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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	165174	A. BUILDING ______ B. WING ______	04/20/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CASA DE PAZ HEALTH CARE CENTER	2121 WEST 19TH STREET SIOUX CITY, IA 51103

(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 5/5/17 The following deficiencies were identified during the facility's annual health survey and investigation of complaint # 67511-C. See the Code of Federal Regulations (42CFR) Part 483, Subpart B-C.	F 000	See attached.	
F 241 SS=D	483.10(a)(1) DIGNITY AND RESPECT OF INDIVIDUALITY (a)(1) A facility must treat and care for each resident in a manner and in an environment that promotes maintenance or enhancement of his or her quality of life recognizing each resident's individuality. The facility must protect and promote the rights of the resident. This REQUIREMENT is not met as evidenced by: Based on observation, record review, family and staff interviews, the facility failed to treat Resident #10 with dignity and respect when caring for the resident. The sample consisted of 13 residents and the facility reported a census of 63 residents. Two facility staff members sat in recliners while on cell phones (talking or viewing) and Resident's call light was activated for 10 minutes. The family went to the staff for assistance. The 2 staff members placed a morbidly obese resident onto a standard commode. The resident had hip surgery and had dressing on the hip area. The resident's hips and back stuck out on the sides and back of the commode. The resident voiced discomfort and yelled out in pain. Findings included:	F 241		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: [signature] TITLE: Administrator (X6) DATE: 5/8/17

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.

POC accepted 5/10/17 [signature]

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F 241	Continued From page 1 1. Resident #10 had an After Visit Summary (discharge instructions from the hospital), dated 4/12/17. The form identified the resident had diagnosis including acute chronic respiratory failure with hypoxia (diminished availability of oxygen to the body tissues) and hypercapnia (elevated carbon dioxide levels in the blood), smoking, morbid obesity with body mass index (BMI) of 50.0-59.9, acute chronic diastolic congestive heart failure, hypertension (elevated blood pressure), diabetes mellitus with long term use of insulin, hypothyroidism (decrease in thyroid functioning), chronic obstructive pulmonary disease (lung disease), acute kidney injury, obstructive sleep apnea (breathing issues while sleeping), acute encephalopathy (a disease of the brain in which an agent effects the brain) and intertrochanteric fracture of the left femur (thigh bone). The same summary documented the resident weighed 308 pounds and 10.3 ounces. Review of a consultation revealed an open reduction internal fixation of the left hip (repair of fracture) performed on 4/3/17. On 4/17/17 at 3:40 PM, the resident's family member was interviewed and stated the resident put on the call light for assistance to the bathroom. After about 10 minutes, the family member stated she went out in the hall and observed 2 staff members in recliners viewing or talking on their cell phones. The staff came to the resident's room and attempted to place the resident on a standard size commode. The family member stated she stepped out of the room, but the another family member remained in the room. The family member stated she could hear the resident screaming out into the hall area. The resident's family also reported the resident	F 241		

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F 241	Continued From page 2 became unresponsive on 4/17/17 while the family was present. During an interview with another family member on 4/19/17 at 3:40 PM, she stated she was in the resident's room when 2 staff [identified as Staff E and Staff F] attempted to place the resident on a standard size bedside commode. She stated the two staff assisted the resident with a gait belt to pivot and sit on the commode. The family member stated the resident voiced he/she didn't fit. The resident was sticking out through the sides and back of the commode. The family member asked the staff if the facility had a bariatric commode. Staff F stated "Like what?" Staff E left the room to look for a bariatric commode. During this time the family member described the resident as moaning and hollering. The staff left the resident on the standard size commode while Staff E left the room to search for the larger commode. The family member stated the resident was upset. Staff E returned and stated there was no bariatric commode. The two staff transferred the resident back to the bed and decided to use a bedpan. The family members filed a grievance with the facility on 4/14/17. The report indicated the family felt as though staff that worked with the resident showed no compassion towards her/him and displayed unhelpful attitudes and making inappropriate comments. During an interview with Staff F (certified nursing assistant) on 4/20/17 at 8:30 AM, she stated on the day of the commode incident, she asked the resident if it was ok to use the commode. Staff F stated she obtained approval from the therapy department if the resident could transfer with the	F 241		

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F 241	Continued From page 3 assistance of 2 staff and a gait belt. Staff F stated she got Staff E to assist her transferring the resident onto the commode. Staff F stated the commode was little small. Staff F asked Staff E to go look for a larger commode. At this time the resident was repeating, "I'm hurting, I'm hurting". Staff F stated the resident's hips were sticking out [of the sides of the commode], but she left the resident on the commode because the resident agreed to. Staff F stated they had to pull the commode off the resident's hips. Staff F stated there were 2 ABD (non-stick highly absorbent pad) dressings on the left hip incision. Staff F stated at this time the resident's daughter was upset and the resident hyperventilated. Staff F stated Staff E couldn't find a large commode. Staff F stated usually the clean commodes are downstairs in the utility room. The staff then decided to let the resident use a bedpan. Staff F stated she worked the day the resident was admitted. During an interview with the Director of Nursing (DON) on 4/20/17 at 8:50 AM, she stated Staff E and Staff F reported to her that the family was upset over the commode incident. She stated the family filed a grievance and concerned the staff didn't display compassion and observed the 2 staff on their cell phones instead of answering call lights. The DON stated the staff are not to use their cell phones while working. During an interview with the DON on 4/19/17 at 10:30 AM, she stated the facility has bariatric commodes and could get one if needed. The DON stated the staff thought they could use a standard size commode for Resident #10. Observation on 4/19/17 at 1:40 PM revealed	F 241		

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F 241	Continued From page 4 there was a bariatric commode in room 205 and room 211. Staff G (registered nurse) looked for a bariatric commode and unable to find one. The policy and procedures titled Cell Phones and Related devices, dated 7/1/15, directed the staff that the use of personal cell telephones in the workplace was not allowed. The commode's manufacturer's product specifications identified the commode (Invacare I Class All in One Commode) identified the weight capacity of 350 pounds with a seat width of 13.75 inches and seat surface depth of 16.5 inches.	F 241		
F 281 SS=E	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 clinical record review and staff interview, the facility failed to follow physician orders to weigh residents complete dressing changes and/or provide pain relieving medications in amounts that minimized potential complications for 5 of 13 current residents reviewed (Resident # 3, #4, #8, #12 and #13). The facility identified a census of 63 residents. Findings included: 1. A Diagnosis Report form dated 4/19/17 recorded Resident #3's diagnoses included heart failure and kidney failure.	F 281		

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F 281	Continued From page 5 A Minimum Data Set (MDS) assessment dated 3/23/17 identified the resident entered the facility on 3/16/17. A History and Physical/Final Report form dated 3/6/17 revealed a physician documented the resident required admission to a hospital on 3/6/17 with an assessment of acute congestive heart failure and acute on chronic renal disease. A Patient Discharge Instructions form dated 3/16/17 revealed a plan for the resident to be discharged from the hospitalization described above, and included orders for daily weights and to call a physician with a weight gain of 3 or more pounds (lbs) in 1 day. A Physician Clinic Sheet form dated 4/3/17 revealed an order to continue daily weights and call a physician with a weight gain of 3 lbs. or more in 1 day. Facility staff noted the order on 4/3/17. Review of Resident #3's record revealed staff failed to weigh the resident as follows (for 17 of 32 days after admission): March 2017- 17, 18, 27, 28, 29, 30 and 31. April 2017- 1, 2, 3, 10, 12, 13, 14, 15, 16 and 17. 2. A Diagnosis Report form dated 4/19/17 recorded Resident #4's diagnoses included dependence on renal dialysis and heart failure. The MDS assessment dated 4/3/17 identified the resident admitted to the facility as 3/28/17. The MDS revealed the resident required dialysis services.	F 281		

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An After Visit Summary report form, revealed the resident had a hospital stay (prior to admission to the facility) from 3/7/17 - 3/28/17. The Summary form revealed the reasons for the hospital stay included severe sepsis (an infection spread throughout the body), congestive heart failure and acute kidney injury.

An Order Summary Report form dated 3/30/17 ordered daily weights for Resident #4.

Review of Resident #4's record revealed staff failed to weigh the resident as follows (for 11 of 20 days after admission):
a. March 30.
b. April- 1, 2, 8, 9, 10, 12, 13, 14, 16 and 17.

3 A Diagnosis Report form dated 4/19/17 recorded Resident #13's diagnoses included artificial knee joint, Methicillin susceptible staphylococcus aeurus infection and diabetes mellitus.

The resident's MDS assessment dated 4/9/17 identified s/he entered the facility as 3/24/17.

Review of a History and Physical Final Report form dated 3/151/7 revealed the resident required hospitalization on 3/15/17 due to and including acute sepsis and left prosthetic (artificial) knee joint septic arthritis.

A Clinical Summary report form dated 3/24/17, revealed the resident's admission date to the hospital on 3/15/17 and a discharge date from the hospital on 3/24/17. The same report form included instructions to change the resident's left knee dressing every day.

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F 281	Continued From page 7 Review of a Dismissal/Intragency Instruction Sheet, signed by a physician on 4/3/17, included instructions to change the resident's PICC line (peripherally inserted central catheter; a flexible tube inserted into a vein in the upper arm and ending in a large vein in the chest) dressing every Tuesday and noted the last dressing change as 3/27/17. Review of Resident #13's Treatment Administration Record (TAR) form dated 3/1 to 3/31/17, revealed staff failed to place the entries on the TAR for the left knee dressing change until 3/27/17, 3 days after the resident's admission to the facility. Because the dressing change had not been entered on the TAR until 3/27/17, the facility lacked documentation the dressing change had been completed on 3/25 and 3/26. Further review of the TAR revealed staff failed to change the dressing on the resident' left knee on 3/27 and 3/29/17. Review of a TAR dated 4/12017 - 4/30/2017 revealed staff failed to change the dressing on the resident's left knee on 4/5, 4/7, 4/8, 4/12 and 4/17/17. Review of the same TAR revealed staff failed to complete weekly PICC line dressing changes as scheduled on 4/11/17 and 4/18/17. During interview on 4/19/17 at 12:10 P.M., the Director of Nursing (DON) stated she expected weights and dressing changes to be documented as ordered on a resident's TAR. The DON confirmed staff failed to enter the Resident #13's left knee dressing change until 3 days after admission to the facility and offered no explanation for the lack of entry. 4. The MDS assessment dated 3/6/17	F 281		

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F 281	Continued From page 8 documented Resident #12 had diagnoses that included hypertension, peripheral vascular disorder, hyperlipidemia, anxiety disorder, depression, manic depression, psychotic disorder, Guillian-Barre syndrome, borderline personality disorder, and pseudo-bubular affective disorder. The MDS identified the resident with a Brief Mental Status score of 15 indicating intact cognitive functioning. The MDS documented the resident verbalized almost constant pain rated 8 on the pain scale of 1-10, disrupting sleep and day to day activities. Review of the Medication Administration Record (MAR) dated 4/1/17-4/30/17 revealed the following duplicate medications administered: a. Arthritis pain tablet ER (extended release acetaminophen, a pain relieving medication 650 milligrams (mg) one tablet 2 times per day; (totaling 1300 mg in 24 hours) with a start date of 3/12/17. b. Tylenol (acetaminophen) ES (extra strength) tablet 500 mg two tablets 3 times per day; (totaling 3000 mg in 24 hours) with a start date of 4/12/17. c. Acetaminophen 650 mg one tablet administered every 6 hours as needed for pain (totaling 650 mg) with a start date of 10/5/15). Review of the same MAR revealed staff administered a total of 4300 mg of Acetaminophen to the resident on 4/13/17 - 4/18/17 within each 24 hour period. Review of physician order on a clinical visit summary form dated 4/12/17 revealed a type	F 281		

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written order for Tylenol 1000 mg three times a day for the next 2 weeks, then back to 650 mg twice a day.

Review of the order details form revealed the Tylenol ES (500 mg) 2 tablets three times day was created by Staff D, registered nurse (RN) on 4/12/17 at 16:16 (4:16 PM).

During an interview with the DON on 4/19/17 at 9:45 AM, she reviewed the MAR and stated the resident had a physician visit 4/12/17. The DON stated the MAR went to the appointment with the resident. She stated the physician or the nurse should have caught the error.

During additional interview with the DON on 4/19/17 at 10:40 AM, she presented a copy of the physician order on a clinical visit summary form dated 4/12/17 for Tylenol 1000 mg three times a day for the next 2 weeks, then back to 650 mg twice a day; not both scheduled Tylenol orders. The DON stated that usually she or the Assistant DON check the physician orders.

Review of information from www.tylenol.com/safety-dosing/usage/dosage-for-adults website dated 2016, the manufacturer guidelines instructed that to encourage safe use of acetaminophen, the makers of Tylenol have lowered the maximum daily dose for single ingredient ES Tylenol products sold in the United States from 8 pills per day (4,000 mg) to 6 pills per day (3,000 mg). The dosing interval had also changed from 2 pills every 4-6 hours to 2 pills every 6 hours.

5. A MDS assessment dated 3/28/17 recorded Resident #8 had diagnoses that included

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F 281	Continued From page 10 hypertension, peripheral vascular disorder, hyperlipidemia, Non-Alzheimer's dementia, anxiety disorder, depression, chronic obstructive pulmonary disease (COPD), uropathy and low back pain. Review of hospital discharge instructions dated 4/7/17 instructed to weigh daily and if the resident gained 2-3 pounds over night or 4-5 pounds in 5 days, to notify the physician. The same discharge instruction included education on COPD and heart failure. Review of an Order Recap Report dated 4/11/17 revealed a physician order dated 4/10/17 to weigh daily and to notify the physician if the resident gained 2-3 pounds overnight or 4-5 pounds in 5 days. Review of a MAR dated 4/1/17- 4/30/17 revealed documentation of daily weights with a start date of 4/10/17. The MAR documented weights on 4/12/17 and 4/13/17 only. During an interview with the DON on 4/18/17 at 1:42 PM, she stated the weights are documented on the MAR only.	F 281		
F 309 SS=G	483.24, 483.25(k)(l) PROVIDE CARE/SERVICES FOR HIGHEST WELL BEING 483.24 Quality of life Quality of life is a fundamental principle that applies to all care and services provided to facility residents. Each resident must receive and the facility must provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being, consistent with the resident's	F 309		

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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.

(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 and family and staff interviews, the facility failed to provide accurate assessment and assure timely intervention for a resident with adverse changes of condition (Resident #10). The sample consisted of 13 residents and the facility reported a census of 63 residents. Resident #10 arrived at the facility and the staff did not complete a thorough assessment and failed to implement interventions (daily weights, notification of physician of weight gain, ted hose application,

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F 309	Continued From page 12 incision assessments, vitals, etc.). The resident was sent to the emergency room for an unresponsive episode. The resident had abnormal laboratory tests which identified sepsis from a urinary source and required admission into the Intensive Care Unit. The resident received antibiotics intravenously and oxygen therapy with BiPAP. Findings include: 1. Resident #10 had an After Visit Summary (discharge instructions from the hospital), dated 4/12/17. The form identified the resident had diagnosis including acute chronic respiratory failure with hypoxia (diminished availability of oxygen to the body tissues) and hypercapnia (elevated carbon dioxide levels in the blood), smoking, morbid obesity with body mass index (BMI) of 50.0-59.9, acute chronic diastolic congestive heart failure, hypertension (elevated blood pressure), diabetes mellitus with long term use of insulin, hypothyroidism (decrease in thyroid functioning), chronic obstructive pulmonary disease (lung disease), acute kidney injury, obstructive sleep apnea (breathing issues while sleeping), acute encephalopathy (a disease of the brain in which an agent effects the brain) and intertrochanteric fracture of the left femur (thigh bone). The same summary documented the resident weighed 308 pounds and 10.3 ounces. Review of a consultation revealed an open reduction internal fixation of the left hip (repair of fracture) performed on 4/3/17. Review of a consultation report identified the resident had surgery for the fractured thigh left hip on 4/3/17.	F 309		

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The Progress Note dated 4/17/17 at 7:28 p.m. indicated a family member called Staff H (licensed practical nurse) LPN to the resident's room due to the concern they could not awaken the resident. The staff tried several times. The nurse took vital signs and blood sugar check, called the physician and then sent the resident to the emergency room.
Review of the hospital Emergency Department note dated 4/17/17 at 7:46 PM documented the resident presented for an unresponsive episode at the nursing home after being admitted to the nursing home status post fractured hip. The note documented the resident had +3 pitting edema (fluid in skin tissue). The note documented the resident weighed 330 pounds and 14.6 ounces.

The Emergency department notes indicated the resident had bilateral decreased breath sounds, 3 plus edema of both lower extremities and a large surgical wound to the left lateral hip with staples in place with surrounding erythema. Laboratory tests included a white count of 18.39 (normal is 4-10 and indicative of infection), red blood count of 3.06 (normal 4.2-6.2), hemoglobin 8.7 (normal 12-15), hematocrit 31.1 (normal 26-45 %), The differential showed an elevated neutrophil count of 80.9 (normal 42-74%). The lymphocytes low at 9.9 (normal 1.4-6.6). The urine specimen identified a large amount of blood with 100 milligrams of protein and a moderate amount of white blood cells and clumps present. A CT (computerized tomography) scan identified no intracranial hemorrhage, mass, lesions or acute infarct. The x-ray of the chest identified mild pulmonary vascular congestion. The physician ordered Vancomycin and Zosyn (antibiotics) intravenously for sepsis due to urinary source.

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F 309	Continued From page 14 The resident was placed on a Bi-PAP machine for breathing and used oxygen. The resident was transferred to the Intensive Care Unit in stable but guarded condition. Review of the After Visit Summary for Resident #10 dated 4/12/17, instructed the staff to change the dressing [on hip] with dry gauze daily and as needed for saturation. Review of the treatment administration record (TAR) dated 4/1/17-4/30/17 identified instructions for a dressing change to the right hip daily and as needed. (The resident's incision was on the left hip). The TAR documented a dressing change on 4/13/17 and 4/16/17 only. Review of the TAR (Treatment Administration Record dated 4/1/17-4/30/17, directed staff to obtain a daily weight and notify the physician if the resident gained 3 pounds in one day or 5 pounds in one week. The TAR revealed no weights recorded including on admission on 4/12/17. The TAR also directed staff to apply TED (compression hose) during the daytime [hours] and remove in the evening. The TAR documented the TED hose placed on the resident on 4/16/17 only. Review of a nursing admission data collection form dated 4/12/17 at 5:30 AM (note that the resident wasn't admitted until 4/12/17 at 1:31 p.m. per progress note) failed to document an admission weight. Per the resident's After Visit Summary dated 4/12/17 recorded a weight of 308 and the hospital emergency department note dated 4/17/17 recorded a weight of 330; the resident's weight increased by 22 pounds in 5 days.	F 309		

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F 309	Continued From page 15	F 309		

During an interview with the resident's family member on 4/19/17 at 4:05 p.m. she stated the resident felt she was full of fluid and couldn't move very well. The daughter stated she never observed TED (compression/anti-embolism) socks on the resident or that the resident had any TEDs to apply.

The Progress Note dated 4/13/17 at 5:54 p.m. identified an entry by Staff F, certified medication aide (CMA) that the resident did not wear any (TED hose) so at this time no TED hose are on.

On 4/20/17 at 8:47 AM, Staff F was interviewed and stated the resident did not have any TED stockings. Staff F stated the resident's legs were swollen and stiff. She stated she elevated the resident's legs on pillows but did not weigh the resident. The record did not contain an assessment of the edema present except in the hospital Emergency Department note dated 4/17/17 at 7:46 PM when the resident was transported to the hospital in an unresponsive condition.

During an interview with the DON (Director of Nursing) on 4/20/17 at 8:50 AM, she stated it wasn't unusual to see the resident with 3 plus edema. The DON stated the staff could have notified the physician but confirmed they did not.

Review of the progress notes from 4/12/17 through 4/17/17 revealed one entry related to observation of the hip dressing on 4/13/17 at 5:45 AM and recorded the dressing as clean, dry and intact.

Review of a nursing admission data collection

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F 309	Continued From page 16 form dated 4/12/17 at 5:30 AM documented an incision to the left hip with no signs and symptoms of infection with the incision approximated well. The assessment documented different scattered bruises to the bilateral upper and lower extremities. The assessment failed to document any edema or any fracture related to a fall. During an interview with the DON on 4/20/17 at 9:10 AM she stated there were no other skin sheets except the initial assessment on 4/12/17.	F 309		
F 312 SS=D	483.24(a)(2) ADL CARE PROVIDED FOR DEPENDENT RESIDENTS (a)(2) A resident who is unable to carry out activities of daily living receives the necessary services to maintain good nutrition, grooming, and personal and oral hygiene. This REQUIREMENT is not met as evidenced by: Based on clinical record review, observation and staff interview, the facility failed to provide assistance with oral cares and face washing with morning hygiene cares for 1 of 13 current residents reviewed (Resident #1). The facility reported a census of 63 residents. Findings included: 1. A Diagnosis Report form dated 4/19/17 revealed Resident #1's diagnoses included dementia and chronic pain. The Minimum Data Set (MDS) assessment dated 1/19/17 recorded Resident #1 had a Brief Interview for Mental Status (BIMS) score of 7, indicating severely impaired memory and cognition. The MDS revealed the resident	F 312		

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F 312	Continued From page 17 required the assistance of one staff to meet his/her personal hygiene needs. Review of a Long Term Care Status Form dated 4/14/17 revealed the resident began receiving Hospice services on 4/14/17. Observation on 4/18/17 at 10:00 A.M., revealed Resident #1 lied in bed, appeared pale in color and spoke in a weak tone of voice when spoken to. Ongoing observation revealed Staff A, Certified Nurse Aid/CNA and Staff B, CNA prepared to complete the resident's morning hygiene cares. The staff completed the resident's perineal hygiene care while the resident lay in bed. At the conclusion of the resident's perineal hygiene cares, Staff A and Staff B straightened the resident's bedding and placed a call light near the resident. Staff B addressed the resident and stated "...there you go...". Staff A reported the resident's morning hygiene cares as completed. Staff failed to assist the resident to wash his/her face and provided no oral hygiene care for the resident. Observation on 4/19/17 at 7:25 A.M., revealed Staff A and Staff C, CNA prepared to complete Resident #1's morning hygiene cares. While the resident lay in bed, Staff A and Staff B completed the resident's perineal hygiene, re-positioned the resident in bed, placed the resident's call light next to the resident and offered a drink of water. The resident continue to speak in a weak tone of voice. At the conclusion of the resident's morning hygiene cares, staff failed to wash the resident's face and failed to complete oral hygiene cares. During interview on 4/19/17 at 12:10 P.M., the Director of Nursing confirmed she expected staff	F 312		

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F 312	Continued From page 18 to wash a resident's face and complete oral cares with morning hygiene assistance. The DON confirmed washing Resident #1's face and completing oral hygiene may feel good to the resident especially because of the resident's decline in physical condition.	F 312		
F 441 SS=D	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 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;	F 441		

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F 441	Continued From page 19 (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) 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, facility policy review and staff interview, the facility failed to obtain pulmonary tuberculosis (TB) test results at the time of admission and/or failed to administer a	F 441		

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F 441	Continued From page 20 purified protein derivative test (PPD- to identify pulmonary TB), at the time of admission, for 3 of 13 current residents reviewed (Resident #3, #4 and #13). The facility reported a census of 63 residents. Findings included: A facility Infection Control Manual, Tuberculosis Infection Control Plan, with a revision date of 5/2016, included the following : The facility will use a coordinated process to reduce the risk of endemic (rapid spread of infection) and epidemic nosocomial (hospital acquired) infections and will not admit and/or treat residents with active Pulmonary Tuberculosis. Residents will be given a baseline TB screening and a two-step TST (tuberculin skin test) upon admission. 1. A Minimum Data Set (MDS) assessment dated 3/23/17, identified the resident's admission date to the facility as 3/16/17. Resident #3's record lacked documentation of TB testing being completed. 2. The MDS assessment dated 4/3/17, identified the resident's admission date to the facility as 3/28/17. An After Visit Summary form, (with an admission date of 3/7/17 and discharge date of 3/28/17), revealed the resident had been hospitalized prior to admission to the facility. A Pulmonology Consult Note dated 3/12/17, revealed the resident saw a pulmonologist (a physician specializing in lung diseases) during the	F 441		

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F 441	Continued From page 21 same hospitalization described above. The consult note revealed the pulmonologist documented the resident with a metastatic (cancerous) lesion of the lung, most likely secondary to staphylococcus bacteremia and TB less likely, but remotely possible. The pulmonologist documented the resident's need for isolation for TB, the need for a quantiferon blood test (to aid in diagnosing TB) and an acid fast bacilli (AFB/sputum test for suspected TB). Review of Resident #4's record lacked results of the quantiferon blood test and/or TB testing prior to admission. On 4/18/17, the surveyor inquired in regards to the quantiferon blood test and the facility obtained the results. Review of the quantiferon test results, with a collection date of 3/12/17, revealed a negative test result with documentation that stated a negative test alone does not exclude infection with TB. Not until 4/20/17 did the facility receive a progress note from a physician dated 3/15/17. The physician documented the resident's quantiferon test as negative, would assume the lesions on the resident's lungs were due to Methicillin-resistant Staphylococcus Aureus (MRSA) and once the resident's AFB had been finalized, the TB isolation could be discontinued. The facility lacked knowledge of the resident's TB testing results prior to admission and Resident #4's record lacked the documentation of TB testing being completed at the time of admission. The. A MDS assessment dated 4/9/17, identified the resident's admission date to the facility as 3/24/17. Resident #13's record lacked documentation of	F 441		

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F 441	Continued From page 22 TB testing being completed. During interview on 4/19/17 at 12:10 P.M., the Director of Nursing (DON), stated the facility admitting nurse is to obtain an order for a resident's TB test at the time of admission if not on the admission orders. The DON stated she needed to educate the admitting nurse in regards to TB testing.	F 441		

This plan of correction does not constitute an 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.

F241: It is the practice of Casa de Paz to treat residents with dignity and respect.

1. Resident #10 discharged from the facility on 4/20/2017; no further corrective action could be implemented.
2. A chart review of residents in the facility was conducted on 5/4/17 to identify residents who use a commode. Residents who use a commode were assessed for commode size and provided appropriate commode.
3. Staff were educated by DON and Administrator on use of proper commode size and cell phone policy on 4/27/17.
4. The Director of Nursing (DON) or designee will assure ongoing compliance through a weekly review of resident commode size. The Administrator or designee will conduct random audits to ensure cell phone policy compliance. Results of the reviews will be reported to the facility Quality Assurance Performance Improvement committee (QAPI) committee monthly for three months.

   Date of compliance is 5/4/17.

F281: It is the practice of Casa de Paz to follow physician orders.

1. Daily weights for Resident #4 was discontinued on 4/30/17 and for resident #8 was discontinued on 5/5/17; no further corrective action could be implemented. Weight for Resident #8 were obtained on 5/3/17 in accordance with physician's orders. The wound for resident #13 was healed on 5/3/17; no further corrective action could be implemented. Resident #12 receives medications in amounts that minimize potential complications and according to physician order.
2. Residents receive medications in amounts that minimize the potential for complications. Physician orders are followed for all residents. The MARS of residents who take Tylenol and/or hydrocodone were reviewed on 5/5/17 to ensure the amounts minimize the potential for complications. A review of the TARs was conducted to ensure daily weights were obtained for those with orders.
3. Staff were educated By DON and Administrator on following physician orders and providing medications in amounts that minimize potential complications on 4/27/17.
4. The DON or designee will assure ongoing compliance through a random review of TARS. The DON or designee will conduct random audits of dosages of dual therapy medications. Results of the reviews will be reported to the facility QAPI committee monthly for three months.

Date of compliance is 5/5/17.

F309: It is the practice of Casa de Paz to provide accurate assessment and assure timely intervention for residents with adverse changes of condition.

1. Resident #10 discharged from the facility on 4/20/2017; no further corrective action could be implemented.
2. A chart review of residents in the facility was conducted on 5/4/17 to identify residents who required assessments and interventions. Assessments and interventions were provided on 5/4/17.
3. Staff were educated by DON and Administrator on completing assessments and intervention implementation on 4/27/17.
4. The DON or designee will assure ongoing compliance through a weekly review of TARS and assessments. Results of the reviews will be reported to the facility QAPI committee monthly for three months.

   Date of compliance is 5/4/17.

F312: It is the practice of Casa de Paz to provide assistance with oral cares and face washing with morning hygiene cares.

1. Resident #1 discharged from the facility on 4/25/17; no further corrective action could be implemented.

2. A chart review of residents in the facility was conducted to identify residents who require assistance with morning cares. An audit was conducted on 5/5/17 to ensure these residents received oral cares and face washing with morning hygiene cares.
3. Staff were educated by DON and Administrator on the provision of oral cares and face washing with morning hygiene cares on 4/27/17.
4. The DON or designee will assure ongoing compliance through random observations of morning cares. Results of the observations will be reported to the facility QAPI committee monthly for three months.

   Date of compliance is 5/5/17.

F441: It is the practice of Casa de Paz to give a baseline TB screening and a two-step TST to residents upon admission.

1. Residents #3, #4, and #13 received TB skin tests on 5/4/17.
2. A chart review of residents in the facility was conducted on 5/4/17 to ensure TB tests were administered.
3. Staff were educated by DON and Administrator on 4/27/17on the requirement to administer a baseline TB screening and a two-step TST to residents upon admission.
4. The DON or designee will assure ongoing compliance through a review of admission documentation on new residents for three months. Results of the review will be reported to the facility QAPI committee monthly for three months.

Date of compliance is 5/5/17.