DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	165293	A. BUILDING _____ OK FILE B. WING _____	C 12/05/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SOUTHERN HILLS SPECIALTY CARE	444 NORTH WEST VIEW DRIVE OSCEOLA, IA 50213

(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 1/11/2019 Facility reported incident 79279-I and complaints 78949-C , 79791-C, and 79793-C were investigated November 26 - December 5, 2018. All 3 of the complaints were substantiated. The facility reported incident was also substantiated. The following deficiencies relate to the Federal Code of Regulations (42-CFR) Part 483, Subpart B-C.	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 meet professional standards of care when staff failed to remove an old Fentanyl patch before applying a new Fentanyl patch. (Resident #2). The facility census was 84 residents. Findings include: According to the Minimum Data Set (MDS) assessment tool with assessment reference date of 9/1/18, Resident #2 had a Brief Interview for Mental Status (BIMS) score of 4 indicating a severely impaired cognitive status. Resident #2 required extensive assistance with transfers,	F 658		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE — TITLE: Administrator — (X6) DATE: 1/11/19

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 participation.

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F 658	Continued From page 1 dressing, toilet use and personal hygiene needs. Resident #2's diagnosis included congestive heart failure and non-Alzheimer's dementia. According to Resident #2's September 2018 Medication Administration Record (MAR), she is to receive a 25 micrograms per hour Fentanyl patch every 72 hours. The MAR indicates a Fentanyl patch was administered on 9/23/18, 9/26/18 and 9/29/18. According to an Emergency Department report dated 9/29/18, Resident #2 was being seen following a fall at the facility and during the assessment it was discovered 2 different Fentanyl patches were found on Resident #2's body. One dated 9/23 and the other dated 9/29. In an interview on 11/27/18 at 5:55 p.m. Staff D, licensed practical nurse, stated she had been made aware that two Fentanyl patches were discovered on Resident #2 when she went to the emergency department on 9/29/18. One was dated 9/23 and the other 9/29. Staff D indicated she was also aware she was the nurse who administered a Fentanyl patch on 9/26/18 and would have been responsible for removing the 9/23 patch. Staff D stated she must have been unable to find the 9/23 Fentanyl patch on 9/26/18 and remembers telling someone. According to the September 2018 MAR, Staff D documented verification that the 9/23 Fentanyl patch was present on Resident #2's body on 9/24/18 and 9/25/18. In an interview on 11/29/18 at 9:29 a.m. Staff E, pharmacist, was questioned about the effects of leaving a Fentanyl patch on beyond 72 hours while continuing to administer additional Fentanyl	F 658		

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F 658	Continued From page 2 patches as ordered. Staff E stated it is likely there would be some medication delivery beyond the 72 hour life of the Fentanyl patch. Staff E stated the standard of practice would be to remove the old patch before applying a new patch.	F 658		
F 677 SS=E	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 and staff interviews, the facility failed to provide the necessary services to maintain good grooming and personal hygiene for 2 of 3 residents reviewed (Resident #2, #5) and based on record review and staff interviews failed to provide adequate eating assistance for a resident known to pocket food and medications. (Resident #3) The facility census was 84 residents. Findings include: 1) According to the Minimum Data Set (MDS) assessment tool dated 9/1/18, Resident #2 had a Brief Interview for Mental Status (BIMS) score of 4 indicating a severely impaired cognitive status. Resident #2 required extensive assistance with transfers, dressing, toilet use and personal hygiene needs. Resident #2's diagnosis included congestive heart failure and non-Alzheimer's dementia. According to Resident #2's plan of care, she	F 677		

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F 677	Continued From page 3 needs assistance with activities of daily living including one assist with personal hygiene needs and she wears upper dentures and a lower partial plate. During an observation of morning cares on 11/28/18 at 7:20 a.m. two aides (Staff F and Staff G) assisted Resident #2 so she sat up at her bedside. They donned her her socks and shoes before transferring her from her bed onto the toilet using an EZ stand lift. Staff provided perineal care and applied a new brief, then combed her hair, dressed her, and applied her glasses before transferring her into her wheel chair and propelling her to the dining room. Staff asked Resident #2 if she had her dentures in and Resident #2 responded yes. However, staff failed to offer oral care or cleaning of her dentures which had been left in all night. Staff also failed to offer a wash cloth for Resident #2 to wash her face and hands. 2) According to MDS dated 11/7/18, Resident #5 had a Brief Interview for Mental Status (BIMS) score of 3 indicating a severely impaired cognitive status. Resident #5 required extensive assistance with transfers, dressing, toilet use, and personal hygiene needs. Resident #3's diagnosis included non-Alzheimer's dementia. According to Resident #5's plan of care, she needed assistance with activities of daily living including assist of 1 staff for personal hygiene needs. Resident #5 had her own teeth. During an observation of morning cares on 11/28/18 at 7:43 a.m. two aides (Staff F and Staff G) assisted Resident #5 to sit up at her bedside and transferred her from her bed onto the toilet	F 677		

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F 677	Continued From page 4 using an EZ stand lift. Staff provided perineal care, a new brief and dressed Resident #5. They then brushed her hair, applied lip stick and put her glasses on. Staff F asked about her teeth and Resident #5 stated she preferred brushing her teeth after breakfast. Staff F had placed some toothpaste on Resident #5's toothbrush and placed it back into the cabinet. Staff failed to offer a wash cloth for Resident #5 to wash her face and hands. Following breakfast, Staff failed to return to Resident #5's room and provide oral care. At 11:40 a.m. the toothbrush remained in the cabinet with toothpaste on it untouched from earlier. During an observation of morning cares on 11/29/18 at 7:08 a.m. two aides (Staff H and Staff G) assisted Resident #5 to sit up at her bedside and transferred her from her bed onto the toilet using an EZ stand lift. Staff provided perineal care, a new brief and dressed Resident #5. They then combed her hair, and applied lipstick and glasses. Staff failed to offer a wash cloth so Resident #5 could wash her face and hands, and failed to offer oral cares. The toothbrush with toothpaste on it remained in the cabinet untouched from yesterday morning. In an interview on 11/29/18 at 8:10 a.m., the Director of Nursing (DON), stated morning cares should include assisting with toilet use assistance, perineal cares, washing face and hands, oral care, hair combing, cleaning glasses, and applying make up and deodorant. She stated dentures should be removed at night and soaked if resident allows, and documented if they refuse, and day shift would rinse dentures and put them back into the resident's mouth.	F 677		

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F 677	Continued From page 5 In an interview on 11/29/18 at 7:55 a.m. Staff G, certified nurse aide, stated routine morning cares include assisting with toilet use, perineal cares, dressing, hair combing, applying glasses and hearing aides, brushing teeth and washing face and hands. Staff G stated Resident #5 preferred oral care after breakfast. Staff G reported dentures should be removed at bedtime and soaked, and day shift then would rinse and put in the dentures. Staff G stated Resident #2 sometimes didn't allow staff to remove her dentures, but they should swab a resident's mouth if they don't remove their dentures. In an interview on 11/29/18 at 7:50 a.m. Staff H, certified nurse aide, stated morning cares should include assisting residents up to the toilet or checking and changing them, perineal cares, dressing, combing hair, brushing teeth or dentures and washing the resident's face and hands. Staff H also stated dentures should be removed at night and soaked, and day shift should rinse them and put them back in. Staff H reported if dentures not soaked overnight, they can provide some care by removing them, cleaning them and swabbing the resident's mouth. 3. According to the MDS dated 10/25/18, Resident #3 had a Brief Interview for Mental Status (BIMS) score of 15 indicating an intact cognitive status. Resident #3 required extensive assistance with transfers, dressing, toilet use and personal hygiene needs, and supervision with eating. Resident #3's diagnosis included cerebrovascular accident, hemiplegia and dysphagia (difficulty with swallowing). Resident #3's plan of care identified difficulty with	F 677		

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F 677	Continued From page 6	F 677		

chewing and swallowing and contained interventions that included providing encouragement and assistance at meals and also providing a pureed diet with honey thickened liquids.

Nurse's notes dated 9/25/18 at 3:40 p.m. and written by Staff I, licensed practical nurse, documented a report from hospital staff that documented Resident #3 ate a mechanically soft diet, and remained at high risk for aspiration. The note directed staff to crush pills very finely and mix with pudding. The note added Resident #3 did not tolerate applesauce well.

In an interview on 12/5/18 at 9:51 a.m. Staff I was asked why the directive to finely crush pills and put in pudding was not added on the medication administration record (MAR) or written as an order. Staff I stated she passed this information on in report and didn't recall getting an order or placing the information on the MAR.

Nurse's notes dated 9/26/18 at 11:30 p.m. indicated Resident #3 had difficulty swallowing and staff gave applesauce with medications.

Nurse's notes dated 9/26/18 at 1:00 p.m. showed Resident #3 had difficulty swallowing pills and family requested staff crush pills. Staff obtained an order to crush the residents medications at 5:20 p.m.

Nurse's notes dated 9/28/18 at 11:00 p.m. indicated Resident #3 required increased time with swallowing medications.

Nurse's notes dated 9/30/18 at 12:30 p.m. indicated staff crushed Resident #3's medications

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F 677	Continued From page 7 and resident continued to hold medications in mouth and had difficulty swallowing. Nurse's notes dated 10/1/18 at 2:50 p.m. indicated Resident #3's diet changed to pureed with nectar thick liquids. Nurse's notes dated 10/2/18 at 10:00 a.m. documented Resident #3 continued to hold medications in his mouth. Nurse's notes dated 10/3/18 at 6:50 p.m. documented Resident #3 as noncompliant with swallowing food and medications and revealed speech therapy evaluation scheduled this shift. Nurse's notes dated 10/4/18 at 10:20 a.m. revealed Resident #3 continued to hold food and medication in mouth. Nurse's notes dated 10/6/18 at 4:15 a.m. indicated Resident #3 pocketed food. Nurse's notes dated 10/11/18 at 2:15 p.m. indicated Resident #3 new order to change liquids to honey thick. Nurse's notes dated 10/12/18 at 12:30 p.m. and 10/14/18 at 9:30 a.m. documented Resident #3 continued to pocket food. Nurse's notes dated 10/15/18 at 9:40 a.m. indicated Resident #3 continued to pocket food and took up to 30 minutes to take crushed pills. Nurse's notes dated 10/17/18 at 10:55 a.m. and 10/18/18 at 9:25 a.m. revealed Resident #3 continued to pocket food.	F 677		

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F 677	Continued From page 8 Nurse's notes dated 11/19/18 at 4:55 a.m. indicated Resident #3 pocketed food and staff cleaned the resident's mouth with a sponge stick. The note documented the resident would not swallow pills. In an interview on 12/5/18 at 8:55 a.m., Staff J, speech therapist, stated Resident #3 received speech therapy with goals which included improving his swallowing skills. Staff J stated having resident alternate between solids and liquids, doing a lingual (tongue) sweep, and post meal oral care to ensure mouth is free of residual food are all good practices for residents with dysphagia. Staff J reported she had not made any formal recommendations related to feeding Resident #3. In an interview on 12/5/18 at 8:15 a.m. Staff K, certified nurse aide, stated Resident #3 sat at a table at which staff provided assistance to residents (assist table) and could feed himself, but often required needed physical assistance and encouragement to swallow, and was known to pocket food. Staff J stated once he has finished at meals, she would make sure that he had swallowed everything in his mouth. In an interview on 12/5/18 at 8:10 a.m. Staff G, certified nurse aide, stated Resident #3 sat at an assist table and had a diet order for pureed diet with thickened liquids. The CNA reported Resident #3 as known to pocket food and needed much encouragement to swallow. Staff G stated she would try to make sure after meals that Resident #3 didn't have any food that remained in his mouth. In an interview on 12/4/18 at 4:30 p.m. the	F 677		

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F 677	Continued From page 9 Director of Nursing (DON) stated Resident #3 had had a stroke and has dysphagia and she would expect her staff to ensure his needs are addressed upon admission and as needed. DON shown nurse's note dated 9/25/18 in which Staff I documented Resident #3 was at high risk for aspiration and to crush his medications up finely and mix them with pudding as resident does not tolerate applesauce. The DON stated that information should have been written within the physician orders and clearly documented on the medication administration recorded. When asked about the documentation indicating Resident #3 pocketed food and medications and what interventions staff had implemented to ensure he swallowed his food and pills, the DON stated she would have expected staff to assist the resident at meals to ensure he was swallowed and that there would be interventions which would guide staff in this process.	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 and staff interviews, the facility failed to ensure that a resident with pressure sores receives the necessary treatment and services to promote healing, prevent infection	F 684		

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F 684	Continued From page 10	F 684		

and prevent new sores from developing. (Resident #3) The facility reported census was 84.

Findings include:

According to Resident #3's Minimum Data Set (MDS) assessment with assessment reference date of 10/25/18, Resident #3 had a Brief Interview for Mental Status (BIMS) score of 15 indicating intact cognitive skills for daily decision making. Resident #3 required extensive assistance with transfers, dressing, toilet use and personal hygiene needs. Resident #3's diagnosis included cerebrovascular accident (stroke), hemiplegia, dysphagia and diabetes mellitus.

Nurse's Notes dated 10/30/18 at 11:00 p.m. indicate a stage two pressure ulcer observed on Resident #3's left gluteal fold (horizontal area where the bottom of the buttock meets the top of the thigh) that measured 2 centimeters (cm) by 2 cm. No drainage or pain. Apply Calazime topically twice a day until healed.

Care plan dated 11/2/18 indicated Resident #3 with a stage II on left gluteal fold of buttock with interventions which include: Calazime twice daily, 2 ounces of house supplement daily, Vitamin A and stress tab with zinc daily, alternating air cushion and change of treatment on 11/12/18 to Medihoney and cover every Monday, Wednesday and Friday.

According to Wound/Skin healing record on 11/5/18 wound enlarged to 3 centimeter by 3 centimeter with no exudates or odor noted. On 11/12/18 wound had enlarged to 5 centimeters by 5.5 centimeters with 0.1 centimeter depth. No

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F 684	Continued From page 11 exudates or odor noted. Nurse's Notes dated 11/13/18 at 10:45 p.m. indicate order to discontinue the Calazime treatment and start Medihoney with cover M/W/F and as needed. No mention of cleaning wound area prior to treatment. Nurse's Notes dated 11/15/18 at 11:00 p.m. reported to this nurse that dressing was off. New dressing applied. Resident tolerated well. Nurse's Notes dated 11/16/18 at 10:00 a.m. no complaints of discomfort with area on buttocks. Treatment completed as ordered. (written by Staff D). In an interview on 11/28/18 at 3:53 p.m. Staff L, certified nurse aide, stated she had worked the days leading up to Resident #3's hospitalization. Staff L stated the wound on Resident #3's bottom was normal appearing until 11/16/18 at which time Resident #3 was having some increased pain and the wound appeared darker than usual. Staff L stated she informed one of the new nurses, but was uncertain whether the nurse looked at the resident. The next day (11/17/18) the wound was getting worse and the resident was scratching himself. The wound looked infected. Staff L stated she informed Staff D, licensed practical nurse, but was uncertain what she did. By Sunday, 11/18/18 Resident #3's scrotum was swollen and hard and resident was in pain. Staff L informed Staff M, registered nurse and Staff M assessed the resident and was trying to get him sent out, but they wanted a culture first. Staff L stated by the end of the shift several aides were begging to have Resident #3 sent out.	F 684		

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F 684	Continued From page 12 In an interview on 11/28/18 at 5:15 p.m. Staff D, licensed practical nurse, stated she remembered treating Resident #3's gluteal wound on 11/16/18 and noted Resident #3 was scratching at his scrotum at the time but noted no areas of concern. Staff D stated she worked on 11/17/18, but doesn't recall seeing his wound that day. On Monday, 11/19/18 she assessed Resident #3's wound upon arriving to work that morning. The wound area had spread onto the resident's scrotum. The wound was necrotic with greenish drainage and foul odor. Staff D stated she contacted the wound nurse and by 7:20 a.m. had orders to send the resident out to the hospital. In an interview on 11/28/18 at 3:30 p.m. Staff M, registered nurse, stated she was working the afternoon of 11/18/18 when Staff L reported Resident #3's wounds were much worse today. Staff M stated she was not familiar with Resident #3's wounds. Staff M assessed the wounds noting the left gluteal fold had a black greenish border and large amount of green drainage. Resident #3's testicles had two dime shaped black areas. The wounds had a strong odor and Staff M stated she knew immediately it was gangrene. Staff M contacted the nurse practitioner and described the resident's condition. The nurse practitioner ordered an antibiotic and wound culture. Staff M stated in hindsight she knew the resident should have been sent out, but didn't question the orders. In a follow up interview on 12/10/18 Staff M asked if she cleaned the wound that afternoon and changed the dressing which would have been soiled by infectious drainage. Staff M stated she did not clean the wound or change the dressing. In an interview on 12/4/18 at 3:38 p.m. the nurse	F 684		

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F 684	Continued From page 13 practitioner (ARNP) stated she had visited Resident #3 on 11/15/18 and at the time he was not having any complaints of pain. The ARNP recalls getting a call on 11/18/18 in which the nurse reported his wound was getting worse with drainage. The ARNP ordered and antibiotic and wound culture and was informed the wound nurse would be in the following morning. The ARNP stated she doesn't recall specifically what was reported, but noted if she ordered an antibiotic and culture the concern must have been significant. The ARNP stated the resident was sent to the hospital the following morning. The ARNP stated wounds can turn necrotic very quickly, especially when there are contributing factors like poor nutrition, diabetes, etc. The ARNP stated she felt the facility was very attentive to reporting and caring for wounds. In an interview on 11/28/18 at 2:45 p.m. Staff O, wound nurse, stated she had first become aware of Resident #3 developing a wound on his left gluteal fold on 10/30/18. The area was immediately treated with Calazime twice daily until healed. Upon her next assessment on 11/5/18 the wound had enlarged to 3 centimeters by 3 centimeters. Staff O stated Resident #3 was placed on an air mattress, pressure relieving device on his wheelchair and using paper chux to reduce moisture from incontinence. By 11/12/18 the wound had enlarged further to 5 centimeters by 5.5 centimeters with noted hardness. Staff O stated she got an order to change his treatment to Medihoney with dressing cover three times weekly thinking it may help with infection risk as well. On 11/18/18 Staff O received a call from Staff M reporting Resident #3's wound was inflamed with a black green border, brown green drainage and his scrotum had black green areas	F 684		

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as well. An order for a culture and antibiotic was initiated. The next morning Staff O assessed the wound noting the green drainage and blackened area spreading to his scrotum. Staff O contacted the physician and had the resident transferred.

Nurse's Notes dated 11/18/18 at 3:30 p.m. nurse assesses resident's wound on buttocks following staff stating area is more inflamed. Area to left buttock fold noted to have black/green border to area with large amount of brown/green discharge. Wound with foul odor. Also noted to bilateral testicles black/green areas, not opened. This nurse called nurse practitioner and obtained orders to culture wound and start resident on an antibiotic. (No mention of cleaning wound area and treatment)

Nurse's Notes dated 11/19/18 at 4:55 a.m. Resident resting in bed at this time. Redness and necrotic tissue on bottom spreading to scrotum, foul odor.

Nurse's Notes dated 11/19/18 at 6:00 a.m. Resident wounds assessed by nurse and wound nurse. Noted wound spread from left side testicle to gluteal fold. Necrotic tissue and greenish drainage with odor. Nurse practitioner notified and Resident #3 sent to emergency room for further evaluation.

In an interview on 12/4/18 at 12:25 p.m. Staff N, licensed practical nurse, stated she was the charge nurse on 11/18/18 from 6:00 a.m. to 6:00 p.m. and assigned to Resident #3. Staff N remembers Resident #3 was up after lunch, had a poor appetite and was refusing medications. That afternoon the aides reported the resident's bottom and scrotum had sores on them. Staff N

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and Staff M looked at Resident #3's bottom. The dressing was soiled by an earlier bowel movement, so they removed it. There was a foul odor and small black circles on Resident #3's scrotum along with greenish drainage. The aides washed, cleansed, and removed the drainage and bowel movement from the resident's skin while Staff M called the physician. Staff N stated a week earlier the wound had mot been infected and was confined to the left gluteal fold area.

In an interview on 12/5/18 at 9:28 a.m. Staff P, licensed practical nurse, stated she worked the overnight shift (6:00 p.m. to 6:00 a.m.) on 11/18/18 and learned staff had notified the nurse practitioner because Resident #3 had infected wounds on his bottom. She reported the nurse practitioner had ordered a culture and an antibiotic, which Staff P had pulled from the Emergency Kit. Staff P stated she crushed the medication with other medications and put them in applesauce, but Resident #3 refused to swallow the medications. Staff P stated she removed the pills and applesauce from the resident's mouth with a swab.

Review of the Hospital History and Physical revealed Resident #3 was admitted with severe sepsis related to Fournier's gangrene, and underwent surgery for a left orchiectomy (testicle removal) and debridement of Fournier's gangrene. Fournier's gangrene is a rare and often severe and sudden death of parts of the tissue in the perineum (area between the anus and scrotum) and genital region. It is frequently due to a synergistic polymicrobial infection (the combined effect of two or more microbes on disease is worse than seen with any of the individual microbes alone). This truly emergent

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F 684	Continued From page 16 condition is typically seen in elderly, diabetic, or otherwise immune-compromised individuals.	F 684		
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 5 residents reviewed (Resident #1). On 10/16/18 at approximately 6:00 p.m., 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 200 feet away and uphill to a neighboring assisted living facility, until notified by staff from said facility approximately at 6:30 p.m. This constituted an Immediate Jeopardy (IJ) to resident health and safety. The facility identified a census of 84 residents. Findings include: According to Resident #1's Minimum Data Set	F 689	Past noncompliance: no plan of correction required.	

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(MDS) assessment tool dated 10/19/18, Resident #1 had a diagnosis of non-Alzheimer's dementia and a Brief Interview for Mental Status (BIMS) score of 7, which meant the resident displayed severely impaired cognitive skills for daily decision making. The MDS documented Resident #1 ambulated (walked) independently and required supervision with dressing, eating and personal hygiene and limited assistance with toilet use and bathing. The MDS revealed Resident #1 admitted to the facility on 9/25/18.

The Elopement Risk Assessment completed upon admission and on 10/8/18 documented Resident #1 had no history of wandering or exit seeking behavior, no statements of wanting to leave, and was determined as at low risk for elopement.

According to a statement written by Staff A, RN, on 10/16/18 and sometime after 6:00 p.m., Staff A heard the front door alarm sound. After about a minute, she responded to the door and didn't observe anyone in front of the building or parking lot. Staff A stated she did not believe any resident would have had time to walk around the building and out of her sight, so she came back into the facility to disarm the alarm. At 6:30 p.m. Staff A was notified that a resident had left the building.

Observation during the investigation revealed the facility remained in an area outside of town with a fenced field and residential street adjacent to the nursing home. The assisted living facility next door was approximately 200 yards away, with a street running from the nursing home to the assisted living facility uphill, at an approximately a 30 degree incline. The open grass hill between the facility contained an incline of approximately

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F 689	Continued From page 18 45 degrees. In an interview on 11/28/18 at 10:00 a.m. the Director of Nursing (DON) stated the evening of 10/16/18 she was in the dining room (back of the building) when she heard the front door alarm sound. The DON stated she walked toward the front, and when she arrived at the front door, Staff A was there and asked how to shut off the door alarm. The DON showed her and asked if everything was fine; Staff A stated yes. About 15-20 minutes later, she was at the nurse's station and a call came in that informed staff Resident #1 found at a neighboring, non-affiliated assisted living facility. The DON reported she notified the Administrator, then drove to the facility to bring the resident home. The DON stated Resident #1 was laughing, smiling and remained unharmed. He wore jeans, a flannel shirt, socks and shoes, but did not have his wheeled walker with him. The DON reported Staff assessed the resident and found no injuries, then notified the family, who stated it was not uncommon for Resident #1 to walk around the community when he lived at home. In an interview on 11/27/18 at 9:45 a.m. the Administrator stated there was no formal facility policy related to responding to door alarms, but noted during new employee orientation she provided education on the proper response to door alarms. The Administrator stated when an alarm sounds, staff are to respond and not shut off the alarm until they have identified the cause for the alarm. Staff should go outside and search and, if no cause can be identified, staff need to initiate missing resident protocols. Missing Resident protocols address procedure	F 689		

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

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F 689	Continued From page 19 once a resident is identified as missing, but failed to direct or address how staff should determine who is missing. In an interview on 11/27/18 at 10:30 a.m. Staff B, licensed practical nurse stated when a door alarm sounded staff should respond immediately to determine the cause. If they observe a visitor leaving, staff should ask if they set off the alarm. If there is no apparent cause she and other staff would search the grounds for the resident and if no resident found, they would initiate a resident count to determine if anyone was missing. Staff B stated Resident #1 was a "mellow" person and not known to exit seek. In an interview on /27/18 at 10:20 a.m. Staff C, certified nurse aide, stated when a door alarm sounds, staff are to respond and find the reason. If it was a visitor, the alarm can be shut off. If unknown, staff are to search outside while other staff initiate a head count. Staff C stated Resident #1 could move pretty fast with his walker, but typically stayed in his hall and dining room and was not known to display exit seeking or wandering behavior. The facility abated the immediate jeopardy on 10/16/18 (the same day) by implementing the following: 1. The facility educated the staff regarding the expectations when a door alarm sounds. Staff should not silence, turn off, or reset the alarm until they have identified the cause for the alarm. The facility directed staff to go outside and search and, if no cause can be identified, staff need to initiate missing resident protocols (beginning with a head count).	F 689		

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F 689	Continued From page 20 2. The facility ensured no staff clocked in to work with residents until they were re-educated about the above policy.	F 689		

Southern Hills POC 1/11/19

F 658

It continues to be the policy of Southern Hills Specialty Care to provide services for residents that meet professional standards of care.

Nurses will apply and remove fentanyl patches per physician orders for resident # 2, as well as for all other residents who received this medication.

Education was provided to nurses on October 11, when the concern was first identified with resident #2. The education was reviewed again with nurses on January 9, 2018. In addition, a system was put in place to have 2 nurses present when fentanyl patches are applied and removed.

Monitoring will be done by DON and/or nurse managers through the facility's QA process.

F 677

It continues to be the policy of Southern Hills Specialty Care that 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.

Good grooming and personal hygiene will be provided to residents # 2 and # 5, as well as all other residents in the facility. Resident #3 no longer resides at the facility. Adequate eating assistance will be provided to all other residents who reside in the facility.

Education was provided to staff on December 5, 2018 related to providing proper AM care and oral hygiene. This education was reviewed again on Jan 10 & 11, 2019 with staff during the facility's CNA skills fair.

Education was also provided related to monitoring residents with swallowing problems who may be pocketing food, and expectations for providing oral cares and inspecting their oral cavity after meals/med pass.

Monitoring of compliance will be a part of the facility's ongoing QA process.

F 684

It continues to be the policy of Southern Hills Specialty Care to ensure that residents receive treatment and care in accordance with professional standards of practice, the comprehensive person-centered care plan, and the resident's choices.

Resident # 3 no longer resides at the facility. Necessary treatment and services will be provided to all residents of the facility to promote healing, prevent infection and prevent new sores from developing.

Education related to pressure ulcer development, assessment and treatment was provided to nurses on December 3, 2018. On January 9, 2019, the facility contacted the QIO at Telligen to request information and training opportunities on pressure ulcer care and prevention.

Monitoring of compliance will be a part of the facility's QA process.