STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	165431	A. BUILDING _____ B. WING _____	09/20/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
TITONKA CARE CENTER	312 FIRST AVENUE NW TITONKA, IA 50480

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 000	INITIAL COMMENTS Correction date 10-22-18 A recertification survey and investigation of facility self reported incident #'s 77686-I, 71593-I, and 69228-I completed 9/17-20/18 resulted in the following deficiencies. #77686-I, substantiated #71593-I, substantiated #69228-I, substantiated (See code of federal regulations (42CFR) Part 483, Subpart B-C)	F 000		10-22-18 PG
F 567 SS=B	Protection/Management of Personal Funds CFR(s): 483.10(f)(10(i)(ii) §483.10(f)(10) The resident has a right to manage his or her financial affairs. This includes the right to know, in advance, what charges a facility may impose against a resident's personal funds. (i) The facility must not require residents to deposit their personal funds with the facility. If a resident chooses to deposit personal funds with the facility, upon written authorization of a resident, the facility must act as a fiduciary of the resident's funds and hold, safeguard, manage, and account for the personal funds of the resident deposited with the facility, as specified in this section. (ii) Deposit of Funds. (A) In general: Except as set out in paragraph (f)(l0)(ii)(B) of this section, the facility must deposit any residents' personal funds in excess of $100 in an interest bearing account (or accounts) that is separate from any of the facility's operating accounts, and that credits all interest earned on	F 567		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE 10/22/2018

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

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F 567	Continued From page 1	F 567		

resident's funds to that account. (In pooled accounts, there must be a separate accounting for each resident's share.) The facility must maintain a resident's personal funds that do not exceed $100 in a non-interest bearing account, interest-bearing account, or petty cash fund.
(B) Residents whose care is funded by Medicaid: The facility must deposit the residents' personal funds in excess of $50 in an interest bearing account (or accounts) that is separate from any of the facility's operating accounts, and that credits all interest earned on resident's funds to that account. (In pooled accounts, there must be a separate accounting for each resident's share.) The facility must maintain personal funds that do not exceed $50 in a noninterest bearing account, interest-bearing account, or petty cash fund.
This REQUIREMENT is not met as evidenced by:
Based on Resident interview, record review, and staff interview the facility failed to maintain resident funds in an interest bearing account as required for 1 of 12 residents reviewed (Resident #15). The facility census was 31 residents.

Findings include:

During an interview on 9/17/18 at 11:04 AM Resident #15 stated that they do have money in an account here at the facility for spending money but they did not believe they received any sort of regular statement to let them know how much money they had in this account but knows there currently is exactly $500 in the account.

During an interview 9/19/18 at 1:15 PM the facility Office Manager verified that Resident #15 does indeed have $500 in the the "Petty Cash" account and that the money is kept in an envelope inside

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F 567	Continued From page 2 the locked file cabinet and showed this surveyor the running total of the residents money in the envelope with dates and amounts of money taken out by the resident and/or money deposited into their account. The Office Manager verified that the resident does not receive any routine statement informing the resident of how much money is in their account but that the facility does have a Surety Bond - an insurance policy to protect the residents from lost/stolen money. Review of facility documents provided by the facility Office Manager on 9/19/18 revealed the facility does have an up to date Surety Bond in force to insure resident funds.	F 567		
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 (D) A decision to transfer or discharge the resident from the facility as specified in §483.15(c)(1)(ii).	F 580		

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F 580	Continued From page 3 (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 record review and staff interview, the facility failed to notify the family of a change of condition for 1 or 14 active residents reviewed (Resident #6). The facility reported a census of 31 residents. Findings include: According to the Minimum Data Set (MDS) assessment, dated 6/21/18, Resident #6	F 580		

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F 607	Continued From page 5 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 review and staff interview, the facility failed to do a criminal history and abuse registry check on 2 of 5 staff prior to hire (Staff D and Staff E). The facility reported a census of 31 residents. Findings include: 1. An Employees Hired Since 6/12/17 form provided by the facility documented Staff D Certified Nursing Assistant (CNA) hired 7/11/17. Staff D's personnel file showed the Single Contact License and Background Check (SING) not completed until 7/17/17. 2. An Employees Hired Since 6/12/17 form provided by the facility documented Staff E CNA hired 8/1/17. Staff E's personnel file showed the Single Contact License and Background Check (SING) not completed until 8/15/17. During an interview on 9/19/18 at 1:55 p.m. the Office Manager stated normally they interview, do the criminal checks, then hire. She confirmed Staff D and Staff E were hired on the dates indicated on the new hire list and they did not have record of criminal or adult abuse record	F 607		

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F 580	Continued From page 4 demonstrated long and short term memory problems and severely impaired skills for daily decision making. The resident required extensive assistance with activities of daily living including bed mobility, transfers and dressing. The resident had diagnoses including Alzheimer's disease. A weight record showed the resident weighed 165# on 6/14/18. On 7/7/18 the resident weighed 247.2#, a 17.8# or 6.72% loss, (with 5% in a month significant). The Care Plan initiated 6/19/18 identified the resident at nutritional risk. The interventions included supplements as ordered for weight loss dated 7/11/18. A facsimile dated 7/7/18 notified the physician the dietician recommended house supplement for weight loss. The physician responded yes. The clinical record lacked documentation of notification of the resident's representative of the weight loss or supplements. During an interview on 9/19/18 at 9:22 a.m. the Director of Nursing (DON) confirmed they had not notified the resident's spouse of the significant weight loss or initiation of supplements.	F 580		
F 607 SS=D	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	F 607		

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F 607	Continued From page 6 checks prior to hire. She could not say why the 2 staff had the checks after hired.	F 607		
F 623 SS=B	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- (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,	F 623		

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F 623	Continued From page 7 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 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	F 623		

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F 623	Continued From page 8 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 record review and staff interview the facility failed to send a copy of a Notice to Transfer to a representative of the Office of the State Long Term Care Ombudsman for 3 residents, (Resident #8, #24 and #28). The facility reported a census of 31 residents. Findings include: 1. According to the Minimum Data Set with assessment reference date of 6/18/18 Resident #8 had a BIMS score of 14, cognitively intact skills for daily decision making. The Nurse's Note for Resident #8 showed on 5/30/18 the resident had been sent out to the emergency room for expiratory wheezes in her	F 623		

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F 623	Continued From page 9	F 623		

left lung and a harsh productive cough. She returned at noon with diagnosis sinusitis and new orders to treat. At 4:30 p.m. the resident had a decline in status , the hospital was notified and order received to transfer per ambulance. At 5:15 p.m. the resident left the facility per ambulance, daughter was aware and will meet at the hospital. At 7:30 p.m. the facility received a phone call from the residents daughter stating Resident #8 was admitted for acute sinus infection, urinary tract infection and upper respiratory infection.

2. According to the Minimum Data Set (MDS) with assessment reference date of 8/3/18 Resident #28 had a BIMS score of 15, cognitively intact cognitive skills for daily decision making.

A Nurse's Note for Resident #28 dated 5/7/18 at 5:35 a.m. noted the resident left the facility for shoulder surgery.

A Skilled Daily Nurse Note dated 7/3/18 showed at 5:15 p.m. Resident #28 was very short of breath, wheezes heard with lung sounds and had a harsh productive cough. At 6:00 p.m. the resident left the facility per ambulance to go to the emergency room. At 8:00 p.m. the facility received a call from the hospital staff and notified the resident was admitted for diagnosis pneumonia.

During interview on 9/19 at 11:22 a.m. the Office Manager showed the log of notification of transfer/discharges to the Ombudsman. It did not include notification of residents transferred to the hospital. She stated she was unaware she needed to include residents that went to the hospital.

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F 623	Continued From page 10 3. According to the Minimum Data Set (MDS) assessment, dated 8/10/18 Resident #24 scored 8 on the Brief Interview for Mental Status (BIMS) indicating cognitive impairment. The resident's diagnoses included dementia. The Nurse's Notes dated 2/28/18 at 3:20 p.m. documented the resident admitted to the hospital. On 3/2/18 at 10:45 a.m. the resident returned from the hospital. During an interview on 9/19/18 at 1:55 p.m. the Office Manager stated they did not submit transfers to the hospital to the Ombudsman.	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.	F 625		

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F 625	Continued From page 11 §483.15(d)(2) Bed-hold notice upon transfer. At 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 record review and staff interview the facility failed to notify a resident and/or the residents representative of the facility policy for bed hold prior to transfer to the hospital for three residents, (Resident #8, #24 and #28). The facility reported a census of 31 residents. Findings include: 1. According to the Minimum Data Set with assessment reference date of 6/18/18 Resident #8 had a BIMS score of 14, cognitively intact skills for daily decision making. The Nurse's Note for Resident #8 showed on 5/30/18 the resident had been sent out to the emergency room for expiratory wheezes in her left lung and a harsh productive cough. She returned at noon with diagnosis sinusitis and new orders to treat. At 4:30 p.m. the resident had a decline in status, the hospital was notified and order received to transfer per ambulance. At 5:15 p.m. the resident left the facility per ambulance, daughter was aware and will meet at the hospital. At 7:30 p.m. the facility received a phone call from the residents daughter stating Resident #8 was admitted for acute sinus infection, urinary tract infection and upper respiratory infection. Resident #8's record did not include	F 625		

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F 625	Continued From page 12 documentation the facility notified the resident or resident representative of the facility policy for bed hold. 2. According to the Minimum Data Set with assessment reference date of 8/3/18 Resident #28 had a BIMS score of 15, cognitively intact cognitive skills for daily decision making. A Nurse's Note for Resident #28 dated 5/7/18 at 5:35 a.m. noted the resident left the facility for shoulder surgery. A Skilled Daily Nurse Note dated 5/10/18 showed at 11:00 a.m. the resident returned from the hospital. A Skilled Daily Nurse Note dated 7/3/18 showed at 5:15 p.m. Resident #28 was very short of breath, wheezes heard with lung sounds and had a harsh productive cough. At 6:00 p.m. the resident left the facility per ambulance to go to the emergency room. At 8:00 p.m. the facility was called by the hospital staff and notified the resident was admitted for diagnosis pneumonia. The Skilled Daily Nurses Note dated 7/7/18 noted Resident #28 returned from the hospital. Resident #28's record did not include documentation the facility notified the resident or resident representative of the facility policy for bed hold. During interview on 9/19/18 ay 2:25 p.m. the ADON stated they did not have documentation of the resident or resident representative given notice of bed hold policy for resident #8 and #28. During interview on 9/19/18 at 11:20 a.m. the	F 625		

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F 625	Continued From page 13 Administrator stated they have not been giving residents bed hold notices when they transfer to the hospital. 3. According to the Minimum Data Set (MDS) assessment, dated 8/10/18 Resident #24 scored 8 on the Brief Interview For Mental Status (BIMS) indicating cognitive impairment. The resident diagnoses included dementia. The Nurse's Notes dated 2/28/18 at 3:20 p.m. documented the resident admitted to the hospital. On 3/2/18 at 10:45 a.m. the resident returned from the hospital. The resident's record lacked any documentation of the facility bed hold policy. During an interview on 9/19/18 at 2:25 p.m. the Director of Nursing (DON) stated they did not do a bed hold when the resident was hospitalized in February.	F 625		
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	F 655		

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F 655	Continued From page 14 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. (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 record review and staff interview, the facility failed to provide the resident representative with a summary of the resident's baseline care plan for 1 of 14 residents reviewed (Reident #6). The facility reported a census of 31 residents. Findings include:	F 655		

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F 655	Continued From page 15 According to the admission Minimum Data Set (MDS) assessment, dated 6/21/18, Resident #6 demonstrated long and short term memory problems and severely impaired skills for daily decision making. The resident required extensive assistance with activities of daily living including bed mobility, transfers and dressing. The resident had diagnoses including Alzheimer's disease. The clinical record lacked documentation the facility provided the resident's representative a summary of the baseline care plan. During an interview on 9/19/18 at 9:25 a.m. the Assistant Director of Nursing (ADON) stated she had no documentation they had provided the resident's representative with a summary of the base line care plan. She talked with the resident's spouse and she did not recall it.	F 655		
F 684 SS=D	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 record review and staff interview, the facility failed to provide adequate assessment for a change of condition for 1 of 14 active residents	F 684		

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F 684	Continued From page 16 reviewed (Resident #14). The facility reported a census of 31 residents. Findings include: According to the Minimum Data Set (MDS) assessment, dated 6/30/17 Resident #14 scored 6 on the Brief Interview For Mental Status (BIMS) indicating severe cognitive impairment. The resident required extensive assistance with activities of daily living (ADL's) including bed mobility and transfer. the resident diagnoses included non-Alzheimer's dementia. The Care Plan revised 3/28/17 identified the resident with increased agitation and anxiety especially when not feeling well or other upset. The resident had the potential for impaired communication related to difficulty with verbalization due to post surgical repair of cerebral aneurysm revised, 1/24/17. The interventions included communication more difficult when agitated or upset, approach with calm manner, allow time to express thoughts, listen attentively and ask questions to clarify statements or questions. The Nurse's Notes dated 9/19/17 at 6:10 a.m. documented the resident moved from a sitting position on the bed to standing after the Certified Medication Aide (CMA) gave her pills and left the room. The CMA heard the resident call out and turned to see her fall. After assessing the resident and inability to move the right shoulder she transferred to the hospital. A hospital Discharge Summary dated 9/21/17 documented the resident admitted after a fall with a fractured humerus (arm), and the resident had	F 684		

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F 684	Continued From page 17 a urinary tract infection. The September 2017 Medication Administration Record (MAR) documented the resident received Ibuprofen 600 mg at 11:59 p.m. on 9/18/18 and documented effective. The MAR documented the resident received Ativan 1 mg at 4:16 a.m. and documented ineffective. A Fall Investigation for the incident 9/19/17 documented per phone conversation Staff B Certified Nursing Assistant (CNA) said the resident rang for help, unsure of time, but after 3 a.m. The resident was restless, wouldn't say what the problem was, but she hurt. Staff G Registered Nurse (RN) just gave meds. The resident continued to cry and whine, couldn't lay still, restless, moaning, and groaning. During an interview on 9/18/18 at 12:00 p.m. Staff B Certified Nursing Assistant (CNA) stated she didn't recall the night in question. In a typed statement dated 9/20/17 Staff G stated the resident called out for something for pain, but unable to say where the pain was, stating everywhere. Staff G gave the resident Ibuprofen and she went back to sleep, and Staff G charted the med effective at 3:20 a.m. At 4 a.m. the resident started crying and hollering help me. Staff G went in to find out what as going on. The resident was beside herself crying and saying help me, you're supposed to help me. The resident did not calm down and became very upset when Staff G asked her to use her words. The resident wanted to sit in the recliner. Staff I CNA came in and helped the resident back to bed. Interventions attempted but nothing worked to calm the resident down enough to tell Staff G	F 684		

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F 684	Continued From page 18 what was wrong. The facility had no statement or information from Staff I regarding the night shift 9/18-19/17. During interview on 9/18/18 at 12:45 p.m. Staff G RN stated she did not do vital signs, and didn't think she necessarily needed to do a head to toe assessment, the resident was an anxious person. She said what she did would be documented in the nurse's notes, and if it wasn't documented it wasn't done. The Nurse's Notes had no documentation from 9/17/17 at 2:10 p.m. to 9/19/17 at 6:10 a.m. The MAR's for June, July, August, and September 1-18/17 showed the resident received no Ativan prior to the administration 9/181/7 (indicating the resident's behavior 9/19/17 prior to the fall not a normal occurrence). During an interview on 9/19/17 at 3:50 p.m. the Director of Nursing stated they did not have behavior sheets. She had not looked at the MAR's to see if the resident had been utilizing the Ativan prior to (the incident) 9/19/17.	F 684		
F 689 SS=G	Free of Accident Hazards/Supervision/Devices CFR(s): 483.25(d)(1)(2) §483.25(d) Accidents. The facility must ensure that - §483.25(d)(1) The resident environment remains as free of accident hazards as is possible; and §483.25(d)(2)Each resident receives adequate supervision and assistance devices to prevent accidents.	F 689		

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F 689	Continued From page 19 This REQUIREMENT is not met as evidenced by: Based on resident record review, staff interview and facility record review the facility failed to ensure each resident received adequate supervision and assistance devices to prevent accidents for one resident, (Resident #13). The facility reported a census of 31 residents. Findings include: According to the Minimum Data Set with assessment reference date 6/16/17 Resident #13 had a BIMS score of 10, moderately impaired cognitive skills for daily decision making, and had diagnosis of dementia. The resident was non-ambulatory and required extensive assist of two staff for transfer. Resident #13 was frequently incontinent of bowel and bladder. The Nurses Notes dated 6/28/17 had a late entry for 6/27/17 that documented while on an activity outing to Smith Lake Staff C Registered Nurse (RN) and the Activity Director attempted to transfer Resident #13 to the toilet with gait belt. As the resident was being pivoted her knees gave out and the resident was slowly lowered to the floor between the toilet and wheelchair with legs flexed and weight on her left hip, not sitting on her ankles or feet. The resident complained of pain but did not holler out in extreme pain. A full assessment was not done as not able to due to the residents position. The resident did move bilateral legs with minimal pain. Staff C, the activity director and the maintenance man positioned a hoyer sling under the resident and she was assisted up and positioned in the wheelchair. The resident did not complain of pain	F 689	Past noncompliance: no plan of correction required.	

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F 689	Continued From page 20 during the transfer. The resident was wheeled in her wheelchair to the shelter house and ate lunch and took her medication. The resident sat quietly with no complaints of pain. At 1:00 p.m. the resident returned to the facility and was taken to her room. Staff C reported the incident to the Charge Nurse. An assessment of the resident legs was completed with no bruising,swelling redness or deformity noted. At 6:20 p.m. the resident stated she felt sick and did not want her supper. The residents husband took her back to her room and staff transferred her to bed via hoyer lift. A registered nurse assessed the resident at 7:00 p.m. and found a large bruise to the right lower leg and a slightly swollen left ankle, warm and tender to the touch and red/pink in color. At 7:30 p.m. the resident was transferred by ambulance to the hospital. At 11:30 p.m. the hospital called and the resident was being transferred to another hospital to see an orthopedic doctor. The History and Physical Final Report dated 6/29/18 noted the resident had a left distal tibia and fibula fractures. The X-rays were discussed with the patients family and conservative treatment recommended due to the patient being non-ambulatory and concerns with poor bone quality and wound healing. The family and patient were in agreement and the resident was placed into a well padded plaster cast. A Therapy Alert dated 8/5/16 noted Resident #13 was a hoyer lift for all transfers. Resident #13's Care Plan with target goal date of 6/26/17 included the intervention; care giver assist of 2 for repositioning and hoyer transfers.	F 689		

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F 689	Continued From page 21 During interview on 9/18/18 at 11:40 a.m. Staff C stated she was out with activity at Smith Lake. She helped take Resident #13 to the bathroom with the Activity Director. During pivot transfer the resident stopped bearing weight and they lowered her to the floor easily with gait belt. She does not recall her complaining of pain. She did an assessment as able, doesn't think she saw anything. Staff C had Maintenance staff come in and the three of them lifted Resident #13 into the wheelchair, she could not recall if they used a sling or gait belt with this transfer. She did not recall any complaints of pain with that transfer. When returned to the facility she reported to the charge nurse what happened and that the resident should be assessed. Staff C did not recall how the resident transferred prior to incident at the lake, she works at the facility prn, maybe two times a month. During interview on 9/18/18 at 1:10 p.m. the Activity Director stated Resident #13's family saw the outing on the activity calendar and thought it would be a good idea for the resident to go. The resident had gone on other outings but not any that long. This was fishing and lunch then to return to the facility. The resident had been saying over and over she had to go to the bathroom, the nurse (Staff C) made the decision to pivot transfer into the bathroom. They used a gait belt and the two of them stood her up and when they were pivoting her she kept saying I can't stand, the resident stopped bearing any weight and they put here down easily. It was so long ago but does not recall her complaining of any pain, just remembered her saying over and over that she could not stand when they were	F 689		

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F 689	Continued From page 22 pivoting her. She did not think the resident was assessed until they returned to the facility. At this time they were trying to figure out how to get her up off the floor, the resident was able to straighten out her legs. The Maintenance Man came and helped them. They completely lifted her up and placed in her in the wheelchair. Then they went and ate lunch. The resident did not appear uncomfortable. They came back to the facility after the meal. She told facility staff what happened and the charge nurse assessed here. The Activity Director stated she did wonder to her self what they would do if the resident needed to go to the bathroom when they were out but did not say anything to anyone. She does not usually work on the floor and does not routinely transfer Resident #13. Review of facility records showed Staff C and the Activity Director were issued verbal counseling on 6/27/17 for not following resident #13's Care Plan for transfers. During interview on 9/18/18 at 1:30 p.m. the Administrator stated Resident #13 went on the activity because her husband wanted her to go. The facility had asked their daughter and she agreed if her Dad wanted her to go she should go. He stated he does not think the thought of toileting the resident out of the facility was even thought about. During interview on 9/19/18 at 8:15 a.m. the ADON stated at the time of the incident the facility did not have a policy in place for residents requiring hoyer transfers and going out of facility for activities. The facility provided a policy titled Resident	F 689		

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F 689	Continued From page 23 Outings created June 28, 2017, to ensure: a. Resident's safety on planned outings. b. Ensure resident's needs are met and Care Plans followed during planned outings.	F 689		
F 700 SS=D	Bedrails CFR(s): 483.25(n)(1)-(4) §483.25(n) Bed Rails. The facility must attempt to use appropriate alternatives prior to installing a side or bed rail. If a bed or side rail is used, the facility must ensure correct installation, use, and maintenance of bed rails, including but not limited to the following elements. §483.25(n)(1) Assess the resident for risk of entrapment from bed rails prior to installation. §483.25(n)(2) Review the risks and benefits of bed rails with the resident or resident representative and obtain informed consent prior to installation. §483.25(n)(3) Ensure that the bed's dimensions are appropriate for the resident's size and weight. §483.25(n)(4) Follow the manufacturers' recommendations and specifications for installing and maintaining bed rails. This REQUIREMENT is not met as evidenced by: Based on record review and staff interview, the facility failed to complete a siderail assessment and obtain signed consent for siderails for 1 resident reviewed with side rails (Resident #14). The facility reported a census of 31 residents. Findings include:	F 700		

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F 700	Continued From page 24 According to the Minimum Data Set (MDS) assessment, dated 7/9/18 Resident #14 demonstrated long and short term memory problems and severely impaired skills for daily decision making. The resident depended on staff for activities of daily living (ADL's) including bed mobility and transfer. The resident's diagnoses included non-Alzheimer's dementia. During an observation on 9/18/18 at 9:09 a.m. Staff H Certified Medication Aide/Certified Nursing Assistant (CMA/CNA) and Staff G Registered Nurse (RN) provided care. The resident had a side rail on each side of the bed. The clinical record lacked a side rail assessment or a signed consent for the use of side rails. During an interview on 9/19/18 at 9:20 a.m. the Director of Nursing (DON) stated she had not done a side rail assessment on the resident.	F 700		
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 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.	F 729		

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F 729	Continued From page 25 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 file review and staff interview, the facility failed to verify certification prior to hire for 1 of 5 nursing assistants reviewed (Staff D). The facility reported a census of 31 residents. Findings include: An Employees Hired Since 6/12/17 form provided by the facility documented Staff D Certified Nursing Assistant (CNA) hired 7/11/17. The staff's personnel file lacked verification of her CNA certification prior to hire. A Direct Care Worker Registry Search showed verification on 7/31/18.	F 729		

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F 729	Continued From page 26 During an interview on 9/19/18 at 1:55 p.m. the Office Manager stated they did not have record of verifying the staff certification prior to her hire.	F 729		

This constitutes Titonka Care Center's allegation of compliance:

F 567 Protection of Personal Funds

Titonka Care Center will continue to safeguard resident funds for residents that chose to deposit personal funds to be held by the facility. Resident #15 financial funds were removed from the office on 9/26/18. Business office manager had resident #15 sign a verification statement that funds were removed.

Regarding all similarly situated residents, Administration has approved for residents choosing to have the facility safeguard personal funds in the amount of $40 or less may be in the business office.

The business office or Designee will manage resident's personal funds do not exceed $40 or more in the office through periodic audits. The results of audits will be reviewed by the Administrator and through QAPI committee.

Compliance date : 10/22/18

F 580 Notification of Changes

Resident #6 spouse was updated on resident weight and supplementation orders.

For all similarly situated resident's resident or Legal representative will be notified of significant changes in weight and new order for supplementation.

A system is being enacted for new orders regarding weight change with supplementation to have nurse place a sticker on the order to document proper noting of physician order. A copy of the order will have a double check completed by DON, or designee that family notification has been provided.

Nurses will receive education on new system by 10/22/18.

DON or Designee will audit that resident/legal representative notification regarding significant weight changes and new orders for supplementation are completed. Audits will be reviewed through the QAPI Committee.

Compliance date: 10/22/18

F 607 Development/Implement Abuse/Neglect Policies

Titonka Care Center will continue to prohibit and prevent abuse and neglect. Employee D had a Single Contact License and Background Check (SING) completed 7/17/17. Employee E had a Single Contact License and Background Check (SING) completed 8/15/17. No abuse was noted after the SING checks were completed.

For all similarly situated residents, the facility abuse policy regarding criminal background checks and dependent adult abuse checks will be followed.

Business Office Manager will be required to utilized a hire checklist starting 10/22/18.

Business Office Manager or Designee will monitor that all new potential employees have criminal background and dependent adult abuse check prior to hire.

Compliance date: 10/22/18

F 623 Notice of Requirements Before Transfer/Discharge

For resident's #8 and #28, The Long-Term Care Ombudsman Office was updated on the resident discharge dates on 9/26/18 by the Business Office Manager.

The directions for use of the Long-Term Care Ombudsman form state the form it to be submitted to the Ombudsman office at the end of each month..

The Administrator or Designee will provide audits through the QAPI program on a periodic basis to ensure proper notification of the LTC Ombudsman office on a monthly basis. Results of audits will be reviewed by the QAPI Committee.

Compliance date 10/22/18

F 625 Notice of bed-hold policy and return.

For resident's #8, #24, #28 and all similarly situated residents a notice of bed-hold will be addressed when a resident discharge's to the hospital.

9/24/18 the facility developed a bed hold form. An education in-service was done on 10/4/18 to educate nurses regarding the bed hold notice form.

The Director of Nursing or Designee will audit weekly times four, then randomly, proper use of bed hold form. Audits completed will be reviewed through the QAPI committee

Compliance date: 10/22/18

F 655 Baseline Care Plan

Titonka Care Center ensure use of a baseline care plan.

Regarding resident #6, care plan coordinator met with spouse on10/15/18 to review the baseline care plan and offered a copy of the baseline care plan.

For similarly situated residents a baseline care plan will be developed within 48 hours of admission. The resident or legal representative will be given a care plan summary.

On 9/20/18 the baseline care plan form was revised with a resident/legal representative signature line and a verification statement they received a copy of the baseline care plan.

Director of Nursing or Designee will audit new admission x 4 weeks to ensure placement of baseline care plan and summary given to resident/legal representative. Audits will be reviewed through the QAPI committee.

Compliance date: 10/22/18

F 684 Quality of Care

For resident #14 and similarly situated residents, nurses will utilize the Behavior Monitoring/Intervention Flow Record Codes for behavior, precipitating Factor Codes, Intervention Codes, and outcomes of Interventions as part of behavioral documentation on the medication administration record prior to administration of anti-anxiety medication.

Nurses will be re-educated on proper documentation using the behavior Monitoring/Intervention Flow Record prior to administration of a anti-anxiety medication by 10/22/18.

Director of Nursing or Designee will perform weekly audits times four, then random audits on PRN anti-anxiety medication use documentation. Results of audits will be reviewed through the QAPI Committee.

Compliance date: 10/22/18

F 689 Free of Accident/Hazards/Supervision/Devices

Resident #13 returned to her previous level of function. The two employees involved in the incident received verbal counseling between 6/27 – 6/28/17.

Titonka Care Center identified there was no procedure in place to guide activity outings in regard to residents requiring mechanical lift transfers. Regarding resident #13 and all similarly situated residents, 6/28/17 a procedure was developed to address resident outings for resident needing mechanical lift transfers. Titonka Care Center respectfully upholds the resident's rights to attend activities.

On 6/28/18 education on the new procedure was provided to all activity personnel.

The Director of Nursing did QAPI audit 9/25/18 and the facility was in compliance with the new procedure. The Director of Nursing of designee will continue to provide random audits and results will be reviewed through the QAPI committee.

Compliance date: 10/12/18

F 700 Side Rails

Resident #14 had a side rail assessment and consent completed on 9/19/18 with resident's son.

For all similarly situated residents a side rail assessment will be completed upon admission and with each Comprehensive MDS starting 10/22/18.

Nursing Admission checklist was updated to include side rail assessment and consent for day of admission.

Nurses will be educated on the new admission checklist by 10/22/18.

The DON or Designee will audit weekly times four and then randomly, that all resident's using side rails have a side rail risk assessment and consent upon admission.

Compliance date: 10/22/18

F 729 Nurse Aide Registry, Verification, Retraining

Employee D had verification of Direct Care Worker Registry completed on 7/31/18.

Business Office Manager will complete Direct Care Worker Registry check prior to hire for all C.N.A.'s.

Business Office Manager will be required to utilize a new employee checklist started 10/22/18

Administrator or Designee will complete QAPI audits that the checklist is effective in ensuring Direct Care Worker Registry checks are completed prior to hire.

Compliance date: 10/22/18

Joseph Jaumann

Administrator
Titonka Care Center