STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	165156	A. BUILDING _____ B. WING _____	03/16/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
FORT DODGE HEALTH AND REHABILITATION	728 14TH AVENUE NORTH FORT DODGE, IA 50501

(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 03/24/2017 The following deficiencies relate to the recertification survey conducted March 13 - 17, 2017. Investigation of complaint 66606-C was also completed and not substantiated. See Code of Federal Regulations (42 CFR) Part 483, Subpart B-C.	F 000	This plan of correction constitutes my written credible allegation of compliance. Correction date 3/24/2017 F226 Correction Date 03/22/2017 The response or providers plan of correction contained herein shall not be considered to be or construed as an admission of the validity of the citation or alleged deficiency to which it is addressed.	
F 226 SS=D	483.12(b)(1)-(3), 483.95(c)(1)-(3) DEVELOP/IMPLMENT ABUSE/NEGLECT, ETC POLICIES 483.12 (b) The facility must develop and implement written policies and procedures that: (1) Prohibit and prevent abuse, neglect, and exploitation of residents and misappropriation of resident property, (2) Establish policies and procedures to investigate any such allegations, and (3) Include training as required at paragraph §483.95, 483.95 (c) Abuse, neglect, and exploitation. In addition to the freedom from abuse, neglect, and exploitation requirements in § 483.12, facilities must also provide training to their staff that at a minimum educates staff on- (c)(1) Activities that constitute abuse, neglect, exploitation, and misappropriation of resident property as set forth at § 483.12.	F 226		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Debra K Koenig	Administrator	03/28/2017 3/28/17

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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	165166	A. BUILDING _____ B. WING _____	03/16/2017

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F 226	Continued From page 1 (c)(2) Procedures for reporting incidents of abuse, neglect, exploitation, or the misappropriation of resident property	F 226		
	(c)(3) Dementia management and resident abuse prevention. This REQUIREMENT is not met as evidenced by: Based on employee personnel records, facility policy and interview, the facility failed to comply with state regulations (Iowa Administrative Codes 481- 50.9(4) and 481-58.11(3) for screening employees prior to employment. The facility failed to obtain a valid employee background check for 1 of 5 new employees. The facility reported a current census of 43 residents. Findings Include: 1. A review of Staff A's personnel file revealed a hire date of 11/4/16. On 9/22/16 the facility obtained a Single Contact and Background Check (SING) for criminal history and dependent adult abuse, which cleared Staff A, Housekeeper to work in the nursing home. A payroll time sheet dated 11/4/16, identified Staff A's first day of employment as 11/4/16. Staff A's employment did not begin within 30 days of the valid abuse/criminal background check results and instead 7 weeks or 49 days later. During interview on 3/14/17 at 8:05 a.m., the facility Administrator confirmed background checks and abuse history checks should be completed within 30 days of hire.		F226 The Fort Dodge Health and Rehab will comply with state regulations (Iowa Administrative Codes 481- 50.9(4) and 481-58.11(3) for screening employees prior to employment. The facility has since obtained a valid employee background check for Staff A's personnel file and will also do so for all new hires. The Human Resource Leader was educated per the Administrator on the requirement of pending employees beginning employment within 30 days of the valid abuse/criminal background check results, on 3/17/17. Criminal Background Checks will be monitored by the Office Manager and QA for a period of 3 months and then reviewed for need to continue or evaluate for changes.	03/22/2017

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F 226	Continued From page 2 The facility's Policy and Procedure titled Nursing Administration dated 11/28/116 instructed the facility to "properly" screen all employees for criminal and abuse prior to hire.	F 226		
F 281 SS=D	483.21(b)(3)(i) SERVICES PROVIDED MEET PROFESSIONAL STANDARDS (b)(3) Comprehensive Care Plans The services provided or arranged by the facility, as outlined by the comprehensive care plan, must- (i) Meet professional standards of quality. This REQUIREMENT is not met as evidenced by: Based on record review and staff interview the facility failed to follow doctor's orders for one resident with an order to report blood sugars greater than 350 (Resident #3) and one resident with an order for weekly weights (Resident #2). The standard sample included 10 current residents. The facility reported a census of 43 residents. Findings included: 1. Resident #3's Medical Diagnosis List documented diagnoses including but not limited to morbid obesity and Type 2 diabetes. The resident's Physician's Orders (Medication Review Report) included an order on 3/8/17 directing staff to obtain an Accu check (blood sugar measurement) 4 times daily before meals and at bedtime for Diabetes and to report to the physician any blood sugar measurement greater than 350 or less than 70. On the Medication	F 281	The services provided or arranged by Fort Dodge Health and Rehab as outlined by the comprehensive care plan, will meet professional standards of quality. FDHR will follow doctor's orders for resident #3, #2, and all other resident's of the facility. The Nursing staff was In-serviced on the new resident policy on weights and the new system put in place on 03/14/2017. Nursing Staff were also educated on following physician orders per the Nursing Point Click Care Communication Page and educated again at the Mandatory monthly scheduled In-Service on 3/24/17. The DNS will monitor weights/doctor orders. The Director of Nursing and or designee will report findings of above education/procedure system(s) monthly times three months through the facility Quality Assurance Program, who will then review/assess for need to continue. The plan will be reviewed and revised as indicated and staff will be re-educated as needed.	3/24/17

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F 281	Continued From page 3 Administration Record (MAR) staff documented the following: On 3/8/17 at 8:00 p.m. staff recorded the resident's blood sugar measured 406. On 3/9/17 at 7:00 a.m. staff recorded the resident's blood sugar measured 486. On 3/10/17 at 11:00 a.m. staff recorded the resident's blood sugar measured 455. On 3/11/17 at 8:00 p.m. staff recorded the resident's blood sugar measured 384. On 3/13/17 at 11:00 a.m. staff recorded the resident's blood sugar measured 450. The resident's record lacked any documentation indicating staff had reported the elevated blood sugars to the physician. During interview on 3/14/17 at 2:11 p.m. the Clinical and MDS Resource Nurse stated no documentation could be found indicating staff reported the elevated blood sugars to the physician. 2. Resident #2's Medical Diagnosis List documented diagnoses including but not limited to protein calorie malnutrition. The resident's current orders included a 1/22/16 order to weigh the resident weekly related to tube feedings and moderate protein-calorie malnutrition. Staff documented the resident's weight only 3 times in March 2016; 3 times in April 2016; 1 time in May 2016; 2 times in June 2016; 1 time in July 2016; 2 times in August 2016; 1 time in September 2016; 1 time in October 2016; 2 times in November 2016; 1 time in December 2016; 1 time in January 2017 and 1 time in February	F 281		

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F 281	Continued From page 4 2017. On 3/14/17 no weights had been recorded for March 2017. During interview on 3/15/17 the Clinical and MDS Resource nurse confirmed the order for weekly weights had not been followed and recently staff had been weighing the resident only monthly.	F 281		
F 309 SS=D	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 Quality of care Quality of care is a fundamental principle that applies to all treatment and care provided to facility residents. Based on the comprehensive assessment of a resident, the facility must ensure that residents receive treatment and care in accordance with professional standards of practice, the comprehensive person-centered care plan, and the residents' choices, including but not limited to the following: (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.	F 309	F309 Each resident must receive and Fort Dodge Health and Rehab will 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. The Fort Dodge Health and Rehab will ensure that residents receive treatment and care in accordance with professional standards of practice, the comprehensive person-centered care plan, and the residents' choices. Fort Dodge Health and Rehab will assess and intervene for Resident #1, #2, #7 and all other residents of the facility. Nursing Staff received education on 3/24/2017 for the following: 1. Assessing and Intervening significant weight loss. 2. Assessing signs and symptoms of respiratory problems. 3. Assessing dislodged catheter incidents.	3/24/17

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F 309	Continued From page 5 (I) 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 by: Based on record review and staff interview the facility failed to assess and intervene for 1 resident with significant weight change (Resident #1), for a resident with signs and symptoms of respiratory problems (Resident #2) and for a resident with a dislodged catheter (Resident #7). The sample included 11 residents. The facility reported a census of 43 residents. Findings included: 1. Staff documented on Resident #1's Weights and Vitals Summary weights as follows: 9/26/16 161.8 pounds 10/10/16 160.1 pounds 10/31/16 161.3 pounds 11/18/16 165.4 pounds 12/15/16 163 pounds On 12/15/16 staff recorded a weight 152.7 but crossed it out and on 12/16/16 noted it an incorrect entry. The record lacked any further weight measurements until 1/25/17 when staff documented the resident weighed 181 pounds. The record lacked any further weights until 2/22/17 when staff documented the resident weighed 137.3 pounds. Staff next weighed the resident on 3/3/17 and documented the resident's weight 133.7.	F 309	The Director of Nursing and or designee will report findings of above monitoring system(s) monthly times three months through the facility Quality Assurance Program, who will then review/assess for need to continue. The plan will be reviewed and revised as indicated and staff will be re-educated as needed.	

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F 309	Continued From page 6 Resident #1's 3/8/17 Progress notes from Palliative Care documented the resident had diagnoses including but not limited to pulmonary emphysema, nausea, generalized abdominal pain and weight loss. The notes stated the resident had lost 30# since January and directed staff to review the chart to assure the accuracy of the record. If so may need to discuss need for abdominal CT scan due to nausea, pain and weight loss - this is a concern. The resident's record lacked any indication staff had rechecked the resident's weight when significant variations from the baseline were recorded. The record lacked documentation indicating staff assessed possible causes of the fluctuations in the resident's recorded weights. The dietitian made a note on the 3/9/17 Dietitian/Resident Nutritional Documentation Record in regard to Resident #1 a significant loss. The weight was wrong 1/25/17. The dietitian had asked for a reweigh multiple times but it was not done. During interview on 3/13/17 at 3:11 p.m. the Dietitian stated she had been aware of the resident's weight variances and had repeatedly asked the then, Director of Nursing (DON) to reweigh the resident but it was not done. During interview on 3/14/16 at 9:42 a.m. the current DON stated she had made a new plan to address significant variances in residents' weights. At 12:51 p.m. she confirmed Resident #1's weight variances and stated she didn't know who had previously been responsible to monitor residents' weights but now she would do that and	F 309		

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F 309	Continued From page 7 meet weekly with the Dietitian to review resident weights. 2. Staff documented in Resident #2's Nursing Progress Notes on 3/11/17 at 2:00 a.m. the resident had 3 emesis, had a temperature 100.2 degrees Fahrenheit (F) and a loose, moist cough. At 9:59 a.m. staff updated the resident's physician who ordered to test for Influenza A and give Pedialyte 4 ounces every hour to keep the resident hydrated. If no further vomiting they could resume the regular scheduled gastrostomy feeding that night. Staff documented the resident's temperature 99.5 F. At 3:01 p.m. staff sent the Influenza A swab to the laboratory. On 3/12/17 at 4:02 p.m. staff documented the resident's temperature had been 100.5 F and staff administered Tylenol. The temperature then measured 99 F. At 8:50 p.m. staff documented the resident's temperature 99 F. Staff did not receive results of the Influenza A testing until 3/13/17 at 11:52 a.m. The specimen tested positive indicating the resident had Influenza A. The record lacked documentation indicating staff assessed the resident's lung sounds, respirations or oxygen saturation levels from 3/11/17 at 2:00 a.m. until 3/13/17 at 8:33 a.m. During interview on 3/15/17 at 8:47 a.m. the Clinical/MDS Nurse stated staff should check lung sounds when residents exhibit respiratory symptoms and also should be checked after an emesis while lying down. 3. According to the Minimum Data Set with assessment reference date of 12/30/16 Resident #7 had diagnoses including Alzheimer's disease and moderately impaired cognitive skills for daily decision making. The resident had an indwelling	F 309		

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F 309	Continued From page 8 urinary catheter. The Progress Notes for Resident #7 noted on 1/15/17 at 9:29 p.m. the resident pulled his/her catheter out with the balloon intact. The resident voided without problems, blood tinged urine noted. A Physician Fax Form sent to the physician. Resident #7's Progress Notes lacked documentation of a nursing assessment done of the resident's voiding until 1/16/17 at 2:30 p.m., 17 hours after the catheter had dislodged. A Physician Fax Form dated 1/16/17 with the narrative, resident pulled his/her catheter out with the balloon intact. The resident voided without problems, small amount of blood tinged urine. Denies any pain. Is it okay to discontinue catheter? Response required today (4-8 hours). The fax was not returned to the facility until 12:23 p.m. on 1/17/17. Resident #7's Progress Notes lacked documentation of the facility making any attempt to speak with a physician after the fax was not returned in the requested time frame. During interview on 3/14/17 at 2:30 p.m. the DON stated if a fax had been sent that a resident's catheter had dislodged and staff did not hear back within an hour she would expect staff to be calling the physician. During interview on 3/15/17 at 2:58 p.m. the Administrator stated she would expect nurse to check and assess every two to four hours if the resident was voiding okay.	F 309		

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F 323	Continued From page 9	F 323		
F 323 SS=E	483.25(d)(1)(2)(n)(1)-(3) FREE OF ACCIDENT HAZARDS/SUPERVISION/DEVICES (d) Accidents. The facility must ensure that - (1) The resident environment remains as free from accident hazards as is possible; and (2) Each resident receives adequate supervision and assistance devices to prevent accidents. (n) - Bed Rails. The facility must attempt to use appropriate alternatives prior to installing a side or bed rail. If a bed or side rail is used, the facility must ensure correct installation, use, and maintenance of bed rails, including but not limited to the following elements. (1) Assess the resident for risk of entrapment from bed rails prior to installation. (2) Review the risks and benefits of bed rails with the resident or resident representative and obtain informed consent prior to installation. (3) Ensure that the bed's dimensions are appropriate for the resident's size and weight. This REQUIREMENT is not met as evidenced by: Based on observation, record review and staff interview, the facility failed to provide adequate supervision to protect residents against hazards from self, others or elements in the environment. Observation revealed an entrance door to the facility Rehabilitation room lacked an audible alarm, other than a Wandergaurd alarm system (electronic device that signals an alarm at the time a resident passes through the door wearing	F 323	F323 Fort Dodge Health and Rehab will continue to provide adequate supervision to protect residents against hazards from self, others or elements in the environment. The Outpatient Entrance door to the facility Rehabilitation room had an audible alarm installed on 03/14/2017. The two doors leading from the facility dining room, and the 300 hallway door to the enclosed courtyard areas were also alarmed with audible alarms and will be locked during the winter season. All of these doors will be monitored per the Maintenance Supervisor on a weekly basis as well as per monthly QA on an ongoing basis. Door alarms continued to be monitored as of 3/17/17	3/24/17

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F 323	Continued From page 10 a Wanderguard electronic bracelet). Two doors leading from the facility dining room to enclosed courtyard areas revealed unlocked doors and lacked any type of alarm and a door leading from Hall 300 to an enclosed courtyard area revealed an unlocked door and lacked any type of alarm. The facility identified 20 independently mobile residents and 2 independently ambulatory, cognitively impaired residents without Wandergaurd bracelets. The facility census was 43 residents. Findings Included: Observation on 3/13/17 at 1:00 P.M., revealed the following: a. 2 doors lead to enclosed outside courtyard areas. The doors were not identified as fire exit doors, were unlocked and lacked an alarm to alert staff if a resident went out either door. b. The 300 hallway revealed an exit door to an enclosed courtyard area, was not identified as a fire exit door, was unlocked and lacked an alarm to alert staff if a resident went out the door. c. Ongoing observation on 3/13/17 at 3:30 P.M., revealed an entrance door to the facility Rehabilitation room revealed an outside entrance door led to an entryway that led to a door to the interior of the Rehabilitation room. The outside door and the interior door lacked any audible alarm when either door opened. Observation revealed the only alarm system on the door was a Wandergaurd alarm system. Observation of the facility Rehabilitation room revealed 2 opened doors led to Hall 200 and Hall	F 323		

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F 323	Continued From page 11 300 (Resident living areas). During the same observation the facility Rehabilitation Director stated at the times when no Rehabilitation staff supervised the Rehabilitation room, the doors to Hall 200 and Hall 300 had been closed and locked. The Rehabilitation Director stated the only exception would be if she needed to run to the Business Office Managers office "...for a minute..." Observation of the facility Business Office Mangers Office on 3/13/17 at 3:55 P.M., revealed the office in the 200 Hall, approximately 9 paces from the Rehabilitation room. Further observation revealed the outside entrance door to the Rehabilitation room as not visible from the Business Office Manager's office. A Weather Underground website revealed the following weather history report at the Fort Dodge airport as follows: 3/10/17 - Actual temperature: 21 degrees Fahrenheit (F) 3/11/17 - Actual temperature: 26 F 3/12/17 - Actual temperature: 26 F 3/13/17 - Actual temperature: 24 F. During interview on 3/14/17 at 7:55 A.M., the Administrator offered no explanation for how staff monitored the unlocked/unalarmed doors in the facility. The Administrator stated the Rehabilitation entrance door and the doors that led to the enclosed courtyard all had door alarms placed as of 3/14/17. During interview on 3/14/17 at 9:00 A.M., the Maintenance Supervisor reported he planned to lock the doors to the enclosed courtyard during	F 323		

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F 323	Continued From page 12 the cold weather months.	F 323		
F 329 SS=D	483.45(d)(e)(1)-(2) DRUG REGIMEN IS FREE FROM UNNECESSARY DRUGS 483.45(d) Unnecessary Drugs-General. Each resident's drug regimen must be free from unnecessary drugs. An unnecessary drug is any drug when used-- (1) In excessive dose (including duplicate drug therapy); or (2) For excessive duration; or (3) Without adequate monitoring; or (4) Without adequate indications for its use; or (5) In the presence of adverse consequences which indicate the dose should be reduced or discontinued; or (6) Any combinations of the reasons stated in paragraphs (d)(1) through (5) of this section. 483.45(e) Psychotropic Drugs. Based on a comprehensive assessment of a resident, the facility must ensure that-- (1) Residents who have not used psychotropic drugs are not given these drugs unless the medication is necessary to treat a specific condition as diagnosed and documented in the clinical record; (2) Residents who use psychotropic drugs receive	F 329		

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	165156	A. BUILDING _____ B. WING _____	03/16/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
FORT DODGE HEALTH AND REHABILITATION	728 14TH AVENUE NORTH FORT DODGE, IA 50501

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F 329	Continued From page 13 gradual dose reductions, and behavioral interventions, unless clinically contraindicated, in an effort to discontinue these drugs; This REQUIREMENT is not met as evidenced by: Based on clinical record review and staff interview, the facility failed to ensure Resident #8's drug regimen remained free from unnecessary drugs through adequate assessment, indications for use and monitoring. Eleven residents were reviewed. The facility reported a census of 43 residents. Findings included: The Minimum Data Set with assessment reference date 1/24/17 documented Resident #8 had diagnoses that included psychotic disorder and malignant neoplasm of brain. Resident #8's Medication Review Report signed by the physician on 2/1/17 included an order for Ativan (an antianxiety medication) 0.5 mg by mouth every two hours as needed (prn) and Ativan 1 milligram by mouth every two hours as needed for anxiety. Resident #8's February 2017 Medication Administration Record (MAR) documented the resident received as needed Ativan 0.5 milligrams 5 times and the Ativan 1 milligram dose 9 times. The PRN Record lacked documentation staff offered any type of non-pharmacological intervention to promote relaxation. Resident #8's March 1-14, 2017 MAR documented the resident received as needed Ativan 0.5 milligrams 7 times and the Ativan 1	F 329	Fort Dodge Health and Rehab will ensure Resident #8 and all other resident drug regimens remain free from unnecessary drugs through adequate assessment, indications for use and monitoring. The Nursing Staff were educated per the Point Click Care Communications that a resident cannot receive a PRN psychotic medication without first trying non-pharmacological interventions first. If those intervention are not successful than the medication may be administered. A list of non-pharmacological interventions are listed on the medication records.3/17/17 The Director of Nursing & Consultant Pharmacist, and or designee will report findings of above monitoring system(s) monthly times three months through the facility Quality Assurance Program, who will then review/assess for need to continue. The plan will be reviewed and revised as indicated and staff will be re-educated as needed.	3/24/17

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F 329	Continued From page 14 milligram dose 6 times. The PRN Record lacked documentation staff offered any type of non-pharmacological intervention to promote relaxation. Resident #8's Progress Notes dated 2/5/17 - 3/14/17 lacked any documentation staff assessed the resident for possible causes of anxiety and/or attempted any interventions to decrease anxiety prior to administering Ativan. During interview 3/15/17 at 1:35 p.m. the Clinical Market Leader stated it is expected for staff to attempt non-pharmacological interventions prior to administering the prn Ativan. Documentation of interventions attempted prior to administration of prn Ativan would be documented in the progress notes or the resident's PRN Record.	F 329		
F 334 SS=D	483.80(d)(1)(2) INFLUENZA AND PNEUMOCOCCAL IMMUNIZATIONS (d) Influenza and pneumococcal immunizations (1) Influenza. The facility must develop policies and procedures to ensure that- (i) Before offering the influenza immunization, each resident or the resident's representative receives education regarding the benefits and potential side effects of the immunization; (ii) Each resident is offered an influenza immunization October 1 through March 31 annually, unless the immunization is medically contraindicated or the resident has already been immunized during this time period; (iii) The resident or the resident's representative	F 334	F334 Resident #9 and all other residents at Fort Dodge Health and Rehab will be offered an influenza immunization October 1 through March 31 annually, unless the immunization is medically contraindicated or the resident has already been immunized during this time period. The Nursing Dept. was educated on the Vaccination Procedure for the 2017 season. The vaccination procedure for 2017 will be conducted per the Director of Nursing Services. The Director of Nursing and or designee will report findings of above monitoring system, following the 2017 Immunization period at the monthly Quality Assurance Program Meeting, who will then review/assess for need to continue. The plan will be reviewed and revised as indicated and staff will be re-educated as needed.	3/24/17

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F 334	Continued From page 15 has the opportunity to refuse immunization; and (iv) The resident's medical record includes documentation that indicates, at a minimum, the following: (A) That the resident or resident's representative was provided education regarding the benefits and potential side effects of influenza immunization; and (B) That the resident either received the influenza immunization or did not receive the influenza immunization due to medical contraindications or refusal. (2) Pneumococcal disease. The facility must develop policies and procedures to ensure that- (i) Before offering the pneumococcal immunization, each resident or the resident's representative receives education regarding the benefits and potential side effects of the immunization; (ii) Each resident is offered a pneumococcal immunization, unless the immunization is medically contraindicated or the resident has already been immunized; (iii) The resident or the resident's representative has the opportunity to refuse immunization; and (iv) The resident's medical record includes documentation that indicates, at a minimum, the following: (A) That the resident or resident's representative	F 334		

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F 334	Continued From page 16 was provided education regarding the benefits and potential side effects of pneumococcal immunization; and (B) That the resident either received the pneumococcal immunization or did not receive the pneumococcal immunization due to medical contraindication or refusal. This REQUIREMENT is not met as evidenced by: Based on clinical record review, staff interview and facility policy review, 1 of 10 residents reviewed received 2 influenza immunizations during the annual immunization time period,(Resident #9). The facility reported a census of 43 residents. Findings include: According to the Minimum Data Set with assessment reference date of 10/28/16, Resident #9 had cognitively intact skills for daily decision making. The resident had a diagnosis of hemiplegia and required extensive assist with activities of daily living. The Progress Notes for Resident #9 included a notation on 10/15/16 at 5:04 p.m. of a flu shot given in the resident's right deltoid (upper arm). Documentation on 10/24/16 at 5:19 p.m. noted the resident received a flu shot today. Medication administration record updated. On 3/15/17 the Administrator provided an Immunization Report dated 11/2/16 that showed Resident #9 had received an influenza immunization on 10/15/16 in the right deltoid. The Medication Administration Record for	F 334		

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F 334	Continued From page 17 Resident #9 for 10/1/16-10/31/16 showed the resident received an influenza immunization on 10/24/16. The Medication Review Report for Resident #9 signed by the physician on 10/1/16 included the order for influenza vaccine per facility policy. The facility policy for Influenza Immunizations revised 5/2007 included: each resident is offered an influenza immunization October 1 through March 31 annually, unless the immunization is medically contraindicated or the resident has already been immunized during this time period.	F 334		
F 441 SS=E	483.80(a)(1)(2)(4)(e)(f) INFECTION CONTROL, PREVENT SPREAD, LINENS (a) Infection prevention and control program. The facility must establish an infection prevention and control program (IPCP) that must include, at a minimum, the following elements: (1) A system for preventing, identifying, reporting, investigating, and controlling infections and communicable diseases for all residents, staff, volunteers, visitors, and other individuals providing services under a contractual arrangement based upon the facility assessment conducted according to §483.70(e) and following accepted national standards (facility assessment implementation is Phase 2); (2) Written standards, policies, and procedures for the program, which must include, but are not limited to: (i) A system of surveillance designed to identify	F 441	F441 Fort Dodge Health and Rehab will follow accepted infection control practices for all residents including Resident #2 with Proper administration of Influenza Vaccine and for all residents with proper administration and documentation of the purified protein derivative test (PPD- to identify Tuberculosis). Resident #5 and resident #6 no longer reside at Fort Dodge Health and Rehab. The Nursing Dept. received education on the immunization and TB testing on March 24th at the monthly meeting held with the Director Of Nursing. The Director of Nursing Services will monitor all immunizations and TB Testing and report at the monthly QA meeting. The Director of Nursing and or designee will report findings of above monitoring system(s) through the facility Quality Assurance Program, who will then review/assess for need to continue. The plan will be reviewed and revised as indicated and staff will be re-educated as needed.	3/24/17

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F 441	Continued From page 18 possible communicable diseases or infections before they can spread to other persons in the facility; (ii) When and to whom possible incidents of communicable disease or infections should be reported; (iii) Standard and transmission-based precautions to be followed to prevent spread of infections; (iv) When and how isolation should be used for a resident; including but not limited to: (A) The type and duration of the isolation, depending upon the infectious agent or organism involved, and (B) A requirement that the isolation should be the least restrictive possible for the resident under the circumstances. (v) The circumstances under which the facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease; and (vi) The hand hygiene procedures to be followed by staff involved in direct resident contact. (4) A system for recording incidents identified under the facility's IPCP and the corrective actions taken by the facility. (e) Linens. Personnel must handle, store, process, and transport linens so as to prevent the spread of infection.	F 441		

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F 441	Continued From page 19 (f) Annual review. The facility will conduct an annual review of its IPCP and update their program, as necessary. This REQUIREMENT is not met as evidenced by: Based on record review and staff interview, the facility failed to follow accepted infection control practices for 1 resident (Resident #2) with Influenza A and failed to administer and accurately document the results of the purified protein derivative test (PPD- to identify tuberculosis) for 2 residents (Residents #5 and #6). The sample included 11 residents. The facility reported a census of 43 residents. Findings included: 1. Staff documented in Resident #2's Nursing Progress Notes on 3/11/17 at 2:00 a.m. the resident had 3 emesis, had a temperature 100.2 degrees Fahrenheit (F) and a loose, moist cough. At 9:59 a.m. staff updated the resident's physician who ordered to test for Influenza A and give Pedialyte 4 ounces every hour to keep the resident hydrated. If no further vomiting they could resume the regular scheduled gastrostomy (tube) feeding that night. Staff documented the resident's temperature 99.5F. At 3:01 p.m. staff sent the Influenza A swab to the laboratory. On 3/12/17 at 4:02 p.m. staff documented the resident's temperature had been 100.5F and staff administered Tylenol. The temperature then measured 99F. At 8:50 p.m. staff documented the resident's temperature 99F. Staff did not receive results of the Influenza A testing until 3/13/17 at 11:52 a.m. The specimen tested positive indicating the resident had Influenza A. The record lacked any documentation indicating	F 441		

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F 441	Continued From page 20 staff attempted to obtain the test results any time sooner or that any precautions taken pending the test results or even after they received the positive test results.	F 441		
	During interview on 3/14/17 at 12:39 p.m. the Director of Nursing (DON) stated they had not received the test results until 3 days after the specimen was sent. She stated the resident had not been isolated or any special precautions taken. At 1:12 p.m. the DON stated she had called the lab and they simply hadn't reported the results of the Influenza A test timely. She stated she expected nursing staff to follow up to assure results obtained in a timely manner. She stated the results should have been available in 2 hours. On 3/14/16 at 12:58 p.m. the resident's door had a sign posted which said "Droplet Precautions". Masks and gloves sat on a table outside the door. Staff D, Licensed Practical Nurse (LPN) stated the sign posted that day about 10:00 a.m. On 3/14/17 at 1:04 p.m. Staff C, Certified Nursing Assistant (CNA), stated she was assigned to Resident #2's hallway. She stated she was just told before lunch that day the resident had Influenza A. She stated she would be more vigilant about handwashing and infection control measures now that she knew. On 3/14/17 2:24 p.m. Staff D, CNA, stated she had worked 2nd shift the day before but was not told about the resident's Influenza A until, "10 minutes ago." 2. The Minimum Data Set with assessment			

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F 441	Continued From page 21 reference date of 12/29/16 identified Resident #5's admission date as 12/22/16. A Clinical Immunizations form for Resident #5 showed the resident had received a TB (tuberculosis) 1 Step Mantoux test on 12/23/16. Resident #5's clinical record lacked documentation of the result of the 1st step and date read. The record lacked documentation of the completion of the 2nd step of the 2 Step Mantoux test. During interview on 3/15/17 at 9:05 a.m. the Administrator stated the facility had no documentation the 12/23/16 TB test was read or documentation that a second TB test given. During interview on 3/16/17 at 9:35 a.m. the Clinical Market Leader stated they were unable to find documentation of an order received to administer a PPD skin test for Resident #5. 3. The Minimum Data Set with assessment reference date of 2/16/17 identified Resident #6's admission date as 2/9/17. Resident #6's clinical record lacked documentation of completion of the 2 Step PPD test. During interview on 3/15/17 at 9:05 a.m. the Administrator stated the facility had no documentation a 2 Step PPD test was given to Resident #6. During interview on 3/16/17 at 9:15 a.m. the Administrator stated they were unable to find documentation of an order received to administer	F 441		

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F 441	Continued From page 22 a PPD skin test for Resident #6. The facility Infection Control Policy for TB Screening revised 9/2007 included: a two step PPD test shall be performed, with a physician's order, for each resident admitted. A TB screening order is to be obtained for each resident admitted if there is no evidence of one performed within 90 days prior to admission. The PPD skin test result, by Mantoux method is recommended and shall be documented on the medication sheet or a PPD form.	F 441		
F 499 SS=D	483.70(f)(1)(2) EMPLOY QUALIFIED FT/PT/CONSULT PROFESSIONALS (f) Staff qualifications. (1) The facility must employ on a full-time, part-time or consultant basis those professionals necessary to carry out the provisions of these requirements. (2) Professional staff must be licensed, certified, or registered in accordance with applicable State laws. This REQUIREMENT is not met as evidenced by: Based on personnel record review and staff interview, the facility failed to verify nursing licensure for 1 of 1 nurses reviewed (Staff B - Registered Nurse/RN) prior to hire. The facility identified a census of 43 residents. Findings include: Review of Staff B's New Hire Sheet revealed a hire date of 11/11/16.	F 499	F499 Fort Dodge Health and Rehab will verify nursing licensure for all nurses as well as other professionals prior to hire. Staff B is no longer employed at Fort Dodge Health and Rehab. Human Resourses were educated per the administrator that an online verification was required PRIOR to employment on 3/17/17 Staff files will be audited on a monthly basis for the next three months and reviewed at the monthly QA meetings. The H/R leader and the administrator will monitor the audits and review/assess for need to continue. The plan will be reviewed and revised as indicated and staff person will be re-educated as needed.	3/24/17

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F 499	Continued From page 23 A Single Contact License and Background Check (SING) dated 11/3/16, revealed facility staff completed an abuse background and criminal history background check, but lacked a check for Staff B's current nursing licensure. Review of a QuickConfirm License Verification Report form revealed facility staff verified Staff B's nursing license on 11/16/16, approximately 5 days after Staff B's date of hire. A time card report revealed Staff B began work in the facility on 11/11/16, completed 2 hours of orientation, returned to work on 11/15/16 and worked 8.5 hours in the facility. During interview on 3/14/17 at 8:05 A.M., the Administrator confirmed a nursing license needed to be verified prior to hire.	F 499		
F 514 SS=D	483.70(i)(1)(5) RES RECORDS-COMPLETE/ACCURATE/ACCESSIBLE (i) Medical records. (1) In accordance with accepted professional standards and practices, the facility must maintain medical records on each resident that are- (i) Complete; (ii) Accurately documented; (iii) Readily accessible; and (iv) Systematically organized (5) The medical record must contain-	F 514	F514 Fort Dodge Health and Rehab will maintain complete medical records for a resident with a fall for resident #7 and all other residents of the facility as needed. The Nursing Dept. was educated on the use of the Point Click Care charting system to ensure a medical record is established in the progress notes in regards to falls on March 24, 2017. The DON or designee will review fall documentation on an ongoing basis to ensure that resident #7 and other like residents of the facility have thorough documentation of falls in the progress notes. The Director of Nursing and or designee will report findings of above monitoring system(s) monthly times three months through the facility Quality Assurance Program, who will then review/assess for need to continue. The plan will be reviewed and revised as indicated and staff will be re-educated as needed.	3/24/17

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F 514	Continued From page 24 (i) Sufficient information to identify the resident; (ii) A record of the resident's assessments; (iii) The comprehensive plan of care and services provided; (iv) The results of any preadmission screening and resident review evaluations and determinations conducted by the State; (v) Physician's, nurse's, and other licensed professional's progress notes; and (vi) Laboratory, radiology and other diagnostic services reports as required under §483.50. This REQUIREMENT is not met as evidenced by: Based on clinical record review, staff interview and facility policy review the facility failed to maintain complete medical records for a resident with a fall, (Resident #7). Eleven residents were reviewed. The facility reported a census of 43 residents. Findings include: According to the Minimum Data Set with assessment reference date of 12/30/16 Resident #7 had moderately impaired cognitive skills for daily decision making. The resident required extensive assist of two staff for transfers. A Progress Note for Resident #7 on 12/27/16 at 5:55 p.m. noted the resident's vital signs and neuro (neurological) checks continue related to recent fall. Review of the progress notes lacked documentation of a fall.	F 514		

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FORT DODGE HEALTH AND REHABILITATION	728 14TH AVENUE NORTH FORT DODGE, IA 50501

(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 514	Continued From page 25 During interview on 3/14/17 at 1:40 p.m. the Clinical Market Leader stated she did not find any documentation in resident #7's chart related to a fall but did find an incident report for his/her fall on 12/24/16. During interview on 3/14/17 at 3:45 p.m. the Director of Nursing stated she would expect Resident #7's fall on 12/24/16 documented in the resident's progress notes. The facility Resident/Accident policy and procedure included: If the incident accident involves a resident the charge nurse will complete a nurses' note entry detalling the event. The nurses' note must include at minimum the following: date,time, location and description of incident/accident, what post incident Interventions (treatment/care/monitoring,etc) were done, notification of appropriate representative of the resident and attending physician.	F 514		