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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	165497	A. BUILDING ______ B. WING ______	C 05/24/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
QHC WINTERSET NORTH, LLC	411 EAST LANE STREET WINTERSET, IA 50273

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F 000	INITIAL COMMENTS Correction date 6/29/18 The following deficiencies result from the facility's survey/investigation revisit and investigation of complaints # 74878-C, # 74968-C, # 75138-C, # 75541-C and # 75579-C and facility-reported incidents # 74420-I, # 74698-I, # 74839-I, # 75245-I and # 75501-I. Investigation of facility-reported incident # 73865-I did not result in deficiency. Complaints # 74698-C and # 75009-C were not substantiated. See the Code of Federal Regulations (42CFR) Part 483, Subpart B-C.	F 000		
F 550 SS=D	Resident Rights/Exercise of Rights CFR(s): 483.10(a)(1)(2)(b)(1)(2) §483.10(a) Resident Rights. The resident has a right to a dignified existence, self-determination, and communication with and access to persons and services inside and outside the facility, including those specified in this section. §483.10(a)(1) A facility must treat each resident with respect and dignity and care for each resident in a manner and in an environment that promotes maintenance or enhancement of his or her quality of life, recognizing each resident's individuality. The facility must protect and promote the rights of the resident. §483.10(a)(2) The facility must provide equal	F 550		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE 06/11/2018

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

POC accepted 7/5/18 [signature]

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F 550	Continued From page 1 access to quality care regardless of diagnosis, severity of condition, or payment source. A facility must establish and maintain identical policies and practices regarding transfer, discharge, and the provision of services under the State plan for all residents regardless of payment source. §483.10(b) Exercise of Rights. The resident has the right to exercise his or her rights as a resident of the facility and as a citizen or resident of the United States. §483.10(b)(1) The facility must ensure that the resident can exercise his or her rights without interference, coercion, discrimination, or reprisal from the facility. §483.10(b)(2) The resident has the right to be free of interference, coercion, discrimination, and reprisal from the facility in exercising his or her rights and to be supported by the facility in the exercise of his or her rights as required under this subpart. This REQUIREMENT is not met as evidenced by: Based on clinical record review, observations and staff interviews, the facility failed to dress and interact with residents in a dignified manner for two of 16 residents reviewed (Residents #1 and #15). The facility identified a census of 52. Findings include: 1. The Minimum Data Set (MDS) assessment dated 3/17/18 documented Resident #15 had diagnoses that included Non-Alzheimer's dementia, anxiety and other somatoform (psychological) disorders. The assessment documented the resident had severely impaired	F 550		

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F 550	Continued From page 2 cognitive skills for daily decision making, she did not speak and required the assistance of two for bed mobility, transfer, dressing, personal hygiene and wheelchair mobility. The care plan problem revised on 8/29/14 identified the resident as at risk for a self-care deficit related to dementia with behavioral disturbances and anxiety. The care plan instructed she required the assistance of one staff with dressing and bathing with the goal for the resident to be clean and well-groomed daily. Observation on 5/16/18 at 4:35 PM revealed Resident #15 sat in the hallway in a wheelchair. The resident had long facial hairs, dried food along the corners of her mouth and wore a duster dress which staff placed backwards on the resident. The resident had a triangular area of her bare back exposed above wheelchair as staff had not fully snapped the dress shut. Observation on 5/18/18 at 9:34 AM revealed Resident #15 sat in a wheelchair in the day room with three other residents. The resident continued to have long facial hairs along the corner of her mouth and wore the same duster dress put on backwards with visible skin exposure. During interview on 5/18/18 at 10:25 AM, the Corporate Nursing Consultant observed the resident upon request. She stated the resident was not appropriately dressed and instructed staff to change her clothing immediately. 2. According to the MDS assessment dated 2/8/18, Resident #1 admitted to the facility on 10/31/17. The MDS indicated Resident #1 had	F 550		

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F 550 Continued From page 3 | F 550

short and long-term memory problems and modified independence with cognitive skills for daily decision-making. The MDS indicated Resident #1 did not exhibit any behavioral symptoms at the time of the assessment. The MDS listed the following diagnoses for Resident #1: hypertension, seizure disorder, depression, uncomplicated alcohol dependence, and alcohol dependence with withdrawal. The assessment recorded Resident #1 displayed independence with bed mobility, transfers and walking in his room. The MDS listed Resident #1 used a wander/elopement alarm daily.

The care plan problem dated 11/17/17 identified Resident #1 had impaired thought processes and some activities of daily living deficits related to a history of alcohol abuse. The care plan instructed to encourage the resident's interactions with staff and peers as appropriate as the resident enjoyed visiting.

During interview on 5/18/18 at 10:26 AM, Staff BB, the facility's former Activity Director, stated she enjoys visiting with Resident #1 about current events and other topics. Staff BB stated she had been assigned to provided 1:1 supervision for Resident #1 when the former Administrator came to the Chronic Confusion and Dementing Illness (CCDI) unit and observed her visiting with Resident #1. The Administrator approached her and Resident #1 and rudely told her she is to not visit with the resident while providing 1:1 supervision; she is only to sit and observe the resident. Staff BB stated the resident then apologized to her for visiting and walked away. Staff BB stated it made her feel really bad because they enjoyed visiting. Staff BB stated that another incident occurred a week or so after

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this incident where the former Administrator observed her assisting Resident #1 in the door from the enclosed courtyard. Staff BB stated the resident patted her on the shoulder in a friendly manner and expressed his thanks for her assistance with the door. Staff BB stated Staff Z, dietary aide, Staff H, certified nursing assistant (CNA) and the Dietary Services Manager (DSM) were present as well. The former Administrator yelled at Resident #1, told him it was inappropriate to touch any staff, he is never to touch staff or peers and then told Staff BB she is never to touch Resident #1. Staff BB stated Resident #1 apologized for causing a problem. Staff BB stated the former Administrator's treatment of her and the resident, in front of other residents and staff, was undignified and caused her and the resident to feel badly. Staff BB stated Resident #1, and all other residents of the facility, should be treated with respect and dignity and friendly touch is only human and welcomed.

During interview on 5/16/18 at 2:00 PM, the DSM recalled the incident when the former Administrator yelled at Resident #1 because he touched Staff BB on the shoulder. The former Administrator yelled it was inappropriate for him to touch staff. It made her uncomfortable; the former Administrator used a loud and rude tone of voice. The incident occurred on 4/24/18.

During interview on 5/18/18 at 11:00 AM Staff H stated she observed Resident #1 touch Staff BB on the arm. The former Administrator raised her voice and told Resident #1 the touch was sexual in nature, he should never to do that again and then chastised Staff BB for allowing Resident #1 to touch her as it not appropriate. Staff H stated it made her feel uncomfortable and felt it was

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F 550	Continued From page 5 wrong the former Administrator talked to the resident is that manner. Staff H stated Staff BB provided 1:1 supervision for the resident while assigned to the CCDI unit. The former Administrator came to the unit and told her and Staff BB they were no longer allowed to talk or provide drinks for Resident #1. They were only to provide 1:1 observation to assure his wanderguard bracelet remained in place. Staff H stated Resident #1 sat in his room at the time with the door partially shut as he was dressing. The former Administrator shoved the room door open without warning and yelled to staff to keep the room door open at all times without regard to the resident's privacy. 3. During interview on 5/16/18 at 2:49 PM Staff H stated the facility ran low of its supply of incontinent briefs. She reported this to the former Administrator who then told her staff must be hiding them or stashing them in resident rooms and care areas. While all the residents were eating supper in the dining room, the former Administrator searched through every resident's room looking in their drawers and closets for briefs without the resident's permission. Staff H stated several residents in the dining room saw the former Administrator going from room to room and searching their items and it upset them. During interview on 5/18/18 at 9:50 AM the facility's Nursing Consultant stated the former Administrator had been suspended pending investigation into the dignity allegations brought to her attention.	F 550		
F 657 SS=D	Care Plan Timing and Revision CFR(s): 483.21(b)(2)(i)-(iii)	F 657		

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F 657	Continued From page 6 §483.21(b) Comprehensive Care Plans §483.21(b)(2) A comprehensive care plan must be- (i) Developed within 7 days after completion of the comprehensive assessment. (ii) Prepared by an interdisciplinary team, that includes but is not limited to-- (A) The attending physician. (B) A registered nurse with responsibility for the resident. (C) A nurse aide with responsibility for the resident. (D) A member of food and nutrition services staff. (E) To the extent practicable, the participation of the resident and the resident's representative(s). An explanation must be included in a resident's medical record if the participation of the resident and their resident representative is determined not practicable for the development of the resident's care plan. (F) Other appropriate staff or professionals in disciplines as determined by the resident's needs or as requested by the resident. (iii)Reviewed and revised by the interdisciplinary team after each assessment, including both the comprehensive and quarterly review assessments. This REQUIREMENT is not met as evidenced by: Based on clinical record review, observation, staff interviews, and facility policy the facility failed to update two of 16 residents' care plans reviewed (Resident #1 and #6). The facility reported a census of 52 residents. Findings include: 1. According to the Minimum Data Set (MDS) assessment dated 2/8/18, Resident #1 admitted	F 657		

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F 657	Continued From page 7 to the facility on 10/31/17. The MDS indicated Resident #1 had short and long-term memory problems and modified independence with cognitive skills for daily decision-making. The MDS indicated Resident #1 did not exhibit any behavioral symptoms at the time of the assessment. The MDS listed the following diagnoses for Resident #1: hypertension, seizure disorder, depression, uncomplicated alcohol dependence, and alcohol dependence with withdrawal. The assessment recorded Resident #1 displayed independence with bed mobility, transfers and walking in his room. The MDS listed Resident #1 used a wander/elopement alarm daily. Review of Resident #1's care plan revealed the following focus: Resident #1 had a tendency to have unsafe items on himself and/or in his room. The care plan listed numerous interventions initiated on 2/21/18: Resident #1's family and the resident received a list of unsafe items, his room will be checked for unsafe items as staff feels is necessary, when he returns from outing with family and friends, staff will search his person and room for unsafe items, if items are found on Resident #1 or in his room please explain to him (if present) why they are unsafe and staff must take the items and return them to his family and staff should report all unsafe items to the Administrator immediately. The Resident #1's POA (Power of Attorney) agreed to the interventions. On 2/27/18, staff added further interventions which included: Resident #1's person and room will be searched after having any visitors in the building (the POA agreed), staff should communicate with Resident #1 about the need for safety of everyone in the building, communication with Resident #1 and his family	F 657		

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F 657	Continued From page 8 regarding these matters will continue to ensure no adverse effects related to policies and procedures being carried out and Social Services would be available to Resident #1 as needed for communication. A Social Service Note date 2/27/18 at 1:54 PM documented during an as needed (PRN) room search in Resident #1's room, staff found a weapon in a coffee storage box. Staff immediately notified the Administrator and seized (ceased) the weapon. Staff notified the local authorities and POA and called a meeting with the following in attendance: Administrator, Director of Nursing (DON), Assistant DON (ADON), Social Services and resident's POA. In the meeting Resident #1's POA agreed to the following terms for Resident #1 to continue to live at the facility: due to the contraband and weapons only being found after outings with the resident's ex-wife, outings with her will now be prohibited. Resident #1's POA may take him out of the building with the understanding that Resident #1 will be searched upon return along with his room. After anyone visits Resident #1 in the facility, Resident #1 and his room will be searched and PRN searches of Resident #1's room as well. At the end of the meeting, the Administrator, DON, ADON, and POA went to Resident #1's room to discuss this with him and do a thorough search of his person and his room with his POA present. Staff updated the resident's care plan to reflect these changes. The resident's care plan lacked documentation about staff finding a gun and other unsafe items he brought in to the facility. The care plan lacked guidance as to what unsafe items staff should look for when completing the searches.	F 657		

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F 657	Continued From page 9 b. Resident #1's revised on 4/30/18 recorded he had a recent elopement. The care plan documented windows have been fixed to allow them to only open a small width, initiated on 4/30/18. On 5/8/18, staff placed Resident #1 on 15 minute checks. A progress note dated 4/30/18 at 6:15 AM revealed Resident #1 eloped from the facility local police found him and returned him to the facility. This part of Resident #1's care plan lacked documentation about the 4/30/18 circumstances of his elopement and previous comments about wanting to leave the facility. Review of the facility's Resident Care Polices and Procedure Manual related to Resident Elopements, revised on 4/5/02, revealed the resident's care plan will be revised to reflect elopement and a prevention plan will be developed. During interview on 5/17/18 at 8:28 AM the Operations Nurse Consultant stated she assisted the ADON with care plans. She stated she provided input on how to customize care plans. She also stated she has not been in the building enough to actually physically work with the care plans. She stated she would have put on the care plan that a gun had been found in Resident #1's room. She would have expected the elopement to be on the care plan with more information about the elopement. During interview on 5/17/18 at 8:56 AM, the ADON stated she did not know she needed more detail on the care plan about the resident's	F 657		

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F 657	Continued From page 10	F 657		

elopement.

2. The MDS assessment dated 2/3/18 documented diagnoses that included diabetes mellitus, unspecified pain, generalized edema, age-related osteoporosis and hypertension for Resident #6. The assessment documented she required the assistance of one with transfers and bed mobility, had total incontinence of bowel and bladder and no skin conditions at the time of the assessment.

The care plan problem initiated 8/4/17 identified the resident with the potential for skin impairment due to incontinence and immobility. The care plan directed staff to consult the wound nurse and/or dietician as needed for skin breakdown as of 8/22/17 and to report any skin concerns to the nurse/doctor as of 11/20/17.

A Non-Pressure Skin Condition Report dated 4/7/18 documented the presence of a 4.0 x 5.0 centimeter (cm) small open area with redness on the resident's left buttock.

Two separate Wound Care *Skin Integrity* Evaluation reports completed by the consulting wound nurse documented Resident #6 had the following ulcers on 4/20/18:
a. A full-thickness pressure ulcer over the left ischial tuberosity which measured 5.0 cm x 3.5 cm with a moderate amount of serosanguineous drainage. The wound bed contained 25% red tissue and 75% black soft eschar. The wound could not be staged due to the presence of the eschar tissue.
b. A full-thickness pressure ulcer over the right ischial tuberosity which measured 2.0 cm x 2.0 cm with minimal serous drainage.

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F 657	Continued From page 11 Both pressure ulcers were documented as facility-acquired. Facility staff failed to update the resident's care plan to identify actual, instead of potential, skin impairment or any interventions for staff to following to assist with treatment and resolution of her ulcers. The facility's undated Weekly Pressure Ulcer Progress Report Policy and Procedure directed the following: Policy: To provide weekly assessment and documentation of all pressure/stasis ulcers. To help prevent infections and other complications of pressure/stasis ulcers And: Point # 7. Charge Nurse/Care plan nurse will be responsible to add skin issues to care plan with each incident to identify interventions to promote healing. The MDS coordinator will be responsible to follow up and monitor care plan and add updates as needed. Point # 8. Updated information regarding resident's skin condition and care plan will be reported to the certified nursing assistant (CNA's) for education to provide quality care and to heal and attempt to prevent further issues.	F 657		
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 clinical record review, observation and	F 658		

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F 658	Continued From page 12 physician interview, the facility failed to follow the physician orders as directed for one of 16 residents reviewed (Resident # 2). The facility identified a census of 52 residents. Findings include: 1. The Minimum Data Set (MDS) assessment dated 2/12/18 for Resident #2 documented diagnoses of Non-Alzheimer's dementia, depression and high blood pressure. The MDS documented the resident's Brief Interview of Mental Status score as zero, indicating severely cognitive and memory impairment. Resident #2 required the assistance of two staff with bed mobility, transfers, walking and toilet use and the assistance of one with eating. The assessment documented Resident #2 weighed 148 pounds and had no weight loss or gain at the time of the assessment. The resident's care plan dated 2/19/18, directed staff to encourage an intake of 75 % or more with meals, monitor and record intakes per facility protocol and notify the doctor and dietary staff of significant weight changes as needed. The physician order dated 2/6/18 (Tuesday) instructed staff to obtain a BMP (basic metabolic profile) test that week (this week. The resident's lab results revealed the facility obtained the resident's BMP on 2/14/18 instead of the week of 2/6/18. Interview on 5/15/18 at 8 a.m. with the resident's physician revealed concerns of timelines of labs ordered.	F 658		
F 684	Quality of Care	F 684		

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F 684 SS=G	Continued From page 13 CFR(s): 483.25 § 483.25 Quality of care Quality of care is a fundamental principle that applies to all treatment and care provided to facility residents. Based on the comprehensive assessment of a resident, the facility must ensure that residents receive treatment and care in accordance with professional standards of practice, the comprehensive person-centered care plan, and the residents' choices. This REQUIREMENT is not met as evidenced by: Based on clinical record review, observation and staff and primary care provider interview, the facility failed to assess a change in condition for one of 16 residents reviewed (Resident # 23). The facility reported a census of 52 residents. Findings include: 1. The Minimum Data Set (MDS) assessment dated 3/30/18 recorded a Brief Interview of Mental Status (BIMS) score of one of 15 for Resident # 23 which indicated severe long and short term memory deficits. The resident had diagnoses that included hip fracture, malnutrition, nontraumatic subdural hemorrhage, hypothyroidism, an unspecified mental disorder, a history of falling, a psychotic disorder and diabetes mellitus. The resident required the assistance of two staff with transfers, bed mobility, dressing, toilet use and personal hygiene and she ate independently. A Physician's Fax Order Request originally dated 2/26/18 revealed a request to discontinue the resident's insulin and blood sugar draws at the families' request as they did not believe the	F 684		

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F 684	Continued From page 14 resident required insulin. Two months later on 4/16/18, the Advanced Registered Nurse Practitioner (ARNP) reviewed the resident's laboratory tests dated 3/8/18. The blood sugar level measured 181 (normal is 70 to 100) and the A1C (the overall level for blood glucose in the system over two to three months) measured 6.5 (normal is 4.5 to 6.0). The ARNP discontinued the resident's insulin and blood sugar tests on 4/16/18. The facility failed to provided any documentation of education to the family on the consequences of elevated blood sugars for the resident's overall physical condition. The Encounter Note and Progress Note dated 4/26/18 revealed an order for Risperidone Suspension Reconstituted at 25 MG (milligrams) and injected intramuscularly once every 14 days. The resident's ARNP reduced the Risperidone from 37.5 MG to 25 MG when she saw the resident in the dining room of the facility on 4/26/18. The ARNP described Resident # 23 as sleepy with her head on the table. The resident received the last injection of 35.5 MG of Risperidone on 4/16/18 and would be due for the next Risperidone 25 MG one 4/30/18. The Nursing Note dated 4/27/18 at 2:41 PM documented the resident's daughter visited and requested the resident be sent to the hospital due to the changes in behavior and mentation. The daughter requested Resident # 23 be sent to the hospital. The Hospital Transfer form date 4/27/18 at 6:45 P.M. identified the resident could not maintain an erect or sitting position before and during the transport. The emergency room Physician's Assistant form documented the resident's appearance as emaciated, frail, lethargic, smelling of stool, obviously distressed	F 684		

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and both lower extremities looked yellow in color. The resident's first diagnoses included electrolyte abnormalities, pneumonia, sepsis, a urinary tract infection and volume depletion (dehydration).

In an interview on 5/14/18 at 7:50 A.M., the emergency room ARNP stated a Certified Nursing Assistant (or CNA, Staff CC from the facility) called her after the resident came to the emergency room (ER). Staff CC reported Resident #23 had been in the same condition for over a month. She described the resident as very contracted and lethargic with assessment. When asked if the condition change may have happened overnight or over a day or two, she stated she thought it went on longer than that and the facility had been neglectful.

The Physician Documentation of the 4/27/18 Emergency Room visit recorded the addition of hypoxia (not getting enough oxygen), right humorous (arm) fracture (unknown to family) and a small open area on the coccyx to the diagnostic list. The resident's laboratory tests included a white blood cell count for signs of infection (high at 14.4), a blood glucose check (high at 370), Bun/Creatinine (renal functions) high at 32 and 1.44). The documentation revealed Resident # 23 received care to stabilize her condition and transferred at 7:02 PM to another hospital with the ending diagnoses of acute respiratory failure with hypoxia, diabetes mellitus with unspecified complications, hyperglycemia (high blood sugars), unspecified altered mental status, hypothyroidism and hypertension. The ARNP documented the resident's condition as serious.

On 4/28/18, at 12:12 P.M., a Nursing Note documented Resident # 23 admitted to the

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receiving hospital with additional diagnoses of a pulmonary embolism, (a blood clot in the lungs) and two blood clots in her left leg.

During interview on 5/16/18 at 8:50 A.M., Staff CC stated she called the ER to inform the ARNP that Resident # 23 had been this way for almost a month, not just the last couple of days as reported. Resident #23 used to eat her meals independently and then changed to not opening her mouth to eat at all. Staff CC stated she would get her up to go to the dining room for meals so she would eat better, but often staff left her in bed because the resident slept quite a bit. Staff CC thought the resident might have suffered a stroke because her hand kind of turned inward towards the last. Staff CC stated she informed the 2 PM to 10 PM charge nurse (Staff D) about the resident's changes in condition several times, but she did not recall the dates.

On 5/15/18 at 2:40 P.M., the Assistant Director of Nursing (ADON) stated some of the CNAs came to her a couple of days before the resident went to the emergency room and reported changes in Resident # 23. The ADON thought the aides were Staff G and Staff GG and they told her they also reported this information to the former Administrator. The ADON stated she had an agency nurse check the resident and she seemed sleepy. The ADON stated the SBAR (Situation, Background, Assessment, Recommendation) Communication form should be made out by licensed nursing staff with any change of resident condition. No SBAR forms could be found for Resident # 23 for the month of April 2018.

On 5/16/18 at 2:33 P.M., Staff HH, Agency RN,

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F 684	Continued From page 17 stated the Administrator asked her to assess Resident #23 on 4/24/18. Staff HH recalled the resident's vitals being normal. The aides (she could not recall their names) told her this resident was not usually so lethargic or nonresponsive. Staff HH could not compare the resident's condition to an earlier time as she never took care of her before. Staff HH reported no unusual findings to the charge LPN (whose name she did not recall) and the former Administrator. The Nursing Note dated 4/24/18 at 7:45 P.M. documented Staff HH assessed Resident # 23. The resident was slumped over and sleeping in a wheel chair at the dining room table. Staff HH assessed the lungs as clear, her respirations easy, responsive to painful stimuli, blood pressure 124/72, pulse of 89, with oxygen saturation check at 91% on room air. Resident # 23 did not make any verbal conversation. One of the CNAs told Staff HH the resident's fluid intake and urine output decreased over the past 24 hours and her food intake was poor as well. **Note: On 4/26/18 (2 days later at the facility), the ARNP-DD saw the resident while sleeping at the dining room table. On 5/16/18 at 1:44 P.M., Staff G, CNA stated she filled out Stop and Watch forms (which indicated resident changes) for Resident # 23. Staff G stated she filled out three of these forms, but management staff told her they could only find one. The Stop and Watch form filled out on 4/24/18 reported Resident # 23 could not bear any weight when transferred and her meal and fluid intake decreased (she slept through meals). Staff G informed the day nurses but could not recall their names except for the ADON. Staff G	F 684		

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observed changes in the resident several weeks prior to being admitted to the hospital. The changes included needing assistance with meals, sleeping more, laying her head on the table and drooling, no weight bearing, decreased behaviors (not propelling her own wheel chair or running into other residents or obstacles) and not eating. The day before the resident's daughter came in, Staff G stated the resident drank four glasses of red juice for her.

During interview on 5/16/18 at 2:49 P.M., the resident's primary ARNP stated on 4/26/18 the nursing assistants told her Resident #23 had not been eating and did not respond as usual. The ARNP did not identify any signs of a stroke for Resident # 23 . The ARNP documented she spent more than 50% of her visit on counseling and coordination of care regarding delusional disorders.

On 5/15/18 at 1:50 P.M., Staff GG, CNA stated she work frequently with Resident # 23 on day shift. The resident would fluctuate on eating. At times, her appetite was good and on others not so good. Staff GG stated she started seeing changes in the resident three to four weeks prior to hospitalization. Resident # 23 became more sleepy, quiet, quit wanting to walk, staying in bed more, not eating and she displayed less behaviors. Staff GG stated she reported the changes to the day charge nurses and filled out the Stop and Watch form but did not keep copies. She remembered telling the ADON about the resident's changes and assumed the nurses took care of it.

On 5/16/18 at 4:24 P.M., Staff D, LPN denied any of the aides informed her of a change in Resident

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23's condition during the month of April. Staff D stated she did know what a Stop and Watch form was or what it was used for and denied seeing any changes in Resident # 23 in the month of April 2018. Staff D worked 2 to 10 P.M. three to four days a week.

On 5/17/18 at 9:32 A.M., Staff II, CNA stated she reported Resident # 23's decline in condition without anything being done until Staff HH did an assessment on 4/24/18. Staff II stated Staff HH just took vitals and pinched the resident's fingernails to check for any response. Staff II stated she reporting the resident's changes to Staff D more than once. These changes included increased sleeping, not eating and needing more assistance, and decreased behaviors.

The shift to shift report sheets for April 2018 used by the nursing staff to identify concerns for the next shift failed to identify any concerns for Resident # 23 concerning assessment of decreased food and fluid intakes, increased sleepiness or changes in behaviors.

The facility's undated policy for Change of Condition-Resident Physician/GNP Notification recorded the attending physician or physician/NP on call with be notified with changes in a resident's condition or health status. These changes could include unconsciousness, significant mental or psychosocial changes and other conditions as deemed necessary. Staff should also document the time of the call, who they notified, orders received and update the plan of care.

F 686 SS=G	Treatment/Svcs to Prevent/Heal Pressure Ulcer CFR(s): 483.25(b)(1)(i)(ii)	F 686		

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§483.25(b) Skin Integrity
§483.25(b)(1) Pressure ulcers.
Based on the comprehensive assessment of a resident, the facility must ensure that-
(i) A resident receives care, consistent with professional standards of practice, to prevent pressure ulcers and does not develop pressure ulcers unless the individual's clinical condition demonstrates that they were unavoidable; and
(ii) A resident with pressure ulcers receives necessary treatment and services, consistent with professional standards of practice, to promote healing, prevent infection and prevent new ulcers from developing.
This REQUIREMENT is not met as evidenced by:
Based on clinical record review, facility policy review, professional reference review and staff interviews, the facility failed to provide the appropriate assessment and treatment of pressure ulcers to promote healing for one of 16 residents reviewed (Resident #6). The facility reported a census of 52 residents.

Findings include:

1. The Minimum Data Set (MDS) assessment dated 2/3/18 documented diagnoses that included diabetes mellitus, unspecified pain, generalized edema, age-related osteoporosis and hypertension for Resident #6. The MDS documented she required the assistance of one with transfers and bed mobility, had total incontinence of bowel and bladder and no skin conditions at the time of the assessment.

The care plan problem initiated 8/4/17 identified the resident with the potential for skin impairment

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due to incontinence and immobility. The care plan directed staff to consult the wound nurse and/or dietician as needed for skin breakdown as of 8/22/17 and to report any skin concerns to the nurse/doctor as of 11/20/17.

The Braden Scale completed on 2/16/18 documented a score of 14 which indicated the resident at moderate risk for pressure sore development.

A Physician Fax Order Request completed by Staff I, licensed practical nurse (LPN) on 4/7/18 documented the resident had skin breakdown to the lower left buttock which measured 4.0 centimeters (cm) x 5.0 cm with 2 small open areas which measured <0.5 cm each. Staff I requested an order for Calmoseptine cream daily with resident care until healed. The physician approved the request on 4/9/18.

Staff I completed a Non Pressure Skin Condition report on 4/7/18. During interview on 5/14/18 at 3:45 PM Staff I stated the skin condition on the lower left buttock was a pressure ulcer but she documented it on a Non-Pressure Skin Condition Report because it was the form available in the skin book. She stated she has not had much education on assessment of pressure ulcers. She requested an order for Calmoseptine Ointment for the area, but did not know if it should be applied to open skin. Staff I stated skin assessment updates are to be done on a weekly basis. There is no schedule for these; nurses are to check the skin book daily to see which ones need to be completed.

Review of the Non-Pressure Skin Condition report for the left buttock revealed staff did not

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F 686	Continued From page 22 assess the area again until 4/19/18 at which time Staff S, LPN documented the area measured 2.2 inches (in) x 1.6 in (or equal to 5.5 cm x 4.0 cm) with no drainage or odor, epithelial tissue in the wound bed and normal surrounding skin and wound edges. During interview on 5/16/18 at 12:15 PM Staff S stated wound and skin assessments are to be updated weekly by the nurse. Charge nurses are to check the skin book daily to see which ones need to be completed but acknowledged she has often been too busy to check the book. A Wound Care*Skin Integrity*Evaluation reports completed by the consulting wound nurse on 4/20/18 documented the following assessment: Wound 1 - A full-thickness pressure ulcer over the left ischial tuberosity which measured 5.0 cm x 3.5 cm with a moderate amount of serosanguineous (reddish) drainage. The wound bed contained 25% red tissue and 75% black soft eschar (dead tissue). The wound could not be staged due to the presence of the eschar tissue. The wound nurse recommended a treatment application of calcium alginate with silver to the wound on the left ischial tuberosity and to cover with a semipermeable dressing. The physician approved the order as recommended on 4/20/18. The facility's undated Weekly Pressure Ulcer Progress Report Policy and Procedure directed the following: Policy: To provide weekly assessment and documentation of all pressure/stasis ulcers. To help prevent infections and other complications of pressure/stasis ulcers Responsibility: Licensed Nurse	F 686		

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F 686	Continued From page 23 Procedure: 1. Upon assessment of pressure/stasis ulcer, document on the weekly pressure ulcer progress report. 2. Documented complete assessment of site on the form including. Stage Size Depth Presence/absence of drainage Odor/color If culture obtained Evaluate for and document any risk/casual factors Documented physician, family, dietician notification 3. Complete Incident/QA (quality assurance) report 4. Document in Nurses Notes. The area will then be monitored on a weekly basis on the weekly pressure ulcer progress report 5. Any signs/symptoms or poor response to treatment will be reported to the DON (Director of Nursing) and to the physician for review for new orders 6. Charge Nurse will assess the ulcer weekly and document 7. Charge Nurse/Care plan nurse will be responsible to add skin issues to care plan with each incident to identify interventions to promote healing. The MDS coordinator will be responsible to follow up and monitor care plan and add updates as needed. 8. Updated information regarding resident's skin condition and care plan will be reported to the certified nursing assistant (CNA's) for education to provide quality care and to heal and attempt to prevent further issues.	F 686		

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Review of the resident's April, 2018 Treatment Administration Record (TAR) with Staff S revealed she applied Calmoseptine ointment to the left buttock pressure ulcer 8 of 11 days from initiation on 4/10 through the day of discontinuation on 4/20. Staff S stated the black tissue was present on all days she applied the ointment, she knew it should not have been applied to open skin, but just followed the order as written.

According to Drugs.com, Calmoseptine is a menthol and zinc oxide ointment used for the following:
A. protect skin from wetness, urine, or stools.
b. treat diaper rash
c. treat minor cuts, scrapes or burns
d. used at wounds or fistula sites

The site further directs not to put Calmoseptine on open or deep wounds, animal bites, infections, or very bad burns or cuts.

During interview on 5/16/18 at 1:32 PM, Staff G, CNA (certified nursing assistant) stated she had been assigned to Resident #6's hall for the first time in a couple of months on 4/19/18. She noted the resident had a half-dollar sized scabbed over open area with surrounding redness on the left buttock crease as well as a spot on the right buttock crease the same size which was red but had no open skin. She refused to get the resident out of bed until the nurse could asses and/or treat the area. The Assistant DON and Staff S observed the wounds and tried to figure out what to put on them, Staff G stated the nurse eventually applied a clear film dressing to both areas.

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F 686	Continued From page 25 The Weekly Pressure Ulcer Record completed by Staff S on 4/19/18 documented a new skin condition on the resident's right buttock which measured 2.0 in x 1.3 in (equal to 5.0 cm x 1.3 cm), with no odor and surrounding skin color pink/red. The record did not assess the wound bed or surrounding tissue/wound edges, the depth or amount/type of drainage or the stage of the pressure ulcer. The Physician Fax Order Request completed by Staff S on 4/19/18 documented the pressure sore on the resident's right buttock measured 1.3 in x 2.2 in, opposite of documentation on the Pressure Ulcer Record, and red/purple in color, not red/pink as recorded on the Pressure Ulcer Record. Staff S requested an order for treatment of the area. The physician ordered A& D ointment to the area two times a day (BID) until healed. Review of the MAR and TAR for April, 2018 revealed no order for A&D initiated as ordered. During the interview on 5/16/18 at 12:15 PM, Staff S stated she has been employed by the facility for approximately three months. She completed the wound assessment of the resident's right and left buttock conditions on 4/19/18; she was "pretty sure" the areas were pressure ulcers but she had not received education to know how assess and stage pressure ulcers. Staff S stated she has been told an RN (Registered Nurse) or a wound nurse should do it. She stated the physician ordered the A&D ointment treatment, but the ADON told her it was not an appropriate order so she did not initiate it. A Wound Care*Skin Integrity*Evaluation reports completed by the consulting wound nurse dated	F 686		

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F 686	Continued From page 26 4/20/18 documented the following skin area: Wound 2 - A full-thickness pressure ulcer over the right ischial tuberosity which measured 2.0 cm x 2.0 cm with minimal serous drainage. The wound nurse recommended the A&D ointment be discontinued and to apply a hydrocolloid dressing covered with a transparent film to be changed every 3 days and PRN. The physician approved the order as recommended on 4/20/18. Review of the Treatment Administration Record and Medication Administration Records for April, 2018 revealed the physician orders for wound treatments ordered 4/20/18 had not been documented on either record. During interview on 5/14/18 at 3:45 PM Staff I reviewed her Progress Notes and TAR for Resident #6 for 4/21 and 4/22 and acknowledged there were no treatment orders to either area on the buttocks. Staff I then obtained a Cutimed Sorbion Sachet border dressing from the treatment cart and stated she thought this dressing it what she saw over both left and right buttock pressure ulcers. The Nurse Meeting held on 3/23/18 documented nurses were educated to the following system for processing physician orders: When a fax is received with a new order it is to be noted, a copy made and the original placed directly in the chart. The copy is to be attached to a triple check form, all processing steps to be completed, then placed in the "to be double-noted" basket. The 6A-2P and 2P-10P shifts are to process all orders when received. DO NOT LEAVE FOR THE NIGHT SHIFT. Night shift is responsible for completing the second check of the order. When completed, the copy of	F 686		

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F 686	Continued From page 27 the fax with attached triple check form is to be placed in the DON/ADON box outside their office and either will complete the third and final check. During interview on 5/16/18 at 4:20 PM the ADON stated the consulting wound nurse completed the treatment to both left and right ischial tuberosities as she recommended after her assessment of the areas on 4/20/18. She provided the triple check form with the original fax order for the wound treatments dated 4/20/18 on the box in her office and she acknowledged the triple check protocol had not been followed. Staff D, LPN verified her initial on the triple check form box which indicated she documented the order in the nurse's notes but Staff D did not transcribe the order to the MAR or TAR and did not order supplies from the pharmacy. Staff D verified the Night shift nurse Staff V, LPN temporary agency nurse also documented the order in the nurse's notes but did not do anything else. The ADON stated she has been very busy because the facility currently has no DON and has not always had time to do all the third and final checks for physician orders. Resident #6's clinical record recorded she admitted to hospice care on 4/22/18 and expired in facility on the same date.	F 686		
F 689 SS=J	Free of Accident Hazards/Supervision/Devices CFR(s): 483.25(d)(1)(2) §483.25(d) Accidents. The facility must ensure that - §483.25(d)(1) The resident environment remains as free of accident hazards as is possible; and §483.25(d)(2)Each resident receives adequate	F 689		

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F 689	Continued From page 28 supervision and assistance devices to prevent accidents. This REQUIREMENT is not met as evidenced by: Based on clinical record review, observations, staff, resident and family interviews and facility policy review, the facility failed to provide supervision to prevent unsafe items in the facility and to prevent elopement (unplanned exit) for one of 16 sampled residents (Resident #1). The facility reported a census of 52 residents. Findings include: 1. According to the Minimum Data Set (MDS) assessment dated 2/8/18, Resident #1 admitted to the facility on 10/31/17. The MDS indicated Resident #1 had short and long-term memory problems and modified independence with cognitive skills for daily decision-making. The MDS indicated Resident #1 did not exhibit any behavioral symptoms at the time of the assessment. The MDS listed the following diagnoses for Resident #1: hypertension, seizure disorder, depression, uncomplicated alcohol dependence and alcohol dependence with withdrawal. The assessment recorded Resident #1 displayed independence with bed mobility, transfers and walking in his room. The MDS listed Resident #1 used a wander/elopement alarm daily. A. Review of Resident #1's care plan revealed the following focus: Resident #1 had a tendency to have unsafe items on himself and/or in his room. The care plan listed numerous interventions initiated on 2/21/18: Resident #1's family and the resident received a list of unsafe items, his room will be checked for unsafe items	F 689		

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as staff feels is necessary, when he returns from outing with family and friends, staff will search his person and room for unsafe items, if items are found on Resident #1 or in his room please explain to him (if present) why they are unsafe and staff must take the items and return them to his family and staff should report all unsafe items to the Administrator immediately. Resident #1's POA (Power of Attorney) agreed to the interventions. On 2/27/18, staff added further interventions which included: Resident #1's person and room will be searched after having any visitors in the building (the POA agreed), staff should communicate with Resident #1 about the need for safety of everyone in the building, communication with Resident #1 and his family regarding these matters will continue to ensure no adverse effects related to policies and procedures being carried out and Social Services would be available to Resident #1 as needed for communication.

Observation on 5/16/18 at 10:30 AM revealed Resident #1 out of his room. Staff A, CNA (certified nursing assistant) stated Resident #1 was at Church Service out front with staff. With Staff A present, the surveyor observed the resident's windows while Staff A did a room search.

A Social Service Note date 2/27/18 at 1:54 PM documented during an as needed (PRN) room search in Resident #1's room, staff found a weapon in a coffee storage box. Staff immediately notified the Administrator and seized (ceased) the weapon. Staff notified the local authorities and POA and called a meeting with the following in attendance: Administrator, Director of Nursing (DON), Assistant DON (ADON), Social

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F 689	Continued From page 30 Services and resident's POA. In the meeting Resident #1's POA agreed to the following terms for Resident #1 to continue to live at the facility: due to the contraband and weapons only being found after outings with the resident's ex-wife, outings with her will now be prohibited. Resident #1's POA may take him out of the building with the understanding that Resident #1 will be searched upon return along with his room. After anyone visits Resident #1 in the facility, Resident #1 and his room will be searched and PRN searches of Resident #1's room as well. At the end of the meeting, the Administrator, DON, ADON, and POA went to Resident #1's room to discuss this with him and do a thorough search of his person and his room with his POA present. Staff updated the resident's care plan to reflect these changes. Review of progress notes 10/31/17 through 5/15/18 revealed no other progress notes about Resident #1 bringing in any other unsafe items in to the facility. Review of the progress notes revealed a gap of no progress notes from 2/14/18-2/27/18. Review of facility's Release of Responsibility for Leave of Absence sign out and sign out sheet revealed the following: On 2/23/18 at 10:35 AM Resident #1's ex-wife signed him out and returned him to the facility at 8:40 PM. On 3/26/18 at 11:50 AM, his ex-wife and mom signed him out and no sign back in date or time available. On 4/25/18 at 11:25 AM, Resident #1's ex-wife signed him out with a return time of 1:07 PM. On 5/13/18 at 12:45 PM, Resident #1's POA signed him out and returned him to the facility at	F 689		

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F 689	Continued From page 31 2:15 PM. The sign out and sign in sheets recorded Resident #1 still left the facility with his ex-wife, alone after the gun was found in his room. Review of the staffing schedule revealed the following: On 2/23/18 Staff D Licensed Practical Nurse (LPN) and Staff P previous charge nurse worked the 2 PM-10 PM shift. On 3/26/18 Staff S LPN worked the 6 AM-2 PM shift and the ADON, Staff Q previous charge nurse, and Staff D worked the 2 PM-10 PM shift. On 4/25/18 Staff M LPN and Staff S worked the 6 AM-2 PM shift. On 5/13/18 Staff L LPN and Staff D worked the 2 PM-10 PM shift. Review of the spreadsheet labeled Resident #1 room checks sheet revealed the following columns: Date, comments, initials, following-up. The columns had the following entries: 2/27/18-door codes with the initials of the Administrator, previous DON, and Social Services 4/25/18-emptied pockets, empty, nothing of interest in room with the initials of the Administrator 5/13/18-returned at 2:15 PM with Staff R Certified Nursing Assistant (CNA) in the follow up section This spreadsheet lacked any information about person and room searches being completed on 2/27/18, 3/26/18 and 5/13/18. This sheet also lacked direction as to what is expected of staff during these searches. During interview on 5/15/18 at 9:08 AM Staff A CNA stated they had previously found a police baton in his room, but did not remember when.	F 689		

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F 689	Continued From page 32 Staff A stated Resident #1 brought this from home and that is when they initiated the searches. Staff A stated after Resident #1 goes out with family he was to be checked at the front door by department management. Staff A also stated that during a random room search, she grabbed the trash bag out of the trash can when she bumped a box on the floor. She stated the box seemed heavier than it should, so she looked inside and saw a brown paper bag. She opened the brown paper bag and saw a loaded .38 millimeter (mm) pistol with an extra clip. Staff A stated she went straight to the Administrator with the gun. On 5/15/18 at 9:40 AM Staff M LPN stated she usually works as the front charge nurse on the 6 AM-2 PM shift. Staff M stated she has not been told what to do when Resident #1 returned from off grounds visits with his family; everything she knows is all hearsay. Staff M stated she heard from the CNAs that management stated Resident #1 is to be searched upon return to the facility but no one has said anything to her about this. Staff M stated she worked when Resident #1 left on Mother's Day (5/13/18) but no one told her what do to when he returned. Staff M stated she asked the Administrator and ADON questions about the gun incident but stated they acted like it was a secret and not to ask questions. Staff M stated she felt as though there should have been a meeting about the loaded gun but there wasn't. During interview on 5/15/18 at 9:58 AM Staff N, the previous Administrator, stated after finding the gun in Resident #1's room, plan-wise nothing was formally put into place. Staff N stated staff would ask Resident #1 if he had anything on him, but does not remember anything in particular that staff were expected to do.	F 689		

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During a staff interview on 5/15/18 at 10:14 AM Staff O, the previous DON, stated Resident #1 had dementia due to his alcohol abuse and was at times not oriented. Staff O stated when he first came to the facility his ex-wife and mom would take him out of the facility with no issues. When issues surfaced, the facility did not allow him to go out of the building with his ex-wife because he would bring back items such as a pocket knife, letter opener and a pistol. Staff O stated staff had checked bags when he would come back and that was when they found the knife. Staff was to check his room the next time he left his room for an activity. Staff O stated a CNA could check Resident #1's room without him in there as his POA gave the facility permission to do so. Staff O stated the CNAs on the unit knew this information but they did not do an all staff meeting because they did not want the story to get out of hand. Staff O stated she asked Resident #1 why he brought the gun to the facility and he stated he just wanted it here and did not plan to hurt himself or others.

During interview on 5/15/18 at 10:40 AM Staff Q overnight charge nurse, stated when Resident #1 went off grounds with visitors he should be searched as well as his belongings. She had heard this from other nurses, not from management staff.

During interview on 5/15/18 at 2:15 PM Staff I LPN stated she heard from other staff members about the gun in Resident #1's room. After that, staff up front was to do a check on him after he returned from off grounds visits and she thought this was being done before the gun was found. She also stated she never remembered being

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F 689	Continued From page 34 updated following the gun incident and heard only hearsay. During an interview on 5/15/18 at 2:20 PM Staff J CNA stated he had never been asked to do a room check for Resident #1. Staff J stated he is not sure if it is documented anywhere to complete the checks. Staff J stated he has never been here when Resident #1 returned from off grounds visits with family and had never been told directly what to do. During interview on 5/15/18 at 4:04 PM Staff K LPN stated she primarily worked at the front of the facility. She had heard no talk about what to do when Resident #1 returned from off grounds visits. On 5/15/18 at 4:08 PM Staff L LPN stated that when Resident #1 left the facility with family, staff were to check his pockets and bags when he returned and he should not leave the facility with his ex-wife. When asked how she knew this, Staff L stated she read it in the nurse's notes and heard it from other nurses. Staff L stated she heard they found a pocket knife prior to the gun but did not know if they were doing checks after that. Staff L stated nurses, the DON, and/or the Administrator were to do the checks after Resident #1 returned. During interview on 5/15/18 at 6:00 PM, Staff U CNA stated she learned of Resident #1 having a gun in his room one week after it happened. Staff U stated she heard staff should check Resident #1 when he returned to the facility to see if he had anything on him but she was never asked to do the checks.	F 689		

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F 689	Continued From page 35 During interview on 5/16/18 at 7:40 AM, when asked if there were any prior incidences where Resident #1 had brought in any weapons to the facility, the ADON only recalled him bringing in the gun. At 4:10 PM, when asked if the facility had a gun policy, the ADON and Administrator stated it hadn't been approved from the corporate office and they are currently waiting for approval. At 4:15 PM the ADON stated corporate staff would not approve the gun policy because it involved lawyers and such, so no policy had been put in place after Resident #1 brought a gun into the facility. At 4:20 PM, the ADON stated she was unsure why staff updated the resident's care plan on 2/21/18. On 5/16/18 at 9:35 AM, Staff H CNA stated she did not work the day they found the gun in Resident #1's room but heard people were told to keep quiet about it. Staff H stated she heard staff should do personal body inspections/checks on Resident #1 when he returned from off ground visits with family. She had never been asked to do the personal checks because he would usually come back after 2 PM and she worked 6 AM-2 PM. During interview of 5/16/18 at 11:25 AM, Staff E Restorative Aide, stated she works either 7 AM-3 PM or 8 AM-4 PM, depending upon where they need her. She works as the restorative aide and fills in on the floor when needed. She stated when she works on the unit it is usually to relieve staff for breaks. On the day the gun was found, she had taken Resident #1 outside for a walk and she learned about the gun via hearsay from other staff members. She stated she had heard staff found a police baton and knives before. Staff D also stated she heard staff should do personal	F 689		

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and room checks when he went off grounds but she was never asked to do them.

During an interview on 5/16/18 at 12:20 PM, Resident #1's POA stated Resident #1 had brought in knives back in November or December 2017. He also stated that Resident #1 had always shown an interest in guns and was good friends with his ex-wife. Resident #1's POA stated after they found the gun in his room, he was not allowed to go out on visits with his ex-wife alone but he could go with his mom and ex-wife together. He stated the ex-wife trusted Resident #1 too much. Resident #1's POA stated if he leaves, staff are to search Resident #1 and his room, especially when he leaves with his ex-wife.

During interview on 5/16/18 at 1:00 PM, Staff S LPN stated she had never been told about a gun being found in Resident #1's room or directed to do any searches when he returned. Staff S stated she was told only Resident #1's mom is the only one to sign him out for visits and staff then are to go through his room when he is gone. She was told the unit staff did that for their own protection.

On 5/16/18 at 1:10 PM Staff A stated, nine residents lived on the CCDI (Chronic Confused and Dementing Illness) unit and eight of those residents could walk independently.

On 5/16/18 at 1:38 PM, Staff F previous MDS Coordinator stated she found out the Administrator and previous DON had found a hand gun in Resident #1's room and they previously found knives in his room. Staff F stated staff were to check Resident #1 after he went out of the facility and felt this would not get done all the time. Staff F stated Resident #1

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F 689	Continued From page 37 would return when no one worked up front, so he would go straight back to his room. Staff F didn't believe all staff knew to check Resident #1 and his room as the facility had no formal meeting about the gun incident. Staff F stated she believed it was communicated on the communication board on the unit but that was as far as it went. Staff F stated they had no meeting about security measures and everything she heard was from what staff learned from each other. During interview on 5/16/18 at 1:58 PM, Staff G CNA stated she worked the 6 AM-2 PM shift. She stated the day the gun was found, she walked in to the Administrator's office and saw the gun with a clip lock through it on her desk. She heard Resident #1 had two clips and the gun was loaded. After finding the gun, staff were supposed to look in his bags, pockets and make sure he wore his wander guard. She had never been asked to check Resident #1 or his room nor did she ever do checks. During interview on 5/16/18 at 2:40 PM, Staff D stated she worked the 2 PM-10 PM shift. Staff D stated she was told Resident #1 could not leave the facility with visitors. Staff D believed staff should do random body checks on Resident #1 but no one asked her to do them. On 5/16/18 at 3:00 PM, when asked if he felt safe at the facility, Resident #1 replied of course; the staff here is awesome and so nice. Resident #1 stated he had no doubt his peers were safe too. On 5/17/18 at 8:13 AM the Administrator stated the reason for the care plan update on 2/21/18 was because of miscellaneous items found in	F 689		

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Resident #1's room such as a small stick and something that looked like a knife. Unit staff found these items.

On 5/17/18 at 8:28 AM the Operations Nurse Consultant stated not all employees have work emails, so she would have expected a meeting about the gun with all staff to have taken place.

During interview on 5/17/18 at 8:56 AM, the ADON stated they updated Resident #1's care plan on 2/21/18 after finding a police baton in his room. She was unsure of the list of unsafe items given to Resident #1's POA and Resident #1. The ADON stated she is just learning about care plans and would get input from the Operations Nurse Consultant. She also stated Resident #1's ex-wife has a history of not keeping a close eye on him. When questioned why no search or check had been completed after the resident returned on 2/23/18, the ADON stated she did not know and could not be sure when they implemented the room check sheet; she thought it may have been 2/21/18 to track and monitor the searches. The ADON agreed the check sheet needed to be more detailed in the comments section as to what staff did and what is expected of staff.

On 5/17/18 at 9:38 AM Staff Y LPN stated she worked on the unit while employed. Staff mentioned to do searches on Resident #1 but she was never asked to do them. Staff Y stated prior to the gun being found, Resident #1 could go off grounds with his ex-wife. After they found the gun, she believed Resident #1 could still go on visits with his ex-wife but his mother had to be there too.

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During interview on 5/17/18 at 12:18 PM Staff W CNA stated she heard about the gun being found in Resident #1's room but no one ever asked her to do a person or room check while working.

On 5/21/18 at 11:05 AM Staff R CNA stated she works the 6 AM-2 PM shift on the unit, all the time. She stated that before finding the gun in Resident #1's room, they had found a police baton and knives and it seemed like every time he would go out with his ex-wife, is when he brought back those items. Staff R stated the Administrator stated Resident #1 could not go with his ex-wife and if he did, the nurses were to do searches. Staff R stated the searches were not being done and no one ever told to do them. She also stated that when management was not in the facility, the nurses were the ones to do them as they were in charge. Staff R stated she worked when he went out on 5/13/18 and he returned as she left for the day.

During interview on 5/22/18 at 11:00 AM the Operations Nurse Consultant stated she could not find any behavior data for Resident #1 in his electronic health record. At 12:33 PM she also stated they could not find the list of unsafe items provided to Resident #1 and his POA.

The police report filed on 2/27/18 at 11:37 AM recorded the Administrator reported Resident #1 had a loaded gun on the unit, police unloaded the gun and it was in their possession. The Administrator stated she would like to speak with an office an officer responded and Resident #1's family was contacted and a gun lock was placed on the gun. The resident's family will make arrangements to pick up the weapon.

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Review of the facility's Firearm Policy revealed it is the policy of this facility to strictly prohibit firearms anywhere on facility property. This applies to residents, visitors and staff. On 5/16/18 the ADON made the following note: there are state laws that require postings at the doors and must be included in admission packet etc. This was looked into but not implemented due to the restraints.

B. Review of Resident #1's care plan, revised on 4/30/18, revealed he had a recent elopement. The care plan documented the facility fixed windows to allow them only to open a small width with an initiated dated of 4/30/18. On 5/8/18, staff updated the care plan by placing Resident #1 on 15 minute checks.

An Elopement progress note dated 4/30/2018 at 6:15 AM recorded Staff S entered the unit and began passing medication to other residents. At 6:35 AM, Staff S knocked on Resident #1's door and upon opening stated, knock, knock. I have your medication. She then turned on his light to see pillows arranged to look like a body under covers in his bed. Staff S called out resident's name again while looking in his closet and bathroom. When she could not find Resident #1, she exited his room and asked Staff R where he was. At this point Staff R started at one end of the hall and Staff S started at the other looking in every room, bathroom, closet, under beds and the dining room. When neither of them could find Resident #1, the Dietary Manager and Staff S looked out in the court yard. Staff S then paged overhead to all staff to assist Resident #1 to his room. Staff S exited the unit with Staff R and Staff A stayed on the unit. Staff S went to East nurse's station where all staff had gathered and informed

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two other CNAs to make a head count on all residents besides the unit as it had already been counted. At this time, Staff R paged Staff S to unit and stated she had found a note from resident stating he was leaving. Staff S called the Administrator and informed her of the situation as she was outside looking around the building. The Social Service designee and Dietary Manager proceeded to get into their personal vehicles and started looking for resident off facility property. The Administrator instructed Staff S to call the police and she informed 911 of the situation. An Officer entered building at 7:15 AM and took a statement. At 7:45 AM Staff S received notice that police found Resident #1 and he was back in the building. Staff S performed a head to toe assessment on the resident. Resident #1 had an abrasion to left shin measuring 1 centimeter (cm) x 0.5 cm, an abrasion to right thumb near palm measuring 0.5 cm x 0.5 cm, an abrasion to right wrist of 2 cm x 0.5 cm and abrasions/scratches to his abdomen around the naval. Staff placed the resident placed on 1:1 supervision at this time. Management called his family and Staff S called Resident #1's primary care provider.

On 5/16/18 at 10:30 AM, during the observation and room search with Staff A, both windows had screws directly above the sliding window on each side, making four screws on his window panel. All four screws were tight. Each window had two release latches with a white, dry substance covering the latches (informed this was gorilla glue).

Observation on 5/15/18 at 4:00 PM revealed the following room windows without screws in them on the CCDI Unit:
a. Room 303 one window with no screws;

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F 689	Continued From page 42 b. Room 305 one window with no screws; c. Room 302 both windows with no screws; d. Room 307 both windows with no screws. Observation on 5/16/18 at 10:39 AM revealed the CCDI unit doors leading to the 200 hall had a key pad to exit the unit. The doors remain locked until the code is entered. Staff S LPN stated the unit doors are not wander-guarded and believed the only door that is would be the front door. The unit doors leading to the 200 hall do not alarm when left open. The observation revealed silver magnets on the walls and doors to help hold the door open and the windows in the living room on the unit showed one out of four window panels had screws over the sliding window. The unit doors to the 300 hall also had a key pad to exit the unit and these doors remained locked unless the code is entered. These doors also do not alarm if left open for an extended period of time. Silver magnets on the walls and doors of 300 hall also helped hold the door open. Resident #1's room is at the front of this hall, next to the unit doors. Continued observation at 11:00 AM revealed the unit doors joining the back half of the 300 hall lead to an exit door; this exit door is alarmed, once the door is opened and there is no key pad to enter a code prior to exit. Once outside, the exit it puts one in the same area where Resident #1 eloped from the facility on 4/30/18. Before getting to that exit door, the 400 hall leads to the dining room and the location of another exit door. This exit door is alarmed, once the door is opened and has no key pad to enter a code prior to exit. Once outside the exit door, it puts one in a grassy area with a broken fence leading to a residential area of town. All windows on the back half of the 300 hall and the 400 hall were not secured.	F 689		

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On 5/17/18 at 8:56 AM a walk through on the unit was completed with the ADON to show her which windows still needed to be secured.

Review of the facility's 15 minute safety checks for Resident #1 revealed the following information:
On 5/10/18 at 12:45 PM, he walked across the hallway into another resident's room and pulled back the curtains, checking the windows.
On 5/15/18 at 12:00 PM, he looked at the windows in a neighboring room and staff told the resident he cannot go in to other's rooms.

The ADON provided a list of residents in the facility that required a bed, chair and/or floor alarm on 5/22/18 which revealed two residents had alarms on the 400 hall, one resident had an alarm on the back half of the 300 hall and two residents had alarms on the CCDI unit.

Review of the facility's Resident Care Polices and Procedure Manual related to Resident Elopements, revised on 4/5/02 revealed a missing resident audit tool will be completed and evaluated at the next quality assurance (QA) meeting. The resident's care plan will be revised to reflect elopement and a prevention plan will be developed.

During interview on 5/14/18 at 2:49 PM Staff R CNA stated she works the 6 AM-2 PM shift, on the unit all the time. When asked if Resident #1 had a history of attempting to leave the facility prior to the elopement, Staff R stated he had made comments when he first came in that he could find a lot of ways to get out of the facility. On 5/21/18 at 11:05 AM Staff R stated she has

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witnessed the unit doors being propped open on the 300 halls when she comes into work at 5:30 AM.

On 5/15/18 at 8:50 AM Staff T Registered Nurse (RN) stated she worked the overnight shift and has witnessed the CCDI unit doors being propped open on that shift. When asked why they were propped open, she stated because they are short staffed. Staff T stated after Resident #1 eloped, the facility placed him on 1:1 supervision and he stated he planned to run again.

During interview on 5/15/18 at 9:08 AM Staff A stated she works the 6 AM-2 PM shift and has witnessed the CCDI unit doors propped open when she comes to work. Staff A stated she has heard Resident #1 say he still wants to leave the facility and has caught him going into to other resident's rooms, checking the windows. Staff A stated after the elopement, Resident #1 was on every 15 minute checks on the 6 AM-2 PM and 2 PM-10 PM shifts, and 1:1 supervision on the 10 PM-6 AM shift.

During interview on 5/15/18 at 9:40 AM Staff M LPN stated she has witnessed the CCDI unit doors propped open down the 200 hall when she would come in for her 6 AM-2 PM shift.

On 5/15/18 at 10:40 AM Staff Q overnight charge nurse, stated she had witnessed the CCDI unit doors propped open on overnights. When asked why they were propped open she stated because they were short staffed.

During interview on 5/15/18 at 2:15 PM Staff I stated she has witnessed the CCDI unit doors propped open when she would come in for her

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shift. Staff I stated there would be a CNA at the entrance of the unit or at the end of the 300 hall and staff prop the doors open during break time.

On 5/16/18 at 9:35 AM, Staff H stated when she would come in to work her 6 AM-2 PM shift she would see the CCDI unit doors propped open. The 300 hall unit doors that split the 300 hall are the doors she would see propped open when she would come in to work.

During an interview on 5/16/18 at 12:20 PM, Resident #1's POA stated Resident #1 talked frequently about wanting to go to Alaska to start over.

On 5/16/18 at 1:00 PM Staff S stated Resident #1 had made comments that he felt like a caged animal and has been witnessed going in and out of other resident's rooms looking at the windows. Staff S stated the screws that are in Resident #1's window frames are loose and they used gorilla glue on the releases in his room.

During an interview on 5/16/18 at 3:00 PM, Resident #1 stated he isn't allowed to go outside any more. Resident #1 stated he left the facility out his window, took the patio furniture to step on to his air conditioning unit and then climbed onto the roof. He stated once he was across the center of the building, he scaled down the roof and took off. Resident #1 stated he packed to heavy so he started to head back to the facility. He stated that is when the officer found him and he surrendered himself. When asked where he was going, he said he wanted to go to Alaska. Resident #1 didn't want to die and never have the chance to go to Alaska. Resident #1 stated he wants to exercise by walking outside. He stated

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F 689	Continued From page 46 he used to be a wrestler and needs to burn calories and get in to shape for his next excursion, but he stated 'you didn't hear me say that'. Resident # 1 wanted to go outside and had no plans of escaping in broad daylight. On 5/16/18 at 3:50 PM, when asked for Resident #1's elopement risk assessment(s), the ADON stated the facility had an old elopement risk assessment tool they previously used but do not use anymore. The ADON stated the admitting nurse had the discretion to put a resident at risk for elopement. During interview on 5/16/18 at 6:29 PM, Staff B stated she worked the 10 PM-6 AM shift and would prop the unit doors open on the 300 hall so she could go the bathroom. Staff B stated she would ask the CNA covering the back half of the 300 hall to watch the unit while she went to the bathroom. On 5/16/18 at 6:36 PM Staff X CNA stated when she has had to go to the bathroom, she had another aide from the 300 hall put a chair in front of the 300 hall unit doors. The doors were left open and the aid sat in front of the doors, looking down the hall. During interview on 5/17/18 at 12:18 PM Staff W CNA stated she worked the 10 PM-6 AM shift, always on the unit. She stated she has propped the unit doors open so she could go to the bathroom. When she props the doors open, she will ask the 400 hall CNA to watch the unit door while she goes to the bathroom. Staff W stated there are no public bathrooms on the unit and she is only gone 2-3 minutes with the unit doors propped open.	F 689		

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F 689	Continued From page 47 During interview on 5/21/18 at 11:05 AM Staff R stated she has witnessed the 300 unit hall doors propped open when she comes in to work her 6:00 AM-2:00 PM shift. When asked what would happen if a bed alarm would go off while the 300 hall aide watched the whole hall, she said good question. On 5/17/18 at 8:13 AM the Administrator stated the CCDI unit doors should never be propped open. On 5/17/18 at 8:56 AM the ADON stated staff have walkie-talkies to communicate with each other and should never prop the unit doors open. She also stated there is a communication board on the unit where staff post pertinent information, but other residents walk through this area and use the phone there so they stopped posting resident information. She stated the CNAs use a pad of paper to communicate information amongst each other. Staff R produced a pad of paper with notes. When asked what she does with the pad once it is full, she stated they shred it and throw it away. The ADON stated the pad will now need to be given to management after it is full. On 5/17/18 at 8:28 AM the Operations Nurse Consultant stated she will make sure all of the windows on the CCDI unit are secured. She also stated staff will be educated on not propping the unit doors open. She stated the electronic health record has an elopement risk assessment tool that should have been utilized.	F 689		
F 692 SS=D	Nutrition/Hydration Status Maintenance CFR(s): 483.25(g)(1)-(3)	F 692		

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§483.25(g) Assisted nutrition and hydration. (Includes naso-gastric and gastrostomy tubes, both percutaneous endoscopic gastrostomy and percutaneous endoscopic jejunostomy, and enteral fluids). Based on a resident's comprehensive assessment, the facility must ensure that a resident-

§483.25(g)(1) Maintains acceptable parameters of nutritional status, such as usual body weight or desirable body weight range and electrolyte balance, unless the resident's clinical condition demonstrates that this is not possible or resident preferences indicate otherwise;

§483.25(g)(2) Is offered sufficient fluid intake to maintain proper hydration and health;

§483.25(g)(3) Is offered a therapeutic diet when there is a nutritional problem and the health care provider orders a therapeutic diet.
This REQUIREMENT is not met as evidenced by:
Based on clinical record review and staff interview, the facility failed to monitor and report ongoing issues of weight loss and decreased hydration in one of 16 residents sampled (Resident #23). The facility reported a census of 52 residents.

Findings include:

1. The Minimum Data Set (MDS) assessment dated 3/30/18 recorded a Brief Interview of Mental Status (BIMS) score of one out of 15 for Resident # 23 which indicated severe long and short term memory deficits. The resident had diagnoses that included hip fracture, malnutrition,

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nontraumatic subdural hemorrhage, hypothyroidism, an unspecified mental disorder, a history of falling, a psychotic disorder and diabetes mellitus. The resident required the assistance of two staff with transfers, bed mobility, dressing, toilet use and personal hygiene and she ate independently.

The resident's plan of care documented a focus area of the potential for altered nutrition related to recent hip fracture, anemia, dementia, and diabetes and with an initiation date of 9/27/17. Interventions instructed staff to provide a general diet per physician's orders (the family did not wish for the resident to follow a diabetic diet despite a history of diabetes), to provide extra protein at meals, 8 ounces of Breeze (supplement) and an evening snack per request every day, record meal intakes, assist the resident at meals and report significant weight changes to the Physician and family.

A notice to the physician from the facility's dietician dated 3/26/18 identified Resident # 23 had a weight loss of 14 % in 6 months and an A1C (blood glucose levels in the system for 2 to 3 months) of 6.5 (normal is 4.5 to 6.0). The dietician recommend 8 ounces of Breeze juice every day and 4 ounces of Med Pass supplement every day. The physician approved the recommendation on 3/27/18.

According to the April 2018 Medication Administration Record (MAR), facility did not begin to offer the Breeze juice and supplement until 4/9/18, 13 days after being ordered. The April MAR documented the resident refused the Breeze juice supplement 6 times in 18 days and refused the Med Pass supplement 8 times in 19

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F 692	Continued From page 50 days. The 4/16/18 Quarterly Nutritional Progress Note used by the Dietician to assess each resident's nutritional needs identified a significant weight loss for 6 months of 14 % . Resident # 23's supplements included 8 ounces of Breeze juice and 4 ounces of Med Pass 2.0 supplement every day. The Follow Up Question Report form concerning meal intakes revealed Resident #23 refused to eat at meals 19 times out of 27 days for all meals for the month of April 2018 and her intake varied from 0 to 50 % The Dietary Recommendations Form of 4/16/18 documented Resident #23 had a 4% weight loss in 30 days and reinforced that staff needed to ensure the resident received the supplements as ordered. After 3/26/18, the medical record contained no further notifications to the physician of the continued decline in weight. On 5/21/18 at 11:10 A.M., the facility's Registered Dietician (RD) stated 3/26/18 was the last time she notified the physician concerning the resident's weight loss. She recalled Resident #23 declined over a period of time. The RD could not confirm Resident # 23 received the ordered supplement on any consistent basis. A couple of months ago, the Administrator and the Assistant Director of Nursing discussed who would be responsible for physician notifications of changes in weights and decided the RD would be responsible; the RD only comes to the facility every two weeks. She did not know if anyone	F 692		

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kept track of the weights falling into the time periods she did not visit. The RD did not think anyone at the facility took care of this and this was a concern.

The undated facility Change of Condition-Resident Physician/GNP Notification form directed staff to notify the physician of changes in the resident's condition or health status as necessary and document the time of the call, who notified, reason for the notification, and any orders received. The care plan should also be updated.

F 727 SS=E RN 8 Hrs/7 days/Wk, Full Time DON F 727

CFR(s): 483.35(b)(1)-(3)

§483.35(b) Registered nurse
§483.35(b)(1) Except when waived under paragraph (e) or (f) of this section, the facility must use the services of a registered nurse for at least 8 consecutive hours a day, 7 days a week.

§483.35(b)(2) Except when waived under paragraph (e) or (f) of this section, the facility must designate a registered nurse to serve as the director of nursing on a full time basis.

§483.35(b)(3) The director of nursing may serve as a charge nurse only when the facility has an average daily occupancy of 60 or fewer residents.
This REQUIREMENT is not met as evidenced by:
Based on facility record review and staff interviews, the facility failed to assure Registered Nurse (RN) coverage for eight out of 24 hours. The facility identified a census of 52.

Finding include:

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	165497	A. BUILDING _____ B. WING _____	C 05/24/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
QHC WINTERSET NORTH, LLC	411 EAST LANE STREET WINTERSET, IA 50273

(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 727	Continued From page 52	F 727		

1. During interview on 5/14/18 at 2:10 PM, the Business Office Manager (BOM) stated Staff O, RN and former director of nursing (DON) last worked in the facility on 3/12/18. After that, Staff F, RN and Minimum Data Set (MDS) Coordinator took over as the facility's DON. Staff F's last worked in the facility on 4/8/18 and since the time the facility has not had a DON.

Review of facility nursing schedules for April and May, 2018 on 5/18/18 revealed the following days with no scheduled RN coverage: 4/8, 4/13, 4/17, 4/20, 4/26, 5/2, 5/3, 5/4, 5/7, 5/12, 5/14, 5/15, 5/16, 5/17 and 5/18.

During interview on 5/14/18 at 4:10 PM the Administrator stated she had been aware of the lack of an RN scheduled daily, but the facility only has one RN on staff and they could not always get one scheduled through temporary staff agencies.

F 842 SS=E — Resident Records - Identifiable Information
CFR(s): 483.20(f)(5), 483.70(i)(1)-(5) — F 842

§483.20(f)(5) Resident-identifiable information.
(i) A facility may not release information that is resident-identifiable to the public.
(ii) The facility may release information that is resident-identifiable to an agent only in accordance with a contract under which the agent agrees not to use or disclose the information except to the extent the facility itself is permitted to do so.

§483.70(i) Medical records.
§483.70(i)(1) In accordance with accepted professional standards and practices, the facility

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F 842	Continued From page 53 must maintain medical records on each resident that are- (i) Complete; (ii) Accurately documented; (iii) Readily accessible; and (iv) Systematically organized §483.70(i)(2) The facility must keep confidential all information contained in the resident's records, regardless of the form or storage method of the records, except when release is- (i) To the individual, or their resident representative where permitted by applicable law; (ii) Required by Law; (iii) For treatment, payment, or health care operations, as permitted by and in compliance with 45 CFR 164.506; (iv) For public health activities, reporting of abuse, neglect, or domestic violence, health oversight activities, judicial and administrative proceedings, law enforcement purposes, organ donation purposes, research purposes, or to coroners, medical examiners, funeral directors, and to avert a serious threat to health or safety as permitted by and in compliance with 45 CFR 164.512. §483.70(i)(3) The facility must safeguard medical record information against loss, destruction, or unauthorized use. §483.70(i)(4) Medical records must be retained for- (i) The period of time required by State law; or (ii) Five years from the date of discharge when there is no requirement in State law; or (iii) For a minor, 3 years after a resident reaches legal age under State law.	F 842		

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F 842	Continued From page 54 §483.70(i)(5) The medical record must contain- (i) Sufficient information to identify the resident; (ii) A record of the resident's assessments; (iii) The comprehensive plan of care and services provided; (iv) The results of any preadmission screening and resident review evaluations and determinations conducted by the State; (v) Physician's, nurse's, and other licensed professional's progress notes; and (vi) Laboratory, radiology and other diagnostic services reports as required under §483.50. This REQUIREMENT is not met as evidenced by: Based on observations, facility policy review and staff interviews, the facility failed to secure resident records against loss, destruction or unauthorized use. The facility identified a census of 52. Findings include: Observation on 5/16/18 at 10:50 AM revealed a large steel storage container located outside of the main dining room exit door. The storage container had two doors, one of which was wide open. The area is located on the northeast yard with staff parking off to the side. At 1:16 PM, observation revealed the door to container still stood open and it contained various cardboard boxes and filing cabinets. The cardboard boxes contained closed medical records with resident's names listed on the boxes, residents' Medicare south, south deposits, quality assurance notes, past residents and boxes with residents' names on them. During interview on 5/16/18 at 2:00 PM the Dietary Services Manager (DSM) stated she just	F 842		

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F 842	Continued From page 55 locked the door on the outside storage unit with a padlock attached to the open door. The DSM stated Staff JJ, housekeeper, told her she assisted the surveyors out the dining room door to observe the open storage unit. The DSM stated she did not know what is stored in the unit and who has a key for it. During interview on 5/16/18 at 2:10 PM, the Administrator stated she did not know the contents of the storage unit and why it was not locked. She presented a Medical Records Storage Policy which instructed that medical records will be retained seven years from the last date of service in a locked environment. The policy contained handwritten documentation the facility wrote and implemented the on 5/16/18 at 1:25 PM.	F 842		
F 868 SS=E	QAA Committee CFR(s): 483.75(g)(1)(i)-(iii)(2)(i) §483.75(g) Quality assessment and assurance. §483.75(g)(1) A facility must maintain a quality assessment and assurance committee consisting at a minimum of: (i) The director of nursing services; (ii) The Medical Director or his/her designee; (iii) At least three other members of the facility's staff, at least one of who must be the administrator, owner, a board member or other individual in a leadership role; §483.75(g)(2) The quality assessment and assurance committee must: (i) Meet at least quarterly and as needed to identifying issues with respect to which quality assessment and assurance activities are necessary.	F 868		

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F 868	Continued From page 56	F 868		

This REQUIREMENT is not met as evidenced by:
Based on facility record review and staff interview, the facility failed to ensure effective quality assurance program in place to provide quality care to residents. The facility identified a census of 52 residents.

Findings include:

Review of the survey activity reports posted in the facility revealed the following deficiencies identified during the survey activities listed below:

a. Dignified treatment and interactions with residents cited during the current investigation and revisit ending 5/24/18, during the annual survey of 3/21/18 and during the investigation ending 11/30/17.
b. A lack of sufficient staffing cited during the current investigation and revisit ending 5/24/18 and during the investigation ending 11/30/17.
c. Development of resident plans of care to reflect current needs during the current investigation and revisit of 5/24/18 as well as during the annual survey of 3/21/18.
d. Provision of nursing supervision during the current investigation and revisit ending 5/24/18, during the survey of 3/21/18 and the investigation ending 11/20/17.
e. Provision of appropriate and timely assessment and intervention for residents with condition changes during the revisit and investigation that ended on 5/24/18 and during the annual health survey of 3/21/18.

During interview on 5/17/18 at 3:05 PM, the Administrator stated she could not locate documentation of monitoring for compliance with

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CENTERS FOR MEDICARE & MEDICAID SERVICES

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F 868	Continued From page 57 deficient practices identified during previous survey activities due to several changes in administrators and directors of nursing in the recent months. The Administrator stated she planned to make the quality assurance process a priority in the upcoming months.	F 868		

This plan of correction constitutes our credible allegation of compliance. Preparation and/or execution of this plan of correction does not constitute admission or agreement by the provider of the conclusion set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because it is required by the provision of the federal and state laws.

F 550

Winterset North treats each resident with respect and dignity and cares for each resident in a manner and in an environment that promotes maintenance or enhancement of his or her quality of life, recognizing each resident's individuality. This includes dressing and interacting with residents in a dignified manner.

- An audit was completed on 06/25/18 and Resident #15 has received daily grooming and hygiene (which includes removal of her facial hair and food from the corners of her mouth) and has been dressed appropriately and in a manner to not expose her back. R #15's was reassessed by the nurse and care plan updated and revised to address daily grooming, hygiene, and dressing.

  Resident #1 was safely discharged from the facility on 5/22/18.

- All residents have the potential of being affected.

  Resident interviews were completed on 06/26/18 to ensure they are being cared for in a manner and in an environment that promotes maintenance or enhancement of his or her quality of life, recognizing each resident's individuality. This includes dressing and interacting with residents in a dignified manner.

- Facility staff were re-inserviced on 06/21/18 and ongoing: Resident Rights

  Facility staff were re-inserviced on 6/21/18 and ongoing: Grooming and Hygiene

- Respect and dignity audits will be conducted by the Administrator or designee including resident interviews and physical observations of grooming and hygiene weekly for 8 weeks, bi monthly times 1 month with results reviewed by the facilities QA Committee for further determination.

- Correction Date: June 29, 2018

F 657

The facility reasonably ensures that each resident has a comprehensive care plan that is reviewed and revised by the interdisciplinary team after each assessment, including both the comprehensive and quarterly or as needed based on the residents condition.

- Resident #1 was safely discharged from the facility on 5/22/18.

  Resident #6 was reassessed by the Licensed Nurse and has no pressure ulcers and skin issues resolved and skin currently intact.

  Resident #12 no longer resides in the facility as of 4/22/18.

- All residents at risk for elopement, having pressure ulcers, and having or bringing in an unsafe item (weapon) in the facility are at risk.

  On 06/25/18 an audit of residents at risk for elopement, having pressure ulcers, or having unsafe items in the facility care plans were reviewed and updated along with adding interventions to provide guidance to the staff for the care and treatment for the resident.

  On 06/25/18 a weekly skin meeting was conducted by the IDT to review the status of residents with pressure ulcers and care plans will be reviewed and updated along with adding interventions that provide guidance to the staff to follow to assist with treatment and resolution of her ulcer.

  An audit was completed on 06/26/18 and facility resident care plans have been reviewed and updated/revised

  The IDT will review the 24 hour report for individuals having unsafe items (weapons) and the resident care plan will be reviewed and updated along with adding interventions to provide guidance to the staff for the care and treatment for the resident.

- The facility staff were re-inserviced on 06/21/18 and ongoing on the facility process/standards on Resident Care Plans.

- Care Plan audits will be conducted by the DON or designee weekly for 8 weeks, bi-monthly times 1 month with results reviewed by the facilities QA Committee for further determination.

- Correction Date: June 29, 2018

F 658

The facility reasonably ensures it meets professional standards by arranging services as outlined in the comprehensive care plan and evidenced by following physician orders.

- On 06/25/18 Resident #2 physician orders have been reviewed by the RN and are being followed.

- All Residents receiving orders for BMP (Basil Metabolic Profile) are at risk

  On 06/25/18 an audit of residents having orders for lab work was completed to ensure physician orders are being followed.

  On 06/25/18 the DON or designee created a flowsheet/log for lab and physician orders and document completion to ensure physician orders are being followed.

- Facility staff were re-inserviced on 06/21/18 and ongoing on the facility processes/standards: Labs and Physician Orders.

- Following physician lab order audits and lab audits will be conducted by the DON or designee weekly for 8 weeks, bi-monthly times 1 month with results reviewed by the facilities QA Committee for further determination.

- Correction Date: June 29, 2018

F 684

The facility reasonably ensures quality of care is the fundamental principle that applies to all treatment and care provided to facility residents, which is based on a comprehensive assessment of the resident and that each resident receives treatment and care in accordance with professional standards of practice, the comprehensive person-centered care plan, and the residents choices.

- Resident # 23 no longer resides in the facility as of 04/27/18.

- All residents have the potential to be affected.

  A facility wide audit was completed on 06/25/18 of residents having a change in condition, to ensure a thorough assessment had been completed with physician being notified of the change in condition along with assessment results, family notification, treatment plan of care in place, documentation completed in the nursing notes, ongoing focused assessment of the residents condition.

  On 06/24/18 the DON developed a daily alert charting/24 hour report flow sheet.

  On 06/24/18 the DON developed a daily grand rounds flow sheet.

- Facility staff were re-inserviced on 06/21/18 on the facility process/standards for Change of Condition-Resident Physician/GPN Notifications

  Facility staff were inserviced on 06/21/18 the new alert charting 24 hour report flow sheet.

- Audits will be conducted by the DON or designee weekly for 8 weeks, bi monthly times 1 month with results reviewed by the facilities QA Committee for further determination.

- Correction Date: June 29, 2018

F 686

The facility reasonably ensures that based on the comprehensive assessment each resident receives care, consistent with professional standards of practice to prevent pressure ulcers and does not develop pressure ulcers unless the individual's condition demonstrates that they are unavoidable and that appropriate assessment and treatment of the pressure ulcers promote healing.

- Resident #6 was reassessed by the Licensed Nurse on 06/11/18, 06/18/18, and 06/25/18 and has no pressure ulcers and skin is currently intact.

  Resident #12 no longer resides in the facility effective 04/22/18.

- All residents at risk or having pressure ulcers, in the facility are at risk.

  An audit of residents was completed on 06/25/18, having pressure ulcers, was completed including review of treatment orders, weekly skin check documentation, physician notification, care plans were reviewed and updated along with adding interventions to provide guidance to the staff for the care and treatment of the pressure ulcer promote healing.

  The DON or designee initiated and conduct weekly skin rounds on individuals with pressure ulcers and skin conditions completing the skin sheets, measurements, review treatment orders, monitoring effectiveness of treatments and notification to the physician as needed.

  A weekly skin meeting was initiated on 06/25/18 and conducted by the IDT to review the status of residents with pressure ulcers, including review of treatment orders, TARS, weekly skin check documentation, physician notification, and care plans were reviewed and updated along with adding interventions to provide guidance to the staff for the care and treatment of the pressure ulcer to promote healing.

  Effective 06/17/18 the facility is contracted with Mobile Would Care to provide facility staff additional resources for the care and treatments of wounds to promote healing.

- The facility staff were re-inserviced on 06/21/18 and ongoing on the facility process/standards on Wound Care.

- Skin and pressure ulcer audits will be conducted by the DON or designee weekly for 8 weeks, bi-monthly times 1 month with results reviewed by the facilities QA Committee for further determination.

- Correction Date: June 29, 2019

F 689

The facility reasonably ensures the resident environment remains free of accidents and hazards as is possible and each resident receives adequate supervision to prevent unsafe items in the facility and prevent elopement (unplanned exit) to prevent accidents.

- Resident #1 was safely discharged from the facility on 5/22/18.

- All residents at risk for elopement and having or bringing in an unsafe items (weapon) in the facility are at risk.

  On 06/25/18 an audit of residents at risk for elopement was completed, which includes ensuring an elopement risk assessment has been completed and care plans were reviewed and updated adding interventions to provide guidance to the staff to prevent elopements (unplanned exits) to prevent accidents.

  On 06/25/18 an audit of residents having unsafe items in the facility was completed on and care plans were reviewed and updated adding interventions to provide guidance to the staff for to prevent unsafe items entering the facility.

  On 06/26/18 a safety and security checklist was developed and audit completed, which includes windows and doors secured, doors not propped opened, door locks secured and functioning, outside area secured.

  On 06/21/18 a monthly meeting was held for all facility staff to discuss pertinent issues related to facility operations, facility policies and protocols, mandatory trainings, and resident care and safety. A monthly all staff meeting calendar was created and posted on 06/21/19. At any time an emergency all staff meeting will be conducted to provide guidance and direction during a critical or serious event.

- The facility staff was re-inserviced on 06/21/18 on the facility Elopement standard/process.

  The facility staff was re-inserviced on 06/21/18 and ongoing the facility Weapons standard/process.

  The facility staff was re-inserviced on 06/21/18 and ongoing not propping the doors open on the secured unit.

- A safety and accidents and hazards audits will be conducted by the Administrator or designee weekly for 8 weeks, bi-monthly times 1 month with results reviewed by the facilities QA Committee for further determination.

- Correction Date: June 29, 2018

F 692

The facility reasonably ensures it provides each resident nutrition and hydration status maintenance, which includes maintaining acceptable parameters of nutritional, is offered sufficient fluids, is offered a therapeutic diet, and monitored in a manner to report significant fluctuations to the Registered Dietician and resident Physician.

- Resident #23 no longer resides at the facility on 04/27/18.

- All Residents at risk for weight loss are at risk.

  On 06/25/18 an audit of residents with a significant weight loss was completed, physician was notified and care plans were reviewed and updated along with adding new interventions to provide guidance to the staff for the care and treatment of the resident.

  A weekly Nutrition/Hydration meeting was initiated and conducted on 06/25/18 by the IDT to review the status of residents with weight. The DON or designee will notify the RD and residents physician of any significant weight loss for recommendations and new orders and will review physician diet orders to ensure being followed. Care plans will be reviewed and updated along with adding interventions that provide guidance to the staff to follow to assist with treatment and resolution of her ulcer.

- Facility staff were re-inserviced 06/21/18 and ongoing on the facility process/standards: Change of Condition-Resident Physician/GNP Notification.

  Facility staff were re-inserviced 6/21/18 and ongoing on the facility process/standards: Physician Orders.

  Facility staff were re-inserviced 6/21/18 and ongoing on the facility process/standards: weight loss.

- Nutrition and weight loss system audits will be conducted by the DON or designee weekly for 8 weeks, bi monthly times 1 month with results reviewed by the facilities QA Committee for further determination.

- Correction Date: June 29, 2018

F 727

The facility does reasonably ensure RN coverage 8 hours a day 7 days a week and an RN designated full time as the Director of Nursing/DON.

- The facility has RN coverage 8 hours a day 7 days a week and an RN designated as the Director of Nursing effective 06/18/18.

- All residents have the potential to be affected.

  On 06/27/18 an audit was completed of nursing hours to ensure a minimum RN coverage of 8 hours a day 7 days a week and an RN designated full time as the Director of Nursing.

  On 06/27/18 the ADON completed the nursing schedule 30 days in advance to ensure 8 hours a day 7 days a week of RN coverage. The DON will review the schedule and be immediately notified in the absence of the scheduled RN to ensure coverage 8 hours a day 7 days a week.

- The DON, ADON, RN's and all staff were re-inserviced on 06/21/18 on the requirements and process for daily RN coverage.

- 8 hour 7 days a week RN coverage audits will be conducted by the DON or designee weekly for 8 weeks, bi monthly times 1 month with results reviewed by the facilities QA Committee for further determination.

- Correction Date: June 29, 2018

F 842

The facility reasonably ensures that each resident records is maintained in accordance with professional standard and ensure the medical record is complete, accurate, readily accessible, systematically organized and kept confidential, safe guarded against loss, destruction, and unauthorized use.

- The storage unit which contains resident medical information/records is locked and maintained to keep the information confidential, safe guarded against loss, destruction or unauthorized use.

- All resident medicals records/information is at risk.

  A facility audit was completed to ensure all resident medical records/information secured and maintained to keep the information confidential, safe guarded against loss, destruction, or unauthorized use.

- Facility staff were re-inserviced on 06/21/18 and ongoing on the process and standards on Resident Medical Records.

- Audit will be conducted to ensure medical records are kept confidential, safe guarded against loss, destruction or unauthorized and will be conducted by the DON or designee weekly for 8 weeks, bi monthly times 1 month with results reviewed by the facilities QA Committee for further determination.

- Correction Date: June 29, 2018

F 868

The facility does reasonably ensure it maintains a Quality Assessment and Assurance Committee consisting of the Director of Nursing, the Medical Director or his/her designee, at least 3 other members of the facility staff, at least one of who must be the administrator, owner, a board member or individual in a leadership role. The meeting must review facility survey reports which includes deficiencies identified during the survey to ensure the facilities compliant to the deficient practice.

- A QAA meeting was conducted on 06/28/18 to review the following: Survey findings/reports and progress towards compliance: Dignified treatment and interaction with residents, a lack of sufficient staffing, development of resident plan of care to reflect current needs, provision of Nursing Supervision, Provision of appropriate and timely assessment and intervention for resident with condition changes.

- All residents residing in the facility have the ability to be effected.

  On 06/28/18 a QAA Committee meeting was conducted of the facilities survey activity and significant events.

  The QAA agenda was revised to include a review of survey activity and the facilities progress. The meeting will review facility survey reports, which includes deficiencies identified during the survey and results of audits to ensure the facilities compliant to the deficient practice.

  A 2018 QAA Committee Meeting dates were scheduled.

- The facility staff were re-inserviced on 06/21/18 and ongoing on the facilities standard/process on the Quality Assessment and Assurance Committee.

- QAA committee meeting audits will be conducted by the Administrator or designee weekly for 8 weeks, bi monthly times 1 month with results reviewed by the facilities QA Committee for further determination.

- Correction Date: June 29, 2018