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	165293	A. BUILDING _____ B. WING _____	02/22/2018

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SOUTHERN HILLS SPECIALTY CARE	444 NORTH WEST VIEW DRIVE OSCEOLA, IA 50213

(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 3-9-18 The following deficiencies result from the facility's annual health survey and investigations of complaints #70602-C, 72031-C, 72987-C, 73375-C and facility-reported incidents #71585-I, 72490-I, 74185-I, which were were substantiated. Complaints # 74117-C and #73235-C were also investigated and were not substantiated. See the Code of Federal Regulations (42CFR) Part 483, Subpart B-C.	F 000		
F 583 SS=D	Personal Privacy/Confidentiality of Records CFR(s): 483.10(h)(1)-(3)(i)(ii) §483.10(h) Privacy and Confidentiality. The resident has a right to personal privacy and confidentiality of his or her personal and medical records. §483.10(h)(l) Personal privacy includes accommodations, medical treatment, written and telephone communications, personal care, visits, and meetings of family and resident groups, but this does not require the facility to provide a private room for each resident. §483.10(h)(2) The facility must respect the residents right to personal privacy, including the right to privacy in his or her oral (that is, spoken), written, and electronic communications, including the right to send and promptly receive unopened mail and other letters, packages and other materials delivered to the facility for the resident, including those delivered through a means other than a postal service.	F 583		

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

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

POC accepted 3/16/18 qm

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F 583	Continued From page 1 §483.10(h)(3) The resident has a right to secure and confidential personal and medical records. (i) The resident has the right to refuse the release of personal and medical records except as provided at §483.70(i)(2) or other applicable federal or state laws. (ii) The facility must allow representatives of the Office of the State Long-Term Care Ombudsman to examine a resident's medical, social, and administrative records in accordance with State law. This REQUIREMENT is not met as evidenced by: Based on record review and Resident and Staff interviews the facility failed to provide privacy for a Resident using the bathroom for 1 of 24 sampled Residents (Resident # 28). The facility reported a census of 81 residents during the survey. Findings include; The 12/07/17 quarterly Minimum Data Set (MDS) assessment tool reported Resident #28 had diagnoses of diabetes and anxiety disorder. The MDS revealed the Brief Interview for Mental Status (BIMS) score of 15 out of 15 indicating intact cognition and documented Resident #28 independent with all activities of daily living. Resident #28's Care Plan dated 9/14/16 reported the resident to be independent with her choices of activities. During an interview with Resident #28 on 02/19/18 at 01:03 PM, Resident # 28 explained staff forgets to knock on the bathroom door when it is shut and she is using the bathroom.	F 583		

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F 583	Continued From page 2 Resident #28 has told staff that they should put gloves outside of the room to use for her roommate. Resident # 28 told staff if the door to the bathroom is shut it is her using the restroom and when they open the door it bothers her. During a subsequent interview on 02/21/18 at 8:50 AM Resident # 28 again said it really bothers her and the staff gets mad at her when she gets upset that they just open the door to the bathroom because they need gloves. Resident #28 has told them more than once when the door is closed she is in there. Resident #28 knows when she is not in the bathroom the door is to be open. The nurses always knock on the door they let me know what they want. It's the girls taking care of my roommate they say they need gloves. Resident #28 explained to them to put a box in her roommate's drawer beside her Bed. Resident #28 stated it's an invasion of her privacy and it really bothers her. During an interview on 02/22/18 at 8:37 AM with Staff L Certified Nurse Aide (CNA) Resident # 28 has not told her about someone opening the door to the bathroom but she sure could see that happening, with staff in taking care of roommate and not thinking about the door being shut and just opening the door to get gloves. During an interview on 02/22/18 at 8:57 AM the Director of Nursing (DON) reported, when asked, she expected staff to knock on a bathroom door before opening it if they do not know where the Resident is.	F 583		
F 656 SS=D	Develop/Implement Comprehensive Care Plan CFR(s): 483.21(b)(1)	F 656		

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F 656	Continued From page 3 §483.21(b) Comprehensive Care Plans §483.21(b)(1) The facility must develop and implement a comprehensive person-centered care plan for each resident, consistent with the resident rights set forth at §483.10(c)(2) and §483.10(c)(3), that includes measurable objectives and timeframes to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment. The comprehensive care plan must describe the following - (i) The services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §483.24, §483.25 or §483.40; and (ii) Any services that would otherwise be required under §483.24, §483.25 or §483.40 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(c)(6). (iii) Any specialized services or specialized rehabilitative services the nursing facility will provide as a result of PASARR recommendations. If a facility disagrees with the findings of the PASARR, it must indicate its rationale in the resident's medical record. (iv)In consultation with the resident and the resident's representative(s)- (A) The resident's goals for admission and desired outcomes. (B) The resident's preference and potential for future discharge. Facilities must document whether the resident's desire to return to the community was assessed and any referrals to local contact agencies and/or other appropriate entities, for this purpose. (C) Discharge plans in the comprehensive care plan, as appropriate, in accordance with the	F 656		

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F 656	Continued From page 4 requirements set forth in paragraph (c) of this section. This REQUIREMENT is not met as evidenced by: Based on observations, clinical record review and staff interview the facility failed to include a treatment ordered by a physician on the care plan for 1 of 24 residents reviewed (Resident #61). The facility identified a census of 81 residents. Findings include: The 1/25/18 quarterly Minimum Data Set (MDS) assessment tool reported Resident #61 had diagnoses of hypertension, diabetes, aphasia (inability to speak), edema (swelling) and flaccid hemiplegia affecting the right dominant side. The MDS also revealed Resident #61 required total assistance of 2 staff for bed mobility, transfers, and toilet use and extensive assistance for dressing and personal hygiene. The MDS documented the resident usually understood others Resident #61's Care Plan last reviewed 2/8/18 failed to contain information or directives regarding the treatment ordered 6/8/17 for tube-grips. The 10/27/17 Physician Order Set included an order to apply tubigrips to the lower legs. The order directed staff to apply tubigrips in the morning and remove them at bedtime (start date 6/8/17). The Treatment Administration Record (TAR) for January and February showed the resident refused on one day with no explanation on the back. Otherwise, staff had initialed the treatment	F 656		

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F 656	Continued From page 5 as completed every day. During an interview on 02/22/18 at 8:58 AM, the Director of Nursing (DON) stated, when asked, the doctor orders should be followed. If a resident refused a treatment, staff should have charted the refusal on the Treatment Administration Record (TAR). The DON verified the back of the TAR was blank. The DON stated she would have expected the tubigrips to be on the care plan because the nurses applied the items. During an interview on 02/22/18 at 09:08 AM with Staff J Nurse Manager (care plan coordinator) agreed the tube-grips should have been on the care plan and they weren't. The tube-grips would not necessarily be on the care card since it is a nurse's treatment the tube-grips are kept on the treatment cart. During a subsequent interview on 02/22/18 at 09:26 AM Staff J Nurse Manager (care plan coordinator) acknowledged the back side of the TAR is blank the nurse should have circle the front and put an explanation on the back as to the refusal to wear the tube-grips.	F 656		
F 658 SS=D	Services Provided Meet Professional Standards CFR(s): 483.21(b)(3)(i) §483.21(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 observations, clinical record review and staff interviews the facility failed to follow	F 658		

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F 658	Continued From page 6 physician orders for 1 of 24 sampled residents (Resident #61). The facility reported a census of 81 at the time of the survey. Findings include: The 1/25/18 quarterly Minimum Data Set (MDS) assessment tool reported Resident #61 had diagnoses of hypertension, diabetes, Aphasia, edema and flaccid hemiplegia affecting the right dominant side. The MDS also reported Resident #61 required total assistance of 2 staff for bed mobility, transfers and toilet use and extensive assistance for dressing and personal hygiene and the Resident usually understans others. Resident #61 Care Plan reviewed on 2/8/18 failed to include tube-grips as an intervention. The 12/17 Physician Order Set included an order for tube-gripes to Bilateral Lower Estimates (BLE) to be on in the morning and off at bedtime with a start date of 6/8/17. Resident #61's Treatment Administration Record (TAR) included tube-grip to BLE to be on in the morning and off at bedtime with a start date of 6/8/17. During an observation on 02/20/18 at 11:34 AM noted Resident #61's right lower extremity swollen with a reddened area including a scabbed area while she sat up in her wheelchair. During an observation on 02/21/18 at 7:26 AM Resident # 61 sat up in her wheelchair in the lobby area on the 300 hallway and had no tube-grips on her BLE. During an observation on 02/21/18 at 9:42 AM	F 658		

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F 658	Continued From page 7 Staff L Certified Nurse Aide (CNA) and Staff I CNA hooked Resident #61 up to the Hoyer and transferred her to bed. Resident #61 did not have tube-grips on her BLE. During an observation 02/22/18 at 8:31 AM Resident # 61 sitting at tray table in the dining area and with no tube-grip on BLE During an observation on 02/21/18 at 12:34 PM Resident # 61 sat at a tray table in the assisted dining room eating lunch and had no tube-grips on her BLE. During an interview on 2/22/18 at with Staff I CNA acknowledged she would look at the care card in each Resident's bathroom to know how to take care of each Resident. During an interview on 02/22/18 at 8:58 AM with the Director of Nursing (DON) the doctor orders should be followed. The DON explained if a resident would refuse treatment that should be charted refused on the TAR. The DON acknowledged the back of the TAR was blank.	F 658		
F 689 SS=G	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:	F 689		

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F 689	Continued From page 8 Based on record review and staff interviews, the facility failed to provide adequate supervision to ensure against hazards (Resident #1,#2). The sample consisted of 3 residents with a high risk of falling. The facility reported a census of 81 residents. Findings include: 1. Resident #1 had a MDS (Minimum Data Set) assessment with a reference date of 8/3/17. The MDS identified the resident had diagnosis including hypertension (elevated blood pressure), orthostatic hypotension (blood pressure drops with positional changes), anxiety, Alzheimer's disease. The MDS also noted that Resident #1 required limited assistance of 1 staff person for most ADLs (activities of daily living) skills including transfer and ambulation. The MDS indicated the resident had inattention, disorganized thing and a BIMS (Brief Interview for Mental Status) score of 0. A score of 0 identified the resident as severely impaired cognitively. The MDS indicated the resident received antipsychotic and antianxiety medications as prescribed. The Care Plan dated 3/30/17 noted the resident to be at risk for falls and instructed staff to keep the bed in the lowest position and a landing mat at the bedside. Revisions noted that a one way slide to the bed had been implemented on 4/3/17, a one way slide to the recliner and a concave mattress on r/8/17, 15 minutes checks when in bed at night on the 5/15/17, gripper socks on at all times on 7/19/17 and Dycem (material placed in seat to keep from sliding) to the wheelchair on 8/1/17,	F 689		

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F 689	Continued From page 9 The Fall Risk Evaluation dated 5/1/17 identified Resident #1 at high risk for falling. A Nurse's Note dated 7/11/17 at 3:50 p.m. indicated the staff found Resident #1 sitting on the floor in front of her recliner with the leg resident still up in place. According to the note, family had been notified and agreed to call visitors that had been there to instruct them Resident #1 should not be left alone in her room. A Nurse's Note dated 7/19/17 at 2:10 a.m. noted staff observed the resident lying face down on the ground near her roommate's bed with a laceration to her upper lip and complaints of bilateral (both) hip pain, right knee pain and facial pain. An x-ray dated 7/24/18 noted an fracture of the ulna (forearm bone) and not identified on a previous x-ray. The subsequent x-ray was ordered because of continuing pain from an injury sustained in the 7/19/17 fall. A Nurse's Note dated 7/31/17 at 10:30 p.m. noted Resident #1 fell trying to get out of her wheelchair and sat on the pedals. A Nurse's Note dated 8/7/17 at 9:25 p.m. indicated Resident #1 was left under the direct supervision of a CNA (certified nursing assistant) at the nurses' station. According to the nurse, she heard a CNA calling for assistance and saying "She's on the floor". The nurse noted that she arrived to find the resident lying on her right side and complained of right hip pain. The nurse obtained orders to send the resident to the emergency room. A Nurse's Note dated 8/7/17 at 1:00 a.m. noted	F 689		

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F 689	Continued From page 10 the physician admitted the resident to the hospital with a right hip fracture. On 2/20/18 at 3:30 p.m., Staff B, CNA, was interviewed and stated she remembered the resident at the nurses' station, sitting in her wheelchair. This is when they went to answer call lights. Staff B stated they found the resident on the floor when they returned. Staff B stated although Staff A, LPN (licensed practical nurse) did not tell her to watch the resident, she knew the resident was a fall risk. Staff B stated she did not hear an alarm sounding when the resident fell, but the resident typically had an alarm on the recliner and the wheelchair. Staff B stated the resident would not sit still, she kept getting up and down. As a result, Staff B stated they took her out to the nurses' station to keep a better eye on her, but she ended up falling any way. Staff B stated the resident would just get up on her own and go; she did not understand that she shouldn't. Staff B stated a co-worker and her were only gone 5 minutes from the nurses' station. Staff B stated she found the resident lying on the floor by the cabinets near the nurses' station. Staff B stated she told Staff C to get the nurse. On 2/20/18 at 3:47 p.m., Staff A was interviewed and stated the resident seemed anxious and restless, which warranted one to one supervision. Staff A stated Resident #1 kept setting off the chair alarm so they transferred her into the wheelchair. Staff A and Staff C were behind the nurses' station charting. Staff A stated she told them to supervise the resident while she went to complete her duties. Staff A stated she could not recall if the alarm got transferred from the recliner to the wheelchair, but should have been transferred. Staff A stated the resident should be	F 689		

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F 689	Continued From page 11 behind the nurses' station because they probably could not have gotten to her in time if she self-transferred. Staff A stated she heard the CNAs calling her to the nurses' station from the end of the 400 hall. Staff A stated once she assessed the resident and obtained orders to send her to the emergency room, she asked the CNAs how she could have fallen once she told them to provide one to one supervision. According to Staff A, they told her they left Resident #1 unattended to answer call lights. Staff A stated she thought the incident could have been prevented if they had supervised her as they were told. Staff A stated it would have eventually happened anyway. On 2/21/18 at 11:35 a.m. Staff C, CNA, was interviewed and stated the resident had sat in her wheelchair behind the nurses' station. Staff C stated she thought her and Staff B were charting. Staff C stated staff A told her to provide one to one supervision to Resident #1 although the behaviors the resident exhibited required close supervision. Staff C stated she remembered Resident #1 getting up frequently and wandering. Staff C stated a resident that required assistance of 2 staff persons had activated the call light and they left to attend to that resident. Staff C stated she could not remember where the nurse was when they left, but they were gone only for about 5 minutes. Staff C stated they found the resident alone on the floor crying out in pain returned. Staff C stated the resident remained in the same position until the ambulance arrived. On 2/21/18 at 12:15 p.m. the Director of Nursing (DON) was interviewed and stated the staff are to remain with a resident if they had been instructed to provide one to one supervision. The DON	F 689		

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F 689	Continued From page 12	F 689		

stated if the nurse did not specify how long they should supervise the resident; it should be assumed they should supervise until hearing otherwise. The DON stated they should inquire or bridge any communication gaps before leaving the resident unsupervised.

2. Resident #68 had a MDS assessment with a reference date of 2/22/18. The MDS identified the resident had diagnosis that included anxiety, urinary tract infection, and Alzheimer's disease. According to the MDS, the resident had short and long-term memory problems and inattention and disorganized thinking. The MDS indicated the resident required limited assistance of 1 staff member for transfers, locomotion on and off the unit and used a wheelchair.

The Care Plan dated 10/21/16, indicated the resident needed assistance with activities of daily living (ADLs) and the resident's primary mode of locomotion is wheelchair propelled by staff.

Observation on 02/19/18 at 11:01 AM, Staff P (CNA) pushed Resident #68 from the TV area to the dining area with no foot pedals on the wheelchair. Staff P pushed the resident in the wheelchair for approximately 22 yards.

Observation on 02/21/18 at 08:41 AM Staff P, CNA pushed resident #68 from the dining area to the TV area with no foot pedals on the wheelchair, approximately 22 yards.

On 02/22/18 at 08:28 AM Staff Q, Nurse Manager was interviewed and stated she would expect staff to use foot pedals while pushing residents.

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F 689	Continued From page 13 Pushing a resident in a wheelchair without foot pedals can be considered hazardous. In the event the resident lowered feet onto the floor, the resident can be propelled out of the chair and onto the floor. The resident can also injure feet and ankles.	F 689		
F 725 SS=E	Sufficient Nursing Staff CFR(s): 483.35(a)(1)(2) §483.35(a) Sufficient Staff. 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). §483.35(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. §483.35(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. This REQUIREMENT is not met as evidenced by:	F 725		

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F 725	Continued From page 14 Based on record review and staff and resident interviews, the facility failed to have adequate nursing staff to answer call lights promptly (within 15 minutes) for Residents #43, 45, 54, 55, 329, and failed to provide adequate supervision and assistance for residents in the activity dining room who required assistance during mealtimes for 2 of 2 meal observations. The facility reported a census of 81 residents. Findings include: 1. According to the MDS (minimum data set) with a reference date of 2/22/18 revealed Resident #45 had a BIMS (brief interview of mental status) score of 15, indicating no cognitive impairment. The MDS indicated Resident #45 required limited assistance of 1 person for bed mobility, transfers, dressing, and toilet use. The MDS indicated Resident #45 was always continent of urine and occasionally incontinent of bowel. The MDS listed the following diagnoses for Resident #45: hypertension, morbid obesity, constipation, insomnia, BMI (body mass index) greater than 70, pain to bilateral knees, and asthma. Review of Resident #45's Care Plan, with a revision date of 1/30/18, identified she required assistance of 1 staff person with personal hygiene, bed mobility, dressing, ambulating in room, and transfers in room. The Care Plan indicated the resident's primary mode of locomotion is a powered wheelchair that is propelled by her, can she can use a walker with ambulation. Resident #45 required assistance of 2 staff members with bathing, ambulation, and transfers. During a resident interview on 02/19/18 at 11:26	F 725		

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F 725	Continued From page 15 AM, she stated she had to wait an hour with her call light on. She stated while waiting, she was incontinent of urine and stool. When asked how this made her feel, she stated she felt awful and at times degrading. When asked how she could keep track of the time, Resident #45 showed me her I-Pad tablet and clock that was on the wall across from her bed. Resident #45 stated she has used her iPad tablet to call the nurse's station to tell them she needed assistance. Resident #45 stated they have been short staffed for a while. Resident #45 stated she has heard staff say they cut staff because of the low census. Resident #45 stated she had seen some staff in tears because they are so busy. Review of the Alarm Response report revealed the following responses for the last 30 days: 2/21/18 38 minutes and 19 seconds, 2/20/18 23 minutes and 20 seconds, 2/20/18 20 minutes and 47 seconds, 2/19/18 20 minutes and 06 seconds, 2/19/18 32 minutes and 01 second, 2/18/18 26 minutes and 52 seconds, 2/18/18 25 minutes and 13 seconds, 2/18/18 23 minutes and 53 seconds, 2/16/18 24 minutes and 18 seconds, 2/14/18 26 minutes and 36 seconds, 2/13/18 44 minutes and 08 seconds, 2/13/18 45 minutes and 27 seconds, 2/12/18 41 minutes and 23 seconds, 2/12/18 22 minutes and 17 seconds, 2/11/18 23 minutes and 44 seconds, 2/10/18 25 minutes and 34 seconds, 2/10/18 22 minutes and 45 seconds, 2/10/18 29 minutes 38 seconds, 2/9/18 43 minutes 37 seconds, 2/9/18 39 minutes and 02 seconds, 2/8/18 30 minutes and 07 seconds, 2/8/18 21 minutes and 15 seconds, 2/8/18 20 minutes and 02 seconds, 2/7/18 31 minutes and 53 seconds, 2/6/18 21 minutes and 16 seconds, 2/6/18 21 minutes and 44 seconds, 2/4/18 24 minutes and 46 seconds, 2/4/18 29 minutes and 2 seconds,	F 725		

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F 725	Continued From page 16 2/3/18 25 minutes and 46 seconds, 2/3/18 28 minutes and 08 seconds, 2/2/18 37 minutes and 13 seconds, 2/1/18 34 minutes and 49 seconds, 2/1/18 37 minutes and 44 seconds, 1/31/18 30 minutes and 10 seconds, 1/31/18 21 minutes and 22 seconds, 1/30/18 22 minutes and 47 seconds, 1/30/18 53 minutes and 32 seconds, 1/29/18 53 minutes and 38 seconds, 1/28/18 40 minutes and 40 seconds, 1/27/18 25 minutes and 33 seconds, 1/26/18 45 minutes, 1/26/18 1 hour, 22 minutes and 30 seconds, 1/26/18 29 minutes and 39 seconds, 1/25/18 25 minutes and 53 seconds, 1/24/18 33 minutes and 22 seconds, 1/23/18 34 minutes and 07 seconds, 1/22/18 23 minutes and 04 seconds. 2. According to the MDS with a reference date of 2/22/18 revealed Resident #55 had BIMS of 15, indicating no cognitive impairment. The MDS indicated Resident #55 was totally dependent of 2 staff for bed mobility, transfers, toilet use, and bathing. The MDS indicated Resident #55 was occasionally incontinent of urine and bowel. The MDS listed the following diagnoses for Resident #55: hypertension, dementia, anxiety, and depression. Review of Resident #55's Care Plan indicated the staff is to ensure the resident has access to a clock or watch at all times. The Care Plan identified her primary mode of locomotion as a powered wheelchair propelled by her as she did not ambulate at this time. The Care Plan indicated Resident #55 required the assistance of 2 staff members with transfers, toileting, and bathing and used a bedpan. The Care Plan indicated Resident #55 required a Hoyer lift for transfers.	F 725		

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F 725	Continued From page 17 During a resident interview on 02/19/18 at 11:06 AM Resident #55 said she has had to wait 30 minutes from staff to answer to call light, while on bed pan. Resident #55 stated some staff will just answer call light and leave, never return. Resident #55 stated she believes they are short staffed and it wasn't like this when she first came in to the facility. Review of the Alarm Response Report revealed the following response times from the last 30 days: 2/21/18 - 20 minutes and 19 seconds, 2/21/18 - 23 minutes and 08 seconds, 2/16/18 - 25 minutes and 34 seconds, 2/16/18 - 22 minutes and 43 seconds, 2/16/18 - 43 minutes and 17 seconds, 2/13/18 - 20 minutes and 32 seconds, 2/12/18 - 21 minutes and 26 seconds, 2/12/18 21 minutes and 31 seconds, 2/12/18 31 minutes and 10 seconds, 2/11/18 20 minutes and 45 seconds, 2/10/18 30 minutes and 58 seconds, 2/9/18 38 minutes and 36 seconds, 1/27/18 20 minutes and 40 seconds, 1/27/18 23 minutes and 49 seconds, 2. Review of Resident #329's baseline Care Plan completed upon admission on 2/15/18 identified the resident as alert and cognitively intact and is verbal. The Care Plan listed Resident #329's vision and hearing as adequate. The Care Plan indicated Resident #329 required assistance of 2 staff for bed mobility, transfers, toileting and utilizes a wheelchair. The Care Plan listed Resident #329 as being incontinent of urine and bowel. Review of Resident #329's diagnosis/history worksheet revealed the following diagnoses: sepsis, alcohol abuse, nicotine abuse, depression, anxiety, and acute kidney failure.	F 725		

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F 725	Continued From page 18 During a resident interview on 02/19/18 at 1:10 PM, Resident #329 stated he knows they are short staffed. Resident #329 stated he has had to wait 20-30 minutes to use the bathroom. Resident #329 stated he has had accidents of bowel and bladder incontinence and it's humiliating. Resident stated he uses his cell phone to watch for the time. During the interview his cell phone was located in his shirt pocket. Review of the Alarm Response Report for 2/16/18-2/21/18 revealed the following response times: a) 2/18/18 40 minutes and 04 seconds b) 2/18/18 55 minutes and 38 seconds c) 2/18/18 22 minutes and 14 seconds d) 2/17/18 20 minutes and 20 seconds. During a staff interview on 2/21/18 at 01:34 PM, Staff M CNA (certified nursing assistant) stated she usually works 6 am-PM, mainly on the 200 hall. Staff M stated all CNAs work together on each hall. She stated staffing does get short when people call in, but the Administrator and Director of Nursing (DON) are on the phone calling to get staff in here. She states it is hard to get to all of the call lights in a timely manner because of the number of residents, but they do try hard to get to them. The Administrator and DON will try to jump in and answer call lights too. During a staff interview on 02/21/18 at 1:45 PM Staff O CNA stated she thinks call lights don't get answered in a timely fashion and a lot of tasks get pushed back because of this. During a staff interview on 02/21/18 at 2:35 PM	F 725		

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F 725	Continued From page 19	F 725		

Staff L CNA stated she usually works 6 am-PM. Staff L stated there are 3-4 aides that share the 100, 200, 300 halls, 2 aides on the 400 hall and 2 aides on the 500 hall. When asked if she felt like there are enough staff to complete everyday tasks, she stated not at all times. When asked if staff can get to call lights in a timely fashion, she stated there are times they can't get to them. Staff L stated there are some residents that require 20-40 minutes of their time if it's their bath days, so that takes time away from other residents. She also stated she gets pulled from doing restorative and to the floor to help when there have been call ins. When that happens, restorative therapy gets put on the back burner and at times it is not getting done.

During a staff interview on 02/21/18 at 03:30 PM Staff H CNA state she works 2-1, stated she is usually on main which is halls 100, 200, 300. Staff H stated they all work together to get stuff done on all the halls. When asked if she felt that they are staffed adequately she stated not usually and they try to do their best to make sure the residents are taken care of. She stated she was told their census was low so they started cutting staff to 3 on main. She stated it gets hard to get everything done when they have a lot of people that require a Hoyer lift. She stated running short staffed with their population is hard. When asked if she felt they were getting to the call lights in a timely fashion she stated no, it takes a while and they try to get to them as soon as they can.

During a staff interview on 9/22/18 at 9:42 am, the DON stated staff are required to answer call lights within 15 minutes. When asked how staff know when a call light is activated, the DON stated there is a marque (digital reader) at the

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F 725	Continued From page 20 end of each hall. When a call light is activated it reads on the marque until the light is shut off. The DON stated all CNAs have pagers that will alarm when a call light is activated. It initially alarms when it's been activated, then another alarm every 5 minutes until it shuts off. The DON stated only the CNAs have the pagers. 4. Resident #43 had a MDS assessment with a reference date of 2/7/18. The MDS identified the resident had diagnosis that included a fractured right tibia and fibula (two leg bones below the knee). The MDS documented the resident had a BIMS score of 15. A BIMS score of 15 identified the resident had no cognitive impairments. The MDS documented the resident required extensive assistance of two staff members for bed mobility and toileting, and had total dependence on two staff for transfers. The MDS documented the resident had bladder incontinence. The Care Plan dated 4/17/13, documented the resident required assistance with activities of daily living. The Care Plan directives included no weight bearing to the right lower extremity, use a Hoyer lift and assistance of 2 staff for transfers, and assistance of one staff when toileted. In an interview on 02/19/18 at 11:27 AM, Resident #43 stated she had waited quite a while at times before staff answered her call light. Review of the Code Alert Alarm Response Report revealed Resident #43 had the following call light response times documented: 2/1/18 -11:24 AM = 47.48 minutes 2/2/18 - 4:26 AM = 20:44 minutes 2/3/18 -12:34 AM = 46.28 minutes 2/3/18 -11:35 AM = 26:40 minutes	F 725		

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F 725	Continued From page 21 2/5/18 - 4:19 AM = 16:46 minutes 2/5/18 - 10:39 AM = 21:56 minutes 2/6/18 - 7:01 AM = 25:42 minutes 2/7/18 - 4:49 PM = 22:56 minutes 2/8/18 - 7:06 AM = 41:05 minutes 2/8/18 - 3:31 PM =18:48 minutes 2/8/18 - 4:28 PM = 23:17 minutes 2/11/18 - 3:26 PM = 25:49 minutes 2/12/18 - 12:29 AM = 27:43 minutes 2/12/18 - 6:19 PM = 25:26 minutes 2/17/18 - 12:38 PM = 16:00 minutes 2/17/18 - 5:14 PM = 29:38 minutes 2/19/18 - 7:58 PM = 29:26 minutes 5. The MDS assessment dated 2/9/18 recorded Resident #54 had diagnoses that included heart failure, seizures, dementia, and shortness of breath. The MDS documented the resident had a BIMS score of 15. The MDS documented the resident required extensive assistance of two staff for bed mobility, transfers, and toilet use. The MDS documented the resident had bowel incontinence. In an interview on 2/19/18 at 2:02 PM, Resident #54 stated he had waited up to an hour before staff answered his call light and provided assistance. The resident reported on 2/17/18, he had soiled his pants while he waited for staff assistance and had call light answered. Review of the Code Alert Alarm Response Report revealed Resident #54 had the following call light response times documented: 1/22/18 -7:44 AM 37:02 minutes 1/22/18 -3:13 PM 33:01 minutes 1/24/18 -2:28 PM 24:12 minutes 2/17/18 -1:32 AM 25:26 minutes	F 725		

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F 725	Continued From page 22 2/21/18 -9:19 AM 21:12 minutes In an interview on 2/21/18 at 2:35 PM, Staff R, CNA, and Staff T, CNA, reported 2 CNA's assigned to 400 hall, 2 CNA's assigned to the 500 Hall, and 4 CNA's assigned to the Main Hall (which included Halls 100, 200, & 300); Staff T reported they currently had 21 residents in the 400 hall, 15 of those residents required the assistance of 2 staff for transfers, or residents who used a Hoyer. Staff R reported the 400 Hall had a heavy load of residents in terms of the type of cares needed. Staff R and Staff T stated when staff called in due to illness or other absence, the facility rarely replaced the staff person, so staff had worked short. Staff R reported she had difficulty answering all of the call lights during certain times of the day. Staff R stated the beeper she carried had gone off several times, and she tried to get to residents as soon as possible, and knew residents had waited longer than 15 minutes for assistance. Staff T stated she doesn't think there is enough staff to care for the types of residents at the facility, and when census dropped, the facility cut staff. In an interview 2/21/18 at 4:55 PM, the Director of Nursing (DON), shared the call light audit. The DON stated she identified a problem with call light response times and an action plan was developed on 7/26/17. The DON reported she started doing call light audits in 9/17, after they had identified a problem with call lights not answered timely. The DON reported she audited the room number, amount of time it took before staff answered the call lights, and the time of day when it took greater than 15 minutes before staff responded to call lights. The DON attributed call light response delayed when had a holiday and	F 725		

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F 725	Continued From page 23 when less staff worked 6. Observations of the Activity Dining Room revealed the following: On 2/20/18 - 8:08 AM, residents in the Activity dining room (ADR) and no facility staff in or by the ADR. - 8:12 AM , no facility staff in the area - 8:17 AM, Staff R, Certified Nursing Assistant (CNA) walked into the ADR and wheeled Resident #46 in a wheelchair (w/c) out of the ADR. - 8:18 AM, No staff in ADR - 8:19 AM, Staff R, CNA, walked past ADR, looked into the ADR, and then walked down the hall. 14 residents in ADR. - 8:20 AM No staff in or near ADR. 13 residents in area at this time eating breakfast and conversing with tablemates. -8:22 AM, 14 residents in ADR and no staff in the area -8:24 AM, Staff S, Licensed Practical Nurse (LPN) walked into ADR and gave Resident #53 a cup of medications, then left the ADR. On 2/21/18 -8:10 - 8:22 AM, 15 Residents in the Activity DR, no staff in the area. -8:23 AM, Resident #47 walked down hall holding pants up. The resident had saliva that hung from his beard. The resident stopped by the ADR and stated he needed someone to help him because his pants had fallen down. -8:24 AM Staff M, CNA, stopped and assisted Resident #47 as she walked down the hall, then left the ADR. - 8:25 AM Dietary staff served Resident #47 breakfast, then wheeled the cart to the kitchen.	F 725		

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F 725	Continued From page 24 Eighteen residents remained in the ADR at this time. - 8:26 AM Resident #53 propelled electric wheelchair to ADR. Resident #10 thrusted upper body and attempted to propel and move w/c forward. The resident had blocked the ADR doorway. Resident #53 asked Resident #10 if she wanted him to get someone to help her. At that time, the Dietary Manager walked by and asked to help Resident #10. then wheeled the resident down the hall toward the main DR. - 8:35 AM, Resident #53 propelled electric w/c down hall to the Main DR and requested a CNA to go to the ADR. - 8:37 AM A CNA from the main DR walked down the hall, entered the ADR, and assisted Resident #110. The nutritional evaluation dated 2/17/18, documented the Resident #54 had dysphagia. The dietician documented the resident currently missing dentures, but tolerated food fine. In an interview on 2/21/18 at 2:35 PM, Staff R, CNA, and Staff T, CNA, reported the facility expected all of the CNA's in the Main DR during mealtime, where most of the residents needed assistance with feeding. No staff were assigned to the ADR. If a resident in ADR needed assistance, sometimes activity staff in their office, next to the DR, assisted the resident but activity staff not always in the office during mealtime. Staff R stated another resident may also let them know when a resident needed assistance in the ADR. If a resident in the ADR not eating or resident required additional feeding assistance and needed moved to the Main DR, then dietary staff let them know.	F 725		

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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 726	Continued From page 25	F 726		
F 726 SS=D	Competent Nursing Staff CFR(s): 483.35(a)(3)(4)(c) §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). §483.35(a)(3) The facility must ensure that licensed 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. §483.35(a)(4) Providing care includes but is not limited to assessing, evaluating, planning and implementing resident care plans and responding to resident's needs. §483.35(c) Proficiency of nurse aides. The facility must ensure that nurse aides are able to demonstrate competency in skills and techniques necessary to care for residents' needs, as identified through resident assessments, and described in the plan of care. This REQUIREMENT is not met as evidenced by: Based on record review, facility policy review and staff interviews, the facility failed to assess 1 of 3 residents reviewed prior to transferring them after a fall with a suspected hip fracture (Residents	F 726		

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F 726	Continued From page 26 #2). The facility reported a census of 81 residents. Findings include: According to the Minimum Data Set (MDS) assessment tool dated 10/19/17, Resident #2 had diagnoses of diabetes, dementia, Parkinson's disease, difficulty walking, lack of coordination, anxiety disorder and depression. The MDS noted Resident #2 required extensive assistance of one staff for some Activities of Daily Living (ADLs) including transfers, and limited assistance of one staff for the others. The MDS documented Resident #2 displayed inattention, disorganized thinking, and moderately impaired daily decision making skills. The MDS documented Resident #2's history of falls and use of antipsychotic, antianxiety and narcotic pain medication. The Care Plan dated 9/13/17 documented Resident #2 as at risk for falls and instructed staff to put gripper socks on her feet at all times, keep her bed in the lowest position and against the wall, use a landing mat at bedside, and apply hipster pads at all times. The Care Plan documented the resident preferred to be up in the recliner at 3:00 a.m. every day, have two staff to assist her with transfers, ambulation (walking), bed mobility, dressing, toilet use and bathing, and to use a baby monitor in her room while she sat in the recliner. The facility revised the Care Plan as follows: Applied a winged mattress to bed on 9/21/17, complete hourly checks beginning on 10/2/17, use a weighted blanket at times on 10/9/17, added a one way slide to the bed on 4/3/17, a one way slide to the recliner and a concave mattress on 4/18/17, assistance of one for transfers, ambulation and toilet use on	F 726		

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F 726	Continued From page 27 4/20/17, hipsters on when up on 5/3/17, fifteen minute checks when in bed at night on 5/15/17, gripper socks on at all times on 7/19/17, and a dycem (non-skid pad) to the wheelchair on 8/1/17. The Falls Protocol Quick Reference dated January 2015 directed the charge nurse to complete a head to toe assessment after a fall occurs. The Protocol instructs staff to administer first aid as the resident's condition warrants and to document the account of the fall and the follow up in nurse's notes. The 10/16/17 Fall Risk Evaluation documented Resident #2 was a high fall risk. A Nurse's Note dated 10/29/17 at 4:30 a.m. documented the nurse found Resident #2 on the floor lying on her back complaining of left hip pain. They sent the resident to ER for an evaluation and treatment. A Nurse's Note dated 10/29/17 at 6:00 a.m. noted that after calling the hospital for an update, Resident #2 sustained a hip fracture. A Nurse's Note dated 10/29/17 at 7:30 a.m. recorded a late entry for 3:40 a.m. Staff E, LPN documented that she had been called to the nurse's station to assess the resident. According to the nurse, Resident #2 complained of pain to her left hip area, but could not rate the pain. The nurse noted that Resident #2 displayed pain that the nurse rated 6 out of 10 according to the pain aid. The nurse noted the left lower extremity appeared slightly shorter than the right with outward rotation. The resident could not complete active range of motion to the left leg. Staff	F 726		

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F 726	Continued From page 28 obtained orders had been obtained to send the resident to the ER. A Nurse's Note dated 10/29/17 at 11:00 p.m. recorded a late entry for 10/29/17 at 3:30 a.m. Staff F, LPN noted that she sat behind the nurse's station charting at 1:45 a.m. while Resident #2 rested in the recliner. The nurse noted that she stood up to find the resident lying on her back at the beginning of 200 hall. The nurse documented that the aids came down the hall from completing their rounds at 3:15 a.m. and the nurse went to get the blood pressure cuff and thermometer at that time. According to the nurse, she pushed the wheelchair behind the resident as the CNAs lifted her into the wheelchair. Because of being unable to obtain vital signs, the nurse noted they transferred the resident from her wheelchair into another chair. The nurse documented noted the resident complained of left hip pain as she held her hip and Staff F administered pain medication. According to Staff F, she went to get Staff E at 3:45 a.m. to assess the resident and because the resident continued to complain of pain. Staff F said they decided Resident #2 needed to be transported. EMTs arrived at 4:15 a.m. X-ray results from the ER on 10/29/17 revealed a left hip fracture that resulted after a fall. An Employee Coaching Worksheet dated 10/29/17 noted Staff F failed to assess a resident and failed to use a gait belt to transfer that resident that had fallen. An interview on 2/20/18 at 1:00 p.m. with the Administrator revealed that Staff F no longer worked at the facility and could not be reached for	F 726		

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F 726	Continued From page 29 an interview. The Administrator said the facility disciplined Staff F for not consulting Staff E to assess Resident #2 before they transferred her off the floor. Through their investigation, the Administrator thought Resident #2 fell about 2:30 a.m., and Staff F summoned Staff G, RN and Staff E about 45 minutes after the fall; they assessed the resident because Staff F had not. The Administrator reported Staff F's charting indicated she gave Resident #2 pain medication, but did not assess her after she held her hip and complained of hip pain. An interview on 2/20/18 at 1:45 p.m. with Staff D, CNA, revealed Staff D said they went down 200 hall to round about 2:30 a.m. after she got report from her coworker. The CNA said about 3:00 a.m., she and the other CNA walked up the hall and the nurse approach Resident #2 who was on the floor. Staff D said they arrived about the same time the nurse did. Staff D said she could see Staff F had not done anything yet, but the other CNA went behind Resident #2 and sat her up on the ground while the nurse brought the wheelchair up behind her and transferred her into it. Staff D said the other CNA and the Staff F then transferred Resident #2 from the wheelchair to the recliner. Staff D said she knew she should have stopped her because you should never pick a resident up without a gait belt and without a nurse assessing them first. Staff D said she sat down beside the resident and held her hand. The CNA said Resident #2 said "I think I did a good one, I think I broke my hip" as she cried in pain. Staff D said Staff F did not intend to call anyone but wait for the day shift to come in instead. Staff D told her she needed to do act now. Staff D said she believed a half an hour passed before Staff F called Staff E and Staff G to help.	F 726		

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F 726	Continued From page 30 In an interview on 2/20/18 at 3:45 p.m. with Staff E confirmed Staff F solicited her help after Resident #2 slipped out of the recliner at the nurse's station. In an interview on 2/21/18 at 12:15 P.M., the DON stated Staff F should have assessed the resident before moving her from where they found her on the floor.	F 726		
F 760 SS=D	Residents are Free of Significant Med Errors CFR(s): 483.45(f)(2) The facility must ensure that its- §483.45(f)(2) Residents are free of any significant medication errors. This REQUIREMENT is not met as evidenced by: Based on clinical record review and staff interviews, the facility failed to ensure residents were free of significant medication errors when the facility failed to administrator the correct dosage of Coumadin (a blood thinner) as ordered by the physician (Resident #54). On, 11/29/18, the physician ordered staff to (increase) Coumadin to 7 mg daily. The staff gave 1 mg daily from 11/30/17 to 12/5/17 (6 days). The facility reported a census of 81 residents. Findings include: According to the Minimum Data Set (MDS) assessment tool dated 10/31/17, Resident #54 had diagnoses that included heart failure, chest pain, atrial fibrillation, and seizure disorder. The MDS documented the resident had received an anticoagulant during the last 7 of 7 days of the look back period.	F 760		

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F 760	Continued From page 31	F 760		

The Care Plan dated 11/4/16, and revised on 12/21/17, documented Resident #54 as at risk of increased bleeding because he was on an anticoagulant (medication to prevent blood clots). The care plan directed staff to obtain labs as ordered, monitor for signs of bleeding, and administer medications as ordered.

The Nurse's Notes revealed the following:

a) 11/29/17 at 10:30 AM - Staff received an order to increase Coumadin (medication to prevent blood clots) to 7 mg daily and recheck PT/INR (lab to assess effect of anti-coagulant) on 12/7/17
b) 12/6/17 at 5:30 PM - Staff received new orders: give Coumadin 10 mg and Lovenox one time, draw PT/INR in the morning and call for dose afterwards.
d) 12/7/17 at 4:10 PM - Labs were drawn and staff held the Coumadin until lab the facility received results.
e) 12/8/17 at 1:50 AM - Staff administered Lovenox and called the lab for results as they weren't back yet.
f) 12/8/17 at 8:30 AM - PT/INR drawn and staff received new orders to draw PT/INR daily (12/7/17 INR =1.1) and continue with Lovenox twice daily as ordered. The physician also ordered staff to administer Coumadin 10 mg that day and then call clinic daily for Coumadin dosing orders.
g) 12/9/17 at 10:10 AM - Staff received INR results (1.1) and called the results to the clinic.

The lab reports revealed the following:

Date	PT	INR
11/16/17	14.1	1.5

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F 760	Continued From page 32 12/9/17 10.4 1.1 The resident's November & December 2017 MARs revealed staff documented (initialed) Coumadin 7 mg administered daily on 11/29, 11/30, 12/1, 12/2, 12/3, 12/4, and 12/5. A Medication Error Report dated 12/7/17 revealed on 11/29/18 the physician ordered staff to (increase) Coumadin to 7 mg daily. The nurse then removed the 6 mg tablet from the medication cart and returned the medication card to pharmacy per protocol. The pharmacy sent a 1 mg pill to the facility. Staff gave the Coumadin 1 mg daily from 11/30/17 to 12/5/17 (6 days). The facility discovered the error when the PT/INR levels were not therapeutic. No communication from pharmacy regarding the 6 mg pill returned from the facility. The incident occurred when the physician changed the Coumadin to 7 mg daily (from Coumadin 6 mg daily). In an interview 2/22/18 at 9:10 AM, Staff U, Primary Care Provider, reported Resident # 54 had been on Coumadin 6 mg daily, but the dose was increased to 7 mg daily on 11/29/17. When INR levels continued to drop or were below normal range, she asked if the resident had received the medication. At that time, she reported the facility staff became upset and thought she had accused staff of not administering the medication. Staff U reported several days later, on 12/6/17, she received notification the resident had only received Coumadin 1 mg. The facility reported the error occurred due to a pharmacy error. She ordered Coumadin 10 mg, Lovenox 0.9 ml, and draw INR daily. Staff U reported a d-dimer (lab to check a level in the blood that, if elevated, could indicate	F 760		

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F 760	Continued From page 33 possible formation of a blood clot) was completed and found to be elevated, so she ordered a CT (Cat Scan) to rule out pulmonary embolism (blood clot in lungs). In an interview 2/22/18 at 9:30 AM, Staff Q, Unit Manager, reviewed Resident #54 records, including nurse's notes, Dr orders, and PT/INR levels. Staff Q reported she recalled an issue related to the resident's Coumadin dose changed, a medication error occurred, and a medication error report completed. Staff Q related the facility received a call from the clinic regarding a concern about low INR levels despite increased an Coumadin dosage for Resident #54. Staff Q helped the staff discover what happened. The nurse thought she gave Coumadin 7 mg, but the pharmacy had a sent medication card that contained Coumadin 1 mg. After the DON spoke with pharmacy, it was determined, there should have been 2 medication cards, 1 which contained 6 mg dose, and 1 which contained 1 mg dose to equal total dose of 7 mg. In an interview 2/22/18 at 9:50 AM, the Director of Nursing (DON) reported she spoke with pharmacy and the nurse involved after medication error discovered. The pharmacy thought the nurse had administered Coumadin 6 mg from the medication card already in the medication cart, and sent a medication card that contained Coumadin 1 mg when the Coumadin order changed. The DON reported there should have been 2 medication cards that contained Coumadin for the resident, but there was only 1 card in the medication cart. The label affixed to the medication card showed 7 mg but the nurse misinterpreted the label; the card actually contained Coumadin 1 mg. The resident received	F 760		

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F 760	Continued From page 34 Coumadin 6 mg instead of 7 mg for 6 days, until the error was discovered. The resident had no adverse outcome or side effects, but had additional labs drawn and a chest CT performed.	F 760		
F 838 SS=D	Facility Assessment CFR(s): 483.70(e)(1)-(3) §483.70(e) Facility assessment. The facility must conduct and document a facility-wide assessment to determine what resources are necessary to care for its residents competently during both day-to-day operations and emergencies. The facility must review and update that assessment, as necessary, and at least annually. The facility must also review and update this assessment whenever there is, or the facility plans for, any change that would require a substantial modification to any part of this assessment. The facility assessment must address or include: §483.70(e)(1) The facility's resident population, including, but not limited to, (i) Both the number of residents and the facility's resident capacity; (ii) The care required by the resident population considering the types of diseases, conditions, physical and cognitive disabilities, overall acuity, and other pertinent facts that are present within that population; (iii) The staff competencies that are necessary to provide the level and types of care needed for the resident population; (iv) The physical environment, equipment, services, and other physical plant considerations that are necessary to care for this population; and (v) Any ethnic, cultural, or religious factors that may potentially affect the care provided by the	F 838		

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F 838	Continued From page 35 facility, including, but not limited to, activities and food and nutrition services. §483.70(e)(2) The facility's resources, including but not limited to, (i) All buildings and/or other physical structures and vehicles; (ii) Equipment (medical and non- medical); (iii) Services provided, such as physical therapy, pharmacy, and specific rehabilitation therapies; (iv) All personnel, including managers, staff (both employees and those who provide services under contract), and volunteers, as well as their education and/or training and any competencies related to resident care; (v) Contracts, memorandums of understanding, or other agreements with third parties to provide services or equipment to the facility during both normal operations and emergencies; and (vi) Health information technology resources, such as systems for electronically managing patient records and electronically sharing information with other organizations. §483.70(e)(3) A facility-based and community-based risk assessment, utilizing an all-hazards approach. This REQUIREMENT is not met as evidenced by: Based on observation, review of facility assessment, and resident and staff interview, the facility failed to adequately evaluate their resident population and identify required resources and staffing levels needed to provide the necessary care and services needed for residents. The facility reported a census of 81 residents. 1.The MDS assessment dated 2/9/18 recorded Resident #54 had diagnoses that included heart	F 838		

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F 838	Continued From page 36 failure, seizures, dementia, and shortness of breath. The MDS documented the resident had a BIMS score of 15 out of 15, which indicated intact cognition. The MDS documented the resident required extensive assistance of two staff for bed mobility, transfers, and toilet use. The MDS documented the resident had bowel incontinence. The nutritional evaluation dated 2/17/18, documented the resident had dysphagia (difficulty swallowing). The dietician documented the resident currently missing dentures, but tolerated food fine. In an interview on 02/19/18 at 2:02 PM, Resident # 54 stated he had waited up to an hour before staff answered his call light and provided assistance. The resident reported he had soiled his pants while he waited for staff to respond to the call light on 2/17/18. Review of the Code Alert Alarm Response Report revealed Resident #54 had the following call light response times documented: 1/22/18 -7:44 AM 37:02 minutes 1/22/18 -3:13 PM 33:01 minutes 1/24/18 -2:28 PM 24:12 minutes 2/17/18 -1:32 AM 25:26 minutes 2/21/18 -9:19 AM 21:12 minutes 2. The MDS assessment dated 2/7/18, recorded Resident #43 had diagnoses that included a fractured right tibia and fibula (two leg bones below the knee) .The MDS documented the resident had a BIMS score of 15 out of 15, which indicated intact cognition. The MDS documented the resident required extensive assistance of two	F 838		

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F 838	Continued From page 37	F 838		

staff for bed mobility and toileting, and was totally dependent on two staff for transfers. The MDS documented the resident experienced bladder incontinence.

The Care Plan dated 4/17/13, documented the resident required assistance with activities of daily living. The care plan directives included no weight bearing to the right lower extremity, Hoyer lift and assistance of 2 staff for transfers, and assistance of one staff with toilet use.

In an interview on 2/20/17 at 11:27 AM, Resident # 43 stated she had waited quite a while at times before she had call light answered.

Review of the Code Alert Alarm Response Report revealed Resident #43 had the following call light response times documented:

2/1/18 -11:24 AM = 47.48 minutes
2/2/18 - 4:26 AM = 20:44 minutes
2/3/18 -12:34 AM = 46.28 minutes
2/3/18 -11:35 AM = 26:40 minutes
2/5/18 - 4:19 AM = 16:46 minutes
2/5/18 - 10:39 AM = 21:56 minutes
2/6/18 - 7:01 AM = 25:42 minutes
2/7/18 - 4:49 PM = 22:56 minutes
2/8/18 - 7:06 AM = 41:05 minutes
2/8/18 - 3:31 PM =18:48 minutes
2/8/18 - 4:28 PM = 23:17 minutes
2/11/18 - 3:26 PM = 25:49 minutes
2/12/18 - 12:29 AM = 27:43 minutes
2/12/18 - 6:19 PM = 25:26 minutes
2/17/18 - 12:38 PM = 16:00 minutes
2/17/18 - 5:14 PM = 29:38 minutes
2/19/18 - 7:58 PM = 29:26 minutes

In an interview on 2/21/18 at 2:35 PM, Staff R,

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	165293	A. BUILDING _____ B. WING _____	02/22/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SOUTHERN HILLS SPECIALTY CARE	444 NORTH WEST VIEW DRIVE OSCEOLA, IA 50213

(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 838	Continued From page 38 CNA, and Staff T, CNA, reported 2 CNA's assigned to 400 hall, 2 CNA's assigned to the 500 Hall, and 4 CNA's assigned to the Main Hall (which included Halls 100, 200, & 300); Staff T reported they currently had 21 residents in the 400 hall, 15 of those residents required the assistance of 2 staff for transfers, or residents who used a Hoyer. Staff R reported the 400 Hall had a heavy load of residents in terms of the type of cares needed. Staff R and Staff T stated when staff called in due to illness or other absence, the facility rarely replaced the staff person, so staff had worked short. Staff R reported she had difficulty answering all of the call lights during certain times of the day. Staff R stated the beeper she carried had gone off several times, and she tried to get to residents as soon as possible, and knew residents routinely had waited longer than 15 minutes for assistance. Staff T stated not enough staff to care for the types of residents at the facility, and when census dropped, the facility cut staff. In an interview 2/21/18 at 4:55 PM, the Director of Nursing (DON), shared call light audits done. The DON reported she started doing call light audits in Sept. 2017, after they had identified call lights not answered timely. The DON reported she audited the room number, amount of time it took before staff responded to call lights, and the time of day when it took greater than 15 minutes before staff responded to call lights. The DON attributed call light response delayed during holidays and when less staff had worked. 3. Observations of the Activity Dining Room revealed the following: On 2/20/18	F 838		

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F 838	Continued From page 39 - 8:08 AM, residents in the Activity dining room (ADR) and no facility staff in or by the ADR - 8:12 AM , no facility staff in the area - 8:17 AM, Staff R, Certified Nursing Assistant (CNA) walked into the ADR and wheeled Resident #46 in wheelchair (w/c) out of the ADR. - 8:18 AM, No staff in ADR - 8:19 AM, Staff R, CNA, walked past ADR, looked into the ADR, then walked down the hall. 14 residents in ADR. - 8:20 AM No staff in or near ADR. 13 residents in area at this time eating breakfast and conversing with tablemates. -8:22 AM, 14 residents in ADR and no staff in the area -8:24 AM, Staff S, Licensed Practical Nurse (LPN) walked into ADR and gave Resident #53 a cup of medications, then left the ADR. On 2/21/18 -8:10 AM, 15 Residents in ADR. no staff in the area. -8:23 AM, Resident #47 walked down hall holding pants up. The resident had saliva that hung from his beard. The resident stopped by the ADR and stated he needed someone to help him because his pants had fallen down. -8:24 AM Staff M, CNA, stopped and assisted Resident #47 as she walked down the hall, then left the ADR. - 8:25 AM Dietary staff served Resident #47 breakfast, then wheeled cart to the kitchen. 18 residents in ADR at this time. - 8:26 AM Resident #53 propelled electric wheelchair to ADR. Resident #10 thrust upper body and attempted to propel and move w/c forward. The resident had blocked the ADR doorway. Resident #53 asked Resident #10 if she wanted him to get someone to help her. At	F 838		

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F 838	Continued From page 40 that time, the Dietary Manager walked by and asked to help Resident #10. then wheeled the resident down the hall toward the main DR. - 8:35 AM, Resident #53 propelled electric w/c down hall to the Main DR and requested a CNA to go to the ADR. - 8:37 AM A CNA from the main DR walked down the hall, entered the ADR, and assisted Resident #110. In an interview on 2/21/18 at 2:35 PM, Staff R, CNA, and Staff T, CNA, reported the facility expected all of the CNA's in the Main DR during mealtime, where most of the residents needed assistance with feeding. No staff assigned to the Activity DR. If a resident in ADR needed assistance, sometimes activity staff in their office, next to the DR, assisted the resident but activity staff not always in office during mealtime. Staff R stated another resident may also let them know when a resident needed assistance in the ADR. If a resident in the ADR not eating or a resident required additional feeding assistance and needed moved to the Main DR, then dietary staff let them know. A review of the Facility Assessment dated 10/1/17, included the following: - Average census = 87 - Number of admissions annually = 80 (average 2 per week) - Number of discharges annually = 100 - Average LOS (length of stay) = 27 days - Top 5 diagnosis's of resident population (as coded on the MDS (minimum data set) assessment - Specialty bariatric residents = 5 - Equipment needs - mechanical lifts and bariatric	F 838		

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F 838	Continued From page 41 equipment - Facility resources = bariatric beds/lifts, CCDI unit, outpatient therapy, therapy gym, and spa tub - Services provided = inpatient and outpatient rehab, senior dental, pharmacy, and Brighter Day health services. - Number of personnel and level of education The assessment did not include the number of residents who required the use of mechanical lifts or other devices, or pertinent facts about the condition of residents, physical disabilities, overall acuity of the resident population, or individualized care needs for population of residents at the facility, such as assistance needed for activities of daily living. In an interview 2/22/18 at 11:31 AM, the Administrator reported she received a report from their corporate office that included comorbities identified in the MDS assessment to determine the acuity of their resident population. The Administrator reported she talked to CNA's about which areas had heavier care needs, and if they needed additional staff. When the facility had open rooms, they had staff float to other areas to help, and they monitored and tracked staff hours weekly. When asked about the determination of equipment and supplies required to meet all resident needs, the Administrator reported they had some bariatric equipment at the facility but rented equipment if needed.	F 838		
F 883 SS=D	Influenza and Pneumococcal Immunizations CFR(s): 483.80(d)(1)(2) §483.80(d) Influenza and pneumococcal immunizations §483.80(d)(1) Influenza. The facility must develop	F 883		

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F 883	Continued From page 42 policies and procedures to ensure that- (i) Before offering the influenza immunization, each resident or the resident's representative receives education regarding the benefits and potential side effects of the immunization; (ii) Each resident is offered an influenza immunization October 1 through March 31 annually, unless the immunization is medically contraindicated or the resident has already been immunized during this time period; (iii) The resident or the resident's representative has the opportunity to refuse immunization; and (iv)The resident's medical record includes documentation that indicates, at a minimum, the following: (A) That the resident or resident's representative was provided education regarding the benefits and potential side effects of influenza immunization; and (B) That the resident either received the influenza immunization or did not receive the influenza immunization due to medical contraindications or refusal. §483.80(d)(2) Pneumococcal disease. The facility must develop policies and procedures to ensure that- (i) Before offering the pneumococcal immunization, each resident or the resident's representative receives education regarding the benefits and potential side effects of the immunization; (ii) Each resident is offered a pneumococcal immunization, unless the immunization is medically contraindicated or the resident has already been immunized; (iii) The resident or the resident's representative has the opportunity to refuse immunization; and	F 883		

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F 883	Continued From page 43 (iv)The resident's medical record includes documentation that indicates, at a minimum, the following: (A) That the resident or resident's representative was provided education regarding the benefits and potential side effects of pneumococcal immunization; and (B) That the resident either received the pneumococcal immunization or did not receive the pneumococcal immunization due to medical contraindication or refusal. This REQUIREMENT is not met as evidenced by: Based on clinical record review, policy review and staff interview, the facility failed to obtain consent and provide education regarding influenza vaccination for 4 of 5 current residents reviewed (Residents #14, #24, #25 and #61). The facility identified a census of 81 residents. Findings include: 1. The Minimum Data Set (MDS) assessment tool dated 2/8/18 documented Resident #14 had diagnoses including anemia, anxiety, depression, hypertension, dementia, hypothyroidism and diabetes mellitus. The clinical record included a form titled "Record of T.B. Tests & Immunizations Record" which documented the resident received a influenza vaccination on 10/11/17. The clinical record lacked documentation the facility obtained a consent and provided education about the influenza vaccination, prior to administration. 2. The MDS assessment dated 12/28/17	F 883		

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F 883	Continued From page 44 documented Resident #24 had diagnoses including multiple sclerosis, neurogenic bladder, depression, retrograde amnesia and peripheral vascular disease. The clinical record contained a form titled "Consent or Declination of Influenza Vaccine" which included education on the vaccination and documented a declination, but the form lacked a signature and date. 3. The MDS assessment dated 12/28/17 documented Resident #25 had diagnoses including dementia, hypothyroidism, anxiety, back pain and heart disease. The clinical record contained a form titled "Record of T.B. Tests & Immunizations Record" which documented the resident received a influenza vaccination on 10/10/17. The clinical record lacked documentation the facility obtained a consent and provided education about the influenza vaccination. 4. The MDS assessment dated 1/25/18 documented Resident #61 had diagnoses including hemiplegia, hypothyroidism, arthritis, aphasia and anemia. The clinical record contained a form titled "Record of T.B. Tests & Immunizations Record" which documented the resident received a influenza vaccination on 10/10/17. The clinical record contained a form titled "Consent or Declination of Influenza Vaccine," dated 10/2/12, which documented acceptance of the vaccination. The clinical record lacked	F 883		

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F 883	Continued From page 45 documentation the facility obtained a consent and provided education about the influenza vaccination prior to the current vaccination. During an interview on 2/21/18, at 10:00 a.m., Staff K, Licensed Practical Nurse, reported she has been responsible for the influenza vaccinations for about 5 years. Staff K reported when she took over the responsibility she was told if they already had a signed consent, in a previous year, the education and consent did not need to be done again. Review of the facility policy titled "Influenza/Pneumonia Vaccination," dated 9/2012, requires the provision of education to the resident or representative on risks, benefits, and side effects of the vaccine before administering injections each time the vaccine is offered and a consent/declination form completed.	F 883		

Southern Hills Specialty Care's Plan of Correction

Preparation and/or execution of this plan of correction does not constitute admission or agreement by this provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of Correction is prepared and/or executed solely because it is required by the provisions of federal and/or state law.

F 583

It continues to be the policy of Southern Hills Specialty Care that residents have the right to privacy and dignity.

Privacy will be provided for resident # 28, as well as for all residents of the facility.

Staff re-education was provided to staff on 2/27/18, reminding them of the need to knock and wait for a response before opening the door of the bathrooms.

Ongoing monitoring will become part of the facility's QA process through observations and resident interviews.

F656

It continues to be the policy of Southern Hills Specialty Care that comprehensive care plans will be developed to reflect physician ordered treatments for use of tube-grips.

The care plan for resident # 61 was revised on 2/22/18 to include the use of the tube-grips. On 2/26/18, care plan coordinators completed an audit of physician ordered treatments and care plans for all residents of the facility to ensure care plans reflected necessary treatments.

On 2/22/18, staff education was completed related to care plan content.

Ongoing monitoring will become part of the facility's QA process.

F 658

It continues to be the policy of Southern Hills Specialty Care to provide services as outlined in the comprehensive care plan.

Resident # 61 as well as all other resident's treatments will be completed as ordered, unless resident chooses to decline the treatment. If that occurs, nurses will document such refusal on the TAR.

Nurses were provided re-education on 2/27/18.

Ongoing monitoring will become part of the facility's QA process.

F 689

It continues to be the policy of Southern Hills Specialty Care that the resident environment remains as free of accident hazards as is possible and that each resident receives adequate supervision and assistance devices to prevent accidents.

Resident # 1 is no longer a resident at the facility.

Following the incident in August, the staff was provided with re-education on the facility's falls protocols. Staff education also included if a resident and is anxious, resulting in 1:1 supervision, that the resident should not be left unattended. Education was completed again during all staff meeting on 3/9/18.

QAPI PIP team is meeting on at least a weekly basis to review falls data and help identify interventions that could help reduce the number of falls.

Resident # 68, as well as all other residents who require use of a wheel chair for mobility, will have foot pedals in place prior to staff propelling the chair.

Staff was provided re-education on 3/8/18 related to the use of foot pedals. All wheel chairs were audited to ensure each has proper foot pedals. On 3/1/18, a storage bag was place on the back of each wheel chair to enable storage for foot pedals when they are not in use, and to enable staff to have access to them, should it be necessary to assist the resident with propelling the chair.

Ongoing monitoring will become part of the facility's QA process.

F 725

It continues to be the policy of Southern Hills Specialty Care to have sufficient nursing staff to meet the needs of the residents.

Resident # 329 no longer resides at the facility. For residents # 43, 45, 54, and 55, as well as for all other residents of the facility, call lights will be answered promptly.

Re-education was provided to staff on 2/26/18 related to need for prompt response to lights. On 3/7/18, staffing assignments were changed to include a staff member responsible for responding to call lights during meal times, and during times call light usage is noted to be the highest. Call light responses are being audited four times a day, and resident interviews are being conducted to ensure satisfaction with call light response.

Supervision in the independent dining room is being provided during all meals. Management team is assisting with supervision in the dining room, and some seating changes are being made to ensure staff is in the dining room to assist residents as needed.

QAPI PIP team is established and will be meeting at least weekly to address the dining room supervision.

Ongoing monitoring will become part of the facility's QA process.

F 838

It continues to be the policy of Southern Hills Specialty Care that the facility assessment will be reviewed and updated as necessary.

The facility assessment was reviewed on 3/9/18 and updated to reflect required resources and staffing levels needed to provide care and services for residents. The facility will be staffed based on budgeted hours, resident acuity, and the current case mix of the resident population.

Ongoing monitoring will become part of the facility's QA process.

F 883

It continues to be the policy of Southern Hills Specialty Care that residents and/or the resident's representative will be provided with education regarding the risks and benefits of potential side effects of immunizations prior to administering the vaccines.

Prior to providing the influenza vaccines for residents # 14, 24, 25, and 61, as well as for all resident of the facility, staff will review the current information of risks and benefits to each resident and/or resident's representative.

Education was provided to nurses on 3/1/18 related to the need to review risks and benefits with each resident prior to administering each vaccine, and obtain a consent form showing they had received this information and whether they have chosen to receive the vaccine or have declined.

Ongoing monitoring will become part of the facility's QA process.