

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

PRINTED: 05/11/2017
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 165448	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 04/26/2017
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NAME OF PROVIDER OR SUPPLIER BISHOP DRUMM RETIREMENT CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 5837 WINWOOD DRIVE JOHNSTON, IA 50131
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F 000	INITIAL COMMENTS Correction Date: <u>4-28-17</u> Investigation of a facility complaint #66498-C and a facility self report #67267-I resulted in the following deficiencies. See Code of Federal Regulations (42CFR) Part 483, Subpart B-C. 483.12(a)(1) FREE FROM ABUSE/INVOLUNTARY SECLUSION	F 000	Allegation of Compliance Date: 04/28/2017 The plan of correction for these deficiencies was executed solely because provisions of state and federal law require it. The preparation of the following plan of correction, for these deficiencies, does not constitute and should not be interpreted as an admission nor an agreement, by the facility, of the truth of the facts alleged or conclusions set forth in the statement of deficiencies.	
F 223 SS=G	483.12 The resident has the right to be free from abuse, neglect, misappropriation of resident property, and exploitation as defined in this subpart. This includes but is not limited to freedom from corporal punishment, involuntary seclusion and any physical or chemical restraint not required to treat the resident's symptoms. 483.12(a) The facility must- (a)(1) Not use verbal, mental, sexual, or physical abuse, corporal punishment, or involuntary seclusion; This REQUIREMENT is not met as evidenced by: Based on observation, record review, and interviews, the facility failed to ensure one (1) of six (6) residents was free from possible abuse (Resident #6). Record review identified Resident #6 relied upon two (2) staff to provide assistance for transfers, bed mobility, ambulating, and toileting assistance. Record review and observation showed Resident #6 had a bruise on the left side of his/her forehead and left upper eye lid. Interview with the nurse practitioner and resident's family revealed the resident's injury had	F 223		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE <i>Heather Kellum</i>	TITLE Executive Director	(X6) DATE 5-15-17
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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.

Plancher 5/16/17

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F 223	<p>Continued From page 1</p> <p>been a result of a substantial hit to the affected area and not a result of the padded right arm rest on the resident's wheelchair. Staff that provided care to the dependent resident revealed no one knew how the resident's sustained the injury. The facility reported a census of 111 residents.</p> <p>Findings include:</p> <p>A Minimum Data Set (MDS) assessment form dated 3/11/17 indicate Resident #6 had diagnoses that included non-Alzheimer's dementia, anxiety and depression. The assessment indicated the resident sometimes had the ability to make him/her(self) understood and understood others. The MDS revealed Resident #6 had severe cognitive impairment and short term and long term memory deficits with continuous inattention, disorganized thinking and an altered level of consciousness. The MDS revealed Resident #6 did not exhibit other behaviors symptoms, such as physical symptoms such as hitting or scratching him/her(self). The MDS revealed the resident did not have psychosis (hallucinations or delusions). The assessment indicated the resident required extensive assistance of 2 staff members for bed mobility, transfers, ambulation, locomotion and toilet use. The MDS revealed the resident as always incontinent of bladder and frequently incontinent of bowels. The MDS revealed Resident #6 had no falls since admission/entry or reentry or prior assessment whichever is more recent; and used a wheelchair and walker for ambulation.</p> <p>A Care Plan with a target date of 6/29/17 had the following focus areas: The resident is alert and oriented times 1 (to</p>	F 223	<p>F 223 Resident Free From Abuse</p> <p>The nurse on duty assessed resident #6 on 4/17/2017. The nurse practitioner and family notified of injury on 4/17/2017 with no new orders given. Major injury determination form completed with the nurse practitioner indicating that the resident's injury was determined not to be a "major injury." The resident's care plan updated to include a padded bolster to right armrest wheelchair on 4/17/2017, assist to bed for periods of rest between meals and at night and assist to wheelchair or recliner when restless on 4/23/2017, padding added to both side rails at the head of the bed on 4/25/2017 and OT/PT referral on 4/28/2017.</p> <p>The Director of Nursing and Administrator reviewed all incident reports to ensure there</p>	

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F 223	<p>Continued From page 2</p> <p>person) with severe long and short term memory problems due to dementia. The resident responded with short responses/body language. The resident's mood appeared stable but he/she can be anxious/frustrate at times. The resident can be resistive with cares and to other residents on occasion. When sitting in the lounge and staff should monitor him/her and keep the resident away from others. Staff should sit/position Resident #6 an arm's length reach from other residents.</p> <p>The care plan identified the resident had a history of falling related to (r/t) general weakness and poor safety awareness due to (d/t) dementia ; and had impaired activities of daily living (ADL). The care plan identified he/she needed extensive assistance of 2 staff members with transfers, bed mobility, ambulation, toileting and on 3/27/17, staff to assist Resident #6 to and from meals/activities.</p> <p>Resident #6 liked to sleep in the recliner in the lounge area at times and staff should offer to assist him/her to bed so that he/she can rest. Resident #6 uses a special reclining wheelchair as his/her primary mode of locomotion. When awake, staff should keep him/her in a visible area when awake.</p> <p>An Occupational Therapy (OT) Plan Of Care dated 3/27/17 indicated the resident displayed forward moderate kyphosis (rounding/describe the abnormal condition of the vertebral column) as well as a right lateral lean.</p> <p>A Medication Administration Record (MAR) form dated 4/1/17 thru 4/30/17 indicated the resident as not on any anti-coagulant medications.</p>	F 223	<p>were no other injuries of unknown origin that needed to investigated, none found. The Director of Nursing and Administrator will review and investigate all incidents of injury with unknown origin. Nursing staff inserviced on Resident Abuse policy and reporting responsibilities on 4/28/2017. Corporate Director of Clinical Services inserviced Administrator and Director of Nursing on Abuse policy and reporting requirements for injuries of unknown origin on 4/21/2017.</p> <p>The Assistant Directors of Nursing will audit all resident incidents and discuss during the Daily Clinical meeting for four weeks.</p> <p>The Director of Nursing will review all reported resident incidents and discuss during the Daily Clinical meeting. The</p>		

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F 223	<p>Continued From page 3</p> <p>An observation 4/19/17 at approximately 10:30 a.m. revealed the resident positioned in a TIS chair as staff propelled him/her down the hallway with a golf ball sized hematoma on his/her left forehead with purple bruising surrounding the area and purple bruising on and around the resident's bilateral eyes.</p> <p>An observation 4/26/17 at approximately 10 a.m. revealed the right and left arm rest of the resident's TIS chair with approximately 3/4 of an inch to 1 inch of padding attached to the rest itself.</p> <p>An Injury form dated 4/17/17 at 8:40 a.m. and revised at 4:29 p.m. indicated the resident had an injury of unknown origin further described at a bruise on the left side of his/her forehead and left upper eye lid that measured 6 centimeter (cm) x (by) 18 cm red and purple in color.</p> <p>An Injury form dated 4/17/17 at 8:40 a.m. and revised at 4:29 p.m. and with an entry dated 4/19/17 revealed the following entry: Summary of findings for 4/17/17. Staff that worked the 3 p.m. until 11 p.m. shift on Sunday 4/16/17 and Sunday night 11 p.m. until 7 a.m. had been interviewed about the bruising found to the resident's forehead at breakfast on 4/17/17. The staff members voiced that no bruising had been noted at meal time on 4/16/17. The 2 staff members that assisted the hour of sleep (HS) cares between 7 p.m. and 9 p.m. stated that no bruising had been noted. Staff reported the resident had often been resistive with cares, would hit and strike at them with his/her arms and kick with his/her legs. The resident had a curvature of his/her spine and often sat bent over at the waist and leaned to the</p>	F 223	<p>Administrator will monitor all of the incident reports and report monthly to the QAPI committee for three months.</p> <p>CAD April 28, 2017</p>		

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F 223	<p>Continued From page 4</p> <p>right.</p> <p>Staff that worked the 11 to 7 shift on the North hall voiced he/she had been toileted and slept in his/her wheelchair in the lobby area.</p> <p>Staff that assisted the resident with toileting around 6:30 a.m. to 7 a.m. voiced he/she had been resistive with cares however staff verbalized no observation of bruising at that time.</p> <p>At approximately 8:30 a.m. the resident had been observed in his/her wheelchair bent over with hair that covered his/her face in the dining room.</p> <p>When staff repositioned the resident to assist with breakfast and the bruising had been noted and immediately reported to the charge nurse and the Administrator. Also noted the resident had his/her head resting on the right arm rest area where the bruising had been noted so an arm bolster had been applied to the right arm rest.</p> <p>Progress Notes forms revealed the following entries:</p> <p>a. 4/17/17 at 4:29 p.m. - During breakfast the resident had been noted to have a bruise on the left side of his/her forehead. The area had been swollen, purple and red in color and the skin intact. The resident rested in the chair and took his/her morning medications. Neurological checks as within normal limits (WNL).</p> <p>b. 4/18/17 at 5:25 p.m. - The resident continued on follow up charting for the bruise on the left side of the forehead. The skin had been intact, purple and red in color with no swelling noted.</p> <p>c. 4/19/17 at 12:30 a.m. - The resident had a head injury to the right side of the head from and unknown source. There had also been significant bruising around the eyes.</p> <p>d. 4/20/17 at 10:35 a.m. - The resident with a large bruise to the right side forehead which extended out to both eyes from an unknown</p>	F 223		

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F 223	<p>Continued From page 5 source.</p> <p>An observation 4/20/17 at 4:05 p.m., revealed the resident positioned on the toilet with obvious kyphosis (lump on the back) on the resident's left side of his/her back and a spinal curvature which resulted in the resident positioned forward and to the right side.</p> <p>During an interview 4/20/17 at 5:02 p.m., Staff L, Certified Nursing Assistant (CNA) confirmed she worked the night shift Sunday 4/16. The staff member indicated the resident slept all night in the TIS chair in the lounge area and she never checked or changed the resident through the night. The staff member confirmed around 6:15 a.m. to 6:30 a.m. herself and Staff K, CNA transferred the resident to the toilet with the use of a gait belt while Staff K remained with the resident the entire time. Upon completion the staff members cleaned the resident up, stood him/her, pulled up the pants and positioned the resident in the TIS chair and returned him/her to the lounge area. The staff member confirmed when the resident sat in the TIS chair and/or on the toilet he/she leaned forward with his/her head down. The staff member indicated she never observed a bruise on the resident's forehead and/or face that morning and never observed the resident having hit his/her head.</p> <p>During an interview 4/20/17 at 5:14 p.m., Staff K confirmed the only time he assisted the resident with cares on 4/16 into 4/17/17 had been when when he transferred the resident per gait belt to the toilet and back to the wheel chair with the assistance of Staff L. The staff member indicated he never left the resident unattended in the</p>	F 223			

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F 223	<p>Continued From page 6</p> <p>bathroom, the resident never hit his/her head during cares and there had been no bruising present on the resident's forehead and/or facial features.</p> <p>During an interview 4/20/17 at 3:31 p.m., Staff D, CNA confirmed she worked the day shift on 4/17/17. When the staff member arrived at work she observed the resident sitting in the TIS chair in the lounge area however his/her head had been down so she could not see the resident's face. The staff member denied having provided any cares for the resident prior to the discovery of the hematoma/bruising. When the staff member first observed the area after breakfast it had been red and protruding as if it had just started. The staff member stated the area had not been as large as it appeared presently.</p> <p>During an interview 4/20/17 at 2:31 a.m., Staff A, CNA confirmed she worked the day shift on 4/17/17. When the staff member arrived at work she observed the resident sitting in the TIS chair in the lounge area with his/her head down however she did not look at the resident long enough to analyze anything. The staff member indicated between breakfast and lunch she observed the goose egg on the resident's forehead with no bruising initially then the bruising appeared and kept spreading throughout the day.</p> <p>During an interview 4/20/17 at 1:55 p.m., Staff I, CNA indicated he had not known where the resident had been when he arrived at work on 4/17/17. The staff member could not recall if he had taken the resident to the dining room for breakfast. The staff member felt the first time he had contact with the resident had been in the dining room for breakfast. The resident had been</p>	F 223			

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F 223	<p>Continued From page 7</p> <p>positioned in the TIS chair with his/her head down with his/her hair a little bit in front of his/her face. The staff member sat down to feed the resident and observed the bruise on the resident's forehead but he could not recall if there had been bruising on the resident's eye. The staff member immediately reported the observation to Staff J, Licensed Practical Nurse (LPN) and then went to assist other residents at another table.</p> <p>During an interview 4/20/17 at 2:14 p.m., Staff B, CNA confirmed he/she worked the day shift on 4/17/17 however she never provided any cares for the resident that morning. At 8:45 a.m. to 9 a.m. a nurse came to her and asked if she had provided cares for the resident that morning because the resident had a bruise on his/her face. When the nurse told her that she looked at the resident and observed a goose egg area with bruising on his/her forehead with no bruising on the resident's eyes however by the end of the shift both eyes had been black and blue in color.</p> <p>During an interview 4/20/17 at 1:20 p.m., Staff J indicated when she arrived at work on 4/17/17 the resident had been positioned in the TIS chair in the lounge area with his/her head down with hair over his/her face. The staff member received report with no information provided about the resident. The staff member indicated between her arrival at work and breakfast, which started at 7:30 a.m. she did not see anyone take the resident to the bathroom however she thought Staff I propelled the resident to breakfast. As she passed morning medications Staff I came to her and said, you are going to be mad, you have to see the resident's face. When she approached the resident his/her head had been bent down so when she repositioned the resident's head back</p>	F 223			

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F 223	<p>Continued From page 8</p> <p>she observed a goose egg with bruising down to his/her left eye lid. The area had been less protruding than it appeared presently. The staff member reported the incident to Staff M, Registered Nurse (RN) who began an investigation as she started an assessment and reported the injury of unknown origin to the Nurse Practitioner (NP) and the resident's son.</p> <p>During an interview 4/20/17 at 2:40 p.m., Staff J confirmed the resident's bruising worsened throughout the day and spread over the resident's nose and to both eyes however the staff member never applied ice.</p> <p>During an interview 4/20/17 at 3:02 p.m., Staff M indicated around 8:30 a.m. she observed the resident in the dining room positioned in his/her chair, leaned to the right and his/her hair over his/her face. Staff I came over to feed the resident and when he sat the resident up, he said "oh my what is that", I am going to tell Staff J right now. At that point the staff member looked at the resident and said oh my gosh as the area had been red and raised with some bruising around the area but not a goose egg at that point and the staff member felt it had been a fresh area. At that point the staff member initiated an investigation. The staff member indicated she attempted application of ice later in the afternoon however the resident refused the intervention. The staff member indicated as the day proceeded the bruising became darker and by 4/18/17 there had been a bruised pocket on the resident's left eye and on 4/19/17 the bruising progressed to both eyes.</p> <p>During an interview 4/20/17 at 8:58 a.m., a family member indicated he/she had not felt the resident</p>	F 223			

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F 223	<p>Continued From page 9</p> <p>could have received a lump like that by moving around in a chair and that someone had not been telling the truth.</p> <p>During an interview 4/20/17 at approximately 9:35 a.m., a family member stated he/she felt the resident could not have sustained the injury from the arm rest of the wheelchair because the resident always leaned to the right and the area had been on his/her left side of the forehead.</p> <p>Review of a History and Physical form dated 4/18/17 at 9:20 p.m. included the following documentation from a Nurse Practitioner:</p> <ul style="list-style-type: none"> a. Head and Face - a left forehead contusion/hematoma without laceration. Dependent swelling and bruising of the left eye. b. Eyes - Not able to view the left eye due to swelling. c. Psychiatric - Judgement: alert and impaired insight. The patient's speech exhibited incoherence. The patient displayed significant memory loss which required supervision. d. Assessment - Head contusion e. Discussion/Summary - Head contusion with unknown even per staff investigation. The resident hunches forward in the wheelchair and now the eye had been edematous also. <p>During an interview 4/21/17 at 11:36 a.m., the Nurse Practitioner (NP) indicated a hematoma developed soon after an injury and could have been large. The bruising on the resident's eyes and face had been gradual and she felt the bruising had been a result of pooling of blood. The NP felt the resident's injury had been a result of a substantial hit to the affected area and not a result of the padded right arm rest of the resident's wheelchair.</p>	F 223			

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F 223	Continued From page 10 An Abuse/Neglect and Reporting Policy revised 9/16 identified that no one should be subject to abuse or neglectful behavior is the most critical step in detecting and preventing abuse. The policy revealed it is necessary for the center to adopt and institute an abuse, neglect prevention system to include protection of residents as well as identifying and investigating all allegations of abuse or mistreatment. The policy defined abuse according to the federal rule F223 as Abuse the resident has the right to be free from physical and mental. The intent of the federal rule 483.13 (b) revealed the resident had the right to be free from all types of abuse including physical abuse; and that residents must not be subject to abuse by anyone including staff, family or volunteers serving the resident. The intent of federal rule 483.13c revealed that each resident had the right to be free from mistreatment, and neglect. The policy defined neglect as the failure to provide the goods and services necessary to avoid physical harm. The policy revealed "Injuries of Unknown Source" should be classified as an "injury of unknown source" when both of the following conditions are met: 1. The source of the injury had not been observed by any person or the source of the injury could not have been explained by the resident: and, 2. The injury had been suspicious because of the extent of the injury or the location of the injury, e.g., the injury had been in an area not generally vulnerable to trauma, or the incidence of injuries over time. The policy identified components of addressed	F 223			

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F 223	<p>Continued From page 11</p> <p>reporting and responding as follows:</p> <p>The policy directed the center to ensure that all alleged violations involving mistreatment, neglect or abuse including injuries of unknown source are reported immediately to the administrator of the center and to other officials in accordance with state law including the state survey agency.</p> <p>The policy identified that CMS (Centers for Medicare & Medicaid Services) believes "immediately" means as soon as possible but should not exceed 24 hours after discovery of the incident in the absence of a shorter time frame requirement. Once reported, the facility should conduct a timely, thorough, objective investigation of all allegations of abuse, neglect, mistreatment of resident/s.</p> <p>The procedure revealed any alleged allegation or actual witness incident of abuse, neglect, "injury of unknown origin" must be reported immediately to the charge nurse and or immediate supervisor 24 hours a day/7 days a week.</p> <p>The policy listed 8 steps for the center to complete including: the Administrator or DON will initiate a preliminary investigation and notify the State Health Department immediately upon discovery of the incident/allegation. Witness statement will be obtained and if there is reason to believe an employee committed an act of abuse, the employee will be suspended; complete the "Final Investigative Summary Report" will be communicated to the State Health Department within 5 business days from the discovery of the incident; and report any "valeted allegation which would indicate unfitness for services as a nurse aide or other facility staff to the State Nurse Aide Registry or Licensing Agency or Authorities.</p>	F 223			

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F 223	Continued From page 12 Review of the facilities Your Rights and Protections as a Nursing Home Resident form (not dated) included the following: You have the right to have been free from verbal, sexual, physical and mental abuse. If you feel you have been mistreated (abused) or the nursing home isn't meeting your needs (neglec), report this to the nursing home or state agency or other local officials.	F 223		
F 225 SS=D	483.12(a)(3)(4)(c)(1)-(4) INVESTIGATE/REPORT ALLEGATIONS/INDIVIDUALS 483.12(a) The facility must- (3) Not employ or otherwise engage individuals who- (l) Have been found guilty of abuse, neglect, exploitation, misappropriation of property, or mistreatment by a court of law; (ii) Have had a finding entered into the State nurse aide registry concerning abuse, neglect, exploitation, mistreatment of residents or misappropriation of their property; or (iii) Have a disciplinary action in effect against his or her professional license by a state licensure body as a result of a finding of abuse, neglect, exploitation, mistreatment of residents or misappropriation of resident property. (4) Report to the State nurse aide registry or licensing authorities any knowledge it has of actions by a court of law against an employee, which would indicate unfitness for service as a nurse aide or other facility staff.	F 225	F225 – Reporting of Abuse The nurse on duty assessed resident #6 on 4/17/2017. The nurse practitioner and family notified of injury on 4/17/2017 with no new orders given. Major injury determination form completed with the nurse practitioner indicating that the resident's injury was determined not to be a "major injury." The resident's care plan updated to include a padded bolster to right armrest wheelchair on 4/17/2017, assist to bed for periods of rest between meals and at night and assist to wheelchair or recliner when restless on 4/23/2017, padding added to both side rails at the head of the bed on 4/25/2017 and OT/PT referral on 4/28/2017.	

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F 225	<p>Continued From page 13</p> <p>(c) In response to allegations of abuse, neglect, exploitation, or mistreatment, the facility must:</p> <p>(1) Ensure that all alleged violations involving abuse, neglect, exploitation or mistreatment, including injuries of unknown source and misappropriation of resident property, are reported immediately, but not later than 2 hours after the allegation is made, if the events that cause the allegation involve abuse or result in serious bodily injury, or not later than 24 hours if the events that cause the allegation do not involve abuse and do not result in serious bodily injury, to the administrator of the facility and to other officials (including to the State Survey Agency and adult protective services where state law provides for jurisdiction in long-term care facilities) in accordance with State law through established procedures.</p> <p>(2) Have evidence that all alleged violations are thoroughly investigated.</p> <p>(3) Prevent further potential abuse, neglect, exploitation, or mistreatment while the investigation is in progress.</p> <p>(4) Report the results of all investigations to the administrator or his or her designated representative and to other officials in accordance with State law, including to the State Survey Agency, within 5 working days of the incident, and if the alleged violation is verified appropriate corrective action must be taken. This REQUIREMENT is not met as evidenced by: Based on observation, clinical record review and staff interviews the facility failed to ensure that all alleged violations involving mistreatment, neglect,</p>	F 225	<p>The Director of Nursing and Administrator reviewed all incident reports to ensure there were no other injuries of unknown origin that needed to be investigated, none found. The Director of Nursing and Administrator will review and investigate all incidents of injury with unknown origin. Nursing staff inserviced on Resident Abuse policy and reporting responsibilities on 4/28/2017. Corporate Director of Clinical Services inserviced Administrator and Director of Nursing on Abuse policy and reporting requirements for injuries of unknown origin on 4/21/2017.</p> <p>The Assistant Directors of Nursing will audit all resident incidents and discuss during the</p>		

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F 225	<p>Continued From page 14</p> <p>or abuse were reported immediately to the Iowa Department of Inspections & Appeals within 24 hours or the next business day. A concern was identified for one (1) of six (6) residents reviewed (Resident #6). The facility reported a census of 111 residents.</p> <p>Findings Include:</p> <p>A Minimum Data Set (MDS) assessment form dated 3/11/17 indicate Resident #6 had diagnoses that included non-Alzheimer's dementia, anxiety and depression. The assessment indicated the resident sometimes had the ability to make him/her(self) understood and understood others. The MDS revealed Resident #6 had severe cognitive impairment and short term and long term memory deficits with continuous inattention, disorganized thinking and an altered level of consciousness. The MDS revealed Resident #6 did not exhibit other behaviors symptoms, such as physical symptoms such as hitting or scratching him/her(self). The MDS revealed the resident did not have psychosis (hallucinations or delusions). The assessment indicated the resident required extensive assistance of 2 staff members for bed mobility, transfers, ambulation, locomotion and toilet use. The MDS revealed the resident as always incontinent of bladder and frequently incontinent of bowels. The MDS revealed Resident #6 had no falls since admission/entry or reentry or prior assessment whichever is more recent; and used a wheelchair and walker for ambulation.</p> <p>A Care Plan with a target date of 6/29/17 had the following focus areas:</p>	F 225	<p>Daily Clinical meeting for four weeks.</p> <p>The Director of Nursing will review all reported resident incidents and discuss during the Daily Clinical meeting. The Administrator will monitor all of the incident reports and report monthly to the QAPI committee for three months.</p> <p style="text-align: center;">CAD April 28, 2017</p>		

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F 225	<p>Continued From page 15</p> <p>The resident is alert and oriented times 1 (to person) with severe long and short term memory problems due to dementia. The resident responded with short responses/body language. The resident's mood appeared stable but he/she can be anxious/frustrate at times.</p> <p>The resident can be resistive with cares and to other residents on occasion. When sitting in the lounge and staff should monitor him/her and keep the resident away from others. Staff should sit/position Resident #6 an arm's length reach from other residents. When awake, staff should keep him/her in a visible area when awake.</p> <p>The care plan identified the resident had a history of falling related to (r/t) general weakness and poor safety awareness due to (d/l) dementia ; and had impaired activities of daily living (ADL). The care plan identified he/she needed extensive assistance of 2 staff members with transfers, bed mobility, ambulation, toileting ; and on 3/27/17 staff to assist Resident #6 to and from meals/activities.</p> <p>Resident #6 liked to sleep in the recliner in the lounge area at times and staff should offer to assist him/her to bed so that he/she can rest. Resident #6 uses a special reclining wheelchair as his/her primary mode of locomotion.</p> <p>An Occupational Therapy (OT) Plan Of Care dated 3/27/17 indicated the resident displayed forward moderate kyphosis (rounding/describe the abnormal condition of the vertebral column) as well as a right lateral lean.</p> <p>A Medication Administration Record (MAR) form dated 4/1/17 thru 4/30/17 indicated the resident as not on any anti-coagulant medications.</p>	F 225			

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F 225	<p>Continued From page 16</p> <p>An observation 4/19/17 at approximately 10:30 a.m. revealed the resident positioned in a TIS chair as staff propelled him/her down the hallway with a golf ball sized hematoma on his/her left forehead with purple bruising surrounding the area and purple bruising on and around the resident's bilateral eyes.</p> <p>An injury form dated 4/17/17 at 8:40 a.m. and revised at 4:29 p.m. indicated the resident had an injury of unknown origin further described at a bruise on the left side of his/her forehead and left upper eye lid that measured 6 centimeter (cm) x (by) 18 cm red and purple in color.</p> <p>An Injury form dated 4/17/17 at 8:40 a.m. and revised at 4:29 p.m. and with an entry dated 4/19/17 revealed the following entry: Summary of findings for 4/17/17. Staff that worked the 3 p.m. until 11 p.m. shift on Sunday 4/16/17 and Sunday night 11 p.m. until 7 a.m. had been interviewed about the bruising found to the resident's forehead at breakfast on 4/17/17. The staff members voiced that no bruising had been noted at meal time on 4/16/17. The 2 staff members that assisted the hour of sleep (HS) cares between 7 p.m. and 9 p.m. stated that no bruising had been noted. Staff reported the resident had often been resistive with cares, would hit and strike at them with his/her arms and kick with his/her legs. The resident had a curvature of his/her spine and often sat bent over at the waist and leaned to the right. Staff that worked the 11 to 7 shift on the North hall voiced he/she had been toileted and slept in his/her wheelchair in the lobby area. Staff that assisted the resident with toileting</p>	F 225			

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F 225	<p>Continued From page 17</p> <p>around 6:30 a.m. to 7 a.m. voiced he/she had been resistive with cares however staff verbalized no observation of bruising at that time. At approximately 8:30 a.m. the resident had been observed in his/her wheelchair bent over with hair that covered his/her face in the dining room. When staff repositioned the resident to assist with breakfast and the bruising had been noted and immediately reported to the charge nurse and the Administrator. Also noted the resident had his/her head resting on the right arm rest area where the bruising had been noted so an arm bolster had been applied to the right arm rest.</p> <p>Progress Notes forms revealed the following entries:</p> <p>a. 4/17/17 at 4:29 p.m. - During breakfast the resident had been noted to have a bruise on the left side of his/her forehead. The area had been swollen, purple and red in color and the skin intact. The resident rested in the chair and took his/her morning medications. Neurological checks as within normal limits (WNL).</p> <p>b. 4/18/17 at 5:25 p.m. - The resident continued on follow up charting for the bruise on the left side of the forehead. The skin had been intact, purple and red in color with no swelling noted.</p> <p>c. 4/19/17 at 12:30 a.m. - The resident had a head injury to the right side of the head from and unknown source. There had also been significant bruising around the eyes.</p> <p>d. 4/20/17 at 10:35 a.m. - The resident with a large bruise to the right side forehead which extended out to both eyes from an unknown source.</p> <p>An observation 4/20/17 at 4:05 p.m., revealed the</p>	F 225			

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F 225	<p>Continued From page 18</p> <p>resident positioned on the toilet with obvious kyphosis (lump on the back) on the resident's left side of his/her back and a spinal curvature which resulted in the resident positioned forward and to the right side.</p> <p>An observation 4/26/17 at approximately 10 a.m. revealed the right and left arm rest of the resident's TIS chair with approximately 3/4 of an inch to 1 inch of padding attached to the rest itself.</p> <p>During an interview 4/20/17 at 5:02 p.m., Staff L, Certified Nursing Assistant (CNA) confirmed she worked the night shift Sunday 4/16. The staff member indicated the resident slept all night in the TIS chair in the lounge area and she never checked or changed the resident through the night. The staff member confirmed around 6:15 a.m. to 6:30 a.m. herself and Staff K, CNA transferred the resident to the toilet with the use of a gait belt while Staff K remained with the resident the entire time. Upon completion the staff members cleaned the resident up, stood him/her, pulled up the pants and positioned the resident in the TIS chair and returned him/her to the lounge area. The staff member confirmed when the resident sat in the TIS chair and/or on the toilet he/she leaned forward with his/her head down. The staff member indicated she never observed a bruise on the resident's forehead and/or face that morning and never observed the resident having hit his/her head.</p> <p>During an interview 4/20/17 at 5:14 p.m., Staff K confirmed the only time he assisted the resident with cares on 4/16 into 4/17/17 had been when when he transferred the resident per gait belt to</p>	F 225		
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F 225	<p>Continued From page 19</p> <p>the toilet and back to the wheel chair with the assistance of Staff L. The staff member indicated he never left the resident unattended in the bathroom, the resident never hit his/her head during cares and there had been no bruising present on the resident's forehead and/or facial features.</p> <p>During an interview 4/20/17 at 3:31 p.m., Staff D, CNA confirmed she worked the day shift on 4/17/17. When the staff member arrived at work she observed the resident sitting in the TIS chair in the lounge area however his/her head had been down so she could not see the resident's face. The staff member denied having provided any cares for the resident prior to the discovery of the hematoma/bruising. When the staff member first observed the area after breakfast it had been red and protruding as if it had just started. The staff member stated the area had not been as large as it appeared presently.</p> <p>During an interview 4/20/17 at 2:31 a.m., Staff A, CNA confirmed she worked the day shift on 4/17/17. When the staff member arrived at work she observed the resident sitting in the TIS chair in the lounge area with his/her head down however she did not look at the resident long enough to analyze anything. The staff member indicated between breakfast and lunch she observed the goose egg on the resident's forehead with no bruising initially then the bruising appeared and kept spreading throughout the day.</p> <p>During an interview 4/20/17 at 1:55 p.m., Staff I, CNA indicated he had not known where the</p>	F 225			

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F 225	<p>Continued From page 20</p> <p>resident had been when he arrived at work on 4/17/17. The staff member could not recall if he had taken the resident to the dining room for breakfast. The staff member felt the first time he had contact with the resident had been in the dining room for breakfast. The resident had been positioned in the TIS chair with his/her head down with his/her hair a little bit in front of his/her face. The staff member sat down to feed the resident and observed the bruise on the resident's forehead but he could not recall if there had been bruising on the resident's eye. The staff member immediately reported the observation to Staff J, Licensed Practical Nurse (LPN) and then went to assist other residents at another table.</p> <p>During an interview 4/20/17 at 2:14 p.m., Staff B, CNA confirmed he/she worked the day shift on 4/17/17 however she never provided any cares for the resident that morning. At 8:45 a.m. to 9 a.m. a nurse came to her and asked if she had provided cares for the resident that morning because the resident had a bruise on his/her face. When the nurse told her that she looked at the resident and observed a goose egg area with bruising on his/her forehead with no bruising on the resident's eyes however by the end of the shift both eyes had been black and blue in color.</p> <p>During an interview 4/20/17 at 1:20 p.m., Staff J indicated when she arrived at work on 4/17/17 the resident had been positioned in the TIS chair in the lounge area with his/her head down with hair over his/her face. The staff member received report with no information provided about the resident. The staff member indicated between her arrival at work and breakfast, which started at</p>	F 225			

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F 225	<p>Continued From page 21</p> <p>7:30 a.m. she did not see anyone take the resident to the bathroom however she thought Staff I propelled the resident to breakfast. As she passed morning medications Staff I came to her and said, you are going to be mad, you have to see the resident's face. When she approached the resident his/her head had been bent down so when she repositioned the resident's head back she observed a goose egg with bruising down to his/her left eye lid. The area had been less protruding than it appeared presently. The staff member reported the incident to Staff M, Registered Nurse (RN) who began an investigation as she started an assessment and reported the injury of unknown origin to the Nurse Practitioner (NP) and the resident's son.</p> <p>During an interview 4/20/17 at 2:40 p.m., Staff J confirmed the resident's bruising worsened throughout the day and spread over the resident's nose and to both eyes however the staff member never applied ice.</p> <p>During an interview 4/20/17 at 3:02 p.m., Staff M indicated around 8:30 a.m. she observed the resident in the dining room positioned in his/her chair, leaned to the right and his/her hair over his/her face. Staff I came over to feed the resident and when he sat the resident up, he said "oh my what is that", I am going to tell Staff J right now. At that point the staff member looked at the resident and said oh my gosh as the area had been red and raised with some bruising around the area but not a goose egg at that point and the staff member felt it had been a fresh area. At that point the staff member initiated an investigation. The staff member indicated she attempted</p>	F 225			

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F 225	<p>Continued From page 22</p> <p>application of ice later in the afternoon however the resident refused the intervention. The staff member indicated as the day proceeded the bruising became darker and by 4/18/17 there had been a bruised pocket on the resident's left eye and on 4/19/17 the bruising progressed to both eyes.</p> <p>During an interview 4/20/17 at 8:58 a.m., a family member indicated he/she had not felt the resident could have received a lump like that by moving around in a chair and that someone had not been telling the truth.</p> <p>During an interview 4/20/17 at approximately 9:35 a.m., a family member stated he/she felt the resident could not have sustained the injury from the arm rest of the wheelchair because the resident always leaned to the right and the area had been on his/her left side of the forehead.</p> <p>Review of a History and Physical form dated 4/18/17 at 9:20 p.m. included the following documentation from a Nurse Practitioner:</p> <ul style="list-style-type: none"> a. Head and Face - a left forehead contusion/hematoma without laceration. Dependent swelling and bruising of the left eye. b. Eyes - Not able to view the left eye due to swelling. c. Psychiatric - Judgement: alert and impaired insight. The patient's speech exhibited incoherence. The patient displayed significant memory loss which required supervision. d. Assessment - Head contusion e. Discussion/Summary - Head contusion with unknown even per staff investigation. The resident hunches forward in the wheelchair and 	F 225			

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F 225	<p>Continued From page 23 now the eye had been edematous also.</p> <p>During an interview 4/21/17 at 11:36 a.m., the Nurse Practitioner (NP) indicated a hematoma developed soon after an injury and could have been large. The bruising on the resident's eyes and face had been gradual and she felt the bruising had been a result of pooling of blood. The NP felt the resident's injury had been a result of a substantial hit to the affected area and not a result of the padded right arm rest of the resident's wheelchair.</p> <p>An Abuse/Neglect and Reporting Policy revised 9/16 identified that no one should be subject to abuse or neglectful behavior is the most critical step in detecting and preventing abuse. The policy revealed it is necessary for the center to adopt and institute an abuse, neglect prevention system to include protection of residents as well as identifying and investigating all allegations of abuse or mistreatment. The policy defined abuse according to the federal rule F223 as Abuse the resident has the right to be free from physical and mental. The intent of the federal rule 483.13 (b) revealed the resident had the right to be free from all types of abuse including physical abuse; and that residents must not be subject to abuse by anyone including staff, family or volunteers serving the resident.</p> <p>The intent of federal rule 483.13C revealed that each resident had the right to be free from mistreatment, and neglect. The policy defined neglect as the failure to provide the goods and services necessary to avoid physical harm.</p> <p>The policy revealed "Injuries of Unknown Source" should be classified as an "injury of unknown source" when both of the following</p>	F 225			

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F 225	<p>Continued From page 24 conditions are met:</p> <ol style="list-style-type: none"> 1. The source of the injury had not been observed by any person or the source of the injury could not have been explained by the resident: and, 2. The injury had been suspicious because of the extent of the injury or the location of the injury, e.g., the injury had been in an area not generally vulnerable to trauma, or the incidence of injuries over time. <p>The policy directed the center to ensure that all alleged violations involving mistreatment, neglect or abuse including injuries of unknown source are reported immediately to the administrator of the center and to other officials in accordance with state law including the state survey agency. The policy identified that CMS (Centers for Medicare & Medicaid Services) believes "immediately" means as soon as possible but should not exceed 24 hours after discovery of the incident in the absence of a shorter time frame requirement. Once reported, the facility should conduct a timely, thorough, objective investigation of all allegations of abuse, neglect, mistreatment of resident[/s].</p> <p>The procedure revealed any alleged allegation or actual witness incident of abuse, neglect, "injury of unknown origin" must be reported immediately to the charge nurse and or immediate supervisor 24 hours a day/7 days a week.</p> <p>The policy listed 8 steps for the center to complete including: the Administrator or DON will initiate a preliminary investigation and notify the State Health Department immediately upon discovery of the incident/allegation. Witness statement will be obtained and if there is reason to believe an employee committed an act of abuse, the employee will be suspended;</p>	F 225			

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F 225	Continued From page 25 complete the "Final Investigative Summary Report" will be communicated to the State Health Department within 5 business days from the discovery of the incident; and report any "validated allegation which would indicate unfitness for services as a nurse aide or other facility staff to the State Nurse Aide Registry or Licensing Agency or Authorities. During an interview 4/20/17 at 3:27 p.m., the Director of Nursing (DON) indicated the reason the facility failed to report the incident had been because the injury failed to change his/her level of care, he/she had not been admitted to a higher level of care and it failed to change his/her activities of daily living (ADL) status.	F 225			
F 242 SS=D	483.10(f)(1)-(3) SELF-DETERMINATION - RIGHT TO MAKE CHOICES (f)(1) The resident has a right to choose activities, schedules (including sleeping and waking times), health care and providers of health care services consistent with his or her interests, assessments, and plan of care and other applicable provisions of this part. (f)(2) The resident has a right to make choices about aspects of his or her life in the facility that are significant to the resident. (f)(3) The resident has a right to interact with members of the community and participate in community activities both inside and outside the facility. This REQUIREMENT is not met as evidenced by: Based on observation, clinical record review, and	F 242			

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F 242	<p>Continued From page 26</p> <p>Interviews, the facility failed to promote a resident's dignity and self-determination for preferred choice for sleeping for one (1) of six (6) residents (Resident #6). The facility identified a census of 111 residents.</p> <p>Findings include:</p> <p>A Minimum Data Set (MDS) assessment form dated 3/11/17 indicate Resident #6 had diagnoses that included non-Alzheimer's dementia, anxiety and depression. The assessment indicated the resident sometimes had the ability to make him/her(self) understood and understood others. The MDS revealed Resident #6 had severe cognitive impairment and short term and long term memory deficits with continuous inattention, disorganized thinking and an altered level of consciousness. The assessment indicated the resident required extensive assistance of 2 staff members for bed mobility, transfers, ambulation, locomotion and toilet use. The MDS revealed the resident as always incontinent of bladder and frequently incontinent of bowels. The MDS revealed Resident #6 used a wheelchair and walker for ambulation.</p> <p>A Care Plan with a target date of 6/29/17 had the following focus areas: The resident is alert and oriented times 1 (to person) with severe long and short term memory problems due to dementia. The resident responded with short responses/body language. The resident's mood appeared stable but he/she can be anxious/frustrate at times. The resident can be resistive with cares and to other residents on occasion. When sitting in the</p>	F 242	<p>F242 – Resident Dignity/Choice</p> <p>Resident #6 care plan updated to include a padded bolster to right armrest wheelchair on 4/17/2017, assist to bed for periods of rest between meals and at night and assist to wheelchair or recliner when restless on 4/23/2017, padding added to both side rails at the head of the bed on 4/25/2017 and OT/PT referral on 4/28/2017.</p> <p>Nursing staff inserviced on resident dignity and resident choice on 4/28/2017. Corporate Director of Clinical Services inserviced Administrator and Director of Nursing on resident dignity and resident choice on 4/21/2017.</p> <p>The Assistant Directors of Nursing will conduct weekly audits of the Look Back Report</p>	
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F 242	<p>Continued From page 27</p> <p>lounge and staff should monitor him/her and keep the resident away from others. Staff should sit/position Resident #6 an arm's length reach from other residents.</p> <p>The care plan identified the resident had a history of falling related to (r/t) general weakness and poor safety awareness due to (d/t) dementia ; and had impaired activities of daily living (ADL).</p> <p>The care plan identified he/she needed extensive assistance of 2 staff members with transfers, bed mobility, ambulation, toileting and on 3/27/17, staff to assist Resident #6 to and from meals/activities.</p> <p>Resident #6 liked to sleep in the recliner in the lounge area at times and staff should offer to assist him/her to bed so that he/she can rest.</p> <p>Resident #6 uses a special reclining wheelchair as his/her primary mode of locomotion. He/she had difficulty setting up straight (to help his/her spine) and staff should keep him/her in the tilted back as he/she tolerated.</p> <p>When awake, staff should keep him/her in a visible area when awake. Resident #6 can be forgetful/confused due to dementia and he/she cannot alert staff of his/her needs with staff needing to check on him/her frequently and anticipate his/her needs.</p> <p>The care plan revealed Occupational Therapy (OT) evaluated Resident #6 for a new wheelchair for positioning (dated 3/26/17).</p> <p>An Occupational Therapy (OT) Plan Of Care dated 3/27/17 indicated the resident displayed forward moderate kyphosis (rounding/describe the abnormal condition of the vertebral column) as well as a right lateral lean.</p>	F 242	<p>for four weeks to ensure residents plan of care for dignity and choice followed.</p> <p>The Director of Nursing will review Look Back Report audits during the Daily Clinical meeting. The Administrator will monitor all of the incident reports and report monthly to the QAPI committee for three months.</p> <p style="text-align: right;">CAD April 28, 2017</p>		

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F 242	<p>Continued From page 28</p> <p>An OT - Therapist Progress form dated 4/18/17 directed the staff to reposition the resident one time per hour while positioned in the Tilt N' Space (TIS) chair.</p> <p>An OT Daily Treatment Note dated 4/4/17 indicated the resident received the TIS chair and the staff educated that the resident could have been repositioned once an hour up to a 30 degree angle for 15-30 minutes for pressure relief.</p> <p>An Injury form dated 4/17/17 at 8:40 a.m. and revised at 4:29 p.m. and with an entry dated 4/19/17 revealed the following entry: Staff that worked the 11 to 7 shift on the North hall voiced he/she had been toileted and slept in his/her wheelchair in the lobby area.</p> <p>Review of Plan of Care (POC) Response History form for turning and repositioning the facility staff repositioned the resident as documented below: a. 4/16 - 5:06 a.m., 2:59 p.m. and 10:50 p.m. b. 4/17 - 5:41 a.m., 9:45 a.m. and 11:42 p.m.</p> <p>Review of a Look Back Report Form revealed the following as dated: a. 4/16 at 5:06 a.m. and 2:59 p.m. - The resident had toileted and transferred and at 10:51 p.m. transferred and 10:52 p.m. toileted. b. 4/17 at 5:41 a.m. - The resident had been toileted.</p> <p>During an interview 4/20/17 at 5:02 p.m., Staff L,</p>	F 242			

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F 242	<p>Continued From page 29</p> <p>Certified Nursing Assistant (CNA) confirmed she worked the night shift Sunday 4/16/17. The staff member indicated the resident slept all night in the TIS chair in the lounge area and she never checked or changed the resident through the night. The staff member confirmed around 6:15 a.m. to 6:30 a.m. herself and Staff K, CNA transferred the resident to the toilet with the use of a gait belt while Staff K remained with the resident the entire time.</p> <p>During an interview 4/20/17 at 5:14 p.m., Staff K confirmed the only time he assisted the resident with cares on 4/16/17 into 4/17/17 had been when he transferred the resident per gait belt to the toilet and back to the wheelchair with the assistance of Staff L.</p> <p>During an interview 4/20/17 at 2:14 p.m., Staff B, CNA confirmed he/she worked the day shift on 4/17/17 however she never provided any cares for the resident that morning.</p> <p>During an interview 4/26/17 at 11:23 a.m., Staff H, Occupational Therapist (OT) indicated there had been no reason the resident could not have slept in his/her bed.</p> <p>An observation 4/26/17 at approximately 10 a.m. revealed the resident positioned in the TIS chair in the lounge area sleeping surrounded by several residents.</p> <p>Review of the facilities Your Rights and</p>	F 242			

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F 242 F 279 SS=D	<p>Continued From page 30</p> <p>Protections as a Nursing Home Resident form (not dated) included the following:</p> <p>a. You have the right to have been treated with dignity and respect.</p> <p>483.20(d);483.21(b)(1) DEVELOP COMPREHENSIVE CARE PLANS</p> <p>483.20 (d) Use. A facility must maintain all resident assessments completed within the previous 15 months in the resident's active record and use the results of the assessments to develop, review and revise the resident's comprehensive care plan.</p> <p>483.21 (b) Comprehensive Care Plans</p> <p>(1) The facility must develop and implement a comprehensive person-centered care plan for each resident, consistent with the resident rights set forth at §483.10(c)(2) and §483.10(c)(3), that includes measurable objectives and timeframes to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment. The comprehensive care plan must describe the following -</p> <p>(i) The services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §483.24, §483.25 or §483.40; and</p> <p>(ii) Any services that would otherwise be required under §483.24, §483.25 or §483.40 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse</p>	F 242 F 279	<p>F279 – Care Planning</p> <p>Resident #6 care plan updated to meet current resident care needs, including a padded bolster to right armrest wheelchair on 4/17/2017, assist to bed for periods of rest between meals and at night and assist to wheelchair or recliner when restless on 4/23/2017, padding added to both side rails at the head of the bed on 4/25/2017 and OT/PT referral on 4/28/2017. The resident's care plan will continue to be updates as the resident's need change.</p> <p>Nursing staff inserviced on importance of updating and following resident care plans on 4/28/2017. Corporate Director of Clinical Services inserviced Administrator and Director of</p>	
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F 279	<p>Continued From page 31 treatment under §483.10(c)(6).</p> <p>(iii) Any specialized services or specialized rehabilitative services the nursing facility will provide as a result of PASARR recommendations. If a facility disagrees with the findings of the PASARR, it must indicate its rationale in the resident's medical record.</p> <p>(iv) In consultation with the resident and the resident's representative (s)-</p> <p>(A) The resident's goals for admission and desired outcomes.</p> <p>(B) The resident's preference and potential for future discharge. Facilities must document whether the resident's desire to return to the community was assessed and any referrals to local contact agencies and/or other appropriate entities, for this purpose.</p> <p>(C) Discharge plans in the comprehensive care plan, as appropriate, in accordance with the requirements set forth in paragraph (c) of this section.</p> <p>This REQUIREMENT is not met as evidenced by: Based on observation, clinical record review, and staff interview, the facility failed to follow all interventions for the comprehensive plan of care for 1 of 4 residents reviewed. (Resident #6). The facility identified a census of 111 residents.</p> <p>Findings include:</p> <p>According to the Minimum Data Set (MDS) assessment form dated 3/11/17 indicated Resident #6 had diagnosis that included</p>	F 279	<p>Nursing on resident care planning on 4/21/2017.</p> <p>The Assistant Directors of Nursing will conduct weekly audits of the Look Back Report for four weeks to ensure residents' plans of care are followed.</p> <p>The Director of Nursing will review Look Back Report audits during the Daily Clinical meeting. The Administrator will monitor audit reports and report monthly to the QAPI committee for three months.</p> <p>CAD April 28, 2017</p>		

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F 279	<p>Continued From page 32</p> <p>Non-Alzheimer dementia, anxiety and depression. The assessment indicated the resident sometimes had the ability to make self understood and understand others, with severely impaired cognitive skills, short term and long term memory deficits, continuous inattention, disorganized thinking and an altered level of consciousness. The assessment indicated the resident required extensive assistance of 2 staff members with be mobility, transfers, ambulation, locomotion and toilet use, as always incontinent of bladder and frequently incontinent of bowels and with no falls.</p> <p>A Care Plan (not dated) had focus areas that informed the staff that the resident my be alert and oriented to person with severe long and short term memory problems due to dementia. The resident may have anxiety and frustration at time and can be resistive with cares at times. The resident my spend time in the lounge to observe others has a history of falling with poor safety awareness.</p> <p>The Care Plan directs the staff to follow the following interventions:</p> <ul style="list-style-type: none"> a. Monitor the resident's location/monitor and supervise as needed. He/she had should be away from others when sitting in the lounge. b. Extensive assistance of 2 staff members with transfers, bed mobility, ambulation and toileting. c. I liked to sleep in the recliner in the lounge area at times. Offer to assist me to bed so that I can rest. 	F 279		

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F 279	Continued From page 33 d. Keep me in a visible area of the staff when awake. e. Occupational Therapy (OT) evaluated for a new wheel chair for positioning (dated 3/26/17) f. I had been forgetful/confused d/t my dementia and I could not alert staff to my needs. Please check on me frequently and anticipate my needs. g. I had a history of reaching and touching other residents positioned within reach. Please sit/position me an arms length reach from other residents. An observation 4/26/17 at approximately 10 a.m. revealed the resident positioned in his/her Tilt N' Space (TIS) chair in the lounge area surrounded by several residents.	F 279			
F 281 SS=D	483.21(b)(3)(i) SERVICES PROVIDED MEET PROFESSIONAL STANDARDS (b)(3) Comprehensive Care Plans The services provided or arranged by the facility, as outlined by the comprehensive care plan, must- (i) Meet professional standards of quality. This REQUIREMENT is not met as evidenced by: Based on observation, clinical record review and staff and family interview, the facility failed to follow physician orders for 1 of 4 residents reviewed. (Resident #3) The facility identified a census of 111.	F 281			

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F 281	<p>Continued From page 34</p> <p>Findings include:</p> <p>According to a MDS assessment dated 2/23/17, Resident #3 had diagnosis that included Non-Alzheimer dementia, anxiety disorder, difficulty walking and lack of coordination. The assessment indicated the resident had a Brief Interview for Mental Status (BIMS) score of 10 out of 15 (moderately impaired), required extensive assistance of staff with bed mobility, transfers, locomotion on and off the unit, toilet use, personal hygiene, required limited assistance of one staff with ambulation and with impairments on both sides of the upper and lower extremities.</p> <p>A Physician's Telephone Orders form dated 1/31/17 indicated the resident received an order to wear shoes when he/she ambulated.</p> <p>An observation 4/13/17 at 2 p.m. revealed Staff C, Registered Nurse (RN) ambulated the resident from his/her bed to the bathroom with a gait belt, walker, gripper socks and 1 staff assist. The staff member failed to put on resident shoes/rubber soled slippers. During an interview at the same time the staff member confirmed the resident's family member brought in rubber soled slippers but cut them on top for more room and now the Velcro would not stick when ambulating the resident and the family member planned to bring in new shoes/rubber soled slippers.</p> <p>An observation 4/19/17 at approximately 9:30 a.m., revealed 4-5 pair of rubber soled slippers in the resident's closet. During an interview at the same time a family member indicated he/she had not planned to buy new shoes as the resident had several pairs of rubber soled slippers and the</p>	F 281	<p>F281 – Physician Orders</p> <p>Resident #3's the physician order were reviewed and updated by the physician and the resident's care plan updated to current care needs on 4/28/2017</p> <p>Nursing staff inserviced on following physician orders on 4/28/2017. Corporate Director of Clinical Services inserviced Administrator and Director of Nursing on following physician orders on 4/21/2017.</p> <p>The Assistant Directors of Nursing will conduct weekly audits of the Look Back Report for four weeks to ensure physician orders followed.</p> <p>The Director of Nursing will review Look Back Report audits during the Daily Clinical meeting. The Administrator will</p>	

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F 281	Continued From page 35 facility had been instructed by a physcian to ambulate the resident in shoes. A Physician's Telephone Order form dated 4/7/17 indicated the resident received an order for a bed bath 2 times a week. Review of a Look Back Report form revealed the resident received a bath/shower as follows: a. 1 bath/shower between 1/21/17 and 1/30/17. b. No baths/shower between 2/11 and and 2/20. c. 1 bath/shower between 2/25 and 3/6. d. 1 bath/shower between 4/5 and 4/17.	F 281	monitor audit reports and report monthly to the QAPI committee for three months. CAD April 28, 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	F 309		

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F 309	Continued From page 36 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 observation, clinical record review and staff interviews, the facility failed to provide the necessary care to maintain the highest physical well being for 1 of 4 residents reviewed. (Resident #3) The facility identified a census of 111. Findings include: According to a MDS assessment dated 2/23/17, Resident #3 had diagnosis that included Non-Alzheimer dementia, anxiety disorder, difficulty walking and lack of coordination. The assessment indicated the resident had a Brief Interview for Mental Status (BIMS) score of 10 out of 15 (moderately impaired), required extensive assistance of staff with bed mobility, transfers, locomotion on and off the unit, toilet use and personal hygiene. An Office Visit: Adult Chronic Office Visit form dated 3/20/17 indicated the resident visited the	F 309	F309 – Highest Well Being Resident #3 completed antibiotic regime completed. Resident no longer has signs and symptoms of constipation and/or nausea and loose stools. The care plan has been update to indicate resident's current care needs. Nurses inserviced on proper assessment and documentation on 4/28/2017. Corporate Director of Clinical Services inserviced Administrator and Director of Nursing on assessment and documentation on 4/21/2017. The Assistant Directors of Nursing will conduct weekly audits of the Look Back Report		

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F 309	<p>Continued From page 37</p> <p>physician and received a diagnosis of constipation with the following new orders:</p> <ol style="list-style-type: none"> Encourage the patient to increase water and fiber intake. Magnesium Citrate 150 milliliters (ml) for 2 days. Colace 100 milligrams (mgs) two times a day then switch to 100 mg's daily once the patient started having soft stools. <p>A Look Back Report form revealed the resident suffered from loose stools on 3/21/17 at 4:17 a.m., 7:38 a.m., 1:33 p.m., 1:52 p.m. and 2:13 p.m.</p> <p>Review of the facilities Progress Notes revealed the following entries as dated with no further documentation and/or assessment of the resident's bowel status and/or nausea following the last entry.</p> <ol style="list-style-type: none"> 3/21/17 at 6:28 a.m. - At bedside per resident request. Resident had multiple loose stools that shift and now complained of nausea. Offered crackers and soda pop. The resident refused medications at that time due to nausea. The facility staff failed to perform an assessment of the resident. 3/21/17 at 8:16 a.m. - The resident alert with complaints of nausea. A call placed to the physician who directed the staff to utilize Zofran 4 mgs one tab by mouth every 4 hours for 3 days. The resident complained of feeling weak and transferred with extensive assistance of one staff, a gait belt and a front wheeled walker to the bathroom. The facility staff failed to perform an assessment of the resident. 	F 309	<p>for four weeks to ensure resident assessments are completed and documented. The Director of Nursing will review Look Back Report audits during the Daily Clinical meeting. The Administrator will monitor audit reports and report monthly to the QAPI committee for three months.</p> <p style="text-align: right;">CAD April 28, 2017</p>		

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F 309	Continued From page 38 c. 3/21/17 at 9:40 a.m. - The resident sat at bed side and ate 15-20% of breakfast. Fluids encouraged and readily taken. A call placed to the physician and received orders for Docusate sodium 200 mg by mouth, 2 times a day and Senna 2 tabs at bedtime and discontinue the Magnesium Citrate order. The facility staff failed to perform an assessment of the resident. During an interview 4/14/17 at 11:30 a.m., Staff M, MDS Coordinator confirmed there are no further assessments on the resident's nausea and loose stools. During an interview 4/19/17 at 1:45 p.m., the Director of Nursing (DON) confirmed she had been aware the facility staff required education on proper assessments. During an interview 4/14/17 at approximately 10:10 a.m. Staff C, Registered Nurse (RN) expected staff to assess and intervene when a resident had a change of condition.	F 309			
F 312 SS=E	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 observation, clinical record review and staff interview, the facility failed to ensure staff provided complete peri-care for 3 of 5 residents reviewed. (Resident #2, #4 and #5) and failed to bath 3 of 4 residents according to their request	F 312			

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F 312	<p>Continued From page 39</p> <p>(#1, #3 and #4) and failed to reposition 1 resident according to the plan of care. (Resident #6) The facility identified a census of 111 residents.</p> <p>Findings include:</p> <p>1. According to a Minimum Data Set (MDS) assessment form dated 1/7/17, Resident #1 had diagnosis that included Non-Alzheimer dementia, Alzheimer's disease, anxiety, depression and muscle weakness. The assessment indicated the resident had severe cognitive ability, had continuous inattention and disorganized thinking and required extensive assistance of staff with bathing.</p> <p>A Care Plan initiated 4/6/17 indicated the resident had a recent fracture of the right hip with surgical repair and required assistance with all activities of daily living (ADL's).</p> <p>A Physician's Telephone Orders form dated 4/7/17 indicated the resident received an order for a bed bath 2 times a week.</p> <p>Review of a Look Back Report form revealed the resident received a bath/shower as follows:</p> <p>a. 1 bath/shower between 1/21/17 and 1/30/17.</p> <p>b. No baths/shower between 2/11 and and 2/20.</p> <p>c. 1 bath/shower between 2/25 and 3/6.</p> <p>d. 1 bath/shower between 4/5 and 4/17.</p> <p>2. According to a MDS assessment dated 1/10/17, Resident #2 had diagnosis that included Non-Alzheimer dementia, anxiety and depression. The assessment indicated the resident had a BIMS score of 4 (severely</p>	F 312	<p>F312 -- ADLs</p> <p>Residents #1, 2, 3, 4, 5 and 6 care plans reviewed and updated as needed to meet current resident care needs. The staff observed during this survey were inserviced on proper care techniques.</p> <p>Nursing staff inserviced on following residents care plans, documentation of bathes/showers, proper pericare techniques and documentations of reposition residents on 4/28/2017. Corporate Director of Clinical Services inserviced Administrator and Director of Nursing on following residents care plans, documentation of bathes/showers, proper pericare techniques and documentations of reposition residents assessment on 4/21/2017.</p>	

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F 312	<p>Continued From page 40</p> <p>impaired cognitive ability) required extensive assistance of 2 staff with bed mobility, transfers, ambulation and toilet use, extensive assistance of 1 staff with personal hygiene and frequent incontinence of both bowel and bladder.</p> <p>A Care Plan initiated 7/21/16 indicated the resident had urinary/bowel incontinence due to a history of urinary retention and urinary tract infections. The interventions included the following:</p> <p>a. Check me for incontinence. Wash, rinse and dry my perineum. Change clothing as needed (PRN) after incontinence episodes. Apply a topical barrier to my skin.</p> <p>b. I utilize disposable briefs. Change me PRN.</p> <p>An observation 4/13/17 at 1:30 p.m. revealed Staff A, CNA and Staff B, CNA transferred the resident to bed, removed his/her pants and pulled back the soiled brief. The staff positioned the resident on his/her right side while Staff B cleansed the resident's mid gluteal region but failed to cleanse the resident's left buttock. The staff positioned the resident on his/her left side while Staff A cleansed the resident's mid gluteal region several times but failed to cleanse the resident's right buttock.</p> <p>3. According to a MDS assessment dated 2/23/17, Resident #3 had diagnosis that included Non-Alzheimer dementia, anxiety disorder, difficulty walking and lack of coordination. The assessment indicated the resident had a BIMS score of 10 (moderately impaired cognitive ability) and dependent on 2 staff members for bathing.</p> <p>A Care Plan (not dated) indicated the resident</p>	F 312	<p>The Assistant Directors of Nursing will conduct weekly audits of the Look Back Report for four weeks to ensure resident proper completion of bathes/showers and repositioning of residents. An Incontinent Care Audit tool implemented. The Assistant Directors of Nursing, or nursing designee, will conduct peri-care audits to ensure proper technique for four weeks.</p> <p>The Director of Nursing will review Look Back Report audits and Incontinent Care Audits during the Daily Clinical meeting. The Administrator will monitor audit reports and report monthly to the QAPI committee for three months.</p> <p style="text-align: right;">CAD April 28, 2017</p>	

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F 312	<p>Continued From page 41</p> <p>had impaired ADL function related to a need for assistance with ADL's and a diagnosis of dementia. The interventions included the following:</p> <ul style="list-style-type: none"> a. I need extensive assistance of 1 staff member with ADL's. b. Per family request please offer me a bed bath instead of a shower. c. I have a history of anxiety, if I became anxious or agitated please ensure my safety and re-approach at a later time or have another staff member attempt to provide cares. <p>During an interview 4/13/17 at approximately 1 p.m. the resident indicated he/she would have liked a bath at least every other day.</p> <p>Review of a Look Back Report form revealed the resident received a bath/shower as follows:</p> <ul style="list-style-type: none"> a. 1 bed bath between 1/28 and 2/5 with no documented refusals. b. 1 bed bath between 2/18 and 2/25 with one documented refusal and no attempts to re-approach. c. 1 bed bath between 2/26 and 3/4 with no documented refusals. d. 1 bed bath between 3/10 and 3/18 with one documented refusal and no attempts to re-approach. <p>4. According to a MDS assessment form dated 2/1/17, Resident #4 had diagnosis that included depression, difficulty walking, muscle weakness, obesity and malaise. The assessment indicated the resident had a BIMS score of 6 (severe cognitive ability), required extensive assistance of 2 staff with toilet use and limited assistance of 2 staff with personal hygiene and always incontinent of urine and frequently incontinent of</p>	F 312			

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F 312	<p>Continued From page 42 bowels.</p> <p>A Care Plan (not dated) indicated the resident had an impaired ADL function related to general debility and need for assistance and with occasional urinary incontinence related to a need for assist with toileting. The interventions included the following:</p> <ul style="list-style-type: none"> a. I like to shower 2 times a week and PRN. b. I wore a brief for my incontinence and dignity and please assist me with incontinence care after each episode. <p>An observation 4/13/17 at 10:36 a.m., revealed Staff F, Certified Nursing Assistant (CNA), Staff D, CNA and Staff E, Registered Nurse (RN) transferred the resident to bed per EZ stand lift device, pulled down the resident's pants, positioned him/her in bed and pulled down his/her brief. Staff E provided anterior perineal care and then positioned the resident on his/her left side. Staff E provided posterior perineal care to the mid gluteal region and the right buttock but failed to cleanse the resident's left buttock.</p> <p>Review of a Look Back Report form revealed the resident received a bath/shower as follows:</p> <ul style="list-style-type: none"> a. 1 bath/shower between 2/18 and 2/27. <p>5. According to a MDS assessment form dated 2/7/17, Resident #5 had diagnosis that included Non-Alzheimer dementia, depression and age related physical debility. The assessment indicated the resident had a BIMS score of 6 out of 15(severe cognitive ability), required extensive assistance of 2 staff with toilet use, extensive assistance of 1 staff with personal hygiene and as always incontinent of his/her bowels and bladder.</p>	F 312			

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F 312	<p>Continued From page 43</p> <p>A Care Plan (not dated) indicated the resident had incontinence related to a history of urgency and limited mobility. The interventions included the following:</p> <ul style="list-style-type: none"> a. Provide incontinence care after each incontinent episode. b. Wore briefs. c. Cue and assist with toileting frequently. <p>A Urinalysis form dated 2/2/17 at 9:47 a.m. indicated a urine culture had been indicated. The test revealed the resident had greater than 100,000 Alpha Hemolytic Streptococcus and 10,000 - 50,000 Streptococcus Agalactiae (Group B) isolated.</p> <p>An observation on 4/13/17 at 10 a.m. revealed Staff A, CNA and Staff B, CNA assisted the resident to bed. The staff members positioned the resident on his/her right side while Staff B cleansed the resident's posterior perineal area from back to front over the rectum and up into the vaginal area 3 times. Staff C, RN interrupted the process and said I can not watch this anymore, you have to go from front to back. Staff B then recleansed the resident appropriately.</p> <p>During an interview 4/13/17 at approximately 11:40 a.m., Staff C confirmed she would not have been in the resident's room during the above stated perineal cares had the surveyor not observed the cares.</p> <p>During an interview 4/13/17 at 11:27 a.m., Staff G, Assistant Director of Nursing (ADON) and Staff N, ADON indicated the facility utilized the standard of practice for perineal care. The standard of care included the following:</p>	F 312			

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 165448	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 04/26/2017
NAME OF PROVIDER OR SUPPLIER BISHOP DRUMM RETIREMENT CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 5837 WINWOOD DRIVE JOHNSTON, IA 50131		
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F 312	<p>Continued From page 44</p> <ol style="list-style-type: none"> a. Cleanse the residents from front to back. b. One wipe per cloth. c. Cleanse the upper anterior perineal area first. d. Cleanse the groin region.. e. Posteriorly cleanse the resident's bilateral buttocks including the outer region. <p>6. A MDS assessment form dated 3/11/17 indicated Resident #6 had diagnosis that included Non-Alzheimer dementia, anxiety and depression. The assessment indicated the resident sometimes had the ability to make self understood and understand others, had severe impaired cognitive skills, short term and long term memory deficits, continuous inattention, disorganized thinking and an altered level of consciousness. The assessment indicated the resident required extensive assistance of 2 staff members with bed mobility, transfers, ambulation, locomotion and toilet use, as always incontinent of bladder and frequently incontinent of bowels.</p> <p>A Care Plan (not dated) had focus areas that included the following:</p> <ol style="list-style-type: none"> a. I am alert and oriented times 1 (to person) with severe long and short term memory problems due to dementia. I responded with short responses/body language. My mood appeared stable but I could get anxious/frustrated at times. I could have been resistive with cares and to other residents on occasion. I spent time in the lounge to observe others. b. I had a history of falling related to (r/t) general weakness and poor safety awareness due to (d/t) dementia. c. I had impaired activities of daily living (ADL) function r/t general weakness and dementia. 	F 312			

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F 312	<p>Continued From page 45</p> <p>The approaches included the following:</p> <ul style="list-style-type: none"> a. Monitor the resident's location/monitor and supervise as needed. The resident is suppose to be away from other residents when setting in the lounge area. b. Extensive assistance of 2 staff members with transfers, bed mobility, ambulation and toileting. c. I liked to sleep in the recliner in the lounge area at times. Offer to assist me to bed so that I can rest. d. Keep me in a visible area of the staff when awake. e. Occupational Therapy (OT) evaluated for a new wheel chair for positioning (dated 3/26/17) f. I had been forgetful/confused d/t my dementia and I could not alert staff to my needs. Please check on me frequently and anticipate my needs. g. I had a history of reaching and touching other residents positioned within reach. Please sit/position me an arms length reach from other residents. h. I had a special reclining wheel chair as my primary mode of locomotion. I had difficulty setting up straight. Keep me tilted back as I tolerated. I needed staff to assist me to and from meals/activities. (dated 3/27/17) <p>Review of a Position in a Tilt N' Space Wheel Chair form (not dated) included the following staff directive which had been Initialed by Staff A, CNA, Staff B, CNA and Staff I, CNA.</p> <ul style="list-style-type: none"> a. One time per hour the patient should have been repositioned to 30-35 degrees for at least 15 minutes to provide pressure relief and then back to 50 degrees for best postural alignment. <p>During an interview 4/26/17 at 1:05 p.m., Staff A</p>	F 312			

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F 312	<p>Continued From page 46</p> <p>confirmed she had not been sure how often the staff had been directed to reposition the resident.</p> <p>During an interview 4/26/17 at 2:35 p.m. Staff B confirmed she had repositioned the resident 3 times today from 6:30 a.m. until present.</p> <p>During an interview 4/26/17 at 1:06 p.m., Staff I confirmed he repositioned the resident 2 times that morning from 6:30 a.m. until present.</p> <p>During an interview 4/20/17 at 5:02 p.m., Staff L, Certified Nursing Assistant (CNA) confirmed she worked the night shift Sunday 4/16. The staff member indicated the resident slept all night in the TIS chair in the lounge area and she never checked or changed the resident through the night.</p> <p>During an interview 4/26/17 at 11:23 a.m., Staff H, Occupational Therapist (OT) confirmed the resident is on a every 1 hour repositioning schedule when in the TIS chair because the resident could not repositioned himself/herself. The staff member indicated there had been no reason the resident could not sleep in his/her bed.</p> <p>Review of Plan of Care (POC) Response History form for turning and repositioning given to the surveyor on 4/26/17 at approximately 2:45 p.m. The staff repositioned the resident as documented below:</p> <ul style="list-style-type: none"> a. 4/26/17 - 4:11 a.m. and 9:50 a.m. b. 4/25 - 5:02 a.m., 1:59 p., and 9:21 p.m. c. 4/24 - 12:06 p.m. and 10:34 p.m. d. 4/23 - 3:44 a.m., 12:47 p.m., 5:45 p.m. and 11:11 p.m. 	F 312			

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F 312	Continued From page 47 e. 4/22 - 11:01 a.m. and 10:25 p.m. f. 4/21 - 4:20 a.m., 9:39 a.m. and 10:59 p.m. g. 4/20 - 12:03 p.m. and 10:09 p.m. h. 4/19 - 3:31 a.m., 1:36 p.m., 10:35 p.m. and 11:26 p.m. i. 4/18 - 2:37 a.m., 9:41 a.m. and 10:42 p.m. j. 4/17 - 5:41 a.m., 9:45 a.m. and 11:42 p.m. k. 4/16 - 5:06 a.m., 2:59 p.m. and 10:50 p.m.	F 312			