STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	165157	A. BUILDING _____ B. WING _____	11/01/2018

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SIOUX CENTER HEALTH ROYALE MEADOWS	1400 7TH AVENUE SE SIOUX CENTER, IA 51250

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F 000	INITIAL COMMENTS Correction Date: 11-30-18 The following deficiencies are the result of the recertification survey completed on 10/29/18-11/1/18 and investigation of complaint #78725-C and Incident #77160-I, for which were both substantiated. (See Code of Federal Regulations (42CFR) Part 483, Subpart B-C.)	F 000		11-30-18 PG
F 550 SS=D	Resident Rights/Exercise of Rights CFR(s): 483.10(a)(1)(2)(b)(1)(2) §483.10(a) Resident Rights. The resident has a right to a dignified existence, self-determination, and communication with and access to persons and services inside and outside the facility, including those specified in this section. §483.10(a)(1) A facility must treat each resident with respect and dignity and care for each resident in a manner and in an environment that promotes maintenance or enhancement of his or her quality of life, recognizing each resident's individuality. The facility must protect and promote the rights of the resident. §483.10(a)(2) The facility must provide equal access to quality care regardless of diagnosis, severity of condition, or payment source. A facility must establish and maintain identical policies and practices regarding transfer, discharge, and the provision of services under the State plan for all residents regardless of payment source.	F 550		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE 11/30/2018

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 550	Continued From page 1 §483.10(b) Exercise of Rights. The resident has the right to exercise his or her rights as a resident of the facility and as a citizen or resident of the United States. §483.10(b)(1) The facility must ensure that the resident can exercise his or her rights without interference, coercion, discrimination, or reprisal from the facility. §483.10(b)(2) The resident has the right to be free of interference, coercion, discrimination, and reprisal from the facility in exercising his or her rights and to be supported by the facility in the exercise of his or her rights as required under this subpart. This REQUIREMENT is not met as evidenced by: Based on record review, observation, and staff interview, the facility failed to maintain dignity for 2 of 3 residents reviewed with a catheter (Resident's #44 and #67). The facility reported a census of 66 residents. Findings include: 1. The Minimum Data Set (MDS) resident assessment, dated 9/21/18, documented Resident #44 moderately impaired cognition, required extensive staff assistance with bed mobility, totally dependent of staff for transfers, had not walked, and had an indwelling catheter. The MDS revealed the resident's diagnoses included diabetes, anxiety, depression, and bipolar depression. The resident's Plan of Care-Bowel and Bladder, revised on 9/25/18 and with a target date of 1/4/19, documented the resident had and	F 550		

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F 550	Continued From page 2 indwelling catheter due to neuromuscular dysfunction of the bladder. Interventions directed staff to monitor the resident for symptoms of a urinary tract infection, offer fluids, and lacked any intervention directed to the use of a privacy bag for the urine collection bag. During an observation 10/30/18 at 7:58 a.m., the resident sat in the dining room eating breakfast. Observation revealed the resident's urine collection bag hanging under the wheel chair the resident sat in without a privacy bag. The privacy bag contained urine. 2. The minimum data set (MDS) assessment dated 10/12/18 for Resident #67 recorded a BIMS (Brief Interview for Mental Status) score of 7 indicative of severe cognitive impairment. The MDS assessment identified diagnoses that included peripheral vascular disease, diabetes mellitus, dementia, and prostate cancer. The assessment revealed the resident totally dependent on 2 persons for transfers and toilet use, and extensive assistance 2 persons for bed mobility and dressing. The MDS further documented the resident with indwelling urinary catheter, The care plan-activities of daily living revised on 2/22/18 directed staff resident has indwelling catheter. Observation on 10/29/18 at 11:40 AM Resident #67 observed in dining room prior to meal service. Urinary catheter collection bad attached to wheelchair not in privacy bag. Further observation on 10/31/18 Staff (W), Certified Nursing Assistant provided catheter care. Urine collection bag, white on one side, and clear on the front side with urine visible. Collection bag	F 550		

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F 550	Continued From page 3 attached to wheelchair, resident prepared to leave room. Staff (W), CNA reported the resident is to have urine collection bag covered with privacy cover, and admitted the resident doesn't have in room but will go to laundry and obtain one. In an interview on 10/31/18 at 2:00 PM Staff A, Registered Nurse (RN) informed no policy at facility that directed the use of privacy bags for urinary catheter collection bags, however would expect all staff to use a privacy cover at all times for dignity	F 550		
F 561 SS=D	Self-Determination CFR(s): 483.10(f)(1)-(3)(8) §483.10(f) Self-determination. The resident has the right to and the facility must promote and facilitate resident self-determination through support of resident choice, including but not limited to the rights specified in paragraphs (f)(1) through (11) of this section. §483.10(f)(1) The resident has a right to choose activities, schedules (including sleeping and waking times), health care and providers of health care services consistent with his or her interests, assessments, and plan of care and other applicable provisions of this part. §483.10(f)(2) The resident has a right to make choices about aspects of his or her life in the facility that are significant to the resident. §483.10(f)(3) The resident has a right to interact with members of the community and participate in community activities both inside and outside the facility.	F 561		

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F 561	Continued From page 4 §483.10(f)(8) The resident has a right to participate in other activities, including social, religious, and community activities that do not interfere with the rights of other residents in the facility. This REQUIREMENT is not met as evidenced by: Based on clinical record review and staff interview, the facility administered as needed medications to three residents prior to 6:00 a.m., when most persons in our society consider the hours between 10:00 p.m. and 6:00 a.m., as normal sleep hours. The facility census was 66 residents. (Resident #27, #9 and #52) Findings include: 1. The Minimum Data Set (MDS) assessment reference dated 8/31/18, documented Resident #27 had diagnosis for which included anemia, heart failure, hypertension, syncope and collapse. The MDS documented the resident with Brief Interview for Mental Status (BIMS) score of 12, moderately impaired decision making abilities. The MDS assessment documented the resident required limited to extensive assistance with personal hygiene, toileting, transfers and bed mobility. The physicians orders sheet signed and dated by the physician on 10/21/18, documented an order for Dulcolax 10 milligrams (mg) suppository rectally daily as needed for constipation. The medication administration record (MAR) dated with no date, documented the resident had an order for a Bisacodyl 10 milligram (mg) suppository, insert one suppository rectally every	F 561		

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F 561	Continued From page 5 day as needed for constipation. The MAR, documented the resident received a Bisacodyl suppository on 5/16/18 at 4:51 a.m. 2. The MDS assessment reference dated 8/3/18, documented Resident #9 with diagnosis which included Alzheimer disease, Multiple Sclerosis, depression, and Schizophrenia. The MDS documented the resident with a BIMS score of 7, for which indicates severe cognitive abilities, and required extensive assistance with all aspect of Activities of Daily Living. The physicians order dated and signed on 10/10/18, documented Bisacodyl suppository 10 milligrams (mg) rectal, as needed for constipation. The MAR documented Bisacodyl suppository 10 milligrams 1 rectally for constipation on the following date and times: 10/27/18 at 5:01 a.m. 5/27/18 at 5:06 a.m. 5/17/18 at 4:59 a.m. 5/3/18 at 4:52 a.m. 4/30/18 at 4:58 a.m. 3/15/18 at 4:37 a.m. 3/7/18 at 5:00 a.m. 3/4/18 at 4:43 a.m. 2/19/18 at 5:21 a.m. 3. The MDS with an assessment reference dated 9/28/18, documented Resident #52 with diagnosis for which included Benign Prostatic Hyperplasia, diabetes mellitus and chronic pain. The MDS documented the resident with a BIMS score of 14, for which indicated cognitively intact and documented the resident with independent to	F 561		

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F 561	Continued From page 6 limited assistance with activities of daily living. The Physicians order sheet signed and dated by the physician on 10/21/18, ordered Dulcolax suppository 10 mg rectally on an as needed basis rectally for constipation. The MAR documented the Dulcolax suppository given on this date and time: *9/25/18 at 4:30 a.m. Interview on 10/30/18 at 6:15 a.m. Staff D (Nursing) and Staff I (Nursing) stated that the suppositories are given before 6:00 a.m., so that the residents don't have an accident at the dining room table during breakfast. Interview on 10/31/18 at 7:20 a.m., Staff J (clinical nurse manager), stated that the expectation of the nursing staff is to give the suppositories after 6:00 a.m. Interview on 10/31/18 at 7:41 a.m., the facility director of nursing stated that the expectation of the nursing staff is to give the suppositories after 6:00 a.m.	F 561		
F 582 SS=D	Medicaid/Medicare Coverage/Liability Notice CFR(s): 483.10(g)(17)(18)(i)-(v) §483.10(g)(17) The facility must-- (i) Inform each Medicaid-eligible resident, in writing, at the time of admission to the nursing facility and when the resident becomes eligible for Medicaid of- (A) The items and services that are included in nursing facility services under the State plan and for which the resident may not be charged; (B) Those other items and services that the	F 582		

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F 582	Continued From page 7 facility offers and for which the resident may be charged, and the amount of charges for those services; and (ii) Inform each Medicaid-eligible resident when changes are made to the items and services specified in §483.10(g)(17)(i)(A) and (B) of this section. §483.10(g)(18) The facility must inform each resident before, or at the time of admission, and periodically during the resident's stay, of services available in the facility and of charges for those services, including any charges for services not covered under Medicare/ Medicaid or by the facility's per diem rate. (i) Where changes in coverage are made to items and services covered by Medicare and/or by the Medicaid State plan, the facility must provide notice to residents of the change as soon as is reasonably possible. (ii) Where changes are made to charges for other items and services that the facility offers, the facility must inform the resident in writing at least 60 days prior to implementation of the change. (iii) If a resident dies or is hospitalized or is transferred and does not return to the facility, the facility must refund to the resident, resident representative, or estate, as applicable, any deposit or charges already paid, less the facility's per diem rate, for the days the resident actually resided or reserved or retained a bed in the facility, regardless of any minimum stay or discharge notice requirements. (iv) The facility must refund to the resident or resident representative any and all refunds due the resident within 30 days from the resident's date of discharge from the facility. (v) The terms of an admission contract by or on	F 582		

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F 582	Continued From page 8 behalf of an individual seeking admission to the facility must not conflict with the requirements of these regulations. This REQUIREMENT is not met as evidenced by: Based on record review and staff interview, the facility failed to provide appropriate notifications on discharge from medicare services for 2 of 3 residents reviewed (Resident #67 and #500). The facility reported a census of 66 residents. Findings include: 1. An SNF Beneficiary Protection Notification Review documented Resident #67 started Part A skilled services on 2/22/18 with the last covered day 3/26/18. The review indicated the resident and/or resident representative received an SNFABN/10055, but lacked identification of the receipt of the NOMNC/10123. The review lacked a reason for not providing the notice. The residents record lacked any SNF ABN/10055 or NOMNC/10123 forms with the residents right to appeal 2. An SNF Beneficiary Protection Notification Review documented Resident #500 started Part A skilled services on 10/9/17 with the last covered day 10/18/17. The review indicated the resident and/or resident representative received an SNF ABN/10055, but lacked identification of the receipt of the NOMNC/10123. The review lacked a reason for not providing the noticed. The resident's record contained an SNFABN/10055, but did not contain an NOMNC/10123 with the resident's rights to appeal.	F 582		

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F 582	Continued From page 9 During an interview on 11/1/18 at 11:08 a.m. the Administrator stated that the clinical record lacked any documentation of the forms being submitted to the families.	F 582		
F 656 SS=E	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.	F 656		

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F 656	Continued From page 10 (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 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 record review and staff interview, the facility failed to document in the care plan potential adverse side effects for psychotropic medications for 5 of 5 residents reviewed for psychotropic medication (Residents #3, #6, #12, #8 and #67). The facility reported a census of 66 residents. Findings include: 1. The Minimum Data Set (MDS) assessment, dated 10/24/18, documented Resident #3 with severely impaired cognition. A Medication Administration Record with a run date of 10/31/18 documented the resident received Risperdal (an antipsychotic) 0.25 mg. (milligrams) daily at 7:00 p.m. and Zoloft (an antidepressant) 100 mg. daily at 6:00 a.m. The resident's Plan of Care-Psychotropics, with a revision date of 10/24/18, documented the resident's diagnoses included major depression and anxiety, received Risperdal and Zoloft, and directed staff to monitor the resident for side effects of the medications. The care plan lacked documentation of actual potential adverse	F 656		

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F 656	Continued From page 11 reactions for the medications. During an interview 10/31/18 at 12:44 p.m., Staff E and Staff F Certified Nurse's Aides (CNA) stated when they needed to know if the resident received psychotropic medications and their adverse effects they checked the resident's care plan. Both staff checked the electronic record care plan and verified the care plan lacked documentation of the side effects for psychotropic medications. Staff E stated the CNA's need to inform the nurse of any changes seen with residents. During an interview 10/31/18 at 4:28 p.m., Staff A, Clinical Coordinator, verified psychotropic medications had no adverse side effects listed on care plans. 2. The MDS assessment, dated 10/19/18, documented Resident #6 with moderately impaired cognition. A Medication Administration Record with a run date of 10/31/18 documented the resident received Celexa (an antidepressant) 10 mg. daily at 6:00 a.m. The resident's Plan of Care-Psychotropics, with a revision date of 10/23/18, documented the resident had diagnoses of depression and anxiety and received Celexa. The care plan directed staff to monitor the resident for side effects of the Celexa and failed to document actual potential adverse side effects of the medication. 3. The MDS assessment, dated 8/23/18, documented Resident #12 with severely impaired cognition.	F 656		

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F 656	Continued From page 12	F 656		

A Medication Administration Record with a run date of 10/31/18 documented the resident received Lorazepam 0.5 mg. twice daily (same as Ativan and used for anxiety), ABHR topically 3 times daily, Risperdal (an antipsychotic) 0.5 mg, daily at bedtime, and Trazodone (an antidepressant) 50 mg at bedtime. An order signed by the physician 2/24/18 directed staff to administer ABHR 1 ml. (milliliter) topically 3 times daily. A Hospice Standing Orders/Comfort Kit, dated 3/18, documented ABHR included Ativan 1mg., Benadryl (an antihistamine that can cause drowsiness) 12.5 mg., Haldol 2 mg. (an antipsychotic), and Reglan 10 mg. (used to treat slow motility in the intestines).

The resident's Plan of Care-Psychotropics, with a revision date of 10/29/18, documented the resident received Trazodone, Risperdal, ABHR, and Ativan and directed staff to monitor and document side effects of the medications. The care plan failed to document actual adverse side effects of the medications.

4.The minimum data set (MDS) assessment dated 10/12/18 for Resident #67 recorded a BIMS (Brief Interview for Mental Status) score of 7 indicative of severe cognitive impairment. The MDS assessment identified diagnoses that included peripheral vascular disease, diabetes mellitus, dementia, anxiety and prostate cancer. The MDS documented the resident received an antipsychotic, antianxiety, and an antidepressant in the last 7 days.

Resident #67's Physician Order Sheet dated 9/25/18 included Effexor-XR (antidepressant)

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F 656	Continued From page 13 37.5mg daily, and ABHR (Ativan-Benadryl-Haldol-Reglan) 1ml topically three times a day. The Care Plan-Psychotropic identified a problem medication side effects related to psychotropic use (Effexor XR and ABHR) initiated on 2/28/18 with an intervention which directed staff to monitor for and document side effects of the medications. The Care Plan failed to identify specific side effects to monitor. 5. The minimum data set (MDS) assessment dated 8/3/18 for Resident #8 recorded a BIMS (Brief Interview for Mental Status) score of 5 indicative of severe cognitive impairment. The MDS assessment identified diagnoses that included dementia, anxiety and depression. The MDS documented the resident received an antipsychotic, antianxiety, and an antidepressant in the last 7 days. Resident #8's Physician Order Sheet dated 9/25/18 included Buspar (antidepressant) 7.5mg twice daily, Lexapro (antidepressant) 20mg daily, and ABHR (Ativan-Benadryl-Haldol-Reglan) 1ml topically three times a day, and Clonazepam (prevent seizures) 0.5mg twice a day. The Care Plan-Psychotropic identified a problem medication side effects related to psychotropic use (antidepressant, ABHR, and clonazepam usage) initiated on 12/6/16 with an intervention which directed staff to monitor for and document side effects of the medications. The Care Plan failed to identify specific side effects to monitor.	F 656		

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F 656	Continued From page 14	F 656		
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 observation, clinical record review, and facility policy and procedure and staff interview, the facility failed to provide complete and proper incontinence care for one resident reviewed. (Resident #9). The facility reported a census of 66 residents. Findings include: 1. The MDS assessment reference dated 8/3/18, documented Resident #9 with diagnosis which included Alzheimer disease, Multiple Sclerosis, depression, and Schizophrenia. The MDS documented the resident with a BIMS score of 7, for which indicates severe cognitive abilities, and required extensive assistance with all aspect of Activities of Daily Living. The MDS assessment documented the resident as frequently incontinent of bladder. The Care Plan with a bladder incontinence focus area dated as initiated on 1/19/17 identified the resident as incontinent two or more times a week, use of brief/pads and refusal to toilet. Intervention include:	F 677		

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F 677	Continued From page 15 a. Good peri care twice daily and as needed as resident allows. b. Toileting plan, prompt toileting as resident allows. If refuses, do check and change protocol. c. Provide positive reinforcement when allowing staff to toilet. During an observation on 10/31/18 at 9:14 a.m., Staff M (certified nursing assistant) and Staff J (certified nursing assistant) proceeded to provide incontinent care on the resident. Staff M cleansed the resident peri area using a wet wash cloth, repeatedly utilized a front to back motion with the same wash cloth in the resident groin area, and across the abdomen. Staff M failed to fold the wash cloth to expose a clean surface or obtain a new washcloth. Continued observation Staff M proceeded to take another clean wet wash cloth and proceeded to cleanse the resident coccyx area, again with a scrubbing motion went from distal to proximal and failed to fold the wash cloth to expose a clean surface or obtain a new washcloth. Staff M confirmed the resident's brief was soiled, stating that the strip down the middle of the brief turns blue when the resident is soiled with urine. The Incontinent Care Policy with a revision dated 1/10, instructed staff to: 1. Put on gloves 2. Provide privacy and explain procedure to resident 3. Remove soiled pads, clothing and linens 4. Remove gloves if soiled and replace with clean gloves. 5. Place towel and clean incontinent pad under perineum 6. Men: cleanse penis by pushing back foreskin and gently wash around penis and	F 677		

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F 677	Continued From page 16 scrotum 7. Turn resident to side and wash buttocks and upper thighs. 8. Wash rectal area 9. Using a clean cloth or disposable wipes, rinse thoroughly 10. Dry thoroughly and remove towel from under perineum	F 677		
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, staff interview, and policy for bowel management, the facility failed to provide care in a manner to assist the resident to meet the highest practice physical, mental, and psychosocial well-being needs for 1 of 17 active residents reviewed (Resident #29). The facility reported a census of 66 residents. Findings include: The Minimum Data Set (MDS) assessment tool,dated 8/31/18, documented Resident #29 with moderately impaired cognition, required limited assistance for bed mobility, transfers, and personal hygiene, extended staff assistance for toilet use, and frequent bowel and bladder	F 684		

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F 684	Continued From page 17 incontinence. The MDS revealed the resident's diagnoses included Alzheimer's disease, non-Alzheimer's disease, and vertebral disc degeneration. Emergency Room Visit Notes, dated 10/23/18, documented the resident had a fall at the facility, had left hip and low back pain, and had been transferred to the hospital where she remained until 10/25/18. A Computed Tomography-Diagnostic Imaging report, dated 10/23/18, revealed the resident had a slightly displaced acute fracture of the left superior and inferior pubic rami, medical aspect. Resident Physician Orders, dated 10/25/18, for facility readmission directed staff the resident to use a walker for left arm support, stand/pivot transfers, no ambulation, stand aide when needed, resume previous medications, and administer Oxycodone/Acetaminophen 5 mg. (milligrams/325 mg. one to two tablets every 4 hours when needed for pain. A hospital Bowel Record revealed the resident had a bowel movement (BM) on 10/25/18. A facility Bowel Record revealed the resident had no BM from 10/25/18 until 10/30/18. The resident's Medication Administration Record with a run date 10/30/18 directed staff to administer Milk of Magnesia 30 ml (milliliter) daily when needed for constipation (start date 12/21/17) and 10/31/18 at 6:00 p.m. The resident's Edit Medication Administration Record documented the resident received Milk of	F 684		

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F 684	Continued From page 18 Magnesia on 10/28/18, day 3 following a BM and not again until 10/30/18. The resident's Edit Medication Administration Record documented the resident received a Bisacodyl suppository on 10/30/18, the 5th day following the resident's BM. The resident's Edit Medication Administration Record documented the resident received a Fleet enema 135 ml on 10/30/18 at 9:15 p.m. During an interview 10/31/18 at 6:00 p.m., Staff R, RN (Registered Nurse), stated a CAN (Certified Nurse's Aide), verbally informed her that the resident had been on the commode the evening of 10/30/18 and expelled 4 hard balls of stool. A facility List Resident Notes entry, dated 10/30/18 at 11:38 p.m. documented a Fleet enema given at 8:30 p.m. and the resident had no results. Emergency Room Visit Notes, dated 10/31/18 documented the facility transferred the resident to the hospital with increasing pain, no BM for a week, not eating well, and the facility concerned about the resident's left pelvis pain that worsens when up. A Radiology report dated 10/23/18 revealed the resident had an ileus, minimal stool in the colon, and results indicated a non-obstructive bowel gas pattern with a mild ileus. During an interview, 11/1/18 at 7:00 a.m. Staff A, Clinical Coordinator, verified staff failed to give the Milk of Magnesia on the second day after a BM and gave the medication on the 3rd and 5th	F 684		

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F 684	Continued From page 19 days after a BM on 10/25/18. Staff A stated the staff had no order to give a Bisacodyl suppository until 10/30/18. During an interview 11/01/18 01:30 PM, the DON (Director of Nursing) stated she expected staff to call for a Dulcolax order for a resident without an order on day 3 after a BM. The facility Bowel Management policy, revised 6/18 directed staff the following: a. When no BM by day 2 give an oral laxative according to the physician's order. b. When no BM by day 3 administer a Dulcolax (same as Bisacodyl) or Glycerin suppository according to physician's orders. c. When no BM by day 4, nurse needs to complete abdominal assessment and notify the physician of any abnormal findings. d. When no BM by day 5, the staff need to notify the physician.	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. This REQUIREMENT is not met as evidenced by:	F 689		

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F 689	Continued From page 20 Based on observation, clinical record review, and staff interviews, the facility failed to ensure residents received adequate supervision to protect against accidents. Clinical record review and staff interviews revealed the facility failed to provide a safe method of transfer for Resident #64. Resident #64 fell and sustained non-displaced fractures of the bones in the left and right feet when staff failed to use a gait belt during transfer. Clinical record review and resident and staff interviews additionally revealed the facility failed to evaluate the ability of Resident #50 to safely operate a power mobility device in the facility which resulted in a fall with major injury to Resident #29, when struck by Resident #50 while operating the mobility device. Additionally, the medication cart was unsecured and unattended in a resident care area. The facility reported a census of 66 residents. Findings include: 1. The Minimum Data Set (MDS) assessment with a reference date of 4/27/18 for Resident #64 identified a Brief Interview for Mental Status (BIMS) score of 14 indicative of intact cognition. According to the MDS, the resident required the extensive assistance of one staff for transfers, bed mobility and personal hygiene, toilet use and dressing. A balance during transition and walking test identified the resident as not steady but able to stabilize without staff assistance when moving from a seated to standing position. The MDS further identified no functional limitation in range of motion on both lower and upper extremities. The resident had diagnosis that included osteoarthritis, diabetes and hypertension. The MDS further identified the resident normally used a wheelchair (manual or electric) mobility device.	F 689		

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F 689	Continued From page 21 A resident note dated 7/5/18 at 9:54 AM documented CNA (Certified Nursing Assistant) transferred resident from bed to commode, resident lost her balance and her left arm slipped on the armrest and the CNA lowered her to the ground. Gaitbelt was not utilized. A provider notification note communicated the resident had a fall 7/5/18 at 7:05 AM, the resident complains of middle right foot pain. The physician documented Left foot 3rd -5th distal intratarsal fracture, and Right for 2nd metatarsal fracture. Resident returned to the facility with an order for no weight bearing on either foot re-X-ray in one month A Radiology report dated 7/5/18 diagnosed: a nondisplaced fracture of the left distal 3rd, 4th and 5th metatarsals (foot bones) and nondisplaced fracture of the proximal metaphysis first distal phalanx (foot bones). A document titled Care Practice Standards directed gait belt will be used for all assistive transfers and ambulation as a safety measure. The fall care plan for the resident dated as initiated on 12/16/16 directed assist of one with walker for all transfers/ambulation, A Fall Risk Assessment dated 4/30/18 documented the resident scored 15, a score of 10 or more indicated a high risk for falls and identified gait belt as a safety device. A document titled 2018 Staff Feedback documented Staff B, CNA educated on 7/5/2018 to use gait belt for all transfers and documented on 8/6/2018 staff in-service included discussion of gait belt expectations.	F 689		

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F 689	Continued From page 22 In an interview on 10/29/18 at 2:30 PM the Director of Nursing (DON) confirmed the staff failed to use a gait belt when the resident transferred on 7/5/18 which resulted in a fall with injury. The DON confirmed facility expectation to use a gait belt with all assist transfers for safety and to prevent falls. 2. The Minimum Data Set (MDS) assessment with a reference date of 9/28/18 for Resident #50 identified a Brief Interview for Mental Status (BIMS) score of 15 indicative of intact cognition. According to the MDS, the resident required the limited assistance of one staff for transfers, bed mobility and personal hygiene and independent for walk in room and locomotion on and off the unit. A balance during transition and walking test identified the resident as not steady but able to stabilize without staff assistance when walking and turning around and facing the opposite direction while walking. The MDS further identified functional limitation in range of motion on both sides for upper extremities. The resident had diagnosis that included osteoarthritis, anxiety and hypertension. The MDS further identified the resident normally used the following mobility devices: a walker and wheelchair (manual or electric). An event note dated 10/23/18 at 10:50 AM documented facility staff witnessed Resident #29 walking back from an activity and was hit from behind by Resident #50 driving an electric scooter. Resident #29 fell to the floor hitting her left side, the resident was seen in the emergency room due to her injuries where an X-ray report dated 10/23/18 revealed a pelvic fracture.	F 689		

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F 689	Continued From page 23 In an interview on 10/30/18 at 9:44 AM the Director of Nursing (DON), stated the facility had failed to evaluate Resident #50's ability to safely operate the power mobility device prior to the incident on 10/23/18, and further stated the facility failed to have a policy that addressed assessment of resident ability to safely operate a power mobility device. The DON clarified the facility only assessed ability if need identified. The DON admitted that after the incident she had been made aware that Resident #50 had previously run into to the wall with power mobility device which required repair by maintenance, but confirmed this had not been reported or investigated. The DON further stated the power mobility device had been removed from the resident until settings on mobility device were adjusted, and the resident was evaluated with the new settings. Further interview with the DON on 10/30/18 at 2:30 PM revealed she had further questioned staff and was now aware that on 10/12/18 Resident #50 had been observed running into a nurse's foot at the flu clinic, and had also become aware staff had observed the resident running into table legs at the dining table. The DON stated would have expected staff to report these observations and concerns when made aware of or witnessed. Additionally, the DON confirmed aware Resident #50 had purchased a new mobility device on 6/7/18 and again admitted the resident had not been assessed for ability to safely operate new equipment and acknowledged facility responsibility to determine to provide a safe environment for residents. The DON provided a proposed policy that would require assessment of residents ability to safely operate power mobility devices, this had not been formally approved, however the DON stated had now assessed	F 689		

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F 689	Continued From page 24 Resident #19 and Resident #40 who also have power mobility devices at the facility. A care plan intervention dated as initiated 11/28/16 directed Resident #50 used an electric wheelchair independently outside the room for longer distances. In an interview on 10/30/18 at 9:05 AM Resident #50 stated she had an accident with her scooter last week and the facility had taken away. Reported she would need to go to therapy to be evaluated for safety before can get back. Stated she had run into another resident on the way back from an activity when the other resident stopped in front of her and she couldn't get stopped in time. A PT (Physical Therapy) evaluation dated 10/24/18 documented a visit for assessment of scooter safety. The evaluation documented the resident had run into another resident causing that resident to fall resulting in a fracture. The evaluation identified a safety concern after tested the residents reaction time, specifically:1 second response time from a stop to command to go, however a 3 second response time when the resident was in motion and given the command to stop until the scooter actually stopped. 2. Observation on 10/30/18 at 9:16 a.m., revealed an unlocked an unattended medication cart on Pod C, inside the medication cart revealed the following resident items: oral medications insulin pens lancets scissors inhalers	F 689		

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F 689	Continued From page 25 eye drops During an interview on 10/30/18 at 9:20 a.m., Staff H (nursing) confirmed and verified that the medication cart needed to be locked at all times and proceeded to lock the medication cart.	F 689		
F 756 SS=D	Drug Regimen Review, Report Irregular, Act On CFR(s): 483.45(c)(1)(2)(4)(5) §483.45(c) Drug Regimen Review. §483.45(c)(1) The drug regimen of each resident must be reviewed at least once a month by a licensed pharmacist. §483.45(c)(2) This review must include a review of the resident's medical chart. §483.45(c)(4) The pharmacist must report any irregularities to the attending physician and the facility's medical director and director of nursing, and these reports must be acted upon. (i) Irregularities include, but are not limited to, any drug that meets the criteria set forth in paragraph (d) of this section for an unnecessary drug. (ii) Any irregularities noted by the pharmacist during this review must be documented on a separate, written report that is sent to the attending physician and the facility's medical director and director of nursing and lists, at a minimum, the resident's name, the relevant drug, and the irregularity the pharmacist identified. (iii) The attending physician must document in the resident's medical record that the identified irregularity has been reviewed and what, if any, action has been taken to address it. If there is to be no change in the medication, the attending physician should document his or her rationale in the resident's medical record.	F 756		

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F 756	Continued From page 26 §483.45(c)(5) The facility must develop and maintain policies and procedures for the monthly drug regimen review that include, but are not limited to, time frames for the different steps in the process and steps the pharmacist must take when he or she identifies an irregularity that requires urgent action to protect the resident. This REQUIREMENT is not met as evidenced by: Based on record review and staff interview, the pharmacist failed to identify and notify the physician of potential medication irregularities for 1 of 5 residents reviewed for unnecessary medications (Resident #12). The facility reported a census of 66 residents. Findings include: The Minimum Data Set (MDS) assessment tool, dated 8/3/18, documented Resident #12 with severely impaired cognition, required extensive staff assistance for bed mobility, transfers, dressing, toilet use, and personal hygiene. The MDS revealed the resident had trouble falling or staying asleep, felt tired or had little energy, and without behaviors. The MDS documented the resident's diagnoses included anemia, arthritis, non-Alzheimer's dementia, chronic hypertensive chromic kidney disease, and an unspecified mood disorder, and had a weight loss of 5% or more in the previous month or 10% in the previous 6 months. The resident's Plan of Care-Psychotropic's, with a start date of 2/27/18 and revision date of 10/29/18, documented the resident received Trazodone, Risperdal, ABHR, and Ativan. The care plan directed staff to monitor and document	F 756		

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	165157	A. BUILDING _____ B. WING _____	11/01/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SIOUX CENTER HEALTH ROYALE MEADOWS	1400 7TH AVENUE SE SIOUX CENTER, IA 51250

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F 756	Continued From page 27 behaviors, reduce negative stimulus as able, offer diversional activities, involve hospice, the facility social worker, and hospice volunteers, and monitor and document side effects of the medications. A Medication Administration Record with a run date of 10/31/18 documented the resident received Lorazepam (same as Ativan and used for anxiety) 0.5 mg. twice daily and started 2/27/18, ABHR topically 3 times daily with a start date of 2/24/18, Risperdal (same as Risperidone and an antipsychotic) 0.5 mg, daily at bedtime and had a start date of 2/16/18, and Trazodone (an antidepressant) 50 mg at bedtime and had a start date of 2/16/18. An order signed by the physician 2/24/18 directed staff to administer ABHR 1 ml. (milliliter) topically 3 times daily. A Hospice Standing Orders/Comfort Kit, dated 3/18, documented ABHR included Ativan 1mg., Benadryl (an antihistamine that can cause drowsiness) 12.5 mg., Haldol 2 mg. (an antipsychotic), and Reglan 10 mg. (used to treat slow motility in the intestines). A Pharmacist Notes/Medication Review, dated 3/24/18, documented the resident's behaviors had improved since scheduled Ativan and ABHR administered. Record review lacked documentation the Consultant Pharmacist recognized the resident received duplicate medication therapy related to Lorazepam/Ativan (antianxiety medication) orally and topically and Haldol topically and Risperdal orally, both antipsychotics and that the physician was made aware of the duplicate therapies. A Consultant Pharmacist Communication to Physician sheet, dated 8/17/18, requested a	F 756		

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F 756	Continued From page 28 GDR (Gradual Dose Reduction) for psychotropic agents,Trazodone and Risperidone, and failed to document the resident received another antipsychotic, Haldol, topically. A Consultant Pharmacist Communication to Physician sheet, dated 10/17/18, requested a GDR the oral psychotropic medication Lorazepam and failed to document the resident also received the medication topically. During an interview 11/1/18 at 10:25 a.m., the Consultant Pharmacist stated she had a meeting a few months ago with the Medical Director and made a request for removal of the Haldol from the ABHR and the physician refused. The Consultant Pharmacist verified the resident's record lacked any documentation the resident received duplicate psychotropic medications.	F 756		
F 761 SS=D	Label/Store Drugs and Biologicals CFR(s): 483.45(g)(h)(1)(2) §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.	F 761		

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F 761	Continued From page 29 §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 observation and staff interview, the facility failed to date a multi dose vial of Tuberculin when opened and discard the vial within 28 days after opening. The facility reported a census of 66 residents. Findings include: Observation on 11/1/18 at 7:15 a.m. with Staff H, RN (Registered Nurse), revealed a medication store room refrigerator held a vial of Tuberculin for administration to resident's. The vial had an expiration date of 12/19 and had no open date written on the vial or box. The vial had a dispensation date of 8/13/18. Staff H stated she was unaware of how long a Tuberculin vial should remain available for administration once opened. During an interview on 11/1/18 at 7:37 a.m., the DON (Director of Nursing) verified the Tuberculin needed thrown away after opened 28 days. The DON presented a record that documented the Tuberculin administered to a resident on 9/25/18 and required discard on 10/23/18.	F 761		
F 812	Food Procurement,Store/Prepare/Serve-Sanitary	F 812		

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F 812 SS=E	Continued From page 30 CFR(s): 483.60(i)(1)(2) §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 observation and staff interview, the facility failed to serve food in a manner to prevent contamination during a meal service. The facility reported a census of 66 residents. Findings include: 1. During an observation on 10/30/18 at 7:45 a.m., Staff K (dietary aide) was in the kitchenette and wearing gloves. Staff K picked up a plate then proceeded touched the tin foil on the outside of the eggs, and then touch the egg as it came out of the tin foil, Staff K proceeded to pick up an orange slice from a plastic container and place on the resident plate, with the same pair of gloves Staff K touched the bottom of their shirt. During	F 812		

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F 812	Continued From page 31 the meal service Staff K touched another plate, handled a pair of tongues with their gloved hand, pick up another slice of orange with the same gloves and then place on the resident plate. Staff K proceeded to do this process for five resident then removed their gloves. Observation at 7:59 a.m. Staff K came back into the kitchenette and proceeded to wash their hands and put on another pair of purple gloves. Staff K took a couple slices of bread from a bag and placed inside the toaster, Staff K then touched a donut and edge of the plate. During an interview on 10/31/18 at 3:37 p.m. the Dietary Assistant Supervisor stated Staff K should not touch surfaces with gloves on and then touch food. The Dietary Assistant Supervisor provided a paper stating, If you wear gloves...Gloves are never a substitute for handwashing. If you regularly use gloves during food handling, keep the following in mind: *Always wash your hands prior to putting on gloves and whenever you change to a new pair. *Gloves are single-use items and should never be washed or reused. *Change your gloves before beginning a new task or if they become torn. *Remember that gloves should be change after any of the activities that would normally require handwashing. *Many people are allergic to latex, so vinyl or another material is preferable. *Gloves must be worn if the food handler has a bandage on their hand. According to the FDA 2013 Food Code 3-304.15, if used, single use gloves shall be used for only	F 812		

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F 812	Continued From page 32 one task such as working with ready to eat food or with raw animal food, used for no other purpose, and discarded when damaged or soiled, or when interruptions occur in the operation.	F 812		
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 33 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 observation, record review, staff interview, and the Infection Control policy, staff failed to maintain infection control practices to provide a safe, sanitary, and comfortable environment and to help prevent the development	F 880		

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F 880	Continued From page 34 and transmission of communicable diseases and infections for 5 residents review, (Residents #46, #42, #33, #9, #39). The facility reported a census of 66 residents. Findings include: 1. The Minimum Data Set (MDS) assessment tool, dated 9/21/18, documented Resident #46 with short and long term memory impairment, had a diagnosis of cerebral palsy, and had a feeding tube for nutrition and fluids. Emergency Room Visit Notes from 10/29/18 and electronically signed by the physician on 10/31/18 directed staff to administer Amoxicillin/Potassium Clavulanate 400 mg (milligrams/57 mg. 5 ml Suspension (same as Augmentin, an antibiotic) to the resident twice daily for 9 days. During an observation 10/30/18 at 5:40 p.m., Staff D, LPN (Licensed Practical Nurse), approached the medication cart to set up a medication and feeding to administer to the resident and failed to wash or sanitize her hands. Staff D poured the correct Augmentin dose into a plastic medication cup. Staff D entered the resident's room, filled a plastic glass with water from the bathroom sink, and returned to administer the resident's medication without washing or sanitizing her hands. Staff D administered the resident's medication via the feeding tube, poured the Jevity into a plastic feeding bag, and realized the end cap for the feeding bag tubing to attach to the resident's feeding tube had fallen to the floor. Staff D left the resident's room to get another feeding bag, washed her hands at the sink in the dining area, obtained another feeding tube, and sanitized her	F 880		

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F 880	Continued From page 35 hands at the medication cart before entering the resident's room. Staff D started the Jevity feeding, left the resident's room, and walked across the hall with sanitizing her hands at the medication cart outside the door. An Infection Control Policy, General Procedures: Hand Hygiene, with a revision date of 6/09, directed staff that the hand hygiene the most important procedure for infection control. The policy directed staff to the following: a. Staff need to wash their hands with soap and water when visibly dirty, contaminated with blood and other body fluids, before eating and bathroom use, and before entering the closet in a resident's room where linen and supplies kept. b. Staff may use an approved alcohol based hand sanitizer when hands not visibly contaminated before direct contact with residents, after contact with a resident's intact skin, after contact with body fluids, excretions, mucous membranes, non intact skin and wound dressings if hands not visibly soiled, when moving from a contaminated body site to a clean body site during care, after contact with inanimate objects including medical equipment in the immediate area of the resident, after removing gloves, and before entering the resident's closet with supplies and linen. 2. The Minimum Data Set (MDS) assessment tool, dated 9/21/18, documented Resident #46 with short and long term memory impairment, had a diagnosis of cerebral palsy, and had a feeding tube for nutrition and fluids. During an observation 10/31/18 at 12:13 PM , Staff C, RN (Registered Nurse), observed to	F 880		

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F 880	Continued From page 36 wash hands in handwashing sink, obtained gloves from medication cart and discontinued feeding from feeding tube port handling the feeding tube and feeding bag. Under constant observation Staff C returned to the medication cart and obtained two gloves from box on the top of the cart, which were put in her pocket. Staff C, failed to wash or sanitize hands prior to handling gloves. Staff C, washed hands and donned gloves from pocket that had been handled with potentially soiled hands. Staff C then observed to obtain supplies from the cabinet and approach resident to rinse feeding tube bag. 3. Observation on 10/31/18 at 8:51 a.m., Staff M (certified nursing assistant) and Staff L (certified nursing assistant), came into Resident #42 room and Staff M failed to wash their hands prior to putting on purple gloves, then proceeded to put the stand up lift up to the resident, Staff M took off their gloves and then proceeded to touch the pillow on the residents bed and failed to wash their hands after taking off the purple gloves. At 9:03 a.m., Staff M put on a clean pair of purple gloves and failed to wash their hands before putting the gloves on Staff M then took off their purple gloves and failed to wash their hands before putting on another pair of purple gloves, Staff M then applied a clean white brief and removed their purple gloves. Staff M failed to wash their hands after removing and putting on clean and dirty gloves, and failed to wash their hands prior to coming into the resident room. 4. Observation on 10/31/18 at 8:21 a.m., Staff M (certified nursing assistant), came into Resident #33 room and failed to wash her hands prior to assisting the resident with their hearing aides, Staff M applied a gait belt around the residents	F 880		

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F 880	Continued From page 37 waist and used a front wheeled walker to transfer the resident to the recliner. Staff M then took the resident wheelchair out of the resident room, came back into the room and failed to wash their hands and proceeded to put on a pair of purple gloves and then proceeded to empty the resident leg bag filled with urine. 5. Observation on 10/31/18 at 9:14 a.m., Staff M (certified nursing assistant) and Staff L (certified nursing assistant), proceeded to do incontinent cares for Resident #9. Staff M came into the room and failed to wash their hands, picked up the blue floor matt up off the floor, gave the resident a drink of water, turned the monitor towards the wall offered resident a choice in what they wanted to wear, Staff M touched the resident clothes, under garments, went into the bathroom and got wash cloths and towels, Staff L knocked on the door and came into the room and failed to wash their hands, Staff M handed a container of deodorant and a brief to Staff L. Staff L went an put on purple gloves with out washing their hands when they came into the room. Staff M put on her purple gloves with a wet wash cloth cleansed the resident groin area with a scrubbing motion and failed to used different parts of the wash cloth, then washed the residents bottom in a scrubbing motion from top to bottom and failed to used different pars of the wash cloth. Staff M removed the soiled brief for which turned the green stripe blue, and then proceeded to place a clean brief on the resident and failed to change gloves, after removing the purpled gloves, Staff M took the basin into the bathroom and dumped the water into the sink, staff failed to wash their hands after removing gloves or used any alcohol gel inbetween using their gloves. Staff M then come out of the bathroom with a fresh basis of water	F 880		

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F 880	Continued From page 38 and put on another pair of purple gloves and failed to use an alcohol get or wash their hands prior to putting on the gloves. Staff M and Staff L failed to wash their hands before or after entering the residents room. 6. Observation on 10/30/18 at 8:24 a.m., Resident #39 transferred themselves from a wheelchair to a recliner in their room with the catheter tubing dragging on the floor the catheter tubing remained on the floor for a total of 45 minutes. 7. Observation on 10/31/18 at 7:25 a.m., revealed resident #39 sitting in a recliner with the catheter tubing on the floor next to the recliner. 8. Observation on 10/31/18 at 1:08 p.m., Staff M (certified nursing assistant), went into the Resident #39 room with purple gloves on, Staff M failed to wash their hands prior to applying the purple gloves, Staff M proceeded to empty the resident catheter bag with the gloved hands, during the process the alcohol wipe fell into the plastic graduate with urine in it. Staff M proceed to lay the catheter bag on the floor next to the recliner and mauve basin.	F 880		

November 30, 2018

Mindla White, Chief
Medicare/Medicaid Bureau II
Health Facilities Division
Lucas State Office Building
321 East 12th Street
Des Moines, IA 50319-0083

Plan of Correction—Annual Survey – Conducted October 29, 2018 – November 1, 2018

F550 – Resident Rights/Exercise of Rights

- The Royale Meadows Care Practice Standards form was updated to include a privacy cover be used for all residents who have a urine collection bag with their catheter. The CNA Staff and Temp Expectations sheet, which is used during orientation, was also updated to include this expectation.
- Additional privacy covers have been obtained and distributed to the appropriate resident rooms.
- All CNA and RN/LPN staff members will receive education regarding this requirement at the department meeting on 11/28/2018 or prior to the end of their first shift worked after the department meeting.
- Four random audits per month will be completed to ensure that a privacy cover is used for all residents who have a urine collection bag. Results will be documented on the department quality indicator report (dashboard). Dashboards are reported to the Quality Committee. The Director of Nursing will be responsible for ongoing compliance.
- Substantial Compliance achieved on 11/28/2018.

F561 – Self-Determination

- No medication will be given between 10:00 p.m. and 6:00 a.m., unless requested by the resident and/or the resident's representative. Requests for exception will be documented in resident charts.
- All RN/LPN staff members will receive education regarding this requirement at the department meeting on 11/28/2018 or prior to the end of their first shift worked after the department meeting.
- A monthly audit of 10 percent of resident charts will be conducted to ensure that no medication is given between 10:00 p.m. and 6:00 a.m. unless an exception is documented in the resident's chart. Results will be documented on the department quality indicator report (dashboard). Dashboards are reported to the Quality Committee. The Director of Nursing will be responsible for ongoing compliance.

- Substantial compliance achieved on 11/28/2018.

F582 – Medicaid/Medicare Coverage/Liability Notice

- The Skilled Nursing Facility Advance Beneficiary Notice and Notice of Medicare Non-Coverage forms were reviewed by the social worker and administrative staff members.
- The Social Worker is responsible for obtaining these signed forms at the transition of care from Medicare covered Part A skilled services when Royale Meadows determines that a resident no longer qualifies for Medicare Part A skilled services and the resident has not used all the Medicare benefit days for that episode.
- All skilled charts will be audited within two weeks of the end of Medicare covered Part A skilled services to ensure both forms are signed and included in the resident chart. Results will be documented on the department quality indicator report (dashboard). Dashboards are reported to the Quality Committee. The Social Worker will be responsible for ongoing compliance.
- Substantial compliance achieved on 11/20/2018.

F656 – Develop/Implement Comprehensive Care Plan

- All residents with psychotropic medications were reviewed and comprehensive nursing care plans were updated to include potential adverse reactions for psychotropic medications.
- All RN/LPN and CNA staff members will receive education regarding side effects being listed on care plans at the department meeting on 11/28/2018 or prior to the end of their first shift worked after the department meeting.
- A monthly audit of four resident charts per month will be conducted to ensure potential adverse reactions for psychotropic medications are included in the comprehensive care plan. Results will be documented on the department quality indicator report (dashboard). Dashboards are reported to the Quality Committee. The Director of Nursing will be responsible for ongoing compliance.
- Substantial compliance achieved on 11/28/2018.

F677 – ADL Care Provided for Dependent Residents

- Education and competency evaluation of complete and proper incontinence care will be completed for all CNA staff members at the department meeting on 11/28/2018 or prior to the end of their first shift worked after the department meeting.
- Four spot checks will be conducted per month to ensure complete and proper incontinence care and handwashing. Results will be documented on the department quality indicator report (dashboard). Dashboards are reported to the Quality

Committee. This monitoring will remain in place until substantial compliance is achieved. The Director of Nursing will be responsible for ongoing compliance.

- Substantial compliance achieved on 11/30/2018.

F684 – Quality of Care

- All RN/LPN staff members will receive education regarding the Bowel Management Policy at the department meeting on 11/28/2018 or prior to the end of their first shift worked after the department meeting.
- A monthly audit of four resident charts per month will be conducted to ensure the Bowel Management Policy is adhered to for all residents. Results will be documented on the department quality indicator report (dashboard). Dashboards are reported to the Quality Committee. The Director of Nursing will be responsible for ongoing compliance.
- Substantial compliance achieved on 11/28/2018.

F689 – Free of Accidents Hazards/Supervision/Devices

- Baseline evaluations for all residents with power mobility devices have been conducted by therapies to ensure each resident is able to safely operate their power mobility devices.
- The Motorized Wheelchair and Scooter Safety policy has been approved by the Sioux Center Health Quality Committee.
- All RN/LPN and CNA staff members will receive education about reporting incidents and near misses to ensure appropriate assessment of resident safety at the department meeting on 11/28/2018 or prior to the end of their first shift worked after the department meeting. Incidents and near misses will also be reviewed with staff members at daily huddle.
- An evaluation of each resident with a power mobility device will be conducted to ensure resident is able to safely operate device upon admission, with any change in condition, in the event of incident/near miss, or at least quarterly. Results will be documented on the department quality indicator report (dashboard). Dashboards are reported to the Quality Committee. The Director of Nursing will be responsible for ongoing compliance.
- Education was provided specific to resident #64 immediately following incident referenced in DIA report. Education regarding appropriate gait belt usage has been completed to all full and part time CNA staff members at the department meeting on 11/28/2018 or via one-on-one education prior to their first shift working after the department meeting.
- Four spot checks per months will be conducted to ensure appropriate gait belt usage and will be documented on the department quality indicator report (dashboard).

Dashboards are reported to the Quality Committee. The Director of Nursing will be responsible for ongoing compliance.

- The Clinical Coordinator provided coaching to Staff H on 11/2/2018 regarding the importance of locking the medication cart before turning away or leaving the medication cart. The conversation was documented as part of the employee's performance record.
- The Controlled Substances policy was reviewed with all RN/LPN staff members at the Department meeting on 11/28/2018 and an email regarding expectations was sent by the Director of Nursing on 11/05/2018.
- An audit of eight checks per month will be completed to assess appropriate locking of medication carts and will be documented on the department quality indicator report (dashboard). Dashboards are reported to the Quality Committee. The Director of Nursing will be responsible for ongoing compliance.
- Substantial compliance achieved on 11/20/2018.

F756 – Drug Regimen Review, Report Irregular, Act On

- On 11/13/2018, the consulting pharmacist was informed of the requirement to identify and notify the physician of potential medication irregularities.
- A chart review on 11/23/2018 showed the Consulting Pharmacist is requesting diagnosis and rationale from the attending physician for each duplicate medication.
- The Consulting Pharmacy will provide a quarterly audit of at least 10 percent of resident charts to ensure the Consulting Pharmacist is identifying and notifying the physician of potential medication irregularities. Results will be documented on the department quality indicator report (dashboard). Dashboards are reported to the Quality Committee. The Director of Nursing will be responsible for ongoing compliance.
- Substantial compliance achieved on 11/20/2018.

F761 – Label/Store Drugs and Biologicals

- Education of the requirement that employees date a multi dose vial of Tuberculin when opened and discard the vial within 28 days after opening was provided to all RN/LPN staff members at the department meeting on 11/28/2018 or prior to the end of their first shift worked after the department meeting.
- An audit will be conducted four times per month ensure appropriate dating and discarding of Tuberculin within 28 days after opening. Results will be documented on the department quality indicator report (dashboard). Dashboards are reported to the Quality Committee. The Director of Nursing will be responsible for ongoing compliance.
- Substantial compliance achieved on 11/28/2018.

F812 – Food Procurement, Store/Prepare/Serve-Sanitary

- Education was provided regarding appropriate glove use and handwashing during meal service at the dietary staff meeting on 11/27/2018 and one-on-one education will be provided to all staff not in attendance by 11/30/2018, or during the first shift worked for those who aren't able to receive the education prior to 11/30/2018.
- An audit will be conducted 8 times per month to ensure appropriate handwashing and glove use during meal service. Results will be documented on the department quality indicator report (dashboard). Dashboards are reported to the Quality Committee. The Dietary Director will be responsible for ongoing compliance.
- Substantial compliance achieved on 11/30/2018.

F880 – Infection Prevention & Control

- Wall mounted hand sanitizer stations were placed outside of each resident room to ensure staff members can easily access hand sanitizer.
- Education was provided regarding the Infection Control Policy and the General Procedures: Hand Hygiene Policy to all RN/LPN and CNA staff members at the department meeting on 11/28/2018 or prior to the end of their first shift worked after the department meeting.
- An audit will be conducted of 8 resident care interactions per month to ensure appropriate handwashing and glove use during resident cares. Results will be documented on the department quality indicator report (dashboard). Dashboards are reported to the Quality Committee. The Director of Nursing will be responsible for ongoing compliance.
- Substantial compliance achieved on 11/28/2018.

Submitted by Joe Heitritter, Senior Services Officer
Sioux Center Health
Provider #165157