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	165161	A. BUILDING _____ B. WING _____	09/26/2018

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TOUCHSTONE HEALTHCARE COMMUNITY	1800 INDIAN HILLS DRIVE SIOUX CITY, IA 51104

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F 000	INITIAL COMMENTS Correction date 10/18/18 The following deficiencies result from the facility's recertification and licensure survey and investigation of complaints and facility-reported incidents #75431-C, #75791-C, #75987-C, #76089-C, #76181-C, #77524-A, #76727-C, #77538-I, #77641-I, #78658-I and #78659-C. Complaint #76068-C was not substantiated. See the Code of Federal Regulations (42CFR) Part 483, Subpart B-C.	F 000		
F 578 SS=D	Request/Refuse/Dscntnue Trmnt;Formlte Adv Dir CFR(s): 483.10(c)(6)(8)(g)(12)(i)-(v) §483.10(c)(6) The right to request, refuse, and/or discontinue treatment, to participate in or refuse to participate in experimental research, and to formulate an advance directive. §483.10(c)(8) Nothing in this paragraph should be construed as the right of the resident to receive the provision of medical treatment or medical services deemed medically unnecessary or inappropriate. §483.10(g)(12) The facility must comply with the requirements specified in 42 CFR part 489, subpart I (Advance Directives). (i) These requirements include provisions to inform and provide written information to all adult residents concerning the right to accept or refuse medical or surgical treatment and, at the	F 578		

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

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

POC accepted 10/15/18 KK

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F 578	Continued From page 1 resident's option, formulate an advance directive. (ii) This includes a written description of the facility's policies to implement advance directives and applicable State law. (iii) Facilities are permitted to contract with other entities to furnish this information but are still legally responsible for ensuring that the requirements of this section are met. (iv) If an adult individual is incapacitated at the time of admission and is unable to receive information or articulate whether or not he or she has executed an advance directive, the facility may give advance directive information to the individual's resident representative in accordance with State Law. (v) The facility is not relieved of its obligation to provide this information to the individual once he or she is able to receive such information. Follow-up procedures must be in place to provide the information to the individual directly at the appropriate time. This REQUIREMENT is not met as evidenced by: Based on clinical record review and staff interview, the facility failed to ensure all staff were aware of residents' health decisions regarding advanced directives (to be resuscitated or not) and failed to document an accurate code status for 1 of 1 current residents reviewed for advanced directives (Resident # 50). The facility reported a census of 77 residents. Findings include: 1. The Minimum Data Set (MDS) assessment dated 7/14/18 documented Resident # 50 had diagnoses of coronary heart disease, hypertension (high blood pressure), end-stage renal disease (kidney disease), thyroid disorder,	F 578		

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F 578	Continued From page 2	F 578		

cerebrovascular accident (stroke), and seizure disorder. The MDS documented 7/7/17 as the resident's admission date.

Review of the resident's care plan, initiated on 7/7/17, revealed Resident # 50 had an advanced directive as a full code and wanted staff intervention for cardiac resuscitation if needed.

Review of the clinical records for Resident # 50 revealed the following:

a. No green or red paper on the interior of Resident # 50's chart which indicated if the resident had a full code status and wanted cardiopulmonary resuscitation (CPR) in the event of a life threatening crisis or a do not resuscitate (DNR) status in the event his heart stopped beating or he stopped breathing.

b. The Medication Review Report summary dated 7/3/18 and 8/14/18 documented Resident #50 had a full code status, and the order dated 8/2/18.

c. A review of the Iowa Physician Orders for Scope of Treatment (IPOST) for CPR/DNR order Form, revealed the resident had indicated he wanted a DNR in the event he had stopped breathing or his heart had stopped beating. The resident signed and dated the form on 7/27/18. The Nurse Practitioner had signed the form on 8/2/18.

d. The clinical physician's orders on Point Click Care (PCC computer system) dated 8/2/18 revealed the resident a full code.

e. The Medication Administration Record for 8/2018 revealed the resident had a full code

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F 578	Continued From page 3 status. The care plan revised on 8/14/18 (after the surveyor spoke with staff and inquired about the resident's code status), revealed an advanced directive for a do not resuscitate order and staff intervention to provide comfort cares. In an interview 8/14/18 at 10:38 AM, Staff D, Licensed Practical Nurse (LPN) revealed in the event of an emergency, she would look on the interior of the chart for a green or red colored paper that had "Full Code" or "No Code/DNR" to determine a resident's code status and act accordingly. Staff D confirmed Resident # 50 did not have a form inside the chart, but the physician's order on the chart and in PCC indicated the resident was a full code.	F 578		
F 580 SS=D	Notify of Changes (Injury/Decline/Room, etc.) CFR(s): 483.10(g)(14)(i)-(iv)(15) §483.10(g)(14) Notification of Changes. (i) A facility must immediately inform the resident; consult with the resident's physician; and notify, consistent with his or her authority, the resident representative(s) when there is- (A) An accident involving the resident which results in injury and has the potential for requiring physician intervention; (B) A significant change in the resident's physical, mental, or psychosocial status (that is, a deterioration in health, mental, or psychosocial status in either life-threatening conditions or clinical complications); (C) A need to alter treatment significantly (that is, a need to discontinue an existing form of treatment due to adverse consequences, or to commence a new form of treatment); or	F 580		

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F 580	Continued From page 4 (D) A decision to transfer or discharge the resident from the facility as specified in §483.15(c)(1)(ii). (ii) When making notification under paragraph (g)(14)(i) of this section, the facility must ensure that all pertinent information specified in §483.15(c)(2) is available and provided upon request to the physician. (iii) The facility must also promptly notify the resident and the resident representative, if any, when there is- (A) A change in room or roommate assignment as specified in §483.10(e)(6); or (B) A change in resident rights under Federal or State law or regulations as specified in paragraph (e)(10) of this section. (iv) The facility must record and periodically update the address (mailing and email) and phone number of the resident representative(s). §483.10(g)(15) Admission to a composite distinct part. A facility that is a composite distinct part (as defined in §483.5) must disclose in its admission agreement its physical configuration, including the various locations that comprise the composite distinct part, and must specify the policies that apply to room changes between its different locations under §483.15(c)(9). This REQUIREMENT is not met as evidenced by: Based on clinical record review, staff interview, family member interview and facility policy review, the facility failed to always report changes in condition including new open areas to the physician and family members in a timely manner for 3 of 21 residents reviewed (Residents #22, #376 & #375). The facility identified a census of	F 580		

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F 580	Continued From page 5 77 current residents. Findings include: 1. According to the MDS (minimum data set) assessment dated 6/5/18, Resident #22 had diagnoses that included anemia, neurogenic bladder, diabetes mellitus, arthritis, depression and spinal stenosis. The MDS identified the resident had a BIMs (Brief interview for mental status) score of 13 which indicated intact cognition. According to the MDS the resident required the assistance of one staff with bed mobility, transfers, dressing and toilet use. The care plan dated 7/6/18 directed staff to change his suprapubic catheter as ordered and monitor for redness and signs and symptoms of infection and if noted tell the nurse. Review of the Braden Scale dated 8/8/18 revealed the resident's score of 16 which indicated the resident at risk. Review of the Facsimile to the Physician dated 4/29/18 revealed notification the resident's buttocks were red and chapped with several open and bleeding areas. Staff identified a current treatment of lotion to the resdient's buttocks. Staff received new orders to apply Tegaderm to the open area and change every 3 days and apply calmosiptine to red area of buttocks. The medical record revealed no further documentation of physician notification concerning skin. 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,	F 580		

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F 580	Continued From page 6 erythematous areas and warm to touch. The resident also had a few areas of breakdown. The resident noted to have likely cellulitis around the suprapubic catheter insertion site as well as cellulitis on his buttocks. Review of the Ostomy/Wound Progress Note dated 8/6/18 revealed the resident had shear injuries on the right lower sacrum measuring 2 cm (centimeter)by 2.5 cm with red tissue base and coccyx which measured 1 cm by 4 cm with pink tissue base. The resident's bottom quite erythemic, rashy. Review of the Hospital Discharge Instruction Sheet dated 8/8/18 revealed the following orders: a. Sacrum and coccyx: Cleanse with normal saline, apply Venelex ointment to open areas on right sacrum and coccyx, cover with ABD dressing. b. Groin: Apply miconazole cream and mcroguard powder to red areas of groin. Review of the Skin Condition Report dated 3/2/18 revealed the buttocks as red and fragile with scattered open areas (not measured) On 3/9/18 the document revealed the resident's buttocks as red and fragile and no further documentation of assessments. On 8/1/18 (presented to surveyor on 8/15/18) revealed direction to continue the previous treatment to the buttocks with no documentation of assessments completed. Review of the Progress Notes dated 4/29/18 at 12:57 PM revealed the resident's buttock red and chapped with several open bleeding areas. At 1:16 PM, staff faxed the physician to notify of the reddened, chapped buttocks with several open areas.	F 580		

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F 580	Continued From page 7 The Progress Note dated 8/6/18 at 7:35 AM documented on 8/3/18 at approximately 2:10 PM, the DON (Director of Nursing) received a phone call from the resident's primary provider (PCP). The PCP voiced concern with the resident's buttock and suprapubic catheter site. She stated that both areas were draining and appeared to be infected. The PCP stated that she was confident the resident had not had peri care or Attend (an incontinence brief) changed in several days and that there was no care provided to his surgical site since his return. The PCP planned to have the resident seen by the wound clinic following the appointment with her and she would follow up with the DON with the findings and plan are. 2. According to the MDS assessment dated 3/22/18. Resident #376 had diagnoses that included anemia, pneumonia, diabetes mellitus, seizure disorder, anxiety disorder and acute respiratory distress syndrome. The MDS identified the resident had a BIMs of 14 which indicated intact cognition. According to the MDS the resident required the assistance of 2 with bed mobility, transfers, dressing and toilet use and the assistance of 1 with eating. The care plan dated 3/26/18 the resident or staff would check his blood glucose before meals. The care plan also identified the resident had a diet of sodium 2000 mg (milligram) and potassium 60 meq (milliequivalents) per day. The care plan also identified the resident had food allergies to fish, poultry and nuts. Review of the Hospital Discharge Instructions dated 3/15/18 revealed the resident had nut allergies with reaction 0 to persistent, moderate,	F 580		

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F 580	Continued From page 8 severe nausea and vomiting. The resident also identified with chicken/poultry, fish allergy-reaction vomiting. Review of the Order Summary Report dated 3/15/18 revealed the order for 2 gram sodium, potassium 60 meq diet. The order also identified allergies for fish, nuts and poultry. Review of the MAR (medication administration record) dated 3/1/18 through 3/31/18 revealed the following orders: a. Insulin Aspart Solution Pen-injector 100 unit/ml (milliliter). On 3/24/18 insulin held due to a blood sugar of 56. b. Glucagon Emergency kit, 1 mg (milligram) intramuscularly as needed for low blood sugar (no parameters). Review of the Progress Notes dated 3/24/18 at 6:00 PM revealed the nurse notified of the resident's low blood sugar of 57. Staff prepared the resident's food and high sugar food. Resident #376 appeared alert and oriented and could make his needs known. The nurse planned to recheck after meal completion and she held the insulin at the time. At 7:20 PM, staff found the resident lying in his bed. Staff checked the resident's blood sugar at 6:00 PM, it measured in the 50's and the nurse alerted staff to make resident a sandwich and give him milk. At that time he did not exhibit any signs or symptoms of hypoglycemia. The resident received his supper tray at approximately 6:15 PM at which time he was alert and orientated. The nurse entered the room to follow up on blood sugar and amount the resident ate, at which time she found him unresponsive. Four staff lowered the residents to the floor and they initiated CPR (cardiopulmonary	F 580		

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F 580	Continued From page 9 resuscitation) as the resident was a full code. The resident had excessive mucous and vomit in his oral cavity so they cleared his airway and continued CPR. A CNA called 911 while nurses stayed and performed CPR. EMS (Emergency Medical Services) arrived and staff handed the resident's care to them. At 9:07 PM, staff received a call from the hospital and the resident was pronounced dead in the ER. The Progress Notes contained no documentation of physician notice with the initial low blood sugar readings. During an interview with family on 8/21/18 at 2:30 PM she stated she received a call from Resident #376 on 3/24/18 and he reported the facility gave him chicken for the noon meal and he didn't eat it. Review of the Policy and Procedure titled Change of Condition or Status dated May 2017 directed staff to do the following: a. Physician Notification: If resident has critical situation/change, an eInteract resident change in condition assessment should be completed before calling the medical doctor (unless life threatening then call 911 and then ER and physician). Complete the eInteract transfer form and send with the resident. If its a non-life threatening change in condition, complete the resident change in condition assessment and call the doctor. b. Dramatic fluctuation of diabetic status (i.e. blood glucose levels, level of consciousness, etc.) 3. The Medicare 5-day MDS assessment dated 5/19/18 identified diagnoses that included cancer, enlarged lymph nodes and bandemia (excess of immature white blood cells which is a signifier of infection or inflammation) for Resident #375. The assessment documented the resident entered the	F 580		

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F 580	Continued From page 10 facility on 5/12/18 for Medicare A-covered skilled nursing level of care. Resident #375 had a BIMS of 15 which indicated intact cognition. The resident required the assistance of one with transfers, walking, eating, dressing, personaly hygiene and toilet use. Resident #375 received intravenous (IV) medication before and after admission to the facility. Two care plan problems initiated 5/14/18 identified the resident entered the facility on antibiotics for skin infection of scrotal/ groin cancer lesions and had a medication port under the skin of his right chest. The care plan directed staff to administer antibiotics as ordered with the goal for resolution of the resident's signs/symptoms of infection. The After Visit Summary dated 5/11/18 documented the resident hospitalized for treatment of bandemia, inguinal adenopathy (immune system glands that enlarge in response to bacterial or viral infection) and metastatic squamous cell carcinoma (cancer) 5/2-5/11/18 and ordered the resident to admitted to the facility for skilled nursing care, as well as physical and occupational therapy and directed staff administer both vancomycin (an antibiotic) 1,500 milligrams (mg) IV and tobramycin (an antibiotic) 20 milliliters (ml) IV every 12 hours for 24 days. The May, 2018 Medication Administration Record (MAR) for Resident #375 documented the facility failed to administer the ordered vancomycin for doses scheduled for 6:00 PM on 5/12 and 6:00 AM and 6:00 PM on 5/13/18. A Progress Notes entry dated 5/13/18 at 8:55 PM documented the vancomycin not administered as the facility awaited delivery from the pharmacy.	F 580		

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F 580	Continued From page 11 The MAR documented the vancomycin not administered until 5/14/18 at 6:00 AM. The May, 2018 MAR also documented the facility failed to administer the ordered tobramycin for doses scheduled for 7:00 PM on 5/12 and 7:00 AM on 5/13/18. A Progress Notes entry dated 5/13/18 at 8:57 PM documented the tobramycin not administered they awaited delivery from the pharmacy. The MAR documented the tobramycin not administered until 5/15/18 at 9:00 AM. During interview on 8/22/18 at 9:40 AM, the nurse for resident's PCP stated the failure to administer vancomycin and tobramycin as ordered is a significant medication error and also stated the physician did not know of the failure to administer medications as ordered until the surveyor identified this.	F 580		
F 584 SS=E	Safe/Clean/Comfortable/Homelike Environment CFR(s): 483.10(i)(1)-(7) §483.10(i) Safe Environment. The resident has a right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely. The facility must provide- §483.10(i)(1) A safe, clean, comfortable, and homelike environment, allowing the resident to use his or her personal belongings to the extent possible. (i) This includes ensuring that the resident can receive care and services safely and that the physical layout of the facility maximizes resident independence and does not pose a safety risk. (ii) The facility shall exercise reasonable care for	F 584		

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F 584	Continued From page 12 the protection of the resident's property from loss or theft. §483.10(i)(2) Housekeeping and maintenance services necessary to maintain a sanitary, orderly, and comfortable interior; §483.10(i)(3) Clean bed and bath linens that are in good condition; §483.10(i)(4) Private closet space in each resident room, as specified in §483.90 (e)(2)(iv); §483.10(i)(5) Adequate and comfortable lighting levels in all areas; §483.10(i)(6) Comfortable and safe temperature levels. Facilities initially certified after October 1, 1990 must maintain a temperature range of 71 to 81°F; and §483.10(i)(7) For the maintenance of comfortable sound levels. This REQUIREMENT is not met as evidenced by: Based on observations, review of manufacturer guidelines and interviews, the facility failed to maintain a clean, comfortable and homelike environment. The facility identified a census of 77. Findings include: 1. Observation of the bathing room on Daisy Lane hall on 8/14/18 at 11:50 AM revealed 2 pairs of unmarked toenail clippers, both soiled with nail clippings and debris stored on top of a linen cart. 2. Observation of the same bathing area on	F 584		

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F 584	Continued From page 13 Daisy Lane hall at 8/14/18 at 3:15 PM revealed the following: a. The floor tiles around the whirlpool tub were very soiled with debris with multiple floor tiles with cracks and missing pieces; b. Debris and pieces of insulation present on the floor near the door to the tub; c. The floor around the toilet soiled d. The toilet bowl soiled with fecal matter; e. The cupboard contained an unmarked electric razor full of whiskers and 3 open and unmarked stick deodorants. The inside of the plastic cupboard had a dried sticky white substance on the interior surfaces. f. The sink soiled with whiskers. 3. Observation of the Daisy Lane bathing room on 8/15/18 at 9:15 AM revealed the following: a. A black substance around the perimeter of the shower area where the floor meets the walls b. Two unmarked hair picks and 2 open and unmarked stick deodorant on the ledge next to the shower area. c. A bag of soiled linen of the floor. d. A cart which contained 2 compartments of soiled linen and 1 compartment of garbage and a strong odor of urine noted in the room; e. The toilet bowel soiled with fecal matter and urine on the underside of the toilet seat; f. The toilet had a missing safety rail on the left side and right side was loose and wobbly; g. Whisker debris remained in the sink; h. The floor around the tub remained soiled; i. The ceiling of the room contained cracks in a previously repaired area and contained yellow-brown stains and discoloration; j. The plastic cupboard contained same soiled items as observed previously.	F 584		

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	165161	A. BUILDING _____ B. WING _____	09/26/2018

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F 584	Continued From page 14 During interview on 8/14/18 at 3:30 PM the supervisor of the contract housekeeping service stated her staff is responsible for mopping the floor and cleaning the toilet and sink in the bathing areas but not on a daily basis. 3. Observation of Room D16 on 8/14/18 at 9:10 AM revealed smashed crackers on the floor around the resident's bed and a dry and partially eaten croissant of the top the resident's dresser. Observation of the shared bathroom between rooms D14 and D16 revealed the following concerns: a. The toilet riser had a right back leg support approximately 1 inch shorter than the other 3 which caused the riser to tilt with pressure on the arm rests; b. Brownish stains on the floor underneath each left of the toilet riser; c. Debris and discoloration around the base of the toilet where it meets the floor; d. The cove base next to the door to room D14 separated from the wall and appeared soiled; e. The wooden doors to both rooms had deep gouges and peeling and missing paint on the metal door frames; f. A 6 " by 3" area behind the toilet tank has peeling paint; g. The top of the toilet tank soiled with dirt and debris; h. The wall above the sharps container showed nickel-sized areas of peeling paint with a blue chalky substance around them; i. An area of missing flooring near the toilet which measured 3.5 " x 2.5" and 0.25" deep; j. A strong odor of urine in the bathroom. Observation on 8/14/18 at 9:55 AM revealed the	F 584		

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F 584	Continued From page 15 out-sources housekeeping supervisor entered Room D 16 and swept up the crackers and removed the partially eaten croissant but did not clean the bathroom.	F 584		
F 607 SS=E	Develop/Implement Abuse/Neglect Policies CFR(s): 483.12(b)(1)-(3) §483.12(b) The facility must develop and implement written policies and procedures that: §483.12(b)(1) Prohibit and prevent abuse, neglect, and exploitation of residents and misappropriation of resident property, §483.12(b)(2) Establish policies and procedures to investigate any such allegations, and §483.12(b)(3) Include training as required at paragraph §483.95, This REQUIREMENT is not met as evidenced by: Based on personnel file reviews, facility policy review and staff interview, the facility failed to provide dependent adult abuse training within 6 months of hire for 3 of 6 current employees sampled (Staff E, NN and K). Additionally the facility failed to secure an evaluation by the Department of Human Services (DHS) to determine if an employee with a criminal history could work in the facility for 1 of 6 current employees sampled (Staff E). The facility identified a census of 77. Findings include: 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	F 607		

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F 607	Continued From page 16 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 months of hire. The Abuse Prevention Plan-Iowa revised October, 2017 directed the following: A. Screening: 2. For all potential employees and contracted workings:	F 607		

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F 607	Continued From page 17 (1) After a conditional offer BUT before an employee starts working, the facility must obtain criminal background checks from the Department of Public Safety and abuse checks from the DHS. B. Training: 1. Complete two hours of training relating to the identification and reporting dependent adult abuse within six months of initial employment (or self-employment)	F 607		
F 623 SS=C	Notice Requirements Before Transfer/Discharge CFR(s): 483.15(c)(3)-(6)(8) §483.15(c)(3) Notice before transfer. Before a facility transfers or discharges a resident, the facility must- (i) Notify the resident and the resident's representative(s) of the transfer or discharge and the reasons for the move in writing and in a language and manner they understand. The facility must send a copy of the notice to a representative of the Office of the State Long-Term Care Ombudsman. (ii) Record the reasons for the transfer or discharge in the resident's medical record in accordance with paragraph (c)(2) of this section; and (iii) Include in the notice the items described in paragraph (c)(5) of this section. §483.15(c)(4) Timing of the notice. (i) Except as specified in paragraphs (c)(4)(ii) and (c)(8) of this section, the notice of transfer or discharge required under this section must be made by the facility at least 30 days before the resident is transferred or discharged. (ii) Notice must be made as soon as practicable before transfer or discharge when-	F 623		

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F 623	Continued From page 18 (A) The safety of individuals in the facility would be endangered under paragraph (c)(1)(i)(C) of this section; (B) The health of individuals in the facility would be endangered, under paragraph (c)(1)(i)(D) of this section; (C) The resident's health improves sufficiently to allow a more immediate transfer or discharge, under paragraph (c)(1)(i)(B) of this section; (D) An immediate transfer or discharge is required by the resident's urgent medical needs, under paragraph (c)(1)(i)(A) of this section; or (E) A resident has not resided in the facility for 30 days. §483.15(c)(5) Contents of the notice. The written notice specified in paragraph (c)(3) of this section must include the following: (i) The reason for transfer or discharge; (ii) The effective date of transfer or discharge; (iii) The location to which the resident is transferred or discharged; (iv) A statement of the resident's appeal rights, including the name, address (mailing and email), and telephone number of the entity which receives such requests; and information on how to obtain an appeal form and assistance in completing the form and submitting the appeal hearing request; (v) The name, address (mailing and email) and telephone number of the Office of the State Long-Term Care Ombudsman; (vi) For nursing facility residents with intellectual and developmental disabilities or related disabilities, the mailing and email address and telephone number of the agency responsible for the protection and advocacy of individuals with developmental disabilities established under Part	F 623		

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F 623	Continued From page 19 C of the Developmental Disabilities Assistance and Bill of Rights Act of 2000 (Pub. L. 106-402, codified at 42 U.S.C. 15001 et seq.); and (vii) For nursing facility residents with a mental disorder or related disabilities, the mailing and email address and telephone number of the agency responsible for the protection and advocacy of individuals with a mental disorder established under the Protection and Advocacy for Mentally Ill Individuals Act. §483.15(c)(6) Changes to the notice. If the information in the notice changes prior to effecting the transfer or discharge, the facility must update the recipients of the notice as soon as practicable once the updated information becomes available. §483.15(c)(8) Notice in advance of facility closure In the case of facility closure, the individual who is the administrator of the facility must provide written notification prior to the impending closure to the State Survey Agency, the Office of the State Long-Term Care Ombudsman, residents of the facility, and the resident representatives, as well as the plan for the transfer and adequate relocation of the residents, as required at § 483.70(l). This REQUIREMENT is not met as evidenced by: Based on clincial record review and resident and staff interviews, the facility failed to notify the Long Term Care (LTC) Ombudsman of discharge/transfer of residents as required for 7 of 7 residents reviewed who were discharged/transferred from the facility (Residents #44, #48, #50, #62, #66, #68 & #69). The facility reported a census of 77 residents.	F 623		

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F 623	Continued From page 20 Findings include: 1. Review of the medical record for Resident #66 with a discharge date of 7/13/18 revealed no documentation of notification to the Long Term Care (LTC) Ombudsman that Resident #66 had been discharged to the hospital as required by federal regulation. During an interview on 8/15/18 at 2:41 p.m. the facility social worker stated that she was not aware of the regulation that the Ombudsmen needs notified of discharges. During an interview on 8/15/18 at 4:10 p.m. the Director of Clinical Services stated the facility is not notifying the Ombudsman of resident transfers out of the facility. 2. Review of the medical record for Resident #44 revealed the resident discharged from the facility on 5/31/18 & 6/8/18 and hospitalized. The clinical record lacked documentation of notification to the LTC Ombudsman that Resident #44 had discharged to the hospital as required by federal regulation. 3. Review of the medical record for Resident #50 revealed the resident had discharged from the facility on 3/9/18, 6/1/18 and 7/2/18 and hospitalized. The clinical record lacked documentation of notification to the LTC Ombudsman that Resident #50 had discharged to the hospital as required by federal regulation. 4. The quarterly Minimum Data Set (MDS) assessment dated 7/30/18 showed that Resident # 69 had an intact cognition with a Brief Interview for Mental Status (BIMS) score of 14. The MDS triggered Resident # 69 for 2-3 hospitalizations.	F 623		

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F 623	Continued From page 21 On 8/14/18 at 3:17 PM, Resident # 69 reported that she had hospital admission because of 4 blood clots and stayed at the hospital for 6 days. However, Resident # 69 denied other hospitalizations prior and after the most recent hospitalization on 7/12/18. The resident's records lacked evidence the facility notified the LTC Ombudsman regarding the hospital admission. 5. Resident # 48's MDS assessments showed a history of hospitalizations on the following dates: 3/19/18, 4/24/18, 5/16/18, 5/30/18, 6/19/18, and 8/1/18. The MDS indicated that these hospital discharges anticipated return to facility. The resident's records lacked evidence the facility notified the LTC Ombudsman regarding the hospital admissions. On 8/15/18 at 10:24 AM, the Unit Manager B, called facility's system in notifying family regarding hospital admissions as 'standard' in that before residents were sent out to the hospital, unless an emergency, the nurses working on the floor would call the family and doctor about it, and then document the notification. However, the Unit Manager said she did not know how or if these notices were sent out to the Ombudsman. On 8/15/18 at 2:15 PM, the Social Worker stated they had not been sending reports to the Ombudsman regarding residents' hospital admissions. 6. The clinical record documented Resident #62 admitted to the facility on 6/29/18. The resident fell on 7/3/18 and went to the hospital, returning	F 623		

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F 623	Continued From page 22 on 7/10/18. The clinical record lacked notification to the LTC Ombudsman of the resident's hospitalization. 7. The clinical record documented Resident #68 admitted to the facility 3/9/18 and discharged home on 3/29/18, returning on 5/14/18. She then went to the hospital on 6/15/18 and re-admitted on 6/27/18. The clinical record lacked notification to the LTC Ombudsman of the resident's hospitalization.	F 623		
F 625 SS=B	Notice of Bed Hold Policy Before/Upon Trnsfr CFR(s): 483.15(d)(1)(2) §483.15(d) Notice of bed-hold policy and return- §483.15(d)(1) Notice before transfer. Before a nursing facility transfers a resident to a hospital or the resident goes on therapeutic leave, the nursing facility must provide written information to the resident or resident representative that specifies- (i) The duration of the state bed-hold policy, if any, during which the resident is permitted to return and resume residence in the nursing facility; (ii) The reserve bed payment policy in the state plan, under § 447.40 of this chapter, if any; (iii) The nursing facility's policies regarding bed-hold periods, which must be consistent with paragraph (e)(1) of this section, permitting a resident to return; and (iv) The information specified in paragraph (e)(1) of this section. §483.15(d)(2) Bed-hold notice upon transfer. At	F 625		

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F 625	Continued From page 23 the time of transfer of a resident for hospitalization or therapeutic leave, a nursing facility must provide to the resident and the resident representative written notice which specifies the duration of the bed-hold policy described in paragraph (d)(1) of this section. This REQUIREMENT is not met as evidenced by: Based on clinical record review and staff interview, the facility failed to provide notice to the resident and/or representative of the facility's bed-hold policy prior to and upon transfer to the hospital for five of six residents reviewed for transfers to the hospital or another facility (Residents #44, #50, #66, #69, and #48). The facility reported a census of 77 residents. Findings include: 1. Review of Resident #44's medical record revealed no documentation of notification to the resident or resident's family regarding the bed-hold policy when the resident transferred to the hospital on 5/31/18 or 6/8/18. Resident #44 had last signed a facility form on 1/16/17, which indicated she had received a copy of the facility's bedhold policy. 2. Review of Resident #50's medical record revealed no documentation of notification to the resident or resident's family regarding the bed-hold policy when the resident transferred to the hospital on 3/9/18, 6/1/18, or 7/2/18. 3. Review of the medical record for Resident #66 revealed no documentation of notification to the resident or resident's family regarding the bed-hold policy when the resident transferred to	F 625		

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F 625	Continued From page 24 the hospital on 7/13/18. During an interview on 8/15/18 at 2:18 p.m. the Business Office Manager stated that it would be an expectation that nurses notify the family of the bed hold policy when a resident transfers to the hospital. Review of the resident's clinical progress notes revealed no documentation staff notified the resident or family. The facility form for this resident regarding the bed-hold policy last signed on 8/25/08. 4. The Minimum Data Set (MDS) assessment dated 7/30/18 showed that Resident # 69 had an intact cognition with a Brief Interview for Mental Status (BIMS) score of 14. The MDS triggered Resident # 69 for 2-3 hospitalizations. On 8/14/18 at 3:17 PM, Resident # 69 reported she went to the hospital because of 4 blood clots and stayed at the hospital for 6 days. However, Resident # 69 denied other hospitalizations prior and after the most recent hospitalization on 7/12/18. The resident's clinical record lacked evidence facility staff notified and provided a bed-hold policy to Resident # 69 or her representative for this particular discharge to the hospital. 5. Resident # 48's MDS assessments showed history of hospitalizations on the following dates: 3/19/18, 4/24/18, 5/16/18, 5/30/18, 6/19/18 and 8/1/18. The MDS indicated these hospital discharges anticipated return to facility. However, the clinical record lacked evidence staff provided a bed-hold policy to Resident # 48 and/or his representative for these multiple hospitalizations.	F 625		

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F 625	Continued From page 25 On 8/15/18 at 2:15 PM, the Social Worker provided a copy of Resident # 48's acknowledgement of notification regarding the facility's bed-hold policy on initial admission date of 2/18/18. The Social Worker reported they only notify residents regarding bed-hold policy during initial admission.	F 625		
F 644 SS=D	Coordination of PASARR and Assessments CFR(s): 483.20(e)(1)(2) §483.20(e) Coordination. A facility must coordinate assessments with the pre-admission screening and resident review (PASARR) program under Medicaid in subpart C of this part to the maximum extent practicable to avoid duplicative testing and effort. Coordination includes: §483.20(e)(1)Incorporating the recommendations from the PASARR level II determination and the PASARR evaluation report into a resident's assessment, care planning, and transitions of care. §483.20(e)(2) Referring all level II residents and all residents with newly evident or possible serious mental disorder, intellectual disability, or a related condition for level II resident review upon a significant change in status assessment. This REQUIREMENT is not met as evidenced by: Based on clinical record review, staff interview and facility policy review, the facility failed to complete a follow-up Preadmission Screening and Resident Review for one out of two residents reviewed in the current sample who had a change in mental health diagnoses and psychotropic	F 644		

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F 644	Continued From page 26 medications (Resident #17). The facility reported a census of 77 residents. Findings include: The significant change Minimum Data Set (MDS) assessment dated 3/1/18, recorded Resident #17 had diagnoses that included non-Alzheimer's dementia, psychotic disorder, acute stress reaction, and depression. The MDS indicated the resident had no serious mental illness and had not met criteria for a Level 2 Preadmission Screening and Resident Review (PASRR). The assessment documented Resident #17 entered the facility on 2/2/07. He had severely impaired decision making skills, and behavioral symptoms of inattention, disorganized thinking, physical behavioral symptoms toward others, rejection of care and wandering. The MDS indicated the resident received antipsychotic and antidepressant medications for 7 or 7 days during the look-back period. The quarterly MDS assessment dated 5/30/18 revealed Resident #17 received antipsychotic, antianxiety and antidepressant medications for 7 of 7 days during the look-back period. The care plan updated on 4/13/18 revealed the resident had diagnosis of vascular dementia, delusional disorder and severe depression with psychotic symptoms. The resident also experienced restlessness, agitation, wandering, physical aggression and spitting. The care plan indicated the resident spoke little English. The care plan directives for staff included monitoring mood/behaviors/combativeness and side effects of antidepressant, anxiolytic and antipsychotic medications and to call an interpreter when	F 644		

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F 644	Continued From page 27 communication assistance is needed. The medication review report and medication administration record for 8/2018 revealed the resident took the following medications: a. Clonazepam for dementia and behaviors, b. Mirtazapine and bupropion for major depression, c. Carbamazepine and risperidone for psychosis, d. Seroquel (medication discontinued on 8/15/18). The medical record revealed a mental illness/intellectual disability screening completed 1/7/09 by Iowa Medicaid Enterprise and no other information available. At the time, the record revealed the resident took trazodone and wellbutrin (antidepressants). Progress notes revealed the following: a. 3/2/18: Resident #17 had increased behaviors on 2-24-18 and transferred to the Emergency Department. The resident returned to the facility and had an order to start Risperidone 0.25 mg twice a day. As of 3/2/18, the resident's condition had stabilized and behaviors more controlled. b. 3/16/18 - Resident #17 tried to go out the front door twice. The resident pushed the door and walked away. Staff easily redirected the resident and left him alone but monitored him from a distance. c. 3/20/18 - Resident #17 had exit seeking behaviors and made several attempts to leave the building. The resident sat on the floor by the door. Staff provided 1:1 observation, made attempts to entice the resident with food/juices and activities and made several attempts to contact his family. The resident exhibited combativeness (tried to hit, scratch and bite) towards staff and kept saying he was going to	F 644		

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F 644	Continued From page 28 Vietnam. Staff contacted the physician and transferred the resident to the hospital for an evaluation. d. 3/21/18 - Resident #17 returned to the facility and staff checked his Wanderguard (a device to maintain resident safety). e. 3/25/18 - Resident #17 nodded his head to all questions asked due to a language barrier. During an interview 8/15/18 at 2:10 PM, the Administrator reported she went back through Resident #17's old records and found PASRR information from 2007 and no other current information could be found. In an interview 8/15/18 at 2:55 PM, the Executive Clinical Director and Social Services Director reported they had looked at the ASCEND website and found no PASRR screening information for Resident #17 since his initial admission in 2007. The Social Services Director reported she had submitted a PASRR screening review as of 8/15/18 per recommendation by the Clinical Director. On 8/15/16 at 3:45 PM, the Executive Clinical Director reported they had no policy for PASRR but provided a document of a resource the facility used for PASRR. The document titled "Adult Mental Health - PASRR" revealed a PASRR is completed to ensure admission and retention of people with serious mental illness in nursing and boarding facilities required level of care, whether or not specialized services for mental health care required, and determined if supportive services met the person's needs in a nursing facility or the community. A level II PASRR is implemented	F 644		

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F 644	Continued From page 29 and determined if a resident had a mental illness or condition that met criteria and if specialized services or routine mental health services beneficial.	F 644		
F 645 SS=D	PASARR Screening for MD & ID CFR(s): 483.20(k)(1)-(3) §483.20(k) Preadmission Screening for individuals with a mental disorder and individuals with intellectual disability. §483.20(k)(1) A nursing facility must not admit, on or after January 1, 1989, any new residents with: (i) Mental disorder as defined in paragraph (k)(3)(i) of this section, unless the State mental health authority has determined, based on an independent physical and mental evaluation performed by a person or entity other than the State mental health authority, prior to admission, (A) That, because of the physical and mental condition of the individual, the individual requires the level of services provided by a nursing facility; and (B) If the individual requires such level of services, whether the individual requires specialized services; or (ii) Intellectual disability, as defined in paragraph (k)(3)(ii) of this section, unless the State intellectual disability or developmental disability authority has determined prior to admission- (A) That, because of the physical and mental condition of the individual, the individual requires the level of services provided by a nursing facility; and (B) If the individual requires such level of services, whether the individual requires specialized services for intellectual disability.	F 645		

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F 645	Continued From page 30 §483.20(k)(2) Exceptions. For purposes of this section- (i)The preadmission screening program under paragraph(k)(1) of this section need not provide for determinations in the case of the readmission to a nursing facility of an individual who, after being admitted to the nursing facility, was transferred for care in a hospital. (ii) The State may choose not to apply the preadmission screening program under paragraph (k)(1) of this section to the admission to a nursing facility of an individual- (A) Who is admitted to the facility directly from a hospital after receiving acute inpatient care at the hospital, (B) Who requires nursing facility services for the condition for which the individual received care in the hospital, and (C) Whose attending physician has certified, before admission to the facility that the individual is likely to require less than 30 days of nursing facility services. §483.20(k)(3) Definition. For purposes of this section- (i) An individual is considered to have a mental disorder if the individual has a serious mental disorder defined in 483.102(b)(1). (ii) An individual is considered to have an intellectual disability if the individual has an intellectual disability as defined in §483.102(b)(3) or is a person with a related condition as described in 435.1010 of this chapter. This REQUIREMENT is not met as evidenced by: Based on clinical record review and staff interviews, the facility failed to complete a follow-up and obtain authorization for an additional period of time for placement and	F 645		

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F 645	Continued From page 31 services according to the Preadmission Screening and Resident Review (PASRR) after a limited 90 day approval stay for two out of seven sampled residents that required a re-evaluation (Residents #11 and #53). The facility reported a census of 77 residents. Findings include: 1. Resident # 53 had a PASRR completed on 1/15/18, which provided a notice for short-term nursing facility services approved for 90 days. The ASCEND report showed the PASRR expired on 4/15/18 and gave the facility a directive to seek authorization for an additional time period if the resident needed continued nursing facility services and/or specialized services for behavioral health or developmental condition. In an interview on 8/15/18 at 9:33 AM, the Social Services Director reported she was unaware Resident #53 PASRR needed to be updated after 4/15/18 and had no updated PASRR for the resident. In an interview on 8/15/18 at 2:55 PM, the Social Services Director reported she completed PASRR when a resident admitted from home and when short-term PASRR needed updated per recommendation on the PASRR. The Executive Clinical Director and Social Services Director reported they had looked at the ASCEND website. Resident #53 had a screening requested on 1/11/18 and no other screening request submitted until 8/15/18, after being brought to their attention by the surveyor. 2. The Minimum Data Set (MDS) assessment dated 5/16/18 documented Resident #11 had	F 645		

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F 645	Continued From page 32	F 645		

diagnoses that included depression, anxiety disorder and manic depression (bipolar disease). The assessment documented Resident #11 felt down, depressed or hopeless and bad about himself for 7-11 days over the past 2 weeks.

The resident's care plan, updated on 7/9/18, recorded a focus area his PASRR indicated he had special needs due to his diagnosis of bipolar disorder, depressive disorder and anxiety disorder. The Care Plan included interventions for ongoing psychiatric services to evaluate responses and effectiveness of psychotic medication, modify his medication and evaluate the need for additional behavioral health services, he would be seen by Associates for Psychiatric Services quarterly and as needed and provided individual therapy by a licensed behavioral health professional 1 to at 2 times a week for 1:1 sessions.

The PASRR Notice for Resident #11 noted short-term nursing facility approval for 60 days. The PASRR identified ongoing psychiatric services by a psychiatrist to evaluate response and effectiveness of psychotropic medication on target symptoms, modify medication orders and to evaluate ongoing need for additional behavioral health services. The PASRR expired on 10/13/17 and the facility failed to obtain authorization for an additional period of time for placement and services.

During an interview on 8/15/18 at 9:45 AM with the Director Clinical Services acknowledged the facility did not have a current PASRR for Resident #11 and when the social service person opened the PASRR system, there had been several requests for information need for Resident #11.

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F 655 SS=D	Baseline Care Plan CFR(s): 483.21(a)(1)-(3) §483.21 Comprehensive Person-Centered Care Planning §483.21(a) Baseline Care Plans §483.21(a)(1) The facility must develop and implement a baseline care plan for each resident that includes the instructions needed to provide effective and person-centered care of the resident that meet professional standards of quality care. The baseline care plan must- (i) Be developed within 48 hours of a resident's admission. (ii) Include the minimum healthcare information necessary to properly care for a resident including, but not limited to- (A) Initial goals based on admission orders. (B) Physician orders. (C) Dietary orders. (D) Therapy services. (E) Social services. (F) PASARR recommendation, if applicable. §483.21(a)(2) The facility may develop a comprehensive care plan in place of the baseline care plan if the comprehensive care plan- (i) Is developed within 48 hours of the resident's admission. (ii) Meets the requirements set forth in paragraph (b) of this section (excepting paragraph (b)(2)(i) of this section). §483.21(a)(3) The facility must provide the resident and their representative with a summary of the baseline care plan that includes but is not limited to: (i) The initial goals of the resident. (ii) A summary of the resident's medications and dietary instructions.	F 655		

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F 655	Continued From page 34 (iii) Any services and treatments to be administered by the facility and personnel acting on behalf of the facility. (iv) Any updated information based on the details of the comprehensive care plan, as necessary. This REQUIREMENT is not met as evidenced by: Based on clinical record review and resident and staff interviews, the facility failed to ensure residents received information on their initial plans for service and care delivery for 3 of 6 residents reviewed (Residents #78, #31 and #62). The facility reported a census of 77. Findings include: 1. The Minimum Data Set (MDS) assessment dated 8/8/18 for Resident #78 showed a Brief Interview for Mental Status (BIMS) of 14 indicating intact cognition. The assessment documented Resident #78 entered the facility on 8/2/18. During an interview with the Director of Clinical Services on 8/15/18 at 9:00 AM stated the facility did not give out the baseline plan of care the residents or their families. During an interview with Resident #78 on 8/15/18 at 9:36 AM, she stated she did not receive a copy of the plan of care and has not seen her plan of care. 2. The quarterly MDS for Resident #31 dated 6/16/18 documented her BIMS score of 14 out of 15 indicating intact memory and cognition. A Care plan conference signature page for Resident #31's 72 hour Transitional Care Meeting	F 655		

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F 655	Continued From page 35 and Discharge Plans did not show she attended the conference. The page listed those in attendance as the Director of Social Services, Recreation Services Manager, Staff B Registered Nurse/Unit Manager and the MDS Coordinator. 3. The MDS assessment dated 8/7/18 documented Resident #62 had diagnoses including diabetes mellitus, multiple sclerosis, seizure disorder, anxiety, depression, and lung disease. The resident scored 15 on the BIMS test, indicating intact memory and cognition. The assessment documented she entered the facility on 6/29/18. The baseline care plan dated 6/29/18 included focus areas of: Respiratory condition that requires a tracheotomy Discharge planning/ Anticipating short stay Seizure disorder managed by medication Eats independently Full code status Adjusting to new environment Fall prevention Pain Assistance with dressing, grooming, toilet use, bed mobility, transfers, walking, and bathing Skin impairment to right upper chest from a surgical incision Intact cognition Psychotropic medications for depression and anxiety. During an interview on 8/13/18 at 2:06 p.m. Resident #62 stated she would she did not receive a copy of a care plan and wanted to participate in the process.	F 655		

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F 656	Continued From page 36	F 656		
F 656 SS=D	Develop/Implement Comprehensive Care Plan CFR(s): 483.21(b)(1) §483.21(b) Comprehensive Care Plans §483.21(b)(1) The facility must develop and implement a comprehensive person-centered care plan for each resident, consistent with the resident rights set forth at §483.10(c)(2) and §483.10(c)(3), that includes measurable objectives and timeframes to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment. The comprehensive care plan must describe the following - (i) The services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §483.24, §483.25 or §483.40; and (ii) Any services that would otherwise be required under §483.24, §483.25 or §483.40 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(c)(6). (iii) Any specialized services or specialized rehabilitative services the nursing facility will provide as a result of PASARR recommendations. If a facility disagrees with the findings of the PASARR, it must indicate its rationale in the resident's medical record. (iv)In consultation with the resident and the resident's representative(s)- (A) The resident's goals for admission and desired outcomes. (B) The resident's preference and potential for future discharge. Facilities must document whether the resident's desire to return to the community was assessed and any referrals to local contact agencies and/or other appropriate	F 656		

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F 656	Continued From page 37 entities, for this purpose. (C) Discharge plans in the comprehensive care plan, as appropriate, in accordance with the requirements set forth in paragraph (c) of this section. This REQUIREMENT is not met as evidenced by: Based on clinical record review, facility policy review, observations and interviews, the facility failed to implement care plan interventions to prevent occurrence of a potential accident related to smoking for 1 of 2 residents (Resident # 53) reviewed for smoking. The facility reported a census of 77. Findings include: The quarterly Minimum Data Set (MDS) assessment dated 7/14/18 showed Resident # 53's Brief Interview for Mental Status (BIMS) score of 14, indicating intact memory and cognition. The Medication Review Report (MRR) dated 8/15/18 listed Resident # 53's medical diagnoses included paranoid schizophrenia, psychotic disorder, insomnia, hemiplegia and hemiparesis following cerebral infarction (stroke). The Smoking Assessment dated 4/16/18 indicated that Resident # 53's smoked morning, noon and night. The assessment also indicated that cigarettes and lighter should be kept with the nurse because Resident # 53 had history of smoking in non-smoking areas such as the facility's entry way and in personal room, and the assessment described Resident # 53 as able to safely smoke and utilize cigarette.	F 656		

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F 656	Continued From page 38 Resident # 53's care plan dated 7/13/18, showed smoking interventions which included directions for staff to escort Resident # 53 outside and retrieve the lighter after Resident # 53's cigarette was lit. The care plan also indicated the facility allowed Resident #53 to smoke at odd hours but he should not keep cigarettes and lighter by himself and that these should be kept in the nurses' cart. During observation on 8/13/18 at 3:03 PM, Resident # 53 propelled his wheelchair out from his room towards Bayberry hallway where he met and gave a cigarette to Resident # 11. Resident # 53 kept a pack of cigarettes in his wheelchair. The two residents proceeded to the smoking area/patio without a staff escort. Resident # 53 lit his cigarette and smoked with Resident # 11. On 8/14/18 at 11:01 AM, Resident # 53 reported that he had always kept lighter and cigarettes in his possession. On 8/15/18 at 11:31 AM, Staff C Registered Nurse (RN), reported there no cigarettes or lighters kept in the nurses' cart and that Resident # 53 kept his own smoking supplies. The facility's policy titled, Smoking Policy Residents dated 6/18 provided the facility shall establish and maintain safe resident practices while protecting the rights of the individual resident. The policy also provided that failure to comply with the smoking policy may result in restricting or forfeiting smoking privileges. The procedures included information about the smoking policy on admission, assessment of resident's ability to safely smoke with or without assistance, designation of smoking areas and	F 656		

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F 656	Continued From page 39 restrictions of smoking in non-smoking areas, and imposition of smoking restrictions on residents at any time if determined that the resident cannot smoke safely. In addition, the procedures indicated that residents who keep their own smoking materials but violated the smoking policy will be required to surrender such and the facility will store and distribute smoking materials.	F 656		
F 657 SS=E	Care Plan Timing and Revision CFR(s): 483.21(b)(2)(i)-(iii) §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	F 657		

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F 657	Continued From page 40 assessments. This REQUIREMENT is not met as evidenced by: 2. The admission record form that revealed resident information dated 8/5/18 for Resident #83 included diagnosis of methicillin resistant staphylococcus aureus (MRS) infection and personal history of other infectious and parasitic diseases. During an observation on 8/13/18 on initial tour of the facility an isolation cart with personal protective equipment was outside of resident's room. The facility's Resident Matrix form dated 8/13/18 indicated Resident #83 as on transmission based precautions. Resident #83's Care Plan dated 8/6/18 lacked a focus and intervention area related to the use of transmission based precautions. The care plan revealed that resident had been recently hospitalized with pneumonia and sepsis (infection) and being treated with intravenous medication. During an interview on 8/13/18 at 1:15 PM with Staff A, RN (Registered Nurse) stated Resident #83 is in isolation due to an infection. On 8/15/18 at 2:47 PM, the MDS Coordinator stated the resident has MRS and is in contact isolation. During an interview on 8/16/18 at 2:58 PM with the Director of Nursing (DON) acknowledged that she would expect the care plan to contain information about transmission based	F 657		

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F 657	Continued From page 41 precautions. 3. The MDS assessment dated 7/14/18 documented Resident #50 had diagnoses of coronary heart disease, hypertension (high blood pressure), end-stage renal disease (kidney disease), thyroid disorder, cerebrovascular accident (stroke), and seizure disorder. The MDS documented the resident required dialysis. a. The care plan dated 7/7/17 revealed Resident #50 had an advanced directive as a full code and wanted staff intervention in the event of a life-threatening condition and cardiac resuscitation needed. A review of the Iowa Physician Orders for Scope of Treatment (IPOST) for CPR/DNR order Form, revealed the resident indicated he wanted DNR status in the event he stopped breathing or his heart stopped beating. The resident signed and dated the form on 7/27/18 and his Nurse Practitioner signed the form on 8/2/18. On 8/14/18, the Assistant Director of Nursing updated the clinical physician's order in Point Click Care and the care plan to reflect the resident's preference for DNR status. b. The care plan updated on 7/18/18 revealed Resident #50 had Stage 5 chronic kidney disease and received dialysis on Tuesdays, Thursdays and Sundays. The care plan also identified the resident needed an early lunch on days and encouraged use of a wheelchair when had dialysis appointments on Mondays, Wednesdays and Fridays. In an interview on 8/13/18 at 3:06 PM, the resident's roommate reported Resident #50 went	F 657		

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F 657	Continued From page 42 to dialysis on Mondays, Wednesdays and Fridays. In an interview on 8/14/18 at 10:38 AM, Staff D, Licensed Practical Nurse confirmed Resident #50 went to dialysis on Mondays, Wednesdays and Fridays. Based on clinical record review, observations and resident and staff interviews, the facility failed to update care plans when needed for 3 of 21 sampled residents (# 35, # 83 and # 50). The facility reported a census of 77 residents. Findings include; 1. The Minimum Data Set (MDS) assessment for Resident # 35 dated 6/27/18 recorded diagnoses that included renal insufficiency, cancer, anxiety disorder, depression and adult failure to thrive. The resident required the assistance of 2 staff for bed mobility, transfers, dressing, eating, toilet use and personal hygiene. The MDS further indicated the Resident # 35 had one unhealed pressure ulcer, identified as unstageable (suspected deep tissue injury). Resident # 35's Care Plan dated 6/6/18 documented that she had a suspected deep tissue injury and to wear a pressure relief boot to left heal when up. The facility failed to revise the care plan for Resident #35 since the she spends all of her time in bed.	F 657		

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F 657	Continued From page 43 The Multidisciplinary Care Conference Summery dated 7/2/18 documented that Resident #35 spends all of her time in bed. An observation on 8/15/18 at 7:23 AM after the CNA's removed the resident's boots of her bilateral heels revealed her heels had dry skin without redness or open areas. During an interview on 8/15/18 at 8:57 AM the Director of Clinical Services acknowledged she would expect the care plan to be updated with the current conditions since the resident does not get out of bed and has not gotten out of bed for a long time now and it should include both boots to float her heels.	F 657		
F 658 SS=E	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 staff interview the facility failed to always provide appropriate communication with a resident's physician for coordination of care for one resident (#36) and failed to follow physician orders for three of 21 residents reviewed (#78, #35 & #52). The facility identified a census of 77. Findings include: 1. According to the MDS (minimum data set) assessment dated 7/4/18, Resident #36 had	F 658		

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F 658	Continued From page 44 diagnoses that included anemia, heart failure, renal insufficiency, diabetes mellitus, arthritis and dementia. The MDS identified the resident had a BIMs (brief interview for mental status) score of 8 which indicated moderate cognitive impairment. According to the MDS the resident required the assistance of two with bed mobility and transfers the assistance of one with dressing and toilet use. Review of the Medical Doctor/Nursing Communications sheet dated 6/20/18 revealed the physician returned a note that nursing home staff should accompany residents to all doctor appointments so the doctor has someone else to ask questions to besides the resident. The resident didn't even know why she was there. When the nurse called the facility and talked to the nurse, she didn't even know why the resident needed to be seen either. The physician also instructed that if a resident is diabetic, a blood sugar log should accompany them to every doctor appointment. Review of the Progress Notes dated 6/20/18 at 2:30 PM revealed the resident left the facility at this time per facility wheelchair van to an appointment with the physician. At 5:45 PM the resident returned from the appointment via facility bus in the wheelchair. The doctor's office requested that someone accompany the resident on future appointments and they also need to sent glucose logs with each appointment. During an interview with Staff L, LPN (licensed practical nurse) on 8/14/18 at 1:20 PM she stated Resident #36 had been sent to the doctor's office and the office and she didn't know why the resident went. The physician's office called the facility and Staff L stated she had not been able	F 658		

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F 658	Continued From page 45 to tell the office why the resident had been there. She further stated staff send a packet with the resident that includes the medication administration record, orders and profile sheets which rarely state the reason for the visit. During an interview with Staff W, Receptionist on 8/17/18 at 9:45 AM she stated all staff can schedule an appointment and put it in the program for transport. She stated the resident's appointment had been in the computer program on the calendar for 6/20/18 with no mention of an escort. She further stated she would have called family member first to try and find an escort for the resident and the facility does for all residents with dementia. During an interview with Resident #36's physician on 8/17/18 at 10:50 AM she stated the resident had been seen at her office and the facility did not provide an escort or identify a concern or any reason for the appointment. The physician's nurse called the facility to receive a report and the resident's nurse could not provide it. 2. The MDS assessment for Resident #78 dated 8/8/18, included diagnoses of a history of falling, fracture and unspecified pain.. The MDS documented the resident required the assistance of one for bed mobility and transfer, and had a Brief Interview for Mental Status (BIMS) score of 14 (cognitively intact). A medication review report for the month of August 2018 recorded an order that due to the resident's fracture in her back, she needed to be switched to a therapeutic air mattress every shift for health maintenance and pain. The order revealed an order date of 8/10/18 and a start date	F 658		

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F 658	Continued From page 46 of 8/10/18. During an observation on 8/13/18 at 4:10 p.m., the resident did not have an air mattress on her bed. The resident stated she had spoken with the Administrator about the air mattress this morning. During an observation on 8/14/18 at 9:49 a.m., the resident continued without an air mattress on her bed. During an observation and interview on 8/14/18 at 9:58 a.m., the Clinical Director and surveyor observed the bed in Resident # 78's room and the Clinical Director verified the lack of an air mattress on the bed. Observation on 8/14/18 at 1:52 P.M. revealed an air mattress had been placed on the resident's bed. Resident #78 stated she had tested the air mattress out and it felt better on her tailbone. 3. The MDS assessment for Resident # 35 dated 6/27/18 recorded diagnoses that included renal insufficiency, cancer, anxiety disorder, depression and adult failure to thrive. The resident required the assistance of 2 staff for bed mobility, transfers, dressing, eating, toilet use and personal hygiene. The MDS further indicated the Resident # 35 had one unhealed pressure ulcer, identified as unstageable (suspected deep tissue injury). The Multidisciplinary Care Conference Summery dated 7/2/18 documented that Resident #35 spent all of her time in bed. The Order Audit Report for Resident #35 documented a verbal order taken on 6/20/18 for Betadine Solution 10 % applied to her left heel	F 658		

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F 658	Continued From page 47 topically every 48 hours for a wound treatment. The order instructed to lightly moisten gauze with Betadine and apply it to the left heel and secure with loosely wrapped Kerlix. The Audit showed the order had not been created until 7/3/18. The resident's Medication Administration Record (MAR) included Betadine Solution 10 % applied to her left heel topically every 48 hours for a wound treatment. The order instructed to lightly moisten gauze with Betadine and apply it to the left heel and secure with loosely wrapped Kerlix with a start date of 7/4/18. During an interview on 8/15/18 at 1:51 PM, the Director of Clinical Services stated she could not find the order for Betadine. The order audit showed a verbal order 6/20/18 for Betadine and staff entered it in the system 7/3/18 with a start date of 7/4/18. The printed order should be in the resident's chart and she could not find an order in the chart. 4. Resident # 52's Medication Review Report (MRR) dated 8/15/18 documented an admission date of 5/1/5/12. The MRR listed Resident # 52's diagnoses included hypertension, diabetes mellitus, chronic kidney disease, long term use of insulin, hypothyroidism, history of falling, insomnia, weakness, pain and mild cognitive impairment. The pharmacist's Consultation Report dated 7/11/18 communicated that Resident # 52 receives insulin, lisinopril, levothyroxine, aspirin, atorvastatin and had not had a A1c [a test to determine average sugar concentration in the blood in the preceding 2 to 3 months] since October and CMP [Comprehensive Metabolic Panel], CBC [Complete Blood Count], TSH	F 658		

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F 658	Continued From page 48 [Thyroid Stimulating Hormone], lipid panel evaluation in the resident record since at least June, 2017. The Consultation Report recommended consideration to monitor the laboratory tests. The physician accepted the recommendations and instructed staff to implement the plan. On 8/15/18 at 1:24 PM, Staff D Licensed Practical Nurse (LPN) stated that laboratory (lab) test order noted on 7/31/18 (16 days ago) should have been drawn and the results back already. Staff D searched in Resident # 52's records and verified there were no lab test results on file for orders entered on 7/30/18. At 1:47 PM, Staff D reported that she called to trace where the lab results had been sent and she would provide them as soon as available. At 5:10 PM, the facility did not yet provide the lab results requested. On 8/16/18 at 8:07 AM, the Director of Clinical Services reported the facility failed to complete the ordered lab tests. The Director of Clinical Services acknowledged this finding as a deficient clinical practice.	F 658		
F 677 SS=D	ADL Care Provided for Dependent Residents CFR(s): 483.24(a)(2) §483.24(a)(2) A resident who is unable to carry out activities of daily living receives the necessary services to maintain good nutrition, grooming, and personal and oral hygiene; This REQUIREMENT is not met as evidenced by: Based on clinical record review, observations and facility policy review, the facility failed to provide assistance to all residents as directed by individual plans of care in order to assure good	F 677		

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F 677	Continued From page 49 personal hygiene and to provide complete incontinence care per accepted professional standards for 1 of 4 residents reviewed for activities of daily living (Resident #70). The facility identified a census of 77. Findings include: 1. The Minimum Data Set (MDS) assessment dated 7/18/18 documented diagnoses that included Non-Alzheimer's dementia, manic depression, arthritis and essential tremor for Resident #70. The same MDS documented a Brief Interview of Mental Status of 0 which indicated severely impaired cognition. The resident exhibited fluctuating inattention and disorganized thinking, required extensive assistance for completion of transfer, ambulation, dressing, hygiene, toileting and bathing and experienced frequent bladder incontinence. Care plan problems initiated 4/10/18 identified she required assistance with dressing, grooming, bathing and toilet use as the resident often had incontinence and direction to assist the resident with full upper and lower dentures, provide a wet washcloth every morning to wash her face, provide extensive assistance of 1 with dressing, grooming and bathing and toilet use with the goal for the resident to be clean and odor-free and to be able to wash her hands and face daily with set-up assistance. Observation on 8/14/18 at 8:25 AM with the facility's Nursing Consultant present revealed Staff M, certified nursing assistant (CNA) entered the resident's room and assisted her to transfer to the wheelchair and to the toilet. Observation revealed Staff M removed the resident's	F 677		

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F 677	Continued From page 50 incontinent brief, completely soiled with urine and fecal material. While seated on the toilet, and Staff M present, the resident wiped the palm of her right hand with toilet paper she moistened by licking it. Staff M then assisted the resident to stand up. Staff M then wiped the resident's rectal area with multiple disposable wipes. Observation reveled Staff M failed to cleanse the resident's frontal perineal area, buttocks and hips which were exposed to the soiled incontinent brief prior to pulling up a clean brief. Staff M then assisted the resident to sit in the wheelchair and transported her down the hallway to the medication cart. Observation revealed Staff M did did not offer the resident and washcloth for her face and hands or offer to set up or assist the resident with oral care. Observation on 8/14/18 at 8:45 AM revealed Staff Z, Transportation Director, transported the resident to the common area nook after Staff D, licensed practical nurse (LPN) administered the resident's medications. Observation revealed the resident had black debris on the outer edge of her right palm and a brownish substance with the appearance of fecal material on the index finger of the same hand. Resident #70 also had blue peeling nail polish on each finger. Staff M provided a washcloth for the resident to use for her hands upon surveyor request. The facility's Perineal Care policy, revised 10/15, documented the purpose of this procedure are to provide cleanliness and comfort to the resident, to prevent skin infections and skin irritation and to observe the resident's skin condition and directed the following: 11. For a female resident:(If BM (bowel matter)	F 677		

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F 677	Continued From page 51 present, a perineal wipe should be utilized. Do NOT use washcloth). a. Wet washcloth and apply skin cleansing agent, or use perineal wipes. b. Wash perineal area, wiping front to back. (1)Separate labia and wash area downward from front to back. Gently pat the area dry, if needed. (2) Continue to wash the perineum moving from inside outward, including the thighs, alternating side to side, and using downward strokes. Use different area of washcloth or separate dampened washcloths for each stroke OR use separate perineal wipe for each stroke. (3) gently pat dry perineum, if needed. c. Instruct or assist the resident to turn on her side with her side with her top leg slightly bent, if able d. Apply skin cleansing spray to washcloth, or use perineal wipes. Wash the rectal area thoroughly, wiping from the base of the labia towards and extending over the buttocks.	F 677		
F 684 SS=K	Quality of Care 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,	F 684		

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F 684	Continued From page 52 staff, physician interview family interviews and facility policy review, the facility failed to always complete accurate and timely assessments and interventions for 8 of 21 residents reviewed (Residents #376, #22, #373, #374, #4, #425, #62 and #68) which resulted in immediate jeopardy for facility residents. The facility identified a census of 77 current residents. Findings include: 1. According to the MDS (Minimum Data Set) assessment dated 3/22/18, Resident #376 had diagnoses that included anemia, pneumonia, diabetes mellitus, seizure disorder, anxiety disorder and acute respiratory distress syndrome. The MDS identified the resident had a BIMS (Brief Interview for Mental Status) score of 14 which indicated intact memory and cognition. According to the MDS the resident required the assistance of two with bed mobility and transfers and the assistance of one with eating. The assessment documented Resident #376 admitted to the facility on 3/15/18. The care plan dated 3/26/18 documented the resident had diabetes and required insulin. The care plan directed staff or the resident to check blood glucose levels before meals. The care plan also identified the resident had a diet of sodium 2000 mg (milligram) and potassium 60 meq (milliequivalents) per day. The care plan also identified the resident had food allergies to fish, poultry and nuts. Review of the Hospital Discharge Instructions dated 3/15/18 revealed Resident # 376 had nuts allergies with reaction 0 to persistent, moderate, severe nausea and vomiting. The resident also	F 684		

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F 684	Continued From page 53 identified chicken/poultry, fish allergy-reaction vomiting. The Discharge Instructions included the following orders: a. Glucagon 1 mg daily as needed for low blood sugar. b. Insulin aspart rapid acting per low dose sliding scale subcutaneous (SQ) with meals 3 times a day. c. Insulin aspart rapid acting 0.5 ml SQ with meals 3 times a day. d. Insulin aspart long acting 8 units SQ with breakfast. e. Diet 2 gram sodium and 60 meq potassium f. Insulin Aspart 100 units/ml sliding scale. Notify medical doctor if blood sugar less than 70 or greater than 400. Review of the Order Summary Report dated 3/15/18 revealed the order for 2 gram sodium, potassium 60 meq diet. The order also identified his allergies to fish, nuts and poultry. Review of the Fire Rescue document dated 3/24/18 revealed that at 8:05 PM Fire Rescue staff arrived at the facility and CPR (cardiopulmonary resuscitation) in progress. Upon arrival Fire Rescue on the scene had the resident supine (flat) on the floor and applied the cardiac monitor showing asystole (no heart rhythm). Large amounts of light brown emesis came out of the resident's mouth and a large amount of loose stool outside of the diaper. The resident did not have a pulse and not breathing and his skin felt pale, warm and very dry. The lung sounds full of possible emesis. Staff stated the resident had a low blood glucose around 6:00 PM, in the 50's, the resident was alert so they gave him a sandwich. They did give him something he was allergic to but caught it right	F 684		

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F 684	Continued From page 54 away. Staff state they did not come back to check on the resident until 8:00 PM when they found him without a pulse and with unknown down time. There was no noted lividity or rigor mortis; staff started CPR. The resident received all his medication today and had no complaints other than the lower blood glucose. Blood glucose obtained and noted to be 178. The rescue staff established an IV, performed suction, administered epinephrine, cleared the resident's airway and then intubated him. The noted no swelling in the airway. The resident transferred to the hospital. Review of the Emergency/Urgent Care Report dated 3/24/18 revealed the resident transferred to the ER (emergency room) from the facility. At about 6:00 PM the facility checked the resident's blood sugar, it had been a little low in the 50's and he ate a sandwich. Staff found the resident in his room at approximately 8:00 PM, called out EMS (emergency management system) at 8:05 PM and they arrived at 8:09 PM. When he was found, he was in PEA (pulseless electrical activity). The nursing home staff initiated CPR. EMS intubated him and continued CPR. He had been given 4 doses of epinephrine prior to arrival and remained in PEA throughout. When Resident #376 arrived in the ER, he was unresponsive, pupils fixed and dilated and CPR in progress; CPR continued and the resident remained with PEA. ER staff gave multiple doses of epinephrine and bicarbonate. A right femoral arterial stick showed a PH (acid/alkaline) of 6.88, potassium 7.3 and lactic acid level over 9. The resident received multiple more doses of epinephrine and 1 gram of calcium chloride. CPR continued and staff repeated blood gases several minuets later. The resident remained in PEA. Second blood gases showed a	F 684		

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F 684	Continued From page 55 PH of 6.96. Shortly after this, the patient went into a very fine ventricular fibrillation. He was shocked at 200 joules and then developed asystole (the absence of a heart rhythm). The resident was pronounced deceased at 8:52 PM. Review of the Diet Guide Sheet titled Lunch Day 14 (3/24/18) revealed the following food items: a. Seasoned Chicken Breast 3 ounce b. Sliced beats 1/2 cup c. Rice 1/2 cup d. Dinner roll/bread 1 with margarine e. Fruit Cocktail 1/2 cup f. Milk 4 ounces Review of the Diet Guide Sheet titled Dinner Day 14 revealed the following food items: a. Meatloaf with gravy 4 ounces b. Capri vegetable blend 1/2 cup c. Noodles 1/2 cup d. dinner roll/bread 1 each e. Vanilla ice cream 1/2 cup f. Milk 4 ounces Review of the Document titled Amount Eaten dated 3/24/18 revealed the following: a. No documented morning meal intake during breakfast. b. 3/24/18 at 11:56 AM - 51% to 75%. c. 3/24/18 at 9:18 PM - 51% to 75%. Review of the MAR (medication administration record) dated 3/1 - 3/31/18 revealed the following orders: a. Insulin Aspart Solution Pen-injector 100 unit/ml sliding. On 3/24/18, staff held his insulin due to a blood sugar of 56. b. Glucagon Emergency kit, 1 mg (milligram) intramuscularly as needed for low blood sugar	F 684		

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F 684	Continued From page 56 (no parameters) not administered. Review of the Progress Notes dated 3/24/18 at 6:00 PM revealed the nurse notified of the resident's low blood sugar of 57. Staff prepared the resident food and high sugar food; he was alert and oriented and able to make his needs known. Staff documented the plan to re-check after the resident completed his meal and held his insulin at this time. At 7:20 PM, staff found the resident lying in his bed without vital signs and unresponsive to pain. The nurse entered the room to follow up on his blood sugar and amount the resident ate, at which time he was found unresponsive. Four staff lowered him to the floor and staff initiated CPR as the resident was a full code. The resident had excessive mucous and vomit in the oral cavity so staff cleared his airway and continued CPR. A CNA (certified nursing assistant) called 911 while the nurses continued to perform CPR. EMS staff arrived and facility staff handed the resident's care over to them. At 9:07 PM, the facility received a call from the hospital and the resident had been pronounced dead in the ER. The facility failed to complete any assessment after a reported low blood sugar. Review of the Certificate of Death dated 3/24/18 revealed the cause of death as lactic acidosis due to diabetes mellitus type 1. During an interview with Staff U, LPN (Licensed Practical Nurse) on 8/17/18 at 1:10 PM she stated she worked on 3/24/18, the facility had been short of staff and she had been the only nurse on duty. They did the best they could with the amount of people they had. At 6:00 PM, Staff X, CNA reported Resident # 376 had a low blood sugar so he did not need his insulin. She had also	F 684		

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F 684	Continued From page 57 reported the resident had a snack and ate it. Staff U stated she had other issues with other residents and did not go into the resident's room and did not assess him due to other resident concerns. She went into the resident's room at approximately 7:40 PM and found the resident in bed and not breathing. She called for assistance on the walkie-talkie and yelled in the hall for staff. She told a CNA to get the DON (Director of Nursing) from her office and call 911. Staff U stated it took her a while to find staff to help put the resident on the floor to do CPR and she saw the resident had emesis in his mouth. She did chest compressions on the resident and gave no breaths due to the emesis. The ambulance came to the facility and transferred Resident #376 to the hospital at approximately 8:00 PM. She stated the DON told her she would do the charting for the incident. She further recalled the resident's family had called (did not remember day or time) the facility and reported the resident had received chicken for a meal and didn't eat it. She didn't know if the resident ate supper or not and did not recall seeing food in his room. During an interview with Staff X, CMA (certified medication aide) on 8/21/18 at 2:15 PM she stated she took the resident's blood sugar approximately 5:00 to 5:30 PM and it measured low. She told the nurse, Staff U, and went on with her pill pass. She stated she had asked a CNA to get the resident some food and drink and when she had been in the resident's room. Resident #376 had been talking and she asked him if peanut and butter would be OK and he said yes. She saw the CNA make the sandwich for the resident. Staff X stated she didn't go back in the room, didn't see him again and did not know if he ate supper or not. Staff U later went to the	F 684		

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F 684	Continued From page 58 resident's room and came out and told her to get the DON and call 911. She went to the DON's office to get her and then called 911. She went to the door to wait for the ambulance and showed them to the resident's room when they arrived. During an interview with the resident's family member on 8/21/18 at 2:30 PM, she stated she received a call from the resident on 3/24/18 and he reported staff gave him chicken for the noon meal and he didn't eat it and she called the facility to report it. She further stated when the resident had a low blood sugar, his blood sugar dropped fast and she had to administer Glucagon on several occasions. During an interview with the DON on 8/30/18 at 5:00 PM she stated she had been working in her office and called to the resident's room. Resident # 376 was a full code' so they moved him to the floor and she instructed staff to begin CPR. She stated she could see peanut butter sandwich in his mouth, only in the corner, and she flipped it out. The resident's airway was not blocked and no Heimlich maneuver required. The emergency medical team came and took over CPR. The DON also stated the expectation for staff to check the parameters for the blood sugar and notify the doctor and follow further instructions. She stated nursing staff did not have the authority to hold drugs or insulin. If the resident is not symptomatic, staff should check the blood sugar again in 15 minutes. Review of the Policy and Procedure titled Change of Condition or Status dated May 2017 directed staff to do the following: a, Physician Notification: If resident has critical situation/change, an eInteract resident change in	F 684		

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F 684	Continued From page 59 condition assessment should be completed before calling the medical doctor (unless life threatening then call 911 and then ER and physician). Complete the elnteract transfer form and send with the resident. If a non-life threatening change in condition, complete the resident change in condition assessment and call the doctor. b. Dramatic fluctuation of diabetic status (i.e. blood glucose levels, level of consciousness, etc.) should result in immediate contact with the resident's physician. During an interview with the resident's physician on 9/24/18 at 5:50 PM he stated the diagnosis of lactic acidosis could have been due to the low blood sugar. He also sated he would have expected the facility to call and notify him of the resident's low blood sugar. He further felt the facility should have been more active, assist and follow up with the resident. 2. According to the MDS assessment dated 6/5/18, Resident #22 had diagnoses that included anemia, neurogenic bladder, diabetes mellitus, arthritis, depression and spinal stenosis. The MDS identified the resident had a BIMS (brief interview for mental status) score of 13 which indicated intact cognition. Resident #22 required the assistance of one with bed mobility, transfers, dressing and toilet use. The care plan dated 8/8/18 directed staff to change his suprapubic catheter as ordered and monitor for redness and signs and symptoms of infection and if noted tell the nurse. Review of the Braden Scale dated 8/8/18 revealed the resident's score of 16 which	F 684		

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F 684	Continued From page 60 indicated the resident as at risk for pressure ulcer 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. Review of the Ostomy/Wound Progress Note dated 8/6/18 revealed the resident had shear injuries on the right lower sacrum measuring 2 cm (centimeter) by 2.5 cm with red tissue base and coccyx which measured 1 cm by 4 cm with pink tissue base. The resident's bottom quite erythemic, rashy. Review of the Hospital Discharge Instruction Sheet dated 8/8/18 revealed the following orders: a. Sacrum and coccyx: Cleanse with normal saline, apply Venelex ointment to open areas on right sacrum and coccyx, cover with ABD dressing. b. Groin: Apply Miconazole cream and microguard powder to red areas of groin. c. Vancomycin 1 gram/250 ml IV (intravenously) for 10 days. d. Cefepime 2 grams every 12 hours IV for 10 days. Review of the TAR (treatment administration record) dated 8/1/18 through 8/31/18 revealed the orders for the sacrum and coccyx - cleanse with normal saline and apply Venelex were not present on the treatment record.	F 684		

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F 684	Continued From page 61 Review of the Progress Notes dated 8/6/18 at 7:35 AM revealed the DON received a phone call at approximately 2:10 PM on 8/3/18 from the resident's primary provider (PCP). The PCP voiced concern in relationship with the resident's buttock and suprapubic catheter site; both areas were draining and appeared to be infected. She stated that she felt confident the resident had not had peri care or briefs changed in 'several days' and no care provided to his surgical site since his return. The PCP planned to have the resident seen by the wound clinic following the appointment with her and they would follow up with the DON with the findings and plan. Observation on 8/15/18 at 8:20 AM revealed Staff R, CNA and Staff S, CNA assisted the resident with morning cares. The resident walked to the bed to lay down. Staff cleansed the resident's groin and peri area from the front position and turned him to the right side. Staff D, LPN (licensed practical nurse) then applied Venelex to the resident's buttocks. The entire buttocks had a dark reddish color and areas that appeared scabbed with scratches and 2 open areas. Staff D then applied antifungal powder to the resident's groin area. On 8/29/18 at 2 PM, the resident had an area on the left upper buttock with slight irritation and no open areas. During an interview with Staff D on 8/15/18 at 1:40 PM, she stated Resident #22 had peeling and scaling skin on the buttocks and he scratches the area a lot. She saw a reddened and flaky area but not scratches; the scratches are new. She also stated she did a wound sheet on Monday when the area had a scratch and not bleeding and she planned one for today. She	F 684		

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F 684	Continued From page 62 stated she did not complete a saline wash and it had not been on the MAR. She stated the resident is going to the wound clinic and they will measure the area. She stated she had not seen the new area before. During an interview with Staff O, CNA on 8/16/18 at 5:50 PM he stated he assisted Resident #22 to the bathroom 2 to 3 days prior to his hospitalization. The resident sat down and he saw bleeding on the resident's bottom. He called the nurse and they waited in the bathroom for her but she didn't come. Staff O then cleansed the area off and he saw open areas, the areas appeared red and puffy with yellow spots. After he cleansed the area, he applied house cream and a new brief and the resident sat down in the recliner. He further stated the area had been worse than he had seen before. 3. The MDS assessment dated 10/5/17 documented Resident #373 had diagnoses that included anemia, heart failure, hypertension, diabetes mellitus, anxiety, chronic obstructive pulmonary disease (COPD), respiratory failure and morbid obesity. The same MDS documented a BIMS score of 13 . Resident #373 showed independence with bed mobility, transfer, walking, dressing, toilet use and personal hygiene and supervision with eating. The resident experienced no shortness of breath and did not use oxygen during the 14-day assessment period ending 10/5/17. The care plan problem initiated 5/14/13 identified the resident had restrictive lung disease with chronic hypoxemia (a low blood oxygen level) and gets short of breath easily. The care plan identified Resident #373 used oxygen and	F 684		

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F 684	Continued From page 63 directed staff to check the resident's oxygen saturation levels as needed (PRN) and to notify the physician of any changes. Review of Progress Notes for Resident #373 revealed the following entries: a. On 10/3/17 at 2:20 PM the resident went to appointment to the cancer center and returned at 4:29 PM. b. On 10/6/17 at 12:15 PM the resident returned from an appointment with no new orders. The following Progress Notes entries were completed by Staff U, LPN on 10/7/17: a. At 10:30 AM, Staff U spoke with the resident's primary care provider (PCP) regarding the resident's complaints of cough and shortness of breath. The physician ordered Robitussin (a cough medication) 5 ml every 4 hours PRN and DuoNeb (an inhalation treatment) every 4 hours PRN for shortness of breath. b. 11:12 AM - Robitussin administered, effective at 12:03 PM. c. 11:20 AM - DuoNeb treatment administered, effective at 2:21 PM. d. 3:17 PM and 7:27 PM - Robitussin administered. e. 3:49 PM - DuoNeb administered. f. 7:30 PM - Staff U called the resident's PCP regarding her request to be sent to the emergency room for evaluation of shortness of breath and congestion. The on-call service could not reach the PCP and would have doctor call back. g. 7:39 PM - DuoNeb administered. h. 9:12 PM - The resident's PCP returned the call and ordered Resident #373 to be sent to the emergency room and Staff U informed the resident of this.	F 684		

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F 684	Continued From page 64 i. 9:55 PM - A Death Note: Resident #373 expired during transport attempt in the ambulance and all assessments performed by the EMT's. The family was notified at 10:01 PM and unit manager notified at 10:00 PM. Staff failed to conduct a physical assessment of Resident #373, despite her deteriorating condition. Review of the Ambulance report of 10/7/17 revealed the following information: ALS (advanced life support) dispatched with the chief complaint that nursing staff reported Resident #373 had increased shortness of breath ongoing for the past couple of days. The resident was alert, with a distressed respiratory effort, crackles in the upper left and right lungs and absent lung sounds posteriorly in both lungs. Oxygen on at 5 LPM (liters per minute), normal carotid (neck) pulses bilaterally, a thready left radial (wrist) pulse and a weak right radial pulse. At 8:32 PM, the resident sat upright on the bed with her feet down and could speak full sentences. Resident #373 reported she had not felt well over the last couple of days and she cannot breathe. The nurse reported the resident is on oxygen at 5 LPM and her saturation rates are decreasing. At this time the resident's saturation level measured 83% (normal 90% or above) via nasal cannula oxygen delivery. The paramedic suggested they needed to get her on the cot due to her deteriorating status, the patient agreed to transport to the hospital and she could stand with the paramedic's assistance. The resident became winded. EMS assisted the resident to a Fowler's position (seated with torso elevated) and the resident fell backwards and yelling 'I can't breathe! Help me!' EMS staff	F 684		

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F 684	Continued From page 65	F 684		

placed oxygen on the resident at 15 LPM per a non-rebreather mask. The resident appeared pale with cyanosis around her lips. At 8:42 PM, the patient transported to the back of the ambulance, with open eyes to verbal cues. The EMS documented CPAP (continuous positive pressure airway pressure) provided at 11 centimeters (cm). Resident #373 went into respiratory arrest but still had a pulse. At 8:48 PM, the paramedics removed the CPAP and applied a BVM (bag valve mask) with 100% oxygen and an oropharyngeal airway and bagged the resident at 10-12 BPM (breaths per minute). The cardiac monitor noted the resident in asystole (no heart beat) and the paramedics initiated CPR; the patient continued to be in cardiac arrest. Resuscitation efforts continued until 9:58 PM, when paramedics spoke with EMS Medical Director who ordered to terminate CPR and divert the patient to a morgue or funeral home.
At 10:05 PM, the paramedic and EMT re-entered the facility to provide support to nursing staff for their loss.

During interview on 8/16/18 at 2:16 PM Staff U stated she worked 6 AM-10 PM (16 hours) on 10/7/17 and was responsible for Resident #373. She stated she contacted the resident's physician in the morning regarding her complaints of cough and shortness of breath and received orders for cough medication and inhalation breathing treatments. Staff U stated she did not do assessments of the resident's status because she was so busy and did not have time but she did check on the resident on and off. Staff U stated the first administered doses of the cough medication and breathing treatments were effective, but the second administered doses

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TOUCHSTONE HEALTHCARE COMMUNITY	1800 INDIAN HILLS DRIVE SIOUX CITY, IA 51104

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F 684	Continued From page 66 were not effective for the resident. Resident #373 told her she did not feel right. Staff U said the resident had COPD and did not look any worse than usual, but then stated the resident looked like she was sick and sounded junky and rattly, but other staff told her the resident always looked sick. Staff U stated that she was not familiar with the resident and she sought direction from Staff B, RN/Nurse Manager. Staff U stated Staff B told her not to send Resident #373 to the hospital as she had to have approval to do so and stated that she was told exactly what to do at every turn by Staff B, but she felt it could have gone differently. Staff U described the resident O2 dependent and that she begged to be sent to the hospital. Staff U stated she called the physician for an order to send the resident to the hospital and Staff B finally told her to call an ambulance. Staff U stated she told the resident relaxed when informed she would be going to the hospital and was alert when the ambulance arrived. She felt the ambulance personnel removal the resident's oxygen in order for her to transfer to the gurney as reason the reason she became very short of breath and went downhill quickly. Staff U stated she was very upset the resident expired as she felt the resident should have gone to the hospital sooner, but Staff B directed her not to send her. Staff U stated she felt "waterlogged" at work and did not have time to fully assess the resident and to document her findings During interview on 8/16/18 at 5:05 PM, Staff R CNA stated he worked the resident's hall for the 2-10 PM shift on 10/7/17. He said the resident acted a little more lethargic than usual and did not verbalize as much. He stated she was a private person, pretty independent and liked to stay in her room. The resident could make her own	F 684		

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F 684	Continued From page 67 decisions. During interview on 8/17/18 at 3:30 PM, Staff EE CNA stated he worked with Resident #373 on the day she died. He described her as a private person that kept to herself. He stated the resident did not feel well and recalled she asked to go to the hospital a few times, with the nurse present at the times she requested to go. During interview on 8/21/18 at 1:30 PM, Staff B stated that she did not know there were changes with the resident's condition until it was dark outside. Staff U called her and she directed her to send the resident to the hospital via ambulance. She gave Staff U specific interventions to use for shortness of breath and adamantly denied that she told Staff U the resident could not go to the hospital. Staff B stated she came to the facility because Staff U acted hysterical. Staff B stated that nurses do not have to have approval of the facility to send residents to the hospital; they are instructed to trust their judgment and to do what they feel is needed. During interview on 8/31/18 at 8:45 AM the Assistant DON (ADON) stated that nurses may send residents to the hospital without a physician order if a resident requests to go and/or it is an emergency. Permission from facility management is not needed to send residents to the hospital. She would expect nurses to assess a resident's vital signs, lung sounds and oxygen saturation level, raise the resident's head of the bed with complaints of shortness of breath and to notify the physician of the resident's condition. She would also expect nurses to document the resident assessments.	F 684		

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F 684	Continued From page 68 During interview on 9/5/18 at 3:13 PM, the resident's physician recalled a nurse contacting him regarding this resident. He could not specifically recall what the nurse related to him regarding the resident's condition. He would have expected the nurse to do vital signs, check lung sounds and oxygen saturation and to visit with the resident about his/her signs and symptoms and to contact him if anything further was needed. The physician stated that nurses can send patients to the hospital without an order and "certainly" send them if they are requesting to go and stated nurses in facilities "do that all the time". When asked if earlier medical intervention could have made a difference for this resident's outcome the physician replied "probably". The Certificate of Death for Resident #373 listed the immediate cause of death as acute respiratory failure for a duration of 8 hours. 4. The MDS assessment dated 5/27/18 documented Resident #374 had diagnoses that included cancer, hypertension, septicemia, diabetes mellitus, thyroid disorder, Non-Alzheimer's dementia, bipolar disorder and obesity. The same MDS documented a BIMS score of 12 which indicated moderately impaired memory and cognition. She required the assistance of 2 with bed mobility, transfer, wheelchair mobility, dressing, eating toileting and hygiene and bathing. The assessment documented she had the life expectancy of less than six months, utilized oxygen and received hospice services. The care plan problem dated 5/2/18 identified the resident re-admitted to the facility from the	F 684		

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F 684	Continued From page 69 hospital with an IV line in the right arm for administration of IV antibiotics for treatment of an infected pressure ulcer on the sacral area. Another care plan problem dated 3/9/17 identified the resident requested full code status and identified the resident as her own decision maker with the goal for the resident to be comfortable and treated with respect by the staff. During interview on 8/14/18 at 2:45 PM Staff L, LPN stated she worked the 6 AM-2 PM shift on 5/11/18. As the resident sat in the common area in her wheelchair, she had a 'spell', could not speak and stared off into space. Staff L stated she recently started at the facility and was not really familiar with the resident but she felt she needed to call 911 and have the resident transported to the hospital. She spoke with Staff D, LPN regarding the resident and she also agreed the resident should be transported to the hospital. Staff L stated the DON yelled at her to hang up the phone in a very aggressive manner and told her she could handle the situation with the resident. The DON assessed the resident's vital signs, took Resident #374 to her room and transferred the resident to bed with maximum assistance of another staff member as the resident still not responsive. Staff L stated the DON tried to figure out what may be going on with the resident and the resident eventually regained consciousness. During interview on 8/16/18 at 10:10 AM Staff D stated she talked with the resident on the day of the incident and she did not seem to be acting right. She remembered she told Staff L she should call 911 as she thought the resident had a history of idiopathic (unknown reason) seizures. Staff L told her she had called the physician but	F 684		

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F 684	Continued From page 70 Staff D told her she did not think there was time for that. Staff D stated another staff member went to summon the DON and Staff L went to the phone to call 911. She stated the DON told Staff L to hang up the phone and then staff transported the resident to her room. Staff D stated the facility has a new policy that directs that before calling a physician, hospital or ambulance staff should call the DON first unless it is 'super-emergent'. Review of the resident's clinical record revealed no documentation of the incident on 5/11/18. Staff L stated during interview on 8/14/18 at 2:45 PM the incident should have been documented in the resident's clinical record. 5. The MDS assessment dated 8/10/18 documented Resident #4 had diagnoses that included hip fracture, Non-Alzheimer's dementia, anxiety, depression and chronic lung disease. The same MDS documented a BIMS score of 9 which indicated moderate cognitive impairment. The resident required the assistance of two with transfers and the assistance of one with bed mobility, walking, dressing, toilet use and bathing. Resident #4 had no skin issues at the time of the assessment, had a pressure reducing device in bed and chair and received nutrition or hydration interventions to manage skin problems. The care plan problem initiated on 1/18/18 identified Resident #4 as at risk for skin breakdown due to the need for assistance with toilet use and hygiene and a history of incontinence. The care plan directed staff to monitor for any potential skin breakdown and nursing staff should observe the resident's skin at least weekly during bathing with the goal to	F 684		

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F 684	Continued From page 71 prevent any kind of skin breakdown though a target date of 11/10/18. Observation on 8/14/18 at 10:00 AM with the Assistant DON (ADON) present revealed Staff M, CNA, assisted the resident with morning cares. Observation revealed the resident had an undated gauze dressing wrapped around her right lower leg above the ankle. 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" 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	F 684		

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F 684	Continued From page 72 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 measured 2.1 cm x 1.0 cm and documented the treatment ordered as oil emulsion dressing covered with a bordered Mepilex dressing every other day and PRN (as needed) until healed. During interview on 8/15/18 at 3:10 PM, Staff D stated she faxed the Skin Condition Report to the resident's physician and the treatment order on the sheet had not technically been ordered yet but when the physician responded, it would be added to the resident's Treatment Administration Record (TAR). During interview on 8/16/18 at 5:30 PM, Staff N, CNA, stated she often bathed Resident #4 and recalled she bathed the resident 2 times in the last week. She stated Resident #4 had had some sort of dressing on her right lower leg on and off for some time and she places a garbage bag over the dressing when she bathes the resident. She stated she does not mark the area on the Bath Sheet which is given to the charge nurses after each completed bath because the nurse must already know because there is a dressing on it. Observation on 8/24/18 at 11:39 AM revealed the dressing above the resident's right ankle dated 8/15/18. Review of the TAR revealed no order for treatment to this area yet received and the Skin Condition Report for this area no updated since completed 8/15/18. The Daisy Lane Skin Assessment schedule indicated the resident's skin condition assessments assigned for	F 684		

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F 684	Continued From page 73 completion on the evening shift on Thursdays (8/23/18). The surveyor notified the nursing consultant of the lack of follow-up from the physician as well as the failure to re-assess this skin area as assigned on 8/23/18. 6. The MDS assessment dated 6/13/18 documented Resident #425 had diagnoses that included hypertension, anxiety, osteoarthritis, edema and repeated falls. The same MDS documented a BIMS score of 15. The resident displayed independence with activities of daily living except eating, which required supervision. Resident #475 used a walker for ambulation and had no falls since the last assessment. The care plan initiated on 5/26/17 identified the resident as independent with ambulation and at risk for falls. Review of the Progress Notes for Resident #425 revealed the following: a. An entry created 8/21/18 at 6:30 PM by Staff C, Registered Nurse, documented the resident's legs weakened while standing in front of the closet and she went to the floor. The resident struck her left lower extremity on the door frame as she turned to go back to her chair. Her left lower ankle looked blue in color and swollen but she did not complain of any other issues. Staff C elevated the resident's leg and applied ice. An entry created 8/22/18 at 8:06 AM documented this incident actually occurred 8/18/18 (Saturday). b. An entry created 8/21/18 at 7:58 PM by Staff C for the effective date (of actual occurrence) on 8/18/18 at 7:11 AM which documented the resident's son came to visit in the morning of	F 684		

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F 684	Continued From page 74 8/19/18 (Sunday). The nurse documented she checked on the resident and asked her how she felt. The resident replied she did not know. The left lower leg swelling had subsided and she had no more bruising than the previous night. Staff C documented she asked the resident's son to ask how she felt about going to the emergency room. The son reported later Resident # 425 got up with assistance and they should wait a day or so and see how she did before going to the emergency room. A late entry completed by Staff L, LPN for the effective date of 8/20/18 at 4:05 PM documented the resident's physician office called and asked how the resident should be transported from the office to the emergency room. An untimed administration note completed by Staff A, RN documented the resident admitted to the hospital on 8/20/18. During interview on 8/23/18 at 3:22 PM Staff C stated she worked a 16 hour shift on Saturday 8/18/18 and an 8 hour shift 8/19/18 and assigned to care for Resident #425. She stated on 8/18 between around 7:00 AM-7:30 AM the resident had been found laying on the floor on her back and they noted her lower leg was swollen with scattered light blue bruising below the knee to mid-calf. Staff C stated she completed range of motion to the resident's arms and right leg as much as the resident would allow but did not do range of motion to the left leg as she could tell the leg caused the resident pain. Staff C said she asked the resident if she wanted to go to the emergency room but the resident was indecisive about it. Staff C stated at the time of the incident she completed an incident report and placed it in	F 684		

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F 684	Continued From page 75 the basket to be delivered to the DON. Staff C did not document in the resident Progress Notes until 8/21/18 and facility staff contacted her because she had not completed documentation correctly; she had been really busy on 8/18/18. She stated there is a stack of forms to be completed when someone falls so she completed the paper incident report correctly and placed it in the DON's box. Staff C stated she did not call the physician or the on-call representative at the time of the fall as the resident could not decide if she wanted to go to the emergency room. Staff C reviewed the Skin Condition Report (non-decub) completed by her on 8/18/18; she stated this is the form she faxed to the physician's office as notification of the fall. The report documented the facsimile sent 8/19/18 at 9:09 PM. During interview on 8/23/18 at 3:57 PM Staff A stated she worked 6 AM-2 PM on 8/20/18 and she made a doctor's appointment for the resident because she complained of pain, had difficulty bearing weight and had a significant bluish bruise on the left lower leg. Staff A held her hands out approximately 7-10 inches to illustrate the size of the bruise. Staff A stated she did not chart any assessment, etc. of the resident. The hospital History & Physical dated 8/20/18 documented the resident's left lower extremity as edematous and bruised and externally rotated and shortened. The ED (emergency department) Physician Notes dated 8/20/18 documented the resident had both knee joints replaced and had a left femur fracture on 12/12/11 and listed the current diagnoses of fracture of the left proximal fibula and peri-prosthetic (around the knee replacement) fracture of the proximal tibia and the resident admitted to the hospital.	F 684		

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F 684	Continued From page 76 During interview on 9/11/18 at 4:33 PM the resident's physician stated she would have expected the facility to notify her, or her on-call designee, of the fall with injury, regardless of whether or not the resident wished to go to the emergency room. She stated the resident had signs of injury at the time of the fall which required follow-up assessments and she would have expected nurses to document them as well. 7. The MDS assessment dated 8/7/18 documented Resident #62 had diagnoses that included diabetes mellitus, multiple sclerosis, seizure disorder, anxiety, depression and chronic lung disease. The MDS documented she required the assistance of one with bed mobility, transfers walking, and personal hygiene. The resident admitted to the facility with surgical wounds. The care plan dated 6/29/18 documented the resident admitted to the facility with a non healing surgical wound to the right upper chest, an abrasion to the left knee and an abrasion to the left hand. The care plan instructed nursing to examine the resident's skin weekly. A Skin Condition Report (Non-pressure) dated 7/10/18 documented a 4 x 2.3 centimeters (cm) scabbed area to the resident's left knee. The clinical record lacked any further assessments A Skin Condition Report (Non-pressure) dated 7/10/18 documented 3 scabbed areas to the resident's left hand that measured 3 x 2 cm, 2 x 2 cm and 2 x 1 cm. The clinical record lacked any further assessments. A Skin Condition Report (Non-pressure) dated 7/10/18 documented a wound to the right upper	F 684		

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F 684	Continued From page 77 chest that measured 4.3 x 4.5 cm with a depth of .1 cm. The clinical record lacked any further assessments. 8. The MDS assessment dated 8/1/18 documented Resident #68 had diagnoses that included anemia, heart failure, hypertension, diabetes mellitus, high cholesterol, depression, chronic lung disease, pneumonia and end stage renal disease. The MDS documented the resident required dialysis. The MDS documented the resident as risk for pressure ulcers but none recorded at the time period for the MDS however the resident have a surgical wound. The MDS documented the resident scored a 15 out of 15 on the Brief Interview for Mental Status indicating intact cognition. The care plan reviewed 8/13/18 listed the resident had an incision on the left upper thigh. A Skin Condition Report (Non-pressure) dated 7/21/18 documented Resident # 68 had a .4 x 1 cm surgical incision to the left upper thigh. The clinical record recorded no further assessments. During an interview on 8/16/18 at 10:30 a.m. the facility's nursing consultant stated she could not locate any further assessments. On 8/23/18, the facility abated the immediate jeopardy (IJ) situation when they provided inservice education to nursing personnel on providing complete assessments and interventions, specifically for residents with diabetes, respiratory infections and seizure activity. These findings lowered the IJ from a "K" severity level to an "E" with ongoing monitoring to ensure facility staff is following adequate	F 684		

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F 684	Continued From page 78 assessments.	F 684		
F 686 SS=E	Treatment/Svcs to Prevent/Heal Pressure Ulcer CFR(s): 483.25(b)(1)(i)(ii) §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, observations and staff and resident interviews the facility failed to complete ordered treatments, to prevent a pressure ulcer from developing and to routinely assess skin issues for 4 of 4 residents reviewed (Residents #12, #35, #68 and #9). The facility reported a census of 77 residents. Findings include; 1. According to the MDS (minimum data set) assessment dated 5/17/18, Resident #12 had diagnoses that included septicemia, viral hepatitis, paraplegia, cellulitis of the left toe and sepsis. The MDS identified the resident had a BIMs (brief interview for mental status) score of 15 which indicated the resident had intact cognition. According to the MDS the resident	F 686		

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 686	Continued From page 79 required supervision with bed mobility, transfer, dressing and toilet use. The assessment documented Resident #12 admitted to the facility on 3/27/18. The care plan dated 5/18/18 directed staff to administer his treatment as ordered to a pressure ulcer on the right buttock. Review of the Ostomy/Wound Progress Note dated 4/13/18 revealed the resident had the following wounds: a. Black encrusted area on right great toe medical aspect measuring 0.4 cm by 0.3 cm, unable to remove with cleansing. b. Partial thickness wound on his right buttock that measured 1 cm (centimeter) by 0.5 cm by 0.2 cm with red tissue base, margins of wound is calloused. c. Orders include: AquacalAG to right buttock wound, cover with Mepilex border dressing. MepilexAG borderless to right great toe, secure with medipore tape. Review of the Discharge Instructions dated 4/16/18 revealed the following wound orders: a. Right buttock: Cleanse wound with shurclens, apply Aquacel AG, cover with Mepilex border dressing. Change every other day. b. Right great toe: Cleanse right great toe to black encrusted area on medial aspect with shurclens, apply piece of Mepilex AG borderless and tape with medipore tape. Change every other day. Review of the Medical Doctor Nursing Communications dated 4/25/18 revealed the order for the right buttock decubitus ulcer: Restart the right buttock wound treatment from 4/17/18 order, perform daily until healed, see hospital	F 686		

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F 686	Continued From page 80 discharge notes. Review of the Weekly Wound Documentation Form revealed the right ischial (buttock) wound had the following measurements: a. 4/25/18 2.0 cm by 1.6 cm by 0.2 cm Stage 2. b 5/2/18 1.8 cm by 1.8 cm by 0.2 cm Stage 2 c. 5/9/18 1.4 cm by 1.6 cm by 1.2 cm Stage 2 d. 5/16/18 1.2 cm by 1.2 cm by 0.1 cm Stage 2 Review of the TAR (treatment administration record) dated 4/1/18 through 5/31/18 revealed staff did not complete the treatment to the right buttock per physician's order from 4/16/18 through 4/25/18. Review of the Policy and Procedure titled Dressings Clean/Aseptic dated August 2018 directed staff to do the following: a. Verify that there is a physician's order for this procedure. b. Review the resident's care plan, current orders and diagnoses to determine if there are special resident needs. c. Check the treatment record. 2. The MDS assessment for Resident # 35 dated 6/27/18 recorded diagnoses that included renal insufficiency, cancer, anxiety disorder, depression and adult failure to thrive. The resident required the assistance of 2 staff for bed mobility, transfers, dressing, eating, toilet use and personal hygiene. The MDS further indicated the Resident # 35 had a current unhealed pressure ulcer, identified as unstageable (a suspected deep tissue injury). The assessment documented she had modified independence with cognitive skills for daily decision-making, having some difficulty with new situations only.	F 686		

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F 686	Continued From page 81 Resident # 35's Care Plan dated 6/6/18 documented she had a suspected deep tissue injury and instructed placement of a pressure relief boot to left heel when up. The facility failed to revise the care plan for Resident #35 since the she spends all of her time in bed. The Comprehensive Evaluation of Skin Inspection and Risk factors form dated 4/26/18 for Resident #35 identified her Braden score of 14 indicated moderate risk for skin breakdown. Other risk factors included the resident's head of bed elevated a majority of the day and the requires assist with ADL's (Activities of Daily Living). The form identified left shoulder bruise 6 cm x 2 cm, left outer axilla bruise 4 cm x 3 cm, left inter wrist 8 cm x 4 cm and a surgical incision 25 cm on right frontal lobe. The analysis of risk factors and interventions directed her skin needs to be inspected within 2 hours of admission/readmission and weekly for 4 weeks with reference to the resident's incontinence, needs with mobility, obesity and the need for assistance with repositioning. The Pressure/stasis/Arterial Skin Report for Resident #35 dated 5/31/18 identified a suspected deep tissue injury first observed 5/31/18 on her left heel. The area measured 7 centimeters (cm) x 8 cm and had bloody drainage with a dark brown /purple color. Initial treatment to cover with Optifoam and boots and signed by the physician on 6/5/18. The resident's Weekly Wound Documentation Forms documented the following: a. 6/6/18 - A left heel pressure measuring 7 cm x 8 cm, a suspected deep tissue injury.	F 686		

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F 686	Continued From page 82 b. 6/6/18 - The left heel pressure ulcer measured 7 cm x 8 cm, suspected deep tissue injury. c. 6/13/18 - The left heel pressure measured 7.1 cm x 7. 8 cm, suspected deep tissue injury, with a treatment plan of Optifoam and heel protectors. Staff requested to change treatment to Betadine moistened 4x4 gauze, loosely wrapped with Kerlix twice a day and awaited physician's orders. d. 6/20/18 - The left heel pressure ulcer measured 6.8 cm x 6.9 cm, a suspected deep tissue injury, current treatment of offloading boots and monitor weekly. e. 6/27/18 - The left heel pressure ulcer measured 6.4 cm x 6.4 cm, suspected deep tissue injury, with a current treatment of offloading boots. f. 7/3/18 - The left heel pressure measured 4.1 cm x 4.3 cm, suspected deep tissue injury, with a current treatment of Betadine moistened gauze pressure reduction boots. Staff documented a goal to keep the wound stable and prevent further deterioration with a Hospice consult as well. The Multidisciplinary Care Conference Summery dated 7/2/18 documented that Resident #35 spends all of her time in bed. The Order Audit Report for Resident #35 documented a verbal order on 6/20/18 for Betadine Solution 10 % to apply to left heel topically every 48 hours for wound. The order includes instructions to lightly moisten gauze with Betadine and apply to the left heel and secure with loosely wrapped Kerlix. The Audit showed staff did not create the order until 7/3/18. The Medication Administration Record (MAR) documented start date of 7/4/18 for this treatment.	F 686		

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F 686	Continued From page 83 The Weekly Wound Documentation Form dated 7/11/18 documented left heel pressure ulcer measured 1.6 cm x 1.6 cm and had improved immensely, most of the necrotic tissue has released and sloughed from the wound only a small area remained. On 7/18/18, the wound had healed. The Prevention of Pressure Ulcers policy, updated 2/14, included the following; General Guidelines 1. Pressure ulcer are usually formed when a resident remains in the same position for an extended period of time causing increased pressure or a decreased of circulation (blood flow) to that area and subsequent destruction of tissue. Interventions and Preventive Measures 1. Identify risk factors of pressure ulcer development. 2. For a person in bed: a. Change position at least every two hours or more frequently in needed. b. Determine if resident needs a special mattress. c. If a special mattress is needed, use one that contains foam, air, gel, or water as indicated. d. Raise the head of the bed as little and for as short a time as possible, and only as necessary for meals, treatment and medical necessity. 3. For a person in a chair a. Change position at least every hour. b. Use a foam, gel, or air cushion as indicated to relieve pressure. 9. Routinely assess and document the condition of the resident's skin per facility wound and skin care program for any signs and symptoms of irritation or breakdown.	F 686		

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F 686	Continued From page 84 During an interview on 8/15/18 at 8:57 AM, the Director of Clinical Services acknowledged she would expect the care plan to be updated with the current conditions since the resident does not get out of bed and has not gotten out of bed for a long time now. She further acknowledged she could not say for sure how long Resident #35 had not gotten out of bed. The Director of Clinical Services thought that offloading boots should have been added to the care plan. During an interview on 8/15/18 at 1:51 PM , the Director of Clinical Services explained she could not find the order for Optifoam or Betadine. The order showed a verbal order 6/20/18 for Betadine, staff entered it in the system on 7/3/18 with a start date of 7/4/18. The Director of Clinical Services stated there should be a printout of the order from the system in the chart and she did not see one. . 3. The MDS assessment of 8/1/18 documented Resident #68 had diagnoses including anemia, heart failure, hypertension, diabetes mellitus, high cholesterol, depression, lung disease with a history of pneumonia, and end stage renal failure. The MDS documented the resident required dialysis. The MDS documented the resident's height as 61 inches and weight at 206 pounds with a significant weight loss and on a weight loss regimen. The MDS documented the resident as risk for pressure ulcers but none recorded at the time period, but the resident had a surgical wound at the time of the assessment. The MDS documented the resident scored a 15 out of 15 on the Brief Interview for Mental Status indicating intact cognition.	F 686		

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F 686	Continued From page 85 The care plan reviewed 8/13/18 did not address the resident's potential and actual pressure areas. A Skin Condition Report (Non-pressure) dated 6/2/18 documented a 5 x 3 centimeter (cm) abrasion on the resident's buttocks. The clinical record had no further assessments. A Skin Condition Report (Non-pressure) dated 7/21/18 documented a pinpoint scab on the resident's buttocks. The clinical record had no further assessments. 4. The MDS assessment dated 5/12/18 recorded Resident #9 had diagnoses of cerebrovascular infarction (CVA or stroke), hemiplegia (paralysis on one side) and diabetes mellitus. The MDS revealed Resident #9 with a BIMS score of 15. Resident #9 required the assistance of one staff for transfers, dressing, toilet use, hygiene and. The MDS documented the resident had bladder incontinence and the risk for pressure ulcer development. The Care Plan revised on 4/7/18, revealed Resident #9 had dry skin and diagnoses of psoriasis and diabetes. The instructed staff to monitor for potential skin breakdown, use a pressure relieving pad on the chair, observe the skin at least weekly, apply lotion to the right hip and arm, perform treatments as ordered, elevate his heels off the chair and place heel protectors at bedtime. The Braden Scale Assessment dated 10/5/17 revealed a score of 20, which indicated resident not at risk for pressure ulcers. The clinical medical record and Point Click Care (PCC computer system) lacked documentation of a	F 686		

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F 686	Continued From page 86 Braden Scale Assessment after 10/5/17. The History and Physical Report dated 6/25/18 documented Resident #9's right buttock felt sore over the ischial tuberosity. The resident reported his symptoms to one of his aides on 6/24/18, who told him his skin had broken down. The resident used a power wheelchair for mobility and had a standard foam cushion in the wheelchair. The resident had diabetes, hemiplegia following a CVA, and could not perform activities of daily living independently. The physician documented the resident had the formation of an early stage pressure ulcer to his right gluteus secondary to an inability to reposition himself due to right hemiparesis and inadequate seating. The foam seat in the wheelchair had not prevented excessive pressure on his right gluteal /ischial tuberosity. The Occupation Therapy (OT)) evaluation on 6/27/18 revealed Resident #9 had pain and decreased skin integrity as a result of wheelchair positioning and weightlifting program (for weight shifting/repositioning). The resident had a risk for further decline in function and pressure sores. The resident discharged from OT on 7/17/18. Review of Progress Notes dated 6/18 - 8/15/18 revealed no documentation or record of skin assessments. The TAR dated 8/18 recorded a skin assessment by the nurse on the evening shift every Wednesday. During observation on 8/14/18 at 8:21 AM, Resident #9 reported his brief felt wet and he had a sore on his right (R) buttock. Staff G, Certified	F 686		

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F 686	Continued From page 87 Nursing Assistant removed Resident #9's pants and two briefs as the resident stood by his walker. Staff G used disposable wipes and provided incontinence care for the resident. The resident had a small slit / (> 0.5 inches) open area and redness to his (R) buttock and a small amount of white cream on the buttock area. Staff G re-applied silicone barrier cream to the resident's buttocks after she performed pericare. In an interview 8/13/18 at 11:45 AM, Resident #9 reported he had a sore on his bottom the past 2 months. In an interview 8/15/18 at 7:20 AM, Staff D, Licensed Practical Nurse (LPN) reported the facility kept skin assessments a white binder by the treatment cart and treatments could be found on the TAR in PCC. Staff D reported she also documented any treatment of skin/wound changes on the skin assessment form. On 8/15/18 at 7:25 AM, Staff B, Registered Nurse (RN)/Unit Manager reported she had the binder of skin assessments in her office. Upon review of the binder, no skin assessment could be found for Resident #9. Staff B reported Resident #9 had his skin assessment done on Fridays per the flow chart with resident room #'s inside the front cover of the binder. Staff B confirmed they had no current skin assessments or wounds on Resident #9, but if the resident had a former skin issue, it would be in the resident's chart or medical records. On 8/15/18 at 7:40 AM, Staff D confirmed Resident #9 had no treatments except for a treatment on his feet at bedtime. Staff D stated Resident #9 had currently had no open sores or	F 686		

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F 686	Continued From page 88 wounds and had intact skin on his bottom. Staff D acknowledged she had been assigned to "D" Hall 8/14-8/16/18, and none of the CNA's had told her about any noted redness or open areas on Resident #9's bottom during the survey week. In an interview 8/16/18 at 6:50 AM, Resident #9 reported the staff used to perform skin checks every week, but had not done it for awhile. Resident #9 stated staff only applied cream on his bottom and no other treatments were done. During observation on 8/16/18 at 08:15 AM, Staff D and Staff B assessed Resident #9's bottom. At the time, the resident's buttocks had no redness and no open area or slit. Resident #9 stated staff had applied some cream on his bottom and the area felt better. In an interview 8/16/18 at 10:10 AM, Staff D reported skin assessments are performed weekly and best done when a resident had a bath, usually on the first bath day of the week. Staff D reported the CNA let nurses know if a resident had any skin issues, and then the nurse looked over the skin. If no skin issues, she marked yes on the MAR or TAR to indicate the assessment completed. Staff D reported if she had noticed a skin concern, then they started a skin sheet, filled out the information on the form, and placed the form in the white binder on the treatment cart.	F 686		
F 689 SS=D	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	F 689		

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F 689	Continued From page 89 §483.25(d)(2)Each resident receives adequate supervision and assistance devices to prevent accidents. This REQUIREMENT is not met as evidenced by: Based on clinical record review, observation, facility policy review and staff interviews, the facility failed to ensure safe transfer assistance for 3 of 5 residents observed for transfers (Residents #9, #424 and #4). The facility reported a census of 77 residents. Findings include: 1. Review of the Minimum Data Set (MDS) assessment dated 5/12/18 revealed Resident #9 had diagnoses of cerebrovascular infarction (CVA or stroke), hemiplegia (paralysis on one side) and a history of falls. The MDS revealed Resident #9 with a brief interview for mental status (BIMS) score of 15 out of 15, which indicated cognition intact. Resident #9 required the assistance of one staff for transfers, dressing, toilet use and personal hygiene. The assessment documented Resident #9 had unsteady balance and could not stabilize without staff assistance. The Care Plan revised on 5/18/18 revealed Resident #9 had a fall risk due to weakness and a CVA. The care plan directives included staff assistance of one for transfers and toileting. During observation on 8/14/18 at 8:21 AM, Staff G, Certified Nursing Assistant (CNA) applied a gait belt around Resident #9's upper waist, placed a front wheeled walker in front of the resident and stood the resident up. Staff G provided pericare for the resident, then asked the resident if he	F 689		

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F 689	Continued From page 90 could continue standing. The resident said "OK". As the resident stood by the walker, Staff G walked over to the sink, obtained a pair of gloves from the glove box and applied a clean pair of gloves, Staff G obtained a tube of barrier cream from a dresser drawer, placed white cream on her gloved hand and applied the barrier cream to the resident's buttocks. Staff G donned a clean brief, then pulled a brief and pants up while the resident stood by the front wheeled walker. Staff G removed the gait belt after the resident sat down in the motorized wheelchair. In a facility policy updated on 1/17, titled Transfer Gait Policy, revealed transfer (gait) belts are used with residents during transfers, ambulation and gait training. Gait belts provided a firm grasping surface for staff and protected the resident from injury and accidental trauma to the skin. The gait belt also provided a sense of security for the resident. The policy directed that staff assisted a resident to a position of comfort and safety in bed or a chair after transfer or ambulation, then removed the gait belt. In an interview 8/16/18 at 8:35 AM, Staff B Unit Manager stated she expected staff to place items within close proximity when they provided cares and not leave a resident unattended or let go of a resident's gait belt. Staff B reported she considered it unsafe when staff left a resident with a gait belt on and walked away and obtained supplies or had done other tasks. 2. The admission MDS assessment dated 4/18/18 documented diagnoses that included CVA, multiple sclerosis, repeated falls, diabetes mellitus, hypertension, obstructive sleep apnea and depression for Resident #424. The same	F 689		

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F 689	Continued From page 91 MDS documented a BIMS score of 13 which indicated intact cognition. The resident required the assistance of 2 for transfers and toilet use, the assistance of one with bathing and utilized a walker and wheelchair for mobility. The care plan focus area initiated 4/11/18 identified the resident required assistance with dressing, grooming, bathing transfers, mobility and ambulation and directed the assistance of 2 for transfers, ambulation and bed mobility with the goal for the resident to be safe in all movements through the target date of 5/1/18. The Progress Notes entry dated 4/23/18 at 11:53 AM completed by Staff V, RN former Unit Manager, documented the resident lost her balance while holding onto the bar in the shower room and had her right leg bent to the right with a twisted ankle and her left leg straight out in front of her. The Note further documented a possible sprained ankle may have resulted from twisting of the ankle. During interview on 8/30/18 at 11:47 AM, Staff V stated Staff AA, former CNA, had been assisting Resident #424 in the shower room at the time of the incident. Staff V stated the resident required assistance of 2 for transfer at the time of the incident and she started an investigation into this incident but turned it over to the Administrator and Director of Nursing (DON) as she felt disciplinary action may have been needed for Staff AA. During interview on 8/31/18 at 10:16 AM Staff AA stated she assisted the resident to stand in the bathroom using a gait belt and having the resident grab the bar on the wall in order to assist the resident to sit in the bath chair. Staff AA	F 689		

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F 689	Continued From page 92 stated she stood the resident up and turned to the side to get the bath chair and heard the resident say 'Oh!' and observed the resident going down to the floor. Staff AA stated she had hold of the resident's gait belt and the resident slid to the floor. Staff AA told her the off-going CNA that day reported to her the resident required one assist with transfers but facility staff changed this to 2 assistants after this incident. The Physical Therapy Treatment Encounter Note dated 4/23/18 documented a discussion with the resident's family regarding 2 reported falls. The resident reported falling out of bed the night before and a fall in the shower which resulted in twisting her ankle and the family expressed concerns the ankle may have been fractured. The physical therapist assessed the resident using Ottawa ankle rules (guidelines for therapists to help decide if a patient with foot or ankle pain should be offered X-rays to diagnose a possible bone fracture) and found the exam negative. The resident bore weight immediately after the incident and her ankle was not tender to palpation. The resident complained of decreased sensation to the right ankle and the family wished to have an X-ray. The therapist transferred the resident to a recliner chair and elevated the foot and applied ice. During interview on 8/13/18 at 2:09 PM the resident's daughter stated the X-ray done at the doctor's office on 4/23/18 showed no fracture of the ankle and she had the doctor write an order for the resident to discharge from the facility to her care on that day as she was concerned about the quality of care. 3. The MDS assessment dated 5/11/18	F 689		

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F 689	Continued From page 93 documented diagnoses that included hip fracture, Non-Alzheimer's dementia, anxiety, depression and chronic obstructive pulmonary disease for Resident #4. The same MDS documented a BIMS score of 9 which indicated moderately impaired cognition. The resident required the assistance of 2 for transfer and bed mobility and had limited functional range of motion in one lower extremity. The resident displayed unsteady balance when moving from a seated to standing position, on and off the toilet and during surface-to-surface transfer. She fell twice without injury since the last MDS assessment. prior. The care plan focus, initiated on 1/18/18 and revised on 8/15/18, identified the resident needed assistance with transfers and bed mobility and no longer walked. The care plan instructed Resident #4 needed the extensive assistance of 2 staff with bed mobility, transfers and ambulation, she pivot transfers and used a walker and a wheelchair for distance. Observation on 8/14/18 at 10:00 AM with the Assistant Director of Nursing (ADON) present revealed Staff M, CNA, assisted the resident to sit on the edge of the bed, placed a gait belt around the resident's waist and assisted the resident to stand/step/pivot to the wheelchair with the assistance of one. Observation at 11:40 AM revealed Staff B transferred the resident from the wheelchair to the toilet and back to the wheelchair using a gait belt and the assistance of one.	F 689		
F 690 SS=D	Bowel/Bladder Incontinence, Catheter, UTI CFR(s): 483.25(e)(1)-(3)	F 690		

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F 690	Continued From page 94 §483.25(e) Incontinence. §483.25(e)(1) The facility must ensure that resident who is continent of bladder and bowel on admission receives services and assistance to maintain continence unless his or her clinical condition is or becomes such that continence is not possible to maintain. §483.25(e)(2)For a resident with urinary incontinence, based on the resident's comprehensive assessment, the facility must ensure that- (i) A resident who enters the facility without an indwelling catheter is not catheterized unless the resident's clinical condition demonstrates that catheterization was necessary; (ii) A resident who enters the facility with an indwelling catheter or subsequently receives one is assessed for removal of the catheter as soon as possible unless the resident's clinical condition demonstrates that catheterization is necessary; and (iii) A resident who is incontinent of bladder receives appropriate treatment and services to prevent urinary tract infections and to restore continence to the extent possible. §483.25(e)(3) For a resident with fecal incontinence, based on the resident's comprehensive assessment, the facility must ensure that a resident who is incontinent of bowel receives appropriate treatment and services to restore as much normal bowel function as possible. This REQUIREMENT is not met as evidenced by: Based on clinical record review, observation, facility policy review and staff interview, the facility failed to provide incontinence and catheter care	F 690		

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F 690	Continued From page 95	F 690		

to minimize the risk of cross-contamination and infection for two of five residents observed for incontinence care (Residents #9 and #22). The facility reported a census of 77 residents.

Findings include:

1. The Minimum Data Set (MDS) assessment dated 5/12/18 recorded Resident #9 had diagnoses of cerebrovascular infarction (CVA or stroke), hemiplegia (paralysis on one side) and a history of falls. The MDS revealed Resident #9 has a brief interview for mental status (BIMS) score of 15 out of 15, which indicated intact memory and cognition. Resident #9 required extensive assistance of one staff for transfers, dressing, toilet use and hygiene. The MDS recorded the resident had bladder incontinence.

The Care Plan, revised on 5/18/18, recorded Resident #9 required assistance of one staff for toilet use, used incontinence products and preferred having pericare provided while in an Easy lift (a mechanical standing lift).

During observation on 8/14/18 at 8:21 AM, Staff G, Certified Nursing Assistant washed her hands, donned a pair of gloves and gathered supplies (a brief and disposable wipes). Staff G removed Resident #9's pants and two briefs as the resident stood by his walker. Resident #9 reported his brief was wet and he had a sore on his right (R) buttock. Staff G took disposable wipes and cleansed the (R) buttock in an upward and downward motion multiple times, then used the same disposable wipe and wiped up and down the left buttock. Staff G folded the disposable wipe and cleansed between the resident's buttocks. The wipe had a small smear

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F 690	Continued From page 96 of brown stool on it. Staff G folded the wipe and cleansed front to back between the buttocks. The resident had a small slit/ open area and redness to his (R) buttock and a small amount of white cream left on the buttock area. Staff G took additional disposable wipes, cleansed the groin and penis front to back, then removed her gloves. Staff G walked over to the sink and donned a clean pair of gloves. Staff G obtained a tube of barrier cream from a dresser drawer, and applied white barrier cream to the resident's buttocks. Staff G removed gloves, donned a clean brief and a pull up brief, pulled the resident's pants up, then washed her hands. A facility policy dated 10/2015 titled "Perineal Care" revealed the following procedural steps: a. assemble equipment and supplies as needed b. arrange supplies within reach. c. wash hands and apply gloves d. For male resident, wash perineal area starting with urethra and working outward e. retract the foreskin and wash urethral area using a circular motion f. cleanse penis, scrotum, and inner thighs. g. use a separate wipe each time or a separate area of cloth h. pat dry i. cleanse rectal area thoroughly, including under the scrotum, anus, and buttocks. j. remove gloves. Perform hand hygiene k. apply new gloves before brief changed or dressing/undressing resident In an interview 8/16/18 at 8:35 AM Staff B, Unit Manager stated she expected staff followed facility protocol for providing incontinence care, wiped periarea front to back and change gloves when soiled or contaminated.	F 690		

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F 690	Continued From page 97 2. According to the MDS assessment dated 6/5/18, Resident #22 had diagnoses that included anemia, neurogenic bladder, diabetes mellitus, arthritis, depression and spinal stenosis. The MDS identified the resident had a BIMs score of 13 which indicated intact cognition. According to the MDS the resident required the assistance of one with toilet use and hygiene and he required a catheter for urination. The care plan dated 8/8/18 directed staff to change Resident #22's suprapubic catheter as ordered and monitor for redness and signs and symptoms of infection and if noted, to tell the nurse. Review of the Progress Notes dated 8/6/18 at 7:35 AM revealed the DON (director of nursing) received a phone call on 8/318 at approximately 2:10 PM from the resident's primary provider (PCP). The PCP voiced concern in relationship with the resident's buttock and suprapubic catheter site. She stated that both areas were draining and appeared to be infected. She stated that she was confident the resident had not had peri care or a brief changed in several days and no care provided to his surgical site since his return. The PCP planned to have the resident seen by the wound clinic fallowing the appointment with her and would follow up with the DON with the findings and plan are. 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 likely had cellulitis around the suprapubic	F 690		

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F 690	Continued From page 98 catheter insertion site as well as cellulitis on his buttocks. Observation on 8/15/18 at 8:20 AM revealed Staff R, CNA (certified nursing assistant) and Staff S, CNA assisted the resident with morning cares. Staff cleansed the suprapubic catheter site and catheter and emptied the catheter into a graduate. The tip of the catheter bag drain visibly touched the inside of the graduate. Staff emptied the urine into the toilet and rinsed it with a second graduate and water. Staff then picked up used paper towels from the floor and dried the inside of the graduate and placed them into a bath basin on the bathroom floor for storage. The resident transferred to the wheel chair and staff placed the urine bag into the dignity bag under the wheelchair. Staff failed to secure the catheter tubing and it drug on the floor while wheeling out of the room. The Nurse Manager observed cares and told staff to secure the tubing prior to the doctor appointment.	F 690		
F 692 SS=D	Nutrition/Hydration Status Maintenance CFR(s): 483.25(g)(1)-(3) §483.25(g) Assisted nutrition and hydration. (Includes naso-gastric and gastrostomy tubes, both percutaneous endoscopic gastrostomy and percutaneous endoscopic jejunostomy, and enteral fluids). Based on a resident's comprehensive assessment, the facility must ensure that a resident- §483.25(g)(1) Maintains acceptable parameters of nutritional status, such as usual body weight or desirable body weight range and electrolyte balance, unless the resident's clinical condition demonstrates that this is not possible or resident	F 692		

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F 692	Continued From page 99 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, observation and staff interview, the facility failed to accurately assess nutritional needs for wound healing for one of five residents reviewed with skin impairment (Resident #68). The facility reported a census of 77 residents. Findings include: The Minimum Data Set (MDS) assessment dated 8/1/18 documented Resident #68 had diagnoses including anemia, heart failure, hypertension, diabetes mellitus, high cholesterol, depression, lung disease with a history of pneumonia, and end stage renal failure. The MDS documented the resident required dialysis. The MDS documented the resident's height as 61 inches and weight at 206 pounds with a significant weight loss on a weight loss regimen. The MDS documented the resident as at risk for pressure ulcers but none recorded at the time period, however the resident had a surgical wound. The MDS documented the resident scored a 15 out of 15 on the Brief Interview for Mental Status indicating intact cognition. The care plan revised 8/13/18 listed the resident had a surgical wound to the left upper thigh upon admission. The nutrition part of the care plan	F 692		

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F 692	Continued From page 100 listed various diagnoses that put the resident at risk such as diabetes, depression, history of edema, abnormal laboratory values, weight fluctuations, and skin breakdown. The care listed interventions including the current diet as no added salt, to monitor for changes in her ability to eat and weigh daily. The Nutrition Review revised dated 3/20/18 documented the resident required 89 milligrams of protein and supplemented the diet with 240 milliliters of Ensure three times a day. The Nutrition Review documented the resident had a sternal incision and a left lower extremity incision. The Skin Condition Report for non-pressure areas dated 5/14/18 documented an incision site to the left upper thigh that continued until observation on 8/15/18 at 4:37 p.m. The Nutritional Assessment Updated dated 5/22/18 documented the resident had a 5% significant weight loss in 1 month but on a prescribed weight loss regimen and staff would notify the physician of the weight loss. The assessment documented no open areas. The clinical record lacked any documentation of the prescribed diet for weight loss and lacked documentation from the Dietitian notifying the physician of the resident's weight loss. The Nutritional Assessment Updated dated 6/19/18 documented a weight loss of 11.6% pounds in the last 90 days and a weight gain of 5.1% in 1 month. The Nutritional Assessment noted the resident's coccyx wound but did not calculate protein needs for wound healing.	F 692		

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F 692	Continued From page 101 The Nutrition Follow-up dated 7/10/18 documented a 10.8% loss in 3 months. The Assessment documented the resident had intact skin and did not calculate the resident's protein needs. The clinical record lacked documentation of physician notification of the resident's weight loss. The Nutrition Follow-up dated 8/7/18 documented a 5.6% weight loss in 1 month and the dietitian would notify the physician. The clinical record lacked documentation of physician notification of the resident's weight loss. During an interview on 8/16/18 at 10:30 a.m. the Director of Clinical Services agreed the nutrition notes had discrepancies. Also, stated she could not locate documentation on physician notification.	F 692		
F 698 SS=D	Dialysis CFR(s): 483.25(l) §483.25(l) Dialysis. The facility must ensure that residents who require dialysis receive such services, consistent with professional standards of practice, the comprehensive person-centered care plan, and the residents' goals and preferences. This REQUIREMENT is not met as evidenced by: Based on clinical record review and staff interview, the facility failed to consistently complete full nursing assessments and monitoring of 2 of 2 residents sampled before and after outpatient dialysis treatments (Residents #68 & #50). The facility reported a census of 77 residents.	F 698		

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F 698	Continued From page 102 Findings include: 1. The Minimum Data Set (MDS) assessment dated 8/1/18 documented Resident #68 had diagnoses including anemia, heart failure, hypertension, diabetes mellitus, high cholesterol, depression, lung disease with a history of pneumonia, and end stage renal failure. The MDS documented the resident required dialysis and she had a surgical wound. The MDS documented the resident scored a 15 out of 15 on the Brief Interview for Mental Status indicating intact cognition. The clinical record documented the resident had a revision of the fistula for dialysis on 6/8/18 and she received dialysis on 7/14/18. Review of the clinical record starting on 7/14/18 lacked documentation of vital signs, assessment of the access site, and pain before and after dialysis. Review of the clinical record for 8/18 lacked documentation of vital signs, assessment of the access site, and pain before and after dialysis. During an interview on 8/16/18 at 10:30 a.m. the Director of Clinical Services stated she could not locate any further documentation for the required assessments before and after dialysis. 2. The MDS assessment dated 7/14/18, documented Resident #50 had diagnoses of coronary heart disease, hypertension (high blood pressure), end-stage renal disease (kidney disease), cerebrovascular accident (stroke), and seizure disorder. The MDS documented the	F 698		

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F 698	Continued From page 103 resident required dialysis. The care plan updated on 7/18/18 revealed Resident #50 had Stage 5 chronic kidney disease, had a fistula in his left arm and had dialysis on Tuesdays, Thursdays, and Sundays. The care plan also record the resident had dialysis appointments on Mondays, Wednesdays, and Fridays and needed an early lunch served on those days. Other staff directives included checking the bruit and thrill (for blood blow in his fistula) each shift and report changes to the physician or dialysis unit. The Treatment Administration Record dated 8/18 revealed Resident #50 had an AV (arteriovenous) fistula (to allow access for hemodialysis) and staff documented the bruit and thrill each shift. The Medication Review Report dated 8/18 documented an order to assess the AV shunt for bruit and thrill every shift. Review of the resident's clinical record revealed the resident he received dialysis on Mondays, Wednesdays and Fridays and the lack of documentation of pre or post dialysis staff assessments.	F 698		
F 725 SS=D	Sufficient Nursing Staff CFR(s): 483.35(a)(1)(2) §483.35(a) Sufficient Staff. The facility must have sufficient nursing staff with the appropriate competencies and skills sets to provide nursing and related services to assure resident safety and attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident, as determined by resident assessments and individual plans of care	F 725		

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F 725	Continued From page 104 and considering the number, acuity and diagnoses of the facility's resident population in accordance with the facility assessment required at §483.70(e). §483.35(a)(1) The facility must provide services by sufficient numbers of each of the following types of personnel on a 24-hour basis to provide nursing care to all residents in accordance with resident care plans: (i) Except when waived under paragraph (e) of this section, licensed nurses; and (ii) Other nursing personnel, including but not limited to nurse aides. §483.35(a)(2) Except when waived under paragraph (e) of this section, the facility must designate a licensed nurse to serve as a charge nurse on each tour of duty. This REQUIREMENT is not met as evidenced by: Based on clinical record review, observation and resident and staff interviews, the facility failed to ensure staff responded and answered residents' call lights within 15 minutes and met residents needs in a timely manner for one of 21 residents sampled (Resident #9) and during two additional random observations. The facility reported a census of 77 residents. Findings include: 1. The MDS (Minimum Data Set) assessment dated 5/12/18, recorded Resident #9 had diagnoses that included cerebral infarction (stroke), hemiplegia (paralysis on one side) and a history of falls. The MDS documented the resident had a Brief Interview for Mental Status (BIMS) score of 15 out of 15, which indicated	F 725		

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	165161	A. BUILDING _____ B. WING _____	09/26/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
TOUCHSTONE HEALTHCARE COMMUNITY	1800 INDIAN HILLS DRIVE SIOUX CITY, IA 51104

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F 725	Continued From page 105 intact memory and cognition. The MDS documented the resident required extensive assistance of one staff for transfers, toilet use, dressing, and personal hygiene. The resident's care plan, updated on 5/18/18, recorded Resident #9 had a fall risk due to weakness following a CVA and he required assistance from one staff for transfers and toilet use. During an interview 8/13/18 at 11:45 AM, Resident #9 reported it took up to two hours to get his call light answered and before he got staff assistance. The resident reported he used a clock on the wall to monitor the amount of time it took for staff response. The resident reported he sat in a wet brief and now had a sore on his bottom. The resident reported the facility didn't have enough help and sometimes only had one aide (certified nursing assistant) working when they normally had more staff working in the hallway he resided in. Continuous observations of call lights on 8/14/18 from 7:36 to 8:21 AM revealed the following: a. At 7:36 AM, Resident #9's call light on. Resident #9 reported he had had his call light on for the past 5 minutes. b. At 7:40 AM, the Director of Nursing entered Resident #9's room, asked the resident what he needed, and shut the call light off. Resident #9 reported he needed his brief changed. The DON told the resident she would round up some staff to help him and left the room. c. At 8:00 AM, Resident #9 reported staff frequently came in and shut his call light off, tell him they would be back and then didn't come back and help him. Resident #9 reported he has	F 725		

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F 725	Continued From page 106 waited up to 2 hrs for staff to provide assistance. d. At 8:15 AM, Resident #9 stated nobody had come to clean him up yet. Resident #9 then turned his call light on again. e. At 8:18 AM, Staff G, Certified Nursing Assistant (CNA), walked down "D" hall, briefly stopped by Resident #9's room and told the resident she would be back in a minute. f. At 8:19 AM, Staff G walked into Resident #9's room and asked the resident what he needed. Staff G turned the call light off and left the room. g. At 8:21 AM, Staff G entered Resident #9's room and provided assistance to the resident. In an interview 8/14/18 at 8:21 AM, Staff G reported she normally worked in the business office and had just helped out the CNA assigned to work on D hall. The staff assignment board located at the nurse's station revealed the facility assigned one CNA to work in D hall 6 AM to 2 PM. In an interview 8/15/18 at 11:00 AM, Resident #9 reported he felt humiliated and discriminated against when he sat in his wheelchair and had a wet brief for an extended period of time while he waited for staff to respond and change him on the morning of 8/14/18. The resident reported it frequently took an extended period of time for staff to answer his call light. 2. Observations revealed the following call lights on: a. 8/14/18 - Room D15 from 3:04 to 3:20 PM, a total of 16 minutes b. 8/15/18 - Room D10 from 8:39 - 9:01 AM, a total of 22 minutes In an interview 8/16/18 at 3:00 PM, the Director of	F 725		

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F 725	Continued From page 107 Nursing (DON) reported she expected call lights to be answered within 15 - 20 minutes. The DON stated if staff shut the resident's call light off and had not provided assistance to the resident, staff needed to remember and go back and assist the resident in a timely manner. 2. According to the MDS dated 5/12/18 Resident #9 had diagnoses that included diabetes mellitus, hemiplegia, stiffness of left shoulder and muscle weakness. The MDS identified the resident had a BIMs score of 15 which indicated intact cognition. According to the MDS identified the resident required extensive assistance with bed mobility, transfers, dressing and toilet use. The MDS identified the resident frequently incontinent of urine and requires use of a wheelchair. The care plan dated 8/7/18 directed staff to provide extensive assist of 1 staff with dressing, grooming and bathing. The care plan also directed staff to provide assist of 1 with toileting needs and prefers not to use the toilet and will ask if wishes to use it and occasionally request to use the urinal. During an interview with the resident on 8/17/18 at 9:00 AM he stated the facility works with short staff and can't get the call answered. It can take over 1 hour when they work short. Overnight, it takes longer than that to answer a call light. He further stated it had caused him to be incontinent.	F 725		
F 729 SS=D	Nurse Aide Registry Verification, Retraining CFR(s): 483.35(d)(4)-(6) §483.35(d)(4) Registry verification. Before allowing an individual to serve as a nurse	F 729		

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F 729	Continued From page 108 aide, a facility must receive registry verification that the individual has met competency evaluation requirements unless- (i) The individual is a full-time employee in a training and competency evaluation program approved by the State; or (ii)The individual can prove that he or she has recently successfully completed a training and competency evaluation program or competency evaluation program approved by the State and has not yet been included in the registry. Facilities must follow up to ensure that such an individual actually becomes registered. §483.35(d)(5) Multi-State registry verification. Before allowing an individual to serve as a nurse aide, a facility must seek information from every State registry established under sections 1819(e)(2)(A) or 1919(e)(2)(A) of the Act that the facility believes will include information on the individual. §483.35(d)(6) Required retraining. If, since an individual's most recent completion of a training and competency evaluation program, there has been a continuous period of 24 consecutive months during none of which the individual provided nursing or nursing-related services for monetary compensation, the individual must complete a new training and competency evaluation program or a new competency evaluation program. This REQUIREMENT is not met as evidenced by: Based on personnel files reviews and staff interviews, the facility failed to verify nurse assistant registry status prior to hire for 3 of 5 currently employed certified nursing assistants (CNA's) sampled (Staff E, K and N). The facility identified a census of 77.	F 729		

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F 729	Continued From page 109 Findings include: 1. The personnel file for Staff E documented hire as a certified nursing assistant (CNA) on 6/15/17. The facility failed to check nursing assistant eligibility through the direct care worker (DCW) registry. Staff E worked full time as a CNA until her licensed practical nurse (LPN) license initially issued one 8/23/17. 2. The personnel file for Staff K, certified nursing assistant (CNA) documented a hire date of 6/7/17. The facility did not check the DCW registry until 9/8/17 which documented Staff K as eligible to work as a CNA. The payroll record 6/7 - 9/7/17 documented Staff K worked 396 hours before verification of CNA eligibility. 3. The personnel file for Staff N, CNA documented a hire date of 5/17/17. The facility did not check the direct care worker DCW registry until 10/2/17 which documented Staff N eligible to work as a CNA. The payroll record 5/17-10/1/17 documented Staff N worked 924 hours before verification of CNA eligibility. During interview on 8/24/18 at 1:55 PM the Human Resources Director confirmed she failed to complete DCW checks for Staff E, K and N prior to hire.	F 729		
F 730 SS=D	Nurse Aide Peform Review-12 hr/yr In-Service CFR(s): 483.35(d)(7) §483.35(d)(7) Regular in-service education. The facility must complete a performance review of every nurse aide at least once every 12 months, and must provide regular in-service	F 730		

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F 730	Continued From page 110 education based on the outcome of these reviews. In-service training must comply with the requirements of §483.95(g). This REQUIREMENT is not met as evidenced by: Based on personnel file reviews and staff interview, the facility failed to assure all certified nursing assistants (CNA's) receive 12 hours of inservice education yearly as well as a yearly performance reviews for 3 of 4 sampled CNA's employed greater than 1 year (Staff K, NN and T). The facility identified a census of 77. Findings include: 1. The personnel file for Staff K, certified nursing assistant (CNA) documented a hire date of 6/7/17. Review of inservice education documentation revealed 3 hours of computer-based education completed and documentation of attending in-facility meetings on 3/14, 5/9/18, 6/13/18 and 8/8/18. The sign-in sheets for the meetings contained no documentation as to the length of time the meetings lasted. The personnel file contained no yearly performance evaluation. 2. The personnel file for Staff NN, CNA documented a hire date of 5/17/17. Review of inservice education documentation revealed Staff NN attended in-facility meetings on 3/4, 3/14, 5/9, 6/13, 7/11 and 8/8/18. The sign-in sheets for the meeting contained no documentation as to the length of time the meetings lasted. The personnel file contained no yearly performance evaluation.	F 730		

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F 730	Continued From page 111 3. The personnel file for Staff T, CNA documented a hire date of 3/17/17. Review of inservice education documentation revealed 10 hours of computer-based education completed and attendance of in-facility meeting on 3/14/18. The personnel file contained no yearly performance evaluation. During interview on 8/24/18 at 1:55 PM the Human Resources Director confirmed the above findings.	F 730		
F 758 SS=D	Free from Unnec Psychotropic Meds/PRN Use CFR(s): 483.45(c)(3)(e)(1)-(5) §483.45(e) Psychotropic Drugs. §483.45(c)(3) A psychotropic drug is any drug that affects brain activities associated with mental processes and behavior. These drugs include, but are not limited to, drugs in the following categories: (i) Anti-psychotic; (ii) Anti-depressant; (iii) Anti-anxiety; and (iv) Hypnotic Based on a comprehensive assessment of a resident, the facility must ensure that--- §483.45(e)(1) Residents who have not used psychotropic drugs are not given these drugs unless the medication is necessary to treat a specific condition as diagnosed and documented in the clinical record; §483.45(e)(2) Residents who use psychotropic drugs receive gradual dose reductions, and	F 758		

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F 758	Continued From page 112 behavioral interventions, unless clinically contraindicated, in an effort to discontinue these drugs; §483.45(e)(3) Residents do not receive psychotropic drugs pursuant to a PRN order unless that medication is necessary to treat a diagnosed specific condition that is documented in the clinical record; and §483.45(e)(4) PRN orders for psychotropic drugs are limited to 14 days. Except as provided in §483.45(e)(5), if the attending physician or prescribing practitioner believes that it is appropriate for the PRN order to be extended beyond 14 days, he or she should document their rationale in the resident's medical record and indicate the duration for the PRN order. §483.45(e)(5) PRN orders for anti-psychotic drugs are limited to 14 days and cannot be renewed unless the attending physician or prescribing practitioner evaluates the resident for the appropriateness of that medication. This REQUIREMENT is not met as evidenced by: Based on clinical record review and staff interviews, the facility failed to follow through with the pharmacist recommendations for a Gradual Dose Reduction (GDR) and failed to provide non pharmacological interventions before administering an as needed (prn) psychotropic medication for one of five residents reviewed for medication review (Resident #11). The facility reported a census of 77 residents. Findings included; 1. The Minimum Data Set (MDS) assessment	F 758		

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F 758	Continued From page 113 dated 5/16/18 documented Resident #11 had diagnoses that included depression, anxiety disorder and manic depression (bipolar disease). The assessment documented Resident #11 felt down, depressed or hopeless and bad about himself during 7 - 11 days over the past two weeks. Resident #11's Care Plan dated 7/2/18 recorded he received antipsychotic, antianxiety and antidepressant medications routinely and took an antianxiety on a prn basis. The interventions instructed to follow the GDR protocol and document attempts and physician refusal, to monitor for adverse side effects of the antidepressant, antianxiety and antipsychotic medications and notify the physician if any occur and to also provide with 1:1 conversation to allow him to express his feelings and assist with coping strategies. The pharmacist's Consultation Report dated 7/12/18 documented Resident #11 received quetiapine (an antipsychotic) 100 mg (milligrams) at bedtime, buspirone (an antianxiety) 15 mg twice a day and paroxetine (an antidepressant) 30 mg daily for bipolar disorder. The pharmacist's Consultation Report dated 8/7/18 documented Resident #11 received anxiolytics lorazepam and hydroxyzine for anxiety and documentation of nonpharmacological interventions could not be found in the medical record. The Medication Administration Record (MAR) for July 2018 included quetiapine 100 mg give 1 tablet by mouth at bedtime with a start date of 9/18/17, paroxetine 30 mg 1 tablet daily with a	F 758		

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F 758	Continued From page 114 start date of 9/18/17 and buspirone (an antianxiety) 15 mg 1 tablet by mouth twice a day with a start date of 9/18/17. The MAR also included as needed medications of hydroxyzine (an antianxiety) 25 mg 1 tablet by mouth every 6 hours as needed with a start date of 12/30/17 and given 7/1, 7/2, 7/6, 7/11, 7/25, 7/28 and 7/30 with documentation of non-pharmacological interventions attempted on 2 of the 7 times given. The MAR for August 2018 included quetiapine 100 mg give 1 tablet by mouth at bedtime with a start date of 9/18/17, paroxetine (an antidepressant) 30 mg 1 tablet daily with a start date of 9/18/17 and buspirone 15 mg 1 tablet by mouth twice a day with a start date of 9/18/17. The MAR also included as needed medications of hydroxyzine 25 mg 1 tablet by mouth every 6 hours as needed with a start date of 12/30/17 and administered on 8/4, 8/5 and 8/9 without documentation of non-pharmacological intervention before the admiration of the medication. During an interview on 8/16/18 at 10:14 AM with the Director of Clinical Services stated she obtained and provided the GDR request from the pharmacy and could not find any signed request forms from the physician in the chart. The Director of Clinical Serviced further acknowledged they should have tried and charted non-pharmacological interventions before giving the as needed medications. During a later interview with the Director of Clinical Services on 8/16/18 at 11:53 AM acknowledged she could not find any signed GDR request form from the pharmacy signed by the physician in the closed chart either.	F 758		

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F 760 SS=D	Residents are Free of Significant Med Errors CFR(s): 483.45(f)(2) The facility must ensure that its- §483.45(f)(2) Residents are free of any significant medication errors. This REQUIREMENT is not met as evidenced by: Based on clinical record reviews, pharmacy policy review and interviews, the facility failed to assure residents were free of significant medication errors for 2 of 21 residents sampled (Residents #8 and #375). The facility identified a census of 77. Findings include: 1. The Medicare 5-day Minimum Data Set (MDS) assessment dated 5/19/18 identified diagnoses that included cancer, enlarged lymph nodes and bandemia (excess of immature white blood cells which is a signifier of infection or inflammation) for Resident #375. The same MDS documented the resident admitted to the facility on 5/12/18 for Medicare A-covered skilled nursing level of care. Resident #375 had a Brief Interview of Mental Status Score (BIMS) of 15 which indicated intact memory and cognition. He required the assistance of one with transfers, walking, dressing, eating, hygiene and toilet use. The assessment documented Resident #375 received intravenous (IV) medication before and after admission to the facility. Two care plan problems initiated 5/14/18 identified the resident admitted to the facility on antibiotics for skin infection of scrotal/groin cancer lesions and had a medication port under the skin of the right chest. The care plan directed staff to administer antibiotics as ordered with the	F 760		

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F 760	Continued From page 116 goal for resolution of the resident's signs/symptoms of infection. The After Visit Summary dated 5/11/18 documented the resident hospitalized for treatment of bandemia, inguinal adenopathy (immune system glands that enlarge in response to bacterial or viral infection) and metastatic squamous cell carcinoma (cancer) from 5/2 to 5/11/18 and ordered the resident admitted to the facility for skilled nursing care, as well as physical and occupational therapy. The Summary directed staff to administer vancomycin (an antibiotic) 1,500 milligrams (mg) IV every 12 hours for 24 days. A second order instructed administration of tobramycin (an antibiotic) 20 ml (milliliters) IV every 12 hours for 24 days. The May, 2018 Medication Administration Record (MAR) for Resident #375 documented the facility failed to administer the ordered vancomycin for doses scheduled for 6:00 PM on 5/12 and 6:00 AM and 6:00 PM on 5/13/18. A Progress Note entry dated 5/13/18 at 8:55 PM documented the vancomycin was not administered as staff awaited delivery from the pharmacy. The MAR documented the vancomycin not administered until 5/14/18 at 6:00 AM. The May, 2018 MAR also documented the facility failed to administer the ordered tobramycin for doses scheduled for 7:00 PM on 5/12 and 7:00 AM on 5/13/18. A Progress Note entry dated 5/13/18 at 8:57 PM documented the tobramycin was not administered as they awaited delivery from the pharmacy. The MAR documented the tobramycin not administered until 5/15/18 at 9:00 AM.	F 760		

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F 760	Continued From page 117 During interview on 8/29/18 at 10:20 AM the Pharmacist stated the facility faxed the resident's medication admission orders to them on 5/12/18 at 2:27 AM. This fax did not include the resident's IV medication orders. The facility faxed the IV medication orders to the pharmacy on 5/13/18 at 2:51 AM. The pharmacist stated the facility should have paged the pharmacy as the pharmacy had closed at that time. A pharmacist saw the orders on the morning of 5/13/18 and called the facility regarding them. Staff W, registered nurse (RN) told the pharmacist the orders needed to be clarified and she would call them when done. Staff never called with clarification orders but a staff member did call on 5/13 at 3:00 PM and stated the vancomycin and tobramycin needed to be delivered. The pharmacy sent the IV medications out and these were delivered to the facility on 5/13/18 at 8:11 PM. During interview on 8/29/18 at 3:55 PM Staff W stated she worked 5/12 and 5/13/18 and the pharmacist had contacted her regarding the IV medication orders. She stated the Director of Nursing (DON) had completed all the admission paperwork for her the day before and when she went to find the IV orders, she found the admission paperwork for the resident scattered all over everywhere. She then told the pharmacist she would verify the orders somehow and call when she had them. Staff X stated that by the time she obtained the orders from the hospital the oncoming nurse had already located the order sent with the resident on 5/12/18 and called the pharmacy to request they deliver them. The Nurse's Infusion Manual for Long Term Care	F 760		

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F 760	Continued From page 118 Facilities provided by the servicing pharmacy contained the following policy revised on 5/1/15: # 2.1 Processing Infusion Therapy Orders Considerations: All orders written for infusion therapies must be complete and promptly communicated to pharmacy staff to assure safe and appropriate care of the patient. Guidance: 1. Orders or solutions/medications will be communicated directly to the pharmacy. 2. Facility must notify pharmacy if order is needed by a specified time; otherwise the order will be sent with the next schedule delivery. 3. If the order is received outside of regular business hours and is needed before the pharmacy reopens, the facility must: # 3.1 Fax the order # 3.2 Call the pharmacy and/or answering service. During interview on 8/22/18 at 9:40 AM the nurse for resident's primary care physician stated the failure to administer vancomycin and tobramycin as ordered is a significant medication error. 2. According to the MDS assessment dated 8/9/18, Resident #8 had diagnoses that included aphasia, chronic obstructive pulmonary disease, cerebral infarction and atrial fibrillation. The MDS identified the resident's BIMs score as not assessed. According to the MDS the resident required the assistance of one with bed mobility, transfers, ambulation, dressing and toilet use. The care plan dated 8/6/18 directed staff to monitor for changes in cognition. The care plan also identified the resident had difficulty with verbalizing her thoughts and may say yes but actually mean no.	F 760		

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F 760	Continued From page 119 Review of the Medication Error Report dated 8/9/18 at 8:14 AM revealed the resident inadvertently administered the wrong medications. The immediate corrective action included the resident sent to the hospital for evaluation. Steps taken to prevent future error included education in medication administration and plans for the Admission Coordinator to upload pictures into the electronic medication record. Review of Resident #78 Physician Orders revealed the following orders for morning medication pass: a. Tylenol 500 mg (analgesic) b. Dicyclomine HCL (hydrochloride) 10 mg (anticholinergics) c. Escitalprom 20 mg (serotonin reuptake inhibitor) d. Folic Acid 1 mg (mineral) e. Levothyroxine 75 mcg (micrograms) (thyroid preparation) f. Lisinopril 20 mg (antihypertensive) g. MVI 1 tablet (vitamin) h. Nebivolor 10 mg (beta blocker) i. Thiamine 100 mg (mineral) j. Pantoprazole 40 mg (proton pump inhibitor) k. Primidone 50 mg (barbiturate) l. Propafenone 225 mg (antiarrhythmic) m. Tranxene T 7.5 mg (benzodiazepine) Review of the Progress Notes dated 8/9/18 at 8:19 AM revealed Resident #8 in the dining room eating breakfast. Staff asked her to verify her name and she shook her head yes; she is asphasic and unable to verbalize. The following medications were administered: Tylenol 500 mg, Dicyclomine HCL 10 mg, Escitalprom 20 mg,	F 760		

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F 760	Continued From page 120 Folic Acid 1 mg, Levothyroxine 75 mcg, Lisinopril 20 mg, MVI 1 tablet, Nebivolor 10 mg, Thiamine 100 mg, Pantoprazole 40 mg, Primidone 50 mg, Propafenone 225 mg, Tranxene 7.5 mg. The nurse returned to the cart to sign off medications and noted they had been inadvertently given to the resident by mistake, as they were another resident's medications. The resident finished her meal and went back to her room. VS (Vital signs) measured: blood pressure - 164/68, pulse oximeter 96 % and pulse 74. The resident appeared to be within normal limits and working with therapy. Staff contacted the resident's physician. The entry at 10:58 AM documented the resident was at the hospital. At 8:45 PM, staff found the resident lying on the bathroom floor, underneath her walker. Family members were present at the time of the incident. The resident transferred by emergency medical staff to the hospital. Her VS measured: blood pressure 164/68, pulse 58, pulse oximeter 97 %, respirations 14. During an interview on 8/15/18 at 3:20 PM with Staff E, LPN (Licensed Practical Nurse) she stated she inadvertently administered morning medications to Resident #8 that were ordered for Resident #78. Staff E stated she had not been on the resident's hall for a time. She had been told Resident #78 was ready for her pills. She asked staff the resident's location and they told her she was in the dining room. Staff E went to the dining room to the resident, introduced herself and thought Resident # 8 was Resident #78. She asked Resident #78's name and Resident #8 she nodded yes. The resident readily took the pills. Staff E went back to the medication cart and saw Resident #78 and it clicked that she gave the medication to the wrong resident. She reported it	F 760		

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F 760	Continued From page 121 to Administration, took the resident's vital signs, notified the physician and went down the resident's hall. Family told her the resident did not feel well. She went to the room and told the family what had happened. The resident got up to the restroom and had an emesis and sat on the floor. She took the resident's blood pressure and a Nurse Practitioner present in the building took over the assessment and sent the resident to the emergency room. Resident #8 returned to the facility 2 days later. Review of the Policy and Procedure titled Medication Pass dated 3/15 directed staff to do the following: a. As you begin the med pass, check the resident name and room number from the MAR/eMAR (medication administration record): Determine the medication name and dose needed and find the corresponding medication in that resident's cared, box or bottle. Check name of resident, room number, drug name and drug dosage between medication container and MAR/eMAR. If you suspect a discrepancy, refer to resident/patient chart and check order. Always follow the five rights: Right resident; right medication; right time; right dose; right route. b. Punch the medication in the med cup. c. Re-check resident/patient name, room number, drug name and dosage before returning care to resident slot. d. Check resident name and room number with MAR/eMAR, and confirm resident I.D. (identification)prior to administration of medication.	F 760		
F 761 SS=E	Label/Store Drugs and Biologicals CFR(s): 483.45(g)(h)(1)(2)	F 761		

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F 761	Continued From page 122 §483.45(g) Labeling of Drugs and Biologicals Drugs and biologicals used in the facility must be labeled in accordance with currently accepted professional principles, and include the appropriate accessory and cautionary instructions, and the expiration date when applicable. §483.45(h) Storage of Drugs and Biologicals §483.45(h)(1) In accordance with State and Federal laws, the facility must store all drugs and biologicals in locked compartments under proper temperature controls, and permit only authorized personnel to have access to the keys. §483.45(h)(2) The facility must provide separately locked, permanently affixed compartments for storage of controlled drugs listed in Schedule II of the Comprehensive Drug Abuse Prevention and Control Act of 1976 and other drugs subject to abuse, except when the facility uses single unit package drug distribution systems in which the quantity stored is minimal and a missing dose can be readily detected. This REQUIREMENT is not met as evidenced by: Based on observations, facility policy review and staff interviews, the facility failed to assure all resident medications secured and prohibited from unauthorized access for 1 of 4 facility medication carts. The facility identified a census of 77. Findings include: 1. Observation on 8/29/18 at 3:23 PM revealed an unattended and unlocked medication cart in the south side nursing work area. Observation revealed the nursing work area accessible to	F 761		

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F 761	Continued From page 123 residents, staff and visitors. The separate narcotics box in the medication cart also observed to be unlocked and contained the following medications: a. A card which contained 16 tablets of 15 milligram (mg) morphine sulfate (an opiod pain medication) extended-release (ER); b. Three separate cards of tramadol (an opiod pain medication) 50 mg tablets-24 tablets on 1st card, 10 tablets on the 2nd card and 20 tablets on the 3rd card; c. Three separate cards of hydrocodone (narcotic pain medication)/acetaminophen tablets 5 mg/325 mg-1st card contained 29 tablets, 2nd card contained 28 tablets and 3rd card contained 30 tablets; d. A card which contained 9 capsules of zolpidem (sleeping medication) 5 mg; e. A card which contained 23 tablets of lorazepam (an anti-anxiety medication) 0.5 mg. Observation revealed Staff X, Registered Nurse (RN) came into the nursing work area at 3:45 PM and locked the medication cart. The surveyor asked Staff X to unlock the medication cart to verify the narcotics box also unlocked. Staff X stated she did not have keys to access this cart as only staff on Bayberry and Daisy Lane have keys as they share the cart. Staff X summoned Staff W, RN to unlock the cart and she verified the narcotics box as unlocked. Staff W and Staff Y, RN unit manager then completed a narcotic count and found all medications were present. Observation of Cherry Blossom Hall revealed 9 of the facility's 77 residents located on this hall. Staff W stated she did narcotics count with the offgoing shift around 2:00 PM and though the offgoing staff member locked the narcotics box and the cart prior to her taking possession of the	F 761		

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F 761	Continued From page 124 keys. Staff W stated the medication cart and narcotics box should be locked when unattended. The facility Medications: Storage of policy revised June 2016 directed the following: Policy: To ensure that medications are stored in a safe, secure and orderly manner. Procedures: 5. Compartments containing medications are locked when not in use. Trays of carts used to transport such items are not left unattended. (Compartments include. but are not limited to, drawers, cabinets, rooms, refrigerators, carts and boxes). Point # 0. All controlled drugs are stored under double-lock and key.	F 761		
F 801 SS=E	Qualified Dietary Staff CFR(s): 483.60(a)(1)(2) §483.60(a) Staffing The facility must employ sufficient staff with the appropriate competencies and skills sets to carry out the functions of the food and nutrition service, taking into consideration resident assessments, individual plans of care and the number, acuity and diagnoses of the facility's resident population in accordance with the facility assessment required at §483.70(e) This includes: §483.60(a)(1) A qualified dietitian or other clinically qualified nutrition professional either full-time, part-time, or on a consultant basis. A qualified dietitian or other clinically qualified nutrition professional is one who- (i) Holds a bachelor's or higher degree granted by a regionally accredited college or university in the United States (or an equivalent foreign degree) with completion of the academic requirements of	F 801		

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F 801	Continued From page 125 a program in nutrition or dietetics accredited by an appropriate national accreditation organization recognized for this purpose. (ii) Has completed at least 900 hours of supervised dietetics practice under the supervision of a registered dietitian or nutrition professional. (iii) Is licensed or certified as a dietitian or nutrition professional by the State in which the services are performed. In a State that does not provide for licensure or certification, the individual will be deemed to have met this requirement if he or she is recognized as a "registered dietitian" by the Commission on Dietetic Registration or its successor organization, or meets the requirements of paragraphs (a)(1)(i) and (ii) of this section. (iv) For dietitians hired or contracted with prior to November 28, 2016, meets these requirements no later than 5 years after November 28, 2016 or as required by state law. §483.60(a)(2) If a qualified dietitian or other clinically qualified nutrition professional is not employed full-time, the facility must designate a person to serve as the director of food and nutrition services who- (i) For designations prior to November 28, 2016, meets the following requirements no later than 5 years after November 28, 2016, or no later than 1 year after November 28, 2016 for designations after November 28, 2016, is: (A) A certified dietary manager; or (B) A certified food service manager; or (C) Has similar national certification for food service management and safety from a national certifying body; or D) Has an associate's or higher degree in food	F 801		

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F 801	Continued From page 126 service management or in hospitality, if the course study includes food service or restaurant management, from an accredited institution of higher learning; and (ii) In States that have established standards for food service managers or dietary managers, meets State requirements for food service managers or dietary managers, and (iii) Receives frequently scheduled consultations from a qualified dietitian or other clinically qualified nutrition professional. This REQUIREMENT is not met as evidenced by: Based on records review, and interviews, the facility failed to ensure that the dietary service manager had the required qualification. The facility identified a census of 77 residents. Findings include: During interview on 8/13/18 at 11:16 AM, the Dietary Services Manager (DSM) said he had been the Dietary Manager since 9/17. However, the DSM acknowledged that he did not have the certification required for his position, and that he is currently enrolled for a 12-month program with the University of Florida and would then be able to secure the Certified Dietary Manager (CD) qualification by January 2019. A document titled, Re: Oversight Management Health Care Services Group Dietary dated 8/16/18, described the DSM's responsibilities in the Dietary Department of the facility that included the day-today operations of the department, as well as being an integral part of the facility team with focus on care of residents from a nutritional therapy perspective. The document further provided the DSM's supervisor conducts at least	F 801		

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F 801	Continued From page 127 monthly visits and the Dietician conducts 12 hour biweekly on-site facility visits for residents' assessments and to make needed nutritional recommendations. During interview 8/16/18 at 12:12 PM, the Administrator acknowledged the Dietician was not employed on full time and the DSM as still in the process of obtaining Dietary Manager certification.	F 801		
F 803 SS=B	Menus Meet Resident Nds/Prep in Adv/Followed CFR(s): 483.60(c)(1)-(7) §483.60(c) Menus and nutritional adequacy. Menus must- §483.60(c)(1) Meet the nutritional needs of residents in accordance with established national guidelines.; §483.60(c)(2) Be prepared in advance; §483.60(c)(3) Be followed; §483.60(c)(4) Reflect, based on a facility's reasonable efforts, the religious, cultural and ethnic needs of the resident population, as well as input received from residents and resident groups; §483.60(c)(5) Be updated periodically; §483.60(c)(6) Be reviewed by the facility's dietitian or other clinically qualified nutrition professional for nutritional adequacy; and §483.60(c)(7) Nothing in this paragraph should be construed to limit the resident's right to make	F 803		

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F 803	Continued From page 128	F 803		

personal dietary choices.
This REQUIREMENT is not met as evidenced by:
Based on observations, clinical record review and interviews, the facility failed to serve all beverages at breakfast as directed by the resident's individual choices for 1 of 21 current residents reviewed (Resident #4). The facility identified a census of 77.

Findings include:

1. The Minimum Data Set (MDS) dated 5/11/18 identified diagnoses that included Non-Alzheimer's dementia, depression, anxiety and chronic obstructive pulmonary disease for Resident #4 The same MDS documented the resident had a Brief Interview of Mental Status (BIMS) score of 9 which indicated mild cognitive impairment. The resident the assistance of 2 with transfers and the assistance of one with eating.

The care plan problem initiated 1/18/18 identified the resident required limited assistance with eating such a cueing and/or partial assistance because she is at risk for weight loss, poor food/fluid intake, abnormal labs and skin breakdown.

Review of the breakfast tray slip dated 8/14/18 directed staff to serve the resident 4 ounces of orange juice, in addition to other food items. Observation on 8/14/18 at 10:18 AM revealed Staff M, certified nursing assistant (CNA) carried the resident's meal tray to the small dining area in the common area. The resident did not receive orange juice.

During interview on 8/15/18 at 4:00 PM the

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F 803	Continued From page 129 Dietary Services Manager (DSM) stated the facility has a juice machine in the main dining room and staff need to go there to obtain juice for residents who eat outside the main area.	F 803		
F 804 SS=D	Nutritive Value/Appear, Palatable/Prefer Temp CFR(s): 483.60(d)(1)(2) §483.60(d) Food and drink Each resident receives and the facility provides- §483.60(d)(1) Food prepared by methods that conserve nutritive value, flavor, and appearance; §483.60(d)(2) Food and drink that is palatable, attractive, and at a safe and appetizing temperature. This REQUIREMENT is not met as evidenced by: Based on observations, clinical record review, professional reference reviews and interview, the facility failed to assure food served at safe and appetizing temperatures for one of 21 sampled residents (Resident #4). The facility reported a census of 77 current residents. Findings include: 1. The Minimum Data Set (MDS) assessment dated 5/11/18 identified diagnoses that included Non-Alzheimer's dementia, depression, anxiety and chronic obstructive pulmonary disease for Resident #4 The same MDS documented the resident had a Brief Interview of Mental Status (BIMS) score of 9 which indicated mild cognitive impairment. The resident the assistance of 2 with transfers and the assistance of one with eating. The care plan problem initiated 1/18/18 identified	F 804		

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F 804	Continued From page 130 the resident required limited assistance with eating such a cueing and/or partial assistance because she is at risk for weight loss, poor food/fluid intake, abnormal labs and skin breakdown. Observation on 8/14/18 at 10:00 AM with the Assistant Director of Nursing (ADON) present revealed a covered meal tray on the resident's bedside table. At 10:18 AM Staff M, certified nursing assistant (CNA) carried the meal tray to the small dining area in the common area and the ADON transported the resident to this area. The ADON washed her hands and cut up the resident's biscuits and gravy, opened the milk carton, unwrapped the resident's silverware and then left the area. At 10:22 AM the resident took a bite of the biscuits and gravy and she shook her 'no' when asked if they were hot. The resident said the hash browns on her tray tasted cold and said no when asked if her oatmeal was hot. Upon request, the Nurse Consultant measured the temperature of the food items; the oatmeal measured at 92 degrees, the biscuits and gravy and hash browns measured 72 degrees and the milk measured 60 degrees. The Nurse Consultant concurred the food temperatures were not within range for palatability and stated she would obtain another breakfast tray for the resident. According to ServeSafe, a food and beverage safety training and certificate program, cold food should be held and served at 41 degrees or less and hot foods held and served at 135 degrees or higher to maintain food safety.	F 804		
F 812 SS=E	Food Procurement,Store/Prepare/Serve-Sanitary CFR(s): 483.60(i)(1)(2)	F 812		

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F 812	Continued From page 131 §483.60(i) Food safety requirements. The facility must - §483.60(i)(1) - Procure food from sources approved or considered satisfactory by federal, state or local authorities. (i) This may include food items obtained directly from local producers, subject to applicable State and local laws or regulations. (ii) This provision does not prohibit or prevent facilities from using produce grown in facility gardens, subject to compliance with applicable safe growing and food-handling practices. (iii) This provision does not preclude residents from consuming foods not procured by the facility. §483.60(i)(2) - Store, prepare, distribute and serve food in accordance with professional standards for food service safety. This REQUIREMENT is not met as evidenced by: Based on observations, facility policy review and staff interviews, the facility failed to ensure practices in the food service areas to maintain cleanliness and prevent the potential spread of infection. The facility reported a census of 77 residents. Findings include: Observations in the kitchen and dining areas showed the following: a. On 8/13/18 at 12:09 PM, Staff I (Cook) donned gloves, received and gathered menu slips handled by other staff members by the doorway to the kitchen. Staff I took the menu slips in the kitchen to the steam table, where he put food on	F 812		

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F 812	Continued From page 132	F 812		

plates and then paired each food plate to the corresponding menu slip, returned to the door either put on top of cart or handed to staff members who waited by the door. At 12:21 PM, Staff I had not removed his gloves and entered the walk-in refrigerator and came back out out holding a small cartoon of milk which he put in a plate that he handed to a staff member at the kitchen door. Staff I then continued the process of serving food at the steam table with the same pair of gloves.

b. On 8/13/18 at 12:30 PM, Staff J (Cook/Dietary Aide) dropped a menu slip on the hallway floor near the food cart, picked it back up, and then handed it to Staff H who still had gloved hands, and continued the same process in the kitchen.

c. On 8/13/18 at 12:43 PM, Staff I entered the walk in refrigerator with gloved hands and came out with 2 salad plates which he placed on the steam table. Staff I spilled one salad plate on food counter, but served the other plate. Staff I re-entered the walk in refrigerator and brought out another salad plate plate. Staff I removed his gloves, turned the stove on and then washed his hands before handling more plates.

d. On 8/14/18 at 11:09 AM, after Staff I prepared pureed cornbread, he removed the bowl and the attachment from the machine mixer and went to have them washed at the dishwashing area. Thereafter, Staff I brought back the mixer bowl and attachment to the food preparation area, where he picked up a towel rag from the lower shelf of the food preparation counter/table and then used the rag to wipe the inside of the mixer bowl and the attachment. The rag was kept together with opened containers of salt, oil,

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F 812	Continued From page 133 ground pepper, and other cooking condiments. In addition addition to the condiments, a gallon plastic container half-filled with water and a rag sat on the counter too. The Dietary Services Manager (DSM) said staff used the plastic container and rag for sanitizing solution to be used on tables and work areas in the kitchen. The DSM also observed Staff I use the rag to wipe the mixer bowl and attachment. e. On 8/15/18 at 9:04 AM, Staff H (Dietary Aide) served breakfast on the steam table for room trays at the Cherry Blossom hallway, where he squatted down and left hand touched his left foot shoe while he opened the sliding doors underneath the steam table. After that, he stood up and continued serving residents' food for room trays. The DSM was also present during the observations. The facility's policy number NS0226, titled, General Infection Control and Prevention in the Food Service Department with latest revision date of 1/17 instructed that sanitary conditions will be maintained throughout the food service department in order to prevent transmission of disease. The procedures directed all employees to effectively sanitize food preparation equipment, dishes and utensils to destroy disease-carrying organisms and to follow standard operation and cleaning procedures for equipment.	F 812		
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:	F 868		

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F 868	Continued From page 134 (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. This REQUIREMENT is not met as evidenced by: Based on facility record reviews and staff interview, the facility failed to ensure an effective quality assurance program in place to provide quality care to residents. The facility identified a census of 77. Findings include: 1. Review of the survey activity reports posted in the facility the following repeated deficient practices were identified in during a total of 5 survey activities during the period of 8/17/17 through this current survey: a. Development and implementation of abuse/neglect policies cited at a D level (isolated with no actual harm with potential for more that minimal harm) on 8/15/17 and during this current survey at an E level (a pattern with no actual harm with potential for more that minimal harm) b. Dignified treatment of residents cited at an E level on 8/15/17 and at a B level (no actual harm with potential for minimal negative impact) on 2/15/18	F 868		

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F 868	Continued From page 135 c. The lack of a clean, comfortable and homelike environment cited at a E level on 8/15/17 and during the current survey; d. Failure to develop resident care plans cited at a D level on 8/15/17 and on 3/22/18, at an E level on 2/15/18 and at a D level during the current survey; e. Services failed to meet professional standards sited a D level on 1/31/18, 2/15/18 and 3/22/18 and at an E level 8/15/17 and a D level during the current survey; f. Failure to provide appropriate assessment and timely intervention for residents with changes in condition cited at a G level (isolated actual harm with potential for more than minimal harm) 8/15/17, cited at a D level 1/15/18 and during current survey cited at Level J (isolated immediate jeopardy to resident health or safety) g. Failure to provide activities of daily living assistance for dependent residents cited at an E level 8/15/17 and at a D level during this current survey h. Failure to provide appropriate care and treatment of pressure ulcers cited at an E level 8/15/17 and cited 1/31/18 and this current survey at a D level; i. Failure to provide adequate nursing supervision cited at a J level 8/15/17 and at a D level during this current survey; j. Failure to provide staffing to assure prompt response to resident call lights cited at an E level 8/17/17 and at a D level during this current survey; k. Failure to meet the nutritional needs of residents in accordance with established national guidelines and to follow the menu as written cited at an L level (widespread immediate jeopardy to resident health for safety) on 8/15/17 and cited at a D level on 1/31/18, 2/15/18, 3/22/18 and this	F 868		

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F 868	Continued From page 136 current survey l. Failure to store/serve and prepare food in a sanitary manner cited at an F level (widespread without actual harm with potential for more than minimal harm) and at an E level 2/15/18 and during the current survey; m. Failure to maintain effective infection control cited at a D level 8/15/and at an E level during this current survey; n. Failure to check the nurse aide registry prior to hire cited at a D level 8/15/17 and during this current survey; o. Failure to evaluate an nurse aide performance and/or failure to provide 12 hours of inservice education yearly cited at a D level 8/15/17 and during the current survey; p. Failure to assure an effective quality assurance program in place to provide quality care cited at an F level 8/15/17 and at an E during this current survey; q. Failure to notify the resident's physician and/or legally responsible party of changes in condition cited at a D level 1/31/18 and during this current survey; r. Failure to maintain adequate nutritional parameters to prevent significant weight loss unless documented as unavoidable cited at a G level on 2/15/18 and at a D level during this current survey; s. Failure to accommodate resident needs for transportation or supervision while going to appointments cited at a D level 3/22/18 as well as this current survey. During interview on 9/13/18 at 2:24 PM, the Administrator stated the facility is monitoring and following the plans of correction for all deficiencies cited in previous surveys. However some deficiencies, like the lack of assessment	F 868		

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F 868	Continued From page 137 and intervention, cover professional standards over a variety of things. The facility monitors for specific issues under a broad variety of federal tags.	F 868		
F 880 SS=E	Infection Prevention & Control CFR(s): 483.80(a)(1)(2)(4)(e)(f) §483.80 Infection Control The facility must establish and maintain an infection prevention and control program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of communicable diseases and infections. §483.80(a) Infection prevention and control program. The facility must establish an infection prevention and control program (IPCP) that must include, at a minimum, the following elements: §483.80(a)(1) A system for preventing, identifying, reporting, investigating, and controlling infections and communicable diseases for all residents, staff, volunteers, visitors, and other individuals providing services under a contractual arrangement based upon the facility assessment conducted according to §483.70(e) and following accepted national standards; §483.80(a)(2) Written standards, policies, and procedures for the program, which must include, but are not limited to: (i) A system of surveillance designed to identify possible communicable diseases or infections before they can spread to other persons in the facility; (ii) When and to whom possible incidents of	F 880		

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F 880	Continued From page 138 communicable disease or infections should be reported; (iii) Standard and transmission-based precautions to be followed to prevent spread of infections; (iv)When and how isolation should be used for a resident; including but not limited to: (A) The type and duration of the isolation, depending upon the infectious agent or organism involved, and (B) A requirement that the isolation should be the least restrictive possible for the resident under the circumstances. (v) The circumstances under which the facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease; and (vi)The hand hygiene procedures to be followed by staff involved in direct resident contact. §483.80(a)(4) A system for recording incidents identified under the facility's IPCP and the corrective actions taken by the facility. §483.80(e) Linens. Personnel must handle, store, process, and transport linens so as to prevent the spread of infection. §483.80(f) Annual review. The facility will conduct an annual review of its IPCP and update their program, as necessary. This REQUIREMENT is not met as evidenced by: Based on clinical record review, observation, staff interview and facility policy review, the facility failed to ensure staff utilized infection control techniques during care for four of 21 residents reviewed (#22, #4, #70 and #50). The facility	F 880		

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F 880	Continued From page 139 reported a census of 77 residents. Findings include: 1. The Minimum Data Set (MDS) assessment for Resident #22 dated 6/5/18 identified diagnoses of neurogenic bladder, urethral stricture (narrowing) and urinary retention. The assessment documented the resident had intact memory and cognition. The MDS indicated the resident required the of one staff for bed mobility, transfers and personal hygiene and he required an indwelling catheter. a. During an observation on 8/14/18 at 2:05 p.m. Staff F, CNA (certified nursing assistant) entered the resident's room and washed his hands and put on gloves. Staff F offered the resident use of the toilet to empty the catheter and resident refused. Staff F placed a barrier on the floor and emptied the urine from the catheter bag. Staff F applied alcohol to the catheter port site and then hung the catheter bag onto the resident's garbage can. The garbage can had trash in it. Unit manager, Staff B, present in the room for this observation, stated the resident currently received an intravenous antibiotic for a urinary tract infection and his new suprapubic site. Staff B also stated there is no good place to put the catheter bag. During an interview on 8/14/18 at 2:33 p.m. with the Clinical Director, she stated that hanging the catheter bag from the garbage can was not a good idea. The Clinical Director and surveyor entered the resident's room and observation revealed the catheter bag continued to hang from the garbage can and a dignity bag did not fully cover the catheter bag.	F 880		

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F 880	Continued From page 140 On 8/14/18 at 2:48 p.m., the Clinical Director stated the catheter bag had been removed from hanging on the garbage can and she educated staff on the floor at this time. b. The care plan dated 7/27/17 directed staff the resident had a history of skin breakdown and identified the resident able to reposition himself but often refuses and will not let staff assist. Review of the Hospital Discharge Instruction Sheet dated 8/8/18 revealed the following orders: a. Sacrum and coccyx: Cleanse with normal saline, apply Venelex ointment to open areas on right sacrum and coccyx, cover with ABD dressing. b. Groin: Apply miconazole cream and microguard powder to red areas of groin. Observation on 8/15/18 at 8:20 AM revealed Staff D, LPN (licensed practical nurse) provided wound care for the resident. She placed the containers of Venelex and antifungal powder directly on the bedside table without the use of a barrier. The bedside table had a large amount of the resident's personal items. She applied Venelex to the residents buttocks. She then applied antifungal powder to the groin area. Review of the Policy and Procedure titled Dressings Clean/Aseptic dated August 2018 directed staff to do the following: a. Adjust the bedside stand to waist level. Clean bedside stand or place barrier/towel down to establish a clean field. Place the clean equipment on the barrier. 2. The MDS assessment dated 5/11/18 documented diagnoses that included hip fracture, Non-Alzheimer's dementia, anxiety, depression	F 880		

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F 880	Continued From page 141 and chronic obstructive pulmonary disease for Resident #4. The same MDS documented a BIMS score of 9 which indicated moderately impaired cognition. Resident #4 required the assistance of 2 with of transfers and the assistance of one with dressing, toilet use and personal hygiene. The resident experienced frequent bladder and bowel incontinence. Care plan problems initiated on 1/18/18 identified the resident needed assistance with dressing/grooming/bathing and toilet use and it directed staff to provide assistance with these tasks and also identified the resident wears incontinent products. Observation on 8/14/18 at 10:00 AM with the Assistant Director of Nursing (ADON) present revealed Staff M, CNA, put on a pair of gloves and gathered the resident's clothing from the closet, handled the resident's bed linen and put on the resident's socks. Wearing the same gloves, Staff M removed the resident brief saturated with urine and performed perineal care for the resident. Staff M handled the disposable wipes package, dropped it on the floor, picked it up and placed on the resident's bedside table and then fastened the resident's clean brief. Staff M placed the resident's soiled top and the urine-soiled bed linen directly on the floor next to the garbage can. Staff M then washed his hands and put on a clean pair of gloves and assisted the resident to put on slacks, to sit on the edge of the bed, put on the resident's shoes and then placed a gait belt around the resident's waist and assisted her to sit in the wheelchair. Wearing the same pair of soiled gloves, Staff M carried the resident's meal tray from the resident's room to the nook area near the nursing work area. At	F 880		

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F 880	Continued From page 142 10:30 AM, Staff M picked up the soiled linen from the floor, bagged it and took it to the linen barrel. Observation revealed Staff M did not sanitize the floor after removing the urine-soiled linen. The facility's Glove Use policy revised 5/14 directed the following under Glove Use With Resident Care: Point 5. When peri-care complete, remove gloves and WASH HANDS. apply clean gloves and assist/place clean undergarments, brief. clean clothing or pajamas. 3. The MDS assessment dated 7/18/18 documented diagnoses that included Non-Alzheimer's dementia, manic depression, arthritis and essential tremor for Resident #70. The same MDS documented a Brief Interview of Mental Status of 0 which indicates severely impaired cognition. Resident #70 required the assistance of one with transfers, toilet use and personal hygiene. He experienced frequent urinary incontinence. Care plan problems initiated 4/10/18 identified the resident required assistance with dressing, grooming, bathing and toileting as the resident as often incontinent. The care plan directed staff to provide extensive assistance of 1 with dressing, grooming and bathing and toilet use with the goal for the resident to be clean and odor-free. Observation on 8/14/18 at 8:25 AM with the Corporate Nursing Consultant present revealed Staff M transferred the resident from the wheelchair to the toilet and removed the resident's incontinent pants soiled with urine and BM (bowel matter). After toilet use, Staff M cleansed the resident's rectal area with	F 880		

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F 880	Continued From page 143 disposable wipes. Observation revealed a smear of BM on the toilet seat and a small amount of BM fell on the floor from the disposable wipes as Staff M reached around to throw in the garbage can. Observation revealed Staff M did not empty the garbage can which held the soiled brief and wipes and gloves or remove the BM from the toilet seat and disinfect the areas prior to leaving the room. At 9:10 AM, 9:30 AM and 9:55 AM, the BM remained on the floor and the toilet seat and the garbage can still contained soiled briefs, wipes and gloves. A strong odor of urine noted in the bathroom. Observation on 8/14/18 at noon with the Nursing Consultant present revealed the BM remained on the toilet and floor and the garbage can contained the soiled briefs, wipes and gloves. She stated all staff have access to cleaning supplies. 4. Observation on 8/14/18 at 3:10 PM revealed Staff N, CNA, just finished assisting Resident #50 with a whirlpool bath. Staff N sprayed the top surfaces of the tub chair and sides of the whirlpool tub with Virex II 256 quaternary sanitizer, scrubbed all the surfaces just sprayed with the sanitizer with a brush and rinsed all with water. Staff N then turned the seat of the whirlpool chair upside down, Sprayed it with Virex II 256. scrubbed it with a brush and rinsed it with water. Observation revealed the whirlpool tub was an Apollo with Remedy UV infection protection system installed. The tub had 4 on 08/14/18 jets; 3 on the back side of the tub and 1 in the bottom of the tub located behind the tub drain. Observation of the jets revealed them soiled on the inside with debris and soap scum. The whirlpool chair handles had a grippable surface and mildew odor and soap scum and	F 880		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	165161	A. BUILDING _____ B. WING _____	09/26/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
TOUCHSTONE HEALTHCARE COMMUNITY	1800 INDIAN HILLS DRIVE SIOUX CITY, IA 51104

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F 880	Continued From page 144 hard water buildup on the back side of the chair. During interview at 4:00 PM Staff N stated staff use Virex II 256 sanitizer spray to disinfect the tub and do not use the built-in tub disinfection system. The manufacturer's guidelines for Bath Disinfecting Process for this tub direct the following: 1. Place the chair in the tub, release the carrier from the tub, and close the door. Close the tub drain. 2. Turn the selector knob to "DISINFECTANT' and the Control Knob to "on". 3. Turn the whirlpool on. Where there is about 2 inches of disinfectant solution in the foot well. turn the whirlpool off. 4. Turn the Control Knob to "off". Lift seat bottom off the chair. Use disinfecting solution to scrub the tub chair and underneath the seat bottom. 5. Leave wet for 10 minutes. After 10 minutes open the tub drain. Turn the Selector Knob to "Rinse" and the Control Knob to "on". 6. Turn the whirlpool on. When clear water comes out all the jets, turn the whirlpool off. 7. Turn the Control Knob to "Off". Use the shower wand to rinse the tub and chair. The manufacturer' guidelines for the use of Virex II 256 direct the following: This product can be applied by mop, sponge, paper towel, coarse trigger sprayer, auto-scrubber or foam gun. Change cloths, sponges or towels frequently to avoid redisposition of the soil. For disinfection, all surfaces must remain wet for 10 minutes.	F 880		

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F 880	Continued From page 145	F 880		

3. During observation on 8/15/18 at 11:16 a.m. Staff E, Licensed Practical Nurse, washed her hands and applied gloves. Staff E removed the dressing from the resident's upper chest. Staff E cleansed the area and opened the dressing. Staff E obtained scissors from her shirt pocket and cut the clean dressing without sanitizing the scissors first.

Based on clinical record review, observation, staff interview, and facility policy review, the facility failed to ensure staff utilized infection control techniques for 2 of 21 residents (Resident #9, #22), and failed to cleanse contaminated surfaces during a treatment (Resident #62) for 1 of 21 residents reviewed. The facility reported a census of 77 residents.

Findings include:

1. During observation on 8/14/18 at 8:21 AM, Staff G, Certified Nursing Assistant washed her hands, donned a pair of gloves, and gathered supplies (brief and disposable wipes). Staff G removed Resident #9's pants and two briefs. Resident #9 reported his brief was wet and he had a sore on his right (R) buttock. Staff G took disposable wipes and cleansed the (R) buttock in an upward and downward motion multiple times, then used the same disposable wipe and wiped up and down the left buttock. Staff G folded the

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F 880	Continued From page 146	F 880		

disposable wipe and cleansed between the buttocks. The wipe had a small smear of brown stool on it. Staff G folded the wipe and cleansed front to back between the buttocks. The resident had a small slit/ open area and redness to his (R) buttock and a small amount of white cream on the buttock area. Staff G took additional disposable wipes, cleansed the groin and penis front to back, then removed her gloves. Staff G walked over to the sink and donned a clean pair of gloves. Staff G obtained a tube of barrier cream from a dresser drawer, and applied white barrier cream to the resident's buttocks. Staff G removed gloves, then donned a clean brief and a pull up brief, then pulled the resident's pants up. Staff G removed the gait belt around the resident's upper waist and placed the resident's feet on the wheelchair platform. Staff G washed hands after she bagged up the trash.

In an interview 8/16/18 at 8:35 AM Staff B, Unit Manager stated she expected staff followed facility protocol for providing incontinence care, wiping front to back, and changed gloves when soiled or contaminated. Staff B reported she performed random pericare audits of staff if she had a concern about how the CNA completed the task or if she had noticed residents had UTI's or other infections.

A facility policy dated 10/2015 titled "Perineal Care" revealed the following procedural steps:
a. wash hands and apply gloves
b. for male resident, wash perineal area starting with urethra and working outward
c. retract the foreskin and wash urethral area using a circular motion
d. cleanse penis, scrotum, and inner thighs.
e. use a separate wipe each time or a separate

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F 880	Continued From page 147 area of cloth f. pat dry g. cleanse rectal area thoroughly, including under the scrotum, anus, and buttocks. h. remove gloves. Perform hand hygiene i. apply new gloves when brief changed or dressing/undressing resident	F 880		

F 578 Advanced Directives

Immediate corrective action:
Resident #50 code status was updated in his hard chart and electronic medical record.

Action as it applies to others:
All resident code statuses were audited to ensure hard chart and electronic medical record contained accurate code status information.

Licensed nurses were provided education regarding code status policy and procedure by 10/18/18.

Date of completion: 10/18/18

Recurrence will be prevented by:
Weekly Audits of resident code status documentation will be completed x 30 days, then monthly x 5 months. The results of these audits will be brought to QAPI committee for review and recommendation to continue or discontinue.

The correction will be monitored by:
DON/Designee

F 580 Change Notification

Immediate corrective action:
Residents # 375, 376 and 22 have discharged from the facility.

Action as it applies to others:
Nursing staff were provided education regarding family and physician notification per change of condition policy and procedure 9/28/18.

Date of completion: 10/18/18

Recurrence will be prevented by:
Weekly audits will be competed x 30 days, then monthly x 5 months to ensure appropriate family and physician notification takes place. The results of these audits will be brought to QAPI committee for review and recommendation to continue or discontinue.

The correction will be monitored by:
DON/Designee

F 584 Safe/Clean/Comfortable/Homelike Environment

Immediate corrective action:
Daisy Lane whirlpool room was cleaned and organized, including cleaning the floor, toilet area, sink and cupboards.

Unmarked razors and unmarked deodorants removed from Daisy Lane whirlpool room.

Ceiling in Daisy Lane whirlpool room was repaired

The shared bathroom between rooms D14 and D16 was cleaned.

The caulking around the toilet in the share bathroom between D14 & D16 was replaced.

The doors and door frames to rooms D14 & D16 were repaired.

The peeling paint was patched in the shared bathroom between D14 & D16.

The floor in the shared bathroom between D14 & D16 was repaired.

Action as it applies to others:
Staff education provided regarding policy and procedure for reporting repair needs to maintenance

Housekeeping staff provided education regarding resident area cleaning procedures.

Nursing staff educated regarding use of dedicated equipment and proper labelling of individual resident equipment.

Date of completion: 10/18/18

Recurrence will be prevented by:
Weekly observation audits will be completed to ensure resident areas are clean and in good repair x 30 days, then monthly x 5 months. The results of these audits will be brought to QAPI committee for review and recommendation to continue or discontinue.

The correction will be monitored by:
Administrator/Designee

F 607 Abuse training

Immediate corrective action:
Staff E completed dependent adult abuse training for mandatory reporters 2/8/18.

Staff E DHS evaluation of criminal history received 9/15/17.

Staff NN completed dependent adult abuse training for mandatory reporters 2/15/18.

Staff K completed dependent adult abuse training for mandatory reporters 7/30/18.

Action as it applies to others:
All employee files were audited to ensure dependent adult abuse training for mandatory reporters is completed per requirements.

All employee files were audited to ensure DHS SING check is completed for clearance to work.

Education provided to HR coordinator regarding dependent adult abuse training for mandatory reporters and DHS SING check requirements.

Date of completion: 10/18/18

Recurrence will be prevented by:
Weekly audits of personnel files will be completed x 30 days, then monthly x 5 months to ensure that dependent adult abuse training for mandatory reporters and DHS SING checks are present. The results of these audits will be brought to QAPI committee for review and recommendation to continue or discontinue.

The correction will be monitored by:
Administrator/Designee

F 623 Notification of Ombudsman

Immediate corrective action:
Long term care Ombudsman was notified of discharge/transfer of residents #44, 48, 50, 62, 66, 68, & 69.

Action as it applies to others:
Education was provided to Social Services Director and Administrator regarding notification of the Long-Term Care Ombudsman of all facility-initiated transfers 10/5/18.

Date of completion: 10/18/18

Recurrence will be prevented by:
Monthly audits will take place x 6 months to ensure LTC ombudsman receives notification of facility-initiated transfers. The results of these audits will be brought to QAPI committee for review and recommendation to continue or discontinue.

The correction will be monitored by:
Administrator/Designee

F 625 Notice of Bed Hold Policy

Immediate corrective action:
Resident #44 has been provided notice of bed hold policy related to her hospitalization 5/31/18.

Resident #50 has been provided notice of bed hold policy related to his hospitalizations dated 3/9/18, 6/1/18 and 7/2/18.

Resident # 66 has been provided notice of bed hold policy related to his hospitalization dated 7/13/18.

Resident # 69 has been provided notice of bed hold policy related to her hospitalization dated 7/128/18.

Resident # 48 has been provided notice of bed hold policy related to his planned hospitalizations dated 3/19/18, 4/24/18, 5/16/18, 5/30/18, 6/19/18, and 8/1/18.

Action as it applies to others:
Licensed nurses have been provided education regarding provision of notice of bed hold policy to residents at the time of transfers to hospital or therapeutic leave.

Date of completion: 10/18/18

Recurrence will be prevented by:
Weekly audits of resident transfers will be completed x 30 days, then monthly x 5 months to ensure notice of bed hold policy is provided and documented in resident record. The results of these audits will be brought to QAPI committee for review and recommendation to continue or discontinue.

The correction will be monitored by:
Administrator/Designee

F 644 Coordination of PASARR

Immediate corrective action:
Follow-up PASRR was completed for resident # 17

Action as it applies to others:
All resident records were reviewed to ensure follow-up PASRR assessments were completed as appropriate with changes in mental health diagnoses.

Education regarding PASRR process and requirements provided to Social Services Director and Administrator 9/10/18.

Date of completion: 10/18/18

Recurrence will be prevented by:
Weekly audits of resident records will be completed x30 days, then monthly x 5 months to ensure follow-up PASSR assessments are completed as necessary. The results of these audits will be brought to QAPI committee for review and recommendation to continue or discontinue.

The correction will be monitored by:
Administrator/Designee

F 645 PASARR Screening for MD & ID

Immediate corrective action:
Follow up PASRR evaluations were completed to obtain authorization for additional period for placement were completed for residents # 11 and 53.

Action as it applies to others:
All resident records were reviewed to ensure follow-up PASRR assessments were completed as appropriate to authorize placement.

Education regarding PASRR process and requirements provided to Social Services Director and Administrator 9/10/18.

Date of completion: 10/18/18

Recurrence will be prevented by:
Weekly audits of PASRR evaluations will be completed x30 days, then monthly x 5 months to ensure follow-up assessments are completed as necessary to authorize additional placement periods. The results of these audits will be brought to QAPI committee for review and recommendation to continue or discontinue.

The correction will be monitored by:
Administrator/Designee

F 655 Baseline Care Plans

Immediate corrective action:
Unable to correct providing a copy of baseline care plan to resident #31 and 62. Residents # 31 and 62 have been provided a copy of their comprehensive care plan that has been developed since survey process.

Resident 78 has discharged from the facility.

Action as it applies to others:
The care plan team was provided education regarding baseline care plans per the care plan policy 10/10/18.

Date of completion: 10/18/18

Recurrence will be prevented by:
Weekly Audits of newly admitted residents will be completed x30 days, then monthly x 5 months to ensure residents received a copy of their baseline care plan. The results of these audits will be brought to QAPI committee for review and recommendation to continue or discontinue.

The correction will be monitored by:
DON/Designee

F 656 Comprehensive Care Plans

Immediate corrective action:
Resident # 53's care plan was reviewed and revised.

Action as it applies to others:
All resident comprehensive care plans will be reviewed for accuracy by 10/18/18.
Licensed nurses and interdisciplinary team provided education regarding the development of the comprehensive care plan

Date of completion: 10/18/18

Recurrence will be prevented by:
Weekly Audits of resident care plans will be completed x30 days, then monthly x 5 months to ensure accuracy of interventions. The results of these audits will be brought to QAPI committee for review and recommendation to continue or discontinue.

The correction will be monitored by:
DON/Designee

F 657 Revision of the care plan

Immediate corrective action:
Resident # 83 has discharged from the facility.

Action as it applies to others:
All resident care plans will be reviewed to ensure accuracy.

Licensed nurses and interdisciplinary team provided education regarding revising and reviewing care plans

Date of completion: 10/18/18

Recurrence will be prevented by:
Weekly Audits of resident care plans will be completed x 30 days, then monthly x 5 months to ensure accuracy of interventions. The results of these audits will be brought to QAPI committee for review and recommendation to continue or discontinue.

The correction will be monitored by:
DON/Designee

F 658 Professional Standards

Immediate corrective action:
Resident # 78 has discharged from the facility.
Resident # 35 unable to correct issue identified during survey process.
Resident # 52 lab work completed.

Action as it applies to others:
Nursing staff provided education regarding following physician orders

Licensed nurses provided education regarding communication with physicians regarding medical appointments.

Date of completion: 10/18/18

Recurrence will be prevented by:
Weekly Audits of resident physician orders and physician consult forms will be completed x 30 days, then monthly x 5 months to ensure orders are followed and reason for physician visit is communicated. The results of these audits will be brought to QAPI committee for review and recommendation to continue or discontinue.

The correction will be monitored by:
DON/Designee

F 677 ADL Care for dependent residents

Immediate corrective action:
Resident #70 unable to correct what occurred during survey process.

All resident's dependent on ADL assistance are at risk.

Action as it applies to others:
Nursing staff provided education regarding assisting dependent residents with ADLs.

Date of completion: 10/18/18

Recurrence will be prevented by:
Weekly Audits of ADL dependent residents will be completed x 30 days, then monthly x 5 months. The results of these audits will be brought to QAPI committee for review and recommendation to continue or discontinue.

The correction will be monitored by:
DON/Designee

F 684 Assessment & Intervention

Immediate corrective action:
Residents #376, 22, 373, 374 and 425 have discharged from the facility.

All areas identified during survey have subsequently healed for residents #4, 62 and 68.

Action as it applies to others:
Licensed nurses provided education regarding care for residents with respiratory distress, residents with diabetes, residents with seizure like activity and residents experiencing an altered mental status 8/22/18

Licensed nurses completed competencies to ensure appropriate skill related to assessment and intervention 8/22/18

Telligen QIO was consulted and provided resources and education that were included in additional education provided to licensed nurses.

Date of completion: 10/18/18

Recurrence will be prevented by:
Weekly Audits of resident changes in condition will be completed x 30 days, then monthly x 5 months to ensure appropriate assessment & intervention. The results of these audits will be brought to QAPI committee for review and recommendation to continue or discontinue.

The correction will be monitored by:
DON/Designee

F 686 Skin- Pressure Ulcers

Immediate corrective action:
Resident #35 orders reviewed for accuracy and care plan updated.

Resident #12 discharged from facility 5/17/18.

Resident #9 Braden assessment completed, care plan reviewed and revised, and orders reviewed for accuracy and implementation

Resident # 68 care plan reviewed and revised.

Action as it applies to others:
Nursing staff provided education regarding incontinence care in relation to skin breakdown

Licensed nurses provided education regarding implementation of orders, revising care plans, weekly wound assessments and documentation.

MDS coordinator provided education regarding timeliness of Braden assessments.

Telligen QIO was consulted and provided resources and education that were included in the education with nursing staff.

Date of completion: 10/18/18

Recurrence will be prevented by:
Weekly Audits of resident Braden assessments will be completed x 30 days, then monthly x 5 months to ensure Braden assessment is completed in a timely manner.

Weekly audits of assessments and physician orders will be completed x30 days, then monthly x5 months to ensure timeliness and accuracy.

The results of these audits will be brought to QAPI committee for review and recommendation to continue or discontinue.

The correction will be monitored by:
DON/Designee

F 689 Accidents/Hazards/Supervision

Immediate corrective action:
Resident # 424 discharged from facility

Residents 9 & 4 unable to correct issues identified during survey process.

Action as it applies to others:
Nursing staff provided education regarding proper transfers and gait belt use.

Date of completion: 10/18/18

Recurrence will be prevented by:
Weekly Audits of resident transfers will be completed x 30 days, then monthly x 5 months to ensure proper technique. The results of these audits will be brought to QAPI committee for review and recommendation to continue or discontinue.

The correction will be monitored by:
DON/Designee

F 690 Incontinence Care

Immediate corrective action:
Resident #9 is being provided appropriate incontinence cares

Resident # 22 expired 10/3/18.

Action as it applies to others:
Nursing staff provided education and competency regarding proper peri-care.

Nursing staff provided education and competency regarding proper catheter care.

Nursing staff provided education and competency regarding draining of catheter drainage bag

Date of completion: 10/18/18

Recurrence will be prevented by:
Weekly Audits of resident catheter and peri-care x30 days, then weekly x 5 months to ensure proper procedures are followed. The results of these audits will be brought to QAPI committee for review and recommendation to continue or discontinue.

The correction will be monitored by:
DON/Designee

F 692 Nutrition/Hydration

Immediate corrective action:
Resident # 68 was assessed for nutritional needs for wound healing 10/9/18.

Action as it applies to others:
All residents with wounds were reviewed to ensure an accurate assessment of nutritional needs for wound healing was completed by dietician.

Date of completion: 10/18/18

Recurrence will be prevented by:
Weekly audits of nutritional assessments will be completed x 30 days, then monthly x 5 months to ensure that nutritional needs for wound healing are address for residents with skin impairments. The results of these audits will be brought to QAPI committee for review and recommendation to continue or discontinue.

The correction will be monitored by:
Administrator/Designee

F 698 Post-Dialysis Assessments

Immediate corrective action:
Residents # 68 and 50 are receiving appropriate post-dialysis assessment.

Action as it applies to others:
Orders entered for all residents who receive hemodialysis to trigger assessment of bruit and thrill or tunneled catheter 9/30/18.

Licensed nurses provided education regarding dialysis assessment and communication

Dialysis Communication form implemented.

Date of completion: 10/18/18

Recurrence will be prevented by:
Weekly Audits of dialysis assessments will be completed for patients receiving hemodialysis x 30 days, then monthly x 5 months. The results of these audits will be brought to QAPI committee for review and recommendation to continue or discontinue.

The correction will be monitored by:
DON/Designee

F 725 Adequate Staffing

Immediate corrective action:
Resident # 9 needs are being met.

Action as it applies to others:
Education provided to staff 9/12/18 regarding the importance of not turning off call lights until resident need is met.

Date of completion: 10/18/18

Recurrence will be prevented by:
Weekly Audits of resident call lights will be completed x 30 days, then monthly x 5 months to ensure call lights are answered and resident needs are met. The results of these audits will be brought to QAPI committee for review and recommendation to continue or discontinue.

The correction will be monitored by:
DON/Designee

F 729 Nurse Aide Registry Verification, Retraining

Immediate corrective action:
Staff E became licensed as an LPN 8/23/17, no longer works as a CNA.

Nurse assistant registry status was verified for Staff K 9/8/17.

Nurse assistant registry status was verified for Staff N 10/2/17.

Action as it applies to others:
All CNA personnel files were reviewed to ensure Nurse Aide Registry Verification is documented.

Date of completion: 10/18/18

Recurrence will be prevented by:
Weekly audits of CNA personnel files will be completed x 30 days, then monthly x 5 months to ensure evidence of Nurse Aide Registry Verification is present. The results of these audits will be brought to QAPI committee for review and recommendation to continue or discontinue.

The correction will be monitored by:
Administrator/Designee

F 730 Nurse Aide Performance Reviews/ in-service

Immediate corrective action:
Staff K, NN and T were not identified.

Action as it applies to others:
All CNA personnel records were reviewed to ensure an annual performance evaluation was completed.

All CNA personnel records were reviewed to ensure 12 hours of in-service are completed annually.

Education provided to HR Coordinator and department directors regarding requirement for annual performance evaluations.

Date of completion: 10/18/18

Recurrence will be prevented by:
Weekly audits of CNA personnel records will be completed x 30 days, then monthly x 5 months to ensure documentation of appropriate in-service as well as performance evaluations are present. The results of these audits will be brought to QAPI committee for review and recommendation to continue or discontinue.

The correction will be monitored by:
Administrator/Designee

F 758 Unnecessary Medications

Immediate corrective action:
Resident # 11 medical record updated to reflect non-pharmacological interventions.

Action as it applies to others:
Nursing staff provided education regarding the use and documentation of non-pharmacological interventions prior to administering medications.

Licensed nurses provided education regarding GDR recommendations.

Date of completion: 10/18/18

Recurrence will be prevented by:
Weekly Audits of resident GDR recommendations and documentation of non-pharmacological interventions will be completed x 30 days, then monthly x 5 months to ensure interventions were attempted and documented. The results of these audits will be brought to QAPI committee for review and recommendation to continue or discontinue.

The correction will be monitored by:
DON/Designee

F 760 Medication Error

Immediate corrective action:
Resident # 375 discharged from the facility.

Resident #8 discharged from the facility.

Action as it applies to others:
Licensed nurses provided education regarding medication administration policy and procedure.

Date of completion: 10/18/18

Recurrence will be prevented by:
Weekly observation audits of medication administration will be completed x 30 days, then monthly x 5 months. The results of these audits will be brought to QAPI committee for review and recommendation to continue or discontinue.

The correction will be monitored by:
DON/Designee

F 761 Storage of Drugs/Biologicals

Immediate corrective action:
Medication cart observed to be unlocked on 8/30/18 was immediately locked.

Action as it applies to others:
Licensed nurses provided education regarding storage of drugs/biologicals.

Date of completion: 10/18/18

Recurrence will be prevented by:
Weekly Audits of medication storage areas will be completed x 30 days, then weekly x 5 months. The results of these audits will be brought to QAPI committee for review and recommendation to continue or discontinue.

The correction will be monitored by:
DON/Designee

F 801 Qualified Dietary Staff

Immediate corrective action:
A specific plan for oversight of the current dietary manager is put in place to ensure qualified Dietary Service Manager until his CDM certification is obtained 2/2019.

Action as it applies to others:
A specific plan for oversight of the current dietary manager is put in place to ensure qualified Dietary Service Manager until his CDM certification is obtained 2/2019.

Date of completion: 10/18/18

Recurrence will be prevented by:
A specific plan for oversight of the current dietary manager is put in place to ensure qualified Dietary Service Manager until his CDM certification is obtained 2/2019.

The correction will be monitored by:
Administrator/Designee

F 803 Menus

Immediate corrective action:
Beverages are being served to resident # 4 as directed by resident's individual choices.

Action as it applies to others:
Staff education provided regarding providing beverages as directed by resident or meal tray ticket.

Date of completion: 10/18/18

Recurrence will be prevented by:
Weekly observation audits of resident meal trays will be completed x 30 days, then monthly x 5 months to ensure that beverages are provided as directed by resident or their tray ticket. The results of these audits will be brought to QAPI committee for review and recommendation to continue or discontinue.

The correction will be monitored by:
Administrator/Designee

F 804 Palatable Food Temps

Immediate corrective action:
Resident #4 is being served meals at safe and appetizing temperatures.

Action as it applies to others:
Education provided to dietary staff regarding food temperature policy and procedure.

Date of completion: 10/18/18

Recurrence will be prevented by:
Weekly audits of meal trays at service will be completed to ensure safe and appetizing temperatures x30 days, then monthly x 5 months. The results of these audits will be brought to QAPI committee for review and recommendation to continue or discontinue.

The correction will be monitored by:
Administrator/Designee

F 812 Food Storage/Sanitation

Immediate corrective action:
Staff I and staff H were provided education regarding handwashing & glove use policy and procedure.

Staff I and Staff H were provided education regarding infection control.

Action as it applies to others:
Dietary staff were provided education regarding Handwashing & glove use policy and procedure.

Dietary staff provided education regarding infection control policy & procedure.

Date of completion: 10/18/18

Recurrence will be prevented by:
Weekly observation audits of meal service and food preparation will be completed x 30 days, then monthly for 5 months to ensure proper handwashing, glove use, and infection control procedures are followed. The results of these audits will be brought to QAPI committee for review and recommendation to continue or discontinue.

The correction will be monitored by:
Administrator/Designee

F 868 QAA Committee

Immediate corrective action:
An Ad Hoc QAPI meeting was held to develop a plan of action for deficient practices 10/10/18

Action as it applies to others:
Additional training on the QAPI process was provided for the QAPI Team members 10/12/18.

All areas found to be deficient in most recent State survey will be reviewed for Root Cause, Action Plans, and audits to ensure corrections are sustained.

Date of completion: 10/18/18

Recurrence will be prevented by:
Telligen QIO was consulted and provided resources for QAPI Committee. Touchstone QAPI Committee will be participating in the next QAPI class beginning in January 2019.

Corporate staff will participate in monthly QAPI meeting x 3 months to ensure sustainability of plans. Deficient areas will be audited x 30 days, then monthly for 5 months to review corrections are sustained. The results of these audits will be brought to the corporate QAPI committee for review and recommendation to continue or discontinue.

The correction will be monitored by:
Administrator/Designee

F 880 Infection Control

Immediate corrective action:
Resident # 22 expired 10/3/18.

Toilet in room D 14 was sanitized.

Whirlpool has been sanitized per manufacturers recommendation.

Action as it applies to others:
Education provided to all staff regarding glove use including not leaving the room with gloves on.

Education to nursing staff on not placing linens directly on the floor to place the dirty linens in a bag, clean up any BM/urine spills with disinfectant, remove any soiled briefs/dirty linens from the room.

Licensed nurses provided education regarding use of barrier/clean field during treatments/dressing change.

Nursing staff provided education regarding peri-care and catheter care.

Nursing staff provided education regarding proper cleaning of whirlpool tub-use solution per manufacturer to clean/run through the jets of the whirlpool tub.

Date of completion: 10/18/18

Recurrence will be prevented by:
Weekly Audits of glove use, catheter care, peri-care and use of clean barrier will be completed x 30 days, then monthly x 5 months to ensure procedures are followed. Weekly observation audits of whirlpool cleaning will be completed x 30 days, then monthly x 5 months. The results of these audits will be brought to QAPI committee for review and recommendation to continue or discontinue.

The correction will be monitored by:
DON/Designee

DEPARTMENT OF INSPECTIONS AND APPEALS

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	IA0429	A. BUILDING: _____ B. WING _____	09/26/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
TOUCHSTONE HEALTHCARE COMMUNITY	1800 INDIAN HILLS DRIVE SIOUX CITY, IA 51104

(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) COMPLETE DATE
S 115	59.5(1) Baseline TB screening procedures 481-59.5(135B,135C) Baseline TB screening procedures for health care facilities and hospitals. 59.5(1) All HCWs shall receive baseline TB screening upon hire. Baseline TB screening consists of two components: (1) assessing for current symptoms of active TB disease and (2) using a two-step TST or a single IGRA to test for infection with M. tuberculosis. This REQUIREMENT is not met as evidenced by: Based on personnel record reviews, facility policy review and interview, the facility failed to assure all staff receive baseline tuberculosis (TB) screening upon hire as outlined in Iowa Administrative Code (IAC) 59. 5(1) for 3 of 6 current employee personnel files reviewed (Staff K, N and V). The facility identified a census of 77. Findings include: 1. The personnel file for Staff K, certified nursing assistant (CNA) documented a hire date of 6/7/17. The Baseline Tuberculin Skin Testing (TST) and Screen for Healthcare Workers (HCWs) documented a TST administered 6/7/17 with a negative result on 6/8/17. The form failed to contain documentation of a second step TST. 2. The personnel file for Staff N, CNA documented a hire date of 5/17/17. The Baseline Tuberculin Skin Testing (TST) and Screen for Healthcare Workers (HCWs) documented an	S 115		

DEPARTMENT OF INSPECTIONS AND APPEALS

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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S 115	Continued From page 1 initial TST with a negative result on 5/17/17. The form failed to contain documentation of a second step TST. 3. The personnel file for Staff V, CNA documented a hire date of 4/18/18. The Baseline Tuberculin Skin Testing (TST) and Screen for Healthcare Workers (HCWs) documented an initial TST with a negative result on 4/18/18. The form failed to contain documentation of a second step TST. During interview on 8/24/18 at 1:55 PM the Business Office Manager stated she could not locate documentation of performance of second TB tests for these employees. The facility Tuberculin Skin Testing (TST) Protocol for Screening Healthcare Workers (HCWs) revised 12/13 directed the following for pre-employment screening for HCWs): completed a history screen and administer two-step TST. First step must be administered and results read prior to first day of working with residents/patients. The policy also directs that if the 1st TST is negative, administer a second TST 7-21 days later.	S 115		

S 115 Baseline TB Screening Procedures

Immediate corrective action:

Staff K, N & V were not identified.

Action as it applies to others:
All employee files were audited to ensure 2 step TB in place

Date of completion: 10/18/18

Recurrence will be prevented by:
Weekly audits of personnel files to ensure TB screening procedures are followed will take place x30 days, the monthly x 5 months. The results of these audits will be brought to QAPI Committee for review and recommendation.

The correction will be monitored by:
DON/Designee