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
	165298	A. BUILDING _____ B. WING _____	09/14/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PINNACLE SPECIALTY CARE	1223 PRAIRIEVIEW ROAD CEDAR FALLS, IA 50613

(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 √ IAC 9/6/17 Correction date 10/5/17 The following deficiencies relate to the facility's annual health survey. (See code of federal regulations (42CFR) Part 483, Subpart B-C)	F 000		
F 225 SS=D	483.12(a)(3)(4)(c)(1)-(4) INVESTIGATE/REPORT ALLEGATIONS/INDIVIDUALS 483.12(a) The facility must- (3) Not employ or otherwise engage individuals who- (i) Have been found guilty of abuse, neglect, exploitation, misappropriation of property, or mistreatment by a court of law; (ii) Have had a finding entered into the State nurse aide registry concerning abuse, neglect, exploitation, mistreatment of residents or misappropriation of their property; or (iii) Have a disciplinary action in effect against his or her professional license by a state licensure body as a result of a finding of abuse, neglect, exploitation, mistreatment of residents or misappropriation of resident property. (4) Report to the State nurse aide registry or licensing authorities any knowledge it has of actions by a court of law against an employee, which would indicate unfitness for service as a nurse aide or other facility staff. (c) In response to allegations of abuse, neglect, exploitation, or mistreatment, the facility must:	F 225		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Kristen Kramer | TITLE: ADM | (X6) DATE: 10/5/17

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

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F 225	Continued From page 1 (1) Ensure that all alleged violations involving abuse, neglect, exploitation or mistreatment, including injuries of unknown source and misappropriation of resident property, are reported immediately, but not later than 2 hours after the allegation is made, if the events that cause the allegation involve abuse or result in serious bodily injury, or not later than 24 hours if the events that cause the allegation do not involve abuse and do not result in serious bodily injury, to the administrator of the facility and to other officials (including to the State Survey Agency and adult protective services where state law provides for jurisdiction in long-term care facilities) in accordance with State law through established procedures. (2) Have evidence that all alleged violations are thoroughly investigated. (3) Prevent further potential abuse, neglect, exploitation, or mistreatment while the investigation is in progress. (4) Report the results of all investigations to the administrator or his or her designated representative and to other officials in accordance with State law, including to the State Survey Agency, within 5 working days of the incident, and if the alleged violation is verified appropriate corrective action must be taken. This REQUIREMENT is not met as evidenced by: Based on clinical record review, staff and resident interview, the facility failed to report an alleged allegation of abuse to the department in a timely manner for one resident reviewed. (Resident #9) The facility census was 82 residents.	F 225		

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F 225	Continued From page 2 Findings include: 1. The Minimum Data Set (MDS) assessment dated 9/8/17, documented Resident #9 had diagnoses of traumatic brain injury, anxiety disorder and depression and had a Brief Interview for Mental Status (BIMS) score of 15, indicating intact cognition. A facility policy titled Timely Abuse Reporting revised May 2017, included a statement that all allegations of resident neglect, exploitation, mistreatment, injuries of unknown origin and misappropriation shall be reported to the Iowa Department of Inspections and Appeals not later that twenty-four (24) hours if the events that cause the allegation involve neglect, exploitation, mistreatment, injuries of unknown origin and misappropriation, but do not result in serious bodily injury. During interview on 9/11/17 at 1:32 p.m., the resident stated Staff G, Certified Nurse Aide, CNA left them on the toilet in the middle of the night two days prior. The resident stated Staff G grabbed their arms when transferring the resident out of bed. The resident stated their arms still hurt and the resident told the charge nurse later that morning. During interview on 9/11/17 at 1:50 p.m., the Director of Nursing (DON) stated they had gotten a call the previous day from Staff I, Assistant Director of Nursing at 12:30 p.m., who reported Staff A, Licensed Practical Nurse, LPN reported the resident had concerns. The DON stated Staff I talked to the resident who reported Staff G had	F 225		

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F 225	Continued From page 3 been rude and left them on the toilet 15 minutes. The resident reported to Staff I when Staff G answered the light they had cursed at the resident. The DON stated they had notified the administrator and nurse consultant. The DON stated they moved Staff G to another hallway to work because the resident had mentioned Staff G in the incident and if there was ever a question about anything staff involved got moved to a different wing. The DON verified at one point in a statement taken, the resident reported Staff G was rough. The DON stated the facility did not feel that warranted verbal abuse so they did not report to the Department of Inspections and Appeals. During interview on 9/11/17 at 2:05 p.m., Staff A, Licensed Practical Nurse, LPN stated the resident had come to them the previous morning at 10:30 a.m., and said they had an incident with Staff G the previous night. Staff A stated the resident reported Staff G had been yelling curse words because they had been soiled with fecal matter and Staff G had been a little rough but mostly verbal. Staff A stated they had asked the resident if Staff G had been physical and the resident reported no.	F 225		
F 281 SS=D	483.21(b)(3)(i) SERVICES PROVIDED MEET PROFESSIONAL STANDARDS (b)(3) Comprehensive Care Plans The services provided or arranged by the facility, as outlined by the comprehensive care plan, must- (i) Meet professional standards of quality. This REQUIREMENT is not met as evidenced	F 281		

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F 281	Continued From page 4 by: Based on observation, clinical record review and staff interview, the facility failed to follow physician orders for three of three residents reviewed. (Resident #8, #11 & #12) The facility census was 82 residents. Findings include: 1. The Minimum Data Set (MDS) assessment for Resident #8 dated 9/1/17, included diagnoses of pulmonary hypertension and edema and had a Brief Interview for Mental Status (BIMS) score of 15, indicating intact cognition. Review of the resident medication orders for September 2017, revealed a directive for Lasix (diuretic) 40 milligrams two times daily. A physician order summary report for the month of September 2017, included a directive for a 2 liter (2000 milliliter/ml) fluid restriction with a start date of 8/28/17. During observation on 9/13/17 at 9:45 a.m., the resident sat on in bed with oxygen at 2 liters via nasal cannula. The resident drank from a water pitcher that sat on a bedside table and finished the water in it. The resident frequently coughed and exhibited shortness of breath, and stated it had been because they had chronic obstructive pulmonary disease. At that time Staff E, Certified Nurse Aide, CNA delivered a full water pitcher to the resident and sat in on the bedside table. The resident began to drink from it. Observation revealed swelling of the residents left lower extremity. At that time the resident stated the leg had been swollen since prior to being admitted to the facility and it had been weeping fluid.	F 281		

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F 281	Continued From page 5 On 9/13/17 at 11:00 a.m., the Dietician verified the resident had an order for a 2000 ml per day fluid restriction. The Dietician provided the fluid restriction plan for the resident dated 8/30/17, and stated they had given it to the Director of Nursing (DON) when the order was received. 2. The MDS assessment for Resident #12 dated 8/1/17, identified diagnoses of cerebral infarction, hypertension and stage 3 kidney disease and the resident had a BIMS score of 15. The Medication Administration Record (MAR) for September 2017, indicates a fluid restriction of 2 liters per day with a start date of 8/12/17. The Medication Review Report (Physician's Orders) dated 8/23/17, indicated an order for a fluid restriction of 2 liters per day with a start date of 8/12/17. The resident had an order for Lasix 40 milligrams (diuretic) twice a day. A form titled Fluid Restriction indicated the resident was to get 480 cc of fluid at meals, 120 cc fluid with medication passes and 80 cc of fluid on the night shift for a total of 2,000 cc in a 24 hour period. Observation on 9/13/17 at 12:40 p.m., revealed two empty 240 cc glasses at the resident's place at a dining room table. A water pitcher containing 480 cc was on the resident's tray table in his/her room. During interview on 9/13/17 at 1:05 p.m., Staff H, CNA and Staff C, CNA, were not aware the resident was on a fluid restriction. Both stated fluid restrictions are found on the resident's	F 281		

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F 281	Continued From page 6 pocket care plan. Staff C pulled up the resident's pocket care plan and it stated to monitor fluid intake with no directives regarding the amount of fluid. Staff H stated any resident on a fluid restriction would not get a water pitcher in their room and the CNA's deliver the water pitchers each shift. 3. The MDS assessment for Resident #11 dated 8/8/17, included diagnoses of heart failure and chronic kidney disease and the resident had a BIMS score of 15. A form titled Physician Notification dated 7/24/17, included a physician order for a 1800 milliliter (ml) fluid restriction. During observation on 9/13/17 at 12:30 p.m., the resident sat in a wheelchair in the room with tray table within reach. The resident stated they had fluid taken off at the hospital. Observation revealed swelling of the residents right and left lower extremity, and right arm swelling with tubigrip (bandage) covering arm. Observation revealed the resident had a water pitcher within reach on the tray table. The resident reported staff brought the pitcher of water in that morning. The resident stated unaware of any limitations on fluid intake. At that time the residents family delivered the residents lunch tray which contained 360 ml of fluids. Family member also stated unaware of limitations on fluid intake. On 9/13/17 at 12:50 p.m., the Dietician verified Resident #11 had an order for a 1800 ml per day fluid restriction. At that time the Dietician provided the surveyor with the fluid restriction plan for the resident and stated they had given it to the facility Director of Nursing (DON) when the order had been received.	F 281		

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F 285 SS=D	483.20(e)(k)(1)-(4) PASRR REQUIREMENTS FOR MI & MR (e) Coordination. A facility must coordinate assessments with the pre-admission screening and resident review (PASARR) program under Medicaid in subpart C of this part to the maximum extent practicable to avoid duplicative testing and effort. Coordination includes: (1) Incorporating the recommendations from the PASARR level II determination and the PASARR evaluation report into a resident's assessment, care planning, and transitions of care. (2) Referring all level II residents and all residents with newly evident or possible serious mental disorder, intellectual disability, or a related condition for level II resident review upon a significant change in status assessment. (k) Preadmission Screening for individuals with a mental disorder and individuals with intellectual disability. (1) A nursing facility must not admit, on or after January 1, 1989, any new residents with: (i) Mental disorder as defined in paragraph (k)(3)(i) of this section, unless the State mental health authority has determined, based on an independent physical and mental evaluation performed by a person or entity other than the State mental health authority, prior to admission, (A) That, because of the physical and mental condition of the individual, the individual requires the level of services provided by a nursing facility; and	F 285		

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F 285	Continued From page 8 (B) If the individual requires such level of services, whether the individual requires specialized services; or (ii) Intellectual disability, as defined in paragraph (k)(3)(ii) of this section, unless the State intellectual disability or developmental disability authority has determined prior to admission- (A) That, because of the physical and mental condition of the individual, the individual requires the level of services provided by a nursing facility; and (B) If the individual requires such level of services, whether the individual requires specialized services for intellectual disability. (2) Exceptions. For purposes of this section- (i)The preadmission screening program under paragraph(k)(1) of this section need not provide for determinations in the case of the readmission to a nursing facility of an individual who, after being admitted to the nursing facility, was transferred for care in a hospital. (ii) The State may choose not to apply the preadmission screening program under paragraph (k)(1) of this section to the admission to a nursing facility of an individual- (A) Who is admitted to the facility directly from a hospital after receiving acute inpatient care at the hospital, (B) Who requires nursing facility services for the	F 285		

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F 285	Continued From page 9 condition for which the individual received care in the hospital, and (C) Whose attending physician has certified, before admission to the facility that the individual is likely to require less than 30 days of nursing facility services. (3) Definition. For purposes of this section- (i) An individual is considered to have a mental disorder if the individual has a serious mental disorder defined in 483.102(b)(1). (ii) An individual is considered to have an intellectual disability if the individual has an intellectual disability as defined in §483.102(b)(3) or is a person with a related condition as described in 435.1010 of this chapter. (k)(4) A nursing facility must notify the state mental health authority or state intellectual disability authority, as applicable, promptly after a significant change in the mental or physical condition of a resident who has mental illness or intellectual disability for resident review. This REQUIREMENT is not met as evidenced by: Based on clinical record review and staff interview, the facility failed to re-submit an expired Pre-Admission Screening and Resident Review (PASRR) evaluation for nursing facility approval for one of two residents reviewed. (Resident #14) The facility census was 82 residents. Findings include: The Minimum Data Set (MDS) assessment for Resident #14 dated 7/27/17, included diagnoses	F 285		

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F 285	Continued From page 10 of depression and mild cognitive impairment. The MDS documented the resident independent with bed mobility and transfer. The care plan dated 11/23/16, included no problem or recommendations related to a PASRR. Clinical record review revealed the resident had a PASRR notice of short-term nursing facility approval with an expiration date of 2/25/17, with no other PASRR evaluation completed. On 9/13/17 at 11:23 a.m., the Social Worker verified the residents PASRR had expired and they had missed it.	F 285		
F 314 SS=G	483.25(b)(1) TREATMENT/SVCS TO PREVENT/HEAL PRESSURE SORES (b) Skin Integrity - (1) Pressure ulcers. Based on the comprehensive assessment of a resident, the facility must ensure that- (i) A resident receives care, consistent with professional standards of practice, to prevent pressure ulcers and does not develop pressure ulcers unless the individual's clinical condition demonstrates that they were unavoidable; and (ii) A resident with pressure ulcers receives necessary treatment and services, consistent with professional standards of practice, to promote healing, prevent infection and prevent new ulcers from developing. This REQUIREMENT is not met as evidenced by:	F 314		

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F 314	Continued From page 11 Based on observation, clinical record review and staff interviews, the facility failed to develop interventions to prevent the development of a pressure ulcer for 1 of 4 residents reviewed (Resident #2). The onsite observation on 9/12/17 showed Resident #2 with a Stage III pressure injury on the resident's mid-spine/mid back. The only documentation the facility could provide regarding the area on the resident's mid back was from an evaluation dated 7/25/17 which documented a weekly skin assessment and noted a red and not open and on the vertebrae (upper middle) with Tegaderm treatment applied. Record review revealed Staff A discontinued assessments of the area on 8/8/17 and the resident's record lacked any further assessment until 9/12/17. Staff D's written statement and interview revealed she was aware of the open area for August and September (2017) and was not concerned enough to notify anyone; and the treatment records revealed no change in treatment during this time (until 9/12/17). Interview with the DON revealed she would expect staff to report an open area on bony prominence. The facility reported a census of 82 residents. Findings include: Resident #2 had a Minimum Data Set (MDS) assessment with a reference date of 6/22/17. The MDS identified the resident with severely impaired memory and cognition. The MDS indicated Resident #2 required extensive assistance of two or more staff persons with bed mobility, transfer, dressing, toilet use, personal hygiene and total dependence for bathing. The MDS identified the resident had no impairment in bilateral upper extremity and lower range of	F 314		

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F 314	Continued From page 12 motion, and used a wheelchair for mobility. The resident's diagnoses included hip fracture, atrial fibrillation, Non-Alzheimer's dementia, and spinal stenosis. The MDS indicated the resident experienced a weight loss of 5% or more in the last month or 10% or more in the last 6 months, not on a physician-prescribed weight loss regimen. The MDS further indicated the resident assessed as not at risk of developing pressure ulcers, and had no unhealed pressure ulcers. The MDS identified the following skin and ulcer treatments utilized: pressure reducing device for chair, and pressure reducing device for bed. [The MDS classified the following Stages of Pressure Ulcers: Stage I-An observable, pressure-related alteration of intact skin, whose indicators as compared to an adjacent or opposite area on the body may include changes in one or more of the following parameters: Skin temperatures (warmth or coldness); Tissue consistency (firm or boggy); Sensation (pain, itching); and/or A defined area of persistent redness in lightly pigmented skin, whereas in darker skin tones, the ulcer may appear with persistent red, blue, or purple hues. Stage II-Partial thickness loss of dermis presenting as a shallow open ulcer with a red or pink wound bed, without slough. May also present as an intact or open/ruptured blister. Stage III- Full thickness tissue loss. Subcutaneous fat may be visible but the bone, tendon or muscle is not exposed. Slough may be present but does not obscure the depth of tissue loss. May include undermining and tunneling. Stage IV-Full thickness tissue loss with exposed bone, tendon or muscle. Slough or eschar may be present on some parts of the wound bed.	F 314		

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F 314	Continued From page 13 Often includes undermining and tunneling. Unstageable-Slough and/or eschar: known but not stageable due to coverage of wound bed by slough and/or eschar.] A Braden Scale for Prediction of Pressure Sore Risk dated as completed 6/22/2017 documented the residents score 18. A score of 15-18 indicated the resident at risk for pressure sore development. A physician notification form dated 4/14/17 ordered an Occupational Therapy (OT) referral, treat and evaluate for wheelchair positioning for pressure reduction to spine, apply Mepilex foam dressing every other day to spine to prevent pressure. A document titled Occupational Therapy OT Evaluation and Plan of Treatment dated as electronically signed 4/28/17 for the certification period 4/21/17-5/21/17 identified the reason for the referral as proper positioning for wheelchair. Evaluation of the current seating system identified thoracic spine kyphosis-fixed and noted the resident demonstrated redness at thoracic spine due to kyphosis. The document summarized the resident at risk of skin breakdown with poor hip alignment and posterior pelvic tilt. Custom modification and adjustments implemented, Comfort Company Element Back applied on 4/21/17 noted increased fit and pressure relief with customization to kyphosis to relieve pressure at bony prominences. A Care Plan with an onset date of 3/14/17, identified a focus area of at risk for pressure ulcers and other skin impairment due to	F 314		

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	165298	A. BUILDING _____ B. WING _____	09/14/2017

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F 314	Continued From page 14 immobility and incontinence related to dementia with a goal, dated initiated on 3/14/17 and updated on 7/13/17 that the resident would have no new skin impairment. The approaches directed staff to notify the primary care provider of any new or worsening skin issues, observe skin daily with cares and complete treatments as ordered. Record review of a Non-Pressure Skin Condition Report revealed an area on Resident #2's mid back healed on 3/21/17. Observations revealed the following: a. On 9/12/17 at 9:10 a.m. Resident #2 observed in room, seated in wheelchair. Resident #2 transferred from bed to wheelchair via Hoyer (mechanical) lift by Staff B, CNA (Certified Nursing Assistant) and Staff C, CNA. Pressure relieving positioning cushion noted in wheelchair with comfort back, and pressure reduction mattress on bed. Observed the Residents turned side to side in bed. b. On 9/12/17 at 9:47 a.m., the Assistant Director of Nursing (ADON) removed dressing and exposed area on the residents mid back. At this time the ADON measured the area and identified as a Stage III pressure area. The ADON stated had not been made aware of nor had seen the area before today. The resident had an area on mid back covering bony prominence of kyphotic (humped) spine that measured 6.0 cm. by 5.3 cm., with an open area 4.2 by 2.2 cm. A scant amount of serosanguineous (red tinged) drainage was noted on the dressing when removed. The open area was observed as red granulation (new) tissue with a white fibrous center. The area surrounding wound bed was noted as dark purple	F 314		

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F 314	Continued From page 15 with yellow slough (dead tissue) at border of the open wound. A Progress Notes dated 9/12/17 written by the ADON identified the onset date of the pressure injury was 9/12/17. The progress note revealed Resident #2 had experienced pain related to the pressure injury. The resident showed non-verbal signs of pain at the location of the pressure injury. Review of a document titled Injury-204, dated 9/12/2017 at 10:19 a.m. revealed the Assistant Director of Nursing (ADON) documented area reported, and assessed. The assessment revealed the following wound measurement as follows: Complete wound measurement is 6.0 x 5.3 cm to mid-spine, open area to middle of the wound measured 4.2 x 2.2 cm, unable to measure depth, 65% of wound described as granulation tissue, some epithelial (outer layer of skin) tissue, and scant amount of bloody drainage. The wound appeared moist, surrounding tissue dark purple color. Area staged as a Stage III pressure area. The only documentation the facility could provide regarding the area on the resident's mid back was a form labeled Nursing: Skin Evaluation: Non-Pressure dated 7/25/17 which documented a weekly skin assessment and noted a red and not open area on the vertebrae (upper mid) and Tegaderm applied. A Discontinue Order created by Staff A, Licensed Practical Nurse (LPN) discontinued the weekly skin evaluation on 8/8/17 and identified the area had healed. The August 2017 and September 2017 treatment administration record (TAR) showed a Mepilex border (dressing) to red areas on spine and	F 314		

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F 314	Continued From page 16 Tegaderm foam adhesive(dressing) was signed as applied to open area on the resident's mid back every 3 days which was started 5/2/17. Staff documented they continued treatment of Mepilex border (dressing) to red areas on spine and Tegaderm foam adhesive (dressing) and signed as applied to open area on the resident's mid back every 3 days for August 2017 [8/3/17, 8/7/17, 8/9/17, 8/15/17, 8/18/17, 8/21/17, 8/24/17, 8/24/17, 8/27/17, 8/30/17] and September 2017 [9/2/17, 9/5/17, 9/8/17 and on 9/11/17]. The TAR directed on 7/25/17 for staff to complete a non-pressure skin evaluation for mid back open area every Tuesday, with a discontinue date of 8/8/17. Review of the clinical record revealed the facility failed to document any further assessments or any further observations of the area on the resident's mid back with change of dressing after 8/8/17 (until identified as Stage III on 9/12/17). A document tilted NSG: Pressure Injury Evaluation-V3, identified the resident experienced a pressure injury with an onset date of 9/12/17. The pressure injury described as pressure, mid-spine. Length: 6.0 cm, width: 5.3 cm, Stage III. A scant amount of serosanguineous drainage, injury bed pink/red granulation tissue, with dark purple surrounding tissue. Identified area as a new area, with treatment started. Physician, dietary, and family notified. In an Interview on 9/12/17 at 10:30 a.m. the Director of Nursing (DON) stated a low air loss pressure relieving air mattress had now been requested for the bed, and the provider had been notified and a new treatment had been ordered. Confirmed area is a pressure area, concurred with stage III assessment.	F 314		

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F 314	Continued From page 17 Staff A's witness statement dated 9/12/17 revealed the area on Resident #2's spine had healed on 8/8/17 and that's why the weekly assessments were discontinued. Staff A documented Mepilex was continued as a preventive measure. [The TAR showed the Mepilex continued for August 2017 and September 2017.] In an interview on 7/6/17 at 12:40 p.m. Staff D, LPN reviewed August 2017 and September 2017 TAR and confirmed had routinely changed dressing, most recently 9/5/17 and 9/11/17. Staff D confirmed area had been open when observed throughout August and September 2017. Staff D described the area as observed today, as on open pressure wound and confirmed expectation to report an open area on bony prominence to DON, however had not reported as assumed DON aware as had been open when oriented in May 2017. Staff D's written statement dated 9/12/17 on the witness statement revealed on 9/5/17 and 9/11/17 revealed she had changed Resident #2's dressing on the resident's back. Staff D noted she would have an aide assist her to get the resident in bed. Staff D wrote a description of the area as follows: the area was open, a white center and it drains off and on; and the area on the outside was red. Staff D documented the wound did not appear to be getting worse or had a lot of drainage. Staff D documented she thought the Mepilex was just to protect the wound and she was not concerned to the point to notify anyone. In an interview on 9/12/17 at 2:10 p.m. Staff C, CNA confirmed frequently cared for the resident.	F 314		

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F 314	Continued From page 18 Stated had observed the area to be open for at least two months. The facility received an order to change treatment on 9/12/17 to Santal and cover with normal saline gauze and dry gauze dressing daily. Further interview on 9/12/17 at 11:45 a.m. the DON stated had not been made aware that an open area on a bony spine had been identified, confirmed would expect staff to report an open area on bony prominence.	F 314		

F000 Please accept this as the facility's credible allegation as of date 10/5/2017 for tags F 225, F 314, F 281, F 285.

Preparation and execution of this plan of correction does not constitute admission or agreement by this provider of the truth of the facts alleged or conclusions set forth in statement of deficiencies. The plan of correction is prepared and/or executed solely because it is required by the provisions of the federal and state law.

F225

This is my credible allegation of compliance to F 225. This allegation does not constitute guilt but that the facility is in compliance to F225.

Resident # 9 was interviewed and did change her story several times as to the incident. It was identified that she has a past history of being abused by males. No male care givers will be caring for resident. Resident was monitored and had no further concerns.

All resident's complaints related to staff care, staff interactions , and concerns related to their care will be investigated and addressed on a case by case basis.

Staff were educated 9/27/17 to report any allegation or potential allegation or resident to resident altercation immediately to Director of Nursing /Administrator. Start investigation immediately. Talk to all residents involved. Key words such as rough, rude, or aggressive need to be investigated further. Ask for details. Director of Nursing/ Administrator will report any allegations of abuse or resident to resident altercations to DIA immediately, but not later than 2 hours after the allegation is made. Witness statements will be obtained as soon as possible for review. Administrator will assure that all alleged

violations will be thoroughly investigated, and reported according to reporting guidelines, and state law. Administrator / DON will assure if alleged violation is verified, corrective action will be taken.

Staff were educated 9/21/17 to report any allegation or possible allegation immediately to Director of Nursing or Administrator. Immediately separate the people involved.

We will continue to monitor for possible allegations by reviewing any concern investigations for possible abuse, neglect, exploitation or mistreatment. Each concern form will be thoroughly investigated and reports of investigation reviewed by Administrator.

Annual abuse training is completed yearly for all employees and upon hire.

F281

Preparation and execution of this plan of correction does not constitute admission or agreement by this provider of the truth of the facts alleged or conclusions set forth in statement of deficiencies. The plan of correction is prepared and /or executed solely because it is required by the provisions of the federal and state law.

This is my credible allegation of compliance to F 281. This allegation does not constitute guilt but that the facility is in compliance to F281.

Residents #8, #11 and #12 all have physicians orders for fluid restrictions in place, and are placed in the computer correctly so the amount of fluids received is documented every shift.

All residents with fluid restrictions in the future will have the order placed correctly in the future so the amount of fluids received is documented every shift.

Licensed Nurses were educated 9/14/17 of the patients currently having a Dr. order for a fluid restriction. The fluid restriction orders were placed correctly in Point Click Care so the amount of fluid for a 24 hour period would be documented daily.

Fluid restriction signs were placed on the residents doors. The fluid restriction order and dietician recommendations for the amount of fluid per shift were placed in the front of each nurses 24 hour report book.

CNA's were educated 9/14/17 that residents on a fluid restriction would have a sign on their door. No water pitchers will be placed in those rooms. They were also educated to report any edema, swelling or shortness of breath, or weight gain to the nurse immediately. Fluid restrictions were also placed in Point Of Care task list for the aides to reference which resident has a fluid restriction.

This will be monitored daily by the licensed nurses when a patient has a new order, or an admission has a fluid restriction. The fluid restriction will be placed in the dietician box at the nurses for review. The nurse will place the order in Point click care, and also the CNA task list. They will notify DON/ ADON of the new order. This will be reviewed weekly at diet meeting by nurse management, dietary manager, and dietician.

Changes in weight will be monitored daily in the computer and addressed by the nurse with appropriate intervention and physician notifications.

The QA team will inspect the resident's rooms that are on fluid restrictions to make sure a sign is posted on the door and no water pitcher is in the room. The QA team will review any issues and further corrective action will occur for any violations.

F285

Preparation and execution of this plan of correction does not constitute admission or agreement by this provider of the truth of the facts alleged or conclusions set forth in statement of deficiencies. The plan of correction is prepared and /or executed solely because it is required by the provisions of the federal and state law.

This is my credible allegation of compliance to F285. This allegation does not constitute guilt but that the facility is in compliance to F285.

Resident #14 PASSAR has been submitted and approved. All recommendations are on the care plan and addressed.

All residents currently have a valid PASSAR in place, and recommendations are addressed on the care plan.

Social services will continue to complete pre-admission screening for individuals with a mental disorder and individuals with intellectual disabilities. We will continue to incorporate the recommendations from the PASSAR level 2 into the resident's assessment, care planning, and transition of care. Social services will submit a PASSAR for any resident prior to the expiration date for any residents that have a notice of short term nursing facility approval. The expiration dates are on a calendar that will be reviewed with the administrator upon admit, and after submitted prior to expiration date and when new approval is obtained.

Social services will review the PASSAR and follow appropriate interventions specific to the needs and recommendations identified for the resident. This will be addressed on the care plan and updated quarterly as needed.

F314

Preparation and execution of this plan of correction does not constitute admission or agreement by this provider of the truth of the facts alleged or conclusions set forth in statement of deficiencies. The plan of correction is prepared and/or executed solely because it is required by the provisions of the federal and state law.

This is my credible allegation of compliance to F 314. This allegation does not constitute guilt but that the facility is in compliance to F 314.

Resident # 2 has been assessed and treatment orders are in place for the pressure area on her mid spine. Weekly pressure evaluations have been completed and will continue until area is healed.

All residents have been evaluated and no new pressure areas were identified. Skin sweeps were completed 9/21/17 and no new skin areas were identified on any of our residents. All residents are receiving treatment orders as prescribed by their physicians, along with weekly skin evaluations.

Nurses were educated 9/15/17 that an incident report will be completed any new skin issue. The incident reports are reviewed daily to assure physician was notified, area was assessed, family was notified and treatment orders are in place. The care plan will be updated as needed. Nurses were also educated they need to tell the RN on duty if there is non -healing wound, an area of concern, or if they are not sure

how to identify the wound. The DON will be notified of any new skin issues or pressure areas. The DON or ADON will assess the areas and document if area is caused by pressure. A weekly skin evaluation will be completed on all skin issues. This will be audited weekly by nurse management for accuracy.

All nurses have a scheduled RELIAS computer training on 10/1/17 to help identify wounds, preventative measures, and documentation.

Braden scales will be completed quarterly and with any significant changes. These will be reviewed for accuracy by the MDS coordinator. Interventions will be put in place for patients who are at high risk for pressure ulcers.

All nurses also have a wound care in-service scheduled 10/4/17 with Sue Bruch ARNP Certified wound care specialist. The education includes types of wounds, causes of wounds, preventative measures, documentation, and staging of wounds.

Pressure wounds are reviewed in QA meetings and also weekly skin meetings. Physicians will be notified if a wound is not healing so a new treatment order can be initiated.