursing of the facility and to other officials in accordance with State law through established procedures (including to the State survey and certification agency)." Relative to the specific findings noted during the survey, the following actions were taken:

    a) All facility Staff was re-in-serviced relative SSK policy/procedure titled Abuse Prevention, Identification, Investigation, and Reporting Policy on January 16, 2017. The entire policy/procedure was reviewed paying special attention to discuss that all allegations of abuse need to be reported to either the Administrator or Director of Nursing and to the Iowa Department of Inspections and Appeals (DIA) all within the required and appropriate timeframes.

    b) Relative to resident #7, allegations of abuse since the January 4, 2017 alleged incident have been reported, investigated by the facility and one reviewed by the DIA, with no factual evidence indicating that the incidences took place. The resident attended a scheduled psychiatric visit on 1/31/17 and a medication change was initiated with positive results to date.

- Monitors: During the daily stand up meetings, any alleged instances of resident abuse of any type will be monitored. Any concerns will be addressed per SSK policy/procedure reference above, including the reporting and investigation requirements. Any ongoing concerns will be addressed via our CQI process.

2. F 226

- Completion Date: February 9, 2017
- Corrective Measures: Per F 226, SSK will continue to..."develop and implement written policies and procedures that prohibit mistreatment, neglect, and abuse of residents and misappropriation of

resident property." Relative to the specific findings noted during the survey, the following actions were taken:

a) Staff D completed her Mandatory Reporter Training program on January 12, 2017.

b) Staff C was rehired on a PRN status only and has not worked again at the facility since before January 1, 2017. She will be deleted from our system effective January 1, 2017.

c) An all staff in-service was held on January 16, 2017 reviewing the facility policy requiring an Iowa criminal record checks and dependent adult/child abuse registry check on all prospective employees.

- Monitors: The Administrator or designee will review for compliance periodically during daily stand up meetings. Any ongoing concerns will be addressed via our CQI process.

3. F 317

- Completion Date: February 16, 2017
- Corrective Measures: Per F 317 SSK will continue to ... "ensure that a resident who enters the facility without a limited range of motion does not experience reduction in range of motion unless the resident's clinical condition demonstrates that a reduction in range of motion is unavoidable." Relative to the specific findings noted during the survey, the following actions were taken:

a) When hospice care is chosen, SSK will communicate with the hospice provider that the facility will continue with the resident restorative programs in place prior to the choice for hospice care and adjust them in coordination with the hospice provider and with any change of condition and/or needs of the resident.

b) Any necessary adjustments will be addressed in the weekly hospice care plan review meetings.

c) Relative to resident number 4, the resident's restorative program was re-initiated on December 13, 2016.

- Monitors: The Director of Nursing or designee will review periodically during the daily stand up meetings. Any ongoing concerns will be addressed via our CQI process.

4. F 323

- Completion Date: February 16, 2017
- Corrective Measures: Per F 323 SSK will continue to ... "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." Relative to the specific findings noted during the survey, the following actions were taken:

a) Relative to resident number 1, he/she remains care planned as an assist of 2 staff with Activities of Daily Living (ADL's). All nursing staff was re-educated regarding this directly by the DON.

b) Relative to resident number 3, the care plan was updated to ensure the pad alarms are checked daily for functionality and a toileting schedule was established for 10 PM and 2 AM. All nursing staff was re-educated regarding the resident's fall interventions that are care planned directly by the DON.

c) Residents with assistive devices to prevent accidents will be appropriately care planned and staff educated to ensure that the devices are reviewed regularly to ensure proper operation.

- Monitors: The Director of Nursing or designee will review weekly and report any concerns during the daily stand up meetings. Any ongoing concerns will be addressed via our CQI process.

5. F 329

- Completion Date: February 16, 2017
- Corrective Measures: Per F 329 SSK will continue to … "ensure that residents who have not used antipsychotic drugs are not given these drugs unless antipsychotic drug therapy is necessary to treat a specific condition as diagnosed and documented in the clinical record…" Relative to the specific findings noted during the survey, the following actions were taken:

    a) Relative to resident number 2, the DON is working directly with the attending physician on a gradual dose reduction plan for his/her psychotropic medication. This will be finalized within the next few days.

    b) Relative to resident number 4, on 1/13/2017 the attending physician changed the Haldol order from 1 mg 3 times a day to 1 mg 2 times a day.

    c) Relative to ongoing gradual dose reductions (GDR), the pharmacy consultant was provided with the current DON's email and contact information which they previously did not have. The DON now is receiving the GDR recommendations and is addressing them. The DON will contact the pharmacy consultant if the monthly report is not received by the 25th.

- Monitors: The Director of Nursing or designee will report any concerns receiving the pharmacy consultant report during the daily stand up meetings. Any ongoing concerns will be addressed via our CQI process.

6. F 497

- Completion Date: February 16, 2017
- Corrective Measures: Per F 497 SSK will continue to … "complete a performance review of every nurse aide at least once every 12 months, and must provide regular in-service education based on the outcome of these reviews." Relative to the specific findings noted during the survey, the following actions were taken:

    a) The DON has been actively completing performing performance reviews with the nursing staff. Staff A and B have had their respective evaluations completed.

    b) Staffs I, J, F, and K were on a PRN status only and have not worked at SSK since before November 25, 2016. Letters have been mailed out to these PRN employees terminating their PRN status and inviting them to reapply if they which to work at SSK in the future.

    c) Staff G as well as staff HW (initials) are both PRN status and both are attending classes at Iowa City and unavailable. Performance reviews will be completed upon their return.

    d) The DON has set up a separate employee file for each nursing staff with their respective review dates flagged.

- Monitors: The Administrator will monitor the completion of staff evaluations to ensure they are completed timely. Any ongoing concerns will be addressed via our CQI process.

7. F 499

- Completion Date: February 16, 2017
- Corrective Measures: Per F 499 SSK will continue to ensure the following: "Professional staff must be licensed, certified, or registered in accordance with applicable State Laws." Relative to the specific findings noted during the survey, the following actions were taken:

    a) The DON's and Staff C's licenses were verified prior to the end of the survey on 1/17/2017.

    b) The DON will ensure that all nursing licenses are verified prior to hire.

- Monitors: The Administrator will monitor the licensure verification of the professional nurses. Any ongoing concerns will be addressed via our CQI process.