STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	165352	A. BUILDING _____ B. WING _____	C 04/01/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
EMMETSBURG CARE CENTER	**2405 21ST STREET EMMETSBURG, IA 50536**

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F 000	INITIAL COMMENTS Amended 6/10/2019 following an IDR. Correction date_____ An investigation of Complaint 80498-C completed 4/1/19 resulted in the following deficiencies. Complaint #80498 was not substantiated. See Code of Federal Regulations (42CFR) Part 483, Subpart B-C.	F 000		
F 580 SS=J	Notify of Changes (Injury/Decline/Room, etc.) CFR(s): 483.10(g)(14)(i)-(iv)(15) §483.10(g)(14) Notification of Changes. (i) A facility must immediately inform the resident; consult with the resident's physician; and notify, consistent with his or her authority, the resident representative(s) when there is- (A) An accident involving the resident which results in injury and has the potential for requiring physician intervention; (B) A significant change in the resident's physical, mental, or psychosocial status (that is, a deterioration in health, mental, or psychosocial status in either life-threatening conditions or clinical complications); (C) A need to alter treatment significantly (that is, a need to discontinue an existing form of treatment due to adverse consequences, or to commence a new form of treatment); or (D) A decision to transfer or discharge the resident from the facility as specified in §483.15(c)(1)(ii). (ii) When making notification under paragraph (g)(14)(i) of this section, the facility must ensure that all pertinent information specified in §483.15(c)(2) is available and provided upon request to the	F 580		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE 04/08/2019

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physician.
(iii) The facility must also promptly notify the resident and the resident representative, if any, when there is-
(A) A change in room or roommate assignment as specified in §483.10(e)(6); or
(B) A change in resident rights under Federal or State law or regulations as specified in paragraph (e)(10) of this section.
(iv) The facility must record and periodically update the address (mailing and email) and phone number of the resident representative(s).

§483.10(g)(15)
Admission to a composite distinct part. A facility that is a composite distinct part (as defined in §483.5) must disclose in its admission agreement its physical configuration, including the various locations that comprise the composite distinct part, and must specify the policies that apply to room changes between its different locations under §483.15(c)(9).
This REQUIREMENT is not met as evidenced by:
Based on record review and staff interview the facility failed to immediately inform the resident; consult with the resident's physician; and notify, consistent with his or her authority, the resident representative(s) when there is- a significant change in the resident's physical, mental, or psychosocial status (that is, a deterioration in health, mental, or psychosocial status in either life-threatening conditions or clinical complications); for 1 of 7 residents reviewed. Resident #3 developed symptoms including loose stools and decreased appetite.The resident was later found to have clostridium difficle (c.difficle) and expired. Cause of death included: c.difficle.

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Facility census was thirty-nine (39) residents.

Findings include:

1. A Minimum Data Set (MDS) with assessment reference date of 11/21/18, assessed Resident #3 with a brief interview for mental status (BIMS) score of "12" (moderate cognitive impairment). The resident required limited staff assistance with bed mobility, transfers, ambulation in and out of room and personal hygiene. The resident required extensive staff assistance with toileting, dressing and bathing. The resident had functional range of motion limitations of the upper and lower extremities on one side of the body. The resident was occasionally incontinent of bowel. The resident had left hip and left humerus fractures from 10/23/18.

Bowel records identified the resident with the following loose stools:
12/2/18 loose diarrhea
12/4/18 4 bowel movements, 3 of them loose stools
12/5/19 4 bowel movements, at least 3 of them with loose stools
12/6/19 loose stools 2 times

A progress note dated 12/6/18 at 1:49 a.m. revealed the resident had loose stools up to 6 times daily. The night of the entry, the resident was up to the toilet and incontinent 7 times. The resident self transferred so she could make it in time. Staff encouraged the resident not to self transfer. Staff prepared a document that included the information for physician review and advise.
12/7/18 loose stools 2 times
12/8/19 loose stools 7 times

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Review of the 12/6/18 progress note identified the physician acknowledged it on 12/15/18 and wrote "patient hospitalized". On 3/18/18 at 11:22 a.m. when the surveyor questioned the delay in the physician response, the director of nursing (DON) stated the physician was out of the country on 12/6/18 and addressed it the day she came back (12/15/18). She stated no one from the facility renotified the physician when no response was received from the 12/6/18 communication. The DON stated if a communication to the physician is not back in 24 hours staff typically calls the physician.

On 3/18/19 at 12:48 p.m. the physician stated the 12/6/18 communication to the physician was a progress note that the facility hand carried to the physician office. Since she was gone, she expected her colleagues to address it. Since it fell through the cracks, and the facility didn't hear from anyone, they should have called the clinic. She stated if she would have worked on 12/6/18 and received the facility communication regarding the resident, she would have ordered stool studies. She stated she cant speak for what her colleagues may have done due to their being more than one way to handle the situation. She stated when the resident had 2 loose stools, the facility may have thought the issue was resolving so she would not expect a call then unless the resident's appetite decreased ,or if she had pain or fever. On 12/8/18 when the resident had 10 loose stools, the facility should have called. She stated delay of notification did not help the resident. The faster the etiology is determined and reversed, the better the outcome is. There may have been a different outcome if they notified sooner but unknown.

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On 3/19/19 at 9:12 a.m. the ADON (assistant director of nursing) stated every day the facility takes printed communication for physicians to the clinic and picks up the finished communication notes that physicians have reviewed. The time of day this is done varies. If a resident is going to the clinic, they will drop off and pick up communication notes at that time.

On 3/19/19 at 10:23 a.m. the DON stated they became aware of the issue with the physician communication sheet not returned sometime after the physician returned on 12/15/18 and before the first of the year. The physician reviewed with her office that other providers need to check her communication notes from the facility when she is gone. She did this between 12/15/18 and the first of the year and again yesterday after the surveyor questioned it. On the same date at 11:27 a.m. the DON stated she is the one that keeps track of physician communications returning timely. She stated she didn't know what happened with Resident # 3's communication note on 12/6/18. She wishes she knew. She stated she keeps track through progress notes if things come back from the doctor. There's been no change in their procedure for tracking physician communication and there has been no other issues.

A progress note dated 12/9/18 at 5:51 a.m. revealed the resident loudly called out for help. Staff observed the resident rolling side to side saying she needed the rest room. The resident felt warm to the touch. Vital signs: temperature 97.9 degrees, pulse 96, respirations 20, blood pressure 112/55 and oxygen saturation 98%. The resident was very weak and unable to stand. The resident's bowel sounds were hypoactive. The

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resident's skin tented on the dorsal aspect of both hands. The resident complained of severe belly cramps. Staff called ER (emergency room) and the resident transported to the hospital.

An ED (emergency department) final report dated 12/9/18 revealed the resident presented weak and dehydrated. The resident's oral mucosa was very dry. The resident's skin turgor was "tenting". The resident's blood laboratory work revealed the following: BUN (blood urea nitrogen) 63 high, creatinine 1.87 high, sodium 146 high, potassium 2.6 low, chloride 118 critical high, CO2 15 low, BUN/creatinine ratio 33.7 high, WBC (white blood cell) 18.8 high. The diagnosis was clostridium difficle (c.difficle) diarrhea.

Hospital discharge documentation dated 12/12/18 identified the resident's admission diagnoses to include: c. difficle colitis, acute diarrhea and acute kidney injury. The discharge diagnoses included: c. difficle colitis currently on oral vancomycin (antibiotic) and IV flagyl (antimicrobial), acute diarrhea slowly improving and acute kidney injury improved. The report revealed the resident would be admitted to skilled care for continued IV fluids and IV antibiotics. Hospice is considered and family will arrive on 12/14/18 to discuss it.

Review of appetite records with percentages of meals eaten revealed a decline in food intake:

12/2/18 11:24 a.m. 25%
12/2/18 12:38 p.m. 75%

12/3/18 9:23 a.m. 12%
12/3/18 1:11 p.m. refused
12/3/18 6:55 p.m. zero

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12/4/18 9:44 a.m. 25%
12/4/18 1:04 p.m. 12%
12/4/18 6:05 p.m. zero

12/5/18 9:45 a.m. 25%
12/5/18 12:44 p.m. 50%
12/5/18 7:04 p.m. zero

12/6/18 9:25 a.m. 12%
12/6/18 12:38 p.m. 12%
12/6/18 7 p.m. 12%

12/7/18 9:26 a.m. 12%
12/7/18 12:28 p.m. 12%
12/7/18 6:13 p.m. 30%

12/8/18 12:07 p.m. 25%
12/8/18 1:01 p.m. 50%
12/8/18 7 p.m. zero

A death certificate filed on 12/28/18 identified the resident expired on 12/16/18 at 6:22 p.m. The medical cause of death information identified the following:
Immediate cause of death: cardiopulmonary arrest
Due to or as a consequence of: Alzheimer's disease
Due to or as a consequence of: clostridium difficle colitis

The facility abated the immediate jeopardy on 3/21/19 after initiation of the investigation by implementing the following:

During business hours Monday through Friday all faxes not requiring immediate phone calls will be faxed directly to the receiving doctor at the clinic. If provider not working that day, any doctor will

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respond to said fax within 24 hours.

The charge nurses create a progress note and then fax the progress note to the physician for review and pending any new orders. the charge nurse would expect a return within 24 hours if non-emergent.

If there is a change in condition requiring a phone call to the provider, no fax will be sent but a call will be made directly to the clinic by the charge nurse asking for the provider and will inform the physician of the change in condition. The charge nurse then will either obtain orders by the physician to either monitor condition or provide treatment options.

During off hours Monday through Friday from 5 p.m. until 8:30 of the next morning, or Friday after close of clinic until Monday morning of clinic opening procedure will be as follows: Any non-immediate fax not requiring a phone call will be faxed to the emergency for notification to the doctor. They will respond in 24 hours.

If condition warrants immediate phone call they are to bypass the fax and call immediately out to said provider on condition and await orders. The charge nurse will then make a progress note stating that a phone call has been made and what orders if any were obtained.

The facility will bypass the fax and the ER (emergency room) nurse will then notify the physician to take the call so the charge nurse can speak with the physician right then and not have to wait unless the ER is in the middle of a trauma, code blue or other emergency situations. The charge nurse would expect a return phone call no

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F 580	Continued From page 8 longer than 4 hours later. The DON is the primary to first check. In her absence the chain of command is as follows, assistant DON, QA (quality assurance) nurse, and administrator will be responsible to place a check mark and initial with date and time to note that the fax was looked at. The charge nurses will be making an entry into the nurses notes reflecting noting if the order and follow up.	F 580		
F 609 SS=D	Reporting of Alleged Violations CFR(s): 483.12(c)(1)(4) §483.12(c) In response to allegations of abuse, neglect, exploitation, or mistreatment, the facility must: §483.12(c)(1) Ensure that all alleged violations involving abuse, neglect, exploitation or mistreatment, including injuries of unknown source and misappropriation of resident property, are reported immediately, but not later than 2 hours after the allegation is made, if the events that cause the allegation involve abuse or result in serious bodily injury, or not later than 24 hours if the events that cause the allegation do not involve abuse and do not result in serious bodily injury, to the administrator of the facility and to other officials (including to the State Survey Agency and adult protective services where state law provides for jurisdiction in long-term care facilities) in accordance with State law through established procedures. §483.12(c)(4) Report the results of all investigations to the administrator or his or her	F 609		

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designated representative and to other officials in accordance with State law, including to the State Survey Agency, within 5 working days of the incident, and if the alleged violation is verified appropriate corrective action must be taken.
This REQUIREMENT is not met as evidenced by:
Based on record review and staff interview the facility failed to ensure that all alleged violations involving abuse, neglect, exploitation or mistreatment, including injuries of unknown source and misappropriation of resident property, were reported immediately, but not later than 2 hours after the allegation is made, if the events that cause the allegation involve abuse or result in serious bodily injury, or not later than 24 hours if the events that cause the allegation do not involve abuse and do not result in serious bodily injury, to the administrator of the facility and to other officials (including to the State Survey Agency and adult protective services where state law provides for jurisdiction in long-term care facilities) in accordance with State law through established procedures have evidence that all alleged violations were thoroughly investigated for 1 of 3 residents. Staff B LPN (licensed practical nurse) allegedly knowingly left a heating pad on Resident #8 leaving 3 burn areas. The facility failed to report the incident to the State agency. Facility census was thirty-nine (39) residents.

Findings include:

1. A Minimum Data Set (MDS) with assessment reference date of 10/19/18 assessed Resident #8 with short and long term memory impairments and moderately impaired decision making ability. The resident required limited staff assistance with bed mobility and extensive staff assistance with

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dressing and toileting. The resident had diagnoses that included: stroke and arthritis. The resident had daily indicators of pain. The resident was occasionally incontinent of urine.

A 12/2018 treatment administration record (TAR) identified an order "apply heat pack to affected area QID (four times a day) for 20 minutes as needed every 6 hours as needed for pain".

Nursing progress notes. dated 12/19/18 at 10:24 a.m. identified the resident as resting in bed with eyes closed. The resident did not respond to verbal or physical stimuli.

Nursing progress notes dated 12/20/18 at 10:15 a.m. and documented by the director of nursing (DON) revealed she was called to the resident's room. When the DON entered the room, the CNAs repositioned the resident and the DON observed redness to the resident's back with 3 blisters.

Nursing progress notes dated 12/20/18 at 10:30 a.m. identified "incident report". A certified nurse aide (CNA) called Staff C RN (registered nurse) to the resident's room during morning care to report a heating pad left under the resident overnight which caused redness with possible blisters beginning. Staff removed the heating pad. Staff administered morphine (narcotic) for possible related pain. Staff C documented 3 small burn areas on the mid left back and left iliac crest measuring 1.5 centimeters (cm.) by 0.5 cm., 1.1 cm. by 1.2 cm. and 1.2 cm. by 1.3 cm. The areas were red and intact.

A follow up note regarding the burns documented by the DON and dated 12/21/19 at 9:11 a.m.

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identified no redness. There was a tiny fading pink line to the bottom of the resident's back. There were 3 blisters. 1 cm. by 0.5 cm. fluid filled, 1.1 cm. by 1.2 cm. scabbed area, 1.2 by 1.3 cm. scabbed area. The current treatment received yesterday was TAO (triple antibiotic ointment) with dressing twice a day until healed. The DON identified the areas were healing.

Nursing progress notes dated 12/21/18 at 1:41 p.m. revealed the resident expired.

Staff Interviews:

On 3/20/19 at 2:25 p.m. Staff C RN stated she did not recall who the CNA was that called her to the room. She didn't know what temperature the heating pad was set on. She stated the CNAs removed it before she got to the room. Staff C stated she was not informed by the off going nurse at shift change report that the resident was using the heating pad.

On 3/21/19 at 12:03 p.m. Staff D CNA stated she called another CNA in to help her turn the resident and found the heating pad on the resident right next to her skin under her back. The resident's back was completely red. She stated the night nurse put it on the resident and didn't shut it off. The staff most likely didn't turn her or they would have noticed the heating pad was on her skin and her skin was red. Staff D stated the resident was not really responsive and couldn't turn herself. The resident could move her hands and could not move her clothing.

On 3/21/19 at 12:55 p.m. Staff E LPN stated she phoned Staff B LPN (night nurse) that morning and Staff B informed her that she placed the

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heating pad on the resident's back and left it on all night because it wasn't on the skin. She said she placed it over the resident's pajamas and the bed pad. Staff B told her she placed it on the resident that night and had done so on other previous nights. She stated she couldn't recall all the details of the conversation but it should be in her statement that she wrote that morning. On 3/22/19 at 12:05 p.m. Staff E typed a statement that was emailed to the surveyor saying her statement from 12/21/18 was not available.

On 3/20/19 at 1:59 p.m. the DON stated the resident could not reposition herself. She could only "flail". The resident wouldn't have a clue. Her only verbalization was moaning or groaning. On the same date at 3 p.m. the DON stated there was no policy for using heating pads or warm/hot packs. She stated if the physician ordered a warm/hot pack that staff could use a heating pad if they wanted to.

On 3/22/19 at 10 a.m. Staff B LPN stated she placed the heating pad next to the resident and slightly under the left hip so the heating pad would not fall off the bed. She placed it there so the resident could warm her hands through the night. She assumed no one would move the heating pad and stated she placed it about 8:30 p.m. or 9 p.m. She last checked on it at midnight or 12:30 a.m.

A major injury determination form dated 12/21/18 at 9:30 a.m. informed the physician that the resident had redness to the back and 3 blisters to the back due to "hot pack". The form further identified the "heating pack" was used to help alleviate pain. The resident was Hospice and not getting out of bed. The physician responded on

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F 609	Continued From page 13 the same date at 1:45 p.m. and identified the injuries as NOT a major injury. On 3/21/19 at 11:34 a.m. the Administrator stated the physician returned the major injury form and identified that it was not a major injury. She did not think of reporting for possible abuse. Policy: Facility policy defined "neglect of a dependent adult" as meaning the deprivation of the minimum food, shelter. clothing, supervision, physical or mental health care or other care necessary to maintain the dependent adult's life or physical or mental health. The policy revealed the employee or staff member shall immediately notify the person in charge or the person's designated agent who shall then notify the department within 24 hours or the next business day of such notification.	F 609		
F 610 SS=D	Investigate/Prevent/Correct Alleged Violation CFR(s): 483.12(c)(2)-(4) §483.12(c) In response to allegations of abuse, neglect, exploitation, or mistreatment, the facility must: §483.12(c)(2) Have evidence that all alleged violations are thoroughly investigated. §483.12(c)(3) Prevent further potential abuse, neglect, exploitation, or mistreatment while the investigation is in progress. §483.12(c)(4) Report the results of all investigations to the administrator or his or her designated representative and to other officials in	F 610		

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accordance with State law, including to the State Survey Agency, within 5 working days of the incident, and if the alleged violation is verified appropriate corrective action must be taken. This REQUIREMENT is not met as evidenced by:

Based on record review and staff interview the facility failed to have evidence that all alleged violations were thoroughly investigated for 1 of 3 residents. Staff B LPN (licensed practical nurse) allegedly knowingly left a heating pad on Resident #8 leaving 3 burn areas. Facility census was thirty-nine (39) residents.

Findings include:

1. A Minimum Data Set (MDS) with assessment reference date of 10/19/18 assessed Resident #8 with short and long term memory impairments and moderately impaired decision making ability. The resident required limited staff assistance with bed mobility and extensive staff assistance with dressing and toileting. The resident had diagnoses that included: stroke and arthritis. The resident had daily indicators of pain. The resident was occasionally incontinent of urine.

A 12/2018 treatment administration record (TAR) identified an order "apply heat pack to affected area QID (four times a day) for 20 minutes as needed every 6 hours as needed for pain".

Nursing progress notes. dated 12/19/18 at 10:24 a.m. identified the resident as resting in bed with eyes closed. The resident did not respond to verbal or physical stimuli.

Nursing progress notes dated 12/20/18 at 10:15 a.m. and documented by the director of nursing

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(DON) revealed she was called to the resident's room. When the DON entered the room, the CNAs repositioned the resident and the DON observed redness to the resident's back with 3 blisters.

Nursing progress notes dated 12/20/18 at 10:30 a.m. identified "incident report". A certified nurse aide (CNA) called Staff C RN (registered nurse) to the resident's room during morning care to report a heating pad left under the resident overnight which caused redness with possible blisters beginning. Staff removed the heating pad. Staff administered morphine (narcotic) for possible related pain. Staff C documented 3 small burn areas on the mid left back and left iliac crest measuring 1.5 centimeters (cm.) by 0.5 cm., 1.1 cm. by 1.2 cm. and 1.2 cm. by 1.3 cm. The areas were red and intact.

A follow up note regarding the burns documented by the DON and dated 12/21/19 at 9:11 a.m. identified no redness. There was a tiny fading pink line to the bottom of the resident's back. There were 3 blisters. 1 cm. by 0.5 cm. fluid filled, 1.1 cm. by 1.2 cm. scabbed area, 1.2 by 1.3 cm. scabbed area. The current treatment received yesterday was TAO (triple antibiotic ointment) with dressing twice a day until healed. The DON identified the areas were healing.

Nursing progress notes dated 12/21/18 at 1:41 p.m. revealed the resident expired.

Staff Interviews:

On 3/20/19 at 2:25 p.m. Staff C RN stated she did not recall who the CNA was that called her to the room. She didn't know what temperature the

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heating pad was set on. She stated the CNAs removed it before she got to the room. Staff C stated she was not informed by the off going nurse at shift change report that the resident was using the heating pad.

On 3/21/19 at 12:03 p.m. Staff D CNA stated she called another CNA in to help her turn the resident and found the heating pad on the resident right next to her skin under her back. The resident's back was completely red. She stated the night nurse put it on the resident and didn't shut it off. The staff most likely didn't turn her or they would have noticed the heating pad was on her skin and her skin was red. Staff D stated the resident was not really responsive and couldn't turn herself. The resident could move her hands and could not move her clothing.

On 3/21/19 at 12:55 p.m. Staff E LPN stated she phoned Staff B LPN (night nurse) that morning and Staff B informed her that she placed the heating pad on and left it on all night because it wasn't on the skin. She said she placed it over the resident's pajamas and the bed pad. Staff B told her she placed it on the resident that night and had done so on other previous nights. She stated she couldn't recall all the details of the conversation but it should be in her statement that she wrote that morning. On 3/22/19 at 12:05 p.m. Staff E typed a statement that was emailed to the surveyor saying her statement from 12/21/18 was not available.

On 3/20/19 at 1:59 p.m. the DON stated the resident could not reposition herself. She could only "flail". The resident wouldn't have a clue. Her only verbalization was moaning or groaning. On the same date at 3 p.m. the DON stated there

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was no policy for using heating pads or warm/hot packs. She stated if the physician ordered a warm/hot pack that staff could use a heating pad if they wanted to.

On 3/22/19 at 10 a.m. Staff B LPN stated she placed the heating pad next to the resident and slightly under the left hip so the heating pad would not fall off the bed. She placed it there so the resident could warm her hands through the night. She assumed no one would move the heating pad and stated she placed it about 8:30 p.m. or 9 p.m. She last checked on it at midnight or 12:30 a.m.

A major injury determination form dated 12/21/18 at 9:30 a.m. informed the physician that the resident had redness to the back and 3 blisters to the back due to "hot pack". The form further identified the "heating pack" was used to help alleviate pain. The resident was Hospice and not getting out of bed. The physician responded on the same date at 1:45 p.m. and identified the injuries as NOT a major injury.

Policy:

Facility policy identified that every abuse allegation needed to be thoroughly investigated including: interviewing all potential witnesses to the occurrence, interview all potential witnesses to the reporting of the occurrence and interviewing other persons who might have witnessed similar events where the alleged behavior could have occurred in order to determine scope and frequency.

The facility did not provide evidence of thoroughly investigating the incident or conducting

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F 610	Continued From page 18 interviews.	F 610		
F 656 SS=D	Develop/Implement Comprehensive Care Plan CFR(s): 483.21(b)(1) §483.21(b) Comprehensive Care Plans §483.21(b)(1) The facility must develop and implement a comprehensive person-centered care plan for each resident, consistent with the resident rights set forth at §483.10(c)(2) and §483.10(c)(3), that includes measurable objectives and timeframes to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment. The comprehensive care plan must describe the following - (i) The services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §483.24, §483.25 or §483.40; and (ii) Any services that would otherwise be required under §483.24, §483.25 or §483.40 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(c)(6). (iii) Any specialized services or specialized rehabilitative services the nursing facility will provide as a result of PASARR recommendations. If a facility disagrees with the findings of the PASARR, it must indicate its rationale in the resident's medical record. (iv)In consultation with the resident and the resident's representative(s)- (A) The resident's goals for admission and desired outcomes. (B) The resident's preference and potential for future discharge. Facilities must document whether the resident's desire to return to the community was assessed and any referrals to	F 656		

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local contact agencies and/or other appropriate entities, for this purpose.
(C) Discharge plans in the comprehensive care plan, as appropriate, in accordance with the requirements set forth in paragraph (c) of this section.
This REQUIREMENT is not met as evidenced by:
Based on record review and staff interview, the facility failed to develop and implement a comprehensive person-centered care plan for each resident, consistent with the resident rights that included measurable objectives and timeframes to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment for 1 of 7 residents. Facility census was thirty-nine (39) residents.

Findings include:

1. A Minimum Data Set (MDS) with assessment reference date of 1/11/19 assessed Resident #2 with a brief interview for mental status (BIMS) score of "6" (severe cognitive impairment). The resident required limited staff assistance with bed mobility, transfers and personal hygiene. The resident required extensive staff assistance with toileting and bathing. The resident required supervision with ambulation in the resident room.

Review of resident progress notes dated 12/10/18 at 4:30 p.m. revealed the resident tested positive for clostridium difficle.

Review of the resident care plan for that time frame did not identify the care plan addressed the issue.

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F 656	Continued From page 20 On 3/19/19 at 3:29 p.m. the Administrator stated she checked and did not see the care plan addressed clostridium difficile on the care plan.	F 656		
F 684 SS=J	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 interview the facility failed to ensure that residents received treatment and care in accordance with professional standards of practice, the comprehensive person-centered care plan, and the residents' choices for 1 of 7 residents reviewed. The facility failed to assess Resident #3's condition changes. .The resident was later found to have clostridium difficile (c.difficle) and expired. Cause of death included: c.difficle. Facility census was thirty-nine (39) residents. Findings include: 1. A Minimum Data Set (MDS) with assessment reference date of 11/21/18 assessed Resident #3 with a brief interview for mental status (BIMS) score of "12" (moderate cognitive impairment). The resident required limited staff assistance with bed mobility, transfers, ambulation in and out of room and personal hygiene. The resident	F 684		

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required extensive staff assistance with toileting, dressing and bathing. The resident had functional range of motion limitations of the upper and lower extremities on one side of the body. The resident was occasionally incontinent of bowel. The resident had left hip and left humerus fractures from 10/23/18 and returned to the facility 10/26/18.

Bowel records identified the resident with the following loose stools:
12/2/18 loose diarrhea
12/4/18 4 bowel movements, 3 of them with loose stools
12/5/19 4 bowel movements, at least 3 of them with loose stools
12/6/19 loose stools 2 times
A progress note dated 12/6/18 at 1:49 a.m. revealed the resident had loose stools up to 6 times daily. The night of the entry, the resident was up to the toilet and incontinent 7 times. The resident self transferred so she could make it in time. Staff encouraged the resident not to self transfer. Staff sent this information to the clinic for the resident's physician to review and advise them.
12/7/18 loose stools 2 times
12/8/19 loose stools 7 times

A progress note dated 12/9/18 at 5:51 a.m. revealed the resident loudly called out for help. Staff observed the resident rolling side to side saying she needed the rest room. The resident felt warm to the touch. Vital signs were: temperature 97.9 degrees, pulse 96, respirations 20, blood pressure 112/55 and oxygen saturation 98%. The resident was very weak and unable to stand. The resident's bowel sounds were hypoactive. The resident's skin tented on the

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dorsal aspect of both hands. The resident complained of severe belly cramps. Staff called ER (emergency room) and the resident transported to the hospital.

An ED (emergency department) final report dated 12/9/18 revealed the resident presented weak and dehydrated. The resident's oral mucosa was very dry. The resident's skin turgor was "tenting". The resident's blood laboratory work revealed the following: BUN (blood urea nitrogen) 63 high, creatinine 1.87 high, sodium 146 high, potassium 2.6 low, chloride 118 critical high, CO2 15 low, BUN/creatinine ratio 33.7 high, WBC (white blood cell) 18.8 high. The diagnosis was clostridium difficle (c.difficle) diarrhea.

In comparison, on 10/30/18 the resident's blood laboratory work was: BUN 23 (slightly above normal range of 7 to 20), creatinine 0.84 (normal), sodium 142 (normal), potassium 3.8 (normal), chloride 111 high (normal range 98 to 107), CO2 24 (normal), BUN/creatinine ratio 27.4 (normal), WBC 9.8 (normal)

Hospital discharge documentation dated 12/12/18 identified the resident's admission diagnoses to include: c. difficle colitis, acute diarrhea and acute kidney injury. The discharge diagnoses included: c. difficle colitis currently on oral vancomycin (antibiotic) and IV flagyl (antimicrobial), acute diarrhea slowly improving and acute kidney injury improved. The report revealed the resident would be admitted to skilled care for continued IV fluids and IV antibiotics. Hospice is considered and family will arrive on 12/14/18 to discuss it.

Review of appetite records with percentages of meals eaten revealed a decline in food intake:

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12/2/18 11:24 a.m. 25%
12/2/18 12:38 p.m. 75%

12/3/18 9:23 a.m. 12%
12/3/18 1:11 p.m. refused
12/3/18 6:55 p.m. zero

12/4/18 9:44 a.m. 25%
12/4/18 1:04 p.m. 12%
12/4/18 6:05 p.m. zero

12/5/18 9:45 a.m. 25%
12/5/18 12:44 p.m. 50%
12/5/18 7:04 p.m. zero

12/6/18 9:25 a.m. 12%
12/6/18 12:38 p.m. 12%
12/6/18 7 p.m. 12%

12/7/18 9:26 a.m. 12%
12/7/18 12:28 p.m. 12%
12/7/18 6:13 p.m. 30%

12/8/18 12:07 p.m. 25%
12/8/18 1:01 p.m. 50%
12/8/18 7 p.m. zero

Review of progress notes and other computer information did not identify the facility assessed the resident or took vital signs:

12/3/18 at 11 a.m. the resident saw the physician for back pain. 12/3/18 at 3:14 p.m. The resident returned from ER. The physician ordered Tramadol (narcotic) 50 milligrams (mg.) every 12 hours as needed for pain and follow up in a week. ER reported an x-ray was done and normal. A urinalysis was also performed.

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12/4/18 no documentation of the resident's condition or assessment/vital signs

12/5/18 4:31 p.m. staff did not administer Pericolace to the resident due to loose stools. At 10:44 p.m. staff documented the resident self transferred twice due to loose stools and was incontinent once. The resident denied stomach pain. No assessment/vital signs

12/6/18 at 1:49 a.m. revealed the resident had loose stools up to 6 times daily. The night of the entry, the resident was up to the toilet and incontinent 7 times. The resident self transferred so she could make it in time. Staff encouraged the resident not to self transfer. Staff prepared communication for the physician regarding this. No assessment/vital signs.

12/7/18 No assessment/vital signs

12/8/18 no assessment/vital signs until a late entry documented 12/9/18 at 6:34 a.m. (after the resident went to the hospital) The entry stated the resident had loose stools and decreased appetite. The resident denied pain. The resident's vital signs were in normal ranges, bowel sounds hyperactive. Dry heaves at times. No emesis.

No further documentation until 12/9/18 at 5:51 a.m. when the resident transported to the ER.

On 3/19/19 at 12:39 p.m. Staff A CNA (certified nurse aide) stated she documented the resident had 7 bowel movements on the bowel record on 12/8/18 at 1:59 p.m. She informed the nurse.

On 3/18/19 at 12:48 p.m. the resident's physician

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stated the facility should have conducted vital signs and assessment. She stated the late entry "vital signs normal" was not adequate on 12/8/18 because there was no way to know what the nurse thought was normal.

A death certificate filed on 12/28/18 identified the resident expired on 12/16/18 at 6:22 p.m. The medical cause of death information identified the following:
Immediate cause of death:cardiopulmonary arrest
Due to or as a consequence of: Alzheimer's disease
Due to or as a consequence of clostridium difficle colitis

The facility abated the immediate jeopardy on 3/20/19 after initiation of the investigation by implementing the following:

Nurses were reeducated regarding nursing assessment and intervention. An educational nurses meeting was held on 3/20/19 at 11 a.m. with all nurses with the exception of 3. One was in the hospital and the other 2 worked the night shift. All 3 will be reeducated prior to working.

Nursing education agenda included scenarios on nursing assessment and process for physician notifications. Proper interventions and follow up to significant change in condition on residents. Review of facility processes in regard to interventions, change in condition and incident follow ups. New process for routing faxes to health care providers.

The DON and/or her designee will monitor and track healthcare provider communications and resident condition changes to ensure appropriate

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	165352	A. BUILDING _____ B. WING _____	C 04/01/2019

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EMMETSBURG CARE CENTER	2405 21ST STREET EMMETSBURG, IA 50536

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F 684	Continued From page 26 and timely communication with providers.	F 684		
F 689 SS=G	Free of Accident Hazards/Supervision/Devices CFR(s): 483.25(d)(1)(2) §483.25(d) Accidents. The facility must ensure that - §483.25(d)(1) The resident environment remains as free of accident hazards as is possible; and §483.25(d)(2)Each resident receives adequate supervision and assistance devices to prevent accidents. This REQUIREMENT is not met as evidenced by: Based on record review and staff interview the facility failed to ensure that the resident environment remained as free of accident hazards as is possible; and each resident received adequate supervision and assistance devices to prevent accidents for 1 of 3 residents. Staff B LPN (licensed practical nurse) allegedly knowingly left a heating pad on Resident #8 leaving 3 burn areas. Facility census was thirty-nine (39) residents. Findings include: 1. A Minimum Data Set (MDS) with assessment reference date of 10/19/18 assessed Resident #8 with short and long term memory impairments and moderately impaired decision making ability. The resident required limited staff assistance with bed mobility and extensive staff assistance with dressing and toileting. The resident had diagnoses that included: stroke and arthritis. The resident had daily indicators of pain. The resident was occasionally incontinent of urine.	F 689		

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A 12/2018 treatment administration record (TAR) identified an order "apply heat pack to affected area QID (four times a day) for 20 minutes as needed every 6 hours as needed for pain".

Nursing progress notes. dated 12/19/18 at 10:24 a.m. identified the resident as resting in bed with eyes closed. The resident did not respond to verbal or physical stimuli.

Nursing progress notes dated 12/20/18 at 10:15 a.m. and documented by the director of nursing (DON) revealed she was called to the resident's room. When the DON entered the room, the CNAs repositioned the resident and the DON observed redness to the resident's back with 3 blisters.

Nursing progress notes dated 12/20/18 at 10:30 a.m. identified "incident report". A certified nurse aide (CNA) called Staff C RN (registered nurse) to the resident's room during morning care to report a heating pad left under the resident overnight caused redness with possible blisters beginning. Staff removed the heating pad. Staff administered morphine (narcotic) for possible related pain. Staff C documented 3 small burn areas on the mid left back and left iliac crest measuring 1.5 centimeters (cm.) by 0.5 cm., 1.1 cm. by 1.2 cm. and 1.2 cm. by 1.3 cm. The areas were red and intact.

Hospice notes dated 12/20/18 at 10:45 a.m. revealed the resident had 3 small blistered areas on the low back. When they arrived, a CNA repositioned the resident and informed Hospice of 3 burned areas on the mid to low back. The CNA stated the resident had a heating pad on her back that was found when day shift came to

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reposition the resident. There was one area in the mid back that was purple in color and measured 0.5 cm. and 0.5 cm. Skin intact. She had 2 small burn blister areas on the low back with blisters open. Nursing staff will apply antibiotic ointment and cover with telfa. The resident was awake and responsive with mumbling. When positioned on her back, the resident fidgeted with facial grimaces. Hospice requested nurse administer morphine (narcotic).

A follow up note regarding the burns documented by the DON and dated 12/21/19 at 9:11 a.m. identified no redness. There was a tiny fading pink line to the bottom of the resident's back. There were 3 blisters. 1 cm. by 0.5 cm. fluid filled, 1.1 cm. by 1.2 cm. scabbed area, 1.2 by 1.3 cm. scabbed area. The current treatment received 12/20/18 was TAO (triple antibiotic ointment) with dressing twice a day until healed. The DON identified the areas were healing.

Nursing progress notes dated 12/21/18 at 1:41 p.m. revealed the resident expired.

Staff Interviews:

On 3/20/19 at 2:25 p.m. Staff C RN (registered nurse) stated she did not recall who the CNA was that called her to the room. She didn't know what temperature the heating pad was set on. She stated the CNAs removed it before she got to the room. Staff C stated she was not informed by the off going nurse at shift change report that the resident was using the heating pad.

On 3/21/19 at 12:03 p.m. Staff D CNA stated she called another CNA in to help her turn the resident and found the heating pad on the

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resident right next to her skin under her back. The resident's back was completely red. She stated the night nurse put it on the resident and didn't shut it off. The staff most likely didn't turn her or they would have noticed the heating pad was on her skin and her skin was red. Staff D stated the resident was not really responsive and couldn't turn herself. The resident could move her hands but could not move her clothing.

On 3/21/19 at 12:55 p.m. Staff E LPN stated she phoned Staff B LPN (night nurse) that morning and Staff B informed her that she placed the heating pad on and left it on all night because it wasn't on the skin. She said she placed it over the resident's pajamas and the bed pad. Staff B told her she placed it on the resident that night and had done so on other previous nights. She stated she couldn't recall all the details of the conversation but it should be in her statement that she wrote that morning. On 3/22/19 at 12:05 p.m. Staff E typed a statement that was emailed to the surveyor saying her statement from 12/21/18 was not available.

On 3/20/19 at 1:59 p.m. the DON stated the resident could not reposition herself. She could only "flail". The resident wouldn't have a clue. Her only verbalization was moaning or groaning. On the same date at 3 p.m. the DON stated there was no policy for using heating pads or warm/hot packs. She stated if the physician ordered a warm/hot pack that staff could use a heating pad if they wanted to.

On 3/20/19 at 3:06 p.m. Staff F CNA stated she went in the resident's room at 2 a.m. and adjusted the resident but didn't move her much. She noticed the heating pad by seeing the light

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on the heat control of the heating pad. She assumed the nurse monitored the heating pad. She wasn't aware the nurse had not taken it off. Staff F didn't recall who the nurse was. She stated she never moved the heating pad.

On 3/22/19 at 10 a.m. Staff B LPN stated she placed the heating pad next to the resident and slightly under the left hip so the heating pad would not fall off the bed. She placed it there so the resident could warm her hands through the night. She assumed no one would move the heating pad and stated she placed it about 8:30 p.m. or 9 p.m. She last checked on it at midnight or 12:30 a.m.

A major injury determination form dated 12/21/18 at 9:30 a.m. informed the physician that the resident had redness to the back and 3 blisters to the back due to "hot pack". The form further identified the "heating pack" was used to help alleviate pain. The resident was Hospice and not getting out of bed. The physician responded on the same date at 1:45 p.m. and identified the injuries as NOT a major injury.

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