STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	165364	A. BUILDING _____ B. WING _____	09/28/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CONCORD CARE CENTER	490 WEST LYON STREET GARNER, IA 50438

(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: 10-29-17 The following deficiencies are the result of the recertification survey completed 9/25-28/17. See Code of Federal Regulations (42CFR) Part 483, Subpart B-C.	F 000		
F 226 SS=E	483.12(b)(1)-(3), 483.95(c)(1)-(3) DEVELOP/IMPLMENT ABUSE/NEGLECT, ETC POLICIES 483.12 (b) The facility must develop and implement written policies and procedures that: (1) Prohibit and prevent abuse, neglect, and exploitation of residents and misappropriation of resident property, (2) Establish policies and procedures to investigate any such allegations, and (3) Include training as required at paragraph §483.95, 483.95 (c) Abuse, neglect, and exploitation. In addition to the freedom from abuse, neglect, and exploitation requirements in § 483.12, facilities must also provide training to their staff that at a minimum educates staff on- (c)(1) Activities that constitute abuse, neglect, exploitation, and misappropriation of resident property as set forth at § 483.12. (c)(2) Procedures for reporting incidents of abuse, neglect, exploitation, or the misappropriation of	F 226		

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.

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F 226	Continued From page 1 resident property (c)(3) Dementia management and resident abuse prevention. This REQUIREMENT is not met as evidenced by: Based on personnel record review, and staff interview, the facility failed to assure the required pre-employment checks were completed for 1 of 5 staff reviewed (Staff B). The facility reported a census of 49 residents. Findings include: A facility New Hire List for 2016-2017 included Staff B Registered Nurse (RN) on 2/1/17. A Hireright corporate criminal screening, documented the completion date 2/17/17 of a national sex offender registry, and wide screen plus national criminal search of Staff B (over 2 weeks after the hire date). The personnel record lacked an abuse registries background check. During an interview on 9/27/17 at 4 p.m. the Administrator stated Staff B contracted through an agency and had never been in the United States before. The contracting agency was responsible for all required checks on Staff B. The Administrator stated the criminal check was not completed until 2/17/17 because she had to be assigned a social security number when she first started. Staff B contracted for 3 years and started 2/1/17, before the (Hireright) criminal check completed. An International Staffing Agreement dated	F 226		

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F 226	Continued From page 2 12/5/16 documented the staffing agency would conduct background investigations as required by visa regulations and laws of the state of Iowa. The facility Abuse Prevention, Training, and Investigations policy revised 8/24/17 defined an employee as any individual who is paid either by the healthcare facility or any other entity (temporary agency, private duty, medicare/medicaid, or independent contractors) to provide direct or indirect treatment or services to residents of the facility. A Single Contact Repository (SING) background record check would be completed through the Iowa Department of Administrative Services website prior to the offering of a position of employment and no more than 30 calendar days before starting employment. The background check would include criminal history, dependent adult and child abuse registries, and the sex offender registry. Verification of the checks were retained on file in the facility (Exception: Independent contractors may provide assurance that the required verification is retained within their primary place of business,	F 226		
F 314 SS=D	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	F 314		

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F 314	Continued From page 3 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: Based on record review and staff interview, the facility failed to assure a resident with a pressure ulcer received necessary services to promote healing for 1 of 2 residents (Resident #3). The facility reported a census of 49 residents. Findings include: According to the Minimum Data Set (MDS) assessment dated 7/24/17, Resident #3 scored 14 on the Brief Interview for Mental Status (BIMS) indicating no cognitive impairment. Resident #3 independently transferred and ambulated, and required limited assistance with dressing. Resident #3's diagnoses included atrial fibrillation. Resident #3 had no pressure ulcers. A Weekly Pressure Ulcer Progress Report, dated 8/21/17, identified Resident #3 with a Stage II pressure ulcer on top of the right foot bunion area measuring 0.9 by 0.6 cm, pink/red in color. A Wound Care, Skin Integrity Evaluation by the wound care nurse dated 8/29/17 documented Resident #3 had a Stage III pressure ulcer of the hallux of the right foot. The Progress Notes dated 9/8/17 at 2:19 p.m. documented the dietician followed Resident #3	F 314		

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F 314	Continued From page 4 for a Stage III pressure ulcer on the right foot (2-1/2 weeks after the pressure ulcer identified. Resident #3 had good intakes at meals with a stable weight. Resident #3 may benefit with Arginaid (dietary supplement to aid in healing) 2 times a day. A Progress Note dated 9/15/17 (a week later) at 4:57 p.m. documented Resident #3 reviewed by the dietician due to monitoring for pressure ulcer to the right bunion, and recommending the resident take Arginaid 1 packet 2 times a day. Staff A Registered Nurse (RN) prepared a fax and sent to the physician to review. The physician responded 9/18/17 the okay to the dietician's recommendation (4 weeks after the pressure ulcer identified). During an interview on 9/26/17 at 1:05 p.m. Staff A stated they needed to get faxes out by 4:30 p.m. on Friday. She could not explain why the fax regarding the Arginaid did not go to the physician until a week after the recommendation. The facility document titled Pressure Ulcer Development Protocol (not dated) listed standard interventions to implement once a pressure ulcer is identified. The interventions included to email the dietician to review the resident's labs, weight trends, and comorbidities for recommendations of additional interventions such as pro-stat, extra protein or house supplement. The clinical record lacked documentation of when the facility notified the dietician of Resident #3's pressure ulcer.	F 314		

Concord Care Center
490 W. Lyon Street • Garner, Iowa 50438
Ph: (641) 923-2677 • Fax: (641) 923-0074

Plan of Correction, submitted October 29, 2017

Preparation and execution of the Plan of Correction should not be construed as an admission of the deficiency cited. This Plan of correction is prepared solely because it is required under State or Federal Law.

F000 Correction Date: October 29, 2017

F266 483.12(b)(1)-(3) 483.95(c)(1)-(3) DEVELOP/IMPLEMENT ABUSE/NEGLECT, ETC POLICIES

The facility has developed and implemented written policies and procedures that prohibit and prevent abuse, details how to investigate allegations of abuse, and includes training regarding abuse.

The facility is disputing this deficiency, and is submitting a response with additional information in a separate document. However, for the required Plan of Correction, the facility submits the following information.

1. The facility entered into a contract with an employment agency to provide to the facility a qualified healthcare professional (Staff B). As staff B's employer, the staffing agency is contractually obligated to perform criminal background investigations as required by US VISA regulations and the laws of the State of Iowa. The facility contacted the employment agency on 9/26/17 and requested a copy of the results of the background checks they performed for Staff B. A SING (Single Contact Repository) background check through the Iowa Department of Administrative Services' was performed by the employment agency on 9/27/17. This check came back with no "hits" or no criminal convictions and no founded abuse on the Central Abuse Registry. The SING results will be kept on file at the facility.
2. Human Resources will verify with staffing employment agencies that required background checks are completed prior to allowing them to work in the facility. The facility may require employment agencies to provide a copy of the results of background checks, and therefore, the facility Human Resources department will request a copy of those documents from the employment agency to be kept on file in the facility. Once the required background checks have been verified as complete, the employee will be eligible to work at Concord Care Center.
3. Through the facility's Quality Assurance Improvement Process, monthly audits for one quarter will be completed by Human Resources to ensure the employment agency has performed the required background checks. The results of those audits will determine the frequency of audits thereafter.

F314 483.25(b)(1) TREATMENT/SVCS TO PREVENT/HEAL PRESSURE SORES

The facility has developed and implemented policies and procedures that prevent and treat pressure ulcers for each resident also as to achieve and maintain the highest possible degree of function, self-care, and independence based on resident choice, where practicable.

The facility is disputing this deficiency, and is submitting a response with additional information in a separate document. However, for the required Plan of Correction, the facility submits the following information.

1. Resident #3's ulcer is healed. Staff will continue to monitor Resident #3's skin integrity and implement appropriate interventions as needed.
2. The facility conducts weekly interdisciplinary team meetings to address resident skin/wound issues. The scheduling of the meetings was adjusted to allow the dietician additional time to review resident records and discuss her recommendations with the team prior to making the written recommendations. The facility will continue to utilize the dietician recommendation form for documentation of recommendations. The dietary manager will attend the weekly meetings starting in October 2017 to assist in follow-up and monitoring of dietary recommendations. Follow-up results of the recommendations will be documented on the form within 1 week.
3. Through the Quality Assurance and Improvement process the Director of Nursing or designee will ensure the completion of dietician recommendations on a weekly basis x4 weeks. The results of those audits will determine the frequency of audits thereafter.

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