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	165497	A. BUILDING _____ B. WING _____	C 11/30/2017

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QHC WINTERSET NORTH, LLC	411 EAST LANE STREET WINTERSET, IA 50273

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F 000	INITIAL COMMENTS Correction date 12/20/17 The following deficiencies were identified during investigation of complaints and facility-reported incidents # 68134-I, 68142-I, 68167-I, 70407-C, 70666-C, 70811-I, 70889-C, 70891-C, 70984-C, and 71594-C and mandatory report # 71702-M conducted 10/19/17 to 11/30/17. Complaints #67057-C, 67572-C, 69521-C, 71794-C and 72035-C were not substantiated. See Code of Federal Regulations (42CFR), Part 483, Subpart B - C.	F 000		
F 159 SS=D	FACILITY MANAGEMENT OF PERSONAL FUNDS CFR(s): 483.10(f)(10)(i)-(iv) (f)(10)(i) ...If a resident chooses to deposit personal funds with the facility, upon written authorization of a resident, the facility must act as a fiduciary of the resident's funds and hold, safeguard, manage, and account for the personal funds of the resident deposited with the facility, as specified in this section. (f)(10)(ii) Deposit of Funds. (A) In general: Except as set out in paragraph (f)(l0)(ii)(B) of this section, the facility must deposit any residents' personal funds in excess of $100 in an interest bearing account (or accounts) that is separate from any of the facility's operating accounts, and that credits all interest earned on resident's funds to that account. (In pooled accounts, there must be a separate accounting for each resident's share.) The facility must maintain a resident's personal funds that do not	F 159		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE 12/15/2017

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F 159	Continued From page 1 exceed $100 in a non-interest bearing account, interest-bearing account, or petty cash fund. (B) Residents whose care is funded by Medicaid: The facility must deposit the residents' personal funds in excess of $50 in an interest bearing account (or accounts) that is separate from any of the facility's operating accounts, and that credits all interest earned on resident's funds to that account. (In pooled accounts, there must be a separate accounting for each resident's share.) The facility must maintain personal funds that do not exceed $50 in a noninterest bearing account, interest-bearing account, or petty cash fund. (f)(10)(iii) Accounting and records. (A) The facility must establish and maintain a system that assures a full and complete and separate accounting, according to generally accepted accounting principles, of each resident's personal funds entrusted to the facility on the resident's behalf. (B) The system must preclude any commingling of resident funds with facility funds or with the funds of any person other than another resident. (C)The individual financial record must be available to the resident through quarterly statements and upon request. (f)(10)(iv) Notice of certain balances. The facility must notify each resident that receives Medicaid benefits- (A) When the amount in the resident's account reaches $200 less than the SSI resource limit for one person, specified in section 1611(a)(3)(B) of the Act; and	F 159		

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F 159	Continued From page 2 (B) That, if the amount in the account, in addition to the value of the resident's other nonexempt resources, reaches the SSI resource limit for one person, the resident may lose eligibility for Medicaid or SSI. This REQUIREMENT is not met as evidenced by: Based on clinical record review, staff interviews and observations, the facility failed to ensure an orderly system to manage resident purchases for two of 24 residents reviewed (Residents #9 and #19). The facility identified a census of 61 current residents. Findings include: 1. The MDS (minimum data set) assessment dated 9/1/17 documented Resident #9 had diagnoses that included aphasia (inability to communicate), dementia, seizure disorder, depression, profound intellectual disabilities, muscle weakness, difficulty walking and lack of coordination. The assessment documented she had short and long term memory problems, an altered LOC (level of consciousness and severely impaired cognitive skills for daily decision making. The 3/27/17 Care Plan noted that one staff member should assist Resident #9 with activities of daily living. A Walmart receipt dated 8/22/17 designated purchases for Resident #9 that included two Norelco electric razors ($39.96 each). A Shopko receipt dated 7/19/17 for Resident #9 listed four deodorants ($4.49 each) purchased for the resident's use.	F 159		

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F 159	Continued From page 3 2. The MDS assessment dated 7/28/17 for Resident #19 documented diagnoses that included Alzheimer's disease, hemiplegia or hemiparesis (paralysis or weakness on one side of the body) aphasia, attention and concentration deficit, cognitive communication deficit, depression, muscle weakness and lack of coordination. Resident #19 never understood others, they never understood him and he had short and long term memory problems. The assessment documented he had severely impaired cognitive skills for daily decision making. A Shopko receipt dated 8/23/17 at 1:30 p.m. and designated as purchases for Resident #19 listed two Norelco electric razors ($34.99 each) and eight deodorants ($4.99 each) purchased for his use. An interview on 10/25/17 at 10:20 a.m. with the facility's owner revealed that she found about a week before the prior Administrator and prior Administrative Assistant left that they had been taking batch withdrawals to purchase multiple things for multiple residents and then taking care of the paperwork after the purchases. According to the owner, the system was faulty in that it was impossible to track all purchases and to account for the surplus supplies they purchased. The owner said they are developing a system that will leave the appropriate paper trail so everything can be tracked. An observation on 10/25/17 at 10:30 a.m. with the current Administrator and current Administrative Assistant in Resident #19's room revealed that electric razors or deodorants could not be found. An observation on 10/25/17 at 11:00 a.m. with	F 159		

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F 159	Continued From page 4 Staff I, CNA (certified nursing assistant) present revealed padlocked wall cabinets behind a locked door on the Memory Unit. According to Staff I, every staff member had access to the keys. The shelves inside the cabinets stored multiple different Tupperware containers labeled with various different residents' names. The Tupperware contained random/miscellaneous belongings and surplus items belonging to the residents and little organization to the storage. An interview on 10/25/17 at 10:30 a.m. with the current Administrative Assistant revealed she did not know of a common storage area where each resident's surplus supplies were stored. According to the assistant, she talked to a nurse that said resident belongings should be labeled and stored in their rooms. An interview on 10/30/17 at 12:15 p.m. with the facility's prior Administrative Assistant revealed the current Administrative Assistant recruited her help last Friday to account for records related to resident's trust accounts that were being questioned. She stated realized she had not debited one resident's account for $13.62 like it should have been. When asked about a surplus of electric razors and deodorants purchased for Resident #9 and Resident #19, the past Administrative Assistant said the CNAs bought those personal care items for the residents because they knew the residents preferred certain things. The past Administrative Assistant named five residents accounts that had been debited because of those preferences. When asked, she said Resident #9 and Resident #19 did not have the cognitive ability to say what they preferred. The past Administrative Assistant said the CNAs suggested things to be purchased for	F 159		

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the residents, and once they discussed it, she authorized them to go and make those purchases. The prior Administrative Assistant said staff members mentioned the shampoo we provided made Resident #19's hair dull and CNAs wanted something better for him. When asked, past Administrative Assistant said she did not know why they spent Resident #9's money for items the facility would have provided. She stated purchases had to be approved by the prior Administrator. She stated CNAs should have labeled the surplus items with resident names and stored them in the shower room for safekeeping. She remembered they put Resident #9 and Resident #19's extra electric razors in the closet of the Administrative Assistant's office; she remembered putting them there, but that was the last time she remembered seeing them. The prior Administrative Assistant said her last day at the facility was 10/13/17 and those razors were not in that closet when she was last there helping the new Administrative Assistant.

A subsequent interview on 10/30/17 at 1:15 p.m. with the current Administrative Assistant revealed that Resident #9's and Resident #19's spare electric razors have not been stored in her closet since she started working there recently. The Administrative Assistant said she recruited the prior Administrative Assistant's help to look for them and the surplus of deodorant last Friday when she was here sorting out the residents' financial issues. She stated she stored some residents' pop and food items in her closet with their names on them. She also stated resident's trust accounts and personal storage had been mismanaged and disorganized in the recent past, but she intended to remedy that problem. The Administrative Assistant said instead of making

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F 159	Continued From page 6 batch withdrawals to purchase multiple things for multiple residents, she intended to keep everything separate so there would not be any confusion. According to the current Administrative Assistant, there will be separate receipts for every purchase made for residents individually. An interview on 10/30/17 at 1:40 p.m. with the current Administrator revealed that she could not answer for why the previous Administration did what they did. The current Administrator said she would never go out and buy 10 deodorants or other surplus supplies for the residents. An interview on 11/6/17 at 8:10 a.m. with the prior Administrator revealed she last worked at the facility about 10/17/17 and she and office staff were authorized to spend from resident's trust accounts. The prior Administrator said she did not necessarily have to approve purchases for things like haircuts and small ticket items, as long as the prior Administrative Assistant had invoices. The prior Administrator said there were only about 5 residents they actually shopped for and she appointed staff members to do their shopping. Any personal items bought for the residents should be labeled and put in their rooms or any surplus supplies or personal items purchased for them should be labeled and put in the shower rooms for their use. When asked how she ensured those items were secured to prevent loss or theft, the prior Administrator thought they should trust CNAs to do the right thing, but in hind sight, the the facility should have had a running inventory sheet to keep better track of their things. The prior Administrator said she knew that the products came in to the building because she verified them against the receipts, but she did not know what happened to them after that.	F 159		

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F 159	Continued From page 7 According to the prior Administrator, the facility was responsible to provide personal care items for the residents unless the family or the residents wanted something they preferred instead; then the money would be spent out of their trust accounts with authorization.	F 159		
F 223 SS=E	FREE FROM ABUSE/INVOLUNTARY SECLUSION CFR(s): 483.12(a)(1) 483.12 The resident has the right to be free from abuse, neglect, misappropriation of resident property, and exploitation as defined in this subpart. This includes but is not limited to freedom from corporal punishment, involuntary seclusion and any physical or chemical restraint not required to treat the resident's symptoms. 483.12(a) The facility must- (a)(1) Not use verbal, mental, sexual, or physical abuse, corporal punishment, or involuntary seclusion; This REQUIREMENT is not met as evidenced by: Based on clinical record review, observations, staff, resident and family member interviews and facility policy review, the facility failed to keep residents free from physical or verbal abuse (#1, #4, #5, #6, #10, #12, and #13). The facility failed to prevent a staff member from confining and assaulting Resident #14. The facility reported a census of 61 residents and the sample consisted of 24 residents. Findings include: 1. Resident #14 had a MDS (Minimum Data Set)	F 223		

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assessment with a reference date of 8/26/17. The MDS identified the resident's diagnosis included dementia. The BIMS (Brief Interview for Mental Status) test scored 0 out of 15. A 0 identified the resident had severe cognitive impairment for decision making. The MDS indicated the resident usually understood others and others usually understood him. The MDS also noted Resident #14 had inattention and disorganized thinking that fluctuated. According to the MDS, Resident #14 depended on extensive assistance of at least one person for all ADLs. The MDS indicated Resident #14 had occasional episodes of bowel and bladder incontinence.

The Care Plan dated 2/24/17 directed the staff to speak slowly and clearly to ensure effective communication. The Care Plan also instructed staff to redirect/reproach/reorient Resident #14 as needed every day. The Care Plan dated 3/1/17 directed the staff to take extra time to listen and understand Resident #14. The Care Plan also instructed staff to assist Resident #14 to clearly understand, and if confusion or misinterpretation occurred, staff should approach slowly and kindly to redirect him. The Care Plan dated 3/31/17 noted Krio as Resident #14's first language; not English.

A Nursing Note dated 10/17/17 at 11:28 a.m. by Staff F, RN, noted she heard and responded to a page, calling a nurse to the Memory Unit. The RN documented she heard a female voice yelling "Listen here you mother f..... [Expletive]" upon entering the unit. Staff F noted she proceeded to where she heard the voice. Staff F also noted that she encountered Staff Q, CNA in the hallway saying "We need you in Resident #14's room". Staff F noted upon entering Resident #14's room,

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she saw him seated on the bed and Staff R, CNA standing above him holding both of his wrists tightly with her hands. Staff F noted she asked Staff R to release Resident #14's hands and asked Staff R if she was the one she heard screaming "Listen here mother f.....(expletive)." Staff F noted the CNA admitted it was her yelling. Staff F documented she asked Staff R to leave the room, at which time she walked to the front lobby and sat in a chair. Staff F also noted Resident #14 allowed her to assist him with putting his pants on. Staff F noted that due to the resident's dark skin color, no bruising or redness had been noted at the time. Staff F noted she immediately informed the previous Administrator about the incident, and then the previous Administrator went to the Memory Unit to speak with Staff R.

On 11/1/17 at 11:10 a.m. Staff O, CNA (certified nursing assistant) was interviewed and stated she knew Resident #14 could be a handful, but only when people got pushy with him. According to Staff O, Resident #14 needed his space when he was resistant. Staff O stated the resident is cooperative if you re-approach him.

On 11/1/17 1:50 p.m. Staff I, CNA, was interviewed and stated she had been off work during the incident that involved Staff R, CNA and Resident #14. According to Staff I, Staff R worked there for about 6 months and then left. Staff I recalled that Staff R had only been rehired a few weeks before the alleged incident occurred. According to the CNA, Staff R always hollered at the residents. Staff I stated that Staff R spoke to another resident like "sit down", in a gruff and demanding voice. Staff I stated Staff R did not show any respect to the residents. According to

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F 223	Continued From page 10 Staff I, Staff R treated another resident (Resident #10) like that too. The CNA stated Staff R "was just mean to the residents." Staff I said it seemed like Staff R seemed to be that way to residents that could not speak for themselves. According to Staff I, other residents that were more assertive stood up to Staff R and just walked away from her instead of being targeted by her. On 11/13/17 at 11:00 a.m. Staff Q, CNA was interviewed and stated she relieved Staff S, CNA, so she could go on break. According to Staff Q, she and Staff R noticed Resident #14 brief was soiled. Staff Q stated Staff R went with Resident #14 to his room to change him. Staff Q stated she heard a noise and went down the hall to investigate. Staff G stated that Staff R asked her if she could assist her, so she went into to Resident #14's room. Staff Q stated Resident #14 stood in the doorway of his bathroom and she approached him. Staff Q stated she attempted to touch his waistband to pull his pants down and he said "no, no, no, no". Staff Q stated he seemed a little agitated and it was apparent he didn't want to be "messed with" at that time. Staff Q stated she suggested leaving Resident #14 alone and re-approaching him after a while. According to Staff Q, Staff R said "We can't leave him wet". Staff Q stated she had never worked with Staff R before. According to Staff Q, she looked at Staff R and said "OK"; basically agreeing to proceed with changing him. Staff Q said she told Staff R to hold Resident #14's hands as she assisted him to walk over to his bed. Staff Q stated Staff R still had a hold of Resident #14 hands as she got his pants pulled down and sat him on the edge of the bed. Staff Q recalled Staff R saying "He's hitting", so she told Staff R to continue holding onto him. Staff Q said she bent down in front of Resident	F 223		

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#14 just off to the side of him as she put his pants on him. Staff Q said he had his pants on up to his knees and she kept feeling him moving around. Staff Q said she looked up and saw Staff R pinning his hands/arms to his chest as she leaned into him holding his arms crossed at the wrists. Stated the resident became more agitated. Staff Q stated she told Staff R "I'm going to get the nurse". According to Staff Q, Staff R and Resident #14 were in the same position when she returned as they were when she left to go page the nurse. Staff Q said she told Resident #14 "we have to put another one on you" (he had ripped it off while Staff Q found a nurse). Staff Q said she got another brief on Resident #14 as Staff R continued holding his wrists. According to Staff Q, she stepped out into the hallway and saw Staff F and the CMS (Corporate Maintenance Supervisor) approaching Resident #14 room. Staff Q stated they heard Staff R say "You mother f.... [Expletive]". According to Staff Q, the 3 of them entered Resident #14's room and Staff F said "Tell me I didn't just hear you say that; and let go of him now". Staff Q stated Staff R responded by saying "Well he head butted me". Staff Q said Staff F repeated that Staff R should let go of Resident #14, which she did. According to Staff Q, Resident #14 stood up and took off the plaid pants he had on. According to Staff Q, Staff F said "It's alright, you both can leave now". Staff Q stated she and Staff R went and sat in the lounge area in the memory unit. Staff Q stated Staff F and the CMS person left the memory unit about 10 minutes later. Staff Q stated Resident #14 was still in his room looking out into the hallway. Staff Q stated Staff R had still been sitting there with them. Staff Q stated about the time Staff R prepared to leave, the previous Administrator entered and said "I need to talk to

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you [Staff R]." Staff Q stated they both [Administrator and Staff R] left and she stayed on the unit with Staff S [Staff S returned]. Staff Q stated Staff R never returned.

On 11/13/17 at 12:30 p.m. with Staff F, Licensed Practical Nurse, LPN was interviewed and stated she heard a page summoning a nurse to the memory unit on 10/17/17. Staff F stated she responded to the call and entered the unit when she heard a female voice saying "Listen here mother f.... [Expletive]" Staff F stated she wondered which resident was so upset because it did not dawn on her that it was a staff member saying that. Staff F stated she saw Staff Q standing with the door open at the opposite end of the hall. According to Staff F, it appeared like Staff Q looked for assistance from someone outside of the memory unit. Staff F stated Staff Q told her they needed her in Resident #14's room due to the resident being combative. Staff F stated she had seen Resident #14 angry before and it could be pretty scary. Staff F stated she saw Staff R standing over Resident #14 as the resident sat on the bed. Staff R used both of her hands to pin Resident #14 hands/arms to his body. Staff F stated she looked at Resident #14 and he looked at her. Staff F stated he looked kind of scared, not the aggressive look she had seen in his eyes on multiple other occasions prior to then. Staff F stated she asked "What is going on here?" and Staff R said "He won't let us put these pants on him". The RN said she told Staff R to let go of his arms. Staff F said she asked Staff R if she had been the one saying "Listen here mother f.... [Expletive)]"? Staff R said "Yes, but he was fighting with me", as if to justify her behavior. Staff F stated she explained to Staff R she should have left him alone and

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re-approached him if he had been refusing help. Staff F stated Resident #14 calmly sat there once Staff R let go of him. She said he had not exhibited any signs of aggression. Staff F stated she asked Staff R to leave the room and Staff Q followed her to the great room where they sat waiting. Staff F stated she assessed Resident #14's arms and did not see any redness or injuries. Staff F stated Resident #14 stood up with his pants in his hands and looked down the hallway from the doorway of his room. The resident pointed to the great room where the CNAs were and said "mean, mean." Staff F said although Resident #14 can be very hard to understand, he can relay information. Staff F stated the resident let her help him put his pants on.

On 11/13/17 at 1:40 p.m. with Staff S, CNA, revealed that Staff Q, CNA had been the person that relieved Staff R and her for their breaks. According to Staff S, Staff R just returned from her break and then she left for hers. Staff S said Resident #14 had not been agitated before she left. Staff S said Resident #14 did not act like himself after she returned from her break. According to Staff S, Resident #14 seemed leery of her and Staff Q and did not want either one of them to take him to his room to be toileted and/or changed. According to Staff S, they left him alone and re-approached him later. Staff S stated she did not know Staff R very well. Staff S said she liked her as a person, but did not like working with her. Staff S said Staff R was not exactly a team player. Staff S said Staff R liked to do everything her way, even if it was not right. Staff S said she told Staff R later "If you're going to hang onto a resident, you're supposed to hang onto their hands, not restrain them." Staff S said she had

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never heard of Staff R restraining anyone prior to that. Staff S said her observations of Staff R interacting with residents prior to that were not positive because she is pushy and because of her attitude.

On 11/14/17 at 11:30 a.m. the Administrator was interviewed and stated the incident between Staff R, CNA and Resident #14 occurred on the previous Administrator's last day. According to the Administrator, Staff R basically admitted to cursing at the resident and holding the resident's arms down. The Administrator stated Staff R asked "Wouldn't you have said the same thing to Resident #14 if you were in that situation"? The Administrator stated she informed Staff R "No, we do not swear in my household."

On 11/15/17 at 9:30 a.m. Staff R, CNA, was interviewed and stated she worked with Staff S in the memory unit that day. According to Staff R, she always worked "up front" so it was her first time working in the Memory Unit. According to the CNA, Staff S stated "I can't change Resident #14 because he doesn't like me". Staff R stated she told Staff S she did not know the residents back there [in unit]. In an effort to familiarize herself with the residents Staff R said she asked Staff S about the residents and their behaviors. Staff R, Staff S stated she told her "we don't really have any behaviors back here". Staff R stated Staff S told her she would help her since she did not know anyone. According to Staff R, she asked Staff S where the pocket care plans were and Staff S said she should not bother with them because they are never current. Staff R said Staff Q entered the unit about 10:30 or 10:45 a.m.; at which time Staff S left for her half hour break. According to Staff R, Staff Q sat in the common

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area with Resident #14. Staff R said Staff Q pointed to Resident #14 and said he needed to be changed because of his brief being saturated (incontinent of urine). Staff R stated Staff S told her sometimes only one person had to assist Resident #14, but other times two people were required. Staff R stated she asked her why and Staff Q told her Resident #14 gets aggressive with people he does not like. Staff R stated she walked over to Resident #14 and said "Let's go for a walk". According to the CNA, Staff Q said "Don't tell him that you're taking him to the bathroom to be changed." Staff R stated she and Resident #14 walked to his room, entered it, and shut the door behind them. Staff R said she had a hold of Resident #14 hand and started to take him into the bathroom. According to Staff R, Resident #14 started to pull back when he realized they were going into the bathroom. Staff R stated Staff Q knocked on the door at that time and asked if she needed help, and she replied yes. Staff R recalled that Resident #14 demeanor changed when Staff S walked into the room. Staff R stated he did not want Staff S touching him. Staff R said Resident #14 changed from a relaxed posture to a very stiff and aggressive posture when Staff S touched him. The CNA said Staff Q held one of Resident #14 hands. Staff R said Staff Q had been very nice at first until Resident #14 struck out at her. Staff R stated she stepped back when Resident #14 hit Staff Q in the ribs because she did not know Resident #14. According to the CNA, Staff Q grabbed Resident #14's wrist to stop him from hitting her again. Staff R said Staff Q got close to his face and said repeatedly (about 3 times) "Resident #14, you don't hit" while pointing her finger within inches of his face. Staff R stated Staff Q looked at her and said "He does this all the time on the night shift".

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Staff R stated it bothered her when Staff Q suggested that they should leave him wet in order to give him a chance to calm down. Staff R stated she insisted on changing him [the soiled brief]. Staff R stated Staff Q held one of his hands and she held his other hand as they walked him over to his bed. Staff R said Resident #14 was somewhat agitated, but willingly walked with them. According to Staff R, Resident #14 sat on the side of the bed without either one of them touching him. Staff R said she stood in front and off to the side of Resident #14 while facing him. Staff R stated Staff Q stood directly in front of him while facing him. Staff R said she asked Staff Q how they should proceed and Staff Q told her she would try and get his brief off of him. Staff R said she ripped one side of his brief and Staff Q ripped the other side while he sat on the bed. Staff R stated Resident #14 would not stand up but proceeded to beat "the crap" out of Staff Q by pounding on her back. In response, Staff R said she grabbed both of Resident #14's wrists. Staff R stated Staff Q got the new pull up above Resident #14's knees when he jerked his arms free and started ripping the new pull up and his pajama pants. Staff R said they got another new brief up to his knees while he continued sitting on the side of his bed. Staff R said she and Staff Q agreed that they needed to go and page for a nurse. Staff R said Staff Q ran down the hall to where the phone was because they did not have walkie talkies. Staff R stated she continued to hold Resident #14's wrists after Staff Q left because he was hitting her. Staff R explained that she thought it was OK to continue holding his wrists to protect herself. Staff R recalled a similar incident when another resident hit her and bruised her ribs. According to Staff R, management told her she should have attempted

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F 223	Continued From page 17 to protect herself to avoid being injured. Staff R said they never really trained any of the CNAs to deal with aggressive residents. Staff R said she left the door open when Staff Q left the room. She said she could hear the page go across the intercom. Staff R said she glanced away from Resident #14 and he reared back and head butted her in the ribs. Staff R said the impact knocked the wind out of her and pushed her back two steps. According to Staff R, she yelled "mother f ... [Expletive]" as a reaction to being head butted; not a name she called Resident #14. Staff R said she would never speak to a resident that way. Staff R said that although she yelled it loud enough that it echoed down the hallway, nobody else had been in the room to witness everything that happened. Staff R stated Resident #14 started hitting her again so she grabbed his wrists again. At that time, Staff R said Staff Q, Staff F walked into the room because they heard her say "mother f..... [Expletive]". According to Staff R, they saw her holding Resident #14's wrists. Staff R recalled that Staff F said "OK, you can stop physically restraining him now." Staff R stated she said "Oh, I didn't know." When asked what she meant by "I didn't know", Staff R said did not know that grabbing and holding a resident's wrists had been considered a physical restraint. Staff R stated she felt like the facility was partially to blame because of the lack of training. Staff R said there the hand book did not have anything in it about dealing with aggressive residents in those situations. Staff R stated that Staff F told her and Staff Q to leave Resident #14's room.	F 223		
F 225 SS=E	INVESTIGATE/REPORT ALLEGATIONS/INDIVIDUALS CFR(s): 483.12(a)(3)(4)(c)(1)-(4)	F 225		

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F 225	Continued From page 18 483.12(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: (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	F 225		

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F 225	Continued From page 19 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 record review, staff and family member interviews and review of the policy and procedures, the facility failed to report to the Iowa Department of Inspections and Appeals of 2 incidents of resident to resident physical altercations involving four residents (#1, #8, #10 and #12) and failed to investigate and report one allegation of staff physically assaulting one resident (#18) of 24 total residents reviewed. The facility reported a census of 61 residents. Findings include: 1. Resident #1 had a MDS assessment with a	F 225		

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F 225	Continued From page 20 reference date of 5/9/17. Resident #1 had a BIMS (brief interview for mental status) score of 10 out of 15, which indicated moderate cognitive and memory impairment. According to the MDS, Resident #1 could make herself understood and usually had the ability to understand others. Resident #1 walked with supervision only and displayed no behavioral symptoms during the assessment period. An interview on 11/15/17 at 3:00 p.m. with Resident #1's granddaughter revealed she and her mother went and spoke with the previous administrator on 7/5/17. The resident's daughter visited Resident #1 the day before and learned about a physical altercation between Resident #1 and Resident #10. The family member said they went to speak with the past administrator to let her know what happened and find out if it had been documented but the past administrator said she had not been informed. An interview on 11/22/17 at 10:00 a.m. with Resident #1's daughter revealed that she visited her mother on 7/4/17 at about lunch time. Her mother was shaking and visibly agitated and she went to speak with a nurse. The resident's daughter asked Staff I, CNA (certified nursing assistant) what happened and Staff I told her she saw Resident #10 in Resident #1's room and they had their hands on each other. The resident's daughter said Resident #1 complained about her shoulder hurting and she noticed her mother's hands and forearms were reddened as if someone had grabbed her. The daughter said she went into the facility the next morning with her daughter to speak with the past administrator, who had no knowledge or record of the incident between Resident #1 and Resident #10.	F 225		

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F 225	Continued From page 21 On 11/27/17 at 8:15 a.m. Staff I (acting CNA) revealed that Resident #10 had gone into Resident #1's room on 7/4/17. According to Staff I, Resident #1 attacked Resident #10 as evidenced by Resident #1 pushing Resident #10 out the door. Staff I stated she told the family Resident #10 was in Resident #1's room and she saw Resident #1 push Resident #10 out the door. Staff I stated she exited another resident's room when she saw Resident #1 push and strike Resident #10 in the hallway by Resident #1's room. Staff I stated she reported the incident to the nurse on duty, but could not recall which nurse. Resident #1's medical record contained no documentation regarding the 7/4/17 physical altercation between Resident #1 and Resident #10. Review of the DIA reporting records, identified no facility report of the incidents. On 11/20/17 at 3:00 p.m. the Administrator was interviewed and stated she could not find incident reports or other evidence the 7/4/17 incident between Resident #1 and Resident #10 and the incident between Resident #8 and Resident #12 (incident around 9/11/17) were reported to administration. 2. The MDS assessment dated 6/1/17 for Resident #10 listed diagnoses that included dementia and Alzheimer's disease. The assessment documented the resident had severely impaired cognitive skills for daily decision making. The MDS noted Resident #10 had memory problems, inattention, disorganized thinking, physical and verbal behavioral symptoms directed towards others and a history of wandering every day. The MDS documented she walked with supervision and received daily	F 225		

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F 225	Continued From page 22 antipsychotic and antianxiety medications. 3. Resident #8 had a MDS assessment with a reference date of 7/31/17. The MDS indicated Resident #8 had a BIMS score of 0 out of 15. A score of 0 identified the resident had severe cognitive impairment with daily decision making skills. According to the MDS, other people sometimes understood Resident #8 and he sometimes understood others. The assessment indicated Resident #8 required limited assistance of two people to walk in his room or in the hall and required supervision only to self-propel his wheelchair throughout the facility. According to the MDS, Resident #8 received daily antipsychotic and antianxiety medication and displayed no behavioral symptoms. An interview on 11/2/17 at 10:35 a.m. with Staff V, Housekeeping, identified Resident #8 assaulted Resident #12 in the dining room. Staff V saw Resident #8 standing over Resident #12 hitting him at least twice with an open hand in the back of the head. Staff V said she and another staff person approached them at the same time and got Resident #8 to sit right down and separated them. An interview on 11/1/17 at 11:10 a.m. with Staff O, CNA revealed she witnessed Resident #8 hitting Resident #12 in the dining room. Staff O stated staff were getting everybody into the dining room for lunch and she sat at one of the back tables getting a resident ready for lunch. Resident #12 sat in his wheelchair when Resident #8 wheeled himself towards Resident #12. Staff O said Resident #8's alarm started sounding so she turned to see Resident #8 pulling himself up by hanging on to Resident #12's wheelchair. Staff	F 225		

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F 225	Continued From page 23 O said Resident #8 stood above Resident #12 and hit him with karate chop motions on Resident #12's shoulder about 2 or 3 times. On 11/16/17 at 9:15 a.m. Staff O stated she witnessed Resident #8 hitting Resident #12 in the dining room on about 9/13/17. Resident #8's record lacked documentation of the physical altercation between Resident #8 and Resident #12 in the dining room on or about 9/13/17 as reported per staff interviews. 4. The MDS assessment with a reference date of 8/18/17 identified Resident #12 had diagnosis of dementia, Parkinson's disease, difficulty walking, muscle weakness and lack of coordination. The BIMS score of 2 out of 15 rated Resident #12 with a severe cognitive impairment. According to the MDS, other people usually understood Resident #12 and he sometimes understood them. The assessment indicated Resident #12 depended on extensive assistance of one person to transfer and to walk in his room and in the halls. The MDS noted Resident #12 utilized a walker and wheelchair and depended on staff to be propelled in his wheelchair throughout the facility. Resident #12's medical record lacked documentation regarding the physical altercation between Resident #8 and Resident #12 in the dining room on or about 9/13/17 and identified per staff interviews. Review of DIA records revealed no report of this resident to resident assault. 5. Resident #18 had a MDS assessment with a reference date of 8/31/17. The MDS identified the resident had diagnoses that included heart failure, diabetes, fracture, anxiety disorder,	F 225		

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depression, obesity and chronic pain syndrome. The resident had a BIMS score of 15, indicating intact memory and cognition. The assessment indicated Resident #18 required the extensive assistance of two people for all activities of daily living

A Resident Concern Form with a date range of 10/7/17 through 10/13/17 and written by Resident #18 described her concerns as: Improper cares by Staff Y, CNA. Resident #18 alleged that Staff Y physically and mentally abused her on her back top rib, shoulder blade and her left side causing pain. Staff Y had also grabbed both of her wrists as she tried to sit up. Resident #18 documented Staff Y told her you're not my mother, with an ugly face and an angry tone. According to Resident #18's documentation, Staff Y attempted to mislead her by saying she was someone else, despite the resident being able to read her nametag.

On 10/23/17 at 10:05 a.m. Resident #18 stated she sat in her wheelchair the week before and Staff Y grabbed her left wrist. Resident #18 stated Staff Y's friend and co-worker (Staff M, CNA) had been with her when it happened that afternoon on the second shift. Resident #18 stated Staff Z grabbed her wrist because she's mean and doesn't like the resident. Resident #18 said she has told other aids, but not the previous Administrator. The resident stated Staff M saw it happen twice and just stood by and watched Staff Y do it without saying something or telling anyone. Resident #18 stated she told Staff Y to stay away from her, but that has not happened.

On 10/19/17 at 12:45 p.m. Staff Z, CNA, was interviewed and stated after dinner on Saturday

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QHC WINTERSET NORTH, LLC	411 EAST LANE STREET WINTERSET, IA 50273

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F 225	Continued From page 25	F 225		

10/7/17, Resident #18 informed her that Staff Y had been verbally aggressive and physically restrained her by holding her wrists. According to the CNA, Staff Y walked into Resident #18's room at that time and Resident #18 said she did not want Staff Y there as she was not nice and b ...ch [Expletive]. Staff Z heard Staff Y reply she was proud to be a b ....ch [Expletive]. Although she did not witness Staff Y restraining Resident #18, Staff Z said there were red marks on the bottom sides of Resident #18's wrists. Staff Z said she told Staff C, LPN (licensed practical nurse) and Staff C told Resident #18 to submit a written complaint.

On 10/24/17 at 2:30 p.m. Staff C was interviewed and stated she did not give Resident #18 a complaint form to fill out. Staff C remembered telling Resident #18 to write her complaint down on a piece of paper, but she never submitted it as far as she knew. Staff C also said the resident told her a couple weeks ago that someone hurt her shoulder. According to Staff C, Resident #18 accused Staff Y of hurting her left shoulder when she [Staff Y] put her to bed. Staff C stated she went in and put Bio freeze (topical pain reliever) on her areas of discomfort and the resident could move her arms normally. Staff C stated she did not report what she knew to the prior administrator or DON.

On 10/24/17 at 3:00 p.m. the Director of Nursing (DON) was interviewed and stated no one told her anything lately of Resident #18 voicing someone hurt her. According to the DON, Resident #18 is very accusatory and fabricates things. The DON said it would be taken seriously and investigated if she said staff hurt her. When asked, the DON said their protocol dictates that

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F 225	Continued From page 26 the DON and Administrator should be notified and they would initiate their investigation (with abuse allegations). The DON stated she would expect staff to follow protocol and relay any information they had about Staff Y allegedly hurting Resident #18. The DON stated she would not have permitted Staff Y to work with Resident #18 anymore if she knew what Resident #18 said about Staff Y. On 10/24/17 at 5:25 p.m. with Staff Y, CNA was interviewed and stated Resident #18 always accuses her of breaking her shoulder and she has never told anyone besides Staff C about the accusations that Resident #18 makes about her. On 10/30/17 at 3:45 p.m. the Administrator was interviewed and stated Staff C informed her that Resident #18 had a history of making allegations and she just let it go because Resident #18 never said anything to her about it before now. Review of the policy and procedures titled Abuse Prevention, Identification, Investigation and Reporting (revised 4/1/17), directed the staff that all allegations of abuse shall be reported to the DIA (Department of Inspections and Appeals) no later than 2 hours after the allegation. All allegations of neglect, exploitation, mistreatment, injuries of unknown origin and misappropriation shall be reported to the DIA, not later than two hours if the events result in serious bodily injury, or not later than 24 hours if neglect, exploitation, mistreatment, injuries of unknown origin and misappropriation do not result in serious bodily injury.	F 225		
F 241 SS=D	DIGNITY AND RESPECT OF INDIVIDUALITY CFR(s): 483.10(a)(1)	F 241		

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F 241	Continued From page 27 (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 by: Base on clinical record review and family and staff interviews, the facility failed to provide dignified care to one of three discharged residents reviewed (Resident #1). The facility reported a census of 61. Findings include: 1. The MDS (Minimum Data Set) assessment dated 8/9/17 documented Resident #1 had diagnoses that included high blood pressure and chronic lung disease. The BIMS (brief interview for mental status) for Resident #1 scored 10 out of 15 which indicated moderately impaired memory and cognition. The assessment documented the resident required setup help with dressing and she had skin issues at the time of the assessment. The 1/27/17 Care Plan instructed staff to monitor and provide for changing care needs of Resident #1 on a daily basis and as needed. An interview on 11/15/17 at 3:00 p.m. with Resident #1's granddaughter revealed she visited Resident #1 on 8/29/17. The granddaughter went to Resident #1's room right after lunch and hugged her like she usually did. She noticed a strong odor had her grandmother's hands smelled foul. She took her Grandmother into the	F 241		

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F 241	Continued From page 28 bathroom and washed her hands. According to granddaughter, Resident #1 tucked her shirt up under her breasts and told her to look; she lifted the breast and noticed it was raw with redness, blisters and open lesions that followed the skin creases from her breast around to her back. She found her grandmother's nurse and told her she would like her to go to Resident #1's room to look at a yeast infection under the resident's breast. She stated the nurse invited her grandmother into the nurses' station so she could assess her skin. Before she or her grandmother had time to object, the nurse lifted Resident #1's shirt and exposed her breasts in front of other residents congregated around the nurses' station. There were other residents that surrounded the nurses station, one of which sat right there in her wheelchair waiting for her medication and another male resident standing there with his walker. The granddaughter stated the nurse positioned her grandmother facing towards hallway with a fully exposed frontal view for anyone in the vicinity to see. Her grandmother told her afterward she felt humiliated and wanted to leave the facility. Review of the resident's Progress Notes revealed no documented skin assessments on 8/29/17. Interviews during the investigation with 4 licensed and registered nursing staff on duty on 8/29/17 revealed no memory of the granddaughter's recollection of events on 8/29/17. Review of the resident's Progress Notes revealed Resident #1 discharged from the facility on 9/5/17.	F 241		
F 281 SS=D	SERVICES PROVIDED MEET PROFESSIONAL STANDARDS CFR(s): 483.21(b)(3)(i)	F 281		

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F 281	Continued From page 29 (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 by: Based on clinical record review, observation and staff and Pharmacist interviews, the facility failed to ensure staff watched residents consume their medications for 2 of 21 current residents reviewed and failed to clarify an order for antianxiety medications for one resident review (Resident #8). The facility iddentified a census of 61 current residents. Findings include: 1. The MDS (Minimum Data Set) assessment dated 8/17/17 recorded Resident #3 had a BIMS (brief interview for mental status) score of 10 out of 15, which indicated a moderate cognitive impairment. The MDS indicated Resident #3 required limited assistance of one person for most ADLs (activities of daily living). The November 2017 MAR (medication administration record) documented that thirteen pills had been administered at the 8:00 a.m. medication pass, one of which was a narcotic. 2. The MDS assessment dated 8/20/17 named arthritis and depression as diagnoses of Resident #4. The MDS also noted that Resident #4 required extensive assistance of at least one person for most ADLs. The MDS lacked any	F 281		

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F 281	Continued From page 30 information related to Resident #4's cognitive status. Observation on 11/14/17 at 7:45 a.m. revealed two residents sitting at a table in the dayroom (room 319). The observation revealed a small pile of pills sitting on top of the table directly in front of and within arm's reach of Resident #3. Resident #3's head hung down and her eyes were closed as if she were sleeping. Resident #4 sat next to Resident #3 at the same table. The pills were also within arm's reach of Resident #4 as she sat in her wheelchair at the table watching TV with her eyes open. After this surveyor stood in the doorway and watched the residents for a couple minutes, Staff D, LPN (licensed practical nurse) entered the room. Staff D prompted Resident #3 to take the medication. After several unsuccessful attempts to get Resident #3 to take her medication, Staff D picked up a couple pills and put them in Resident #3's hand. With continued prompting, Resident #3 finally took all of the medication. An interview on 11/21/17 at 4:30 p.m. with the facility's current Administrator revealed they do not have a specific medication handling policy; they regard it as a professional standard of practice. The Administrator said she expected staff to supervise residents during medication administration. 3. The MDS assessment dated 7/31/17 documented Resident #8 had the diagnoses of acute sinusitis. The resident had a BIMS score of 0 out of 15, indicating severely impaired cognitive skills. Resident #8 received daily antianxiety medication.	F 281		

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F 281	Continued From page 31 The Physician Fax Order Request dated and signed by the physician on 8/17/17 instructed staff to administer 1 mg (milligram) topical Ativan cream (an antianxiety medication) TID (three times a day). The 10/17 Order Review Report noted the following prescriptions ordered on 8/17/17, started on 8/17/17 and discontinued on 10/31/17 >> 1 mg Lorazepam (Ativan) transdermal compound (topical) gel to wrists every 6 hours as needed (PRN) for prophylaxis related to generalized anxiety disorder and 1 mg topically TID for prophylaxis related to generalized anxiety disorder and 1 mg Ativan cream BID (twice a day) to wrist for agitation/anxiety. The 10/17 QHC Order Review Report also documented more Ativan ordered on 9/21/17 and started on 9/21/17; Ativan Solution 2 mg/ml (2 mg in each ml), inject 2 mg subcutaneously (beneath the skin) every 6 hours as needed for severe agitation related to generalized anxiety disorder. The October MAR (medication administration report) noted that Resident #8 had 1 mg topical Ativan cream scheduled five times a day as a result of staff not clarifying the order. According to the MAR, the resident received four scheduled doses on three days throughout the month of October and three scheduled doses on the remainder of the days in October. The MAR also documented that Resident #8 also received a 2 mg injection of PRN Ativan on eleven separate occasions in October. An interview on 10/31/17 at 10:15 a.m. with Staff X of Montross Pharmacy revealed the last order and most current order they had on file for	F 281		

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F 281	Continued From page 32 Resident #8's Ativan cream was 1 mg BID and Q 6 hrs PRN. Staff X stated it is up to the facility to inform and update the pharmacy with new orders and dosage changes. She said the last delivery of Resident #8's Ativan cream to QHC North occurred on 10/23/17 or 10/24/17. According to Staff X, three 10 ml syringes equaled 10 day supply.	F 281		
F 309 SS=D	PROVIDE CARE/SERVICES FOR HIGHEST WELL BEING CFR(s): 483.24, 483.25(k)(l) 483.24 Quality of life Quality of life is a fundamental principle that applies to all care and services provided to facility residents. Each resident must receive and the facility must provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being, consistent with the resident's comprehensive assessment and plan of care. 483.25 Quality of care Quality of care is a fundamental principle that applies to all treatment and care provided to facility residents. Based on the comprehensive assessment of a resident, the facility must ensure that residents receive treatment and care in accordance with professional standards of practice, the comprehensive person-centered care plan, and the residents' choices, including but not limited to the following: (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,	F 309		

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F 309	Continued From page 33 and the residents' goals and preferences. (I) 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 observations, record review and staff and family interviews, the facility failed to assess residents' skin conditions and failed to provide timely intervention in order to promote healing (Resident #1, #2). The facility reported a census of 61 residents and the sample consisted of 3 residents with skin issues. Findings include: 1. Resident #1 had a MDS (Minimum Data Set) assessment with a reference date of 5/9/17. The BIMS (brief interview for mental status) identified a score of 10 out of 15. A score of 10 indicated the resident as moderately cognitively impaired for daily decision making. According to the MDS, bathing had not occurred during the assessment period and the resident required supervision of one staff person for physical assist with hygiene. The 1/27/17 the Care Plan instructed staff to monitor and provide for changing care needs of Resident #1 on a daily basis and as needed. The 3/27/17 revised Care Plan noted Resident #1 should be bathed/showered weekly and as needed with the assistance of one staff member. The August 2017 ADLs (activities of daily living) report indicated Resident #1 had not received a	F 309		

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F 309	Continued From page 34 shower between 8/17/17 and 8/31/17. The August 2017 Order Review Report revealed Nystatin Cream had been ordered and started on 8/31/17. The August 2017 Location of Administration Report documented Nystatin was applied under both of Resident #1's breasts only on 8/31/17 throughout the month of August. The Office-Clinic Notes from Adair County Health System dated 8/31/17 identified a physician visit report. The document titled History of Present Illness, Resident #1 lived in the dementia unit until the family removed the resident from the facility. The document titled Administration Note, dated 9/1/17 at 10:10 a.m. and written by Staff C, LPN, indicated that Nystatin Cream should be applied under both of Resident #1's breasts every evening, related to a diagnosis of other specified virus infection, characterized by skin and mucous membrane lesions. An interview on 11/15/17 at 3:00 p.m. with a family interview indicated she visited Resident #1 on August 29, 2017. According to the family member, she lifted the breast and noticed the skin as raw with redness, blisters and open lesions that followed the skin creases from her breast around to her back. On 11/21/17 at 8:15 a.m. Staff B (licensed practical nurse) was interviewed and stated she generated the 8/31/17 Skin/Wound Note as a way of bringing it to the wound nurse's attention. Staff B stated she questioned if the initial fax had been sent on 7/26/17 because the physician did not	F 309		

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F 309	Continued From page 35 respond until 8/30/17. On 11/21/17 at 12:20 p.m. the Administrator was interviewed and stated she would have expected staff to follow up with the 7/26/17 fax, notifying the physician of Resident #1's skin condition and request for Nystatin. The Administrator stated she expected the shower aides to pay attention for newly developed skin conditions and report it to the nurses. 2. Resident #2 had a MDS assessment with a reference date of 8/14/17. The MDS identified the resident had diagnosis including, coronary artery disease, diabetes, dementia, muscle weakness, anxiety and depression. The BIMS score of 0 out of 15 scored Resident #2's cognitive status as severely impaired. According to the MDS, Resident #2 required extensive assistance of 2 for most ADLs, including bed mobility and total dependence on staff for bathing. The MDS noted Resident #2 utilized a wheelchair for mobility and always had episodes of bladder and bowel incontinence. The 8/1/17 Care Plan indicated Resident #2 required an EZ stand (mechanical sit to stand device) for all transfers and a wheelchair for mobility. The Care Plan also instructed staff to provide peri care [perineal cleansing] after each episode of incontinence. Because Resident #2 had the potential for impaired skin integrity related to impaired mobility and disease processes, the staff were supposed to assist the resident to reposition frequently, keep skin areas over bony prominences clean, dry, moisturized daily and use lift sheets to move/reposition the resident while in bed to reduce shearing forces. The Care Plan also instructed staff to provide	F 309		

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F 309	Continued From page 36 assistance with ADLs every day and as needed. Observation on 11/7/17 at 2:45 p.m. identified a 1 cm (centimeter) open sore on the resident's inner left buttock. Staff E CNA, assisted the resident with toileting when observation identified the area. According to Staff E, she noticed the sore the day before and reported it to Staff C, LPN. Observation on 11/9/17 at 9:55 a.m. revealed an approximately 0.5 cm sore on Resident #2's left inner buttock as 2 CNAs toileted the resident. No residual cream/ointment or treatment observed on the wound. On 11/8/17 at 11:20 a.m. Staff C (Licensed Practical Nurse) was interviewed and she recalled being informed about the area on the resident's left inner buttock on 11/6/17. Staff C stated a CNA described the sore as being reddened like an abrasion, but the nurse said she did not assess it after being told. According to Staff C, she overheard the off going CNAs telling the oncoming CNA at shift change between the first and second shifts. Staff C stated she asked them if they reported it to the day nurse, Staff A, LPN and they said no. Staff C said Staff A did not tell her anything about it when she reported off to her on 11/6/17. On 11/9/17 at 8:18 a.m. the DON (director of nursing) was interviewed and stated the facility did not have a policy or procedure once a newly open skin area identified. According to the DON, she expected whoever would find a wound to report it to the nurse so they can follow through appropriately. The DON stated they call the Dr. for orders, notify the family and Staff A (Licensed Practical Nurse) starts a skin sheet. The DON stated she always reads the nurses' notes to stay	F 309		

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F 309	Continued From page 37 informed. On 11/9/17 at 11:45 a.m. the DON was again interviewed and stated she did not know about the open area identified on 11/6/17 on Resident #2's left inner buttock. According to the DON, Staff C should have followed through if she knew about it. The DON said "A sore on Resident #2's bottom is a big deal because she's incontinent and it can break down very fast". The DON said it should have been assessed and the physician notified to determine a course of treatment. On 11/21/17 at 4:30 p.m. the Administrator was interviewed and stated she could not find documentation to verify a nursing assessment had been performed or the physician and family notified.	F 309		
F 312 SS=E	ADL CARE PROVIDED FOR DEPENDENT RESIDENTS CFR(s): 483.24(a)(2) (a)(2) A resident who is unable to carry out activities of daily living receives the necessary services to maintain good nutrition, grooming, and personal and oral hygiene. This REQUIREMENT is not met as evidenced by: Based on clinical record review and staff and family member interviews, the facility failed to provide showers and/or baths and shaving assistance on a routine basis for 6 of 21 current residents reviewed (Residents #9, #10, #14, #15 #16 and #17). The facility reported a census of 61. Findings include:	F 312		

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F 312	Continued From page 38 1. The MDS (Minimum Data Set) assessment dated 9/1/17 documented Resident #9 required the assistance of one staff in order to bathe and experienced occasional urine incontinence and frequent bowel incontinence. The resident's 3/27/17 Care Plan instructed that one staff member should assist Resident #9 for ADLs (activities of daily living), but it did not specify bathing frequency. Review of the resident's Bathing/shower records indicated Resident #9 received 5 baths or showers from 9/4/17 through 11/6/17. 2. The MDS assessment dated 8/31/17 recorded Resident #10 depended on the extensive assistance of one staff for personal hygiene and bathing and she experienced frequent urinary incontinence and occasional bowel incontinence. The revised 3/24/17 Care Plan noted that one staff member should assist Resident #10 with ADLs, bathing and showering. Review of the resident's Bathing/shower records indicated Resident #10 received 7 baths or showers from 9/4/17 through 11/6/17. 3. The MDS assessment dated 8/26/17 documented Resident #14's needed the assistance of one staff with personal hygiene and physical help with bathing. The assessment indicated he had occasional episodes of bowel and bladder incontinence. The resident's 2/24/17 Care Plan instructed staff to provide showers and baths per the facility protocol as needed and weekly. An intervention	F 312		

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F 312	Continued From page 39 dated 11/20/17 directed to provide shower or baths twice a week as the resident will allow. Review of the resident's Bathing/shower records indicated Resident #14 received 12 baths or showers from 4/18/17 through 11/27/17. 4. The MDS assessment dated 8/27/17 documented Resident #15 had frequent episodes of bowel and bladder incontinence and depended on extensive assistance of one person for hygiene and bathing. The resident's 8/16/17 Care Plan directed staff to provide the assistance of one with personal hygiene. Review of the resident's Bathing/shower records indicated Resident #15 received 3 baths or showers from 9/4/17 through 11/6/17. 5. The MDS assessment dated 8/28/17 documented Resident #16 required supervision to maintain his personally hygiene and with bathing. The assessment documented he experienced occasional urinary incontinence. The resident's 9/8/17 Care Plan instructed staff to provide a weekly or as needed shower or bath per facility protocol. Review of the resident's Bathing/shower records indicated Resident #16 received 3 showers or baths from 9/4/17 through 11/6/17. 6. The MDS assessment dated 10/25/17 documented Resident #17 required the assistance of one staff with personal hygiene and physical help in order to bathe.	F 312		

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F 312	Continued From page 40	F 312		

The resident's 1/11/17 Care Plan instructed to provide a weekly or as needed shower or bath per facility protocol.

Review of the resident's Bathing/shower records revealed Resident #17 received 3 showers or baths from times 9/4/17 through 11/6/17.

An interview on 10/24/17 at 2:30 p.m. with Staff C, LPN (Licensed Practical Nurse) revealed that her daughter resides at the facility. According to the LPN the residents are not getting their baths because they are short of staff. Staff C said last week the facility went without hot water. She said they told her they only had a minimal amount of lukewarm water, but they were reserving it until they restored the hot water system. Staff C they had hot water up front so she asked why her daughter could not bathe up front. Staff C said they told her the daytime aids did not have enough time. According to Staff C, her daughter tells her she does not always get bathed.

An interview on 10/25/17 at 1:45 p.m. with Staff G, CNA, revealed that management had been pulling bath aids to work the floor for quite a while because of being short staffed. On 11/6/17 at 10:30 a.m. Staff G stated she got pulled as the restorative aid about ½ an hour ago because they did not have a bath aid. Staff G said CNAs try to fit resident's baths into their schedules when there is not a bath aid, but as a result, something else just gets overlooked. She concluded that residents in the memory unit are not getting their baths.

An interview on 10/25/17 at 3:00 p.m. with Staff M, CNA stated they have to pull the bath aid to

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F 312	Continued From page 41 cover the floor quite a bit or the bath aid might be the one to call in. Either way, there has been a problem with residents getting their baths and the problem has been going on for months. Staff M said frequent revisions to the schedule have also caused a problem with being short staffed. An interview on 11/6/17 at 9:05 a.m. with Staff E, CNA stated she had been assigned as a bath aid that day but had not been trained on baths yet. Staff E stated she did not know how to run the whirlpool and did not feel comfortable giving baths. An interview on 11/6/17 at 9:23 a.m. with Staff L, CNA revealed she worked there for 2 ½ years, left for a month and returned about three weeks ago. Staff L noted that the shower aid called in that day. Staff L said the shower aid arranged to have someone work in her place, but that person had not showed up yet. Staff L said a lot of residents have not been shaved for about a week or two. An interview on 11/27/17 at 3:10 p.m. with the facility's current Administrator revealed that she looked in three places and could not find the facility's showering/bathing protocol.	F 312		
F 323 SS=D	FREE OF ACCIDENT HAZARDS/SUPERVISION/DEVICES CFR(s): 483.25(d)(1)(2)(n)(1)-(3) (d) Accidents. The facility must ensure that - (1) The resident environment remains as free from accident hazards as is possible; and	F 323		

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F 323	Continued From page 42 (2) Each resident receives adequate supervision and assistance devices to prevent accidents. (n) - Bed Rails. The facility must attempt to use appropriate alternatives prior to installing a side or bed rail. If a bed or side rail is used, the facility must ensure correct installation, use, and maintenance of bed rails, including but not limited to the following elements. (1) Assess the resident for risk of entrapment from bed rails prior to installation. (2) Review the risks and benefits of bed rails with the resident or resident representative and obtain informed consent prior to installation. (3) Ensure that the bed's dimensions are appropriate for the resident's size and weight. This REQUIREMENT is not met as evidenced by: Based on clinical record review, observations and staff and resident interviews, the facility failed to provide sufficient staff necessary to safely operate the mechanical transfer devices for 2 residents (#2 and #7) and failed to implement fall prevention measures following a fall with injury for one resident (#11) of 24 total residents reviewed. The facility reported a census of 61. Findings include: 1. The MDS (Minimum Data Set) assessment dated 8/14/17 documented Resident #2 had diagnoses that included coronary artery disease, diabetes, dementia, muscle weakness, anxiety and depression. The resident had a Brief Interview for Mental Status (BIMS) score of 0 out of 15 indicating severely impaired memory and	F 323		

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F 323	Continued From page 43 cognition. The assessment documented Resident #2 required the physical assistance of 2 staff with transfers and she did not walk. The 8/1/17 Care Plan indicated Resident #2 required an EZ Stand for all transfers and a wheelchair for mobility. The Care Plan also instructed staff to assist with ADLs every day and as needed. Review of the facility's bed listing revealed Resident #2 resided on the 400 hall of the facility. Observation on 11/7/17 at 2:45 p.m. revealed Staff E, CNA as she used the EZ stand by herself to transfer Resident #2 from her wheelchair to the bedside commode and from her bedside commode back to her wheelchair. 2. The MDS assessment dated 8/15/17 documented Resident #7 had diagnoses that included depression, anxiety, cellulitis of the right lower extremity. The assessment documented a BIMS score of 12 out of 15 indicating moderately impaired memory and cognition. Resident #7 required the assistance of 2 staff with transfers and did not walk during the assessment period. According to the 8/3/17 Care Plan, staff may use the EZ Stand with the assistance of two. Review of the facility's bed listing revealed Resident #7 resided on the 400 hall of the facility. Observation on 11/8/17 revealed a sign posted behind the 400 nurses instructing staff "2 with EZ Stand for Transfers". An interview on 11/7/17 at 3:05 p.m. with	F 323		

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F 323	Continued From page 44 Resident #7 revealed staff have transferred him with the EZ Stand alone because they could not find anyone to help them. An interview on 11/8/17 at 8:15 a.m. with Staff H, CNA revealed that she started working at the facility about seven years ago. Staff H stated she has been told to use 2 people to operate both Hoyer lifts and EZ Stands. Staff H showed this surveyor the sign the facility posted behind the nurses station on 400 halls instructing the use of 2 staff with EZ stand transfers. An interview on 11/8/17 at 9:00 a.m. with Staff K, CNA, revealed as far as she knows, everyone understands that 2 people are supposed to operate all mechanical lift transfers, both Hoyer and EZ Stands. However, sometimes there are residents that have to go whenever they get the urge so you have to transfer them alone if staff cannot find help. Staff K said some nurses will help, but they are overwhelmed with they have going on too. Staff K said she talked to facility's prior Administrator, but the only solution she offered was to rely on nurses, restorative or activities personnel. Staff K said they were not available to help very often because they are doing their own jobs. Staff K said they would help if they were available. An interview on 11/8/17 at 9:50 a.m. with Staff J, CNA revealed memory of being formally trained to use two people for Hoyers and EZ stands in the past. Staff J said knew of the sign posted at the 400 hall nurses' station that instructed them to use two people for EZ Stand transfers but they have to transfer people with EZ stands alone quite a bit in order to get all their work done; they get in trouble if they do not get the work done.	F 323		

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F 323	Continued From page 45 According to Staff J, she saw other staff members attempting to use a Hoyer by themselves to transfer a resident on two separate occasions in the last three weeks. According to Staff J, she interfered before they were able to complete the transfer. Staff J said she told them they should not do it by themselves. Staff J also said she believed they would have completed the transfers by themselves if she had not seen them and intervened. An interview on 11/8/17 at 2:55 p.m. with the current Administrator revealed that Invacare's (the brand of mechanical lift) instructions recommend the healthcare professional evaluate the need for assistance to determine whether more than one assistant is appropriate in each case because medical conditions are so variable. The Administrator said she had not been aware of the sign posted at the 400 nurses station desk reading "2 with EZ Stand for Transfers". The current Administrator said since they don't have a policy and the sign said to use two people to operate an EZ stand, she will develop a policy that clearly states they expect two people to operate an EZ Stand so everyone is on the same page. 3. The Admission Record dated 8/30/17 documented Resident #11 entered the facility on 8/22/17. The record documented she had diagnoses that included Parkinson's disease and high blood pressure. A Fall Note dated 8/29/17 at 8:15 PM documented Resident #11 fell in the dining room. The Progress Note dated 8/30/17 at 12:24 p.m. documented the resident complained of left hip pain. Staff called her physician who ordered the	F 323		

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F 323	Continued From page 46 resident transferred to the emergency room. The resident left the facility by medical transport at 11:15 a.m. An Orders-Administration Note dated 9/6/17 documented that Resident #11 returned from the hospital after having a total left hip replacement on 8/31/17. The author noted that staff assistance had increased to two. The Incident QA (quality assurance) form dated 8/29/17 at 10:15 p.m., under Immediate Intervention(s), recorded that staff checked the resident's vital signs, conducted an assessment and assisted the resident up with the assistance of two after she fell. The Immediate Intervention section contained no fall prevention information. A document dated 8/30/17 and authored by the facility's prior administrator detailed the complaints of pain following the resident's fall. The prior administrator wrote the facility would put additional measures in place upon the resident's return to the facility. The resident's 8/23/17 Care Plan documented the risk for falls related to the progression of Parkinson's disease as evidenced by impaired physical mobility. The Care Plan indicated Resident #11 required assistance of one staff member for transfers, utilized a wheelchair for mobility, to place the resident's call light in reach and assure glasses in place. The care plan showed no documentation of additional fall prevention measures put into place to prevent additional falls.	F 323		
F 353 SS=D	SUFFICIENT 24-HR NURSING STAFF PER CARE PLANS	F 353		

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F 353	Continued From page 47 CFR(s): 483.35(a)(1)-(4) 483.35 Nursing Services The facility must have sufficient nursing staff with the appropriate competencies and skills sets to provide nursing and related services to assure resident safety and attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident, as determined by resident assessments and individual plans of care and considering the number, acuity and diagnoses of the facility's resident population in accordance with the facility assessment required at §483.70(e). [As linked to Facility Assessment, §483.70(e), will be implemented beginning November 28, 2017 (Phase 2)] (a) Sufficient Staff. (a)(1) The facility must provide services by sufficient numbers of each of the following types of personnel on a 24-hour basis to provide nursing care to all residents in accordance with resident care plans: (i) Except when waived under paragraph (e) of this section, licensed nurses; and (ii) Other nursing personnel, including but not limited to nurse aides. (a)(2) Except when waived under paragraph (e) of this section, the facility must designate a licensed nurse to serve as a charge nurse on each tour of duty. (a)(3) The facility must ensure that licensed	F 353		

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F 353	Continued From page 48 nurses have the specific competencies and skill sets necessary to care for residents' needs, as identified through resident assessments, and described in the plan of care. (a)(4) Providing care includes but is not limited to assessing, evaluating, planning and implementing resident care plans and responding to resident's needs. This REQUIREMENT is not met as evidenced by: Based on clinical record review and resident interview, the facility failed to respond to one out of three resident's call lights to meet a resident's needs for 1 of 21 current residents reviewed (Resident #7). The facility reported a census of 61. Findings include: 1. The MDS (minimum data set) assessment dated 8/15/17 documented Resident #7 had diagnoses that included anemia, atrial fibrillation, coronary artery disease, arthritis, other fracture, depression, anxiety, repeated falls and cellulitis of the right lower extremity. The MDS noted that the resident always understood others and always made himself understood. The assessment documented a BIMS (Brief Interview for Mental Status) score of 12 out of 15 indicating moderately impaired cognitive status. Resident #7 required the assistance of 2 with transfers, dressing and toilet use and the assistance of one with bed mobility and personal hygiene activities. The 8/2/17 Care Plan noted Resident #7's total dependence on staff for transfers. The Care Plan also indicated staff should assist him with ADLs (activities of daily living) as needed and his skin	F 353		

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F 353	Continued From page 49 should be kept clean and dry. An interview on 11/7/17 at 3:05 p.m. with Resident #7 revealed he has had to wait for someone to respond to his call light for ½ hour many times. Resident #7 pointed to his clock and stated he timed it when asked how he knew how long it took. The resident stated he has told aids and nurses before, but never the DON (director of nursing) or Administrator. The resident said it used to frustrate him because they never did anything about it after he complained, but he gave up hoping that something would be done.	F 353		
F 441 SS=D	INFECTION CONTROL, PREVENT SPREAD, LINENS CFR(s): 483.80(a)(1)(2)(4)(e)(f) (a) Infection prevention and control program. The facility must establish an infection prevention and control program (IPCP) that must include, at a minimum, the following elements: (1) A system for preventing, identifying, reporting, investigating, and controlling infections and communicable diseases for all residents, staff, volunteers, visitors, and other individuals providing services under a contractual arrangement based upon the facility assessment conducted according to §483.70(e) and following accepted national standards (facility assessment implementation is Phase 2); (2) Written standards, policies, and procedures for the program, which must include, but are not limited to: (i) A system of surveillance designed to identify	F 441		

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F 441	Continued From page 50 possible communicable diseases or infections before they can spread to other persons in the facility; (ii) When and to whom possible incidents of communicable disease or infections should be reported; (iii) Standard and transmission-based precautions to be followed to prevent spread of infections; (iv) When and how isolation should be used for a resident; including but not limited to: (A) The type and duration of the isolation, depending upon the infectious agent or organism involved, and (B) A requirement that the isolation should be the least restrictive possible for the resident under the circumstances. (v) The circumstances under which the facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease; and (vi) The hand hygiene procedures to be followed by staff involved in direct resident contact. (4) A system for recording incidents identified under the facility's IPCP and the corrective actions taken by the facility. (e) Linens. Personnel must handle, store, process, and transport linens so as to prevent the spread of infection.	F 441		

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F 441	Continued From page 51 (f) Annual review. The facility will conduct an annual review of its IPCP and update their program, as necessary. This REQUIREMENT is not met as evidenced by: Based on clinical record review, observations and staff interviews, the facility failed to ensure staff performed hand hygiene when indicated while providing incontinence care for two of four incontinent residents reviewed (Residents #2 and #11). The facility reported a census of 61. Findings include: 1. The MDS (Minimum Data Set) assessment dated 8/14/17 documented Resident #2 had diagnoses that included dementia and muscle weakness. The assessment recorded she required the assistance of two staff with toilet use and the assistance of one staff with personal hygiene. The resident experienced routine bladder and bowel incontinence. The 8/1/17 Care Plan instructed staff to provide perineal care after each incontinent episode. Observation on 11/7/17 at 2:45 p.m. revealed Staff E, CNA (certified nursing assistant) transferred Resident #2 from her wheelchair to the bedside commode, removed the resident's brief and assisted her to sit on the commode. Staff E then assisted Resident #2 to stand using an EZ stand (a mechanical lift). After cleansing the resident's rectum after she had a loose bowel movement, Staff E did not remove her gloves and instead opened a drawer looking for another disposable brief. Staff E opened a closet, applied a new brief, pulled up the resident's pants, held the remote control and operated the EZ stand to	F 441		

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(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 441	Continued From page 52	F 441		

transfer Resident #2 to her wheelchair. Staff E then removed the EZ stand strap from around the resident, handled and attached the foot rests to the wheelchair before she covered the resident with a blanket. Once Staff E addressed Resident #2's needs, she took the removable plastic pan from under the commode and held the spray wand in the resident's bathroom to wash feces out of the pan and then flushed the toilet. At that point, Staff E moved the EZ stand into the hall. Staff E returned to Resident #2's room, removed the plastic liner from the trash container and removed the lid from the trash receptacle in the hallway to dispose of the bag, at which time she finally removed the gloves she used to perform incontinence care.

2. The Admission Record dated 8/30/17 documented Resident #11 entered the facility on 8/22/17. The record documented she had diagnoses that included Parkinson's disease and high blood pressure.

The 8/23/17 Care Plan noted Resident #11's noted Resident #11's risk for impaired skin integrity related to impaired physical mobility and instructions for staff to keep her skin clean and dry. According to the Care Plan, Resident #11 required assistance of two people for personal hygiene.

An observation on 11/7/17 at 9:45 a.m. revealed Staff AA, CNA and Staff BB, CNA assisted Resident #11 to stand, pivot and transfer from her wheelchair to the commode. Staff pulled the resident's visibly wet brief down far enough so she could be seated on the commode to urinate. While sitting on the commode, Resident #11 checked her brief to see if it was wet by feeling

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	165497	A. BUILDING _____ B. WING _____	C 11/30/2017

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the inside of it with both of her hands. After standing the resident to provide incontinence care, the staff members changed the resident's brief and pulled her pants up to seat her in the wheelchair. Staff BB handed Resident #11 a Kleenex as Staff AA combed the resident's hair and applied lotion to her arms and legs. As the resident sat, she touched both padded arm rests with both hands, touched her face with her left hand multiple times and held Staff AA's hands. Staff AA opened a drawer as she and Resident #11 touched many things in the drawer in search of a small mirror. Resident #11 opened her purse using both hands to look through it. Staff AA used her hands after holding Resident #11's hands to grab Resident #11's water pitcher, give it to the resident to drink from and then took it back and set it on the table. Staff AA did not wash her hands after she held Resident #11's hands.

The Hand Washing and Hand Hygiene Policy provided by the facility noted its purpose as:
1. To ensure appropriate hand hygiene which is essential in preventing transmission of infectious agents.
2. Medical asepsis (absence of bacteria, viruses and other microorganisms) to control infection.
According to General instructions, hand hygiene must be performed after touching blood, body fluids, secretions, excretions and contaminated items, whether or not gloves are worn; immediately after gloves are removed and when otherwise indicated to avoid transfer of microorganisms to other residents, personnel, equipment and/or environment.

An interview on 11/27/17 at 3:10 p.m. with the current Administrator revealed she expected staff to follow their hand hygiene and infection control

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F 441	Continued From page 54 protocols.	F 441		

5. Completion Date 12/15/2017

F241

Winterset North strives to provide dignified care to all residents.

1. Resident #1 is no longer a resident
2. Residents will have interactions with staff that provide for dignity to be maintained.
3. Staff have been in-serviced from 12/4/2017 – 12/15/2017 on dignity.
4. Administrator and/or designee will complete routine audits regarding dignity and will report the finding at the monthly QAPI meetings.
5. Completion Date 12/30/2017

F281

Winterset North strives to assure all residents are watched to assure consumption of medicines and clarify orders as needed.

1. Resident #8 is no longer at the facility. Residents # 3 and #4 are receiving their meds according to nursing protocols.
2. All residents are receiving their meds according to nursing protocols.
3. Nursing staff were in-service between 11/9 and 12/15 about protocols regarding passing of medications.
4. DON and/or designee will complete routine audits regarding med pass and report the findings at the monthly QAPI meetings.
5. Completion Date 12/30/2017

F309

Winterset North strives to assess skin conditions and provide timely intervention.

1. Resident #1 is no longer a resident of the facility. Resident #2 did have the area assessed and intervention initiated.
2. All residents who have a skin issue will have an assessment and intervention initiated.
3. Nursing staff were in-service between 12/4 and 12/15 on timely assessment and intervention of skin issues.
4. DON and/ or designee will complete routine audits on skin issues and results of the audits will be brought to the monthly QAPI meeting for 3 months.
5. Completion Date 12/15/2017

F312

Winterset North strives to provide showers, baths and shaving assistance routinely.

1. Residents #9, #10, #15, #16, #17 are being bathed on a regular schedule. Resident #14 has recently passed away.
2. Residents are being offered baths 2 X per week.

F000

This plan of correction constitutes our credible Allegation of Compliance. Preparation and or execution of this plan or correction does not constitute admission or agreement by the provider of the conclusion set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because it is required by the provision of the federal and state laws. All deficiencies will be corrected by 12/30/2017 except F 223, F225 and F309 which were corrected on 12/15/2017.

F159

Winterset North strives to follow an orderly system to manage resident purchases for our residents.

1. The facility will replace the funds for residents #9 and #19.

2. A policy has been developed that details the process for management of resident trust monies. All resident transactions made from the trust will follow this policy.

3. Staff were in-serviced on this policy at different times from 11/9/2017 -12/1/2017.

4. Administrator and/or designee will complete routine audits on the trust account. Results of the audit will be discussed at QAPI for 6 months.

5. Completion date 12/30/2017

F223

Winterset North strives to protect the residents from all types of abuse.

1. The staff person involved was terminated immediately after interview with her that day.
2. Staff will continue to follow the facility policy and procedure for preventing and reporting resident abuse.
3. Staff have been in-serviced between the dates of November 9th and December 1st, 2017 regarding abuse prevention and reporting.
4. Administrator will discuss all abuse allegations and outcomes at the monthly QAPI meeting.
5. Completion date 12/15/2017

F225

Winterset North strives to report all allegations of abuse.

1. Residents# 1 and 8 are no longer residents here. Resident #10 has been assessed under the abuse policy.
2. All residents fall under our abuse reporting policy.
3. Staff were in-serviced between 11/9 and 12/15 on abuse reporting.
4. Administrator and/or designee will complete routine audits and will report the findings at the monthly QAPI meeting.

3. Staff were in-serviced about the facility policy of bathing 2 X per week between November 9th and December 15th
4. DON and/or designee will complete routine audits and will report results of audits at QAPI each month for 3 months.
5. Completion Date 12/30/2017

F323

Winterset North strives to provide sufficient staff to safely operate mechanical devices and implement fall prevention measures following a fall or injury.

1. Residents #2 and #7 are being transferred with 2 staff. Resident #11's care plan has been updated.
2. All residents are being transferred according to facility policy and procedure.
3. All nursing staff were in-serviced between 12/4 and 12/15 on the facility policy and procedure of using 2 staff with any mechanical device. Nurses will be in-serviced again of policy of need to update care plan with interventions after any fall by December 30th.
4. DON and/or designee will complete routine audits of transfers and updating of care plans after a fall. Results of both audits will be brought to the QAPI meeting monthly for 3 months.
5. Completion Date 12/30/2017

F353

Winterset North strives to respond to resident call lights in a timely manner.

1. Resident # 7's call light will be responded to within the 15 minute state standard.
2. Residents will have call lights answered within the 15 minute state standard.
3. Nursing staff will be in-serviced by 12/29/2017 on the facilities policy and procedure of answering call lights within 15 minutes.
4. DON and/or designee will complete routine audits regarding call lights and will report the finding to the monthly QA meeting.
5. Completion Date 12/30/2017

F441

Winterset North strives to ensure staff performes hand hygiene with incontinence cares.

1. Resident's number 2 and 11 will have cares provided following the facilities policy and procedures regarding hand washing.
2. Residents will have cares provided following the facilities policy and procedure regarding hand washing.
3. Staff will be in-serviced by December 30th regarding the facilities policy and procedures regarding hand washing.
4. DON and/or designee will complete routine audits regarding hand washing and will report the findings to the monthly QA committee.
5. Completion Date 12/30/2017