STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	165198	A. BUILDING _____ B. WING _____	C 01/19/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
IOWA CITY REHAB & HEALTH CARE	3661 ROCHESTER AVENUE IOWA CITY, IA 52246

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 000	INITIAL COMMENTS	F 000		
JC 2/5/18	Correction date 1/25/18			
	The following deficiency relates to the investigation of complaint #72154, #72230 & #72721. (See code of Federal Regulations (42 CFR), Part 483, Subpart B-C).			
	Incident #72722 & complaint #72568 & #72628 was not substantiated.			
F 309 SS=G	PROVIDE CARE/SERVICES FOR HIGHEST WELL BEING CFR(s): 483.24, 483.25(k)(l)	F 309		
	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.			

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
[signature]	Administrator	01/25/2018

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

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	165198	A. BUILDING _____ B. WING _____	C 01/19/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
IOWA CITY REHAB & HEALTH CARE	3661 ROCHESTER AVENUE IOWA CITY, IA 52245

(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 309	Continued From page 1 The facility must ensure that pain management is provided to residents who require such services, consistent with professional standards of practice, the comprehensive person-centered care plan, and the residents' goals and preferences. (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 observation, record review and staff interviews, the facility failed to appropriately assess Resident #1 and Resident #2 following a change of health condition and then implement interventions. The facility identified a census of 63 residents. Findings include: Resident #1 had a Minimum Data Set (MDS) assessment with a reference date of 9/30/17. The MDS identified the resident's diagnoses included diabetes mellitus, hyperlipidemia, chronic obstructive pulmonary disease, and atrial fibrillation (rapid and irregular heart rhythm). The MDS revealed the resident with a BIMS (Brief Interview for Mental Status) score of 15. A score of 15 reflected the resident had no cognitive impairments. The MDS indicated the resident required extensive assistance of two staff members for bed mobility, transfers, dressing, and toilet use, and required the assistance of one staff member for walking and personal hygiene. The MDS documented the resident used a wheelchair as a mobility device.	F 309		

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	165198	A. BUILDING _____ B. WING _____	C 01/19/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
IOWA CITY REHAB & HEALTH CARE	3661 ROCHESTER AVENUE IOWA CITY, IA 52245

(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 309	Continued From page 2 The Care Plan, with an initiated date of 11/18/16, identified a focus area that identified the resident had ADL (activities of daily living) self-care performances skills due to a hip fracture and weakness. The interventions included and directed the staff to do the following: Staff are to assist the resident with use of the toilet, Staff are to assist the resident during transfers with a front wheeled walker and gait belt, Staff are to encourage the resident to participate to the fullest extent possible with each interaction. Review of the Progress Notes dated 11/2/17 at 7:48 pm indicated Resident #1 was seen at the medical clinic today and given an antibiotic medication for a chest cold. Review of physician encounter nursing home visit dated 11/3/17 indicated Resident #1has a recent course of bronchitis and receiving antibiotics for this. The note indicated the resident feels he still does have a bit of a productive cough. The resident denies fever, chills and the resident's appetite is good, bowels are working fine and pain is adequately controlled. The Progress Notes indicated the following: On 11/4/17 at 3:05 am, Resident #1 continued on antibiotic for upper respiratory infection. Resident in bed with eyes closed, blood pressure 130/76 (normal), pulse 76 (normal 60-100), and temperature 97.8 (normal 98.6). Fluids encouraged when awake, no apparent distress noted, will continue to monitor. (The note did not	F 309		

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	165198	A. BUILDING _____ B. WING _____	C 01/19/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
IOWA CITY REHAB & HEALTH CARE	3661 ROCHESTER AVENUE IOWA CITY, IA 52245

(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 309	Continued From page 3 identify the respiration rate or lung sounds). On 11/4/17 at 2:09 pm Resident #1 had no adverse reactions noted to the antibiotic therapy. Resident has no shortness of breath and lungs sounds are diminished. Resident respirations are even and unlabored on room air. Resident is able to make needs known and call light within reach. The resident resumed smoking and reeducated on the risks of continued smoking. The resident declined a nicotine patch. On 11/5/17 at 12:51 pm indicated the Assistant Director of Nursing, (ADON), approached the nurses' station and observed the resident sitting with the charge nurse on duty. The resident wore and receiving oxygen. The note indicated the ADON asked the charge nurse what was happening and the charge nurse reported "Everyone says the resident is jaundice (a yellow tint to the skin)". The note indicated the charge nurse reported the resident's oxygen saturation between 90-91% (normal 97-100 percent). The resident on room air and vitals are stable (although no vital signs documented). The ADON questioned the resident if he felt short of breath and the resident denied this and any pain or discomfort. Instead the resident stated he felt tired. The charge nurse reported she gave the resident a nebulizer treatment (breathing treatment) because resident's oxygen saturation was low between 90-91% (normal 95-100%). The charge nurse again stated she thought the resident to be jaundice and that is why she put the resident on oxygen. The charge nurse reported oxygen on at 2 liters for 2-5 minutes. The note indicated the ADON questioned the charged nurse if she obtained a physician order for the oxygen and she had not at this time. The	F 309		

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	165198	A. BUILDING _____ B. WING _____	C 01/19/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
IOWA CITY REHAB & HEALTH CARE	3661 ROCHESTER AVENUE IOWA CITY, IA 52245

(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 309	Continued From page 4 oxygen taken off resident for approximately 10 minutes and the resident's oxygen saturation checked and noted to be 94-95% on room air. The ADON, under better lighting assessed the resident. The resident's skin and sclera (white part of eyes) noted no jaundice. Skin noted to be pink and warm, lung sounds with very faint wheezing noted to the upper left lung, no coughing noted. The resident's bilateral feet and legs noted to be tight with 1 to 2 plus edema (swelling with excessive fluid in tissue) per resident's baseline. Again the resident denied shortness of breath. Resident began propelling self in wheelchair in the halls visiting with other residents without any distress noted. Resident did go to dining room for lunch. On 11/5/17 at 5:30 pm Resident #1 in bed and refused supper. The resident reported being short of breath earlier in the day. This nurse told resident as a diabetic he needed to take something in [eat]. Resident given chicken broth and two glasses of cranberry juice per request and took a couple sips of chicken broth and drank one glass of cranberry juice. The nurse assisted the resident with lifting legs into the bed. The resident did not complain of shortness of breath and took nebulizer breathing treatment at this time. The resident voiced he went outside to smoke earlier but would not be going out at 7 pm to smoke. On 11/5/17 at 7:45 pm the resident's vital signs are temperature 96.6, pulse 88, respiration rate 32 (elevated), and blood pressure 141/74. The resident is taking antibiotic for upper respiration infection. The note indicated the resident spoke of going to the hospital. The ADON put resident on oxygen at 2 liters per nasal cannula and this	F 309		

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	165198	A. BUILDING _____ B. WING _____	C 01/19/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
IOWA CITY REHAB & HEALTH CARE	3661 ROCHESTER AVENUE IOWA CITY, IA 52245

(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 309	Continued From page 5 nurse going to page the physician on-call. On 11/5/17 at 7:50 pm (the next entry) indicated the physician was paged at this time. Resident #1 rested comfortably in bed at this time, call light in reach. On 11/5/17 at 8:45 pm Resident #1sitting on the bed and took off the oxygen. The resident stated "I left the oxygen on for 5 minutes and it is uncomfortable. Think I just want to go to the hospital". On 11/5/17 at 8:50 pm the nurse paged the physician again. A call came back and update given to physician. Physician ordered for Resident #1 to be treated and evaluated in the emergency room. The nurse contacted the hospital and spoke with the hospital administrator and emergency room department for transfer of the resident. The nurse contacted the ambulance for transfer [to hospital emergency room]. On 11/5/17 9:05 pm Resident #1 in bed and assisted with putting on a gown on pending arrival of ambulance. Resident told this nurse "Just don't feel good, think there is a problem". Resident thanked the nurse for getting him ready. On 11/5/17 at 9:15 pm the ambulance crew here and CNA (certified Nurse Aide) called out that the resident not responding. CPR (Cardiopulmonary Resuscitation) initiated. On 11/5/17 at 10:09 pm. Physician notified at this time, resident is a full code but despite CPR continuously all this time no response. Order given to cease CPR and resident pronounced [death] at this time. ADON notified and medical	F 309		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	165198	A. BUILDING _____ B. WING _____	C 01/19/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
IOWA CITY REHAB & HEALTH CARE	3661 ROCHESTER AVENUE IOWA CITY, IA 52245

(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 309	Continued From page 6 examiner called. Review of the Ambulance Prehospital Care Report dated 11/5/17 indicated they received a call to respond to the facility for a resident with difficulty breathing to be transported to the emergency room. In route without delay. Upon arrival, nurse is giving us report that resident has been on antibiotic for a week for bronchitis. Resident was seen by personal medical provider on Friday. Resident complaining of difficulty breathing all day today and oxygen via nasal cannula had been attempted. Resident refuses to leave oxygen on and continues to smoke. Resident last set of vital signs were blood pressure 141/74, pulse 88, temperature 96.6, respirations 32, and oxygen saturation 91% on room air. Nurse stated resident demanded to go to the hospital at 8:10 pm. Resident is a full code. As nurse finished the report, staff yelled from the resident's room that resident is unresponsive. Resident is unresponsive, pale, pulseless and apneic (temporary cessation of breathing). The resident was moved to the floor with the assistance of 4 attendants and CPR initiated. After 30 minutes, physician called and declared time of death. On 1/5/18 at 12:06 p.m. Staff B, Licensed Practical Nurse (LPN) was interviewed and stated she worked the day shift on 11/5/17 and assigned to care for Resident #1. Staff B stated that morning the resident was in therapy and one of the therapist came to her and reported the resident looked jaundice. Staff B stated she took the resident's vital signs and the vitals were normal but did not recall if she documented the vital signs. Staff B stated the resident did not appear jaundice and normal. Staff B stated after	F 309		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	165198	A. BUILDING _____ B. WING _____	C 01/19/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
IOWA CITY REHAB & HEALTH CARE	3661 ROCHESTER AVENUE IOWA CITY, IA 52245

(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 309	Continued From page 7	F 309		

that, the resident was preoccupied with wanting to go to the emergency room for jaundice. Staff B, educated the resident about liver function and contacting his physician tomorrow to get lab testing. Staff B, stated the resident asked her 2-3 times about going to the emergency room. Staff B, stated she told the resident she would send him but first let's figure out want is wrong. Staff B stated she asked the ADON to assess the resident also and the ADON reported resident's vital signs are normal, color is okay, and she talked to the resident about lab work for the liver. Staff B stated the resident is normal, had no signs or symptoms of anything wrong and the resident seemed to be preoccupied with jaundice. Staff B, stated she reported this to the oncoming nurse.

On 1/5/18 at 2:17 pm and 1/10/18 at 3:14 pm Staff A, Licensed Practical Nurse (LPN) was interviewed and stated she came into work on 11/5/17, second shift (2:00 p.m.) and assigned to care for Resident #1. Staff A stated she did not get a report from the off going nurse, Staff B, regarding anything going on with Resident #1. Staff A stated the resident did not wear oxygen when she came in at 2 pm and the resident went out to smoke at that time. Staff A reported at 5:30 pm, the resident told her he was not going to supper due to not feeling well, no shortness of breath, just feeling tired. Staff A, LPN, stated resident told her he was short of breath earlier, but it had resolved, but had not been feeling good all day. Staff A stated at 7:45 pm, she assessed the resident's vital signs and noted respiration rate at 32 (elevated), oxygen saturation at 91-93% (low) on room air, and resident complained of shortness of breath. Staff A stated the ADON went into the resident's room to assess the resident. Staff A stated the ADON told the

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	165198	A. BUILDING _____ B. WING _____	C 01/19/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
IOWA CITY REHAB & HEALTH CARE	3661 ROCHESTER AVENUE IOWA CITY, IA 52245

(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 309	Continued From page 8	F 309		

resident he is on an antibiotic, and to stay here and try the oxygen. The resident okay with that. Staff A stated she paged the on-call physician twice and received an order to send the resident to the emergency room. Staff A stated when the ambulance arrived a CNA, called out that resident is not responding and she and the ambulance crew initiated CPR. Staff A stated later Staff B, LPN, told her Resident # had problems all day with shortness of breath and that she had put oxygen on the resident.

On 1/9/18 at 8:46 am Staff D, Certified Nurse Aide (CNA) was interviewed and stated on 11/5/17 she came into work at 2 pm and received report from the off going CNA. The off going CNA informed her that Resident #1 did not feel well and has been requesting to go to the hospital. Staff D stated she saw the resident and he did not look so good and the resident stated he felt bad. Staff D stated she reported this to Staff A (nurse) what the resident told her and was instructed by Staff A to do extra cares for the resident. Staff D, stated the resident refused to eat his supper and she reported this to Staff A.

On 1/5/18 at 2:51 pm Staff C, Certified Nurse Aide (CNA) was interviewed and stated she came into work at 2 pm and saw Resident #1 at the nurses' station telling Staff A that he wasn't feeling well and wanted to go to the hospital. Staff C stated she heard Staff A tell the resident she was doing all she could for him and she didn't have time to deal with him. Staff C stated she noted resident's color was a little greyish in color.

On 1/5/18 at 3:18 pm with Staff E, Certified Nurse Aide (CNA) stated she came into work at 4 pm on 11/5/17 and noted the resident at the main

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	165198	A. BUILDING _____ B. WING _____	C 01/19/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
IOWA CITY REHAB & HEALTH CARE	3661 ROCHESTER AVENUE IOWA CITY, IA 52245

(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 309	Continued From page 9 entrance. Staff E stated resident told her that he did not feel well and has tried to go to the emergency room all day. Staff E stated she knew he did not feel well because his skin color was pale/yellowish and not normal. Staff E stated she did not recall if she reported this to the nurse or not. On 1/9/18 at 10:09 am Assistant Director of Nursing (ADON) was interviewed and stated she came into the facility the first time on 11/5/17 around 10:00 or 10:30 pm. The ADON stated at 12:00 or 12:30 pm she saw Resident #1 at the nurses' station with Staff B and noted the resident had oxygen on. The ADON stated Staff B told her the resident's oxygen saturation was 90-91% and vital signs were normal and that everyone is saying resident is jaundice in color. The ADON stated she assessed the resident's color and did not note abnormal color and she removed the oxygen and after 10 minutes assessed resident's oxygen saturation to be 93-95% on room air. The ADON stated she instructed Staff B she needed a physician order for the oxygen and Staff B said she would call the resident's physician. The ADON stated the resident did not request to be sent to the hospital nor did Staff B indicate the resident wanted to go to the hospital. The ADON stated she left the facility and returned again around 5:30 or 6:00 pm and went to her office. The ADON stated around 7 pm Staff A came to her stating there is something truly wrong with Resident #1. The ADON stated she went to the resident's room and noted the resident to be short of breath, purse breathing through his lips, and requesting to go to the hospital. The ADON stated she went and got the oxygen and put it on the resident and assessed his vital signs and Staff B called the physician on-call. The ADON stated	F 309		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	165198	A. BUILDING _____ B. WING _____	C 01/19/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
IOWA CITY REHAB & HEALTH CARE	3661 ROCHESTER AVENUE IOWA CITY, IA 52245

(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 309	Continued From page 10 she spent about a half hour with the resident and then left the facility around 9 or 9:15 pm when the ambulance was on its way. The ADON stated she never talked to any other staff members besides Nurse A and Nurse B. On 1/10/18 at 10:34 am an interview was conducted with the resident's physician. The physician stated he has done some education with the facility after this with staff members. The physician stated he instructed them if a resident needs to go to the hospital to send them. The physician stated he reviewed the resident's chart and it appeared there's a disconnect in assessment with staff members. 2 . Resident #2 had a MDS assessment with a reference date of 12/14/17. The MDS identified the resident had diagnosis including hypertension (elevated blood pressure), neurogenic bladder (neurological bladder condition), viral hepatitis (disease of the liver), depression, Arnold-Chiari Syndrome (a condition in which brain tissue extends into the spinal canal, present at birth), dysphagia (difficulty swallowing), cervicalgia (pain in the neck), and chronic pain. The MDS indicated the resident had a BIMS) score of 15 out of 15. The MDS indicated the resident required limited assistance of 1 staff member for bed mobility, dressing, locomotion, and toilet use, and extensive assist of one staff member for personal hygiene. The MDS documented the resident used mobility devices of a walker and a wheelchair. The MDS indicated the resident receives a pain medication regimen, both scheduled and as needed and receives non-medication intervention for pain. The MDS documented frequent pain in the last 5 days that rates a 9 on a scale of 0 to 10. The scale is 0	F 309		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	165198	A. BUILDING _____ B. WING _____	C 01/19/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
IOWA CITY REHAB & HEALTH CARE	3661 ROCHESTER AVENUE IOWA CITY, IA 52246

(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 309	Continued From page 11 being no pain and 10 as the worst pain. A Care Plan, with an initiated date of 09/28/17, identified a focus area with chronic pain related to cervicalgia. The interventions directed staff to: Staff are to anticipate the resident's need for pain relief and respond immediately to any complaints of pain. Staff are to monitor and record pain characteristics every shift and as needed, severity 1 to 10 pain scale. The resident's pain is alleviated/relieved by rest and medication management. Review of the MAR (Medication Administration Record) dated November 2017, identified an order for hydromorphone (narcotic analgesic) 2 mg (milligrams) and give 2 tabs every four hours as needed for pain. Review of the Controlled Medication Utilization Record for hydromorphone revealed one tablet administered at 9:00 am on 11/5/17, leaving the count of the medication at zero. Review of the Controlled Medication Utilization Record for hydromorphone revealed 60 tablets received and two tablets administered at 2 am on 11/6/17. On 1/10/18 at 11:53 am Staff G, LPN (Licensed Practical Nurse), was interviewed and stated she administered 1 tablet of hydromorphone to the resident around 9 am on 11/5/17 and that was the last tablet. Staff G stated she did not know how to	F 309		

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	165198	A. BUILDING _____ B. WING _____	C 01/19/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
IOWA CITY REHAB & HEALTH CARE	3661 ROCHESTER AVENUE IOWA CITY, IA 52245

(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 309	Continued From page 12 order the pain medication for the resident and the resident complained of pain. Staff G stated she worked from 6 am to 10 pm on 11/5/17. Staff G stated the resident's family was here and upset the resident did not have pain medication. Staff G stated she did not call the pharmacy or the resident's physician about not having pain medication for the resident. Staff G stated she administered Tylenol as ordered for the resident's complaints of pain. On 1/10/18 at 3:14 pm with Staff A, LPN (Licensed Practical Nurse), was interviewed and stated the resident approached her the afternoon of 11/5/17. The resident expressed being upset,d in pain and no pain medication available. Staff A stated she called the pharmacy and ordered the medication for the resident and was told it would take 6 hours for the medication to be delivered. Staff A stated the facility's medication emergency kit did not have the resident's pain medication in it. Staff A reported she instructed Staff G to give the resident Tylenol for pain. Staff A stated she never called the resident's physician. On 1/8/18 at 10:09 am the ADON (Assistant Director of Nursing) was interviewed and stated she was informed the facility ran out of the resident's pain medication, Hydromorphone. The ADON stated she did education with staff members. The ADON stated she expected staff to have ordered the pain medication before they ran out, to check the emergency kit to see if medication is available for resident, to call the pharmacy and order it immediately, and or call the resident's physician to see if another pain medication that can be ordered for the resident and available in the facility's medication emergency kit immediately.	F 309		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	165198	A. BUILDING _____ B. WING _____	C 01/19/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
IOWA CITY REHAB & HEALTH CARE	3661 ROCHESTER AVENUE IOWA CITY, IA 52245

(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 309	Continued From page 13 Review of the Clinical Change In Condition Management dated 06/2015 included assessment of residents clinical status when a change in condition is identified. This may include but is not limited to: vital signs, lung sounds, pulse ox, mental/neurological status, bowel sounds, skin color, turgor, temperature, pain. Contact the physician and provide clinical data and information about the resident condition. Document this notification of the physician in the resident's medical record and physician response. Initiate any new physician orders.	F 309		

This plan of correction does not constitute an admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. This plan of correction is prepared solely because it is required by State and Federal Law.

Date of compliance for this plan of correction is: 1/25/2018

F-309

It is the practice of Iowa City Rehabilitation to provide for the highest well being of the residents.

#1- Resident #1 no longer resides at Iowa City Rehab. No further Action necessary.

Resident #2- Facility medication e-kit updated to include pain medication for resident #2.

#2- For all similar residents, a staff huddle was held on 11/9/17 and 1/26/18 with nursing staff to discuss and identify any potential change in condition and to determine if there are any unavailable medications. Any concerns identified were immediately addressed. An In-service regarding medication administration was held on 11/7/17 and 1/26/18 to review expectations regarding medication administration and what to do if a medication is not readily available.

#3- The director of nursing and/or designee will hold nursing staff huddle meetings 5 days per week to discuss resident conditions and identify any possible changes for the next 30 days and 3 times a week thereafter for a minimum of 2 months.

#4- The Director of Nursing or designee will report the progress of this plan of correction to the QAPI Committee for a minimum of 3 months to ensure ongoing compliance.