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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	165524	A. BUILDING _____ B. WING _____	08/24/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BETHANY LUTHERAN HOME	SEVEN ELLIOTT STREET COUNCIL BLUFFS, IA 51503

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F 000	INITIAL COMMENTS Correction date 9/8/17 The following deficiencies relate to the facility's annual health survey and investigation of complaint # 69353-C Complaint # 69431-C was not substantiated and investigation of facility-reported incidents # 69356-I and # 70262-I did not result in deficiency. See the Code of Federal Regulations (42CFR) Part 483, Subpart B-C.	F 000	***"This plan of correction constitutes a written allegation of substantial compliance with Federal Medicare and Medicaid requirements."*** Correction date is September 8, 2017 **HEALTH FACILITIES** SEP 19 2017	
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:	F 309	Resident #21 no longer resides at the facility. Resident #21 was sent to the ER on 4/10/17 for low oxygen saturation and was admitted to the hospital for a fracture of the left hip. Residents who have had falls, increase in pain, abnormal vital signs, decrease in ADL's or a change of condition will be reported on the 24 hour report sheet for the DON or designee to monitor and audit the progress notes to ensure if there is an actual change of condition that the physician is properly notified in a timely manner.	9/08/2017

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE: CEO | (X6) DATE: 09/08/2017

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.

POC accepted 9/19/17 VS

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F 309	Continued From page 1 (k) Pain Management. The facility must ensure that pain management is provided to residents who require such services, consistent with professional standards of practice, the comprehensive person-centered care plan, and the residents' goals and preferences. (l) Dialysis. The facility must ensure that residents who require dialysis receive such services, consistent with professional standards of practice, the comprehensive person-centered care plan, and the residents' goals and preferences. This REQUIREMENT is not met as evidenced by: Based on record review, and physician and staff interviews, the facility failed to perform ongoing thorough assessments and timely intervention for a resident with a change in condition after a fall (Resident #21). The sample consisted of 20 residents and the facility reported a census of 115 residents. Findings included: 1. Resident #21 had an admission Minimum Data Set (MDS) assessment with a reference date of 3/29/17. The MDS identified the resident had diagnoses of anemia, hypertension (elevated blood pressure), gastroesophageal reflux disease (GERD), benign hypertrophic prostate (BPH), neurogenic bladder (neurological disorder of the bladder), urinary tract infection, hyperlipidemia (HLD), non-Alzheimer's disease, macular degeneration (incurable eye disease that causes blindness), dementia without behavioral disturbances, metabolic encephalopathy, generalized muscle weakness, dysphagia (difficulty swallowing) and lack of coordination.	F 309	Licensed nurses have been in-serviced prior to the date of compliance by the DON/Designee on assessing for significant changes and timely notification to the physician. C.N.A.'s were also in-serviced prior to date of compliance on reporting changes immediately to a licensed nurse of any change in residents condition, decrease in ADL's, abnormal vital signs and increased pain. The DON or Designee will review the nursing progress notes daily on the residents with falls, residents reported on the 24 hour report sheet as having increased pain, change of condition and residents reported to the DON or Designee on daily rounds reported by the nurses of any residents having increased pain, change of condition or falls. Progress notes will be audited on the residents identified that meet the criteria listed above daily x 3 months and reported to the QAPI committee monthly x 3 months. The QAPI committee will then determine if further reporting and or monitoring is to continue.	

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F 309	Continued From page 2 The MDS documented a Brief Mental Status (BIMS) score of 4. A score of 4 identified the resident had a severe cognitive impairment. The assessment documented the resident required extensive assistance of 2 or more people with bed mobility, walking in the room and corridor, toileting. The resident required limited assistance of 3 people with transferring between surfaces. The MDS also documented the resident as unsteady and able to stabilize only with staff assistance. Review of a Care Plan dated 4/10/17, identified a problem with pain affecting the activities of daily living (ADLs) due to impaired mobility and a compression fracture with pain usually in the back. The Care Plan instructed the staff to administer pain medication as ordered for pain relief. The same Care Plan identified a problem due to recent hospitalization for Clostridium Difficile, weakness, GERD, HLD, neurogenic bladder, anemia, dementia and compression fracture. The Care Plan instructed the staff to ambulate the resident in the room and to/from meals with a front wheeled walker (FWW) and wheelchair to follow (1 person to assist and 1 person to push the wheelchair. The Care Plan instructed to give the resident verbal cues to complete tasks, keep the foot plates on when in the wheelchair and always recline when in the recliner. The Care Plan also identified the resident with a history of falls due to impaired mobility and balance, weakness, poor vision and decreased safety. The Care Plan documented the resident had a fall 4/10/17 and sustained a skin tear from this fall. The Care Plan documented the resident fell out of bed trying to cough up something stuck in his/her mouth.	F 309		

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F 309	Continued From page 3 Review of the a physical therapy (PT) Progress Notes identified the following: Review of a PT Daily Treatment Note dated 3/22/17 indicated the resident ambulated with a FWW and CGA with wheelchair to follow for safety to include shout bout in therapy room of 10 feet and then a longer walk of 300 feet. On 4/4/17 the resident was able to safely transfer from the bed to the wheelchair requiring caregiver assist (CGA) to stand-by assist (SBA) with moderate verbal cuing (VC) for coordination and safety. The PT Progress Note documented patient and caregiver education on safety recommendations of CGA-SBA for transfers and mobility informing the family that this means to have a staff member ambulating with the resident due to unsteadiness and need for VC for safety. On 4/7/17, revealed the resident performed 4 sit to stand transfers from the wheelchair with CGA and minimal assistance with verbal cues for hand placement prior to sit/stand. Review of the Resident Progress Notes indicated on 4/10/17 at 2:01 AM, when checking on residents, the staff reported the resident on the floor next to his/her bed. The note documented the staff assessed the resident and found to have full range of motion (ROM) without pain and then lifted the resident to bed with a Hoyer lift (mechanical full body lift). The resident obtained a 2 centimeter (cm) by 2 cm skin tear to the left elbow. The note documented the nurse cleansed the tear and placed Steri-Strips (tape to hold wound in place) to the wound, covered with Telfa (non-stick wound covering) and gauze. The staff started cranial checks due to this being an	F 309		

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unwitnessed fall. The note documented the resident was further assessed for any other injury and none was found (except neurological assessment). The staff facsimile (faxed) and notified the physician. The fax identified the physician replied on 4/10/177 at 1:34 p.m.

Review of a PT Daily Treatment Note dated 4/10/17 at 12:14 PM, revealed the resident performed seated bilateral lower extremity exercises active range of motion (AROM) to improve strength and functional mobility. The resident required maximum VC and encouragement to perform. The resident performed long arc quad (LAQ), heel/toe raises and marched approximate 5-10 times each. The note documented the resident not agreeable to participation throughout the treatment. Staff reported the resident fell in the morning and complained of pain in the left ankle and bilateral groin area.

A physician telephone order dated 4/10/17 at 2:45 PM indicated the physician ordered steri-strips to the left elbow, change as needed, cover with Telfa and gauze, change every day and as needed until healed. The physician ordered a chest x-ray.

The Resident Progress Note dated 4/11/17 at 3:31 AM indicated the resident continued on fall monitoring. The note documented the resident was restless and pain medication was administered because the resident reported being uncomfortable. The staff repositioned the resident as well.

The Medication Administration Record (MAR) indicated the nurse administered Tramadol

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F 309	Continued From page 5 (narcotic analgesic for moderate to intensive pain) on 4/11/17 at 8:26 AM. Review of an Observation Detail List report dated 4/11/17 at 10:33 AM revealed the resident required assistance of 2 staff persons with transfer and did not ambulate in the room or corridor on that shift. The nursing assessment on this date also documented the resident complained of neck pain and required a pain medication. The note documented the resident required one person for transfer assistance in the morning but after breakfast, the resident required 2 person assistance. Review of an Observation Detail List report dated 4/11/17 at 5:15 PM, revealed a nursing assessment that the resident complained of neck, shoulder and hip pain. The nurse administered pain medication. The MAR identified the nurse administered Tramadol 50 milligrams (mg) on 4/11/17 at 9:00 PM. On 4/12/17 at 1:38 PM the physician ordered to have Hospice to talk with the family. The resident had bilateral ribs, right shoulder, left hip and left knee series of x-rays and ordered Norco (narcotic pain medication) 5/325 1 to 2 tablets orally every 4 hours as needed. The MAR indicated the nurse administered Tramadol 50 milligrams on 4/12/17 at 1:53 PM. Review of a PT Daily Treatment Note dated 4/12/17 at 2:27 PM, identified the resident reported pain when PT lifted his/her legs to help don [put on] pants. The PT changed the patient to assist of 2 nursing staff for transfers and bed mobility with a Hoyer lift as needed for safety.	F 309		

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F 309	Continued From page 6 A MAR identified the nurse administered Ibuprofen (non-steroidal anti-inflammatory medication) 400 mg on 4/12/17 at 5:47 PM. A medication administration record (MAR) dated 4/2017 indicated the nurse administered hydrocodone/acetaminophen (Norco) 5-325 milligrams (mg) one tablet administered on 4/12/17 at 8:52 PM for pain. Review of a Resident Progress Note dated 4/12/17 at 10:54 PM indicated at 9:00 PM the resident complained of pain. The staff administered pain medication (see note above). The notes documented the staff assessed the right and left legs. The note documented a large round swelling on the inside of the left knee with bruising noted to both knees. The left knee bruise measured 2.4 cm (centimeters) by 1.8 cm. The right knee bruise measured 2.1 cm by 1.4 cm. The left hip measured 4.3 cm by 3.5 cm. The note documented the resident had no ROM to the left leg. At 3 PM on 4/12/17, the resident was able to bend his/her knee during the x-ray but unable at this time. The staff took the resident's vital signs and oxygen saturation at this time was 80% on room air. The staff applied oxygen per nasal cannula at 2 liters per minute and called the physician who ordered the resident to the emergency room. The Resident Progress Note indicated the resident went to the hospital via ambulance at 10:30 p.m. Review of a fax dated 4/12/17 notified the physician of bruising to the left knee measuring 2.4 cm by 1.8 cm; right knee measuring 2.1 by .4 cm and left hip 4.3 cm by 3.5 cm. The fax included a request to monitor until healed. The fax did not identify the date and time of the fax	F 309		

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F 309	Continued From page 7 and when received. Review of an Observation Detail List report dated 4/12/17 at 11:08 PM, identified a nursing assessment that by the end of the shift there was no ROM (range of motion) to the left lower extremity, the resident refused to move related to pain and discomfort. The nurse documented the resident did not transfer or ambulate during the shift. The staff transferred the resident via slide from the bed to the gurney. Review of a radiology report dated 4/12/17 identified an acute displaced intertrochanteric fracture of the left hip. The Resident Progress Notes dated 4/13/17 at 8:30 AM indicated the facility placed a call to the hospital Intensive Care Unit nurse to inform the resident's x-ray results identified an acute displaced intertrochanteric fracture of the left hip. On 8/23/17 at 12:30 PM Staff A (registered nurse) was interviewed and stated on 4/12/17, the resident held up his/her legs when the certified nursing assistants (CNAs) tried to transfer him. Staff A stated she saw a decline in the resident on 4/12/17 but did not remember faxing or calling the physician about it. Staff A recalled giving the resident pain medication for back or neck pain. Staff A stated the resident had been SBA (stand by assistance) and doing pretty well, and then had a decline. She stated she didn't recall if the resident walked to the dining room but was propelled by staff in a wheelchair. On 8/23/17 at 3:35 PM, Staff B (licensed practical nurse-LPN) was interviewed and stated she remembered on 4/12/17, she gave the resident	F 309		

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F 309	Continued From page 8	F 309		

pain medication for shoulder, hip and knee pain. She stated she was training; mostly was administering medication that day. She stated the resident wasn't walking on 4/12/17. Staff B stated before she was an LPN, she had worked with the resident as a CNA. She stated the resident was walking then. Staff B recalled she was working with Staff C, LPN and they assessed the resident's hip and knee. She stated the knee and hip looked dark and swollen so they asked for an x-ray. Staff B stated if a resident has a change of condition, the nurse should call the physician.

On 8/23/17 at 3:47 PM, Staff C (licensed practical nurse-LPN) was interviewed and stated she remembered the resident had a fractured hip. Before he fractured his/her hip, he was able to ambulate in his/her room and used Tramadol for pain. Staff C stated when there is a change in condition; you notify the physician or therapy if it's minor.

On 8/24/17 at 7:50 AM, Staff E (licensed practical nurse-LPN) was interviewed and stated the facility no longer used any body-alarms but did use one-three motion sensors she thinks. The resident usually used a walker or wheelchair to ambulate.

On 8/24/17 at 8:15 AM, the physician was interviewed and stated he came to the facility 2 days after the resident's fall and suspected the resident had a fracture. He ordered x-rays and additional pain medication. The physician stated he would expect the facility to notify him if a resident had increased pain and decreased function after a fall.

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F 514 F 514 SS=B	Continued From page 9 483.70(i)(1)(5) RES RECORDS-COMPLETE/ACCURATE/ACCESSIBLE (i) Medical records. (1) In accordance with accepted professional standards and practices, the facility must maintain medical records on each resident that are- (i) Complete; (ii) Accurately documented; (iii) Readily accessible; and (iv) Systematically organized (5) The medical record must contain- (i) Sufficient information to identify the resident; (ii) A record of the resident's assessments; (iii) The comprehensive plan of care and services provided; (iv) The results of any preadmission screening and resident review evaluations and determinations conducted by the State; (v) Physician's, nurse's, and other licensed professional's progress notes; and (vi) Laboratory, radiology and other diagnostic services reports as required under §483.50. This REQUIREMENT is not met as evidenced by: Based on clinical record review and staff	F 514 F 514	Resident #23 no longer resides in the facility. Report from the facility to the Hospital was given over the phone and no negative outcome was identified by the deficient practice. All residents who are discharged to the ER or a higher level of care are put on the 24 hour report sheet which are reviewed daily by the DON or Designee. The DON or Designee will follow up daily and ensure that any transfers of our residents to the ER or higher level of care have a transfer form completed and a copy is in the Medical record. Licensed nurses have been in-serviced prior to date of compliance by the DON/Designee that all residents transferred to the ER or higher level of care need to complete a transfer form that communicates pertinent information about the resident from the facility to the receiving ER or higher level of care facility and must retain a copy of this form in the residents current medical record.	9/08/2017

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F 514	Continued From page 10 interview, the facility failed to provide a transfer form a resident transferred from the facility for 1 of 23 total residents reviewed (Resident #23). The facility reported a census of 115 current residents. Findings include The Minimum Data Set (MDS) assessment, dated 5/31/17, documented Resident #23 had diagnoses that included heart failure, peripheral vascular disease (PVD; reduced blood flow in the limbs) and chronic lung disease. The MDS also revealed the brief interview for mental status (BIMS) score of 15, which indicates no cognitive or memory impairment. The MDS revealed the resident required the assistance of two with bed mobility, transfers and toilet use and the assistance of one with dressing and personal hygiene. Review of Resident Progress Notes for Resident #23 revealed that on 5/31/17 at 10:16 p.m., the resident had increased lethargy and their family requested the resident to be sent to the hospital emergency room (ER). The ER transport arrived to take Resident #23 to the hospital at 5:40 p.m. Resident #23 admitted to hospital on the critical care floor at 8:30 p.m. No Transfer form could be located in the resident's clinical record. An interview with the Director of Nursing (DON) on 8/24/17 at 8:50 a.m. revealed the facility did not have the transfer form sent with the resident as it went with the resident and they could not get it back. The nurses are instructed to make copies of the transfer form prior to sending it with the resident, but staff did not make a copy to keep in the clinical record. She planned to make a	F 514	Transfer forms will be a duplicate copy form, so that a copy will always be available in medical record. The DON or Designee will also audit all transfers to the ER or higher level of care daily or as they occur to ensure the transfer form was completed and that either the copy was made (until the duplicate forms are created and received back from the printer) or duplicate is in the resident's medical record. Results of the audits will be reported to the QAPI committee monthly x 3 months. The QAPI committee will then determine if further reporting and or monitoring is to continue.	

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F 514	Continued From page 11 transfer form with a duplicate copy already made.	F 514		