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	165235	A. BUILDING _____ B. WING _____	C 04/18/2017

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LENOX CARE CENTER	111 EAST VAN BUREN LENOX, IA 50851

(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 05/10/2017 Investigation of facility-reported incident #67272-I resulted in deficiency. See Code of Federal Regulations (42CFR) Part 483, Subpart B-C.	F 000	This plan of correction does not constitute admission or agreement by the provider of the truth of the facts alleged or the conclusions set forth in the statement of deficiencies. This plan of correction is prepared solely because it is required by State and Federal Law. F000: Deficiencies Corrected by 05/10/2017	
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	F 309 It is the practice of the facility to ensure staff follow policy and procedures on timely interventions for all residents 1.For resident #1, staff were educated between March 30, 2017 and April 10, 2017 to provide timely interventions to resident number 1 if resident's condition changes. 2.For all similar residents, staff were educated between March 30, 2017 and April 10, 2017 to provide timely interventions to all other residents if resident's condition changes. 3.The Director of Nursing or designee will conduct random audits to ensure staff are following policy and procedures 3 times per week for 3 weeks, then weekly for a minimum of 3 months and randomly thereafter. 4.Results of the audits will be reported monthly for a minimum of 3 months to the facility QAPI committee for tracking/trending to ensure ongoing compliance.	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Julie Brown — TITLE: Administrator — (X6) DATE: 5-9-17 ~~05/02/2017~~

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.

POC accepted 5/10/17 SK

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F 309	Continued From page 1 (l) Dialysis. The facility must ensure that residents who require dialysis receive such services, consistent with professional standards of practice, the comprehensive person-centered care plan, and the residents' goals and preferences. This REQUIREMENT is not met as evidenced by: Based on clinical record review, interviews with the on-call physician assistant (PA), radiologist and staff, the facility failed to provide timely intervention for 1 of 4 residents (Resident #1). Staff documented the resident had pain and swelling in his/her knee from 3/23/17 until a knee fracture was discovered on 3/29/17. Resident #1 received pain medication which was effective except with movement. Staff assessed the area during this time, and reported they faxed the physician. The initial fax communication could not be located and was not received by the physician; and no one followed up with the physician until 3/29/17 when an X-ray showed a fractured knee with treatment for a knee immobilizer. The facility reported a census of 30 residents. Findings include: Resident #1's Minimum Data Set (MDS) with an assessment reference date (ARD) dated of 1/16/17 identified he/she had diagnoses of a left knee replacement, osteoarthritis, trigeminal neuralgia, history of falls, spinal stenosis and non-Alzheimer's dementia. The staff assessment for mental status revealed the resident had severe cognitive impairments with short and long term memory problems. The resident needed the assistance of 2 staff for transfers, bed mobility, and 1 staff for mobility.	F 309		

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A care plan with focus area dated 3/12/14 identified risk for pain related to trigeminal neuralgia, spinal stenosis and degenerative arthritis.
The interventions included monitor for increased signs and symptoms of pain and report to charge nurse and medical doctor (MD) if needed. A focus area dated 4/20/10 identified risk for falls related to dementia, safety awareness, weakness, spinal stenosis and a history of self-transfer. The interventions directed staff to keep the bed a low position, bolsters to bed and fall mat on floor when bed is occupied.

A progress notes dated 1/13/17 revealed Resident #1 totally dependent on staff for all activities of daily living (ADLs). Resident #1 unable to perform daily tasks used a wheelchair for mobility that staff propels. Staff transfers Resident #1 with a mechanical lift and 2 staff assistance.

The Medication Administration Records (MARs) for 3/1/17 to 3/31/17 documented physician orders for pain medications and dates of administration as follows:

1. An order dated 9/23/16 for Motrin 400 Milligrams (mg), every 6 hours as needed (prn); which was administered on 3/22/17 to 3/24/17 and on 3/27/17 to 3/29/17.
2. An order dated 3/30/17 for Motrin 400 mg, twice daily; administered on 3/31/17 and stopped on 4/2/17.
3. An order dated 9/23/16 for Acetaminophen (APAP) 650 mg - every 4 hours prn; administered on 3/22/17, 3/23/17, 3/26/17 and twice on 3/29/17.

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F 309	Continued From page 3 4. An order dated 3/30/17 for APAP 650 mg 4 times daily for pain; administered only twice on 3/31/17. 5. An order dated 3/30/17 for Morphine Sulfate .25 milliliters (ml) every 4 hours prn; not administered. MARs for March 2017 revealed staff assessed pain levels completed twice daily 3/1/17 to 3/19/17 recorded no pain (0) using a pain scale of 1-10, with 10 being the highest pain level. Pain assessments completed on 3/20/17 to 3/31/17, documented pain levels as ranging from a low of 2 and a high of 7. A review of effectiveness of prn pain medications - Motrin and Tylenol given on 3/22/17 to 3/30/17 had been documented as effective. The MARs for 4/1/17 to 4/18/17 documented the physician order's and dates of administration as follows: 1. An order dated 4/2/17 Motrin suspension (Ibuprofen) 400 mg twice daily for pain; administered on 4/1/17 to 4/2/17. 2. An order dated 4/2/17 Motrin suspension 400 mg twice daily for pain; administered on 4/3/17 to 4/13/17. 3. An order dated 4/4/17 APAP 650 mg 4 times daily for pain; administered on 4/1/17 to 4/2/17. 4. An order dated 4/2/17 APAP 650 mg 4 times daily for pain give and give rectally if the resident won't take orally; administered on 4/3/17 and 4/4/17. This order discontinued 4/4/17. 5. An order dated 9/23/16 for APAP liquid 650 mg every four hours prn for pain; not administered for April 2017. 6. An order for Morphine Sulfate .25 milliliters (ml) every 4 hours prn. A review of effectiveness	F 309		

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F 309	Continued From page 4 of prn pain medications - Morphine Sulfate given 4/3/17 to 4/4/17 had been documented as effective Staff assessed pain levels completed twice daily 4/1/17-4/13/17 recorded pain levels ranging from no pain (0) to 7 entries ranging from 1-4, using a pain scale of 1-10. Pain assessments were not completed for scheduled pain medication administration. Progress notes dated 3/22/17 at 12:05 a.m. documented Motrin 400 mg given for pain as the resident crying in pain in h/her legs when repositioned. Notes dated 3/23/17 at 11:29 a.m. revealed staff observed left knee edematous, hot to touch but no redness at knee or leg. No signs of discomfort with movement at hip or ankle, only at knee with flexion and extension. Progress notes dated 3/23/17 at 11:29 a.m. documented the resident had left knee discomfort during cares. Observed left knee edematous, hot to touch but no redness at knee or leg. No signs of discomfort with movement at the hip or ankle, only at the knee with flexion and extension. The resident is unable to fully extend either knee due to contractures. The resident received prn APAP and Motrin and will continue to monitor. Progress notes dated 3/24/17 at 3:10 a.m. documented the resident's left knee remained edematous with no increased redness or increased warmth and no signs or symptoms of pain. Notes dated 3/24/17 at 11:13 a.m. revealed the left knee remained swollen, no redness or warmth. The resident complained of pain with movement and prn pain medications given as ordered, staff awaiting physician's reply.	F 309		

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F 309	Continued From page 5 Progress notes dated 3/25/17 at 1:52 a.m. documented left knee remains swollen and tender to touch indicated pain with movement with no increased redness or warmth noted. Staff will continue to administer Ibuprofen 400 mg prn and waiting for response from physician. Staff will continue to monitor and keep the resident as comfortable as possible. Progress notes dated 3/27/17 at 1:03 a.m. documented the resident's left knee remained swollen and tender to touch, no redness noted and prn APAP given for pain. Notes of the same date at 10:44 a.m. documented the resident's left knee edematous, warm to touch, no redness to area and appeared to have fluid on the medial side. Staff administered Ibuprofen prn. Progress notes dated 3/28/17 at 3:40 p.m. documented the resident's left knee remained swollen, no redness or warmth noted. The resident continues to wince and complain of pain with movement. Utilized prn pain medications as order and will continue to monitor. Progress notes dated 3/29/17 at 8:55 a.m. documented above the resident's left knee as edematous and warmer than his/her thigh and foot; and there was no redness to the knee. Facility staff phoned the physician's assistant (PA), as the resident's physician was on leave and ordered a portable X-ray. Progress notes dated 3/29/17 at 11:37 p.m. documented a physician's order for APAP 325 mg - 2 tablets every 6 hours. An X-Ray report dated 3/29/17 documented an exam of the left knee	F 309		

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demonstrated oblique fracture of the distal femoral diaphysis with overriding fracture fragments. The fracture appeared to extend to the anterior margin of the femoral prosthesis status post total knee arthroplasty. The tibia and fibula are intact with vascular calcifications and soft tissue swelling. The fracture is presumably acute.

Progress notes dated 3/30/17 at 7:50 p.m. documented a nurse accompanied the resident to the appointment and the physician's PA did not look at the resident's knee or perform any ROM; but looked at the x-ray report. The resident returned to the facility with an order to wear an immobilizer to the left knee at all times and complete skin checks for evidence of skin breakdown. The resident's primary physician was notified of the resident's appointment and in agreement with the new orders. Staff documented the immobilizer was in place to the left knee with routine medications given and showing no signs or symptoms of pain or discomfort.

Hospital orthopedics and sports medicine progress notes dated 4/4/17 at 3:23 p.m. revealed the resident seen 3/30/17. The resident was unable to communicate, so all communications are done through h/her caretaker from the facility. The caretaker (identified as the assistant director of nursing at the time of this visit) reported 2 weeks earlier the patient began grabbing h/her left knee and acting like h/she had pain about his/her knee. A physical examination revealed the resident grimaces with palpation. The caretaker's questions about the possibility of moving the resident or transferring could cause the fracture.

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F 309	Continued From page 7 The PA stated it is reasonable this could happen as the resident had significant amount of arthritis; however, the physician documented he did not think he could rule out this being caused by a traumatic injury either. A written statement by the facility's medical director dated 4/3/17 at 1:48 p.m. reported the resident had lived at the facility for many years and swelling an apparent pain with one of the knees had been noted and resulted in an X-ray which showed a displaced fracture of the distal femur. The fracture starts just above a total knee prosthesis placed more than 20 years ago. A concern that the resident may have been dropped from the Hoyer lift, but the nursing home staff denies any incidents of trauma. The most credible explanation for the fracture is severe osteoporosis. The minor stress involved in positioning the legs or using a Hoyer lift would not result in any damage to normal bones but can cause fractures in "brittle" ones. There have been no observed bruising, tears, burst lacerations or shearing injury to the skin of the involved knee. A fall would result in one of these types of skin trauma, but a stress fracture would not. The fracture is a result of the resident's advanced age and natural disease. Twenty-four hour (24hr) Nursing Report dated 3/23/17 documented the resident's left knee edematous, hot and pulses present and the doctor faxed. The 24 hour Nursing Report dated 3/24/17 documented the resident's left knee edematous - doctor faxed. The 24 hour Nursing Reports dated 3/25/17-3/29/17 documented daily the resident's left knee swollen. During an interview by phone dated 4/17/17 at	F 309		

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F 309	Continued From page 8 9:34 a.m., the resident's PA reported she never received a fax or notification from the facility regarding the resident's left knee or hip. It wasn't until 3/29/17 when the facility requested an order for an X-ray of the resident's left leg that she knew of the resident's swollen left knee and thigh. A written statement without a date listed, Staff A, a registered nurse (RN) reported she worked of 3/21/17-3/22/17 from 6:00 p.m. - 6:00 a.m. During routine 1st rounds with a CNA both changed the resident's incontinent undergarments and repositioned the resident. She noted the resident's left knee appeared swollen compared to the right knee. An additional written statement dated 3/29/17, Staff A reported the night of 3/21/17 she reported the resident's knees always looked swollen but the resident complained of pain. She gave the resident Motrin and noted bruising behind the knee. During an interview dated 4/17/17 at 4:12 p.m. Staff A reported she had taken care of the resident for the last five years and the resident's knees would be slightly swollen. The resident had commented in the past, when h/she had higher cognition would tell her it really didn't bother h/her. She reported to the on-coming nurse to monitor the resident's knee for any changes. A written statement dated 4/3/17 at 2:00 p.m., Staff B, a certified nursing assistant (CNA) reported the night of 3/22/17 the resident had a swollen left knee. A nurse gave the resident pain medication. She reported she had never noticed any bruising on the resident's thigh or any other	F 309		

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F 309	Continued From page 9 part of his//her leg. A written statement dated 3/29/17, Staff C, CNA, reported on 3/23/17 the resident complained of leg pain. She felt the resident's knee and noted it was warm to the touch. She reported her findings to the nurse. She reported it is not normal for the resident to complain of leg pain as she provided personal cares on a daily basis. During an interview dated 4/17/17 at 11:10 a.m., Staff C reported she confirmed the accuracy of her written statement of 3/29/17. She reported the resident didn't complain of pain unless h/she did not want to do something staff wanted h/her to do. On 3/23/17 she repositioned the resident and the resident pointed to h/her knee and said h/her left leg hurt. A written statement dated 4/3/17 at 12:15 p.m., Staff D, CNA reported on 3/23/17 at 2:00 p.m. she received beginning of shift report and told the resident's knee remained swollen and the resident complained of pain when moved. She reported she had been told nursing staff had already been notified. On 3/25/17 at 7:00 a.m. she asked to Staff E, a licensed practical nurse (LPN) to assess the resident's thigh as it appeared swollen. Staff E assessed the resident's thigh and told Staff D she would contact the resident's physician. A written statement dated 330/17 at 2:45 p.m., Staff F, CNA reported the resident complained of pain to h/her left leg when she had assisted the resident with dressing the morning of 3/30/17. During an interview dated 4/18/17 at 8:02 a.m. she stated the swelling of the resident's leg isn't normal and the resident's crying sounded	F 309		

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different. She knew of no incident of the resident injuring h/her knee or leg.

During an interview dated 4/13/17 at 1:17 p.m., Staff G, LPN reported she had sent a copy of the progress note dated 3/23/17 at 11:29 a.m., by fax to the physician assistant (PA), as the resident's physician had been on maternity leave. She reported she hadn't heard back from the physician that day. She reported she didn't return to work until 3/27/17 and worked 3/28/17, 3/29/17 and again on 3/31/117 but hadn't checked to see if the PA had responded. She reported the fax she had sent could not be located. The PA and the clinic had reported they never received a fax from the facility or notification of the resident's change in status until 3/29/17 when another nurse had requested an X-ray of the resident's left leg and knee.

During an interview dated 4/17/17 at 11:50 a.m., the Acting Director of Nursing reported she couldn't explain why the facility did not have a copy of the fax that had been sent on 3/23/17 as reported by Staff G. She reported the 24 hour Nursing Reports showed facility staff were aware of the resident's swollen left knee and the pain h/she had been experiencing, but the facility failed to contact the PA when the PA hadn't responded to their fax of 3/23/17. She reported she expected staff to follow-up with the resident's provider if the provider hadn't contacted them. She provided a copy of a facsimile report showing a fax had been sent on 3/23/17 at 11:41 to the PA, but she couldn't verify if that fax date had been the fax sent to the PA regarding the resident's status.
The Acting Director of Nursing reported she reviewed (during this investigation) the resident's

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F 309	Continued From page 11 chart and 24 hour. Nursing Reports and couldn't find any documentation of the resident's PA notified regarding the written statement by Staff D regarding the observation she made of the resident's left thigh being swollen on 3/25/17. Staff D reported she requested the nurse (Staff E) on duty to assess the resident left thigh. Staff E did assess the resident and told her she would fax the resident's physician. The acting director of nursing reported the statement made in hospital orthopedics and sports medicine progress notes dated 4/4/17 at 3:23 p.m. were inaccurate. She reported she accompanied the resident to appointment and reported staff had noticed the resident had some discomfort during repositioning and the resident's knee had some swelling on 3/22/17 or 3/23/17. When the resident's knee appeared to look out of place the facility requested an X-ray be taken. At no time did she report the resident had been grabbing h/her knees in pain two weeks prior. The resident had never done that prior to or since it happened. During a phone interview dated 4/18/17 at 10:45 a.m., the previous Director of Nursing reported it was her responsibility to check the 24 hour Nursing Reports daily, which she did on the days she worked. On the days she didn't work the Assistant Director of Nursing has this responsibility. She stated she hadn't called the PA who had been contacted on 3/23/17 regarding the resident's change in health status. She stated she didn't recall seeing the fax that had been sent on 3/23/17. During an interview dated 4/18/17 at 11:55 a.m., the Acting Director of Nursing reported she was the assistant Director of Nursing until 4/10/17	F 309		

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LENOX CARE CENTER	111 EAST VAN BUREN LENOX, IA 50851

(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 12 when the Director of Nursing (DON) resigned. As the assistant director of nursing she is responsible to review the 24 hour Nursing Reports when the DON is not in the building but she did not review the reports and therefore didn't follow-up with the PA who the facility had contacted on 3/23/17 regarding the resident's change of health status. A review of Resident #1's clinical record revealed no documentation of staff notifying the PA. Staff E could not be interviewed as she was out of the country and unavailable. During a phone interview dated 4/18/17 at 1:20 p.m., the Orthopedic PA who had seen the resident on 3/30/17 reported a delay in receiving treatment would not have a negative outcome of his/her health status as he/she received the course of care as ordered on 3/30/17. During a phone interview dated 4/18/17 at 1:30 p.m. the radiologist who interpreted the X-ray of the resident's left leg dated 3/29/17 stated despite the resident's age and diagnosis of osteopenia, some kind of force, a traumatic injury, a force such as a fall or movement caused the leg fracture.	F 309		