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

3-1-18 pd.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	166428	A. BUILDING _____ B. WING _____	C 01/31/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CAREAGE HILLS REHABILITATION AND HEALTHCARE	725 NORTH SECOND STREET CHEROKEE, IA 51012

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 000	INITIAL COMMENTS Correction date: 2-1-18 The following deficiencies are a result of the investigation of complaints #71562-C, #72749-C and incident #73056-I, completed on 12/29/17 through 1/31/18. Complaint #71562-C was not substantiated. Complaint #72749-C was substantiated. Incident #73056-I was substantiated. See Code of Federal Regulations (45 CFR) Part 483, Subpart B-C.	F 000		
F 580 SS=D	Notify of Changes (Injury/Decline/Room, etc.) CFR(s): 483.10(g)(14)(i)-(iv)(15) §483.10(g)(14) Notification of Changes. (i) A facility must immediately inform the resident; consult with the resident's physician; and notify, consistent with his or her authority, the resident representative(s) when there is- (A) An accident involving the resident which results in injury and has the potential for requiring physician intervention; (B) A significant change in the resident's physical, mental, or psychosocial status (that is, a deterioration in health, mental, or psychosocial status in either life-threatening conditions or clinical complications); (C) A need to alter treatment significantly (that is, a need to discontinue an existing form of treatment due to adverse consequences, or to commence a new form of treatment); or (D) A decision to transfer or discharge the resident from the facility as specified in §483.15(c)(1)(ii). (ii) When making notification under paragraph (g)(14)(i) of this section, the facility must ensure that	F 580		

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

Admin | 03/01/2018

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

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F 580	Continued From page 1 all pertinent information specified in §483.15(c)(2) is available and provided upon request to the physician. (iii) The facility must also promptly notify the resident and the resident representative, if any, when there is- (A) A change in room or roommate assignment as specified in §483.10(e)(6); or (B) A change in resident rights under Federal or State law or regulations as specified in paragraph (e)(10) of this section. (iv) The facility must record and periodically update the address (mailing and email) and phone number of the resident representative(s). §483.10(g)(15) Admission to a composite distinct part. A facility that is a composite distinct part (as defined in §483.5) must disclose in its admission agreement its physical configuration, including tho various locations that comprise the composite distinct part, and must specify the policies that apply to room changes between its different locations under §483.15(c)(9). This REQUIREMENT is not met as evidenced by: Based on record review, staff interview and policy review the facility failed to notify 1 of 6 residents reviewed physician and family of a significant weight loss. (Resident #6) The facility identified a census of 29 current residents. Findings include: 1. According to the MDS (minimum data set) dated 11/24/17 Resident #6 had diagnoses that included encephalopathy. The MDS identified the resident had a BIMs (brief interview for mental	F 580		

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F 580	Continued From page 2	F 580		

status) score of 00 which indicated severe cognitive impairment. According to the MDS the resident required extensive assistance with eating. The MDS documented the resident's weight 143 pounds.

The care plan dated 11/8/17 identified Resident #6 had a potential nutritional problem related to condition and weakness. The Care Plan identified a Goal Resident #6 will maintain adequate nutritional status as evidenced by maintaining weight with no sign/symptoms of malnutrition through 11/8/17.
Interventions included:
a. Administer medications as ordered.
b. If resident eats less than 50%, offer meal replacement.
c. Meals in dining room if resident is in agreement, Staff to assist.
d. Monitor and report to physician as needed for any signs symptoms of decreased appetite, nausea, vomiting, unexpected weight loss or complaints of stomach pain.

Review of Point Click Care revealed Resident #6 on admission to the facility 11/6/17 weighted 142.8.

Review of the November 2017 Weights and vitals summary revealed the following:
a. 11/6/17 142.8 pounds
b. 11/30/17 131.2 pounds (8.1 % loss)

Review of the hand written documents identified as resident weekly weights revealed the following:
a. 11/14/17 142.8 pounds.
b. 11/20/17 182.4 subtracted chair weight (45.6) equals 136.8 pounds.
c. 11/28/17 131.2 pounds- trial pureed diet for 3

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F 580	Continued From page 3 days. During an interview with the Director of Nursing on 1/11/18 at 10:50 AM she stated the facility policy to notify the Physician of significant weight loss at 30 days. The resident's weight had been put in point click care system on 11/30/17 and triggered the significant change. The facility would have had a meeting on the following Monday and the Doctor would have been notified at that time. The facility Policy and Procedure titled Weighing Ambulatory Residents dated 5/2007 directed staff to notify physician and DNS of any significant weight loss or gain. Minimum standards for significant weight loss wound be; 5% in 30 days, 7.5% in 60 days and 10% in 180 days.	F 580		
F 689 SS=J	Free of Accident Hazards/Supervision/Devices CFR(s): 483.25(d)(1)(2) §483.25(d) Accidents. The facility must ensure that - §483.25(d)(1) The resident environment remains as free of accident hazards as is possible; and §483.25(d)(2)Each resident receives adequate supervision and assistance devices to prevent accidents. This REQUIREMENT is not met as evidenced by: Based on record review, observation, staff interviews and review of policy and procedures, the facility failed to provide Resident #1 with adequate supervision to ensure against hazards to self and elements of the environment when the resident eloped from the facility and found in the local grocery store parking lot. Although the resident had no injuries, the elopement placed	F 689	Past noncompliance: no plan of correction required.	

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F 689	Continued From page 4	F 689		

the resident in an immediate jeopardy situation with health and security. Prior to the investigation, the staff received education on 12/15/17 to prevent elopements and proper procedures when an activated door alarms. The sample consisted of 6 residents and the facility reported a census of 29 residents.

Findings include:

1. Resident #1 had a MDS (Minimum Data Set) assessment with a reference date of 12/5/17. The MDS indicated the resident had diagnoses that included diabetes mellitus, anxiety disorder, schizophrenia (mental illness) and degenerative disease of the nervous system. The MDS indicated the resident had a BIMS (Brief Interview for Mental Status) score of 3. A score of 3 identified the resident had a severe cognitive impairment. The MDS indicated the resident required supervision with bed mobility, transfers, ambulation, dressing and toilet use.

The Care Plan dated 2/5/17, identified the resident at risk for elopement due to attempts to go out the door and elopement risk assessment results. The interventions directed the staff to apply a Wander Guard (device to alert staff if leaves through activated door) to the right wrist, distract resident from wandering by offering pleasant diversions, structured activities, food conversation, television, book. document wandering behavior and attempted diversional interventions, provide structured activities, toileting and walking inside and outside. The interventions directed the staff to reorientation strategies including signs, pictures and memory boxes. On 12/18/17 the Care Plan was updated to direct staff of a failed dose reduction of Lithium

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F 689	Continued From page 5	F 689		

(medication for mental illness), implement 150 mg (milligrams) every morning in addition to the bedtime dose, frequent checks, and take for a car ride weekly.

Review of the Elopement/Wandering Evaluation dated 12/4/17 revealed the resident had a score of 7. A score of 7 represented a low risk for an elopement.

Review of the Fall Risk Evaluation dated 12/4/17 reflected at a medium risk for falls.

Review of the TAR (Treatment Administration Record) dated 11/1/17 through 11/30/17 and 12/1/17 through 12/31/17 identified the Wander Guard bracelet to the right wrist and checked every shift (2 times a day) for wandering.

Review of the Progress Notes dated 12/15/17 at 2:50 p.m. indicated the resident observed in the parking lot at the local grocery store. Another staff member observed the resident, approached and returned the resident to the facility. The resident noted to wear long sweatpants, polo shirt, winter jacket, stocking hat, socks, closed toed shoes and eye glasses. The weather temperature identified as 41 degrees, no wind noted, clear skies. A head to toe assessment identified no visible injuries noted. Vital signs are: temperature 98.6 (normal), pulse 84 (normal 60-100), respirations 20 (normal 16-20), pulse oximetry 96 percent (normal 97-100 percent). The note indicated the staff interviewed and determined a nursing assistant shut sounding alarm off on the east door alarms without checking who exited after another mentally impaired resident reported to her it was an employee. All employees were educated on door

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F 689	Continued From page 6 alarms and proper procedure. Frequent checks initiated. The Progress notes dated 12/18/17 at 1:21 PM revealed the resident eloped on 12/15/17 and had been rocking back and forth in his chair. The resident had a failed dose reduction of lithium. New order included restart lithium carbonate 150 mg capsule by mouth every morning for depression. Review of the Document titled Frequent checks dated 12/15/17 through 1/5/18 revealed documentation of the resident's location and activity every 15 minutes. Review of the In-service Attendance Record dated 12/15/17 through 12/18/17 revealed staff education on proper procedure when answering door alarms. Review of the In-service Attendance Record dated 12/20/17 revealed all staff were provided mental health/elopement/door alarms. During an interview with the State Climatologist on 1/4/17 at 3:26 PM, he stated on December 15, 2017 at 2:35 PM at the Cherokee County Airport, the temperature at 43 degrees Fahrenheit, wind from the west at 15 miles per hour with gusts of 21 mile per hour and clear skies. The wind chill at 36 degrees Fahrenheit. On 1/3/18 at 2:00 PM Staff A (nursing assistant) was interviewed and stated she worked from 6:00 AM to 2:00 PM and had errands to do after work. Staff A stated she went to the grocery store and left at 2:45 PM. Staff A stated she noticed the resident in the parking lot, stopped him and talked	F 689		

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F 689	Continued From page 7	F 689		

him into her car. She called the facility and notified them she had the resident and will return to the facility. She denied the resident had stated he planned to leave during the day.

On 1/3/18 at 5:40 PM Staff C (licensed practical nurse) was interviewed and stated Staff C arrived at the facility approximately 2:45 PM with the resident. Staff C stated staff did not know he was gone. Staff C stated she interviewed all staff and found Staff J, CNA had turned off the door alarm because she had been told by another resident; a staff member had gone through that exit. She stated Staff J knew she had done wrong.

During an interview with the Director of Nursing on 1/11/18 revealed the facility had 7 residents that required Wander Guard devices. Three of the residents with Wander Guards were identified as smokers who routinely smoke outdoors.

The policy and procedure dated 2/17 directed the staff to do the following when a door alarm sounds:
a. Check the alarm panel to determine check door had been opened. Do not assume someone else had already done this.
b. Check that exit door for any exiting resident by means of a visual check.
c. Visual check means observing the area around the exit, and may require leaving the building.
d. If a resident is discovered outside the facility inappropriately, staff will assist him/her back into the facility.
e. Reset the door alarm after it is determined by visual check that no residents had exited the facility inappropriately, or is returned to the facility.
f. If for any reason the door alarms are turned off, the staff will continually visually monitor the doors.

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F 689	Continued From page 8 g. If an alarm is discovered de-activated, staff will perform an immediate head count to ensure all residents are accounted for. h. The unit nurse, Director of Nursing Services or Administrator will investigate and determine how the door alarm was de-activated and intervene accordingly.	F 689		
F 692 SS=D	Nutrition/Hydration Status Maintenance CFR(s): 483.25(g)(1)-(3) §483.25(g) Assisted nutrition and hydration. (Includes naso-gastric and gastrostomy tubes, both percutaneous endoscopic gastrostomy and percutaneous endoscopic jejunostomy, and enteral fluids). Based on a resident's comprehensive assessment, the facility must ensure that a resident- §483.25(g)(1) Maintains acceptable parameters of nutritional status, such as usual body weight or desirable body weight range and electrolyte balance, unless the resident's clinical condition demonstrates that this is not possible or resident preferences indicate otherwise; §483.25(g)(2) Is offered sufficient fluid intake to maintain proper hydration and health; §483.25(g)(3) Is offered a therapeutic diet when there is a nutritional problem and the health care provider orders a therapeutic diet. This REQUIREMENT is not met as evidenced by: Based on record review, staff interview and policy review the facility failed to implement interventions in a timely manner to prevent weight loss for 1 of 6 residents reviewed. (Resident #6) The facility identified a census of 29 current	F 692		

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F 692	Continued From page 9 residents. Findings include: 1. According to the MDS (minimum data set) dated 11/24/17 Resident #6 had diagnoses that included encephalopathy. The MDS identified the resident had a BIMs (brief interview for mental status) score of 00 which indicated severe cognitive impairment. According to the MDS the resident required extensive assistance with bed mobility, transfers, dressing, eating and toilet use. The MDS documented the resident's weight 143 pounds. The care plan dated 11/8/17 identified Resident #6 had a potential nutritional problem related to condition and weakness. The Care Plan identified a Goal Resident #6 will maintain adequate nutritional status as evidenced by maintaining weight with no sign/symptoms of malnutrition through 11/8/17. Interventions included: a. Administer medications as ordered. b. If resident eats less than 50%, offer meal replacement. c. Meals in dining room if resident is in agreement, Staff to assist. d. Monitor and report to physician as needed for any signs symptoms of decreased appetite, nausea, vomiting, unexpected weight loss or complaints of stomach pain. Review of Point Click Care revealed Resident #6 on admission to the facility 11/6/17 weighted 142.8. Review of the November 2017 Weights and vitals summary revealed the following:	F 692		

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F 692	Continued From page 10 a. 11/6/17 142.8 pounds b. 11/30/17 131.2 pounds (8.1 % loss) Review of the hand written documents identified as resident weekly weights revealed the following: a. 11/14/17 142.8 pounds. b. 11/20/17 182.4 subtracted chair weight (45.6) equals 136.8 pounds. c. 11/28/17 131.2 pounds. trial pureed diet for 3 days. During an interview with the Director of Nursing on 1/11/18 at 10:50 AM she stated the facility policy to notify the Physician of significant weight loss at 30 days. The resident's weight had been put in point click care system on 11/30/17 and triggered the significant change. The facility would have had a meeting on the following Monday and the Doctor would have been notified at that time. The facility Policy and Procedure titled Weighing Ambulatory Residents dated 5/2007 directed staff : a. All residents to be weighted on admission and weekly after admission for 4 weeks and as ordered thereafter. b. Weigh residents prior to administering diuretics and establish a weekly weight record to determine effect of diuretic. c. Periodic weight checks should be made on residents with physical disorders, such as anorexia, dehydration, obesity, edema or whenever indicated. d. Record weight on weight sheet. e. Notify physician and DNS of any significant weight loss or gain. Minimum standards for significant weight loss wound be; 5% in 30 days, 7.5% in 60 days and 10% in 180 days. f. Refer the resident to the weight committee for	F 692		

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F 692	Continued From page 11 review, if loses or gains in weight are within this range.	F 692		

Submission of the plan of correction should not be construed as a waiver of this provider's right to contest any and all deficiencies, nor is such a submission of admission that the facts are as alleged, or that any regulatory violation occurred.

The following is to be considered our Credible Allegation of Compliance. All deficiencies will be corrected by Feb 1, 2018.

F580 Notify of Changes (Injury/Decline/Room, etc.)

Notify of Changes

The Director of Nursing completed an audit January 20, 2018 to assure that all residents with a significant weight loss had Dr. and/or family notification in the progress notes.

The Director of Nursing has educated current staff Jan 11, 2018 regarding notification of Dr.'s and/or family with significant weight loss or gains.

New residents/readmission residents are being weighed weekly x 4 weeks and at least monthly after and Weekly Weight Risk Meetings being held every week after all weights have been obtained. MDS nurse (or designee) appointed to do weekly weight risk meetings and instructed on charting, Dr. notification and family notification. During the risk meetings IDT team will review and assure that Dr.'s are notified in a timely manner.

The Director of Nursing and or designee will report findings of above monitoring system(s) monthly times three months through the facility Quality Assurance Program, then review/assess for need to continue. The plan will be reviewed and revised as indicated and staff will be re-educated as needed.

F692 Nutrition/Hydration Status Maintenance

Nutrition/Hydration Status Maintenance

The Director of Nursing completed an audit January 20, 2018 to assure that all residents with a significant weight loss have an intervention in a timely manner to prevent weight loss.

The Director of Nursing has educated current staff Jan 11, 2018 on the importance of implementing interventions, notifying Dr.'s for interventions and notifying dietician.

New residents/readmission residents are being weighed weekly x 4 weeks and at least monthly after and our Weekly Weight Risk Meetings being held every week after all weights have been obtained. MDS nurse (or designee) appointed to do weekly weight risk meetings and upon reviewing weights with IDT team, interventions will be implemented and the proper steps will be made in order to ensure timely interventions to help prevent weight loss.

The Director of Nursing and or designee will report findings of above monitoring system(s) monthly times three months through the facility Quality Assurance Program, then review/assess for

need to continue. The plan will be reviewed and revised as indicated and staff will be re-educated as needed.

F689 Free of Accident Hazards/Supervision/Devices

Free of Accident Hazards/Supervision/Devices

Past Non-Compliance- no POC needed