

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

PRINTED: 05/12/2017
FORM APPROVED
OMB NO. 0938-0391

5-18-17 pg.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 165180	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 05/04/2017
NAME OF PROVIDER OR SUPPLIER ODEBOLT SPECIALTY CARE			STREET ADDRESS, CITY, STATE, ZIP CODE 801 SOUTH DES MOINES STREET ODEBOLT, IA 51458		
(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: <u>5-18-17</u> The following deficiencies are the result of the recertification survey and investigation of Incident #67803-I and #67800-I, completed 5/1/17 - 5/4/17. Incident #67803-I and #67800-I, was not substantiated. See Code of Federal Regulations (42CFR) Part 483, Subpart B-C. F 157 483.10(g)(14) NOTIFY OF CHANGES SS=D (INJURY/DECLINE/ROOM, ETC) (g)(14) Notification of Changes. (i) A facility must immediately inform the resident; consult with the resident's physician; and notify, consistent with his or her authority, the resident representative(s) when there is- (A) An accident involving the resident which results in injury and has the potential for requiring physician intervention; (B) A significant change in the resident's physical, mental, or psychosocial status (that is, a deterioration in health, mental, or psychosocial status in either life-threatening conditions or clinical complications); (C) A need to alter treatment significantly (that is, a need to discontinue an existing form of treatment due to adverse consequences, or to commence a new form of treatment); or (D) A decision to transfer or discharge the	F 000			
		F 157			

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE

05/22/2017

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.

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

PRINTED: 05/12/2017
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 165180	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 05/04/2017
NAME OF PROVIDER OR SUPPLIER ODEBOLT SPECIALTY CARE			STREET ADDRESS, CITY, STATE, ZIP CODE 801 SOUTH DES MOINES STREET ODEBOLT, IA 51458		
(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 157	Continued From page 1 resident from the facility as specified in §483.15(c)(1)(ii). (ii) When making notification under paragraph (g) (14)(i) of this section, the facility must ensure that all pertinent information specified in §483.15(c)(2) is available and provided upon request to the physician. (iii) The facility must also promptly notify the resident and the resident representative, if any, when there is- (A) A change in room or roommate assignment as specified in §483.10(e)(6); or (B) A change in resident rights under Federal or State law or regulations as specified in paragraph (e)(10) of this section. (iv) The facility must record and periodically update the address (mailing and email) and phone number of the resident representative(s). This REQUIREMENT is not met as evidenced by: Based on record review and staff interview, the facility failed to notify a Physician in regards to a self harm attempt and/or gesture for 1 of 9 active residents reviewed (Resident #5). The facility reported a census of 32 residents. Findings included: According to the Minimum Data Set (MDS) assessments dated 2/7/17, and 5/2/17, Resident #5 had diagnoses that included anxiety disorder, depression and post traumatic stress disorder. Review of both MDS assessments revealed the resident's Brief Interview for Mental Status (BIMS)	F 157			

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

PRINTED: 05/12/2017
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 165180	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 05/04/2017
NAME OF PROVIDER OR SUPPLIER ODEBOLT SPECIALTY CARE			STREET ADDRESS, CITY, STATE, ZIP CODE 801 SOUTH DES MOINES STREET ODEBOLT, IA 51458		
(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 157	Continued From page 2 score of 15 indicating the resident's memory and cognition as intact. The MDS assessments documented the resident verbalized feeling down, depressed or hopeless, had trouble falling asleep, felt bad about his/herself and had thoughts of being better off dead or hurting his/her on several days during the 2 week assessment period. Resident #5's Care Plan, with a problem onset date of 1/9/17, included an intervention for the resident to use oxygen (O2) daily via a nasal cannula. According to Nurse's Notes dated 2/11/17 at 3:00 P.M., staff documented the resident removed his/her oxygen (O2) from his/her nose, stated he/she wanted to go to sleep and die and proceeded to wrap the O2 tubing around his/her neck. The same note dated 2/11/17 at 3:00 P.M. continued onto a following page and staff dated the continuation as 2/12/17 at 3:00 P.M. rather than 2/11/17. (During interview on 5/2/17 at 2:45 P.M., the facility interim Director of Nursing confirmed staff misdated the entry on 2/11/17 at 3:00 P.M., and should have been dated 2/12/17). The continued note or entry dated 2/12/17 at 3:00 P.M., revealed staff documented the resident stated he/she wanted to take 100 Oxycodone (for pain) pills, overdose and die and stated he/she had a knife and wanted to cut him/herself to death. Staff placed the resident on 5 minute observations by staff and conducted a room search for sharp objects. Further review of Nurse's Notes revealed staff failed to inform the resident's attempt of self harm to a Physician until 2/13/17 at 8:45 A.M. On 2/13/17 at 8:45 A.M., staff documented notification of the resident's Physician for an	F 157			

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

PRINTED: 05/12/2017
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 165180	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 05/04/2017
NAME OF PROVIDER OR SUPPLIER ODEBOLT SPECIALTY CARE			STREET ADDRESS, CITY, STATE, ZIP CODE 801 SOUTH DES MOINES STREET ODEBOLT, IA 51458		
(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 157	Continued From page 3 immediate psychiatric evaluation due to statements of self harm. Review of a Nurse's Notes dated 2/13/17 at 9:45 A.M., revealed staff documented the resident's Physician ordered an immediate psychiatric evaluation for Resident #5. During interview on 5/2/17 at 2:50 P.M., the facility MDS Coordinator stated she had notified the residents Physician on 2/13/17 after she became aware of the resident's self harm attempt on 2/12/17. The MDS Coordinator stated she wanted to make sure the Physician was aware of the incident as she could find no documentation a Physician had been notified at the time of the incident. During interview on 5/4/17 at 8:25 A.M., the facility interim Director of Nursing stated she would have notified the resident's Physician right away after the incident with the O2 tubing around the resident's neck on 2/12/17.	F 157			
F 285 SS=D	483.20(e)(k)(1)-(4) PASRR REQUIREMENTS FOR MI & MR (e) Coordination. A facility must coordinate assessments with the pre-admission screening and resident review (PASARR) program under Medicaid in subpart C of this part to the maximum extent practicable to avoid duplicative testing and effort. Coordination includes: (1) Incorporating the recommendations from the PASARR level II determination and the PASARR evaluation report into a resident's assessment, care planning, and transitions of care.	F 285			

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

PRINTED: 05/12/2017
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 165180	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 05/04/2017
NAME OF PROVIDER OR SUPPLIER ODEBOLT SPECIALTY CARE			STREET ADDRESS, CITY, STATE, ZIP CODE 801 SOUTH DES MOINES STREET ODEBOLT, IA 51458		
(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 285	Continued From page 4 (2) Referring all level II residents and all residents with newly evident or possible serious mental disorder, intellectual disability, or a related condition for level II resident review upon a significant change in status assessment. (k) Preadmission Screening for individuals with a mental disorder and individuals with intellectual disability. (1) A nursing facility must not admit, on or after January 1, 1989, any new residents with: (i) Mental disorder as defined in paragraph (k)(3)(i) of this section, unless the State mental health authority has determined, based on an independent physical and mental evaluation performed by a person or entity other than the State mental health authority, prior to admission, (A) That, because of the physical and mental condition of the individual, the individual requires the level of services provided by a nursing facility; and (B) If the individual requires such level of services, whether the individual requires specialized services; or (ii) Intellectual disability, as defined in paragraph (k)(3)(ii) of this section, unless the State intellectual disability or developmental disability authority has determined prior to admission- (A) That, because of the physical and mental condition of the individual, the individual requires the level of services provided by a nursing facility;	F 285			

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

PRINTED: 05/12/2017
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 165180	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 05/04/2017
NAME OF PROVIDER OR SUPPLIER ODEBOLT SPECIALTY CARE			STREET ADDRESS, CITY, STATE, ZIP CODE 801 SOUTH DES MOINES STREET ODEBOLT, IA 51458		
(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 285	Continued From page 5 and (B) If the individual requires such level of services, whether the individual requires specialized services for intellectual disability. (2) Exceptions. For purposes of this section- (i) The preadmission screening program under paragraph(k)(1) of this section need not provide for determinations in the case of the readmission to a nursing facility of an individual who, after being admitted to the nursing facility, was transferred for care in a hospital. (ii) The State may choose not to apply the preadmission screening program under paragraph (k)(1) of this section to the admission to a nursing facility of an individual- (A) Who is admitted to the facility directly from a hospital after receiving acute inpatient care at the hospital, (B) Who requires nursing facility services for the condition for which the individual received care in the hospital, and (C) Whose attending physician has certified, before admission to the facility that the individual is likely to require less than 30 days of nursing facility services. (3) Definition. For purposes of this section- (i) An individual is considered to have a mental disorder if the individual has a serious mental disorder defined in 483.102(b)(1).	F 285			

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

PRINTED: 05/12/2017
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 165180	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 05/04/2017
NAME OF PROVIDER OR SUPPLIER ODEBOLT SPECIALTY CARE			STREET ADDRESS, CITY, STATE, ZIP CODE 801 SOUTH DES MOINES STREET ODEBOLT, IA 51458		
(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 285	Continued From page 6 (ii) An individual is considered to have an intellectual disability if the individual has an intellectual disability as defined in §483.102(b)(3) or is a person with a related condition as described in 435.1010 of this chapter. (k)(4) A nursing facility must notify the state mental health authority or state intellectual disability authority, as applicable, promptly after a significant change in the mental or physical condition of a resident who has mental illness or intellectual disability for resident review. This REQUIREMENT is not met as evidenced by: Based on clinical record review and staff interview, the facility failed to submit a change of status and/or the need for evaluation for a Preadmission Screening and Resident Review (PASRR) when 2 of 4 resident's (Resident # 7 and #1) reviewed extended their stay in the nursing facility. The facility reported a census of 32 residents. Findings included: 1. Review of a Minimum Data Set (MDS) with an assessment reference date of 3/1/17, revealed Resident #7's diagnoses included anxiety disorder, manic-depression and depression. The assessment documented a Brief Interview for Mental Status as a score of 15 indicating intact cognitive functioning. The MDS recorded an admission date of 12/1/16. Review of a Notice of PASRR Convalescent Approval form dated 10/19/16 revealed approval to a Medicaid certified nursing home for up to 60 calendar days. The form instructed the facility that	F 285			

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

PRINTED: 05/12/2017
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 165180	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 05/04/2017
NAME OF PROVIDER OR SUPPLIER ODEBOLT SPECIALTY CARE			STREET ADDRESS, CITY, STATE, ZIP CODE 801 SOUTH DES MOINES STREET ODEBOLT, IA 51458		
(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 285	Continued From page 7 if the resident's stay extended beyond 60 days, a nursing facility representative must submit a Status Change Level 1 to the Medicaid contracted agency. Review of the record revealed no Level II screening occurred before the 60 day expiration. During an interview with the acting director of nursing (DON) on 5/3/17 at 8:30 AM, she stated the facility staff spoke the Medicaid contracted agency yesterday about Resident #7 not having a Level II PASRR. The DON stated that at 9:00 AM, the facility will have a telephone training session with the Medicaid contracted agency. During an interview with Staff B, PASRR clinical analyst on 5/3/17 at 9:00 AM, she stated that the first Level II screening occurred on 2/1/16. The resident was discharged from a nursing facility elsewhere and then admitted to an acute care facility. When the resident was admitted to this facility, the 60 day period was approved for convalescence. It is the nursing facility's responsibility to submit a change of Level status to the Medicaid contracted agency if the resident remained in the facility over 60 days. The Medicaid contracted agency suggested a 10 day notification before the 60 days run out. 2. According to a Physician Orders form dated April 2017, Resident #1's diagnoses included spondylolisthesis (vertebral slippage), lack of coordination and paralytic syndrome (paralysis). A PASRR form with a determination date of 9/1/16, identified the resident with a mental illness and documented the resident's psychiatric diagnoses as mood disorder, depressive disorder	F 285			

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

PRINTED: 05/12/2017
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 165180	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 05/04/2017
NAME OF PROVIDER OR SUPPLIER ODEBOLT SPECIALTY CARE			STREET ADDRESS, CITY, STATE, ZIP CODE 801 SOUTH DES MOINES STREET ODEBOLT, IA 51458		
(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 285	Continued From page 8 and generalized anxiety disorder. The PASSR identified the need for Resident #1's short term placement of 180 days in the facility to assist with rehabilitation needs, medication administration, assistance with self care and psychiatric conditions. The PASSR form directed facility staff to submit for a repeat evaluation at the end of the approved 180 days (expiring 2/28/17). Record review revealed no repeat PASSR evaluation had been completed on or about 2/28/17.	F 285			
F 496 SS=E	483.35(d)(4)-(6) NURSE AIDE REGISTRY VERIFICATION, RETRAINING d)(4) Registry verification Before allowing an individual to serve as a nurse aide, a facility must receive registry verification that the individual has met competency evaluation requirements unless- (i) The individual is a full-time employee in a training and competency evaluation program approved by the State; or (ii) The individual can prove that he or she has recently successfully completed a training and competency evaluation program or competency evaluation program approved by the State and has not yet been included in the registry. Facilities must follow up to ensure that such an individual actually becomes registered.	F 496			

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

PRINTED: 05/12/2017
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 165180	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 05/04/2017
NAME OF PROVIDER OR SUPPLIER ODEBOLT SPECIALTY CARE			STREET ADDRESS, CITY, STATE, ZIP CODE 801 SOUTH DES MOINES STREET ODEBOLT, IA 51458		
(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 496	Continued From page 9 (d)(5) Multi-State registry verification Before allowing an individual to serve as a nurse aide, a facility must seek information from every State registry established under sections 1819(e)(2)(A) or 1919(e)(2)(A) of the Act the facility believes will include information on the individual. (d)(6) Required retraining If, since an individual's most recent completion of a training and competency evaluation program, there has been a continuous period of 24 consecutive months during none of which the individual provided nursing or nursing-related services for monetary compensation, the individual must complete a new training and competency evaluation program or a new competency evaluation program. This REQUIREMENT is not met as evidenced by: Based on personnel file review and staff interview, the facility failed to verify nurse aide registry eligibility prior to employment for 1 Certified Nurse Aid/CNA personnel file reviewed (Staff A) The facility reported a census of 32 residents. Findings include: 1. Review of a Employee Action form, revealed Staff A's hire date of 2/27/17. A Single Contact License & Background (SING) check form dated 2/20/17, revealed facility staff checked Staff A's abuse and criminal history background checks, but lacked a check for CNA eligibility. A SING form dated 3/1/17, revealed facility staff	F 496			

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

PRINTED: 05/12/2017
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 165180	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 05/04/2017
NAME OF PROVIDER OR SUPPLIER ODEBOLT SPECIALTY CARE			STREET ADDRESS, CITY, STATE, ZIP CODE 801 SOUTH DES MOINES STREET ODEBOLT, IA 51458		
(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 496	Continued From page 10 checked Staff A's CNA verification on 3/1/17 (2 days after hire). A Time Card Report revealed Staff A began work in the facility on 2/27/17. During interview on 5/2/17 at 10:00 A.M., the facility Administrator confirmed Staff A was hired on 2/27/17, and began employment on 2/27/17, prior to verification of her CNA certification. The Administrator stated the Director of Nursing at the time Staff A began employment, hadn't understood the hiring process.	F 496			

DEPARTMENT OF INSPECTIONS AND APPEALS

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: IA0107	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED 05/04/2017
NAME OF PROVIDER OR SUPPLIER ODEBOLT SPECIALTY CARE		STREET ADDRESS, CITY, STATE, ZIP CODE 801 SOUTH DES MOINES STREET ODEBOLT, IA 51458		
(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) COMPLETE DATE
C 148	50.7(5) Additional notification 481-50.7(10A, 135C) Additional notification. The director or the director's designee shall be notified within 24 hours, or the next business day, by the most expeditious means available: 50.7(5) When a resident attempts suicide, regardless of injury. This REQUIREMENT is not met as evidenced by: Based on clinical record review and staff interview, the facility failed to report Resident #5's attempt of self harm within 24 hours to Department of Inspections and Appeals (DIA) for one (1) of ten (10) residents. The facility reported a census of 32 residents. Findings included: A Minimum Data Set (MDS) assessment dated 2/7/17, revealed Resident #5's diagnoses included anxiety disorder, depression and post-traumatic stress disorder. The MDS revealed a Brief Interview for Mental Status (BIMS) score of 15 indicating the resident's memory and cognition as intact. The assessment revealed the resident required no assistance from staff with transfer or ambulation in his/her room and had no impairment in range of motion in either upper or lower extremities. The MDS documented the resident verbalized feeling down, depressed or hopeless, had trouble falling asleep, felt bad about him/her and had thoughts of being better off dead or hurting his/her on several days during the 2 week assessment period.	C 148		

DIVISION OF HEALTH FACILITIES - STATE OF IOWA

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE

05/22/17

DEPARTMENT OF INSPECTIONS AND APPEALS

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: IA0107	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED 05/04/2017
NAME OF PROVIDER OR SUPPLIER ODEBOLT SPECIALTY CARE		STREET ADDRESS, CITY, STATE, ZIP CODE 801 SOUTH DES MOINES STREET ODEBOLT, IA 51458		
(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) COMPLETE DATE
C 148	Continued From page 1 Resident #5's Care Plan, with a problem onset date of 1/9/17, included an intervention for the resident to use oxygen (O2) daily via a nasal cannula. The resident's care plan identified he/she will have no adverse side effects or injury from use of psychotropic medications. Staff will monitor his/her behaviors, report concerns and redirect if able. Staff will continually assess the resident's physical and emotional need for medication. According to Nurse's Notes dated 2/11/17 at 3:00 P.M., staff documented the resident removed his/her oxygen (O2) from his/her nose, stated he/she wanted to go to sleep and die and proceeded to wrap the O2 tubing around his/her neck and said "just let me die". Resident #5 then proceeded to talk about cutting him/her(self) and bleeding out. The same note dated 2/11/17 at 3:00 P.M. continued onto a following page and staff misdated the entry writing 2/12/17 instead of 2/11/17. At 3:00 P.M. Resident #5 stated he/she wanted to take 100 oxycodone (for pain) pills, overdose and die. The resident stated he/she had a knife and wanted to cut him/herself to death. Staff placed the resident on 5 minute observations and conducted a room search for sharp objects. The next nurse's notes misdated 2/12/17 at 3 p.m., revealed Staff removed the pocket knife combo, butter knife, scissor and nail clippers from his/her room and called the new administrator. The nurse's notes misdated 2/12/17 [2/11/17] at 5:30 p.m., revealed the resident told the aide he/she took a bunch of pills and was fading fast. There was no evidence of pills in his/her room prior and at that time. Staff documented five minutes late the resident walked down the hall	C 148		

DEPARTMENT OF INSPECTIONS AND APPEALS

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: IA0107	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED 05/04/2017
---	--	--	--

NAME OF PROVIDER OR SUPPLIER ODEBOLT SPECIALTY CARE	STREET ADDRESS, CITY, STATE, ZIP CODE 801 SOUTH DES MOINES STREET ODEBOLT, IA 51458
---	---

(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) COMPLETE DATE
C 148	Continued From page 2 smiling. The nurse's notes misdated 2/12/17 [2/11/17] late entry 4 p.m. revealed resident at the nurses desk asking for oxygen tank and staff went to grab keys and they were initially missing. Staff made three attempts for the resident to go to the hospital, however the resident refused. The nurse's note dated 2/13/17 at 6:30 a.m., identified Resident #5 had been yelling due to pain and staff administered pain medication. Resident #5 explained he/she wanted his/her things back including his/her utility tool and scissors. The next nurse's notes dated 2/13/17 at 8:45 a.m., revealed staff contacted the physician for an immediate psych evaluation for the resident due to statements of self harm per notes of weekend. During interview on 5/2/17 at 2:45 P.M., the facility interim Director of Nursing confirmed staff misdated the entry on 2/11/17 at 3:00 P.M., and should have been dated 2/12/17. A facility report to DIA, revealed facility staff reported the above incident (that occurred on 2/12/17 at 3:00 P.M.) on 2/15/17 at 12:56 P.M., approximately 3 days later (exceeding the required 24 hour reporting period). During interview on 5/1/17 at 11:30 A.M., the facility Administrator confirmed the above incident had not been reported timely as the Administrator in charge at the time had not been certain if the incident had been a self-harm attempt or gesture. The facility did not have a policy for reporting and provided the Department a checklist. The Resident Suicide checklist did not address any specifics about timely reporting to DIA.	C 148		

DEPARTMENT OF INSPECTIONS AND APPEALS

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: IA0107	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED 05/04/2017
NAME OF PROVIDER OR SUPPLIER ODEBOLT SPECIALTY CARE		STREET ADDRESS, CITY, STATE, ZIP CODE 801 SOUTH DES MOINES STREET ODEBOLT, IA 51458		
(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) COMPLETE DATE
C 148	Continued From page 1 Resident #5's Care Plan, with a problem onset date of 1/9/17, included an intervention for the resident to use oxygen (O2) daily via a nasal cannula. The resident's care plan identified he/she will have no adverse side effects or injury from use of psychotropic medications. Staff will monitor his/her behaviors, report concerns and redirect if able. Staff will continually assess the resident's physical and emotional need for medication. According to Nurse's Notes dated 2/11/17 at 3:00 P.M., staff documented the resident removed his/her oxygen (O2) from his/her nose, stated he/she wanted to go to sleep and die and proceeded to wrap the O2 tubing around his/her neck and said "just let me die". Resident #5 then proceeded to talk about cutting him/her(self) and bleeding out. The same note dated 2/11/17 at 3:00 P.M. continued onto a following page and staff misdated the entry writing 2/12/17 instead of 2/11/17. At 3:00 P.M. Resident #5 stated he/she wanted to take 100 oxycodone (for pain) pills, overdose and die. The resident stated he/she had a knife and wanted to cut him/herself to death. Staff placed the resident on 5 minute observations and conducted a room search for sharp objects. The next nurse's notes misdated 2/12/17 at 3 p.m., revealed Staff removed the pocket knife combo, butter knife, scissor and nail clippers from his/her room and called the new administrator. The nurse's notes misdated 2/12/17 [2/11/17] at 5:30 p.m., revealed the resident told the aide he/she took a bunch of pills and was fading fast. There was no evidence of pills in his/her room prior and at that time. Staff documented five minutes late the resident walked down the hall	C 148		

DEPARTMENT OF INSPECTIONS AND APPEALS

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: IA0107	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____		(X3) DATE SURVEY COMPLETED 05/04/2017
NAME OF PROVIDER OR SUPPLIER ODEBOLT SPECIALTY CARE			STREET ADDRESS, CITY, STATE, ZIP CODE 801 SOUTH DES MOINES STREET ODEBOLT, IA 51458		
(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) COMPLETE DATE	
C 148	Continued From page 2 smiling. The nurse's notes misdated 2/12/17 [2/11/17] late entry 4 p.m. revealed resident at the nurses desk asking for oxygen tank and staff went to grab keys and they were initially missing. Staff made three attempts for the resident to go to the hospital, however the resident refused. The nurse's note dated 2/13/17 at 6:30 a.m., identified Resident #5 had been yelling due to pain and staff administered pain medication. Resident #5 explained he/she wanted his/her things back including his/her utility tool and scissors. The next nurse's notes dated 2/13/17 at 8:45 a.m., revealed staff contacted the physician for an immediate psych evaluation for the resident due to statements of self harm per notes of weekend. During interview on 5/2/17 at 2:45 P.M., the facility interim Director of Nursing confirmed staff misdated the entry on 2/11/17 at 3:00 P.M., and should have been dated 2/12/17. A facility report to DIA, revealed facility staff reported the above incident (that occurred on 2/12/17 at 3:00 P.M.) on 2/15/17 at 12:56 P.M., approximately 3 days later (exceeding the required 24 hour reporting period). During interview on 5/1/17 at 11:30 A.M., the facility Administrator confirmed the above incident had not been reported timely as the Administrator in charge at the time had not been certain if the incident had been a self-harm attempt or gesture. The facility did not have a policy for reporting and provided the Department a checklist. The Resident Suicide checklist did not address any specifics about timely reporting to DIA.	C 148			

Odebolt Specialty Care

801 South Des Moines Street

Odebolt, Iowa 51458

Plan of Correction Annual Survey 2017

Preparation and/or execution of this plan of correction does not constitute admission or agreement by this provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The Plan of Correction is prepared and/or executed solely because it is required by the provisions of Federal and/or State law. This constitutes my credible allegation of compliance and all deficiencies will be corrected by 05/18/2017.

F157

Staff failed to timely inform the doctor of resident #15's attempt of self-harm.

No other resident was affected.

Nursing department was educated on 05/17/2017 on how to immediately inform the resident; consult with the resident's physician; and notify, consistent with his or her authority, the resident representatives(s) when there is an accident involving the resident which results in injury or potential injury and has the potential for requiring physician intervention.

Completion date: 05/17/2017

F285

Facility failed to submit for a PASSR re-evaluation for Resident #1 and #7. PASSR in compliance for resident #1 and #7 on 05/05/2017.

No other residents were affected.

Facility Department Heads were educated by PASSR personal on 05/03/2017 on PASSR process. All PASSR have been reviewed and are in compliance.

Completion date: 05/05/2017.

F496

Facility staff failed to check for CNA eligibility in a timely manner.

A SING form dated 03/01/2017, revealed facility staff checked Staff A's CNA verification on 03/01/2017 (2 days after hire.) Designated department heads and a pre-hire checklist were implemented to assure new hire paperwork is done timely on 03/01/17.

Completion date: 05/05/2017

C148

Facility staff failed to notify the director or the director's designee within 24 hours.

Facility will notify facility director or designee and Department of Inspections and Appeals within 24 hours when a resident attempts suicide, regardless on injury.

Completion date: 05/17/2017

Sincerely,

Kelsey J. Schenk

Kelsey J. Schenk, Provisional Administrator

May 17, 2017