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	165399	A. BUILDING _____ B. WING _____	C 12/17/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
REGENCY CARE CENTER	815 HIGH ROAD NORWALK, IA 50211

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F 000	INITIAL COMMENTS Correction Date 1/3/2019 Investigation of mandatory report # 77478-M resulted in deficiency. Complaints # 79277-C, # 79492-C and # 79764-C were substantiated. Complaints # 78928-C and # 79048-C were not substantiated. See Code of Federal Regulations, 42 CFR, Subpart B-C.	F 000	F 658 Regency Care Center will ensure that staff provides and documents wound care as prescribed and ordered by the physician. Staff education/meetings presented by the administrator were held as follows: 11/15/2018, 12/5/2018 (daily QA/managers only), 12/6 /2018, 12/12/2018 (night shift only), and 12/10/2018 (all staff meeting), 12/14/2018. On 12/7/2018 a QAPI meeting with the Medical Director and other team members was held to discuss the survey findings and corrective action taken to achieve compliance. A meeting was held with the managers on 12/18/2018 to discuss continued compliance. The nurse consultant worked side-by-side the nurse managers on 12/13/2018-12/14/2018 to verify adequate monitoring of the system correction and continued compliance. Charge nurses are monitoring thoroughness of documentation and completion of doctor ordered treatment from shift to shift with report. Nurse managers are monitoring documentation on each tour of duty.	
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 clinical record review and staff interviews, facility staff failed to provide wound care as prescribed and ordered by the physician and changed a wound care treatment without authorization of the physician for one of three residents reviewed with prescribed wound care (Resident #4). The facility reported a census of 66 residents. Findings include: The Minimum Data Set (MDS) assessment dated 3/19/18 recorded Resident #4 scored 15 out of 15 points on the Brief Interview for Mental Status	F 658		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Carla Kroll | TITLE: 1/4/2019 | (X6) DATE: 01/03/2019

POC accepted 1/30/19 NCummins

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F 658	Continued From page 1 (BIMS) test, indicating intact memory and cognition. The resident required the assistance of at least one staff to reposition in bed, bathe, dress, use the toilet and complete personal hygiene and the assistance of two staff for transfers to and from bed. A hospital History and Physical dated 11/1/18 documented Resident #4 had diagnoses that included quadriplegia, osteomyelitis with progressive bone destruction of left pelvis and femur head, and a Stage 4 pressure ulcer of contiguous region involving buttock and hip (full thickness tissue loss with exposed bone, tendon or muscle). Physician orders transcribed on 10/6/18 directed staff to: 1. Cut calcium alginate to size of wound, apply to his mid back wound and, cover with bordered gauze daily. 2. Cleanse the right heel with wound cleanser, pat dry, apply triple antibiotic ointment to open area and a non-adherent pad and secure both with rolled gauze daily. 3. Crush Flagyl 250 milligram pill (an anti-fungal medication, for oral administration) apply Flagyl powder to calcium alginate and pack in right buttocks wound, cover with bordered gauze daily. 4. Paint bilateral toes with Betadine twice daily for scabbed areas. 5. Cleanse the wound on back of right calf with wound cleanser, pat dry, apply Santyl ointment, cover it with bordered gauze, and change daily. 6. Cleanse the area on left calf with wound cleanser, pat dry, apply hydrogel with silver, cover with small bordered gauze daily. 7. Cleanse wound on left heel with wound cleanser, pat dry, cut calcium alginate to size of	F 658	A system change is the implementation of a charge nurses/certified medication aide verification document that is completed together by the two staff members to attest completion of the doctor's orders per the MAR and TAR review prior to the end of their tour of duty. Another system change is that all existing doctor's orders, to included treatments, are discontinued at the time of a discharge to ensure more clarity upon return from the hospital as the nurse has no prior orders showing in the PCC system. The action taken will ensure continued compliance with the requirements for Resident #4 and all other facility residents.	

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F 658	Continued From page 2 wound, cover with non-adherent pad and secure with rolled gauze daily. Review of the resident's 10/18 Treatment Administration Record (TAR) revealed staff did not complete the ordered wound care treatments on 10/7/18, 10/11/18, 10/12/18 and 10/15/18. Review of his progress notes revealed Resident #4 discharged to the hospital on 10/8/18, returned to facility on 10/11/18, and discharged to the hospital on 10/16/18. Wound care orders transcribed on 10/27/18 directed staff to: 1. Cleanse his left heel with wound cleanser, pat dry, apply sodium hypochlorite moistened gauze to wound bed, cover with ABD gauze (an approximate 5 inch by 7 inch by 1/2 inch thick gauze) and secure all with rolled gauze daily and as needed. 2. Cleanse the right heel with wound cleanser, pat dry, apply sodium hypochlorite moistened gauze to wound bed, cover with ABD gauze, secure with rolled gauze daily and as needed. 3. Cleanse the right hip wound with wound cleanser, pat dry, apply sodium hypochlorite moistened gauze to wound bed and cover with bordered foam dressing daily and as needed. 4. Cleanse the back of his right calf wound with wound cleanser, pat dry, apply sodium hypochlorite moistened gauze to wound bed, cover with ABD, secure it with rolled gauze daily and as needed. 5. Cleanse the back of left calf wound with wound cleanser, pat dry, apply sodium hypochlorite moistened gauze to wound bed, cover with ABD, secure with rolled gauze daily and as needed. 6. Cleanse his mid back wound with wound	F 658		

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F 658	Continued From page 3 cleanser, pat dry, apply sodium hypochlorite moistened gauze to the wound bed and, cover it with bordered foam dressing daily and as needed. 7. Irrigate the coccyx wound with normal saline, pat dry, gently pack with sodium hypochlorite solution moistened gauze and cover it with bordered foam dressing daily and as needed. Review of the resident's 11/18 TAR revealed staff failed to complete the ordered treatments on 11/9/18, 11/10/18 and 11/11/18. Record review revealed the resident returned from the hospital on 10/24/18 and discharged to the hospital on 11/12/18 at 7:45 a.m. During an interview on 11/15/18 at 3:20 p.m., the Director of Nursing, (DON) stated she made rounds on the evening of 11/9/18 with a wound care specialist nurse from a wound care company that provided services at the facility in the past. The wound care specialist provided Resident #4's wound care, made recommendations to change the wound care orders and the recommendations were faxed (sent by facsimile) to the physician who had not approved the recommendations. Staff discontinued the wound care orders on the TAR on 11/9/18 and she planned to check with staff who worked between 11/10/18 and 11/12/18 to determine if they performed wound care. On 12/6/18, the facility provided a written statement signed by Staff G, LPN (Licensed Practical Nurse) who stated she performed the scheduled wound treatment on 11/11/18. The facility could not provide documentation of what wound care staff performed on 11/11/18.	F 658		

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F 658	Continued From page 4 During an interview on 12/6/18, the corporate consultant nurse stated staff should have physician authorization prior to the change or discontinuation of physician orders.	F 658	F 686 Regency Care Center will provide care to prevent the development of pressure ulcers.	
F 686 SS=G	Treatment/Svcs to Prevent/Heal Pressure Ulcer CFR(s): 483.25(b)(1)(i)(ii) §483.25(b) Skin Integrity §483.25(b)(1) Pressure ulcers. Based on the comprehensive assessment of a resident, the facility must ensure that- (i) A resident receives care, consistent with professional standards of practice, to prevent pressure ulcers and does not develop pressure ulcers unless the individual's clinical condition demonstrates that they were unavoidable; and (ii) A resident with pressure ulcers receives necessary treatment and services, consistent with professional standards of practice, to promote healing, prevent infection and prevent new ulcers from developing. This REQUIREMENT is not met as evidenced by: Based on clinical record review, observation and staff and family member interviews, the facility failed to provide care to prevent the development of pressure ulcers for one of three residents reviewed with pressure ulcers (Resident #1). The facility reported a census of 66 residents. Findings include: The Minimum Data Set (MDS) assessment dated 6/17/18 recorded Resident #1 had diagnoses that included arthritis, anxiety, Alzheimer's disease and schizophrenia. Resident #1 scored 4 out of 15 points on the Brief Interview for Mental Status (BIMS) cognitive assessment, indicating indicated	F 686	Staff education/meetings presented by the administrator were held as follows: 12/5/2018 (daily QA/managers only), 12/6/2018, 12/12/2018 (night shift only), 12/14/2018 and 12/10/2018 (all staff meeting). On 12/7/2018 a QAPI meeting with the Medical Director and other team members was held to discuss the survey findings and corrective action taken to achieve compliance. At that meeting there was a review of resident-specific information. The care plan, care guide, and treatment sheet for Resident #1 and the other residents with skin area, braces, splints, casts, immobilizers, etc. were reviewed to ensure all preventive measures were in place. A meeting was held with the managers on 12/18/2018 to discuss continued compliance. The nurse consultant worked side-by-side the nurse managers on 12/13/2018-12/14/2018 to verify adequate monitoring of the system correction and continued compliance.	

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F 686	Continued From page 5 severe memory and cognitive impairment. The resident required the assistance of one with bed mobility, the assistance of two with transfers and used a wheelchair for mobility. The assessment documented she had no risk of pressure ulcer development and no ulcers at the time of assessment. The resident's care plan documented she had the potential for impaired skin integrity problem related to decreased mobility, incontinence and poor circulation problem and showed an initiation date of 10/21/14. The care plan instructed to provide supplementation as directed by the dietician, to handle Resident #1 carefully due to fragile skin and to float her heels on pillows as tolerated when in bed. Staff care planned an actual impaired skin integrity problem related to immobilizer leg braces on 10/29/18. The care plan directed staff to assess the areas to both (bilateral) lower extremities and initiate skin sheets, initiate treatments per physician orders, and measure the areas per facility guidelines. A hospital Discharge and Transfer Form dated 8/8/18 revealed the resident transferred to the facility under Hospice care with bilateral femur fractures and a fracture of the left 5th digit (finger). The resident did not walk or bear weight and had no skin breakdown identified. The Hospice Comprehensive Assessment and Plan of Care Report for the 8/8/18 to 10/6/18 period revealed the resident as bedbound with bilateral leg immobilizers in place. Review of a Skin Assessment form dated 9/27/18 revealed a 5 centimeter (cm) by 1.5 cm area	F 686	The nurse manager assessed each resident with devices to ensure there were no concerns with skin integrity. On 12/11/2018 the MDS nurse did a facility-wide audit reviewing each resident's skin assessment risk and interventions. Charge nurses are informed and educated related to performing skin inspections on each tour of duty for residents with appliances that can cause skin breakdown ie, braces, splints, immobilizers, casts, etc. and documenting completion of the inspection Nurse managers are monitoring documentation on each tour of duty. The action taken will ensure continued compliance for Resident #1 and all other facility residents.	

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F 686	Continued From page 6 noted on the right ankle and an old scab noted to the right inner ankle with redness that surrounded the scab. A Physician Order dated 9/28/18 directed staff to check the skin to the resident's bilateral lower extremities underneath the immobilizers each shift. On 10/19/18, the weekly wound assessment described the area as a Stage 3 pressure ulcer (full thickness tissue loss, subcutaneous fat may be visible but bone, tendon or muscle is not exposed) that measured 3.2 cm by 3 cm, without depth, with 80 percent slough tissue in the wound, and interventions that included floating her heels and application of sheep's wool to the areas under the immobilizer brace. On 10/29/18, staff documented the right inner ankle wound had worsened Stage 3 pressure ulcer that measured 3.5 cm by 4 cm, with 85 to 90 percent slough in the wound bed, and odorous. A Physician Order dated 10/30/18 directed staff to cleanse her right inner ankle wound with wound cleanser, pat it dry, apply calcium alginate with silver to the wound bed, cover it with a border foam dressing and change daily until healed. Observation of wound care performed by Staff F, LPN (Licensed Practical Nurse) on 11/15/18 revealed a circular shaped open wound on the resident's right inner ankle that measured approximately 3 cm wide, with approximate 0.3 - 0.4 cm depth, slough tissue at the wound bed, tan wound drainage, and a margin of 0.4 - 0.5 cm of redness that surrounded the edge of the wound.	F 686		

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F 686	Continued From page 7 Staff F stated at that time the condition of the wound had greatly improved. During interviews on 12/6/18, the Administrator and Consultant Nurse stated Resident #1 was on bed rest with full length bilateral leg immobilizers with metal bars worn 24 hours per day since her return from the hospital on 8/8/18. Staff turned the resident at least every two hours and the facility had not implemented other skin interventions specific to the leg immobilizers before identification of the pressure ulcer on 9/27/18.	F 686	F 689 Regency Care Center will ensure that each resident receives adequate supervision and assistance devices to prevent accidents. Staff education/meetings presented by the administrator were as follows: 8/5/2018, 8/6/2018, and 8/10/2018 with topic being gait belt use, pocket care plan use, immediate incident reporting, and details related to Resident # .	
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: Based on clinical record review, observation, and resident, family and staff member interviews, the facility failed to ensure that staff performed safe resident transfers which resulted in serious injury for one of six residents reviewed (Resident #1). The facility reported a census of 66 residents. Findings include: The Minimum Data Set (MDS) assessment dated 6/17/18 recorded Resident #1 had diagnoses that included arthritis, anxiety, Alzheimer's disease	F 689	On 8/9/2018 we held a QAPI meeting with the physician to review the self-report/incident and all pertinent information for Resident #1 and all action taken to date. Staff education/meetings presented by the administrator were held as follows: 12/5/2018 (daily QA/managers only), 12/6/2018, 12/12/2018 (night shift only), 12/14/2018 and 12/10/2018 (all staff meeting). On 12/7/2018 a QAPI meeting with the Medical Director and other team members was held to discuss the survey findings and corrective action taken to achieve compliance. A meeting was held with the managers on 12/18/2018 to discuss continued compliance.	

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F 689	Continued From page 8 and schizophrenia. Resident #1 scored 4 out of 15 points on the Brief Interview for Mental Status (BIMS) cognitive assessment, indicating indicated severe memory and cognitive impairment. The resident required the assistance of one with bed mobility, the assistance of two with transfers and used a wheelchair for mobility. The resident's care plan documented a focus area of self care deficit, initiated 8/18/16, which directed two staff were required to transfer the resident, the resident did not walk and she used a wheel chair for mobility. The pocket care plan utilized by the certified nursing assistants (CNA's) last revised on 7/23/18 revealed Resident #1 required the assistance of two staff for transfers. The facility's self-reported incident dated 8/2/18 documented that staff found the resident with multiple bruised areas that morning, the resident said yes when asked if someone had hurt her, had pain upon movement of her left leg and sent to the hospital Emergency Room (ER) for further assessment. X-rays performed in the ER on 8/2/18 revealed a comminuted impacted fracture of the distal right femur and an impacted comminuted fracture of the distal left femur (upper leg bones, the areas near the knee). The facility's investigative summary revealed Staff A, agency CNA, had been assigned to the resident on the 2:00 p.m. to 10:00 p.m. shift on 8/1/18 and she stated she knew the resident required two staff assist to transfer and had the pocket care plan that stated the resident required two for transfer, Staff A stated she transferred the resident from the bed to the wheel chair by	F 689	The nurse consultant worked side-by-side the nurse managers on 12/13/2018-12/14/2018 to verify adequate monitoring of the system correction and continued compliance. The MDS nurse does a weekly review to reconcile each resident's care guide and care plan with the actual transfer technique. Transfer audits are being done on an ongoing basis to ensure proper technique and staff reference to the care guide/care plan. The action taken will ensure compliance with the requirements for Resident #1 and all other facility residents.	

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F 689	Continued From page 9	F 689		

herself and lowered the resident to her knees on the floor prior to the evening meal on 8/1/18. She then lifted the resident back to the bed and to the wheel chair, also by herself. Staff A did not report the incident to any staff as required.

On 12/17/18 at 2:55 p.m., Staff A stated she transferred the resident to bed with Staff B earlier in the shift. She stated the agency she worked for didn't provide her with a gait belt and she didn't have the pocket care plan. Staff A thought everyone transferred Resident #1 by themselves. Staff A stated when she got the resident up for supper she locked the wheel chair, attempted to transfer the resident by herself from bed and the wheel chair scooted back. She lowered the resident to her knees on the floor, her legs were bent under her, she was able to lift her off the floor to her bed, then transferred her to the wheel chair. She stated if a resident falls or is lowered to the floor staff are supposed to report it to the nurse, but she didn't report the incident because she didn't think it was that serious. When questioned the following day by the Administrator, she didn't admit she lowered the resident to the floor because she heard the resident was injured and felt scared of what would happen to her.

During an interview on 11/7/18 at 1:41 p.m., Staff B, CNA, stated she worked on 8/1/18 from 2:00 p.m. - 10:00 p.m. Staff B stated she transferred Resident #1 to bed with Staff A between 2:30 p.m. and 3:00 p.m. without incident. Staff A had asked her to help transfer her from bed for supper and when she got to the room the resident wasn't ready. She asked Staff A to get her when the resident was ready for transfer. Staff B did not assist with the transfer, but Staff A may have had another staff member help her. Staff B saw the

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F 689	Continued From page 10 resident in the dining room for supper that day. The next day, everyone had to write statements because the resident's legs were broken, Staff A approached her and said she already spoke to the Administrator and told her that she (Staff B) assisted with her transfer for supper on 8/1/18. Staff B informed Staff A that wasn't true and she wasn't going to lie for her. On 11/7/18 at 1:53 p.m., Staff C, CNA, stated she worked on 8/1/18 from 2:00 p.m. - 10:00 p.m., she assisted Staff A to transfer Resident #1 from her wheel chair to bed after supper with a gait belt and without incident. The resident needed 2 staff to transfer, the agency CNA's had pocket care plans accessible and available to them, and if they had questions they could ask the nurse questions about a resident's care requirements. During interview on 11/7/18 at 4:34 p.m., Staff E, CNA, stated she worked on 8/1/18 from 10:00 p.m. until 6:00 a.m. At approximately 5:15 a.m. on her last rounds, she turned the lights on to provide care and prepare the resident for day shift and noted a bruise on the resident's left hand. Staff E reported it to the nurse and assisted the nurse when she examined the resident. There were more bruises, the resident had not fallen, got out of bed or indicated pain prior to that on her shift. On 11/8/18 at 10:21 a.m., Staff D, licensed practical nurse (LPN), stated she worked on 8/1/18 from 10:00 p.m. until 6:00 a.m. Staff E called her to the resident's room approximately 5:45 a.m. and asked if she was aware of the resident's bruises. No injuries had been reported by the previous shift. Staff D assessed the resident with another nurse present, noted	F 689		

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REGENCY CARE CENTER	815 HIGH ROAD NORWALK, IA 50211

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F 689	Continued From page 11 multiple bruises that she measured and recorded. The resident grimaced with pain and yelled when her left leg was moved. She called the Director of Nursing and the physician, she received orders to transfer the resident to the ER. During an interview on 11/14/18 at 3:45 p.m., the resident's husband stated he visited Resident #1 every afternoon and saw Staff A transfer the resident alone from the wheel chair to her bed 3 or 4 days before the incident. He told Staff A at the time Resident #1 was a 2 person transfer.	F 689		