STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	165478	A. BUILDING _____ B. WING _____	C 04/24/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ARBOR COURT	701 EAST MAPLELEAF DRIVE MOUNT PLEASANT, IA 52641

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F 000	INITIAL COMMENTS Correction Date 06/02/18 The following deficiencies relate to the investigation of complaints 75049-C and 75104-C, conducted 4/15/18 - 4/24/18. Both complaints were substantiated. See Code of Federal Regulations (42CFR) Part 483, Subpart B -C	F 000	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 this statement of deficiencies. The plan of correction is prepared and/or executed solely because it is required by state and/or federal law. Please accept this as our credibe allegation of compliance.	
F 557 SS=D	Respect, Dignity/Right to have Prsnl Property CFR(s): 483.10(e)(2) §483.10(e) Respect and Dignity. The resident has a right to be treated with respect and dignity, including: §483.10(e)(2) The right to retain and use personal possessions, including furnishings, and clothing, as space permits, unless to do so would infringe upon the rights or health and safety of other residents. This REQUIREMENT is not met as evidenced by: Based on observation, record review, and resident, responsible party, staff and dialysis staff interviews, the facility failed to treat each resident with dignity and respect, for 1 of 7 active resident records reviewed (Resident #3). The facility reported a census of 40 residents. Findings include: The 2/1/18 Minimum Data Set (MDS) Assessment tool revealed Resident #3 admitted to the facility on 1/18/18 with diagnoses that included diabetes, cerebrovascular accident (a stroke) and hypertension (high blood pressure),	F 557	Elements detailing how we will correct the deficiency as it relates to the individual: Restorative nurse re-assessed the residents toileting plan and d/c it due to it being ineffective. How facility will act to protect residents in similar situations: Restorative nurse will be designated individual to start toileting plans. She will review with resident/responsible party and have plan signed if in agreement. Measures the facility will take or system we will alter to ensure problem does not recur: Individualized toileting plans will be reviewed at least quarterly after they are established to ensure effectiveness and resident satisfaction with the plan. How facility plans to monitor performance to make sure solutions are permanent: Director of nursing or designee will perform QA audits to ensure compliance.	04/26/18 06/02/18 06/02/18 Ongoing

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Sheila Mathenes — TITLE: Administrator — (X6) DATE: 5/31/18

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 557	Continued From page 2 4/17/18 at 8:35 a.m., the director of nursing (DON) stated the resident said she had to go to the bathroom all the time, so she put her on a toileting schedule before her hospitalization, and thought this had helped somewhat. When asked, the DON reported the facility had not considered if the resident had urinary retention or altered sensation as a result of her hemiparesis and neuropathy, and had not assessed for urinary retention. 4/17/18 at 8:08 a.m., Staff A, registered nurse (RN) stated the resident was put on a 1 and 1/2 hour toileting schedule because of frequent requests to go to the bathroom. She added that the resident urinated about 25 percent of the time after she the requests. 4/16/18 at 4:12 p.m., Staff I, certified nursing assistant (CNA), stated the resident stated she had to go to the bathroom and staff put her on the bedpan, but then she didn't always urinate. Staff I reported they put the resident on a 1 and 1/2 hour toileting schedule and the resident didn't like it. Staff I stated the staff are supposed to follow the toileting schedule, but if the resident requested to toilet she would put her on the bed pan, even if sooner than 1 and 1/2 hours because it wasn't right to let someone wet themselves. 4/17/18 at 6:25 a.m., Staff D, CNA, stated the resident would request the bedpan, urinate in it, and would request the bedpan again not very long afterward. She was put on a toileting schedule every 1 and 1/2 hours to train her bladder, but she would put her on the bedpan sooner after a meal or before the resident left for dialysis. The resident would say "I know you are	F 557		

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F 757	Continued From page 4 stated in paragraphs (d)(1) through (5) of this section. This REQUIREMENT is not met as evidenced by: Based on record review, and staff, pharmacist, physician and responsible party interviews, the facility failed to ensure residents were free from unnecessary drugs when they administered Warfarin 2 mg daily without adequate monitoring (Resident #8). This constituted an Immediate Jeopardy (IJ) to resident health and safety. The facility identified a census of 40 residents. Findings include: The Minimum Data Set (MDS) Assessment tool dated 3/21/18 revealed Resident #8 admitted to the facility on 3/15/18 with diagnoses that included atrial fibrillation (irregular heart beat), hypertension (high blood pressure), pneumonia, and congestive heart failure. The MDS documented the resident scored 7 out of 15 points possible on the Brief Interview for Mental Status (BIMS) cognitive assessment that indicated the resident experienced cognitive impairment. The MDS revealed Resident #8 required extensive assistance of at least 2 staff for transfers to and from bed and chair, ambulation (walking), bathing, dressing, toilet use and personal hygiene, and remained continent of bowel and bladder. Physician orders dated 3/15/18 for the resident's hospital discharge and nursing home admission directed staff to administer medications that included: 1. Warfarin (Coumadin, a blood-thinning, anticoagulant medication) 2 milligrams (mg)	F 757	Past noncompliance: no plan of correction required.	

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F 757	Continued From page 6 The nursing care plan, dated as implemented on 3/15/18, included a bleeding risk problem due to anticoagulant medication, and directed staff to perform lab work as ordered by the physician, assess for signs or symptoms of bleeding, and notify the physician. An INR performed 3/21/18 at 5:25 a.m., with critical lab value results telephoned to Staff A, registered nurse (RN), on 3/21/18 at 8:00 a.m., reported a 14.4 INR result. Physician orders transcribed after admission included: 1. Administer oxygen at 2 liters (per minute) per nasal cannula to keep oxygen (saturation) above 90 percent (normal value 95 to 100 percent without oxygen), transcribed on 3/16/18 at 4:00 p.m. 2. A facsimile (fax) to the physician on 3/20/18 at 9:49 a.m. described the resident ambulated to the bathroom without assistance, and the staff requested an order for a floor alarm to alert staff due to the resident's orthostatic hypotension (sudden drop in blood pressure upon standing), with order received on 3/20/18 at 2:27 p.m. 3. Vitamin K (medication administered as an antidote for blood clotting problems) 5 mg administered now by intramuscularly (IM) injection, for critical INR value, repeat INR on 3/22/18, hold Warfarin and aspirin indefinitely, with order transcribed on 3/21/18 at 10:21 a.m. Nurse's Notes revealed the following entries: 3/16/18 at 4:00 p.m. - oxygen saturation 65 percent during assessment, physician notified with order for oxygen at 2 liters per nasal cannula as needed to keep saturation above 90 percent.	F 757		

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F 757	Continued From page 8 respirations for 2 minutes at 6:20 a.m. Physical and Occupational Therapy notes revealed the following entries: By Staff B, physical therapy assistant (PTA): 3/19/18 at 4:34 p.m. - unable to stand longer than 62 seconds (with walker) on 1st attempt, 51 seconds on 2nd attempt and 22 seconds on 3rd attempt, with substantial rest breaks required between attempts. 3/20/18 at 1:40 p.m. - resident reports she felt extremely tired, doesn't have much pep. Unable to stand with assist from recliner, recliner elevated to approximately 45 degrees and able to stand with 50 percent assist by therapist, stood 65 seconds on 1st attempt, 42 seconds on 2nd attempt, and 15 seconds on 3rd attempt, immediate loss of trunk control upon 2 steps with wheeled walker. 3/21/18 at 1:51 p.m. - resident found in the restroom unattended last night, now alarmed with a pressure mat. Resident constantly complained of being too cold throughout the entire treatment, oxygen saturation 85 percent on 2 liters nasal cannula. Resident unable to sit unsupported for more than 40 seconds before fatigued, 20 seconds on 2nd attempt and 15 seconds on 3rd attempt. Frequent rest breaks required. By Staff C, occupational therapy assistant (COTA): 3/16/18 at 2:16 p.m. - maximal assistance required to stand from lift chair, transfer to wheel chair, and to don and doff clothes.	F 757		

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F 757	Continued From page 10	F 757		

each time she observed it. Staff D stated the day the resident passed she had walked very slowly to the bathroom and was too weak to stand from the toilet, so the CNA called for help. It took 3 staff to carry the resident to bed, there was blood in the toilet, and the resident was non-responsive.

4/16/18 at 3:48 p.m., Staff F, LPN, stated staff reported the resident had blood in her stool, observed reddish brown stool in the toilet, called the physician on call and was directed to monitor her blood pressure. An INR was already scheduled for the next lab day. During another interview on 4/19/18 at 10:41 a.m., Staff F stated she had contacted the physician on call at approximately 9:00 p.m., the doctor asked what the INR was, and she looked through the chart and couldn't find an INR result. She then looked in the lab book and it was scheduled on the next lab day (3/21/18). When asked, she confirmed she was not aware the INR ordered for 3/16/18 had not been done.

4/17/18 at 6:06 a.m., Staff G, LPN, stated he worked on the night shift, the resident self-transferred to the bathroom and wasn't supposed to, had dark stools on 3/19/18, there was a fax from the doctor to get an INR if indicated. He said there wasn't one set up and scheduled it for the next lab day on 3/21/18. Staff were supposed to watch her blood pressure. The night before she died her blood pressure had dropped 10 points. During another interview on 4/19/18 at 11:52 a.m., Staff G stated he knew to schedule the INR because of the fax from the physician on 3/19/18 that ordered the INR if warranted. Staff G felt a nurse couldn't make that determination so he scheduled the INR for the next lab day. He was not aware the INR ordered

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F 757	Continued From page 12 4/16/18 at 3:41 p.m., Staff J, registered pharmacist (RPh) from the facility's pharmacy, stated delayed-release aspirin is not the same as chewable aspirin. Staff J reported the pharmacy would have provided delayed-release aspirin if specified by the facility but it was not transcribed on the orders. Staff J stated chewable aspirin would affect actions of the Warfarin. 4/16/18 at 2:35 p.m., the director of nursing (DON), confirmed she transcribed the resident's physician orders for facility admission, she saw the INR lab order for 3/16/18, it was not transcribed on the orders she wrote and was not performed. Since then, the facility initiated a process where a 2nd nurse manager proof read all transcribed physician orders to ensure all orders were accurate. During another interview on 4/18/18 at 1:15 p.m., the DON stated she became aware the 3/16/18 INR order was missed when she returned to work on 3/22/18, the facility aware on 3/21/18 when INR results performed that day were called to the facility with critical value. 4/17/18 at 7:16 a.m., the assistant director of nursing (ADON), stated she admitted the resident on 3/15/18, saw the order for the INR on 3/16/18 but it was missed on the orders, the aspirin order was for delayed-release and chewable aspirin was not delayed-release. She reported orders were now double checked, sometimes triple checked by either the DON, QA (quality assurance) nurse or herself. 4/17/18 at 11:50 a.m., Staff L, physician assigned to the resident with admission to the facility, stated staff should have followed physician orders	F 757		

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F 757	Continued From page 14 information from her Emergency Room visit on 3/2/18. Staff M stated it is required for the death certificate to be completed within 72 hours. During another interview on 4/30/18 at 4:07 p.m., Staff M stated she was not aware of the resident's 14.4 INR or symptoms of gastrointestinal/rectal bleeding when she completed the death certificate on 3/26/18, because didn't have other laboratory data or medical tests at the time of the resident's death and an autopsy was not performed. During an interview on 4/18/18, the resident's RP stated he/she arrived at the facility after staff notified him of the resident's death. The RP reported the resident was in bed, there were drops of blood on the floor between the bed and the bathroom, and red blood in the toilet. On 4/24/18 at 3:15 p.m., the administrator and DON stated the facility didn't have a policy or procedure for following physician orders; it was a professional standard staff were expected to follow. The facility abated the Immediate Jeopardy situation on 3/22/18 by implementing the following: 1. Changed the policy to require two of these three individuals to verify admission orders: Director of Nursing, Assistant Director of Nursing, and Quality Assurance Nurse. 2. Educated all nurses regarding physician's orders, routine INRs and admission orders.	F 757		