STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	165167	A. BUILDING _____ B. WING _____	C 01/17/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE VILLAGE	1203 NORTH E STREET INDIANOLA, IA 50125

(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 2/7/19 Investigation of facility-reported incidents # 76847-I and # 79941-I resulted in facility deficiencies. Complaint # 78851-C was not substantiated. Please see the Federal Code of Regulations (42-CFR) Part 483, Subpart B-C	F 000	F000 This constitutes our written credible allegation of compliance as of 2-7-19.	
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: The following deficiency relates to facility self report # 79941-I: Based on clinical record review, observations, and staff and family member interviews, the facility failed to recognize a door alarm sounding, leading to the unknown exit (elopement) of one of four sampled residents (Resident #1). The facility reported a census of 52. Findings include: According to Resident #1's Minimum Data Set (MDS) assessment dated 11/14/18, Resident #1	F 689	F 689 PLAN OF CORRECTION This plan of correction does not constitute an admission or agreement by the provider to the accuracy of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of corrections is prepared and/or executed solely because it is required by the provisions of federal and state law. Completion dates are provided for procedural processing purposes and correlation with the most recently completed or accomplished corrective action and do not correspond chronologically to the date the facility maintains it is in compliance with the requirements of participation, or that corrective action was necessary.	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE 01/31/2019

POC accepted 2/18/19 VS Iowa/Nebraska

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	165167	A. BUILDING _____ B. WING _____	C 01/17/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE VILLAGE	1203 NORTH E STREET INDIANOLA, IA 50125

(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 1 had a Brief Interview for Mental Status (BIMS) score of 2 indicating severely impaired cognitive skills for daily decision making. Resident #1 walked independently and required assistance with dressing, toilet use and personal hygiene needs. Resident #1's diagnoses included Non-Alzheimer's dementia, anxiety and restlessness and agitation. Resident #1 admitted to the facility on 10/31/17 and resided on a locked memory care unit. Resident #1's care plan initiated on 10/26/18 indicated he will wander into other resident rooms and at times will try to leave the dementia unit. Approaches included moving Resident #1 closer to the nurse's station for safety, redirection and interaction strategies to help keep him calm. Interdisciplinary notes reviewed from 10/1/18 through 11/30/18 revealed several entries in which Resident # 1 wandered and/or attempted exit from the nursing facility. On 10/13/18 at 5:39 p.m. Resident #1 sought exit multiple times and set off facility door alarms. On 10/29/18 at 6:15 a.m. Resident #1 wandered and targeted exit doors. Resident #1 eventually opened an exit door into the stairwell and the exterior door outside. Staff redirected him back into the facility. On 11/18/18 at approximately 7:45 p.m. Resident #1 was escorted onto the memory care unit accompanied by three staff. Resident #1 wore pajamas and slippers and had no visible injuries. On 11/19/18, Resident # 1 woke at 4:00 a.m. and confused stating it was time to milk the cows. Resident #1 made several attempts to open the exit door and attempted to enter other resident rooms. In an interview on 1/14/19 at 3:00 p.m. Staff G,	F 689	The Village has completed the following interventions as a result of the incident on November 18, 2018 and the findings from the survey exiting January 16, 2019. The interventions were developed to address the resident directly affected by the incident, the residents with the potential to be affected, the system changes necessary to prevent reoccurrence, the monitoring process for successful implementation of the changes, and the quality assurance process that will be implemented and monitored. The facility was in substantial compliance as of 01/15/19. F689 SS-IJ Free of Accident Hazards/Supervision/Devices	1-31-19

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	165167	A. BUILDING _____ B. WING _____	C 01/17/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE VILLAGE	1203 NORTH E STREET INDIANOLA, IA 50125

(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 2 licensed practical nurse (LPN), stated prior to Christmas, Resident #1 was frequently wandering and pushing on doors. Staff G remembered him once exiting into the north stairwell. Staff G stated Resident #1 would not come back in and they left the alarm sounding until additional help arrived. Staff G stated standard protocol when door alarms sound is to respond immediately and verify the cause for the alarm. If there is not a clear reason for the alarm to sound, staff are to step outside and search and if still uncertain, conduct a head count of residents to ensure everyone is accounted for. In an interview on 1/10/19 at 2:31 p.m. a family member of another resident stated that on the evening of 11/18/18 she and her husband visited her father and walked back to the guest residence. As they exited the building through the blue doors into the meditation garden, they saw a male resident (Resident #1) walking towards them dressed in pajamas and slippers. Resident #1 stated he wanted to go home. The family member escorted Resident #1 back into the building and got someone to help. Review of the Device Activity Report on 11/18/18 indicated the south stairwell alarm activated at 7:35.04 p.m. and the front entrance into the memory care unit alerted at 7:39.44 p.m. The time frame from when Resident #1 first activated the south stairwell door alarm until visitors brought him back into the memory care unit measured 4 minutes and 40 seconds. A facility video (copy) of door (blue) in which resident was escorted back into facility did not contain a timestamp, but did record time. Based on video time and known Device Activity Report, Resident #1 exited the south stairwell at 7:35.19 p.m., was	F 689	1. On 11/18/18, immediately implemented 15-minute checks after the resident returned to the building and completed a full head to toe assessment, notified the physician and notified the family. 2. On 11/18/18, shortly after the incident, Administrator tested all door alarms and pagers to ensure proper functioning and sounding loudly. 3. Implemented immediate education on 11/19/18 for the three team members on shift (2 CNAs, 1 licensed nurse). Our team members were educated on the elopement process and checking/responding to pager system immediately. 4. All staff education was provided on elopement process, checking and responding to pager system timely on 1/29/18 and 11/30/18 and 12/28/18. 5. Added audio monitors on 1/15/19 by the south and north stairwells to assist CNAs ability to hear door alarm when in other residents rooms. In-serviced staff on 1/15/19 and 1/16/19 on the audio monitor system. The audio monitor was in place until our wanderguard system installation was completed on 1-31-19	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	165167	A. BUILDING _____ B. WING _____	C 01/17/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE VILLAGE	1203 NORTH E STREET INDIANOLA, IA 50125

(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 3 discovered by the visiting family at 7:36.30 p.m., escorted into the facility at 7:36.40, staff arrived at 7:37.14, other staff, including the Administrator arrived at 7:38.19 p.m. and escorted Resident #1 into the memory care unit at 7:39.44 p.m. Observation of the distance from the south exit to the blue door entry revealed approximately 115 feet of flat sidewalk with some elevated landscaping along the north edge of the sidewalk. The sidewalk was snow covered and the reported temperature measured 22 degrees Fahrenheit. The other direction lead to a small parking area, open grass field and residential neighborhood. In an interview on 1/15/19 at 12:10 p.m. the Administrator stated the evening of 11/18/18 he was in the facility when he learned that Resident #1 had been discovered outside by some visitors and escorted back in. The Administrator and two other staff responded to the hallway and escorted Resident #1 back to the memory care unit where he resides. Upon entering the memory care unit, the Administrator stated he could hear the south stairwell door alarm sounding. The Administrator stated the staff working on the memory care unit came from the dining room area (opposite side of the unit from south stairwell) and were unaware of the sounding door alarm or that Resident #1 exited. The Administrator had the south door alarm deactivated and tested it again. The south door alarm functioned properly and sounded. Staff A, LPN, stated she didn't hear the alarm and it didn't activate on her pager. Staff B, certified nurse aide (CNA) and Staff C, CNA also stated their pagers did not alert them of the door alarm. The Administrator stated they checked Staff B's pager and it had dead batteries. The Administrator replaced the batteries and then	F 689	6. On 1-15-19 the door checking process was amended to also include checking pagers. Nursing staff were In-serviced, with live demonstration provided, 1-15-19 and 1-16-19 as they came on shift on our amended process to check pagers, at change of shift, at all exits. Training was also conducted at mandatory meetings on 1-17-19 and 1-18-19. Training included that a log to check for proper pager function, in conjunction with the door alarm system checks, has been implemented every shift. Issues are to be reported to the DON immediately. 7. Wander guard equipment was already in place in Juniper and Magnolia halls at the time of survey. Wanderguard installation was completed in Willows on 1-31-19. 8. Housekeeping supervisor will check door alarm system monthly and log the results and will report results through the community QA Process. 9. The DON or designee will develop a PIP related to Elopement and the elopement monitoring/communication systems which will be reviewed during the community QAPI meetings.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	165167	A. BUILDING _____ B. WING _____	C 01/17/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE VILLAGE	1203 NORTH E STREET INDIANOLA, IA 50125

(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 4	F 689		

activated the door alarm again, this time noting that all three pagers alerted properly. The Administrator stated the staff were all re-educated on responding to door alarms and on the process of elopements. The facility is in the process of getting a Wanderguard system as a secondary system. The Administrator stated the door alarm volumes cannot be adjusted and they considered some form of an amplification system. The Administrator stated the Director of Nursing (DON) checked on the weather conditions for the evening of 11/18/18 and stated the temperature was 22 degrees Fahrenheit. In a follow up interview on 1/17/19 at 11:10 a.m. the Administrator stated when he had entered the memory care unit on 11/18/18 with Resident #1, he remembered requesting the pager from Staff A and remembered Staff A having to go back to the nurses station to get her pager.

On 1/10/19 at 2:00 p.m. Staff A, LPN, stated she worked the evening of 11/18/18 on the memory care unit, in the dining room area supervising a tube fed resident and a couple of others who needed supervision. Her aides, Staff B and Staff C, provided resident cares in a room on the north side of the unit. Staff A stated it was only her second day working alone as a new nurse. She heard a faint buzzing sound but didn't recognize it as a door alarm and didn't respond to the area to investigate the sound. About that same time another resident walked into the dining room area from the south side of the unit. Staff A asked the resident why she was up (resident was in bed earlier). The resident stated because of that loud sound. At that time, Staff D, Staff E and the Administrator walked onto the memory care unit, escorting Resident #1. Staff A learned Resident #1 had exited through the south stairwell and was

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	165167	A. BUILDING _____ B. WING _____	C 01/17/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE VILLAGE	1203 NORTH E STREET INDIANOLA, IA 50125

(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	F 689		

found outside. Staff A stated she carried the nurse pager and it never went off. In a follow up interview on 1/14/19 at 11:35 a.m. Staff A, stated she had been orientated regarding sounding door alarms and the standard response, but was not given demonstration on what a door alarm sounds like. Staff A stated they had pagers which were suppose to alert them if exit door alarms sound, but hers did not activate when Resident #1 exited through the south stairwell. Staff A stated the Administrator asked if the pagers alerted them and she told him no. The Administrator then tested the door alarm and pagers and Staff A stated her pager again did not activate when the south stairwell alarm was activated. In a follow up interview on 11/17/19 at 11:20 a.m. Staff A reiterated her pager did not sound on the evening of 11/18/18 when Resident #1 exited through the south stairwell. Staff A remembered her pager activated when the Administrator and others entered the memory care unit through the front entrance and she had the pager in her possession. Staff A stated as part of her shift responsibilities she has checked door exits for proper functioning, but noted she only checks to see if the green light is on and doesn't actually activate the alarm.

In an interview on 1/14/19 at 8:36 a.m. Staff B, CNA stated she worked a double shift (day/evening) on 11/18/18. At around 7:30 p.m. she and Staff C were in a resident's room (1352 north side) assisting with a transfer and cares. The door was closed and they did not hear a door alarm sound. Once finished they walked into the TV/dining area as Resident #1 was being escorted onto the memory care unit. They were informed Resident #1 had eloped. Staff B stated she has a pager which will activate when door

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	165167	A. BUILDING _____ B. WING _____	C 01/17/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE VILLAGE	1203 NORTH E STREET INDIANOLA, IA 50125

(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	F 689		

alarms sound, but her pager batteries were dead. In a follow up interview on 1/14/19 at 11:46 a.m. Staff B stated her pager was dead on the evening of 11/18/18. She worked a double shift that day and didn't make sure her pager remained charged. Staff B stated she usually places her pager on vibrate as the sounding alarm bothers residents, especially on the memory care unit. Staff B stated pagers are programmed specifically for each unit, but she did not know whether all pagers are set up to respond to all door alarms.

In an interview on 1/10/19 at 3:37 p.m. Staff C, CNA stated she worked the evening shift on the memory care unit on 11/18/18 and around 7:30 p.m. she worked in room 1352 with another aide (Staff B) putting a resident to bed. The door was closed and Staff C could not hear any door alarms sounding. Staff C stated she left the room a few moments ahead of Staff B. When Staff C walked around the corner into the TV/dining room area, several staff were standing with Resident #1. Staff C learned Resident #1 had exited through the south stairwell and a visitor discovered him outside. Staff C stated she had a pager, but it never activated. Staff C stated she looked at the pager afterwards and it had no entry of the south door alarm sounding.

In an interview on 1/10/19 at 10:50 p.m. Staff F, Housekeeping Supervisor, stated she is responsible for monitoring door alarm function each month and as needed issues are identified. Staff F stated a device activity report was printed out for the memory care unit on 11/18/18. Staff F stated when a door alarm activates, it will open after a 15 second delay and show up as cleared on the device activity report, but will continue to

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	165167	A. BUILDING _____ B. WING _____	C 01/17/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE VILLAGE	1203 NORTH E STREET INDIANOLA, IA 50125

(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 sound until manually deactivated by a key. In a follow up interview on 1/14/19 at 11:58 a.m. Staff F stated she checks door alarms each month to ensure door alarms are functioning properly, but does not document the checks. Staff F also runs off a report that will tell her what isn't working. Pagers are set up for each specific unit related to call lights and door alarms. Pagers that are not working will show up on the monthly report. Staff also have extra batteries at the nurse's station on each unit. Staff F stated she does not check alarm volumes at different locations on the unit. During an observation on 1/10/19 at 11:10 a.m. this surveyor, accompanied by Staff F, depressed the south stairwell door bar. The door alarm immediately sounded and opened following a 15 second delay. The alarm continued to sound until manually keyed off. The second door in the stairwell was pushed, but would not open. Staff F stated the door will not open unless keyed open; the facility locked the second door after the elopement incident. When tested, the three pagers on the memory care unit activated properly when the door alarm activated. This surveyor then walked to the far north side of the memory care unit and had Staff F activate the south stairwell door alarm. While in the north hallway, the tone was very faint and inaudible if in a resident room with the door shut. The TV/dining area was a little more audible, but still faint. On 1/14/19 at 12:27 p.m. the pagers were again tested on the memory care unit. All three pagers alerted within 20 seconds of the door alarm activating. In an interview on 1/16/19 at 2:30 p.m. the DON stated nursing staff are to check door alarms each shift and record the functioning status.	F 689		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	165167	A. BUILDING _____ B. WING _____	C 01/17/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE VILLAGE	1203 NORTH E STREET INDIANOLA, IA 50125

(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 Starting today, nurses have been directed to include checks of the pagers for proper functioning. The DON provided documentation of door alarm checks in each unit for October, November and December 2018. The elopement incident detailed above resulted in an Immediate Jeopardy (IJ) situation for facility residents. The facility abated the IJ on 1/17/19 through a combination of 15-minute checks for Resident #1, ensuring audibility and function of pager system, all staff education of the facility's elopement procedures, adding audio monitors on south and north stairwells and a Wanderguard system and providing staff direction to check the door alarms, exit doors and bracelets for function every shift.	F 689		
F 730 SS=B	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 facility record review and staff interview, the facility failed to ensure nurse aides receive annual performance evaluations for four of ten nurse aides reviewed. The facility identified a census of 52 residents. Findings include: Record review of ten certified nurse aides	F 730	F 730 PLAN OF CORRECTION This plan of correction does not constitute an admission or agreement by the provider to the accuracy of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of corrections is prepared and/or executed solely because it is required by the provisions of federal and state law. Completion dates are provided for procedural processing purposes and correlation with the most recently completed or accomplished corrective action and do not correspond chronologically to the date the facility maintains it is in compliance with the requirements of participation, or that corrective action was necessary. §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).	1-31-19

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	165167	A. BUILDING _____ B. WING _____	C 01/17/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE VILLAGE	1203 NORTH E STREET INDIANOLA, IA 50125

(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 9 revealed nine aides in which performance evaluations were not being completed at least every 12 months: a. Staff M began working at the facility on 6/17/13. Staff M had records of performance evaluations in 6/14, 9/16 and 6/17 only. b. Staff N's hire date was 9/14/16. Staff N had the record of one performance evaluation in 11/18. c. Staff R's hire date was 10/4/11. Staff R had records of performance evaluations in 10/13, 11/15 and 11/18. d. Staff S began work at the facility on 5/11/16. Staff S had a record of a performance evaluation in 6/17 only. In an interview on 1/15/19 at 4:45 p.m. the Director of Nursing (DON) stated annual performance evaluations were not being completed consistently by the previous DON and she has been working to get everyone up to date.	F 730	- To correct the deficiency: The evaluations for all four staff members had already been completed before the time of the survey. -To ensure problem does not recur: The HR director will provide DON with evaluation due dates at least one month prior to review date. - As part of The Village ongoing commitment to quality assurance the DON and/or designee shall monitor the system for compliance and take any concerns through our QAPI committee.	
F 755 SS=E	Pharmacy Srvcs/Procedures/Pharmacist/Records CFR(s): 483.45(a)(b)(1)-(3) §483.45 Pharmacy Services The facility must provide routine and emergency drugs and biologicals to its residents, or obtain them under an agreement described in §483.70(g). The facility may permit unlicensed personnel to administer drugs if State law permits, but only under the general supervision of a licensed nurse. §483.45(a) Procedures. A facility must provide pharmaceutical services (including procedures that assure the accurate acquiring, receiving, dispensing, and administering of all drugs and biologicals) to meet the needs of each resident.	F 755		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	165167	A. BUILDING _____ B. WING _____	C 01/17/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE VILLAGE	1203 NORTH E STREET INDIANOLA, IA 50125

(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 755	Continued From page 10 §483.45(b) Service Consultation. The facility must employ or obtain the services of a licensed pharmacist who- §483.45(b)(1) Provides consultation on all aspects of the provision of pharmacy services in the facility. §483.45(b)(2) Establishes a system of records of receipt and disposition of all controlled drugs in sufficient detail to enable an accurate reconciliation; and §483.45(b)(3) Determines that drug records are in order and that an account of all controlled drugs is maintained and periodically reconciled. This REQUIREMENT is not met as evidenced by: The following deficiency relates to facility self report # 76847-I: Based on clinical record review and staff interviews, the facility failed to implement a procedure to ensure an accurate dispensing and administering of controlled medications, ensure the integrity of controlled medication packaging and ensure an account of all controlled medications is maintained and periodically reconciled for one of four residents reviewed (Resident #2). The facility identified a census of 52 residents. Findings include: The Minimum Data Set (MDS) assessment dated 11/21/18 documented Resident #2 had a Brief Interview for Mental Status (BIMS) score of 15 indicating intact memory and cognitive status.	F 755	F 755 PLAN OF CORRECTION This plan of correction does not constitute an admission or agreement by the provider to the accuracy of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of corrections is prepared and/or executed solely because it is required by the provisions of federal and state law. Completion dates are provided for procedural processing purposes and correlation with the most recently completed or accomplished corrective action and do not correspond chronologically to the date the facility maintains it is in compliance with the requirements of participation, or that corrective action was necessary. §483.45 Pharmacy Services The facility must provide routine and emergency drugs and biologicals to its residents, or obtain them under an agreement described in §483.70(g). The facility may permit unlicensed personnel to administer drugs if State law permits, but only under the general supervision of a licensed nurse.	7-11-18

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	165167	A. BUILDING _____ B. WING _____	C 01/17/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE VILLAGE	1203 NORTH E STREET INDIANOLA, IA 50125

(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 755	Continued From page 11 Resident #2 received a scheduled pain medication regimen, had pain during the assessment timeframe and rated her worst pain at four with ten being the worst pain imaginable. The June 2018 Medication Administration Record recorded Resident #2 received Acetaminophen 650 milligrams twice daily in the morning and at 3:00 p.m. and Acetaminophen with Codeine (or Tylenol #3) two tablets at bedtime. Resident #2 also had an as needed order for Acetaminophen with Codeine two tablets daily. In an interview on 1/9/19 at 4:38 p.m. Resident #2 stated she remembered the evening (6/18/18) in which a nurse (Staff H) tried to give her regular Tylenol instead of Tylenol #3. The nurse insisted he was right, but finally gave her her right medications. Resident #2 stated she has had no further medication problems since. In an interview on 1/9/19 at 2:49 p.m. Staff H, licensed practical nurse (LPN) stated he remembered on night (6/18/18) in which he came in at 6:00 p.m. and completed the shift change narcotic count, noting everything was fine and he took possession of the medication cabinet keys. Sometime around 9:00 p.m. he took Resident #2 her bedtime pain medication (Acetaminophen/codeine #3). Staff H stated he was told Resident #2 could take her medications independently, so he delivered the medications and left the room. A short time later an aide reported Resident #2 felt upset and wanted her pain medication. Staff H started down the hall as Resident #2 headed up the hall. Resident #2 was crying and saying the medications given to her were not Tylenol #3, but instead just regular Tylenol. Staff H stated he returned to the	F 755	-To correct the deficiency the DON or ADON Immediately did an audit of packaging on all narcotics on 6-20-18. The DON provided education on proper storage of medication, narcotic policy/procedure, proper medication administration and narcotic audits. Completed on 7-11–8. -To ensure problem does not recur, The DON/ and or designee Completed daily narcotic audits x 30days then weekly. - As part of The Village ongoing commitment to quality assurance the DON and/or designee shall monitor the system for compliance and take any concerns through our QAPI committee.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	165167	A. BUILDING _____ B. WING _____	C 01/17/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE VILLAGE	1203 NORTH E STREET INDIANOLA, IA 50125

(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 755	Continued From page 12	F 755		

medication cabinet and realized he had pulled the medication from the as needed (prn) bubble pack containing Tylenol #3 instead of the routine bedtime bubble pack of Tylenol #3. Staff H removed two tablets of Tylenol #3 from the routine bedtime bubble pack and gave those to Resident #2. Staff H then took the initial medication cup with the regular Tylenol pills to Staff I and showed her. Together they verified the pills were in fact regular Tylenol. Staff H stated the pills that he had removed from the prn bubble pack of Tylenol #3 had been previously taped over, but he did not ensure what he gave was in fact Tylenol #3. Staff H stated they called the nurse supervisor (Staff J), who stated they needed to go through everyone's narcotics to ensure no other narcotics had been tampered with and that any narcotics with tape over the back shall be photo copied and the medication destroyed. Staff H stated Staff I pulled several bubble packs with taped over backing, removed the effected doses and wasted the medications. Staff H stated there were a handful of pills, maybe 7-10, that they placed in the drug buster (for drug disposal). Staff H did not verify whether the medications were what they should have been or substitutes, but stated he signed the controlled medication utilization records with Staff I. Staff H stated he later discovered the keys for one unit would also open the cabinets on the other units.

In an interview on 1/17/19 at 2:30 p.m. Staff I, LPN, stated she worked the evening (6/18/18) when Staff H approached her, claiming Resident #2 felt upset because she she received the wrong medications. Resident #2 was supposed to receive Tylenol #3 at bedtime and given instead regular Tylenol. Staff H had reported pulling two

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	165167	A. BUILDING _____ B. WING _____	C 01/17/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE VILLAGE	1203 NORTH E STREET INDIANOLA, IA 50125

(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 755	Continued From page 13	F 755		

pills from the prn bubble pack of Tylenol #3 and that it had tape over the back of the foil. Staff I stated they gave Resident #2 the correct medication and contacted the on call supervisor. The supervisor instructed her to go through all of the bubble packs to ensure no other medications were tampered with. Staff I stated there were two additional bubble packs which had been taped over, but in each of those cases the medication in the packaging was correct. Staff I could not recall the details regarding why two tabs of Tylenol #3 from the prn bubble pack were recorded as destroyed, when those two tabs were actually regular Tylenol.

In an interview on 1/9/19 at 4:46 p.m. Staff J, Registered Nurse, stated she received a phone call on the evening of 6/18/18 from Staff I reporting Tylenol #3 belonging to Resident #2 had been replaced with regular Tylenol. Staff I instructed Staff J to go through all of the narcotics to ensure no other narcotics were being tampered with. Staff J recalled a couple of additional bubble packs which had pills taped over, but the pills were legitimate. Staff J stated Staff I photocopied the bubble packs, but doesn't recall that staff destroyed the medications.

On 1/17/19 at 10:15 a.m. the Director of Nursing (DON) stated there is no formal policy related to controlled medications packaging being tampered with or specifically with staff examining packaging during shift change narcotic counts. The DON would expect that any packaging with tampering or tape over the foil should immediately cause concern and the DON should be notified so that an investigation can be initiated. The DON stated it was unacceptable for any narcotic or non-narcotic to be placed back into a bubble pack

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	165167	A. BUILDING _____ B. WING _____	C 01/17/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE VILLAGE	1203 NORTH E STREET INDIANOLA, IA 50125

(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 755	Continued From page 14 and putting tape over the back and once a narcotic is removed from the bubble pack, it should be destroyed per facility protocols if not administered.	F 755		