STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	165455	A. BUILDING _____ B. WING _____	05/17/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HAWKEYE CARE CENTER CARROLL	2241 NORTH WEST STREET CARROLL, IA 51401

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 000	INITIAL COMMENTS Correction date 5/18/17 The following deficiencies result from the facility's annual health survey and investigation. Investigation of complaint #67871-C and facility self-reported incident #67804-I resulted in deficiencies. Complaint #65891-C was not substantiated. See the Code of Federal Regulations (42CFR) Part 483, Subpart B-C.	F 000	F000 Credible allegation of compliance listed in each F tag summary.	
F 323 SS=K	483.25(d)(1)(2)(n)(1)-(3) FREE OF ACCIDENT HAZARDS/SUPERVISION/DEVICES (d) Accidents. The facility must ensure that - (1) The resident environment remains as free from accident hazards as is possible; and (2) Each resident receives adequate supervision and assistance devices to prevent accidents. (n) - Bed Rails. The facility must attempt to use appropriate alternatives prior to installing a side or bed rail. If a bed or side rail is used, the facility must ensure correct installation, use, and maintenance of bed rails, including but not limited to the following elements. (1) Assess the resident for risk of entrapment from bed rails prior to installation. (2) Review the risks and benefits of bed rails with the resident or resident representative and obtain	F 323		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

POC accepted 6/6/17 VN

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	165455	A. BUILDING _____ B. WING _____	05/17/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HAWKEYE CARE CENTER CARROLL	2241 NORTH WEST STREET CARROLL, IA 51401

(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 323	Continued From page 1 informed consent prior to installation. (3) Ensure that the bed's dimensions are appropriate for the resident's size and weight. This REQUIREMENT is not met as evidenced by: Based on record review, observation, and staff interviews, the facility failed to protect residents from environment hazards when residents' beds were placed with the side of the beds against the baseboard heater. Resident #4 attempted to get out of bed unassisted and fell on the baseboard heater sustaining burns. Observation identified sixteen remaining beds were located near heaters and unsafe. The facility failed to ensure a bed side rail functioned properly and a bed lowered to a safe height (Resident #1). The sample consisted of 7 residents. The facility reported a census of 74 residents. Findings include: Resident #4 had an admission MDS (Minimum Data Set) assessment, with a reference date of 4/12/17. The MDS identified the resident had diagnoses including hypertension (elevated blood pressure), high cholesterol level, dementia, and stroke (a cerebrovascular disease). The MDS documented the resident had impaired long and short term memory loss, displayed no behavioral symptoms, required extensive assistance of 2 staff members for bed mobility, transfers and did not walk. The Care Plan identified the resident at risk for falls due to a CVA (Cerebral Vascular Accident-stroke), weakness, and immobility. The Care Plan listed the following interventions:	F 323	F323 Credible allegation of compliance: Abatement for IJ May 10, 2017, remainder May 18, 2017. It is the policy of, and Hawkeye Care Center Carroll will, attempt to protect residents from environmental hazards. Resident #4's bed is located outside of the manufacturer recommendations for the heater. Resident #1's bed siderail is in secure working order. Staff were educated on 5/10/17 regarding placement of items within manufacturer directions of the heaters. Red tape clearance lines were installed by 5/15 around all resident room heaters. Grate systems around the heaters are part of the abatement plan. All heater areas were assessed in the evalutation of the abatement concerns and continue to be routinely audited. All beds were audited for concerns of side rail malfunctions. Ongoing audits continue through the monthly bed inspection process. Maintenance and Nursing will report on going concerns to the QA Committee.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	165455	A. BUILDING _____ B. WING _____	05/17/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HAWKEYE CARE CENTER CARROLL	2241 NORTH WEST STREET CARROLL, IA 51401

(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 323	Continued From page 2 On 4/6/17- Assess quarterly and as needed for risk of falls; On 4/6/17-Assure appropriate footwear on when up; On 5/8/17- High low bed; On 5/4/17- Use a recline back wheelchair; On 5/2/17-Personal alarm at all times The Care Plan identified the resident had an activities of daily living deficit and listed the following interventions: On 4/26/17-t transfer with 2 staff members and a Hoyer (mechanical) lift. The Skin Integrity Investigation dated 4/27/17 at 7:15 a.m. documented a burn/blister to the left lower leg, left foot 2nd, 3rd, and 4th toes. The prevention intervention listed to move the bed from the radiator. The Care Plan documented the resident as at risk for skin breakdown and had blisters on the lower leg as well as toes due to attempting to transfer unassisted out of bed. The resident sustained blisters from touching heater on the wall. The Care Plan listed the following interventions: On 4/26/17-Air mattress overlay on the bed On 4/26/17- Heel protectors in bed On 4/6/17-Monitor skin with cares, alert the nurse of any open/red areas so the physician can be contacted. On 4/27/17-Keep bed away from radiant heater On 5/8/17- Treatment to blisters, as ordered. The Hospice Physician Certification/Recertification of Terminal Illness dated 4/18/17, identified the resident had a wound to the right lateral left leg that measured	F 323		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	165455	A. BUILDING _____ B. WING _____	05/17/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HAWKEYE CARE CENTER CARROLL	2241 NORTH WEST STREET CARROLL, IA 51401

(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 323	Continued From page 3 3.5 (centimeters) x [by] 1.7 cm. The note lacked physician notification and or treatment orders. The Progress Notes dated 4/20/17 at 2:30 a.m. indicated Staff B, Registered Nurse from a staffing agency, documented the resident had a 4 cm x 2 cm old blistered site. Staff documented the area as not open, no drainage, no warmth, no discomfort, and surrounding skin slightly pink. During an interview on 5/10/17 at 12:56 p.m. Staff B stated she worked the night shift on 4/20/17 and documented in the Progress Notes there was documentation about an area on the resident's right calf. Staff H, certified nurse aide, alerted her to the area. Staff B stated the area appeared to be an abrasion. Staff B stated she looked through the resident's chart and found no documentation of the area. Staff B stated she did not notify the physician or family due to the hour [during the night]. Staff B reported the information to the next shift. During an interview on 5/10/17 at 1:55 p.m. Staff H told Staff B he observed a red area to the resident's right calf that looked like an opened blister. Staff H stated the resident had restless legs and kicked legs out of bed. During an interview on 5/10/17 at 3:34 p.m. Staff F, Hospice nurse, stated she observed the area on the 4/21/17 and obtained treatment orders. Staff F stated the area originally looked like an abrasion from the Hoyer lift sling and now the area looked like a burn. The Progress Notes dated 4/21/17 at 10:39 a.m. documented the Hospice social worker visited the resident and stated the Hospice nurse will be	F 323		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	165455	A. BUILDING _____ B. WING _____	05/17/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HAWKEYE CARE CENTER CARROLL	2241 NORTH WEST STREET CARROLL, IA 51401

(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 323	Continued From page 4 called regarding the open area on the resident's right calf. The Progress Notes documented the skin as an open area. The Skin Condition Report dated 4/21/17 documented a scabbed area with drainage to the resident's right lateral calf that measured 3.5 cm x 1.7 cm. On 4/24/17 the area measured 3.5 cm x 1.7 cm. On 5/2/17 the area measured 5.7 cm x 4 cm. On 5/8/17 the area measured 12 cm x 5 cm. The record lacked notification of the right leg wound's increase in size to the physician. The Medication Administration Record documented an order for Bactroban ointment (antibiotic ointment) 3, started 4/21/17 or 4 days when staff first observed the area until the physician gave the treatment order. The Progress Note dated 4/27/17 at 9:21 p.m. documented the resident attempted to get out of bed and the resident laid the left leg on the radiator causing a burn to the left lower extremity causing a blister that measured 7.8 cm x 6.2 cm with superficial open areas to the 2nd, 3rd, and 4th left foot toes. The Progress Notes documented the staff sent a facsimile to the physician and notified the family. The new skin area dated 4/27/17 documented the resident had a burn on the left lower leg and left toes sustained during an attempt to transfer from bed landing on the radiator by the bed.	F 323		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	165455	A. BUILDING _____ B. WING _____	05/17/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HAWKEYE CARE CENTER CARROLL	2241 NORTH WEST STREET CARROLL, IA 51401

(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 323	Continued From page 5 A facsimile dated 4/27/17 sent to the physician at 7:43 a.m. asked for triple antibiotic ointment to the resident's burns to the left leg and 2nd, 3rd, 4th on the left foot. The facsimile did not include the measurements or description of the wounds. The Skin Condition Report dated 4/27/17 documented a skin area on the left lower leg that measured 7.6 cm x 6.2 cm, left foot 2nd toe that measured 1.9 cm x .7 cm, left foot 3rd toe circular area that measured .9, and left foot 4th toe circular area that measured .8 cm. The Skin Condition Report dated 5/2/17 documented the left leg area measured 5.7 cm x 4 cm, left foot 2nd toe circular area that measured .6 cm, left foot 3rd toe circular area that measured 1 cm x .1 cm, and left foot 4th toe area that measured 1.2 cm x .7 cm. The Skin Condition Report dated 5/8/17 lacked documentation of the left leg area. The measurements for the toe areas remained unchanged. The Quality Assurance Performance Improvement (undated) documented a plan to move all beds away from heating registers. During an interview on 5/10/17 at 7:45 a.m. the Assisted Director of Nursing (ADON) stated after the incident, the facility moved all beds away from the baseboard heaters and moved all beds away from the head of the bed against the baseboard heaters. The ADON stated a certified nurse aide (could not recall the name) informed him the resident had fallen onto the baseboard heater. The ADON stated the resident had one leg in bed and the other leg lying on the baseboard heater.	F 323		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	165455	A. BUILDING _____ B. WING _____	05/17/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HAWKEYE CARE CENTER CARROLL	2241 NORTH WEST STREET CARROLL, IA 51401

(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 323	Continued From page 6 The ADON touched the heater and found it hot. The ADON stated he did not know about the light switch by the bed that controlled the activation of the baseboard heater. The ADON stated he measured the areas and sent a facsimile to the physician requesting triple antibiotic ointment. The ADON stated he performed the weekly examinations of the residents with skin impairment. The ADON could not definitely say the cause of the right leg area but stated it could have been a burn. The ADON stated a physician had not yet examined the wounds. During an interview on 5/16/17 at 11:37 a.m. Staff V, certified nurse aide, stated the other aide on duty discovered the resident half in the bed and leg on top of the heater. Staff V stated the resident kicked his/her legs out of bed frequently and would not wear socks in bed. The resident had foam boots but would kick the boots off. On 5/10/17 at 8:05 a.m. a tour of the resident rooms identified an additional 16 beds were located against the heater and the head of the bed against the heater. In the resident's room, observation identified a switch; located on the wall to activate the heater (the switch resembled a light switch). The switch was activated. Two minutes after activation, the heater temperature tested at 174 degrees Fahrenheit. During an observation on 5/9/17 at 8:00 a.m. Staff G, certified nurse aide, and Staff E, certified nurse aide, assisted the resident with personal cares. The resident moved the lower extremities with ease and kicked legs out of bed multiple times during the assistance with personal cares.	F 323		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	165455	A. BUILDING _____ B. WING _____	05/17/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HAWKEYE CARE CENTER CARROLL	2241 NORTH WEST STREET CARROLL, IA 51401

(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 323	Continued From page 7 Staff used the Hoyer mechanical lift to transfer. The Hoyer lift straps went around the upper thigh area and did not have contact with the calf area. During an observation on 5/10/17 at 1:09 p.m. Staff C, licensed practical nurse, performed the dressing changes. Photographs identified multiple wounds on the toes and leg. Note: At the time of the complaint investigation, the complaint was coded at a "K", immediate and serious jeopardy. By 5/10/17, the facility had implemented measures that adequately addressed the jeopardy and the grid placement was lowered to the "E" level. The facility audited each room for placement of the beds and followed the manufacturer recommendation for clearance around each heating unit. All staff received an in-service about heat registers, burns, heater panel switches to activate the heaters and about other electrical items plugged in that required supervision. The facility plan to install a guard system around each heater and anticipate a date of completion to be 5/30/17. All heater switches were labeled and the dial adjusted and regulated to 2-2.5 on the dial. As of the 5/17/17 exit conference, the facility continued to need to: Monitor resident rooms to ensure the beds are away from the base heaters per the manufactures recommendation. Monitor heater switch dials to ensure the switches are identified and labeled. Monitor the heater guard system to ensure the devices provide safety for residents. 2. Resident #1 had a MDS assessment with a reference date of 2/15/17. The MDS identified	F 323		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	165455	A. BUILDING _____ B. WING _____	05/17/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HAWKEYE CARE CENTER CARROLL	2241 NORTH WEST STREET CARROLL, IA 51401

(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 323	Continued From page 8 the resident had diagnoses that included diabetes, non-Alzheimer's dementia, heart failure (CHF), and depression. The MDS indicated the resident had severely impaired cognition and decision making skills. The MDS documented the resident required extensive assistance of two staff for transfers and bed mobility. The Care Plan dated 11/16/15, and revised on 2/28/17, identified the resident had a fall risk. The Care Plan directed staff to place ½ side rails up on the bed to aide with transfers and bed mobility, remind the resident to use the call light, use a hi-lo bed and mat at the bedside, and place items within reach. An incident report dated 2/27/17, at 10:30 p.m., identified staff found the resident lying on the floor by the bed and complained of left shoulder pain. The resident reported he/she fell out of bed when tried to get up to go to the bathroom. The progress notes dated 2/18/17, at 1:30 p.m., revealed a hi-lo bed used and mat placed at the bedside whenever the resident in bed. An x-ray report dated 2/28/17 identified no left shoulder fractures. During observation on 5/9/17, at 6:47 a.m., Staff J, Certified Nursing Assistant (CNA), provided pericare (perineal cleansing) for Resident #1, then left the resident's bedside to assist a co-worker and the resident's roommate in the bathroom. Staff J left Resident #1's bed in the high position, and left the side rail on the bed in a vertical position, but did not engage or lock the side rail in place. The resident laid on his/her right side and held onto the side rail attached to the right side of the bed. At that time, observation identified no mat on the floor by the	F 323		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	165455	A. BUILDING _____ B. WING _____	05/17/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HAWKEYE CARE CENTER CARROLL	2241 NORTH WEST STREET CARROLL, IA 51401

(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 323	Continued From page 9	F 323		

resident's bed, and the call light cord wrapped around a bar on the side rail but the call light button rested on the floor and away from the resident. At 6:51 a.m., Staff J opened the bathroom door and walked by the resident's bed. Staff J reported the resident's side rail looked funny, and then asked Resident #1 what he/she had done with his/her side rail. Staff J lowered the resident's bed toward the floor.

In an interview on 5/11/17, at 10:35 a.m., Staff K, CNA, reported the facility required staff to lower beds toward the floor on all residents for safety reasons. Staff K reported Resident #1's side rail should be in the up position and a mat placed on the floor by the resident's bed whenever the resident in bed.

On 5/10/17, at 8:05 a.m., the bed side rails at the facility were observed. Observation revealed the side rail on Resident #1's bed in a vertical position attached to the bed frame. The metal side rail could be turned 360 degrees in a clockwise and then a counterclockwise direction without the side rail engaged and the side rail attached loosely on the bed.

On 5/10/17 at 11:55 a.m., Staff I, Maintenance Assistant, was interviewed and reported the facility performed preventative measures on the bed equipment annually, but Resident #1 rented the bed from an outside vendor and the vendor had the responsibility to check and repair the beds. Staff I confirmed he had received no work order for a malfunctioning or broken side rail in the 300 Hall. Staff I confirmed Resident #1's side rail as loose and it should not rotate 360 degrees clockwise or counterclockwise on the bed. Staff I planned to follow up to have the side rail repaired.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	165455	A. BUILDING _____ B. WING _____	05/17/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HAWKEYE CARE CENTER CARROLL	2241 NORTH WEST STREET CARROLL, IA 51401

(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 323	Continued From page 10 On 5/10/17, at 5:00 p.m., the Corporate Compliance Officer, was interviewed and stated she expected the vendor who supplied equipment or beds to inspect the equipment before bringing it to the facility. On 5/11/17, at 10:40 a.m., observation revealed both side rails in an up position on Resident #1's bed. The observation identified the side rails secured to the bed frame and engaged appropriately when raised to an up position, and no longer turned clockwise or counterclockwise.	F 323		
F 325 SS=G	483.25(g)(1)(3) MAINTAIN NUTRITION STATUS UNLESS UNAVOIDABLE (g) Assisted nutrition and hydration. (Includes naso-gastric and gastrostomy tubes, both percutaneous endoscopic gastrostomy and percutaneous endoscopic jejunostomy, and enteral fluids). Based on a resident's comprehensive assessment, the facility must ensure that a resident- (1) Maintains acceptable parameters of nutritional status, such as usual body weight or desirable body weight range and electrolyte balance, unless the resident's clinical condition demonstrates that this is not possible or resident preferences indicate otherwise; (3) Is offered a therapeutic diet when there is a nutritional problem and the health care provider orders a therapeutic diet. This REQUIREMENT is not met as evidenced by: Based on record review, observation and interviews with resident, family member and staff	F 325		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	165455	A. BUILDING _____ B. WING _____	05/17/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HAWKEYE CARE CENTER CARROLL	2241 NORTH WEST STREET CARROLL, IA 51401

(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 325	Continued From page 11 interviews, the facility failed to provide planned nutritional interventions, document consumption of supplements and communicate effectively regarding nutritional interventions to maintain acceptable parameters of nutritional for 4 of 17 residents reviewed (Residents #1, #3, #4, and #21). The facility reported a census of 74 residents. Findings include: 1. The Minimum Data Set (MDS) assessment dated 2/15/17; documented Resident #1 had diagnoses that included diabetes, non-Alzheimer's dementia, heart failure (CHF), and depression. The resident scored 5 out of 15 on the Brief interview for Mental Status (BIMS) interview indicating severe cognitive and memory impairment. The MDS documented the resident needed supervision and set up for eating. The assessment documented the resident had an unplanned weight loss and to receive a mechanically altered diet. The Care Plan dated 3/29/15, and revised on 2/23/17, documented the resident had a nutritional risk due to diagnoses of dementia, depression, diabetes, and CHF (congestive heart failure). The Care Plan directed staff to follow recommended dietary interventions to ensure adequate nutrient intake, serve a regular diet with ground meat, and provide a sippy cup during meals as needed. The Care Plan identified the resident had broken dentures. The resident's diet change order for 2/13/17 identified chocolate milk with meals to increase caloric intake. The diet change order dated 3/29/17, gave direction to serve Ensure pudding	F 325	F325 Credible allegation of compliance: May 18, 2017 It is the policy of, and Hawkeye Care Center Carroll will , attempt to ensure planned nutritional interventions are provided, and consumption documented of supplements. Resident # 1,#3,#4,#21 have had their need for supplements reviewed and altered as necessary by the Registered Dietician. Dietary and Nursing staff were educated on the use, and documenting consumption of supplements. Audits of all residents were completed for need of supplements. The Weight Managment Committee will routinely audit the use, and consumption, of supplements. The Weight Management Committee will report concerns to the QA Committee.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	165455	A. BUILDING _____ B. WING _____	05/17/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HAWKEYE CARE CENTER CARROLL	2241 NORTH WEST STREET CARROLL, IA 51401

(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 325	Continued From page 12 at lunch. The facility provided a list of the resident's weight, which included the following: 11/10/16 -209 pounds (lbs.) 12/9/16 - 207 lbs. 1/9/17 - 201 lbs. 2/20/17 - 199 lbs. 3/20/17 - 190.5 lbs. 4/24/17 - 184.5 lbs. The weights reflect a 3 % weight loss in 1 month (March-April 2017). The weights reflect a 7.3 % weight loss in 3 months (February -April 2017). The weights reflected a significant weight loss of 11.7 % in 6 months (November -April 2017). The Dietary Progress Notes recorded the following: On 1/9/17, resident on a regular, ground meat diet and had a continued slow weight loss. The dietician recommended offering high calorie snacks to the resident. On 2/13/17, chocolate milk started with meals to increase caloric intake. On 3/2/17, a family member expressed concerns the resident had lost weight and did not eat well. On 3/20/17, the resident refused chocolate milk; chocolate milk discontinued. On 3/29/17, the resident weighed 188 lbs. and had significant weight loss in 6 months. The dietician recommended Ensure pudding at lunch to increase nutrient intake. On 5/8/17, the resident weighed 183.5 lbs. and the dietician wrote the resident received Ensure pudding at lunch. A fax to the physician on 2/2/17 requested a	F 325		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	165455	A. BUILDING _____ B. WING _____	05/17/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HAWKEYE CARE CENTER CARROLL	2241 NORTH WEST STREET CARROLL, IA 51401

(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 325	Continued From page 13 Hospice evaluation due to a decline in the resident's weight. A fax to the physician on 3/1/17 requested supplements twice a day for weight maintenance because the resident had broken their dentures 3 months ago. Dining observations identified the following: On 5/9/17 at 7:40 a.m. Resident #1 sat in the dining room and fed self potato chips. Observation identified the resident had a sippy cup which contained juice, bowl of corn flakes with milk, sausage and toast on the table in front of the resident. At 12:20 p.m. the resident sat in a wheelchair in the dining room and a family member sat next to the resident. The resident had a plate sitting in front of in/her. On the plate contained the following: pulled pork, scalloped potatoes and broccoli/cauliflower. A bread plate and a glass of water sat on the table in front of the resident. The resident drank tomato juice from a sippy cup. On 5/10/17 at 8:05 a.m. Resident #1 sat in a wheelchair in the dining room and fed self corn flakes with milk. The resident drank tomato juice in a sippy cup. At 12:50 p.m., the resident sat in the dining room and fed self spaghetti. A sippy cup with tomato juice sat on the table by the resident. In an interview 5/10/17 at 2:20 p.m. the resident's family member reported s/he had lost weight and was supposed to have a supplement. The family member routinely visited during the meal time and reported the resident had not received a	F 325		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	165455	A. BUILDING _____ B. WING _____	05/17/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HAWKEYE CARE CENTER CARROLL	2241 NORTH WEST STREET CARROLL, IA 51401

(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 325	Continued From page 14 supplement at that time and reported he/she felt concerned if the resident received their recommended supplements. The family member stated it was their decision to not fix the broken dentures, but the diet should reflect food the resident could eat. 2. The MDS assessment dated 4/19/17 documented Resident #3 had diagnoses that included cerebrovascular accident (CVA) or a stroke), dysphagia (difficulty swallowing) and muscle weakness. The MDS documented the resident needed supervision and set up for eating. The assessment documented the resident had no or unknown weight loss in 1 or 6 month period. The Care Plan dated 5/16/16 and revised on 4/24/17 documented the resident had a nutritional risk due to diagnoses of CVA and dysphagia. The Care Plan indicated the resident had a slow weight loss. The Care Plan directed staff to serve recommended dietary interventions to increase nutrients and fluid intake, serve a regular diet and obtain weights per facility protocol. The resident's diet change order for 2/20/17 directed to serve whole chocolate milk during meals to increase caloric intake. The diet change order 4/24/17 indicated Ensure Clear served during meals to increase caloric intake and fluids. The facility provided a list of the resident's weight, which included the following: 11/2/16 -143 lbs. 12/6/16 - 139 lbs. 1/6/17 - 136 lbs. 2/7/17 - 133.5 lbs. 3/7/17 - 136.5 lbs.	F 325		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	165455	A. BUILDING _____ B. WING _____	05/17/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HAWKEYE CARE CENTER CARROLL	2241 NORTH WEST STREET CARROLL, IA 51401

(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 325	Continued From page 15 4/4/17 - 130.5 lbs. The weights reflected a 4.19 % weight loss in 1 month (March-April 2017). The weights reflected a 2.09 % weight loss in 3 months (February -April 2017). The weights reflected an 8.74 % weight loss in 6 months (November -April 2017). The Dietary Progress Notes recorded the following: On 1/23/17 - Resident #3 received a regular diet and had their meat cut up. The resident had a slight weight loss from 140's to 130's. On 2/20/17 - The Dietician recommended chocolate milk or whole milk at meals to increase caloric intake due to a significant weight loss in 30 days. On 3/3/17 - Chocolate milk discontinued because the resident refused the chocolate milk at meals. The dietician recommended continued monitoring of the resident's weight. On 4/24/17 - The resident had a continued slow weight loss. The dietician recommended Ensure Clear with meals for increased nutrient intake and weight loss prevention. Dining observations revealed the following: On 5/9/17 at 9:15 a.m. the resident sat in the dining room and fed self his/her breakfast. The resident dunked toast in a cup of coffee and the observation revealed no other beverages on the table by the resident. At 12:10 p.m., the resident sat in a wheelchair in the dining room and fed self. The resident had a cup of coffee next to his/her plate on the table. An empty glass sat upside down on the table and no other beverages were on the table by the resident.	F 325		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	165455	A. BUILDING _____ B. WING _____	05/17/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HAWKEYE CARE CENTER CARROLL	2241 NORTH WEST STREET CARROLL, IA 51401

(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 325	Continued From page 16 On 5/10/17, at 8:15 a.m. the resident sat in the dining room and drank tea from a cup. Observation revealed no other beverages on the table by the resident. On 5/11/17 at 10:20 a.m. Staff M, Dietary Cook, was interviewed and reported they had a list of residents who received dietary supplements recommended by the dietician. Staff M reported the dietary aides are assigned to pass out any dietary nutritional supplements such as chocolate milk, Ensure pudding or other nutritional products. Staff M confirmed Resident #1 and Resident #3 on the list and supposed to receive Ensure pudding during the lunch meal. On 5/11/17 at 11:05 a.m. Staff M and Staff N, Dietary Aides, were interviewed and reported the staff documented the resident intakes on an IPAD, but they had no way to chart the individual dietary product consumed, such as chocolate milk, ensure pudding, or ensure clear liquid. The staff could only record the total fluid amount consumed by each resident. 3. Resident #4 had a MDS with a reference date of 4/12/17. The MDS identified diagnoses that included hypertension, high cholesterol, dementia and stroke. The resident had impaired long and short term memory problems. The MDS documented the resident weighed 157 pounds. The Nutrition Assessment dated 5/24/17 documented the resident lost 21 pounds since admission on 4/5/17. The dietician recommended chocolate milk at meals. During observation on 5/9/17 at 12:30 p.m., staff fed the resident lunch. Staff did not provide chocolate milk. During observation on 5/10/17 at	F 325		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	165455	A. BUILDING _____ B. WING _____	05/17/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HAWKEYE CARE CENTER CARROLL	2241 NORTH WEST STREET CARROLL, IA 51401

(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 325	Continued From page 17 8:17 a.m., staff fed the resident breakfast. Staff did not provide chocolate milk. During an interview on 5/9/17 at 3:08 p.m., the resident's spouse stated the resident loved chocolate milk. 4. The MDS assessment dated 4/14/17 documented Resident #21 had a diagnosis of postprocedural intestinal obstruction. The assessment documented she/he entered the facility on 4/7/17, had no memory or cognitive impairment and required supervision with eating. The assessment documented Resident #21 received nutritional approaches while at the facility. The Weekly Weight Summary report documented Resident #21 weighed 182.5 pounds on 4/17/17, 183 pounds on 4/24/17, 164.5 pounds on 5/1/17 and 160.5 pounds on 5/8/17. The Dietary Nutritional Intervention sheet dated 4/24/17 documented Resident #21 was to receive the dietary intervention of chocolate milk with meals. Observation of the meal service on 5/8/17 at 12:00 p.m. identified Resident #21 did not receive chocolate milk on the tray delivered to his/her room. The resident stated she/he received two large glasses of white milk and drank only one. Resident #21 stated she/he would have drank the chocolate milk but didn't want two glasses of white milk. On 5/8/17 at 12:55 p.m. the dietician was interviewed and stated Resident #21 needed increased calories due to chemotherapy and weight loss. The dietitian provided a copy of a diet order dated 5/1/17 for Resident #21 to have	F 325		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	165455	A. BUILDING _____ B. WING _____	05/17/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HAWKEYE CARE CENTER CARROLL	2241 NORTH WEST STREET CARROLL, IA 51401

(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 325	Continued From page 18 chocolate milk with all meals and Ensure Clear twice a day for snacks. The Dietary Manager provided the meal card on 5/8/17 at noon for Resident #21 which had no documentation of the direction for chocolate milk with meals. They subsequently added the notation when the Dietitian directed to do so.	F 325		
F 353 SS=G	483.35(a)(1)-(4) SUFFICIENT 24-HR NURSING STAFF PER CARE PLANS 483.35 Nursing Services The facility must have sufficient nursing staff with the appropriate competencies and skills sets to provide nursing and related services to assure resident safety and attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident, as determined by resident assessments and individual plans of care and considering the number, acuity and diagnoses of the facility's resident population in accordance with the facility assessment required at §483.70(e). [As linked to Facility Assessment, §483.70(e), will be implemented beginning November 28, 2017 (Phase 2)] (a) Sufficient Staff. (a)(1) The facility must provide services by sufficient numbers of each of the following types of personnel on a 24-hour basis to provide nursing care to all residents in accordance with resident care plans: (i) Except when waived under paragraph (e) of this section, licensed nurses; and	F 353		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	165455	A. BUILDING _____ B. WING _____	05/17/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HAWKEYE CARE CENTER CARROLL	2241 NORTH WEST STREET CARROLL, IA 51401

(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 353	Continued From page 19 (ii) Other nursing personnel, including but not limited to nurse aides. (a)(2) Except when waived under paragraph (e) of this section, the facility must designate a licensed nurse to serve as a charge nurse on each tour of duty. (a)(3) The facility must ensure that licensed nurses have the specific competencies and skill sets necessary to care for residents' needs, as identified through resident assessments, and described in the plan of care. (a)(4) Providing care includes but is not limited to assessing, evaluating, planning and implementing resident care plans and responding to resident's needs. This REQUIREMENT is not met as evidenced by: Based on record review, staff and family interviews, observation and an interview with a group of residents, the facility failed to ensure the facility had sufficient staff assigned to meet the needs of the residents and prevent a major injury for 1 of 7 residents reviewed (Resident #14). The facility reported a census of 74 residents. Findings include: 1. Resident #14 had a MDS (Minimum Data Set) assessment with a reference date of 4/29/17. The MDS identified an admission date of 4/26/17. The MDS identified the resident able to make self understood and could understand others. The MDS revealed the resident required the limited physical assistance of 1 person for transfers, walking in room and corridor, and for locomotion on and off the unit. The MDS coded the	F 353	F353 Credible allegation of compliance: May 18, 2017 It is the policy of, and Hawkeye Care Center Carroll will, ensure the facility has sufficient staff assigned to meet the needs of residents. Resident #1 no longer resides in the facility. Staffing patterns were altered to ensure that the needs of the residents, within their plan of care, could be met. Concerns will be addressed through the Grievance Procedure, Care Plan Resident Satisfaction surveys and Resident Council. The ADON, Social Worker, and MDS Coordinator will report concerns to the QA Committee.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	165455	A. BUILDING _____ B. WING _____	05/17/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HAWKEYE CARE CENTER CARROLL	2241 NORTH WEST STREET CARROLL, IA 51401

(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 353	Continued From page 20 resident's balance during transitions and walking as not steady, only able to stabilize with staff assistance for the following: moving from seated to standing position; walking; turning around and facing the opposite direction while walking; moving on and off toilet; and surface-to-surface transfer. The MDS marked the use of a walker and wheelchair for mobility devices. The MDS documented diagnoses that included disc degeneration of the lumbar region and low back pain. The Brief Interview for Mental Status dated 4/26/17 at 11:10 a.m. documented a score of 12. A score of 12 indicated moderate cognitive impairment. The Care Plan identified a focus area revised 4/27/17 for an ADL (activities of daily living) deficit due to weakness. The Care Plan directed staff to provide assistance of 1 (person), walker, and gait belt for transfers. The Care Plan contained no entries pertaining to removal of a wheelchair from the resident's room. The Task List Report printed 5/3/17 documented a Nursing Rehab program initiated on 4/27/17. The task directed staff to ambulate the resident to and from all meals and activities with walker and the assistance x1 (one person). The task scheduled the ambulation to be done at 9:00 a.m., 1:00 p.m., 6:00 p.m., and PRN (as needed). The Rehab Communication 2 form dated 4/27/17 documented recommendation/instructions from the therapist. The form recorded the resident needed: assist x1 with FWW (front wheeled walker) for all gait and transfers; to ambulate to/from all meals and activities with FWW and	F 353		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	165455	A. BUILDING _____ B. WING _____	05/17/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HAWKEYE CARE CENTER CARROLL	2241 NORTH WEST STREET CARROLL, IA 51401

(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 353	Continued From page 21 assist x1; and the wheelchair to be removed from the resident's room. The Progress Notes dated 4/27/17 at 10:25 a.m. documented the resident skilled for PT (physical therapy)/OT (occupational therapy) for observation and assessment. The entry recorded the resident ambulated with assist of 1 with walker. The entry documented the resident non-compliant with using call light, up walking with walker in the room, gait steady, balance good, and education on the use of the call light and awaiting assistance. The Progress Notes dated 4/27/17 at 10:46 a.m. documented the care plan changed. The resident to receive assist x1 with walker for all gait and transfers; ambulate to and from meals and activities with walker, assist x1; therapy removing wheelchair from the room; and the Care Plan updated. The Progress Notes dated 4/27/17 at 8:21 p.m. documented the resident used a FWW in the room independently and ambulated with a steady gait. The Progress Notes dated 4/29/17 at 6:23 p.m. documented the nurse called to the resident's room due to the resident experiencing an unwitnessed fall with the resident on the floor in front of the chair. The entry recorded the resident alert and oriented. The untitled incident report dated 4/29/17 at 6:30 p.m. and revised on 5/8/17 at 1:11 p.m., documented the resident experienced an unwitnessed fall. The report recorded the resident stated he/she tried to get up from the	F 353		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	165455	A. BUILDING _____ B. WING _____	05/17/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HAWKEYE CARE CENTER CARROLL	2241 NORTH WEST STREET CARROLL, IA 51401

(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 353	Continued From page 22 wheelchair after supper, missed, and fell on the floor bumping head on the wall but not hard. The Progress Notes dated 4/29/17 at 6:30 p.m. documented a change in condition form completed and faxed to the MD (medical doctor). The Progress Notes dated 4/29/17 at 8:15 p.m. documented the on-call doctor called and a verbal order received to send the resident to the ER (emergency room) for evaluation. The Progress Notes dated 4/29/17 at 8:27 p.m. documented a late entry by Staff P, LPN (Licensed Practical Nurse). The entry recorded Staff P responded and assessed the resident on the floor. The entry documented the resident's speech clear, the resident able to answer questions, and the resident stated he/she hit his/her head on the wall but it didn't hurt. The Progress Notes dated 4/29/17 at 8:30 p.m. documented the ambulance arrived to pick up the resident. The entry recorded the ambulance personnel attempted to ask the resident questions regarding the fall, but the resident gave no rx (response) and speech slurred/garbled. The Progress Notes dated 4/29/17 at 8:45 p.m., documented by Staff Q, LPN, recorded the resident stated he/she bumped his/her head on the wall but not hard. The entry documented the resident made the statement at the time of the fall when alert/oriented x4. Staff Q wrote the residents VS (vital signs) WNL (within normal limits) for the first 4 checks but the B/P (blood pressure increased and the resident started to slur speech, and the began to vomit. The Imaging Report dated 4/29/17 recorded the	F 353		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	165455	A. BUILDING _____ B. WING _____	05/17/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HAWKEYE CARE CENTER CARROLL	2241 NORTH WEST STREET CARROLL, IA 51401

(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 353	Continued From page 23 results of a CT (computer tomography) scan of the resident's head. The subtitled section Impression, documented an acute left subdural hematoma with local mass effect and left-to-right herniation (a traumatic collection of blood around the brain). The Progress Notes dated 4/30/17 at 1:10 p.m. documented a report call received from the hospital ER RN. The entry recorded ER RN reported the resident unresponsive most of the time in the ER and admitted for comfort cares as remained unresponsive. The Major Injury Determination Form signed on 5/5/17 by the resident's physician, documented the physician reviewed the circumstances, injury, and prognosis of the patient and believed the injury sustained was a major injury. Staff statements, staff interviews, family interviews: In a written statement dated 4/30/17, Staff R, CNA (Certified Nurse Aide), documented she saw the resident on the floor in a sitting position in the resident's room on 4/29/17 at 6:00 p.m. Staff R recorded she asked the resident what happened and the resident stated he/she tired of waiting in the dining room so he/she pushed him/herself back in wheelchair with walker in front of him/her. Staff R documented the resident said when he/she got back to his/her room, he/she thought he/she could stand up and walk over to the couch. Staff R stated the resident reported he/she fell hitting head on wall. On 5/3/17, Staff O, MDS/RN (Registered Nurse) Coordinator, typed a statement regarding the	F 353		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	165455	A. BUILDING _____ B. WING _____	05/17/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HAWKEYE CARE CENTER CARROLL	2241 NORTH WEST STREET CARROLL, IA 51401

(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 353	Continued From page 24	F 353		

resident's therapy recommendation. Staff O documented therapy gave her a communication/recommendation paper on 4/27/17 at 10:45 a.m. Staff O wrote the paper recommended the resident: receive assist x1 with walker for all gait and transfers; be ambulated to and from all meals and activities with walker and assist x1; and remove the wheelchair from the room. Staff O explained the recommendation was so the resident would ambulate to and from all meals and not ride in the wheelchair from the room. Staff O documented since the Care Plan already directed the assistance of 1 staff person, walker, and gait belt for transfers, she did not include removing the wheelchair from the resident's room in the Care Plan; that way if the resident needed the wheelchair for long rides, appointments, or if tired, the resident could still use the wheelchair. Staff O wrote she entered an ambulation program, based on the therapy recommendations, into the Tasks in PCC (the section of the computer program called point click care where the CNA's documented and received information). Staff O documented she then removed the wheelchair from the resident's room.

In an interview on 5/8/17 at 3:10 p.m., Staff P (Agency nurse) stated he recalled the resident's fall on 4/29/17 around 6:15 p.m. Staff P said he went to assess the resident when he/she on the floor. Staff P reported the resident said something about going to the loveseat. Staff P commented the resident at that time very alert and oriented with no signs/symptoms of dementia. Staff P stated he did not feel there was enough staff that night to meet the resident's needs. Staff P recalled no CNA for the 100 hall because staff split the hall (CNA's assigned to

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	165455	A. BUILDING _____ B. WING _____	05/17/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HAWKEYE CARE CENTER CARROLL	2241 NORTH WEST STREET CARROLL, IA 51401

(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 353	Continued From page 25 other hallways take a few rooms each to oversee). Staff P commented honestly felt not safe for aides to split the assignment of the 100 hall. In an interview on 5/9/17 at 6:10 p.m., Staff R (certified nursing assistant) stated she clocked in at 6:00 p.m. on 4/29/17. Staff R said she walked down 100 hall and saw the resident sitting on the floor. Staff R reported the resident stated he/she got tired of waiting in the dining room so got wheelchair and walker and took self to room. Staff R commented the resident said he/she thought he/she could stand and walk to couch but fell hitting head on the wall. Staff R reported she completed vitals on the resident every 15 minutes 4 times and then on the 1st 30 minute check she noticed the resident changed. Staff R said the resident laid over on the couch, non-coherent. Staff R responded when asked about enough staff she did not feel there was enough staff. Staff R commented they had enough that night but Staff U, CNA, had to leave and Staff G, CNA, from the 100 hall had to take his place on another hall. Staff R stated she thought the 100 hall had 6 or 7 residents living there that night. Staff R reported if staff called in on overnights, the facility pulled the 100 hall aide and the other 3 CNA's must split the 100 hall. Staff R stated that 1 resident on the 100 hall required assist of 2 staff members. Staff R stated the facility staffed short a lot and she shared her concern with management. Staff R commented management responded they should be able to handle it. On 5/9/17 at 6:30 p.m., Staff T, CMA (Certified Medication Aide) was interviewed and stated she does not like when the 100 hall aide is pulled because there is a resident on 100 hall with an	F 353		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	165455	A. BUILDING _____ B. WING _____	05/17/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HAWKEYE CARE CENTER CARROLL	2241 NORTH WEST STREET CARROLL, IA 51401

(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 353	Continued From page 26 alarm. Staff T said the 200 hall has approximately 20 residents as does the 300 hall. Staff T reported the residents on the 200 and 300 halls want to get to bed but call lights going on the 100 hall. Staff T stated the 300 hall aide responsible to cover rooms 103, 108, and 109. Staff T said the facility often short staffed with no 100 hall aide. Staff T reported the residents on the 100 hall have the following needs: 1 resident has a personal alarm and constantly self transfers; 1 resident needed 2 staff members to assist with cares; 1 resident on the call light a lot because needs assist to use the bathroom a lot; and another resident that received medical treatments required frequent trips to the bathroom. Staff T stated the 400 hall aide covers the resident with the alarm but the alarms can't be heard on the 400 hall and Staff T felt that was a danger. On 5/9/17 at 6:50 p.m., Staff S, CNA, stated she worked from 2:30 p.m. to 11:00 p.m. on 4/29/17. Staff S reported the 100 hall to be for those residents needing therapy and mostly independent. Staff S responded yes and no when asked if she felt the facility had enough staff to meet resident needs. Staff S commented she did not think splitting the 100 hall doable because when on the 300 hall she can't see the 100 hall and when assigned to the 200 hall she can't hear anything from the 100 hall. Observation on 5/9/17 at 7:00 p.m. identified when standing on the 300 or 400 hall, as unable to see the 100 hall. Observation revealed an extra-large activity room at the end of the 100 hall and must walk thru the room, turn 90 degrees right to get to the 400 hall. Observations further revealed when standing on the 400 hall or at the	F 353		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	165455	A. BUILDING _____ B. WING _____	05/17/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HAWKEYE CARE CENTER CARROLL	2241 NORTH WEST STREET CARROLL, IA 51401

(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 353	Continued From page 27 end of the 200 or 300 halls, could not hear residents living in the 100 hall. On 5/9/17 at 7:45 p.m., a family member was interviewed and stated he/she visited the resident on 4/28/17. The family member stated the resident reported he/she would put light on and not get help. The family member stated the resident said he/she was supposed to get help. The family member reported he/she unable to talk to the resident at the hospital due to the resident in a coma until he/she passed away on 5/7/17. In an interview on 5/10/17 at 12:40 p.m., Staff G, CNA, stated she was scheduled to the 100 hall on 4/29/17. Staff G reported Staff U left from 5:00 p.m. to 8:00 p.m. so she had been pulled to cover his hall. Staff G stated she assisted the resident to walk to supper but not back. Staff G said she walked the resident with the walker while pulling the wheelchair behind them and the resident sat in the wheelchair in the dining room. Staff G reported the wheelchair obtained from the resident's room. Staff G commented when Staff R came at 6:00 p.m., she called for help because the resident laid on the floor. Staff G reported after she was pulled from the 100 hall assignment, the 400 hall aide would have been in charge of the resident because the hall was split assignment. Staff R said she did not see anyone assist the resident out of the dining room. Staff G stated she had not taken care of the resident before that night. Staff G said her 1st interaction with the resident occurred at 2:30 p.m. when she introduced herself to the resident and the 2nd interaction occurred when she walked the resident to the dining room. Staff G reported she did not assist the resident with any cares before	F 353		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	165455	A. BUILDING _____ B. WING _____	05/17/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HAWKEYE CARE CENTER CARROLL	2241 NORTH WEST STREET CARROLL, IA 51401

(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 353	Continued From page 28	F 353		

or after walking. Staff G stated it was very often typical for the 100 hall to be split and she did not feel the facility could safely meet the residents' needs because so far away from the other hallways can't hear the alarms.

On 5/10/17 at 1:16 p.m., the Administrator stated the 100 hall was dedicated to skilled short term residents except for 2 residents that are long term with behaviors. The Administrator stated depending on time and complexity, the facility tried to staff a dedicated CNA if 4 or 5 skilled residents are on the hall. The Administrator stated with the census under 77, she did not feel case load there. The Administrator stated 1 resident on the 100 hall required assist of 2 staff members. The Administrator stated she thought therapy removed the wheelchair due to the resident's sciatica (nerve pain) and wanted the resident to move. The Administrator acknowledged she did not see any documentation of the resident refusing to walk. The Administrator stated the facility did have some pendent call lights (necklace) but the resident did not have one.

On 5/10/17 at 2:40 p.m., Staff Q stated she worked 2:00 p.m. to 10:00 p.m. 4/29/17. Staff Q said she conversed with the resident after the fall and they had a good conversation. Staff Q stated she questioned the resident about what he/she was doing and the resident responded he/she tried to get up but did not have the wheelchair backed up to the wall. Staff Q said the resident reported he/she hit his/her head on the wall but not hard. Staff Q stated at the 7:30 p.m. check, the resident couldn't get any clear speech out. Staff Q reported that day to be the 1st time she met the resident. Staff Q stated the 1st time she saw the resident, she saw him/her in the dining

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	165455	A. BUILDING _____ B. WING _____	05/17/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HAWKEYE CARE CENTER CARROLL	2241 NORTH WEST STREET CARROLL, IA 51401

(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 353	Continued From page 29 room in a wheelchair but did not know who he/she was yet. Staff Q said the resident did not have a pendent call light and the residents that walk have pendent call lights. Staff Q recalled the resident self-propelled from the dining room in a wheelchair towards the hallways. Staff Q stated she did not know the resident was supposed to be ambulated because she did not recognize who he/she was the 1st time she seen him/her. Staff Q recalled Staff G pulled at 5:00 p.m. from the 100 hall because Staff U left. Staff Q stated the aides on the other 3 halls are responsible for covering the 100 hall. Staff Q said if on the 400 hall, she could not hear the 100 hall because of the big activity room between the halls. Staff Q said she could not hear the 100 hall from the 200 or 300 halls either. Staff Q commented with people with alarms, needed to have someone assigned to the 100 hall. Staff Q stated she understood 100 hall for the skilled short term residents and those residents needed more focus and attention. Staff Q said it seemed the 100 hall got pushed to the back burner when split rather than focusing on it due to greater acuity. In a family interview on 5/10/17 at 4:25 p.m., a family member stated he/she visited the resident on the morning of 4/29/17. The family member stated the resident reported when he/she put the call light on it took a long time for someone to respond. In an interview on 5/10/17 at 4:45 p.m., Staff A, RN/Corporate Compliance Nurse, stated the expectations is the plan of care tasks (Task List Report) to be completed by the CNA's. Staff A confirmed the resident should have been ambulated to and from the dining room.	F 353		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	165455	A. BUILDING _____ B. WING _____	05/17/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HAWKEYE CARE CENTER CARROLL	2241 NORTH WEST STREET CARROLL, IA 51401

(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 353	Continued From page 30 100 Hall Census Information: The Daily Census report printed 5/10/17 documented the following number of residents residing on the 100 hall from 4/19/17 thru 5/10/17: a. 6 on 4/19 b. 5 on 4/20, 4/21 c. 4 on 4/22, 4/23, 4/24, 4/25 d. 5 on 4/26, 4/27 e. 6 on 4/28, 4/29 (1 discharged and 1 admitted this day), 4/30, 5/1 f. 5 on 5/2, 5/3, 5/4, 5/5, 5/6, 5/7, 5/10 Staffing assignments: From 4/1/17 thru 5/11/17, the daily hall assignment sheets titled Today's Care Givers, assigned no CNA's to the 100 Hall directly for the Day Shift (6:00 a.m. to 2:00 p.m.) on these dates: a. April - 4/15, 4/18 from 6:00 a.m. to 11:00 a.m., 4/22, 4/23, 4/24, 4/25, 4/26, 4/27, 4/28, 4/29, 4/30 b. May - 5/1, 5/2, 5/3, 5/4, 5/5, 5/6, 5/7, 5/8, 5/9, 5/10 From 4/1/17 thru 5/11/17, the Today's Care Givers, assigned no CNA's to the 100 Hall directly for the Eve Shift (2:00 p.m. to 10:00 p.m.) on these dates: a. April - 4/10, 4/15 from 2:00 p.m. to 6:00 p.m., 4/17, 4/18 from 6:00 p.m. to 10:00 p.m., 4/22, 4/23, 4/24, 4/25, 4/26, 4/27, 4/28, 4/29 from 5:00 p.m. to 8:00 p.m., 4/30 b. May - 5/1, 5/2 from 2:00 p.m. to 7:00 p.m., 5/3, 5/4, 5/5, 5/6, 5/7, 5/8, 5/9, 5/10 from 6:00 p.m. to 10:00 p.m., 5/11 From 4/1/17 thru 5/11/17, the Today's Care Givers, assigned no CNA's to the 100 Hall directly for the Overnight Shift (10:00 p.m. to 6:00 a.m.)	F 353		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	165455	A. BUILDING _____ B. WING _____	05/17/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HAWKEYE CARE CENTER CARROLL	2241 NORTH WEST STREET CARROLL, IA 51401

(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 353	Continued From page 31 on these dates: a. April - 4/7 from 10:00 p.m. to 4:00 a.m., 4/20, 4/21, 4/22, 4/30 from 10:00 p.m. to 2:00 a.m. b. May - 5/3, 5/5, 5/6, 5/7 On 5/8/17 at 3:00 p.m. a group of 5 residents were interviewed. Five of the 5 residents in attendance voiced the facility is short staffed on Saturdays.	F 353		

DEPARTMENT OF INSPECTIONS AND APPEALS

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	IA0105	A. BUILDING: _____ B. WING _____	05/17/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HAWKEYE CARE CENTER CARROLL	2241 NORTH WEST STREET CARROLL, IA 51401

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
L1093	58.12(1)l Admission, transfer, and discharge 58.12(135C) Admission, transfer, and discharge. 58.12(1) General admission policies. l. For all residents residing in a health care facility receiving reimbursement through the medical assistance program under Iowa Code chapter 249A on July 1, 2003, and all others subsequently admitted, the facility shall collect and report information regarding the resident's eligibility or potential eligibility for benefits through the Federal Department of Veterans Affairs as requested by the Iowa commission on Veterans Affairs. The facility shall collect and report the information on forms and by the procedures prescribed by the Iowa commissions on veterans affairs. Where appropriate, the facility may also report such information to the Iowa department of human services. In the event that a resident is unable to assist the facility in obtaining the information, the facility shall seek the requested information from the resident's family members or responsible party. For all new admissions, the facility shall collect and report the required information regarding the resident's eligibility or potential eligibility to the Iowa commission on veterans affairs within 30 days of the resident's admission. For residents residing in the facility as of July 1, 2003, and prior to May 5, 2004, the facility shall collect and report the required information regarding the resident' s eligibility or potential eligibility to the Iowa commission on veterans affairs within 90 days after May 5, 2004. If a resident is eligible for benefits through the federal Department of Affairs or other third-party payor, the facility shall seek reimbursement from such benefits to the maximum extent available before seeking reimbursement from the medical	L1093		

DEPARTMENT OF INSPECTIONS AND APPEALS

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	IA0105	A. BUILDING: _____ B. WING _____	05/17/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HAWKEYE CARE CENTER CARROLL	2241 NORTH WEST STREET CARROLL, IA 51401

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
L1093	Continued From page 1 assistance program established under Iowa Code chapter 249A. The provisions of this paragraph shall not apply to the admission of an individual as a resident to a state mental health institute for acute psychiatric care or to the admission of an individual to the Iowa Veterans Home. (II,III) This Statute is not met as evidenced by: Based on facility record review and staff interview, the facility failed to submit 3 of 8 sampled residents to the Iowa Department of Veterans Affairs submission list within 30 days of admission (Residents #10, #11 and #12). The facility reported a census of 74. Findings include: During an interview on 5/9/17 at 11:30 a.m., the Business Office Manager, acknowledged that Resident #10 was a spouse of a Navy veteran and admitted on 4/11/16. The facility submitted the resident's name to the Department of Veteran's Affairs (VA) on 5/20/16, according to the Iowa VA Resident Eligibility web listing. During an interview on 5/9/17 at 11:30 a.m., the Business Office Manager, acknowledged that Resident #11 was a veteran of Army Air Corp and admitted on 9/2/16. The facility submitted the resident's name to VA on 11/30/16, according to the Iowa VA Resident Eligibility web listing. During an interview on 5/9/17 at 11:30 a.m., the Business Office Manager, acknowledged that Resident #12 was a veteran of the Army and admitted on 8/31/16. The facility submitted the resident's name to VA on 10/7/16, according to the Iowa VA Resident Eligibility web listing.	L1093	L1093 Credible allegation of compliance: May 18, It is the policy of, and Hawkeye Care Center Carroll will, submit residents information to the Iowa Department of Veterans Affairs. Residents #10,#11,#12 were submitted to the Iowa Dept of Veterans Affairs. The Social Worker responsible for this task is no longer in employment. The task has been moved to the Office Manager. All current resident files were audited for compliance. The Business Office Manager will audit routinely and report findings to the QA Committee.	

DEPARTMENT OF INSPECTIONS AND APPEALS

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	IA0105	A. BUILDING: _____ B. WING _____	05/17/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HAWKEYE CARE CENTER CARROLL	2241 NORTH WEST STREET CARROLL, IA 51401

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
L1093	Continued From page 2 During the interview, the Business Office Manager said the submissions had been the responsibility of social services person who no longer worked at the facility.	L1093		