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FORM APPROVED
OMB NO. 0938-0391

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
		03/20/2017

FORM CMS-2567(02-99) Previous Versions Obsolete Event ID: G5CI11 Facility ID: IA0619 If continuation sheet Page 1 of 15

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

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 165345	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 03/07/2017
NAME OF PROVIDER OR SUPPLIER PARKRIDGE SPECIALTY CARE			STREET ADDRESS, CITY, STATE, ZIP CODE 5800 NE 12TH AVENUE PLEASANT HILL, IA 50327		
(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 309	Continued From page 1 by: Based on observation, record review, review of facility protocols and staff, family, and physician interviews, the facility failed to ensure Resident #2 received treatment and care timely for 1 of 4 residents reviewed. Resident #2 displayed symptoms of a stroke and the facility did not implement timely interventions (ongoing assessments and timely inform physician of urgent change of condition events) to prevent further decline of the resident's condition. The facility identified a census of 88 residents. Findings include: 1.The Admission Record for Resident #2, identified diagnoses including type 2 diabetes mellitus without complications, unspecified dementia without behavioral disturbances, hypertensive heart disease with heart failure, and aphasia (impairment of language). The Minimum Data Set (MDS) assessment with a reference date of 01/27/17 indicated Resident #2 had a BIMS (Brief Interview for Mental Status) score of 5. A score of 5 represented the resident with severely impaired cognitive status. The MDS identified the resident required extensive assistance of 1 staff person for ambulating and transferring. The resident independently fed self with staff assistance setting up the service. The MDS indicated the resident had no functional limitations of range of motion on either the upper or the lower extremities. The Care Plan, updated on 11/11/16, directed a facility staff person to provide assistance with ambulation as well as to not leave the resident unattended in the wheelchair in order to prevent	F 309			

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F 309	Continued From page 2 self-transfers. According to the 12/27/12 Cardiopulmonary Resuscitation/DNR Order Declaration Form (signed by physician and resident responsible party), Resident #2 did not want resuscitation. The Progress Notes documentation identified the following: On 2/13/17 at 11:17 a.m., staff monitored the resident due to a change in condition and possible TIA (transient ischemic attack), "mini - stroke" which often resolves). The resident had slight left side facial drooping, left side weakness with grips, and was unable to do push/pulls. The resident's speech was clear, with stable vital signs as well as pupils equal and reactive to light and accommodation (PERLA) [normal]. The resident thought the change of condition to be from the water. The nurse faxed the physician. On 2/13/17 at 11:33 am, staff left messages for the power of attorney (POA) and next of kin (NOK) to call for an update on the resident's condition change. The certified nurse's aide (CNA) reported Resident # 2 had increased difficulty with transfers in the bathroom. The note indicated the staff would continue to monitor. On 2/13/17, at 21:30 PM, staff received a return fax regarding that the resident was having a possible stroke. There was a nursing order for speech therapy to evaluate and treat. The POA had returned the phone call. Neither the POA nor the NOK wanted anything further done regarding a possible stroke. On 2/14/17, at 3:22 am, Resident # 2 was	F 309			

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F 309	Continued From page 3 confused and forgetful at times. The resident had slight left side facial drooping, clear speech, and equal grips. The resident was able to move all extremities as per usual. On 2/14/17 at 10:23 AM, Resident # 2 continued to have right-sided weakness that was almost flaccid. The resident did not lift either the right arm or leg. The left grip was much stronger than the right. The resident's face was asymmetrical. The resident was now in the assisted dining room for monitoring. On 2/14/17, at 3:45 PM, the resident's daughter gave permission for speech therapy to evaluate and treat Resident # 2. At 9:49 PM on 2/14/17, resident #2 continued to have difficulty swallowing. The resident coughed with eating and drinking. The left sided facial drooping was more prominent. The resident's right arm was flaccid. There was no right grip. There was a weak left grip. The resident was the assist of 2 staff with transfers. The 2/13/17 physician notification sheet revealed the following information. There was a date/time stamp of 02/13/17 at 3:30 PM across the top. The resident had slight left side facial droop with normal speech. The left grip was weak. The push pulls were uncertain, as the resident was unable to perform these. The resident was a DNR. Additionally, the resident was having increased coughing with water and food, as well as medications. The staff requested an order for speech (therapy) evaluation and treatment. The resident was having increased difficulty with transfers from left sided weakness. The response from the doctor was that this was concerning for a stroke. The staff was advised to	F 309			

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F 309	Continued From page 4 ask the family what, if anything, the family wanted done. The doctor was fine with the speech evaluation and treatment request. The document was acknowledged on 2/13/17 at 9:30 PM. The facility protocol titled, Change of Condition/Hot Chart Protocol, dated January 2015, directed the staff to do the following: Observe/assess the resident to determine the resident's status; Notify the physician as appropriate; Notify the responsible party/family; Carry out the new orders; Monitor the resident for a response; Establish advanced directive status as needed. The same document directed facility staff to document: The date and time of assessments and interventions until the problem resolved; The date and time of physician notification and if there were any orders received; The date and time of the family/responsible party notification. During a 2/20/17 telephone interview at 1:47 PM, Resident # 2's (POA) stated that over last weekend, Resident #2 apparently had suffered a slight stroke. When staff called the POA, the staff indicated Resident # 2 had suffered minimal changes. When the POA saw the resident the next day, the POA was surprised at the resident's condition. The POA thought that the resident's changes were more than minimal. On 2/21/17, during another telephone interview at 4:02 PM, the POA stated that the staff contacted the POA in the afternoon. The unknown staff member told the POA that Resident # 2 had had a mini stroke.	F 309			

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F 309	Continued From page 5 The resident's mouth drooped on one side. Additionally, the resident was weak on either one or both sides, but mainly the one side. The staff member didn't ask the caller about sending the resident to the hospital. Rather, the staff member told the POA that they were watching Resident # 2 and had notified the doctor. The POA told the staff member this was fine as long as they were doing what Resident # 2 indicated. The POA thought she had talked to the facility once that day regarding Resident # 2's condition. The POA stated she was shocked at Resident # 2's condition when visiting the next morning. The POA reported she trusted the staff to tell her when Resident # 2 needed to go to the hospital. The staff told the POA at this visit that they thought the resident was a little worse. The POA clarified that upon admission, when there were several facility staff members in the room, Resident # 2 had indicated he/she didn't want to be kept alive artificially but didn't want to be in pain. The POA stated she was upset over the resident's decline. In an interview on 2/20/17 at 1:12 PM, Staff A, a Registered Nurse (RN), reported being Resident # 2's nurse on 02/13/17. The resident was a DNR. A CNA, possibly Staff B, told Staff A that Resident # 2's face was drooping on the right side. The facial drooping was so slight that Staff A didn't initially see it. The resident's right grip was slightly less strong than the left, but the resident was able to move both sides of his/her body. The resident was confused, but spoke clearly. Additionally, the resident's vital signs were within normal limits (WNL). Staff A left messages for both the POA and the NOK. Both called back. The POA didn't want to do anything. The decision was to see how things progressed,	F 309			

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F 309	Continued From page 6 so Staff A faxed the doctor. Resident # 2 had no additional changes by the time that Staff A left at the end of the day shift. Staff A gave Resident # 2 medications and a nebulizer breathing later in the shift. Staff A stated by the time she returned to work a few days later, Resident # 2 had gotten worse. The Unit Manager, Staff C, stated she had talked to the family. Currently, the resident was not using his/her right arm to feed him/herself as per usual. During a 2/21/17 at 2:57 PM interview, Staff A stated that on 2/13/17, Staff B and another staff member brought Resident # 2 to the nursing station, saying, "I think Resident # 2's just had a stroke". Staff B reported the resident had right facial drooping. This was right after breakfast, when Staff A was finishing up med pass. Staff A thought this was between 9:30 and 10:00 am, as this was when Staff A usually completed the medication pass. Staff A did Resident # 2's vital signs, and had the resident talk and smile. It was hard to see the facial drooping. Staff A stated she checked the resident's hand grips. Staff A tried to get Resident # 2 to push/pull with his/her feet against Staff A's hands. Resident # 2 was unable to do this. However, Staff A couldn't determine if the resident couldn't do this, or wasn't able to follow directions, which was typical for the resident due to his/her cognition. Resident #2's smile was a little crooked, but the resident spoke clearly. The resident stated that all of this was from the water. Staff C then assessed Resident # 2. Staff A did not again assess Resident # 2 that shift. Staff A reviewed the 2/13/17 progress notes and 2/13/17 fax. Staff A clarified that she thought she had spoken to the family before preparing the fax	F 309			

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F 309	Continued From page 7 and sending it to the doctor. The incident might have happened closer to 11 am, which would explain the 11:17 am entry re faxing the doctor. Staff A stated that she was going to fax Resident # 2's doctor anyway due to the resident having some swallowing problems - the day before, Resident # 2 was coughing and spitting when taking crushed medications. Staff A stated earlier on 2/13/17; Staff A had given Resident # 2 his/her medications. The resident was able to hold the cup when drinking, and seemed ok. Staff A couldn't remember which hand the resident had used to hold the cup and the resident coughed quite a bit when taking medications and sprayed out fluid. The resident subsequently settled down and ate breakfast without difficulty. Staff A stated Resident # 2 seemed per usual self at that time. There had been nothing in shift change report regarding the resident acting differently. Staff A stated that on 2/13/17, all of Resident # 2's changes were subtle. Staff A thought that the resident was having a TIA. Staff A clarified that the fax was incorrect - the concerns regarding the left sided facial drooping and left side movement should be written as right sided. Staff A also clarified that she didn't remember the exact times - everything was nonstop once Staff B had said that Resident # 2 was having a stroke. During a 2/20/17 3:05 interview, Staff C, the Unit Manager, couldn't remember the date of this incident. Staff C stated Staff A notified her that Resident # 2 was weak on the right side. This information was from the aides. Staff A asked Staff C to "check out" the resident's right leg. This limb had the largest deficit - the resident wasn't helping to hold it up - it dropped when Staff C lifted and then let it go. The resident could	F 309			

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F 309	Continued From page 8 faintly squeeze with the right hand. Staff C told Staff A to contact the family and fax the doctor. The resident's face drooped a bit on the right side. All of this was a change. The staff wanted to wait on the family's response to see how aggressive they wanted to be. Staff C stated the staff was always to call the doctor for a change of condition. The family didn't want to send Resident # 2 to the hospital. The family wanted to have the staff watch the resident at the facility to try to figure out if the changes were long term or temporary. The family wanted speech therapy, but not hospitalization. Staff C stated she did not think any facility staff contacted the doctor again on Resident # 2's condition, including when the resident really wasn't able to move his/her right side. The staff did tell therapy. The family was at the facility or calling for updates more frequently than usual. Staff C stated she thought that the facility had followed the family's direction to keep Resident # 2 at the facility. During a 2/20/17 interview at 3:26 PM, Staff D, CNA, reported being assigned to Resident # 2 on the 2/13/17, 2:00 PM to 10:00 PM shift. Staff D noticed Resident # 2 was no longer able to pull him/herself up and turn as he/she had been. The resident now needed a second person to transfer. Staff D reported that the day shift CNA said she had told the nurse about this. Staff D didn't double check with the 2/13/17 evening nurse to ensure that this nurse was aware of Resident # 2's condition. The resident stayed the same that shift and didn't have any additional changes. Staff D didn't think she had cared for Resident # 2 since then.	F 309			

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F 309	Continued From page 9 During a 2/21/17 9:16 am interview, Staff E, an RN, stated that staff should call the doctor if a resident had a significant condition change, as well as make the family aware. Staff E was not assigned to Resident # 2 the day of the incident. However, Staff C had asked her to look at Resident # 2. The resident's right side was flaccid. Staff E thought that the resident must have had a big one. Before this incident, Resident # 2 was able to walk to the bathroom. Staff E had cared for Resident #2 post incident. Staff E had not updated the doctor on the resident's condition. Staff E knew that the family didn't want the resident sent to the hospital because other staff had told her this. During an interview on 2/21/17 at 9:40 am, Staff G, an evening shift nurse, stated that after report she typically checked on the residents, and then called the doctor if there was anything concerning. On the day of the incident, Staff G thought Resident # 2 had woken up with the possible stroke. The day nurse had left the fax for Staff G to do. Staff G called one of the family members and read what the doctor had written on the fax. Staff G didn't remember the time. The family didn't want anything done. Staff G thought that the stroke had already happened by the time Staff G arrived at work. Therefore, it was past time to do anything about it. Staff G thought that she had contact with the family over the next few days as they were at the facility a lot then. Staff G, during a second interview on 2/22/17 at 3:09 PM, stated that she had assumed that Resident # 2's symptoms had started when the CNA had gotten her up for breakfast that morning. However, no one had given Staff G a specific time so she didn't actually know when the	F 309			

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F 309	Continued From page 10 resident's symptoms had started. Staff G hadn't contacted the doctor - why would she? The 2/13/17 fax was back when Staff G arrived at 2:00 PM. Staff spoke with the resident's POA. Staff G read the doctor's response to the POA, and asked if the POA wanted to do anything further. The POA declined. Staff G thought that she had spoken with the POA after supper. Staff G stated that she had assessed Resident # 2 the evening of 2/13/17, probably at the start of the shift. Staff G expressed dismay that she hadn't documented the assessment after the surveyor read the 9:30 PM 2/13/17 entry. When assessed, Resident # 2 was unable to lift her right arm, but had a little bit of a grip. The resident also had a little bit of left sided facial drooping, not right sided. The resident was able to drink but coughed with her medications. The resident's speech was clear. Staff G thought that Resident # 2 was currently doing better. Today, the resident was able to lift his/her right arm above his/her head, and fed himself/herself at breakfast. Staff F, a CNA, was interviewed on 2/21/17 at 1:21 PM. Before 2/13/17, Resident # 2 could walk to the bathroom with a walker and stand by assistance. The resident probably couldn't walk as far as the dining room. Staff F stated on 2/13/17, she got Resident # 2 up around 6:45 to 7:00 am. Resident # 2 said he/she was too tired to get up out of bed. The resident needed a lot more help to get to the wheelchair, as he/she could only partially bear weight. Staff F stated she had to get help to get the resident to the bathroom. This was unusual. Staff F didn't really look at the resident's face. Staff F took Resident # 2 out to the main dining room after completing cares. Staff F told the nurse, possibly Staff A. Staff F also passed on this information to the	F 309			

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F 309	Continued From page 11 oncoming evening shift CNA. Staff F stated Resident # 2 usually didn't eat much, but was having more trouble that day. Resident # 2 was choking and coughing consistently on nectar thick fluids. The resident had some issues already with his/her right hand, but had a lot more that meal. If one of the CNAs lifted the resident's right hand, and let go, the arm fell back into the resident's lap. The resident wasn't using his/her right hand. Staff F fed Resident #2. It was unusual for the resident to need to be fed. Staff F thought she had spoken to Staff A around 7:15 am. Staff F told the nursing that the resident was weak, and needed 2 staff to transfer. This needed to be passed on to the second shift nurse. After breakfast, another CNA, Staff B, noticed that Resident # 2 was having facial drooping. Staff B took the resident out to the nursing station. The nurse was possibly on a break, so staff F found Staff C. Staff F thought this was around 9:00 am. Staff F watched Staff C assess Resident # 2. Staff C spoke out loud. Staff C said that Resident # 2's right hand grip was weaker. If Staff C lifted Resident # 2's right hand, it would just fall because the resident didn't have the strength to keep it up. The same thing happened when Staff C lifted the resident's right leg. Staff C told the resident, "don't just let me push it", and the resident's leg fell. Staff F left to go answer lights after Staff A arrived. Resident # 2 stayed out at the desk. Staff C stated Resident # 2 was having signs of a stroke. Staff A said there wasn't much to do for the resident and that Resident # 2 was now assist of 2 staff. Staff A also said the family didn't want Resident # 2 sent to the hospital. Staff F told the oncoming shift	F 309			

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F 309	Continued From page 12 that Resident # 2 was now required the assistance of 2 staff members. During a 1:50 PM interview on 2/22/17, the Director of Nursing, (DON) stated not knowing if the facility had a specific policy for physician notification. It was up to nursing judgement to decide how to notify the doctor. The DON expected the nurses to call versus fax if that the concern needed immediate attention. During a 3:34 PM interview on 2/22/17, the resident's doctor stated that he was a resident who worked under faculty supervision. The residents and faculty took turns covering for each other. The doctor was not the one that was notified and responded to the 2/13/17 fax. The doctor couldn't answer if it would have been more appropriate to call versus faxing. However, if a resident had similar progressing symptoms, the doctor thought it would be appropriate to send the resident to a higher level of care for an evaluation. Staff B was interviewed on 2/25/17 at 10:31 am. Staff B stated that prior to this incident; Resident # 2 used a walker to walk to and from the bathroom. The resident fed him/herself. He/she may have hurt one wrist as he/she sometimes had trouble gripping with that hand and said it hurt. The resident could, however, move both arms. On the day of the incident, Staff B didn't get report on Resident # 2 as Staff B was assigned to different residents. After breakfast, Staff B noticed that one side of Resident # 2's face was drooping. Staff B didn't remember which side. Also, the resident's dominant side seemed weaker. Staff B and another staff member took	F 309			

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

PRINTED: 03/17/2017
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 165345	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 03/07/2017
NAME OF PROVIDER OR SUPPLIER PARKRIDGE SPECIALTY CARE			STREET ADDRESS, CITY, STATE, ZIP CODE 5800 NE 12TH AVENUE PLEASANT HILL, IA 50327		
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F 309	Continued From page 13 Resident # 2 out to the nursing station. Staff B told the other staff member to notify both Staff A and Staff C of the resident's symptoms. Staff B stated that Staff A didn't always follow through on concerns, so she wanted staff C also notified. Staff B then left the area. Staff B saw the resident later that day at lunch. Resident # 2 couldn't lift up the affected hand. Staff B also said something to the facility administrator regarding the resident now possibly needing to eat in the assisted dining room. At 9:08 am, on 2/20/17, Resident # 2 was observed sitting in a wheelchair in the assisted dining room. The resident was using his/her left hand to eat. The resident did not move his/her right arm/hand. The resident sat angled away from the surveyor so his/her face was not fully visible. The resident's face looked asymmetrical. On 02/21/17, at 8:04 am, Resident # 2 was again sitting in the assisted dining room. The resident's face drooped on the right side. Note: At the time of the complaint investigation, the complaint was coded at a "J", immediate and serious jeopardy. By 2/22/17, the facility had implemented measures that adequately addressed the jeopardy and the grid placement was lowered to the "D" level. The facility provided in-services to the nurses. The nurses received education about the change of condition evaluation assessment form (previously known as SBAR) must be completed on every resident with an acute condition change when contacting the physician by a telephone. The nurses received direction they must contact the physician by telephone instead of fax with any acute condition change that required physician intervention, regardless of family decision for	F 309			

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F 309	Continued From page 14 treatment. As of the 2/27/17 exit conference, the facility continued to need to: Continue to monitor the licensed nursing staff compliance with the use of the Change in Condition Evaluation form and informing physician's by telephone for any acute condition changes.	F 309			

This plan of correction constitutes our credible allegation of compliance. Deficiency F309 was corrected on 2/22/17.

F309

It continues to be the policy of Parkridge Specialty Care to provide the necessary care and services to attain or maintain the highest practicable, physical, mental and psychosocial well being in accordance with the comprehensive assessment and plan of care.

Resident #2's physician was notified and aware of their acute condition. Appropriate physician notification will be done for all residents with condition changes.

Nurses were educated on the change of condition evaluation assessment form that they must complete on each resident with an acute condition change. They were also directed to call the physician by telephone instead of fax with any acute condition change that required physician intervention, regardless of family decision for treatment. This education was completed on 2/22/17 during the survey. A revised monitoring system was implemented and acknowledged by nurses by 3/12/17.

Monitoring will be a part of the facility's QA process.