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	165260	A. BUILDING _____ B. WING _____	10/05/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
DONNELLSON HEALTH CENTER	901 STATE STREET DONNELLSON, IA 52625

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F 000	INITIAL COMMENTS Correction Date 10/20/17 The following deficiencies are the result of the annual health survey and investigation of 68223-I, 70186-I, 67379-I, 66712-I, 66708-I, 69140-C, 65603-C, 69134-C, conducted 10/2/17-10/5/17. Substantiated: 66712-I, 67379-I, 65603-C Not substantiated: 66708-I, 68223-I, 70186-C, 69140-C, 69134-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,	F 225		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Sheryl Lewis	Administrator	10/20/2017

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

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F 225	Continued From page 1 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: (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:	F 225		

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F 225	Continued From page 2 Based on record review, interviews, and facility policy, the facility failed to report an allegation of abuse timely to the Department of Inspections and Appeals for 1 of 12 residents reviewed (Resident #11). The facility identified a census of 47 residents. Findings include: 1. Record review revealed on 1/14/17 Resident #11 had been admitted to the facility for skilled care for a fracture of the right ankle. According to the physician ' s order dated 1/1/4/17, the resident to receive Oxycontin (narcotic pain medication) 10 milligrams (mg) twice daily by mouth. Review of a written statement signed by Staff C, Registered Nurse (RN) dated 1/28/17 revealed Staff C counted narcotics with Staff D, Licensed Practical Nurse (LPN), approximately the third week of January 2017. It was determined by both nurses the count for the resident's Oxycontin was over by one 10 mg pill. Staff C stated she observed Staff D take the extra pill and place it in her pocket. Staff C also noted in the written statement that prior to that time there was an separate occasion approximately 4 weeks prior to this incident were the narcotic count was off and Staff D again removed the Xanax (anti-anxiety medication) and put it in her pocket. Staff C could recall the resident or the dosage of the Xanax. During an interview on 10/3/7 at 9:04 am Staff C reported she witnessed two separate incidents of Staff D placing extra pills in her pocket. Staff C stated she saw Staff D remove [residents] pills and placed them in her pocket. Staff C stated	F 225		

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F 225	Continued From page 3 Staff D did not say anything when she placed the pills in her pocket during either incident. Staff C stated she did not question Staff D at the time. Staff C stated she could not recall which resident ' s pills it was the first time as it occurred sometime back in December 2016. Staff C stated she did not report the incidents to administration until she was interviewed later by the facility administrator because of a suspected drug diversion. She stated she did not report to the administration because she was afraid of retaliation by Staff D. The facility investigation revealed Staff C reported she had witnessed Staff D take Resident #11 ' s Oxycontin from the medication package and [on a separate occasion] Staff D removed a xanax from the package and placed these in her pocket. Staff C did know which resident the xanax belong to. The investigation revealed the facility would review [timely] reporting expectation with Staff C. During an interview with the Director of Nursing (DON) on 10/2/17 at 12:45 PM she stated she would expect all staff to report suspected abuse to their superior immediately as per facility policy. Record review of an undated facility policy titled Dependent Adult Abuse Reporting staff observing an incident of resident abuse or suspected abuse must immediately (within 24 hours) report such incidents to the Department of Inspections and Appeals and the charge nurse. II. Based on record reviews, staff and resident interviews, and a review of policy and procedures, the facility failed to notify the Iowa Department of Inspections and Appeals (DIA) of resident to resident abuse involving Residents #8 and #9.	F 225		

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F 225	Continued From page 4 Two additional incidents identified during the investigation revealed facility staff failed to report suspected abuse involving Residents #8, #9, and #11 to facility administration in a timely manner. The facility reported a census of 47 residents and the survey sample consisted of 12 residents. 1. Resident #8's Minimum Data Set (MDS) assessment completed 8/16/17 documented the following diagnoses: hypertension (high blood pressure), diabetes mellitus, and severe intellectual disabilities. It also identified the resident required extensive to total assistance of 2 staff with all activities of daily living, did not ambulate (walk) and utilized a wheel chair an their main mobility device. The resident triggered on previous MDS assessments to have verbal behaviors 4 to 6 days out of the 7 day assessment period and physical behaviors 1 to 3 days of the 7 day assessment period. The care plan with a target date of 11/29/17 identified the resident with a diagnosis of intermittent explosive disorder related to the intellectual disability. It directed nursing staff to administer medications as ordered by the doctor, monitor/record/report to the doctor as needed if the resident at risk for harming others, displayed increased anger, labile mood or agitation. Also if the resident felt threatened by others or had thoughts of harming someone, or had possession of weapons or objects that could be used as weapons. 2. Resident #9's Minimum Data Set (MDS) annual assessment completed 8/18/17 had documentation of the following diagnoses: hypertension (high blood pressure), diabetes mellitus, and moderate intellectual disabilities. It	F 225		

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F 225	Continued From page 5 also identified the resident as independent to required limited assistance of 1 staff with all activities of daily living, did not ambulate and utilized a walker or wheel chair for mobility devices. The resident triggered on the MDS assessment to have verbal behaviors 4 to 6 days out of the 7 day assessment period. The care plan with a target date of 11/22/17 identified the resident had attention-seeking behaviors with a goal of resident to not hurt themselves with the behaviors. It directed nursing staff to be aware the resident can be verbally aggressive at times, can have socially inappropriate behaviors, and can be resistive to cares. If resistive to cares, staff directed to give the resident some time and try again. Review of the facility's self reported incident received in the office on 2/22/2017 stated staff witnessed Resident #9 strike out and hit. Resident #8 on 2/20/17. The staff did not report the resident to resident altercation to nursing staff until the next day on 2/21/2017. Further review of the facility-reported incident showed the facility delayed sending the information to the office until 2 days after the altercation. During an interview on 10/3/17 at 1:43 p.m., Staff A, Licensed Practical Nurse (LPN)/Restorative Nurse recalled it was after lunch (12:30 p.m.) or in the afternoon on 2/21/17 when Staff B, Activity Assistant/Certified Nurse Aide (CNA) talked to him/her. Staff A was in the restorative room and Staff B came in to talk and reported the night before (2/20/17) around 6:30 p.m., Resident #8 got too close to Resident #9. Staff B then observed Resident #9 react by striking out at Resident #8. Staff A did not know if Resident #9	F 225		

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F 225	Continued From page 6	F 225		

hit or punched, but Staff B did report there was contact made. The 2 residents were by the medication carts in the front part of the facility. Staff A asked Staff B if she reported the incident and Staff B commented 2 nurses were standing there and assumed they saw it. Staff A then stated she went to the Director of Nursing (DON) and Assisted Director of Nursing (ADON) and reported what Staff B reported. Staff A then wrote a statement about the incident. Staff A did not complete an Incident Report and was not directed to do so. Staff A stated she had no further involvement with the situation.

During an interview on 10/3/17 at 2:07 p.m., Staff B Activity Assistant/CNA reported working on Monday, 2/20/17 from 12:00 p.m. to 8:30 p.m. doing usual activities that started at 6:30 p.m. Staff B stated she exited the Memory Unit and walked up the center hall toward the front common area where the Nurse's medication carts were located. Staff B reported she then saw Resident #8 and #9 in close proximity of each other, but she was not close enough to hear if anything was said between the 2 residents. Staff B stated Resident #9 swung his/her right arm toward Resident #8 with a closed fist and hit him/her in the biceps area, outer aspect of the left arm. Staff B heard Resident #8 yell "ow!" Staff B stated she did not hear Resident #9 warn Resident #8 first. Staff B said by the time she trotted toward the residents and stated, "Hey, hey, let's stop that and you two get away from each other." Resident #8 pretty much stayed put and Staff B diverted Resident #9 toward the main dining room door. Staff B explained two 2 nurses stood at the medication carts when this happened, that is why he/she did not report it; The 2 were near Resident #8. Staff B reported

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F 225	Continued From page 7 the next day (2/21/1017), she talked with Staff A about the "craziness" of the night before. She told Staff A it was loud/busy and Resident #9 hit Resident #8. Staff A said "what do you mean?" Staff B repeated what was said. After Staff A clarified the altercation had not been reported, she and Staff A then reported to the DON and ADON the incident. Staff B stated there had been no more further problems with the 2 residents once separated. Staff B stated did know his/her responsibility of reporting possible abuse, it was just that night thought the 2 Nurses saw the incident too. Staff B reported truly thought the Nurses saw it and had reported it. During an interview on 10/3/17 at 2:43 p.m., the DON reported shortly after Staff B talked to Staff A about the incident between Resident #8 and #9, Staff A came to the DON and ADON. The DON reported called Staff B in and asked him/her about the incident. Staff B reported saw one of the 2 residents hit the other. The DON stated asked for more description form Staff B and learned that Resident #9 had hit Resident #8 in the left arm with a closed fist. Both DON and ADON inquired to Staff B if had reported the incident to the Nurse, and Staff B stated he/she did not and did not remember the reason why. The DON had Staff B write a statement and educated the staff on proper protocol and the time frame involved to get incidents like that reported in a timely fashion. The DON reminded Staff B that phone numbers are posted to call and report possible abuse. The DON stated did notify the Department of Inspections and Appeals of the situation, but not exactly sure of the date or time. The DON reported Resident #8 assessed immediately after talking with Staff A and no injuries found. The resident asked about the	F 225		

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F 225	Continued From page 8 situation and could not remember or say he/she was hurt. The DON talked to Resident #9 next and he/she reported did not remember doing that, but as the DON talked more with the resident, he/she teared up as if remorseful or in trouble. The DON stated did educate Resident #9 on keeping hands to self and the resident said "okay" and agreed to do that. The DON reported there has been no other problems between the 2 residents. The DON talked to Staff G, Registered Nurse from Agency staffing. Staff G reported didn't witness the incident nor had a report given to him/her about it. The DON further reported tried to reach the other Nurse working that night of 1/20/17, Staff F, LPN and left a message about the incident and Staff F did not call back and no longer works at the facility. During the interview with the DON on 10/3/17, the DON did call 3 local staffing agencies utilized at the facility to find a phone number where Staff G might be contacted with. The DON unsuccessful to find Staff G. During the survey process 2 different attempts made, one on 10/2/17 and 10/3/17 to contact Staff F, LPN. Messages left both times to call back with no response.	F 225		
F 241 SS=D	483.10(a)(1) DIGNITY AND RESPECT OF INDIVIDUALITY (a)(1) A facility must treat and care for each resident in a manner and in an environment that promotes maintenance or enhancement of his or her quality of life recognizing each resident's individuality. The facility must protect and promote the rights of the resident. This REQUIREMENT is not met as evidenced	F 241		

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F 241	Continued From page 9	F 241		

by:
Based on record review, interviews and chart review the facility failed to ensure staff treated 1 of 2 residents in a dignified and respectful manner in constant affirmation of the resident's individuality (Resident #7). The facility identified a census of 47 residents.

Findings include:

1. According to the Minimum Data Set(MDS) assessment tool dated 8/5/17, Resident #7 had diagnoses of diabetes, depression and chronic obstructed airway disease. The MDS documented the resident experienced moderately impaired cognition with a Brief Interview for Mental Status score of 12 out of a possible 15. The MDS also documented the resident required extensive assistance of two staff for transfers, dressing, and toilet use.

The Care Plan with a target date of 10/25/17, identified the resident could display irritability, disorganized behavior, aggression, agitation, and crying. The Care Plan directed the staff to offer reassurance, supportive listening, interventions, or distraction. The care plan also instructed staff to provide a homelike environment.

On 3/30/17, the facility notified the Department of Inspections and Appeals of a staff-to-resident incident.
The facility also provided documentation of witness statements and reported they terminated Staff H, CNA, on 3/30/17 after an investigation.

Review of Staff H's personnel record revealed documentation of the incident 3/29/17. The personal record also revealed documentation of

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F 241	Continued From page 10 foul language used by Staff H, CNA on 10/22/16. An interview on 10/3/17 at 10:30 a.m. with Resident #7 revealed concerns with a staff person and the use of foul language in his/her presence. Resident #7 revealed the facility staff removed the staff from his/her room, and expressed no harm related to the incident. An interview with Staff I, CNA, on 10/3/17 at 9:40 a.m., revealed on one occasion she and the nurse on duty removed Staff H from Resident's #7 room related to foul language and disrespectful remarks. Staff I reported no further observations of disrespectful mannerisms or language from other staff. During an interview with the Director of Nursing (DON) on 10/4/17, at 10:30 a.m. identified Staff H as a "good worker," and felt the staff on the night of the incident "just had enough." She stated staff reported the incident and the facility terminated Staff H. During an interview on 10/4/17 at 2:00 p.m., the current Administrator reported at the time of the incident, the CNA and the nurse on duty removed Staff H from Resident's #7 room. The facility reported the incident, investigated, and terminated Staff H, CNA. The Administrator stated the facility had no tolerance for inappropriate staff behavior. Review of the Residents' Bill of Rights dated 11/16 documented the resident had a right to a dignified existence. The review revealed a facility must treat each resident with respect and dignity and care for each resident in a manner that promotes maintenance or enhancement of	F 241		

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F 241	Continued From page 11 his/her quality of life and recognizing each one's individuality, and to protect and promote the rights of the resident.	F 241		
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,	F 285		

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F 285	Continued From page 12 (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; 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-	F 285		

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F 285	Continued From page 13 (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 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 document review and staff interview, the facility failed to implement specialized services identified on the Level II PASRR (Preadmission Screening and Resident Review) assessment and failed to list the specialized services on the care plan for 1 of 2 records	F 285		

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	165260	A. BUILDING _____ B. WING _____	10/05/2017

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F 285	Continued From page 14 reviewed with a Level II PASRR (Resident #16). The facility reported a census of 47 residents. Findings include: 1. The MDS (Minimum Data Set) assessment tool, dated 8/15/17, listed a diagnosis for Resident #16 of anxiety and schizophrenia. The MDS revealed the resident required extensive assistance of 1 staff for eating, extensive assistance of 2 staff for bed mobility, transfers, dressing, toilet use, and personal hygiene, and depended totally on 2 staff for bathing. The MDS documented the resident had the following symptoms between 7-11 days over the last 2 weeks: little interest of pleasure in doing things, trouble falling or staying asleep. The MDS also documented the resident had the following symptoms for 12-14 days of the last 2 weeks: feeling tired or having little energy. The MDS listed the resident's BIMS (Brief Interview for Mental Status) score as 7 out of 15, indicating severely impaired cognition. The PASRR assessment tool, dated 2/28/16, revealed recommended specialized services for the resident that included: a. Ongoing psychiatric services by a psychiatrist to evaluate response and effectiveness of psychotropic medication on target symptoms, modify medication orders, and to evaluate ongoing need for additional behavioral health services. b. Individual therapy by a licensed behavioral health professional c. Socialization/leisure/recreation activities d. Facilitate family involvement in the individual's care plan	F 285		

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F 285	Continued From page 15 e. Obtain archived psychiatric records to clarify history and to provide to treating physicians The resident's care plan did not list the above recommendations and the facility lacked documentation the resident received ongoing psychiatric services or individual therapy by a licensed behavioral health professional. During an interview on 10/4/17 at 11:00 a.m., the MDS Coordinator stated she thought she added the PASRR recommendations to the care plan but hadn't. She stated she added them to the care plan "today." During an interview on 10/4/17 at 1:30 p.m., the DON (Director of Nursing) stated the resident had an appointment for psychiatric services in March but the resident was in the hospital at that time. She stated the facility set up another appointment in June, but the resident was too ill to attend. She stated she called the family on 10/4/17 regarding the arrangement of other psychiatric services.	F 285		
F 309 SS=D	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	F 309		

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F 309	Continued From page 16 applies to all treatment and care provided to facility residents. Based on the comprehensive assessment of a resident, the facility must ensure that residents receive treatment and care in accordance with professional standards of practice, the comprehensive person-centered care plan, and the residents' choices, including but not limited to the following: (k) Pain Management. The facility must ensure that pain management is provided to residents who require such services, consistent with professional standards of practice, the comprehensive person-centered care plan, 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, resident and family interview the facility failed to provide proper assessment and interventions regarding post surgical care in a timely fashion for 1 of 11 residents reviewed (Resident #11). The facility reported a census of 47 residents. Findings Include: 1. Resident #11's Minimum Data Set (MDS) discharge assessment completed 1/26/17 had documentation of the following diagnoses: unspecified closed fracture of right foot, hypertension (high blood pressure), diabetes mellitus. It also identified the resident as totally	F 309		

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F 309	Continued From page 17	F 309		

dependent on staff with all activities of daily living and noted the resident had not ambulated (walked) since admission. The resident's scored 15 of 15 on the Brief Interview of Mental Status (BIMS) which indicated the resident displayed intact cognitive status.

The care plan with an initiation date of 1/16/17 identified the resident sustained a right ankle fracture. The care plan directed staff the resident had broken their right ankle and could not walk on it yet. The care plan also directed the resident to only let the right leg dangle for 10 minutes at a time, and to provide transfer assistance of 2 staff with a Hoyer lift, and assistance of 1 to 2 staff for bed mobility.

Review of Resident 11's medical record showed the resident admitted to the facility on 1/14/17 due to a fractured right ankle with an external fixator (a metal apparatus used to keep the ankle bone in place with metal pins that protruded from the resident's ankle) in place. Review of the physician telephone order dated 1/20/17 directed staff to provide daily pin care with alcohol swabs, elevate the ankle, and to ensure the resident's ankle dangled for no more than 10 minutes at a time; otherwise, the resident was on strict non-weight bearing status.

Review of the January 2017 Treatment Administration Record (TAR) for Resident #11 showed an entry for Pin Care Daily dated 1/21/2017 (cleanse pin sites with alcohol daily).

During an interview on 10/3/17 at 12:15 p.m., a family member reported when the doctor saw Resident #11 in the office on 1/23/17, the resident commented the facility did not follow his/her

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F 309	Continued From page 18 orders with regard to wound care and dressing changes. The family member stated the dressing from 1/20/17 remained in place on 1/23/17, and staff failed to provide pin cares over the weekend. During an interview on 10/4/17 at 10:40 a.m., the Director of Nursing (DON) reported on Monday, 1/23/17 the physician's office called the facility and reported the dressing the doctor had applied on Friday, 1/20/17 remained in place, staff had not completed the daily pin care over the weekend, and the doctor's office was not happy. The DON stated she spoke with Staff D, Licensed Practical Nurse (LPN) as she was the 6:00 a.m. to 2:00 p.m. nurse over the weekend. Staff D stated the pin care was only done as needed and there was no drainage noted to the dressing. The DON reported she reviewed the TAR for the resident for 1/21/17 and 1/22/17, and found Staff D's initials to signify the cares were completed as ordered. The DON reported the facility had no formal policy, but she expected the nursing staff to follow doctor's orders and basic nursing protocols. During an interview on 10/4/16 at 11:10 a.m., Staff E, LPN stated remembered when working with Resident #11 on 1/23/17 and going to give the resident his/her pain pill medication. Staff E got ready to do the pin care to the right ankle external fixator. The resident reported the doctor had just done the pin care at his/her office that day. Then the resident told Staff E nobody did the pin care all weekend and it should have been done daily. Staff E looked at the TAR and saw Staff D had signed the TAR as if she had completed the pin care on 1/21/17 and 1/22/17. Staff E talked with the DON on 1/23/17 and reported what happened; the DON asked Staff E	F 309		

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F 309	Continued From page 19 to write a statement.	F 309		
F 428 SS=D	483.45(c)(1)(3)-(5) DRUG REGIMEN REVIEW, REPORT IRREGULAR, ACT ON c) Drug Regimen Review (1) The drug regimen of each resident must be reviewed at least once a month by a licensed pharmacist. (3) A psychotropic drug is any drug that affects brain activities associated with mental processes and behavior. These drugs include, but are not limited to, drugs in the following categories: (i) Anti-psychotic; (ii) Anti-depressant; (iii) Anti-anxiety; and (iv) Hypnotic. (4) The pharmacist must report any irregularities to the attending physician and the facility's medical director and director of nursing, and these reports must be acted upon. (i) Irregularities include, but are not limited to, any drug that meets the criteria set forth in paragraph (d) of this section for an unnecessary drug. (ii) Any irregularities noted by the pharmacist during this review must be documented on a separate, written report that is sent to the attending physician and the facility's medical director and director of nursing and lists, at a minimum, the resident's name, the relevant drug, and the irregularity the pharmacist identified. (iii) The attending physician must document in the	F 428		

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F 428	Continued From page 21 dated 8/2/17 documented a need for a gradual dose reduction attempt on Xanax, Mirtriazapine, and Vilbryd. The pharmacist documented a reduction attempt was not warranted due to documentation in the clinical record regarding aggressive behaviors. The physician signed agreement on 8/14/17. The physician did not address each medication for a gradual dose reduction or a rationale for the continued use of the medications. The Note To Attending Physician/Prescriber dated 9/6/17 listed the resident had an order for an as needed antianxiety medication. The physician did not document a clinical rationale or a duration of the antianxiety medication. During an interview on 10/5/17 at 9:10 a.m. the consultant pharmacist agreed the physician needs to provide a rationale for each individual medication based on their review of the chart.	F 428		

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F 428	Continued From page 20 resident's medical record that the identified irregularity has been reviewed and what, if any, action has been taken to address it. If there is to be no change in the medication, the attending physician should document his or her rationale in the resident's medical record. (5) The facility must develop and maintain policies and procedures for the monthly drug regimen review that include, but are not limited to, time frames for the different steps in the process and steps the pharmacist must take when he or she identifies an irregularity that requires urgent action to protect the resident. This REQUIREMENT is not met as evidenced by: Based on clinical record review and staff interview, the facility failed to provide a clinical rationale for continued use and duration of psychotropic medications for 1 of 6 current residents reviewed (Residents #1). The facility reported a census of 47 residents. Findings include: 1. The Minimum Data Set (MDS) assessment dated 9/21/17 documented Resident #1 had diagnoses including hypertension, dementia, anxiety, and depression. The MDS documented the resident scored a 2 out of 15 on the Brief Interview for Mental Status (BIMS) indicating severely impaired cognition. The Medication Administration Record for August 2017 listed an order for Xanax (antianxiety), Mirtlazapine (antidepressant), Vilbryd (antidepressant), and Ziprasidone (antipsychotic). The Consultant Pharmacist's Progress Note	F 428		

The statements made in this plan of correction are not an admission to and do not constitute an agreement with the alleged deficiencies. To remain in compliance with State and Federal regulations the facility has completed the following actions set forth in the plan of correction. All deficiencies have been completed by October 27, 2017.

F225:

The facility does and will continue to ensure to report allegations of abuse timely to the Department of Inspections and Appeals.

1. On January 28, 2017 staff C received counseling by the DON and ADON on reporting any witnessed or suspected drug theft immediately.

On January 29, 2017 all nurses and medication aids employed received counseling by the DON and ADON on reporting any witnessed or suspected drug theft immediately.

On February 3, 2017 each Nurse was required to review the following policies:

Medication Administration
Controlled Substances
Medication Administration

Measures taken: Nurses and med aids will receive annual training on reporting any witnessed or suspected drug theft immediately and annual review of the following policies:

Medication Administration
Controlled Substances
Medication Administration

2. On February 21, 2017 Staff B received individual counseling by DON and ADON on abuse reporting policy.

F225: Continued

Measures taken: On March 30, 2017 all employees were required to review the following:

Dependent Adult Abuse Prevention
Dependent Adult Abuse Reporting
Dependent Adult Abuse Investigation

On April 21, 2017 at mandatory employee meeting, the following items were reviewed:

Dependent Adult Abuse Prevention

Dependent Adult Abuse Reporting
Dependent Adult Abuse Investigation

On June 23, 2017 at mandatory employee meeting, the following items were reviewed:

Abuse and Neglect
Abuse Investigation and Reporting
Abuse Prevention Program

In September 2017 employees were required to review the following:

Abuse and Neglect
Abuse Investigation and Reporting
Abuse Prevention Program

Quarterly reviews of the following will continue:

Abuse and Neglect
Abuse Investigation and Reporting
Abuse Prevention Program

F241:

The facility does and will continue to ensure all staff treat residents in a dignified and respectful manner in constant affirmation of the resident's individuality.

On March 29, 2017 Staff member H was removed from the situation and not allowed to return to work pending investigation. Investigation By the DON and ADON was concluded on March 30, 2017 and staff member H was terminated prior to their scheduled shift.

Measures taken: On March 30, 2017 all employees were required to review the following:

Dependent Adult Abuse Prevention
Dependent Adult Abuse Reporting
Dependent Adult Abuse Investigation

On April 21, 2017 at mandatory employee meeting, the following items were reviewed:

Dependent Adult Abuse Prevention
Dependent Adult Abuse Reporting
Dependent Adult Abuse Investigation

On June 23, 2017 at mandatory employee meeting, the following items were reviewed:

Abuse and Neglect
Abuse Investigation and Reporting
Abuse Prevention Program

In September 2017 employees were required to review the following:

F241: Continued

Abuse and Neglect
Abuse Investigation and Reporting
Abuse Prevention Program

Quarterly reviews of the following will continue:
Abuse and Neglect
Abuse Investigation and Reporting
Abuse Prevention Program

F285:

The facility does and will continue to ensure that specialized services identified on the Level II PASRR are listed on the care plan.

On October 4, 2017 MDS coordinator added the level II PASRR recommendations to the care plan. Interviewer was notified of correction.

Resident had been involved with psychiatric services until her March appointment when she was hospitalized. Residents appointment had been rescheduled for June but resident remained medically ill and unable to attend. Residents Guardian was contacted on October 4, 2017. Permission received to have resident seen by facilities psychiatric service. Resident was seen by psychiatrist on October 27, 2017.

Measures taken: All level II PASRR's care plans will be completed by the MDS coordinator and reviewed by the DON, ADON, or Administrator within 20 days for accuracy.

F309:

The facility does and will continue to ensure proper assessment and interventions regarding post surgical care in a timely fashion.

On January 23, 2017 pin care education provided to all nursing staff caring for the resident.

Staff member E was terminated on January 30, 2017 after a thorough investigation was completed. A report was filed with the Iowa Board of Nursing as staff member E failed to comply with Iowa Board of Nursing Chapter 6 section 6.3(10).

Measures taken: As of March 2017 nurses now attend QA meetings Monday through Friday mornings were new orders, education needs, questions and concerns are addressed by fellow nursing staff, MDS coordinator, Restorative nurse, Director of Rehab, DON, ADON, and Administrator.

F428:

The facility does and will continue to ensure a clinical rationale is given for continued use and duration of each psychotropic medication.

On October 27, 2017 a Drug Regimen Review Policy was drafted by Donnellson Health Center. The policy will be reviewed at the October 30, 2017 QUAPI meeting. The final draft will be distributed to the pharmacy, medical director, and all physicians caring for residents if appropriate.

Measures taken: Per policy, completed medication review reports will be reviewed by the DON or designee and the nurse coordinating the residents care. The DON or designee will review for completeness

F428: Continued

including that each medication for GDR is addressed or a rationale for the continued use of each medication is given.