STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	165162	A. BUILDING _____ B. WING _____	C 10/30/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ALTOONA NURSING AND REHABILITATION CENTER	200 SEVENTH AVENUE SW ALTOONA, IA 50009

(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 12/23/18 The following deficiencies relate to an investigation regarding facility reported incident #78204-I and complaint #78504-C conducted 10/9/18 - 10/30/18. Both the complaint and the incident were substantiated.	F 000		
F 658 SS=D	Services Provided Meet Professional Standards CFR(s): 483.21(b)(3)(i) §483.21(b)(3) Comprehensive Care Plans The services provided or arranged by the facility, as outlined by the comprehensive care plan, must- (i) Meet professional standards of quality. This REQUIREMENT is not met as evidenced by: Based on record review and staff interviews, the facility failed to provide nursing care according to professional standards of quality and regulation by the Iowa Board of nursing for care of a resident with a peripherally inserted central catheter (PICC) intravenous line, for 1 of 6 resident records reviewed (Resident #3). The facility reported a census of 89 residents. Findings include: The Minimum Data Set (MDS) Assessment tool dated 7/19/18 revealed Resident #3 admitted to the facility on 2/23/18, with diagnoses that included diabetes and morbid obesity. The MDS documented the resident scored 11 out of 15 points possible on the Brief Interview for Mental Status (BIMS) cognitive assessment that showed the resident experienced moderate cognitive impairment, displayed no symptoms of delirium,	F 658		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE: Administrator | (X6) DATE: 12/21/18

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.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	165162	A. BUILDING _____ B. WING _____	C 10/30/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ALTOONA NURSING AND REHABILITATION CENTER	200 SEVENTH AVENUE SW ALTOONA, IA 50009

(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 658	Continued From page 1 and required the supervision of 1 staff for transfers to and from bed, ambulation (walking), dressing, toilet use, and personal hygiene. The MDS also documented the resident as continent of bladder with an ostomy appliance in place for bowel elimination. A history and physical dated 8/16/18 revealed the resident had undergone a bowel resection with colostomy performed on 10/29/17, a wound dehiscence on 10/31/17, acute cholelethiasis that required hospitalization on 8/11/18, with a cholecystotomy (gallbladder removal) and drain placed on 8/16/18. The nursing care plan included the following problems with interventions: 1. At nutritional risk related to total parenteral nutrition (TPN, a highly concentrated solution delivered intravenously for protein and nutrition). Staff directed to provide sterile PICC site dressing changes weekly. 2. Alteration in elimination with 2 ostomies for bowel elimination; administer TPN per physician orders. Physician orders directed staff: 3/26/18 PICC dressing change with sterile technique weekly. 4/20/18 Hook up TPN at 4:00 p.m. daily, flush with 10 milliliters of sodium chloride prior to TPN hook up. 4/5/18 Unhook TPN at 11:00 a.m. daily, flush with 20 milliliters of sodium chloride after unhooked,	F 658		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	165162	A. BUILDING _____ B. WING _____	C 10/30/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ALTOONA NURSING AND REHABILITATION CENTER	200 SEVENTH AVENUE SW ALTOONA, IA 50009

(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 658	Continued From page 2 cap line with orange cap. The facility's Parenteral Nutrition General Policies policy dated 8/16 directed that only nurses with documented education and training in infusion therapy, including parenteral nutritional administration, and central venous access device care as designated by the facility and as allowed by state regulations may administer parenteral nutrition. The Iowa Board of Nursing rules specific to intravenous care and medication administration, chapter 6, rule 6.5(3) directed that a licensed practical nurse (LPN) shall be permitted to perform procedures related to the expanded scope of practice of intravenous (IV) therapy upon completion of the board-approved expanded IV therapy certification course, once completed, the LPN could change the PICC line dressing per sterile technique, if delegated by the RN, per rule 6.5(6)f. The chapter 6 6.5(7) rule specifically prohibited the LPN from TPN administration, only an RN could administer TPN. Review of the monthly Medication Administration Records (MARS) from June, 2018 through September 5, 2018 revealed Staff M, LPN, Staff N, LPN and Staff O, LPN routinely signed to indicate the TPN had been administered and disconnected daily, the PICC line flushed (Staff M documented it 16 times), and the PICC dressing changed with sterile technique (Staff M documented the completed care twice). Personnel files revealed Staff M, N and O had not completed the required intravenous therapy certification course; Staff M was enrolled in the certification course that began 9/10/18. Additionally, agency LPN, Staff P, also signed the	F 658		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	165162	A. BUILDING _____ B. WING _____	C 10/30/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ALTOONA NURSING AND REHABILITATION CENTER	200 SEVENTH AVENUE SW ALTOONA, IA 50009

(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 658	Continued From page 3 MAR 8 times for TPN administration and IV care. Staff P had not completed the intravenous therapy certification course. During an interview on 10/24/18 at 4:51 p.m., Staff M stated she started the Intravenous therapy certification class on 9/11/18, she signed Resident #3's MAR when an RN administered the TPN and flushed the PICC line because the RN's refused to sign the MAR and just had her do it. During an interview on 10/30/18 at 10:52 a.m., Staff P, agency LPN, stated she signed the TPN administration and intravenous line flush on the resident's MAR when the care was done, she looked for an RN to perform the care, usually the ADON (assistant director of nursing) or another nurse, she had not had any IV training and knew she could not perform IV care. During an interview on 10/25/18 at 12:15 p.m., Staff Q, RN and ADON, stated she had disconnected the resident's TPN and flushed the line, and if she hadn't signed the MAR she would have expected staff to contact her and remind her to sign it. During an interview on 10/24/18 at 4:58 p.m., Staff R, RN and ADON, stated nurses should not sign for activities performed by other nurses, each nurse should sign the care and activities performed by them. During an interview on 10/25/18 at 10:00 a.m., the director of nursing (DON) stated he thought the LPN's that signed the IV care on the resident's MAR were IV certified and was not aware that they weren't. He verified nurses should not sign for care completed by another	F 658		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	165162	A. BUILDING _____ B. WING _____	C 10/30/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ALTOONA NURSING AND REHABILITATION CENTER	200 SEVENTH AVENUE SW ALTOONA, IA 50009

(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 658	Continued From page 4 nurse, and the staff members identified were disciplined because they performed care outside of their scope for nursing practice.	F 658		
F 689 SS=J	Free of Accident Hazards/Supervision/Devices CFR(s): 483.25(d)(1)(2) §483.25(d) Accidents. The facility must ensure that - §483.25(d)(1) The resident environment remains as free of accident hazards as is possible; and §483.25(d)(2)Each resident receives adequate supervision and assistance devices to prevent accidents. This REQUIREMENT is not met as evidenced by: Based on record review and staff interviews, the facility failed to provide adequate supervision to prevent a resident with impaired decision-making skills from leaving the facility without knowledge or authorization of the staff (elopement) for 1 of 6 residents reviewed (Resident #1). On 9/9/18, Resident #1 left the facility through a door equipped with an alarm. The door alarm sounded, but staff failed to assess the cause of the alarm and determine if all residents remained in the facility. As a result, staff were unaware Resident #1 had wandered outside 400 feet away and not visible door window area, until found by Dietary staff that had reported to work. This constituted an Immediate Jeopardy (IJ) to resident health and safety. The facility reported a census of 89 residents. Findings include: The Minimum Data Set (MDS) Assessment tool dated 9/6/18 revealed the Resident #1 admitted	F 689		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	165162	A. BUILDING _____ B. WING _____	C 10/30/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ALTOONA NURSING AND REHABILITATION CENTER	200 SEVENTH AVENUE SW ALTOONA, IA 50009

(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 689	Continued From page 5 to the facility on 8/9/18 with diagnoses that included congestive heart failure, diabetes and depression. The MDS documented the resident scored 9 of 15 points possible on the Brief Interview for Mental Status (BIMS) cognitive assessment that showed the resident experienced moderate cognitive impairment and displayed no symptoms of delirium. The MDS also documented Resident #1 required extensive assist by at least 1 staff for transfers to and from the bed, ambulation (walking), dressing, toilet use, personal hygiene and bathing. The nursing care plan initiated 8/9/18 identified problems and included interventions: 1. Required assistance with activities of daily living (ADLs) due to weakness and some confusion. The care plan directed staff to setup, cue and provide 1 staff assist as needed with dressing, hygiene and bathing. 2. At risk for falls related to confusion, oxygen tubing (trip hazard), history of hallucination, weakness, and decreased mobility. The care plan directed staff to ensure the resident ambulated with walker, keep environment free of clutter, transfer with assist of 1 person, and utilize wheel chair for longer distance mobility. An elopement risk assessment completed on 8/10/18 revealed the resident did not have a history of wandering or attempts to open doors or windows (exit seeking behavior), did not express anger related to nursing home placement, and did not have a history of elopement from home or facility. The facility's undated Missing Resident/Elopement Policy & Procedure directed	F 689		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	165162	A. BUILDING _____ B. WING _____	C 10/30/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ALTOONA NURSING AND REHABILITATION CENTER	200 SEVENTH AVENUE SW ALTOONA, IA 50009

(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 689	Continued From page 6 staff: 1. Prevent a resident's departure from the facility if possible. 2. If a resident exited the building, or staff identified a resident was missing, staff to enlist assistance from nearby staff, inform the charge nurse, and make a thorough search of the building and premises. If unable to locate resident, notify the administrator, Director of Nursing (DON), the resident's guardian, physician, and law enforcement; provide a picture of the resident to law enforcement upon arrival. 3. Upon return of the resident, examine for injuries, notify physician of findings, complete an incident report, and document event in the nursing notes. Include time of the event, persons notified, condition of resident upon return to the facility, physician notification and orders, treatment if indicated, and any other pertinent information. 4. Maintenance personnel responsible to ensure the door alarms remain operational for 24 hour service and checked on a routine basis. Documentation completed by the certified nursing assistants (CNAs) revealed: 9/9/18 at 11:28 a.m., Staff S, CNA, recorded the resident required 1 person assist for transfers and bed mobility, and limited assistance for ambulation in room. 9/9/18 at 2:45 p.m., Staff T, CNA, recorded the resident used the toilet and completed their own personal hygiene independently. The facility reported incident described Resident #1 exited a west door at approximately 3:00 p.m. on 9/9/18. The door alarm sounded and staff	F 689		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	165162	A. BUILDING _____ B. WING _____	C 10/30/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ALTOONA NURSING AND REHABILITATION CENTER	200 SEVENTH AVENUE SW ALTOONA, IA 50009

(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 689	Continued From page 7 looked out the window but did not go outside to check the reason for the alarm. The facility reported a dietary employee found the resident outside at approximately 3:05 p.m. The resident was returned to the building without injury ,and staff applied a Wanderguard transponder device to the resident's person. The facility reported they then re-educated all staff regarding door alarms and elopement procedures. According to https://weather.com/weather/monthly/l/50009:4:US, the outside temperature at the time was approximately 76 degrees. The staff assignment sheet for the 2 p.m. to 10 p.m. shift on 9/9/18 revealed Staff T originally assigned to the resident's hall, then changed to the C hall. The sheet further revealed Staff U, CNA, originally assigned to the A hall, then changed to Resident #1's hall. Observation during a walk with the DON on 10/23/18 at 9:55 a.m., from the west exit door to the dumpsters in the parking lot, revealed the resident had been found at least 400 feet away and not visible from the window by the door. According to Google Maps https://www.google.com/maps/place/Altoona+Nursing+%26+Rehabilitation+Center/@41.6510696,-93.4754447,861m/data=!3m1!1e3!4m5!3m4!1s0x0:0x9ee4ca3e91ff4967!8m2!3d41.6498459!4d-93.473293, behind the back yard of the facility bordered a wooded area with dry creek beds that abut a 2 acre lake. Review of Mccracken, Jim and the Staff at Recreational Guides. "Des Moines and Polk County Fishing and Floating Guide Book: A	F 689		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	165162	A. BUILDING _____ B. WING _____	C 10/30/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ALTOONA NURSING AND REHABILITATION CENTER	200 SEVENTH AVENUE SW ALTOONA, IA 50009

(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 689	Continued From page 8 Complete fishing and floating information for Polk County, Iowa." Ed. Recreational Guides, January 25, 2018. Page 6, ebook., the lake contains 3 types of fish with no depth given. A residential road bordered the front and side yard of the facility with a speed limit of at least 25 miles per hour. Staff interviews revealed: 10/18/18 at 2:32 p.m., Staff U, CNA stated on 9/9/18, Staff V, CNA, announced over the intercom to check and clear the west hall door. Resident #1 was initially assigned to Staff T, then assigned to her sometime after the shift started. Staff U reported she was in the Break Room on a 15 minute break sometime between 3:30 p.m. and 4:00 p.m., and left the break room to check to door. She stated no alarm sounded when she checked it, the alarm was reset at the panel at the nurse's station, she looked out through the window by the door and didn't see anyone. Staff U reported she thought someone had not punched in the code and then opened the door. A kitchen employee came in and said they found the resident outside by the dumpster's, so a Wanderguard was applied to the resident and she monitored the resident closely after that. Staff U also reported the resident continued to go to the west door several times and to the front door that evening, but didn't get anywhere do to the Wanderguard alarm. 10/22/18 at 3:20 p.m., Staff T, CNA, stated he did not recall that Resident #1 was assigned to him on 9/9/18, but he remembered a resident got outside and staff got in trouble because they didn't go outside to check the door alarm. Staff T reported if a door sounded, staff had to go	F 689		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	165162	A. BUILDING _____ B. WING _____	C 10/30/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ALTOONA NURSING AND REHABILITATION CENTER	200 SEVENTH AVENUE SW ALTOONA, IA 50009

(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 689	Continued From page 9 outside to check, and if they couldn't determine the cause for the alarm they went from room to room to account for all residents. Staff T stated he learned this in orientation at this facility and every other facility he worked at. 10/23/18 at 4:16 p.m., Staff V, CNA, stated he worked the 2 to 10 shift on 9/9/18 and was assigned to the B hall. Staff V reported he did not hear a door alarm that day and denied he had paged overhead to clear the alarm. Staff V stated other CNAs had called in that day, so Staff T was assigned to Resident #1's hall and had passed ice water when they determined they had to revise assignments due to the call-ins. At that time he then was assigned to the C hall and Staff U assigned to the resident's hall. Staff V remembered that Staff X, dietary aide, walked in with Resident #1 around 3:15 p.m.; the resident had her walker but didn't have oxygen applied. Staff V assisted the resident to a wheel chair and transported her to the front nurse's station. Staff V stated he learned in orientation at the facility that staff had to check outside when a door alarm sounded. 10/22/18 at 2:36 p.m., Staff X, dietary aide (DA), stated when she pulled into the parking lot to work on 9/9/18 at approximately 2:45 p.m., she saw Resident #1 by the dumpsters as she headed away from the building. Staff X reported the resident was dressed with shoes on, and said she was going home She was able to convince the resident and assisted her to return to the building to tell the nurse, Staff Y, she found the resident outside. 10/22/18 at 4:00 p.m., Staff Y, RN, stated on 9/9/18, she was in a resident's room when Staff X	F 689		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	165162	A. BUILDING _____ B. WING _____	C 10/30/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ALTOONA NURSING AND REHABILITATION CENTER	200 SEVENTH AVENUE SW ALTOONA, IA 50009

(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 689	Continued From page 10 was in the hall with Resident #1, and said she found her outside and directed her to get her nurse, Staff Z. Staff Y reported she instructed Staff Z, an agency nurse, to assess the resident and call the manager on duty to report it. 10/23/18 at 8:42 a.m., Staff Z, staffing agency RN, stated she worked on 9/9/18 was told by 1 of the nurses that 1 of her residents was missing. Staff Z reported the resident was in the hall with Staff V who said the resident was just brought in and the resident said she was going home. Staff Z reported she assessed the resident and there were no injuries, she applied a Wanderguard and called the Director of Nursing and the manager on call. Staff Z stated if a door alarm sounded, they were to check the board to identify what door, check and clear the alarm, and if they can't clear the alarm then staff does a head count. She stated she had she has had to do that a different day that she had worked at the facility. 10/23/18 at 7:44 a.m., the Administrator and DON stated maintenance checked all door alarms weekly, the alarms were checked on 9/7/18 then again on 9/10/18 due to the elopement, and staff check Wanderguard alarms daily. They reported staff required to go outside to check and clear door alarms as they were instructed during orientation. 10/24/18 at 8:10 a.m., The DON stated the resident was weak and required physical therapy when admitted to the facility, got stronger with therapy, and that enabled her independent departure. The DON reported staff last saw Resident #1 at 2:45 p.m. on 9/9/18 when Staff T took her to the bathroom.	F 689		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	165162	A. BUILDING _____ B. WING _____	C 10/30/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ALTOONA NURSING AND REHABILITATION CENTER	200 SEVENTH AVENUE SW ALTOONA, IA 50009

(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 689	Continued From page 11 The facility abated the Immediate Jeopardy on 9/10/18 by implementing the following actions: 1. The facility reassessed all residents for potential elopement risk. 2. The facility updated the "Elopement Book" to contain the most current Elopement Policy, pictures of each resident identified as at risk for elopement, and demographic information related to said resident. 3. The Director and Assistant Director of Nursing re-educated staff regarding the Elopement Policy prior to working with residents again. 4. The facility contracted with a vendor to retrofit and rewire the exit door with a key pad which required a code rather than a button to push to clear the alarm. 5. The facility audited wanderguards and ensured function tests recorded as completed (to be done daily going forward). 6. The facility completed door alarm checks (to be completed weekly thereafter) 7. The facility increased Elopement Drills to monthly on each shift for the next three months and/or until compliance achieved. 8. The facility reviewed all care plans for all residents deemed to be at risk for elopement based on elopement assessments to ensure interventions documented to protect each resident and ensure interventions in place to protect each resident and ensure resident safety.	F 689		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	165162	A. BUILDING _____ B. WING _____	C 10/30/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ALTOONA NURSING AND REHABILITATION CENTER	200 SEVENTH AVENUE SW ALTOONA, IA 50009

(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 730	Continued From page 12	F 730		
F 730 SS=E	Nurse Aide Peform Review-12 hr/yr In-Service CFR(s): 483.35(d)(7) §483.35(d)(7) Regular in-service education. The facility must complete a performance review of every nurse aide at least once every 12 months, and must provide regular in-service education based on the outcome of these reviews. In-service training must comply with the requirements of §483.95(g). This REQUIREMENT is not met as evidenced by: Based on record review and staff interviews, the facility failed to ensure that each certified nursing assistant (CNA) employee received the mandated 12 hours of inservices annually for 5 of 6 personnel files reviewed of CNA's employed at the facility for over a year. The facility reported a census of 89 residents. Findings include: Review of A staff education records for selected CNAs revealed: 1. Staff H, CNA, hired 11/9/01, completed 3.5 hours of inservice education since 11/1/17. 2. Staff I, CNA, hired 8/7/04, completed 0.5 hours of inservice education since 11/1/17. 4. Staff J, CNA, hired 6/4/01, completed 5.0 hours of inservice education in October, 2017, and had not completed any education since then. 5. Staff K, CNA, hired 5/12/15, completed 5.75 hours of inservice education since 11/1/17. 6. Staff L, CNA, hired 8/13/13, completed 4.5	F 730		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	165162	A. BUILDING _____ B. WING _____	C 10/30/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ALTOONA NURSING AND REHABILITATION CENTER	200 SEVENTH AVENUE SW ALTOONA, IA 50009

(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 730	Continued From page 13 hours of inservice education since 11/1/17. The facility's Inservice Training Program, Nurse Aide policy, last reviewed October, 2017, directed that all CNA's were required to participate in regularly scheduled in-service training classes, in-service education programs based on the needs identified on annual CNA performance reviews, no less than 12 hours of education provided annually, records of in-service attendance maintained in the employee's file, and staff paid to attend all education programs. Staff interviews revealed: 10/30/18 at 8:53 a.m., Staff F, Human Resources, stated employees are instructed upon hire that they are to complete a minimum of 1 education program each month on the computer, and she printed a report from the computer monthly that detailed staff education participation. 10/30/18 at 8:55 a.m., the director of nursing (DON), hired 7/16/18, stated there were 2 or 3 computers available at the facility for staff use for education. He reported he was unaware Staff G had not completed any education until he reviewed the education reports printed. 10/30/18 at 9:03 a.m., the administrator, hired 7/9/18, stated staff participation in education was not at the level he wanted, but not aware the CNA's had not completed the required 12 hours of education annually.	F 730		
F 842 SS=D	Resident Records - Identifiable Information CFR(s): 483.20(f)(5), 483.70(i)(1)-(5) §483.20(f)(5) Resident-identifiable information.	F 842		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	165162	A. BUILDING _____ B. WING _____	C 10/30/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ALTOONA NURSING AND REHABILITATION CENTER	200 SEVENTH AVENUE SW ALTOONA, IA 50009

(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 842	Continued From page 14 (i) A facility may not release information that is resident-identifiable to the public. (ii) The facility may release information that is resident-identifiable to an agent only in accordance with a contract under which the agent agrees not to use or disclose the information except to the extent the facility itself is permitted to do so. §483.70(i) Medical records. §483.70(i)(1) In accordance with accepted professional standards and practices, the facility must maintain medical records on each resident that are- (i) Complete; (ii) Accurately documented; (iii) Readily accessible; and (iv) Systematically organized §483.70(i)(2) The facility must keep confidential all information contained in the resident's records, regardless of the form or storage method of the records, except when release is- (i) To the individual, or their resident representative where permitted by applicable law; (ii) Required by Law; (iii) For treatment, payment, or health care operations, as permitted by and in compliance with 45 CFR 164.506; (iv) For public health activities, reporting of abuse, neglect, or domestic violence, health oversight activities, judicial and administrative proceedings, law enforcement purposes, organ donation purposes, research purposes, or to coroners, medical examiners, funeral directors, and to avert a serious threat to health or safety as permitted by and in compliance with 45 CFR 164.512.	F 842		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	165162	A. BUILDING _____ B. WING _____	C 10/30/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ALTOONA NURSING AND REHABILITATION CENTER	200 SEVENTH AVENUE SW ALTOONA, IA 50009

(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 842	Continued From page 15 §483.70(i)(3) The facility must safeguard medical record information against loss, destruction, or unauthorized use. §483.70(i)(4) Medical records must be retained for- (i) The period of time required by State law; or (ii) Five years from the date of discharge when there is no requirement in State law; or (iii) For a minor, 3 years after a resident reaches legal age under State law. §483.70(i)(5) The medical record must contain- (i) Sufficient information to identify the resident; (ii) A record of the resident's assessments; (iii) The comprehensive plan of care and services provided; (iv) The results of any preadmission screening and resident review evaluations and determinations conducted by the State; (v) Physician's, nurse's, and other licensed professional's progress notes; and (vi) Laboratory, radiology and other diagnostic services reports as required under §483.50. This REQUIREMENT is not met as evidenced by: Based on record review and staff interviews, the facility failed to maintain an accurate and complete medical record that detailed all conditions and care provided by nursing staff for 1 of 6 resident records reviewed (Resident #3). The facility reported a census of 89 residents. Findings include: The Minimum Data Set (MDS) Assessment tool dated 7/19/18 revealed Resident #3 admitted to the facility on 2/23/18, with diagnoses that included diabetes and morbid obesity. The MDS	F 842		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	165162	A. BUILDING _____ B. WING _____	C 10/30/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ALTOONA NURSING AND REHABILITATION CENTER	200 SEVENTH AVENUE SW ALTOONA, IA 50009

(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 842	Continued From page 16	F 842		

documented the resident scored 11 out of 15 points possible on the Brief Interview for Mental Status (BIMS) cognitive assessment that showed the resident experienced moderate cognitive impairment. The MDS documented the resident displayed no symptoms of delirium, and required supervision of 1 staff for transfers to and from bed, ambulation (walking), dressing, toilet use, and personal hygiene. The MDS also documented the resident as continent of bladder with an ostomy appliance in place for bowel elimination.

A history and physical dated 8/16/18 revealed the resident had undergone a bowel resection with colostomy performed on 10/29/17, a wound dehiscence on 10/31/17, acute cholelithiasis (gallstone formation) that required hospitalization on 8/11/18, with a cholecystectomy (gallbladder removal) and drain placed on 8/16/18.

The nursing care plan included the following problems with interventions:

1. Impaired skin integrity related to surgical incision, staff to perform surgical incision treatments as ordered, and resident constantly picked at the abdominal dressing and staff required to change the dressing several times a day.

2. Alteration in elimination with 2 ostomies for bowel elimination, staff to administer TPN per physician orders, provide ostomy site care per physician orders, and encourage the resident not to pick at the dressing and ostomy bag to avoid need for dressing and ostomy bag changes several times daily.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	165162	A. BUILDING _____ B. WING _____	C 10/30/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ALTOONA NURSING AND REHABILITATION CENTER	200 SEVENTH AVENUE SW ALTOONA, IA 50009

(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 842	Continued From page 17 Physician orders directed staff: 5/18/18 Cleanse skin with warm water, utilize no products that contain alcohol, and apply small amount of stoma powder to the skin along the edges of the fistula/stoma and the skin separating the two. Then, dust off any extra powder with ostomy appliance change every 3 days and as needed. The June, 2018 through September, 2018 MAR's revealed the wound and ostomy care provided every 3 days, but did not reveal documentation of the abdominal dressing and ostomy appliance changes performed by staff when needed.. Staff interviews revealed: 10/24/18 at 4:51 p.m., Staff M, LPN, stated the resident picked at his abdominal dressing and colostomy bag and staff had to change them multiple times each shift. 10/30/18 at 10:52 a.m., Staff P, Agency LPN, stated the resident removed his dressing and ostomy bag, which required staff to change the dressing and appliance many times per shift. 10/29/18 at 4:03 p.m., Staff Q, ADON and facility wound nurse, stated the resident constantly picked at his dressing and ostomy appliance and removed them,which required staff to change them from 3 to 6 times every day. 10/29/18 at 4:40 p.m., the facility's corporate nurse stated the resident removed his abdominal dressing and ostomy bag several times every day. The nurse reported staff should have documented the dressing changes in the nurse's	F 842		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	165162	A. BUILDING _____ B. WING _____	C 10/30/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ALTOONA NURSING AND REHABILITATION CENTER	200 SEVENTH AVENUE SW ALTOONA, IA 50009

(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 842	Continued From page 18 notes as there wasn't an area on the MAR for staff to document every time they changed them. The August and September, 2018 nurse's notes did not reveal any documentation that showed staff changed the abdominal dressing or colostomy appliance when needed.	F 842		

Altoona Nursing and Rehabilitation Center Plan of correction

This serves as the credible allegation of compliance for Altoona Nursing and Rehabilitation Center. We assert that all correctives described on this plan of correction have been implemented. In regards to the specific deficiencies, we have outlined our corrective actions and continued interventions to assure compliance with regulations and our plan of actions. The staff of Altoona Nursing and Rehabilitation Center is committed to delivering high quality health care to its residents to obtain their highest level of physical, mental, and psychosocial functioning. We respectfully submit that Altoona Nursing and Rehabilitation Center is in substantial compliance as set forth below. We are confident that we will be found in substantial compliance upon re-survey.

The statements made on this plan of correction are not an admission to and do not constitute an agreement with the alleged deficiencies. Altoona Nursing and Rehabilitation Center has completed the following interventions as a result of the findings from survey exiting 10/30/18. The facility will be in substantial compliance by 12/23/18.

F 658 SS=D SERVICES PROVIDED MEET PROFESSIONAL STANDARDS: Altoona Nursing and Rehabilitation Center will ensure professional standards of practice are followed while caring for a resident with a peripherally inserted catheter. Licensed staff were re-educated by the Director of Nursing on 10/25/18 regarding care of a PICC (Peripherally Inserted Central Catheter) line. All licensed staff have been re-educated that only RN's or IV certified LPN's may complete any PICC line management. The facility will have RN or IV certified LPN's while any IV therapy is in house. Weekly audits will be completed by the DON and/or ADON reviewing documentation of PICC (Peripherally Inserted Central Catheter) care including dressing changes during infusions. Concerns identified will be addressed and reported in the facilities quality assurance compliance meetings for additional intervention as indicated.

F 689 SS=J FREE OF ACCIDENT HAZARDS/SUPERVISION/DEVICES: Altoona Nursing and Rehabilitation Center will ensure each resident receives adequate supervision and assistance to prevent accidents. (Abated Immediate Jeopardy 9/10/18)

1. All residents were assessed for potential elopement risk.
2. The facility updated the "Elopement Book" to contain the most current Elopement policy, pictures of each resident identified as at risk for elopement, and demographic information related to said resident.
3. The Director and Assistant Director of Nursing re-educated staff regarding the Elopement policy prior to working with residents again.
4. The facility contracted with a vendor to retrofit and rewire the exit door with a key pad which required a code rather than a button to push the alarm.
5. The facility audited wander guards and ensured function tests recorded as completed and will remain ongoing.

6. The facility will complete door alarm checks through Tels on a weekly basis.
7. Elopement drills were increased to monthly on each shift for the next three months and/or until compliance achieved.
8. All care plans were reviewed for residents deemed to be at risk for elopement and updated accordingly to protect each resident.

Concerns identified will be addressed and reported in the facilities quality assurance compliance meetings for additional intervention as indicated.

F 730 SS=E NURSE AIDE PERFORM REVIEW-12/HR IN-SERVICE: Altoona Nursing and Rehabilitation Center will ensure each employee receives an annual performance review and receives regular in-service education per policy and regulation. Employee performance evaluations have been updated on all employees and a tickler file completed by the HR Director to track due dates. Employee personnel records have been audited and all required education has been completed. The facility HR Director will assign the required training modules to employees through RELIAS (A computerized training program). The HR Director will track completion of courses and review progress in morning meeting. Concerns identified will be addressed and reported in the facilities quality assurance compliance meetings for additional intervention as indicated.

F 842 SS=D RESIDENT RECORDS-IDENTIFIABLE INFORMATION: Altoona Nursing and Rehabilitation Center will ensure accuracy in medical records is maintained detailing conditions and care provided by the nursing staff. Resident # 3 no longer resides at the facility. Licensed staff have been re-educated by the Director of Nursing on 12/21/18 regarding the importance of documenting treatments appropriately. The DON and/or ADON will audit medical record documentation of MARS/TARS and nurses notes on a weekly basis until compliance achieved. Nurses notes will be printed and reviewed by the DON/or ADON in the morning meeting from the previous 24-48 hours to ensure ongoing compliance with documentation. Concerns identified will be addressed and reported in the facilities quality assurance compliance meetings for additional intervention as indicated.