STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	165248	A. BUILDING _____ B. WING _____	05/11/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PLEASANT ACRES CARE CENTER	309 RAILROAD STREET HULL, IA 51239

(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 VKK 5/26/17 Correction date 5-11-2017 The following deficiencies relate to the facility's annual health survey. (See Code of Federal Regulations (45 CFR) Part 483, Subpart B-C). Complaint #67846 & facility reported incident #67907 was not substantiated.	F 000		
F 309 SS=G	483.24, 483.25(k)(l) PROVIDE CARE/SERVICES FOR HIGHEST WELL BEING 483.24 Quality of life Quality of life is a fundamental principle that applies to all care and services provided to facility residents. Each resident must receive and the facility must provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being, consistent with the resident's comprehensive assessment and plan of care. 483.25 Quality of care Quality of care is a fundamental principle that applies to all treatment and care provided to facility residents. Based on the comprehensive assessment of a resident, the facility must ensure that residents receive treatment and care in accordance with professional standards of practice, the comprehensive person-centered care plan, and the residents' choices, including but not limited to the following: (k) Pain Management. The facility must ensure that pain management is provided to residents who require such services, consistent with professional standards of practice, the comprehensive person-centered care plan,	F 309		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Tamara Lund
TITLE: Administrator
(X6) DATE: 05/25/2017

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.

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F 309	Continued From page 1 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 record review, physician and staff interviews and review of the policy and procedures, the facility failed to perform ongoing thorough assessment and timely intervention, including notification to the physician, when a resident had a change of condition (Resident #4). The sample consisted of 15 residents and the facility reported a census of 57 residents. Findings included: Resident #4 had a quarterly MDS (Minimum Data Set) assessment with a reference date of 2/26/17. The MDS identified the resident had short term memory loss, moderately impaired cognition, made poor decisions and required cues and supervision. The MDS indicated the resident required extensive assistance from 2 staff members for bed mobility, transfer, toilet use and personal hygiene. The MDS identified the resident as frequently incontinent of bowel. According to a Diagnosis Report form dated 5/10/17, Resident #4's diagnoses included urinary tract infection (UTI), urine retention, acute kidney failure, aphasia (inability to express speech), and hemiplegia and hemiparesis (paralysis) following cerebrovascular (CVA) disease (area of the brain that is temporarily or permanently affected by	F 309		

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F 309	Continued From page 2 bleeding or lack of blood flow). Review of a physician note dated 3/7/17, indicated the resident was recently hospitalized on 2/27/17 with hematuria (blood in the urine), had an acute kidney injury, may have had an infection and required the use of a Foley catheter (urinary catheter). A Care Plan with a revision date of 3/2/17 included a focus for alteration in elimination and frequent incontinence of bowel and bladder. The Care Plan indicated the resident had a history of UTI's and had a Foley catheter (indwelling catheter tube in bladder to drain urine into a bag). The Care Plan included an intervention for staff to monitor the resident for signs and symptoms of a UTI such as urinary frequency, urgency, bloody urine, odorous urine, painful urination, flank discomfort and directed staff to notify a physician of any of the above signs and symptoms. A facility document form titled, Clinical Change in Condition Management dated 6/2015, included an overview for the facility to strive to identify and manage residents who experienced a change in condition and included the following procedures: Assess a resident when a change in condition is identified, which may include but not limited to: vital signs (temperature, pulse, respirations and blood pressure), lung sounds, pulse oximetry (a sensor that monitors oxygenation of the blood), mental and neurological status, bowel sounds, pain, skin color and temperature. Review the resident's condition with a registered nurse, contact a physician and provide information about the resident's condition. Review of Resident #4's nursing Progress Notes	F 309		

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F 309	Continued From page 3 identified the following: On 4/26/17 at 2:30 P.M. - Staff changed the resident's Foley catheter with difficulty, had return of pale yellow urine with some blood noted and notified the resident's physician. On 4/26/17 at 6:31 P.M. - The Resident continued to have pain at the catheter insertion site, noted blood in the urine and documented the need to continue to monitor for any increased blood. Record review revealed staff failed to document any further assessment of the resident such as vital signs, lung sounds, bowel sounds, observation of or palpation (touch) of the resident's abdominal area or an attempt to communicate with the resident in regards to his/her pain severity. Not until 4/27/17 at 3:08 A.M. (approximately 8 1/2 hours later), staff described the resident as moaning and crying some. Unable to understand what he/she needed and the Foley catheter drainage bag had no urine in it. Staff flushed and advanced the catheter with a return of a small amount of pink urine. The resident had 2 large bowel movements and a suppository for bladder spasms due to the Foley catheter being change earlier in the day. The note lacked any further assessment of the resident such as vital signs, lung sounds, bowel sounds, palpation or exam of the resident's abdomen, or an attempt to communicate with the resident in regards to his/her pain. Not until 4/27/17 at 8:03 A.M. - (5 hours after the last assessment in regards to the resident moaning and crying), the resident still had near to nothing urinary output, staff flushed the catheter	F 309		

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F 309	Continued From page 4 with few blood clots. Monitor the resident to see if he/she gets any better at the time staff assisted the resident out of bed. On 4/27/17 at 8:30 A.M. - Staff assisted the resident out of bed. The resident had a large dark brown emesis and she/he became unresponsive for a few seconds. Staff documented the resident's vital signs as temperature- 103.1 degrees Fahrenheit, pulse-136 beats per minute, respirations- 38 and blood pressure 112/72. Staff recorded a pulse oximetry of 88% on room air. Staff documented the resident's lung sounds as diminished and administered oxygen. The following range determines normal vital signs: Temperature: 97.7 - 99.5, Pulse: 60-100 beats per minute and Respirations: 16-18 per minute. A Pulse Oximetry reading of 95-100 % is considered normal. On 4/2717 at 8:35 A.M. - Staff contacted a nurse in an Emergency room and documented the need for the resident to be transferred to the Emergency room via ambulance. On 5/2/17 at 1:45 - The resident returned to the facility after hospitalized for approximately 5 days. Review of Emergency Room Visit Notes dated 4/27/17, included the following Physician documentation: Laboratory results revealed severe sepsis (life threatening condition that arises when the body's own response to infection causes injury to its own tissue and organs) documented the resident in critical status and admitted to eICU (intensive care unit). The physician documented a primary impression as severe sepsis with septic shock.	F 309		

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F 309	Continued From page 5 A hospital Discharge Summary dated 5/2/17, identified the resident's physician documented the resident's diagnoses at the time of hospitalization to be sepsis due to UTI. During an interview on 5/10/17 at 8:30 A.M., Staff C, Licensed Practical Nurse/LPN stated if a resident moaned and cried in pain, she needed to obtain vital signs and do a thorough assessment of the resident. During a telephone interview on 5/10/17 at 9:10 A.M., the resident's physician confirmed an assessment of the resident's vital signs in the middle of the night on 4/27/17, may have been beneficial in assessment of a change in condition in the resident, especially because of the resident's inability to speak. During an interview on 5/10/17 at 9:30 A.M., the facility Administrator/Registered Nurse confirmed she expected nursing staff to perform further assessment of a resident moaning and crying in pain. During an interview on 5/10/17 at 9:40 A.M., Staff D, LPN stated if a resident moaned and cried in pain she needed to complete a head to toe assessment and obtain vital signs.	F 309		
F 496 SS=D	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-	F 496		

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F 496	Continued From page 6 (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. (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 record review, facility policy review and staff interview, the facility failed to verify nurse aide registry eligibility prior to employment for two of three Certified Nurse Aide, CNA reviewed. (Staff A & Staff B). The facility census was 57 residents.	F 496		

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F 496	Continued From page 7 Findings include: 1. A New Employee Summary Information form revealed Staff A was hired 4/26/17 with a start date of 4/27/17. A Single Contact License & Background (SING) check form dated 4/6/17, revealed the facility checked Staff A's abuse and criminal history background checks, but lacked a check for CNA eligibility. Review of a Direct Care Worker Demographics form revealed the facility checked Staff A's CNA eligibility, but the form lacked a date to show the date the eligibility was checked. Review of an electronic time card report form revealed Staff A began employment in the facility on 5/8/17. Review of a Direct Care Worker Search Results form revealed the facility checked Staff A's CNA eligibility on 5/9/17. 2. A New Employee Summary Information form revealed Staff B was hired 3/8/17 with a start date of 3/13/17. A SING check form dated 2/22/17, revealed the facility checked Staff B's abuse and criminal history background checks, but lacked a check for CNA eligibility. Review of a Direct Care Worker Search Results form revealed the facility checked Staff B's CNA eligibility, but the form lacked a date to show the date the eligibility was checked.	F 496		

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F 496	Continued From page 8 Review of an electronic time card report form revealed Staff B began employment in the facility on 4/3/17. Review of a separate Direct Care Worker Search Results form revealed the facility checked Staff B's CNA eligibility on 5/9/17. During interview on 5/9/17 at 10:05 a.m., the Administrator stated the facility had confirmed Staff A and Staff B's CNA eligibility on 5/9/17. The Administrator had no reason in regards to the initial CNA eligibility checks lacking dates. Review of a facility Abuse Prevention Program & Reporting Policy included the following in regards to screening potential employees prior to hire: Screening will consist of inquiries into the State nurse aide registry.	F 496	See attached	

This plan of correction does not constitute an admission or agreement by the provider of the truth of the facts alleged or the conclusions set forth in the statement of deficiencies. This plan of correction is prepared solely because it is required by State and Federal law.

F309 It is the practice of the facility to perform thorough assessment and timely intervention, including notification to the physician, when a resident has a change of condition.

1. For resident #4, staff nurses working with resident #4 on 4/26/17 and 4/27/17 were educated on change of condition policy, and the importance of conducting a thorough assessment including vital signs with any possible change in a resident's condition and reporting significant changes to physician timely. Resident #4's orders and progress notes were reviewed to ensure orders and plan of care are current and up to date with accurate information.
2. Charts of all residents with Foley catheters were reviewed on 5/10/17 to ensure physician's orders are current and up to date with accurate information. Urinary output every shift was added to MAR as a nursing intervention to ensure output is monitored regularly. Progress notes for all current residents were reviewed by Administrator (RN) for past 7 days to ensure any condition changes were appropriately assessed and appropriate interventions implemented.
3. In-service education was provided to RN's and LPN's on 5/10/17 and 5/11/17 by Administrator (RN) and interim DON regarding nursing assessment of condition change, implementing appropriate interventions including obtaining full vital signs, physician notification, and timely follow up with appropriate documentation.
4. DON/designee will audit progress notes each weekday to ensure any condition changes are appropriately assessed and appropriate interventions and follow up implemented. DON/designee will report findings to QAPI committee x 3 months.

Completion date: 5/11/17

F496 It is the practice of the facility to verify nurse aide registry eligibility prior to employment.

1. For staff A and Staff B the C.N.A. registry verification of licensure was rechecked and current licensure verified on 5/9/17.
2. All C.N.A.'s currently employed by the facility were reviewed on 5/10/17 to ensure they are current on the registry and licensed in Iowa.
3. Administrator and Business Office staff were inserviced on the need to ensure that a date is on the C.N.A. registry verification documentation to prove that the registry was checked prior to date of hire.
4. Administrator/designee will review all new hire documentation prior to employee beginning to work with residents to ensure the C.N.A. registry verification was completed appropriately. Administrator/designee will report findings to QAPI committee x 3 months.

Completion date: 5/11/17