Citation Number: 6859  Facility Name:		Survey		ber 4, 2018	
Touchstone Healthcare Community Facility Address/City/State/Zip: 1800 Indian Hills Drive Sioux City, IA 51104	MW/SS	August	: 13 to Se	eptembe	r 26, 2018
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residents. The resides shall provide, as appropring services under qualified nurses with a these rules:  58.19(2) Medication at j. Provision of accurate intervention for all reseadverse symptoms who mental, emotional, or Based on clinical recephysician interview fareview, the facility failed and timely assessment residents reviewed (R #4, #425, #62 and #66 jeopardy for facility recensus of 77 current residents, seizure disording to the MI assessment dated 3/2 diagnoses that include mellitus, seizure disording to the All assessment dated 3/2 diagnoses that include mellitus, seizure disording to the All assessment dated 3/2 diagnoses that include mellitus, seizure disording to the All assessment dated 3/2 diagnoses that include mellitus, seizure disording to the All assessment dated 3/2 diagnoses that include mellitus, seizure disording to the All assessment dated 3/2 diagnoses that include mellitus, seizure disording to the All assessment dated 3/2 diagnoses that include mellitus, seizure disording the All assessment dated 3/2 diagnoses that include mellitus, seizure disording the All assessment dated 3/2 diagnoses that include mellitus, seizure disording the All assessment dated 3/2 diagnoses that include mellitus, seizure disording the All assessment dated 3/2 diagnoses that include mellitus, seizure disording the All assessment dated 3/2 diagnoses that include mellitus, seizure disording the All assessment dated 3/2 diagnoses that include mellitus, seizure disording the All assessment dated 3/2 diagnoses that include mellitus, seizure disording the All assessment dated 3/2 diagnoses that include mellitus as	de assessment and timely dents who have an onset of hich represent a change in physical condition. (I, II, III)  rd review, observation, staff, mily interviews and facility policy ed to always complete accurate hts and interventions for 8 of 21 esidents #376, #22, #373, #374, 8) which resulted in immediate sidents. The facility identified a	I	\$10,000 held in suspen	n	Upon Receipt
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	and the assistance of or	ith bed mobility and transfers ne with eating. The ed Resident #376 admitted to					
	had diabetes and requir directed staff or the resi levels before meals. The resident had a diet of so potassium 60 mEq (mill	26/18 documented the resident red insulin. The care plan dent to check blood glucose e care plan also identified the odium 2000 mg (milligram) and iequivalents) per day. The care resident had food allergies to					
	3/15/18 revealed Reside with reaction 0 to persist and vomiting. The reside chicken/poultry, fish alled Discharge Instructions if a. Glucagon 1 mg daily be insulin aspart rapid a subcutaneous (SQ) with certain aspart rapid at times a day.  d. Insulin aspart long access in the control of the	ergy-reaction vomiting. The included the following orders: as needed for low blood sugar. cting per low dose sliding scale in meals 3 times a day. cting 0.5 ml SQ with meals 3 eting 8 units SQ with breakfast.					
		mmary Report dated 3/15/18 gram sodium, potassium 60					
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meq diet. The order als nuts and poultry.	o identified his allergies to fish,				
revealed that at 8:05 Pl the facility and CPR (ca progress. Upon arrival the resident supine (flat cardiac monitor showin Large amounts of light resident's mouth and a outside of the diaper. T pulse and not breathing and very dry. The lung Staff stated the residen around 6:00 PM, in the they gave him a sandw something he was aller Staff state they did not resident until 8:00 PM v pulse and with unknow noted lividity or rigor me resident received all his complaints other than ti glucose obtained and n staff established an IV, administered epinephric airway and then intubat in the airway. The resid  Review of the Emerger 3/24/18 revealed the re	gic to but caught it right away. come back to check on the when they found him without a n down time. There was no ortis; staff started CPR. The s medication today and had no he lower blood glucose. Blood noted to be 178. The rescue				Page <b>3</b> of
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	been a little low in the 5 Staff found the resident 8:00 PM, called out EM system) at 8:05 PM and he was found, he was ir activity). The nursing he intubated him and contil 4 doses of epinephrine PEA throughout. When ER, he was unresponsive CPR in progress; CPR or remained with PEA. Exepinephrine and bicarbot stick showed a PH (acid 7.3 and lactic acid level multiple more doses of calcium chloride. CPR of blood gases several mir remained in PEA. Second 6.96. Shortly after this fine ventricular fibrillatio joules and then develop heart rhythm). The resid at 8:52 PM.						
	d. Dinner roll/bread 1 wi e. Fruit Cocktail 1/2 cup					Page <b>4</b> of	
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	revealed the following for a. Meatloaf with gravy 4 b. Capri vegetable blends. Noodles 1/2 cup d. dinner roll/bread 1 ea e. Vanilla ice cream 1/2 f. Milk 4 ounces  Review of the Documer 3/24/18 revealed the fol a. No documented more breakfast. b. 3/24/18 at 11:56 AM c. 3/24/18 at 9:18 PM -  Review of the MAR (medated 3/1 - 3/31/18 revea. Insulin Aspart Solution sliding. On 3/24/18, staff sugar of 56. b. Glucagon Emergency intramuscularly as need parameters) not administrational Review of the Progress PM revealed the nurse blood sugar of 57. Staff high sugar food; he was	d ounces d 1/2 cup  ach cup  at titled Amount Eaten dated lowing: ning meal intake during  - 51% to 75%.  51% to 75%.  edication administration record) ealed the following orders: an Pen-injector 100 unit/ml if held his insulin due to a blood by kit, 1 mg (milligram) led for low blood sugar (no				
		ent completed his meal and				Page <b>5</b> of 3
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	resident lying in his bed unresponsive to pain. If follow up on his blood sate, at which time he wastaff lowered him to the the resident was a full dexcessive mucous and cleared his airway and continued to perform Cleared his airway and continued	The nurse entered the room to ugar and amount the resident as found unresponsive. Four floor and staff initiated CPR as ode. The resident had vomit in the oral cavity so staff continued CPR. A CNA ant) called 911 while the nurses PR. EMS staff arrived and resident's care over to them. At eived a call from the hospital en pronounced dead in the ER. aplete any assessment after a arr.  The of Death dated 3/24/18 eath as lactic acidosis due to the facility had been short of staff only nurse on duty. They did the examount of people they had. At reported Resident # 376 had a did not need his insulin. She esident had a snack and ate it.				Page <b>6</b> of
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breathing. She called for talkie and yelled in the light get the DON (Director or call 911. Staff U stated to help put the resident saw the resident had er chest compressions on breaths due to the eme the facility and transferr hospital at approximate DON told her she would incident. She further recalled (did not remember reported the resident had and didn't eat it. She did supper or not and did not room.  During an interview with medication aide) on 8/2 took the resident's bloo 5:30 PM and it measure U, and went on with her asked a CNA to get the and when she had been Resident #376 had been peanut and butter would saw the CNA make the X stated she didn't go be again and did not know later went to the resident.	resident in bed and not or assistance on the walkie-hall for staff. She told a CNA to of Nursing) from her office and it took her a while to find staff on the floor to do CPR and she mesis in his mouth. She did the resident and gave no sis. The ambulance came to red Resident #376 to the sly 8:00 PM. She stated the do do the charting for the called the resident's family had er day or time) the facility and ad received chicken for a meal dn't know if the resident ate ot recall seeing food in his  In Staff X, CMA (certified 21/18 at 2:15 PM she stated she do sugar approximately 5:00 to see low. She told the nurse, Staff or pill pass. She stated she had a resident some food and drink in the resident's room.  In talking and she asked him if do be OK and he said yes. She sandwich for the resident. Staff oack in the room, didn't see him if he ate supper or not. Staff Unit's room and came out and told call 911. She went to the						
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	to the door to wait for the them to the resident's round an interview with on 8/21/18 at 2:30 PM, from the resident on 3/2 gave him chicken for the and she called the facilistated when the resident blood sugar dropped face Glucagon on several or During an interview with PM she stated she had called to the resident's recode' so they moved hir instructed staff to begin see peanut butter sandwards orner, and she flipped was not blocked and now The emergency medica CPR. The DON also state check the parameters for the doctor and follow furnursing staff did not have insulin. If the resident is check the blood sugar and Review of the Policy and	a the resident's family member she stated she received a call 24/18 and he reported staff e noon meal and he didn't eat it try to report it. She further at had a low blood sugar, his st and she had to administer casions.  The DON on 8/30/18 at 5:00 been working in her office and room. Resident # 376 was a full me to the floor and she CPR. She stated she could wich in his mouth, only in the it out. The resident's airway of Heimlich maneuver required. I team came and took over atted the expectation for staff to be the blood sugar and notify of the instructions. She stated we the authority to hold drugs or not symptomatic, staff should					
	a, Physician Notification	n: If resident has critical				Page <b>8</b> of	
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	condition assessment s calling the medical doct call 911 and then ER are elnteract transfer form a non-life threatening charesident change in conductor.  b. Dramatic fluctuation of glucose levels, level of cresult in immediate control physician.  During an interview with 9/24/18 at 5:50 PM he sacidosis could have been He also sated he would call and notify him of the He further felt the facility active, assist and follows.  2. According to the MDS Resident #22 had diagrameurogenic bladder, diagrameurogenic	a the resident's physician on stated the diagnosis of lactic en due to the low blood sugar. have expected the facility to e resident's low blood sugar. y should have been more up with the resident.  S assessment dated 6/5/18, loses that included anemia, betes mellitus, arthritis, stenosis. The MDS identified S (brief interview for mental the indicated intact cognition. he assistance of one with bed					
		symptoms of infection and if				Page <b>9</b> o	
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	noted tell the nurse.					
		cale dated 8/8/18 revealed the hich indicated the resident as r development.				
Review of the History and Physical dated 8/3/18 revealed the resident's suprapubic catheter had a significant erythematous changes around the area. The resident's buttocks had significant red, erythematous areas and felt warm to touch. The resident also had a few areas of breakdown. The resident had likely cellulitis around the suprapubic catheter insertion site as well as cellulitis on his buttocks.						
	8/6/18 revealed the resi right lower sacrum mea cm with red tissue base	Vound Progress Note dated dent had shear injuries on the suring 2 cm (centimeter) by 2.5 and coccyx which measured 1 sue base. The resident's rashy.				
	dated 8/8/18 revealed the a. Sacrum and coccyx: apply Venelex ointment and coccyx, cover with a b. Groin: Apply Miconaz powder to red areas of c. Vancomycin 1 gram/2 days.	Cleanse with normal saline, to open areas on right sacrum ABD dressing. cole cream and microguard				
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	dated 8/1/18 through 8/3 the sacrum and coccyx and apply Venelex were record.  Review of the Progress revealed the DON recei approximately 2:10 PM primary provider (PCP). relationship with the rescatheter site; both area to be infected. She state resident had not had pe 'several days' and no casince his return. The PC seen by the wound cliniwith her and they would the findings and plan.  Observation on 8/15/18 CNA and Staff S, CNA amorning cares. The residown. Staff cleansed the from the front position a Staff D, LPN (licensed power venelex to the resident' had a dark reddish coloscabbed with scratches applied antifungal powd On 8/29/18 at 2 PM, the	atment administration record) 31/18 revealed the orders for - cleanse with normal saline e not present on the treatment  Notes dated 8/6/18 at 7:35 AM ved a phone call at on 8/3/18 from the resident's The PCP voiced concern in ident's buttock and suprapubic s were draining and appeared ed that she felt confident the ri care or briefs changed in are provided to his surgical site CP planned to have the resident of following the appointment of following the appointment of follow up with the DON with  at 8:20 AM revealed Staff R, assisted the resident with dent walked to the bed to lay or resident's groin and peri area and turned him to the right side. Oractical nurse) then applied s buttocks. The entire buttocks or and areas that appeared and 2 open areas. Staff D then or to the resident's groin area. Or resident had an area on the light irritation and no open				Page 11 of	
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	areas.					
	she stated Resident #22 on the buttocks and he saw a reddened and flat scratches are new. She sheet on Monday when bleeding and she planneshe did not complete a sheen on the MAR. She the wound clinic and the stated she had not seen.  During an interview with 5:50 PM he stated he ashathroom 2 to 3 days proversident sat down and horesident's bottom. He can in the bathroom for her then cleansed the area areas appeared red and he cleansed the area, how brief and the reside further stated the area horeseen before.  3. The MDS assessme Resident #373 had diagon heart failure, hypertensichronic obstructive pulmer respiratory failure and mod MDS documented a BIM street in the same and mod social street in the seen before.	n Staff O, CNA on 8/16/18 at ssisted Resident #22 to the rior to his hospitalization. The				
	orrod maopondonoo (	200 mooney, namoron,	1	1		Page <b>12</b> of 3
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	supervision with eating, shortness of breath and 14-day assessment per The care plan problem is resident had restrictive hypoxemia (a low blood of breath easily. The care is a say and resident's oxygen and resident's oxygen satura and to notify the physician. On 10/3/17 at 2:20 Plappointment to the cand PM.  b. On 10/6/17 at 12:15 If an appointment with no The following Progress by Staff U, LPN on 10/7 a. At 10:30 AM, Staff U primary care provider (Fromplaints of cough and physician ordered Robit mI every 4 hours PRN at treatment) every 4 hours	initiated 5/14/13 identified the lung disease with chronic oxygen level) and gets short are plan identified Resident directed staff to check the ation levels as needed (PRN) an of any changes.  The ses for Resident #373 revealed of the resident went to the certain directed at 4:29. The resident returned at 4:29. The resident returned from the resident returned from the resident were completed of the resident were completed of the resident set of the resident's dispose with the resident's dispose of breath. The russin (a cough medication) 5 and DuoNeb (an inhalation is PRN for shortness of breath. In administered, effective at				Page <b>13</b> of 3		
	b. 11:12 AM - Robitussi 12:03 PM. c. 11:20 AM - DuoNeb t	n administered, effective at						

If, within thirty (30) days of the receipt of the citation, you (1) do not request a formal hearing or; (2) withdraw your request for formal hearing, and (3) pay the penalty; the assessed penalty will be reduced by thirty–five percent (35%) pursuant to lowa Code section 135C.43A (2013).

Date

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e. 3:49 PM - DuoNeb f. 7:30 PM - Staff U or regarding her reques room for evaluation or congestion. The on-PCP and would have g. 7:39 PM - DuoNeb h. 9:12 PM - The resi ordered Resident #37 room and Staff U infoi. 9:55 PM - A Death during transport atter assessments perform notified at 10:01 PM in PM.  Staff failed to conduct Resident #373, despite the following information ALS (advanced life secomplaint that nursing had increased shorth couple of days. The redistressed respiratory and right lungs and a both lungs. Oxygen on normal carotid (neck) radial (wrist) pulse ar 8:32 PM, the resident	alled the resident's PCP to be sent to the emergency of shortness of breath and call service could not reach the doctor call back. administered. dent's PCP returned the call and a to be sent to the emergency armed the resident of this. Note: Resident #373 expired ont in the ambulance and all one by the EMT's. The family was and unit manager notified at 10:00  at a physical assessment of the her deteriorating condition.				Page <b>14</b> of	
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	of days and she cannot the resident is on oxyge rates are decreasing. A saturation level measure via nasal cannula oxyge suggested they needed deteriorating status, the the hospital and she con assistance. The resider assisted the resident to with torso elevated) and and yelling 'I can't breat placed oxygen on the representer mask. The respectation cyanosis around her lips transported to the back eyes to verbal cues. The (continuous positive preprovided at 11 centimet into respiratory arrest but the paramedics remove BVM (bag valve mask) oropharyngeal airway as 12 BPM (breaths per minoted the resident in as paramedics initiated CP in cardiac arrest. Resus 9:58 PM, when paramed Director who ordered to patient to a morgue or fat 10:05 PM, the parameters.	ers (cm). Resident #373 went ut still had a pulse. At 8:48 PM, d the CPAP and applied a with 100% oxygen and an nd bagged the resident at 10-inute). The cardiac monitor ystole (no heart beat) and the PR; the patient continued to be citation efforts continued until dics spoke with EMS Medical terminate CPR and divert the				Page <b>15</b> of
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	she worked 6 AM-10 PM was responsible for Rescontacted the resident's regarding her complaint breath and received ord inhalation breathing treath of the was so busy and dicheck on the resident of first administered doses breathing treatments we administered doses were Resident #373 told her said the resident had Coworse than usual, but the like she was sick and so other staff told her the resident and she sough RN/Nurse Manager. Staff U stated that she were approval to do so exactly what to do at evit could have gone differesident O2 dependent sent to the hospital. Staphysician for an order to hospital and Staff B final ambulance. Staff U starelaxed when informed	aff U stated Staff B told her not to the hospital as she had to and stated that she was told ery turn by Staff B, but she felt rently. Staff U described the and that she begged to be aff U stated she called the posend the resident to the				Page <b>16</b> of 3		
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	gurney as reason the rebreath and went downhing was very upset the resident should have go Staff B directed her not felt "waterlogged" at wo assess the resident and During interview on 8/16 stated he worked the reshift on 10/7/17. He said more lethargic than usu much. He stated she with independent and liked to resident could make her buring interview on 8/17 stated he worked with Ridied. He described her herself. He stated the recalled she asked to go with the nurse present a go.  During interview on 8/27 that she did not know the resident's condition unticalled her and she direct the hospital via ambular interventions to use for severe and she direct the severe and she direct the hospital via ambular interventions to use for severe and she direct the hospital via use for severe and she direct the severe and she	er for her to transfer to the ason she became very short of ill quickly. Staff U stated she dent expired as she felt the one to the hospital sooner, but to send her. Staff U stated she rk and did not have time to fully to document her findings  6/18 at 5:05 PM, Staff R CNA sident's hall for the 2-10 PM d the resident acted a little al and did not verbalize as as a private person, pretty o stay in her room. The rown decisions.  7/18 at 3:30 PM, Staff EE CNA desident #373 on the day she as a private person that kept to esident did not feel well and to to the hospital a few times, at the times she requested to				Page <b>17</b> of 3
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	to the facility because S stated that nurses do not facility to send residents instructed to trust their j feel is needed.  During interview on 8/3′ DON (ADON) stated that the hospital without a phrequests to go and/or it from facility management residents to the hospital assess a resident's vital oxygen saturation level, the bed with complaints notify the physician of the would also expect nurse assessments.  During interview on 9/5/ physician recalled a nur this resident. He could require he would have expected check lung sounds and with the resident about and to contact him if any The physician stated that the hospital without an oif they are requesting to facilities "do that all the	oital. Staff B stated she came staff U acted hysterical. Staff B of have to have approval of the sto the hospital; they are udgment and to do what they are udgment and to do nysician order if a resident is an emergency. Permission on the is not needed to send a signs, lung sounds and raise the resident's head of of shortness of breath and to the resident's condition. She are to document the resident what the parding the resident's condition. If a state of the nurse to do vital signs, oxygen saturation and to visit this/her signs and symptoms you thing further was needed. The are to do retainly send them go and stated nurses in time. When asked if earlier and have made a difference for				Page <b>18</b> (
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	immediate cause of deafor a duration of 8 hours  4. The MDS assessme Resident #374 had diag hypertension, septicemidisorder, Non-Alzheime and obesity. The same score of 12 which indicate memory and cognition. 2 with bed mobility, transfersing, eating toileting. The assessment docume expectancy of less than and received hospice see The care plan problem or resident re-admitted to the with an IV line in the right antibiotics for treatment on the sacral area. And 3/9/17 identified the resident re-sident re-sident resident resident the resident resident resident the resident resi	a for Resident #373 listed the ath as acute respiratory failure is.  Int dated 5/27/18 documented moses that included cancer, and diabetes mellitus, thyroid r's dementia, bipolar disorder MDS documented a BIMS ated moderately impaired She required the assistance of sfer, wheelchair mobility, and hygiene and bathing. The six months, utilized oxygen ervices.  Idated 5/2/18 identified the the facility from the hospital that arm for administration of IV of an infected pressure ulcer other care plan problem dated ident requested full code status ent as her own decision maker				
	treated with respect by the During interview on 8/14 stated she worked the 6	ident to be comfortable and the staff.  4/18 at 2:45 PM Staff L, LPN AMDE AM-2 PM shift on 5/11/18. As common area in her wheelchair,				Page <b>19</b> of :
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Rule or	rive	MW/SS				
Code Section	Natur	e of Violation	Class	Fine A	Amount	Correction date
space and she trans LPN resident states very the states very very the states very the states very very very very very very very very	ce. Staff L stated shas not really family needed to call 911 a sported to the hospid regarding the resident should be transfed the DON yelled a aggressive manner situation with the resident's vital signs, too transferred the resident's vital signs, too transferred the resident exponsive. Staff L what may be going of dent eventually regardent eventually regardent exponsive to the physician but a there was time for member went to suit to the phone to call staff L to hang up the sported the resident accility has a new pong a physician, hosping a physician, and a supplication of the phone to call the physician and physician, hosping a physician, hosping a physician, hosping a physician, and provided the physician and	not speak and stared off into he recently started at the facility iar with the resident but she felt and have the resident tall. She spoke with Staff D, ent and she also agreed the sported to the hospital. Staff L at her to hang up the phone in a rand told her she could handle sident. The DON assessed the book Resident #374 to her room dent to bed with maximum raff member as the resident still stated the DON tried to figure on with the resident and the lined consciousness.  6/18 at 10:10 AM Staff D stated dent on the day of the incident of be acting right. She taff L she should call 911 as the had a history of idiopathic lines. Staff L told her she had Staff D told her she did not that. Staff D stated another limmon the DON and Staff L ll 911. She stated the DON he phone and then staff to her room. Staff D stated olicy that directs that before bital or ambulance staff should is it is 'super-emergent'.				Dama 20 v
						Page <b>20</b> o

Citation Numb	oer:	Date: October 4, 20			er 4, 2018	
Facility Name Touchstone I	: Healthcare Community		Survey August		eptember	· 26, 2018
Facility Addre 1800 Indian H Sioux City, IA		MW/SS				
Rule or Code Section	Natur	e of Violation	Class	Fine A	Amount	Correction date
	documentation of the in stated during interview of incident should have be resident's clinical record.  5. The MDS assessment Resident #4 had diagnor Non-Alzheimer's demer chronic lung disease. The BIMS score of 9 which is impairment. The resident two with transfers and the mobility, walking, dressing Resident #4 had no skirt.	ent dated 8/10/18 documented uses that included hip fracture, atia, anxiety, depression and the same MDS documented a andicated moderate cognitive at required the assistance of the assistance of one with bed and, toilet use and bathing. In issues at the time of the assure reducing device in bed anutrition or hydration				
	Resident #4 as at risk for need for assistance with history of incontinence. monitor for any potential staff should observe the	nitiated on 1/18/18 identified or skin breakdown due to the toilet use and hygiene and a The care plan directed staff to I skin breakdown and nursing resident's skin at least weekly goal to prevent any kind of skin get date of 11/10/18.				
	DON (ADON) present re the resident with morning	at 10:00 AM with the Assistant evealed Staff M, CNA, assisted ag cares. Observation revealed ated gauze dressing wrapped ag above the ankle.				
						Page <b>21</b> c

Facility Name: Touchstone Healthcare Community Facility Address/City/State/Zip: 1800 Indian Hills Drive Sioux City, IA 51104  Rule or Code Section  Review of the resident's Physician Orders revealed no order for any treatment to the right lower leg. Review of the skin sheet book revealed no orgoing assessments for skin integrity issue for this resident.  Observation on 8/15/18 at 12:15 PM with Staff DD, CMA, present revealed the resident had an undated gauze dressing wrapped around the right lower leg above the arkle. Upon request, Staff D observed the dressing on the resident's ankle and removed it at 2:00 PM. Observation revealed a circular area, brown in color, with a 2'x 2' brittle inner dressing adhered to this area. Staff D stated she did not know what type of dressing it was, but she would check the resident's orders and return. At 2:15 PM, Staff D returned to the resident's room accompanied by the nurse consultant. The nurse consultant repeatedly soaked the brittle dressing with a sterile saline solution until it could be removed. The open area measured 2.4 cm x 1.0 cm with a small amount of serosanguineous drainage, shiny in appearance with dry flaky skin on the outside edges. The nurse consultant placed a piece of Vaseline gauze dressing over the area and covered it with an Optifoam Gentle adhesive dressing and dated it. Observation at this time also revealed the resident had 2 steri-strips present on the outer aspect of the right knee. The nurse consultant soaked them off with normal saline solution and applied two 1/4" steri-strips to the areas.  The Skin Condition Report (non-decub) initiated by Staff D on 8/15/18 documented the right shin area	Citation Number: 6859		Date: October 4, 2				er 4, 2018		
Rule or Code Section  Review of the resident's Physician Orders revealed no order for any treatment to the right lower leg. Review of the skin sheet book revealed no ongoing assessments for skin integrity issue for this resident.  Observation on 8/15/18 at 12:15 PM with Staff DD, CMA, present revealed the resident had an undated gauze dressing wrapped around the right lower leg above the ankle. Upon request, Staff D observed the dressing on the resident's ankle and removed it at 2:00 PM. Observation revealed a circular area, brown in color, with a 2" x 2" writtle inner dressing adhered to this area. Staff D stated she did not know what type of dressing it was, but she would check the resident's orders and return. At 2:15 PM, Staff D returned to the resident's room accompanied by the nurse consultant. The nurse consultant repeatedly soaked the brittle dressing with a sterile saline solution until it could be removed. The open area measured 2.4 cm x 1.0 cm with a small amount of serosanguineous drainage, shiny in appearance with dry flaky skin on the outside edges. The nurse consultant placed a piece of Vaseline gauze dressing over the area and covered it with an Optifloam Gentle adhesive dressing and dated it. Observation at this time also revealed the resident had 2 steri-strips present on the outer aspect of the right knee. The nurse consultant soaked them off with normal saline solution and applied two 1/4" steri-strips to the areas.  The Skin Condition Report (non-decub) initiated by Staff D on 8/15/18 documented the right shin area		re Community							
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i duc <b>ee</b> oi	order for the sassess.  Observed CMA, pauze above dressin PM. Ocolor, withis are dressin orders resider. The nudressin remove with a sashiny in edges. Vaselir with an it. Observed the same control of the sa	or any treatment skin sheet book rements for skin in ments for skin in ration on 8/15/18 oresent revealed dressing wrapper the ankle. Upon a gon the resident beervation revealed it was, but she and return. At 2: at Staff D stated and return. At 2: at second a star a second a star a second a star a second a second a second a star a second a s	to the right lower leg. Review evealed no ongoing tegrity issue for this resident.  at 12:15 PM with Staff DD, the resident had an undated d around the right lower leg request, Staff D observed the t's ankle and removed it at 2:00 led a circular area, brown in le inner dressing adhered to d she did not know what type of would check the resident's 15 PM, Staff D returned to the branied by the nurse consultant, peatedly soaked the brittle aline solution until it could be a measured 2.4 cm x 1.0 cm serosanguineous drainage, h dry flaky skin on the outside ultant placed a piece of g over the area and covered it adhesive dressing and dated me also revealed the resident on the outer aspect of the onsultant soaked them off with applied two 1/4" steri-strips out (non-decub) initiated by				Page <b>22</b> 0		

Citation Numb	oer:	Date: October 4, 20°			er 4, 2018	
Facility Name: Touchstone F	: Healthcare Community		Survey August		eptember	· 26, 2018
Facility Addre 1800 Indian H Sioux City, IA		MW/SS				
	,					
Rule or Code Section	Natur	e of Violation	Class	Fine A	Amount	Correction date
	treatment ordered as oil with a bordered Mepilex PRN (as needed) until 18/15/18 at 3:10 PM, Sta Condition Report to the treatment order on the sordered yet but when the would be added to the radministration Record (During interview on 8/16 stated she often bathed bathed the resident 2 tir stated Resident #4 had her right lower leg on an places a garbage bag of bathes the resident. Sharea on the Bath Sheet nurses after each component already know becaused of the treatment to this area yet Condition Report for this completed 8/15/18. The schedule indicated the rassessments assigned shift on Thursdays (8/2) the nursing consultant of	TAR).  6/18 at 5:30 PM, Staff N, CNA, Resident #4 and recalled she mes in the last week. She had some sort of dressing on a doff for some time and she ver the dressing when she restated she does not mark the which is given to the charge leted bath because the nurse ause there is a dressing on it.  at 11:39 AM revealed the dent's right ankle dated TAR revealed no order for extreceived and the Skin is area no updated since in Daisy Lane Skin Assessment.				Page <b>23</b> of 3
 Faci	lity Administrator		 ate			

Citation Numb	per:				Date: Octob	er 4, 2018
Facility Name: Touchstone F	: Healthcare Community		Survey August		eptember	· 26, 2018
Facility Addre 1800 Indian H Sioux City, IA		MW/SS				
Rule or	1		Class	Fine A	Amount	Correction
Code Section	Natur	e of Violation				date
	area as assigned on 8/2	23/18.				
	Resident #425 had diag hypertension, anxiety, o repeated falls. The sam score of 15. The reside with activities of daily liv required supervision. R	nt dated 6/13/18 documented moses that included steoarthritis, edema and ne MDS documented a BIMS nt displayed independence ring except eating, which esident #475 used a walker for falls since the last assessment.				
	The care plan initiated or resident as independent falls.	on 5/26/17 identified the t with ambulation and at risk for				
	Review of the Progress revealed the following:	Notes for Resident #425				
	Registered Nurse, docu weakened while standin went to the floor. The reextremity on the door from the chair. Her left low and swollen but she did issues. Staff C elevated ice. An entry created 8/	/18 at 6:30 PM by Staff C, mented the resident's legs ag in front of the closet and she esident struck her left lower ame as she turned to go back wer ankle looked blue in color not complain of any other d the resident's leg and applied /22/18 at 8:06 AM documented curred 8/18/18 (Saturday).				
	the effective date (of ac 7:11 AM which docume	1/18 at 7:58 PM by Staff C for tual occurrence) on 8/18/18 at nted the resident's son came to /19/18 (Sunday). The nurse				
						Page <b>24</b> of 3
Faci	lity Administrator	Da	 ate			

Citation Numb	er:				Date: Octob	er 4, 2018
Facility Name: Touchstone H	lealthcare Community		Survey Dates: August 13 to September 26, 2018			
Facility Addres 1800 Indian H Sioux City, IA		MW/SS				
Rule or Code Section	Natur	e of Violation	Class	Fine A	Amount	Correction date
	her how she felt. The reknow. The left lower leg she had no more bruisir Staff C documented she ask how she felt about of The son reported later Fassistance and they she how she did before goin A late entry completed be date of 8/20/18 at 4:05 I physician office called a should be transported froom.  An untimed administrati RN documented the reson 8/20/18.  During interview on 8/20 she worked a 16 hour sh	ed on the resident and asked esident replied she did not swelling had subsided and ing than the previous night. It is asked the resident's son to going to the emergency room. Resident # 425 got up with ould wait a day or so and seeing to the emergency room.  By Staff L, LPN for the effective PM documented the resident's and asked how the resident from the office to the emergency on note completed by Staff A, sident admitted to the hospital and assigned to care for ted on 8/18 between around esident had been found laying and they noted her lower leg red light blue bruising below aff C stated she completed esident's arms and right leg as ould allow but did not do range as she could tell the leg caused C said she asked the resident her emergency room but the				Page 25 of
	lity Administrator					Page <b>25</b> of

Citation Number	er:				Date: Octob	er 4, 2018
Facility Name: Touchstone H	ealthcare Community		Survey Dates: August 13 to September 26, 20			· 26, 2018
Facility Addres 1800 Indian Hi Sioux City, IA		MW/SS				
Rule or Code Section	Nature	e of Violation	Class	Fine /	Amount	Correction date
	time of the incident she and placed it in the bask Staff C did not documer Notes until 8/21/18 and because she had not co correctly; she had been stated there is a stack of someone falls so she correport correctly and place stated she did not call the representative at the time could not decide if she worked (non-decub) completed this is the form she faxed notification of the fall. The facsimile sent 8/19/18 at During interview on 8/23 she worked 6 AM-2 PM doctor's appointment for complained of pain, had had a significant bluish of the staff A held her hands of the total complete the size of the did not chart any assess. The hospital History & Face documented the resider edematous and bruised shortened. The ED (em	B/18 at 3:57 PM Staff A stated on 8/20/18 and she made a rethe resident because she difficulty bearing weight and bruise on the left lower leg. but approximately 7-10 inches he bruise. Staff A stated she sment, etc. of the resident.  Physical dated 8/20/18 and externally rotated and				Page <b>26</b> o
						raye <b>20</b> 0

Citation Numb	oer:				Date: Octob	er 4, 2018	
Facility Name: Touchstone F	: Healthcare Community		Survey Dates: August 13 to September 26, 2018				
Facility Addre 1800 Indian H Sioux City, IA		MW/SS					
Rule or Code Section	Nature	e of Violation	Class	Fine A	Amount	Correction date	
	femur fracture on 12/12 diagnoses of fracture of peri-prosthetic (around to female fracture) of the proximal tibia and hospital.  During interview on 9/12 physician stated she wo to notify her, or her oncomingury, regardless of what to go to the emergency had signs of injury at the follow-up assessments and the follow-up assessment follow-up a	joints replaced and had a left /11 and listed the current the left proximal fibula and the knee replacement) fracture If the resident admitted to the Ithe resident wished room. She stated the resident at time of the fall which required and she would have expected in as well. It dated 8/7/18 documented roses that included diabetes is, seizure disorder, anxiety, lung disease. The MDS and the assistance of one with walking, and personal hygiene. Ithe facility with surgical refers the resident with a non healing surgical refers, an abrasion to the left of the left hand. The care plan amine the resident's skin it (Non-pressure) dated 7/10/18 entimeters (cm) scabbed area				Page 27 of	
						Page <b>27</b> of	
Faci	lity Administrator	Da	ate				

Citation Numb	er:				Date: Octob	er 4, 2018
Facility Name: Touchstone H	lealthcare Community		Survey Dates: August 13 to September 26, 2018			
Facility Address 1800 Indian H Sioux City, IA		MW/SS				
Rule or Code Section	Nature	e of Violation	Class	Fine A	Amount	Correction date
	any further assessments A Skin Condition Report documented 3 scabbed hand that measured 3 x. The clinical record lacked A Skin Condition Report documented a wound to measured 4.3 x 4.5 cm clinical record lacked an 8. The MDS assessment Resident #68 had diagon heart failure, hypertensic cholesterol, depression, pneumonia and end state documented the resident documented the resident but none recorded at the however the resident had documented the resident Brief Interview for Mental cognition.  The care plan reviewed an incision on the left up A Skin Condition Report documented Resident #	t (Non-pressure) dated 7/10/18 areas to the resident's left 2 cm, 2 x 2 cm and 2 x 1 cm. ed any further assessments.  t (Non-pressure) dated 7/10/18 of the right upper chest that with a depth of .1 cm. The my further assessments.  It dated 8/1/18 documented oses that included anemia, on, diabetes mellitus, high chronic lung disease, ge renal disease. The MDS at as risk for pressure ulcers time period for the MDS at a surgical wound. The MDS at a surgical wound. The MDS at scored 15 out of 15 on the all Status indicating intact  8/13/18 listed the resident had oper thigh.  t (Non-pressure) dated 7/21/18 are 68 had a .4 x 1 cm surgical at thigh. The clinical record				
Eacil	ity Administrator		ate			Page <b>28</b> of

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Citation Numb 6859	er:				Date: Octob	er 4, 2018
Facility Name:			Survey I	Dates:		
Touchstone H	ealthcare Community		August	13 to Se	eptembei	r 26, 2018
Facility Addres	ss/City/State/Zip:					
1800 Indian Hi		MW/SS				
Sioux City, IA	51104					
Rule or			Class	Fine A	mount	Correction
Code Section	Nature	e of Violation				date
Section						
					<u> </u>	
	During an interview on 8	3/16/18 at 10:30 a.m. the				
		ant stated she could not locate				
	any further assessment	S.				
	On 8/23/18, the facility a	abated the immediate jeopardy				
		provided inservice education to				
	nursing personnel on pr	oviding complete assessments				
	and interventions, speci					
		ections and seizure activity. the IJ from a "K" severity level				
		nonitoring to ensure facility staff				
	is following adequate as					
E0 44/2\	404 E0 44/42EC\ Doro	annal				
58.11(3)	481—58.11(135C) Pers	ninal record checks, child abuse				
	checks and dependent					
		viduals who have committed a				
	crime or have a founded					
		with the requirements found in C.33 as amended by 2013 lowa				
		and rule 481—50.9(135C)				
	related to completion of	criminal record checks, child				
		endent adult abuse checks and				
	to employment of individed to the complex or have a founded to the complex of the	duals who have committed a				
		abuse. (I, II, III)				

Facility Administrator	Date

If, within thirty (30) days of the receipt of the citation, you (1) do not request a formal hearing or; (2) withdraw your request for formal hearing, and (3) pay the penalty; the assessed penalty will be reduced by thirty–five percent (35%) pursuant to lowa Code section 135C.43A (2013).

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Citation Numb	er:				Date: Octob	er 4, 2018
Facility Name: Touchstone H	lealthcare Community		Survey August	r 26, 2018		
Facility Addres 1800 Indian H Sioux City, IA		MW/SS				
Rule or Code Section	Natur	e of Violation	Class	Fine A	mount	Correction date
50.9(3)c	and child abuse record 50.9(3) Requirements for an individual. Prior to experson in a facility, the fidepartment of public sath history check and the deperform child and deperchecks of the person in c. If a person being combeen convicted of a crime undepartment of public satupon the request of the human services will periodetermine whether the other between the person's employment.  Based on personnel file and staff interview, the fidependent adult abuse for 3 of 6 current employ K). Additionally the facile evaluation by the Depar (DHS) to determine if an history could work in the	premployer prior to employing imployment of a facility shall request that the fety perform a criminal epartment of human services indent adult abuse record this state.  Sidered for employment has ince. If a person being inent in a facility has been der a law of any state, the fety shall notify the facility that facility the department of form an evaluation to crime warrants prohibition of int in the facility. (I, II, III)  Teviews, facility policy review facility failed to provide training within 6 months of hire yees sampled (Staff E, NN and	II	\$ 500		Upon Receipt
		·····				
Facil	ity Administrator	Da	ate			

Facility Name: Touchstone Healthcare Community  Facility Address/City/State/Zip: 1800 Indian Hills Drive Sioux City, IA 51104  Rule or Code Section  Nature of Violation  Rule or Code Section  1. The personnel file for Staff E documented hire as a certified nursing assistant (CNA) on 6/15/17. The personnel record contained a certificate which documented completion of dependent adult abuse training for mandatory reporters on 2/8/18, almost 8 months after hire.  A Single Contact License & Background Check (SING) dated 6/8/17 documented a possible criminal history for Staff E and Form S dated 6/12/17 confirmed the criminal history. The facility failed to obtain DHS evaluation of Staff E's criminal history for clearance to work until 9/15/17. Review of the time sheet record for Staff E revealed she worked 52 days for a total of 391.5 hours from 6/15/17 to 9/14/17.  2. The personnel file for Staff NN, CNA documented a hire date of 5/17/17. A Certificate of Completion contained in the personnel file documented Staff NN did not complete dependent adult abuse training for mandatory reporters until 2/15/18, almost 9 months after hire.  3. The personnel file for Staff K, CNA documented a hire date of 6/7/17. A Certificate of Completion contained in the personnel file documented Staff K did not complete dependent adult abuse training for mandatory reporters until 7/30/18, more than 13 months after hire.  During interview on 8/24/18 at 1:55 PM the Human Resources Director stated she failed to assure all staff receive dependent adult abuse training for mandatory reporters until 7/30/18, more than 13 months after hire.	Citation Numb	er:				Date: Octob	er 4, 2018
Rule or Code Section  1. The personnel file for Staff E documented hire as a certified nursing assistant (CNA) on 6/15/17. The personnel record contained a certificate which documented completion of dependent adult abuse training for mandatory reporters on 2/8/18, almost 8 months after hire.  A Single Contact License & Background Check (SING) dated 6/8/17 documented a possible criminal history for Staff E and Form S dated 6/12/17 confirmed the criminal history. The facility failed to obtain DHS evaluation of Staff E's criminal history for clearance to work until 9/15/17. Review of the time sheet record for Staff E revealed she worked 52 days for a total of 391.5 hours from 6/15/17 to 9/14/17.  2. The personnel file for Staff NN, CNA documented a hire date of 5/17/17. A Certificate of Completion contained in the personnel file documented Staff NN did not complete dependent adult abuse training for mandatory reporters until 2/15/18, almost 9 months after hire.  3. The personnel file for Staff K, CNA documented a hire date of 6/7/17. A Certificate of Completion contained in the personnel file documented Staff K did not complete dependent adult abuse training for mandatory reporters until 7/30/18, more than 13 months after hire.  During interview on 8/24/18 at 1:55 PM the Human Resources Director stated she failed to assure all staff receive dependent adult abuse training within 6					· 26, 2018		
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		certified nursing assista personnel record contain documented completion training for mandatory months after hire.  A Single Contact Licens dated 6/8/17 documenter for Staff E and Form Socriminal history. The facevaluation of Staff E's cowork until 9/15/17. Rev Staff E revealed she word 391.5 hours from 6/15/17. A contained in the person did not complete dependent mandatory reporters unafter hire.  3. The personnel file for hire date of 6/7/17. A contained in the person not complete dependent mandatory reporters unafter hire.  During interview on 8/24 Resources Director states.	ant (CNA) on 6/15/17. The med a certificate which of dependent adult abuse eporters on 2/8/18, almost 8 as & Background Check (SING) and a possible criminal history dated 6/12/17 confirmed the cility failed to obtain DHS riminal history for clearance to riew of the time sheet record for orked 52 days for a total of 17 to 9/14/17.  The Staff NN, CNA documented a Certificate of Completion nel file documented Staff NN dent adult abuse training for til 2/15/18, almost 9 months  The Staff K, CNA documented a certificate of Completion nel file documented Staff K did that adult abuse training for til 7/30/18, more than 13				Dago 24 c
	F. 1	it. A designation					. ago <b>01</b> 0

	September	Correction
Fine	Amount	
Fine	Amount	
		date

If, within thirty (30) days of the receipt of the citation, you (1) do not request a formal hearing or; (2) withdraw your request for formal hearing, and (3) pay the penalty; the assessed penalty will be reduced by thirty–five percent (35%) pursuant to lowa Code section 135C.43A (2013).

Date

Facility Administrator